ANNUAL REPORT AND ACCOUNTS

2025/26

PROUD TO CARE

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Annual Report and Accounts 2025/26

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a)
of the National Health Service Act 2006

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Foreword from the Chair

Welcome

Bob Alexander, Interim Chair, North West London Acute Provider Group

On behalf of all four acute trusts in north west London—Chelsea and Westminster Hospital, Imperial College Healthcare, London North West University Healthcare and The Hillingdon Hospitals—we should be proud to reflect on a year defined by achievement, commitment and a strong sense of shared purpose, during a time of significant challenge for the whole of the NHS.

The four trusts have been working increasingly closely together as the North West London Acute Provider Collaborative, now Group. This has enabled us to strengthen our collective contribution to the health and care of the 2.4 million people of north west London and many more beyond.

This progress is reflected in the new NHS oversight framework or 'league tables'. As of the end of September, the latest results showed three of our trusts in the highest performing category, with the other in category 2, representing some of the biggest in-year improvements in the NHS. These results show tangible benefits for patients and local communities, and are a tremendous credit to our staff, to whom I am very grateful on behalf of the Board in Common for all their hard work and expertise.

More joined-up working across acute care in north west London is also helping us deliver broader service transformations. Last year, that included a new care pathway for people with sickle cell disease across London North West University Healthcare and Imperial College Healthcare. We were able to create a dedicated unit at Hammersmith Hospital for people in sickle cell crisis, enabling them to avoid emergency department waits and get immediate access to specialist care. At the same time, we are planning a bigger facility for outpatient sickle cell care at Central Middlesex Hospital, allowing us to expand treatment offers to our shared population.

Research and innovation is a growing focus across all our trusts too, drawing on a range of academic partnerships. Last year saw the UK's first birth following a womb transplant at Queen Charlotte's and Chelsea Hospital. And the North West London Commercial Research Delivery Centre at Northwick Park Hospital has one of the highest numbers of active studies nationally and ranks in the top five for participant recruitment.

These developments are underpinned by a growing, shared infrastructure and common ways of working. Our trusts have shared an electronic patient record since 2023, allowing teams to see complete information for individual patients and helping to drive improvements. For example, last year our trusts developed a single approach to identifying and recording patients at risk of deteriorating, which supports clinical teams to follow best clinical practice consistently. We are also streamlining our staff systems, for example setting up staff 'passports' to enable staff to work across different trusts without having to duplicate mandatory training.

It is important to note last year's key milestones in the evolution of our partnership. To enable us to simplify and speed up shared decision-making, we agreed to formalise our Collaborative by becoming a Group. Professor Tim Orchard was appointed as the Group's

first chief executive and the accountable officer for all four trusts, and the Group was established on 1 April 2026.

I am very grateful to Tim Orchard and the other trust chief executives, Lesley Watts and Pippa Nightingale, and the wider executive teams for their commitment and focus while leading their organisations through significant change.

I look forward to working more closely with Professor Julian Redhead, who became interim chief executive of Imperial College Healthcare on 1 April 2026. We will also be seeking a new trust-level chief executive for London North West University Healthcare during 2026, as we will sadly be saying goodbye to Pippa following her recent appointment as chief executive for Bedfordshire Hospitals.

Meanwhile, Matthew Swindells, whose vision enabled us to begin our journey to become a Group, completed his four-year term as Chair of all four trusts at the end of March. We are incredibly grateful to Matthew; his guidance and expertise has been instrumental to all we have achieved so far. Many thanks too to all our non-executive directors, with a number of changes during the year as we adapted our governance to support our Group approach.

There is, of course, much we need to do but I am excited to see what we can achieve in the year ahead with and for our patients, local communities and staff.

Bob Alexander
Interim Chair, North West London Acute Provider Group

SECTION 1

PERFORMANCE REPORT

OVERVIEW OF PERFORMANCE

Statement from the Chief Executive

It is with pride that I present the 2025/26 Annual Report for Chelsea and Westminster Hospital NHS Foundation Trust.

This has been another demanding year for the NHS, requiring resilience, focus and adaptability from our teams. Despite sustained operational pressures, rising demand and ongoing financial challenge across the system, our staff have continued to deliver safe, compassionate and high-quality care for patients. Throughout the year, we have remained committed to transforming how care is delivered, making best use of innovation, collaboration and data, while keeping patient experience at the heart of everything we do.

It has been a busy and at times challenging 12 months for the Trust. We have sustained performance across our core services while continuing to improve care for those in our communities who need us most—particularly patients with complex needs and those living with frailty. A key focus this year has been improving patient flow and access to care across urgent and emergency pathways. Initiatives such as the Fit to Sit project, which provides additional capacity in the emergency department for ambulant patients, improvements to emergency department waiting areas at West Middlesex, and the expansion of discharge-ready capacity have helped patients be assessed, treated and discharged more efficiently, while maintaining safety and quality.

Alongside this, we have continued to strengthen how we care for older patients and those living with frailty. The launch of the Same Day Emergency Care frailty pilot at West Middlesex has enabled rapid assessment and treatment, helping to avoid unnecessary admissions and deliver more responsive, personalised care. These developments reflect our continued commitment to safe, timely and patient-centred services.

Urgent and emergency care remained under significant pressure throughout the year, particularly during the winter months. I want to thank colleagues across our emergency departments, acute wards and supporting services for their extraordinary efforts. Our teams have maintained performance close to national standards, reduced long waits, and ensured patient safety remained our highest priority—even during periods of industrial action and increased infection risk. We recognise that patient flow and timely discharge remain inconsistent, and improving this will continue to be a core priority in the year ahead.

Recovery of elective care has remained a major priority. We have continued to treat cancer and urgent patients first, while focusing on reducing the number of longest waiting patients. Referral to Treatment performance improved steadily over the year. Clinical teams demonstrated flexibility and commitment, delivering additional activity through revised theatre and outpatient timetables and, in some services, super-surgery weekends. These efforts have enabled us to treat more patients and make meaningful progress on elective recovery.

A significant achievement this year was the opening of the new Day Surgery Unit at Chelsea and Westminster Hospital. The purpose-built facility has expanded our surgical and recovery capacity, with two state-of-the-art theatres supporting a wider range of procedures in the day surgery setting. Recovery capacity has increased substantially through individual patient spaces that enhance privacy, safety and patient experience while reducing unnecessary bed transfers. The inclusion of a dedicated anaesthetic block

room is supporting quicker recovery and improved outcomes, while releasing capacity in main theatres for more complex surgery, including greater use of surgical robotics.

Digital innovation and the smarter use of data have continued to underpin progress across the Trust. Major digital developments delivered clear operational benefit this year, including the introduction of the Demand Centre and the inpatient theatre scheduling tool, supporting safer, more efficient and more reliable care.

Our commitment to innovation has also been recognised nationally. Our virtual ward programme received national recognition at the Royal College of Physicians' Excellence in Patient Care Awards for digital transformation, reflecting its positive impact on patient flow and early discharge. We also played a leading role in the national rollout of Cancer 360, a digital tool that brings together cancer patient information, reduces administrative burden and accelerates diagnosis and treatment.

We have continued to invest in our estate and infrastructure to support future service delivery. At West Middlesex University Hospital, development has progressed on the Diagnostic, Treatment and Education Centre (DTEC), a major new facility, scheduled to open later in 2026, that will transform early diagnosis and support better outcomes for the local community. The centre will deliver modern diagnostic and treatment services for cancer, renal conditions and advanced imaging, alongside high-quality education and training space for staff. Designed as an all-electric building and aligned to national wayfinding guidance, DTEC reflects our long-term commitment to sustainability, workforce development and reducing health inequalities.

Our performance this year has been reflected in the latest NHS Oversight Framework results. In the most recent Quarter 3 publication, Chelsea and Westminster ranked 11th among acute trusts nationally and continues to sit in Segment 1, the highest oversight category. The Trust achieved High Performing ratings across access, patient safety, workforce, finance and productivity, with an Above Average rating for effectiveness and experience of care, providing strong external assurance of performance.

None of this progress would be possible without the dedication, professionalism and compassion of our people. The 2025 NHS Staff Survey results reflected this strength, with more than half of our staff taking part and the Trust ranking above the national acute average across all nine NHS People Promise elements. These results demonstrate strong engagement, a positive learning culture and growing confidence in speaking up.

While we are encouraged by these results, we also recognise where further improvement is needed, particularly in ensuring that every colleague experiences a safe and inclusive working environment. We remain committed to listening closely to staff feedback and taking action where it matters most.

This year also brought significant challenges. Financial constraints, workforce pressures and rising demand required sustained focus and difficult decisions. While not all ambitions were achieved, we remained committed to learning, improvement and responsible stewardship of resources. A strong grip on productivity and cost improvement, including major progress in reducing unnecessary pathology testing, has helped strengthen our position while continuing to support high-quality care.

Looking ahead, we will accelerate partnership working across the newly formed North West London Acute Provider Group and the wider system. Working at Group scale will

support shared learning, stronger clinical collaboration and more effective use of expertise, while maintaining clear local leadership and accountability at our Trust. Alongside this, we will continue to invest in our people and infrastructure, and build on the use of innovation and data to improve outcomes and experience for our patients.

I would like to thank our staff, partners, patients and local communities for their continued trust and support. It is through this shared commitment that we will continue to strengthen our services and make a meaningful difference for the people we serve.

Our values

The Trust values are firmly embedded throughout our organisation. They outline the standard of care and experience that our patients and members of the public should expect from any of our staff and services.

They are:

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

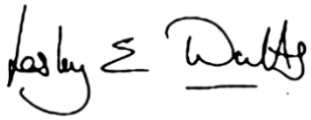
Our priorities

Our Board-agreed strategic priorities have remained the same as the previous year:

Strategic priority 1: Deliver high-quality, patient-centred care
Patients, their friends, family and carers will be treated with unfailing kindness and respect by every member of staff in every department, and their experience and quality of care will be second to none.

Strategic priority 2: Be the employer of choice
We will provide every member of staff with the support, information, facilities and environment they need to develop in their roles and careers. We will recruit and retain the people we need to deliver high-quality services to our patients.

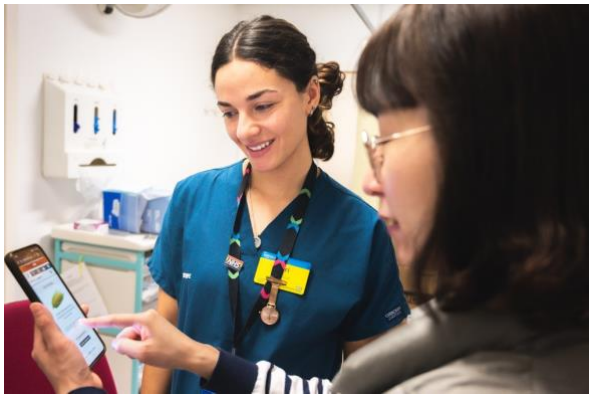
Strategic priority 3: Delivering better care at lower cost
We will look to continuously improve the quality of care and patient experience through the most efficient use of available resources, including financial and human resources, staff, partners, stakeholders, volunteers and friends.



Lesley Watts
Chief Executive Officer

The year in photos

April 2025



We joined a national trial exploring if early iron supplements in pregnancy can improve outcomes.

We launched a new Timely Care Hub to improve real-time discharge planning and ward oversight.

May 2025

Our International Medical Graduate Programme was shortlisted for a national RCP Excellence in Patient Care Award.

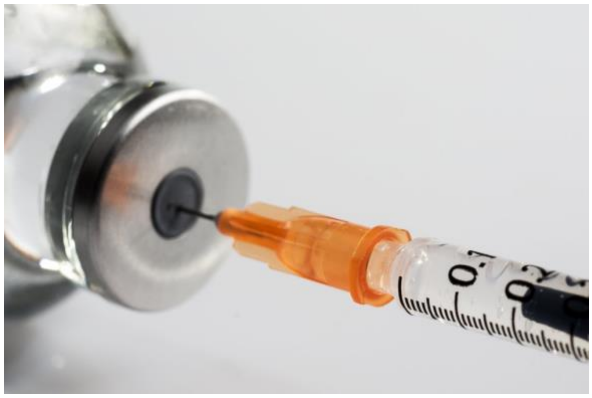
We brought communities together to raise awareness of women's health inequalities and support more equitable, inclusive care.

June 2025

We won national recognition for digital innovation and AI-enabled care at the HSJ Digital Awards.

We hosted an international conference on global health challenges, Hot Topics in Global Health.

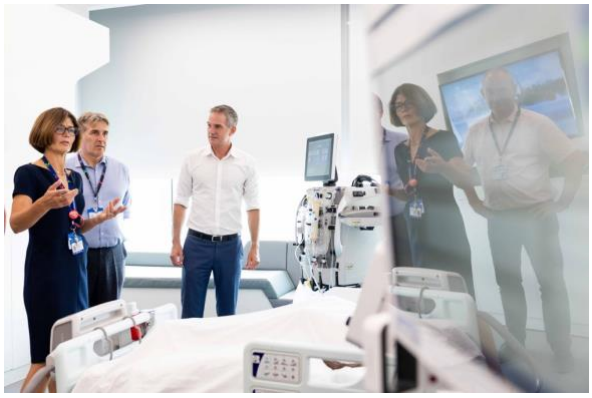
July 2025



Our sexual health services joined a world-first NHS vaccination programme to help prevent gonorrhoea.

Our cardiac virtual ward team won national recognition for using digital technology to improve care for patients at home.

August 2025



We were recognised nationally as an AI exemplar supporting patient care during a government visit.

Our night-shift cleaners were featured in a Wellcome Collection story celebrating NHS unsung heroes.

September 2025

We collaborated on SAFE, a film centred on trans, queer and non-binary lives.

We marked World Patient Safety Day by highlighting innovations improving safety for newborns, children and families.

October 2025

National policymakers visited our sexual health services to learn from our innovative approaches to care and testing.

More than 150 walkers raised more than £27,000 for CW+ to support care, wellbeing and innovation across our hospitals.

November 2025

Opt-out testing in our Emergency Departments identified 67 people with HIV, supporting the goal to end new transmissions by 2030.

Sexual Health Hounslow and Hounslow Council launched a campaign helping women access trusted contraception advice and services.

December 2025

Chelsea FC and Brentford FC brought festive cheer to patients, families and staff across our hospitals.

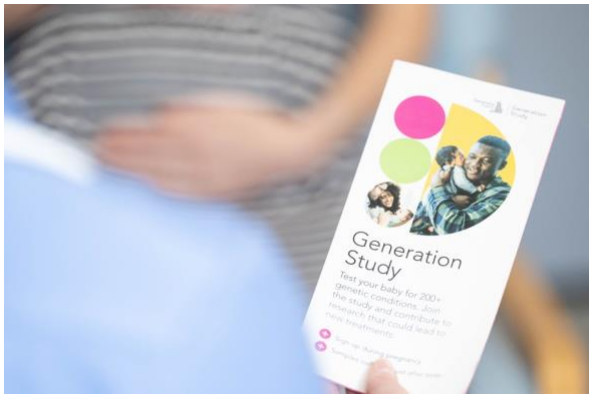
We celebrated 30 years of the Magill Symposium, showcasing innovation in anaesthesia, critical care and perioperative medicine.

January 2026

We launched a first-in-human trial of new vaccines against Ebola, Marburg and Lassa fever in partnership with Imperial College London.

We launched a new specialist valve clinic, improving access to earlier diagnosis and care for patients with heart valve disease.

February 2026



More than 2,400 newborns joined the Generation Study, a national study screening for over 200 rare genetic conditions.

Our Fit to Sit programme enabled A&E patients who did not need a cubicle to receive faster assessment and treatment.

March 2026

We became the first NHS Trust to use augmented reality technology to help patients better understand endometriosis and their treatment.

Young people worked with clinicians and researchers to help shape future child health research and NHS services.

History and statutory background of the Trust

Chelsea and Westminster Hospital NHS Foundation Trust (the Trust) has operated as a statutory body since 1 October 2006, established under the Health and Social Care (Community Health and Standards) Act 2003. The organisation took a significant step forward in 2015 with the acquisition of West Middlesex University Hospital NHS Trust, bringing together two major acute hospitals alongside an expanding portfolio of community services.

Chelsea and Westminster Hospital opened in 1993 on the former St Stephen's Hospital site, bringing together the heritage, expertise and staff of five long-standing London hospitals: Westminster Hospital, Westminster Children's Hospital, West London Hospital, St Mary Abbots Hospital and St Stephen's Hospital. These institutions, some dating back to the 18th and 19th centuries, contributed a rich legacy of pioneering practice, from maternity innovation and paediatric care to infectious disease treatment.

West Middlesex University Hospital has an equally longstanding role within its community. First established in 1894 as the Brentford Workhouse Infirmary, it evolved into West Middlesex Hospital by the early 20th century and underwent major redevelopment between 2001 and 2003, with ongoing modernisation to meet current clinical needs. Today, both hospitals provide state-of-the-art facilities and remain central to the communities they serve.

We are a member of the North West London Acute Provider Collaborative (Acute Provider Group as of 1 April 2026), a formal partnership with the other acute NHS trusts in the sector: Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundation Trust. We work together to make the most effective use of our collective resources to provide better care, for more people, more fairly. Between us, we run 13 hospitals, employ around 33,000 staff and serve a local population of more than 2.2 million. We remain independent organisations with a Chair in Common and a Board in Common.

Purpose and activities of the Trust

The Trust delivers a broad range of acute and specialist services across its two hospital sites—Chelsea and Westminster Hospital and West Middlesex University Hospital—both of which host major A&E departments and provide one of the largest maternity services in the country.

Our specialist services include the regional burns service, an extensive children's programme, cardiology intervention and nationally recognised HIV care. We also deliver a wide portfolio of community and outreach services, including our award-winning sexual health provision, which extends beyond our immediate catchment into neighbouring boroughs.

As a committed partner within the North West London Integrated Care System (ICS), we work alongside NHS organisations and local authorities to support population health, ensure high-quality and equitable access to services, and deliver integrated planning and governance. In line with NHS England's expectations, we have exercised our statutory functions in alignment with ICB plans and have contributed to joint capital and service planning arrangements across the system.

Through the North West London Acute Provider Collaborative, we work closely with Imperial College Healthcare NHS Trust, The Hillingdon Hospitals NHS Foundation Trust and London North West University Healthcare NHS Trust. Together, we focus on reducing unwarranted variation, reducing health inequalities and coordinating mutual aid—for example, diagnostics and long-wait recovery in gynaecology.

The Trust serves a population of more than one million people across Brent, Central London, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, Richmond and Wandsworth. In addition, our specialist services support patients across wider London and nationally.

We also maintain strong partnerships with local authorities, including engagement with Health and Wellbeing Boards, Scrutiny Committees and local Healthwatch groups.

Five-year strategy

In September 2024, we launched an updated Clinical Services Strategy shaped through extensive engagement with patients, staff, partners and community representatives. The strategy sets out a five-year vision across acute and specialised care, population health, equity and sustainability, research, innovation and workforce development. Progress against delivery milestones is monitored through the Trust's Executive Management Board, with oversight from the Trust's Standing Committee.

Equality of service delivery

The Trust is committed to ensuring that all patients receive fair, equitable and personalised care. Rooted in our values and strategic priorities, we aim to eliminate discrimination and remove barriers to access so that every part of our diverse community can benefit from high-quality services.

In delivering services, the Trust has had due regard to the Public Sector Equality Duty, using data on protected characteristics, deprivation and access to identify and address unwarranted variation in outcomes and experience across different population groups.

As a provider of wide-ranging acute and community services, we continue to refine how our services meet the needs of different groups. Over 2025/26, as part of the North West London Acute Provider Collaborative, we strengthened our use of data and system-wide metrics to reduce health inequalities, supporting equitable access to services and embedding inclusive practices across care pathways.

Tackling health inequalities

Reducing health inequalities remains a core priority for the Trust and is embedded within our role as part of the North West London system. In line with NHS England's statement under section 13SA(1) of the NHS Act 2006, the Trust has strengthened its approach to collecting, analysing and acting on information relating to health inequalities, using this insight to inform service improvement and resource prioritisation.

Working through the North West London Acute Provider Group (APG), the wider Integrated Care System and local authorities, the Trust uses population health data to identify unwarranted variation in access, experience and outcomes. Analysis of deprivation, ethnicity and other population characteristics has highlighted inequalities

across key pathways, including outpatient attendance, elective waiting times, maternity access and urgent care.

In response, the Trust has aligned to shared APG priorities focused on four system-wide ‘access’ metrics—outpatient did-not-attend (DNA) rates, referral to treatment waits over 40 weeks, late maternity booking and timely pain relief for patients with sickle cell disease—as set out in the paper received by the Board in Common in April 2026.

Targeted interventions have been implemented to address these inequalities. These include deprivation-informed patient outreach and booking approaches to reduce non-attendance, strengthened waiting list management to support equitable elective recovery, community engagement to improve early maternity access, and improved pathways for timely pain relief in sickle cell services. This work has been supported by improved data capture and standardised reporting across the Group to enable consistent monitoring and benchmarking.

Through these actions, the Trust has seen improved engagement with priority population groups, better identification of patients at risk of non-attendance, and strengthened system oversight of health equity metrics. This includes enhanced use of data to understand the underlying drivers of inequality and inform service redesign.

The Trust’s Health Inequalities Committee provides oversight of this programme, bringing together clinical and operational leaders to review data, share learning and track delivery. Delivering and sustaining improvement requires ongoing engagement across clinical services, supported through the NWL Health Equity Working Group, which brings together expertise from across the Acute Provider Group, the Integrated Care Board, local authorities and academic partners. Progress is reported through the Trust’s governance structures and to the Acute Provider Group Executive Management Board and Board in Common on a six-monthly basis, ensuring that consideration of health inequalities is embedded within decision-making and aligned with the Well-Led framework.

The Trust will continue to build on this work in 2026/27, with a focus on embedding equity within clinical pathways, strengthening collaboration across the Acute Provider Group and improving outcomes for the population of north west London.

Principal risks for 2025/26

The Trust’s principal risks are derived from the Board Assurance Framework (BAF) and represent those that could materially impact the achievement of the Trust’s strategic objectives. These are reviewed regularly by the Board and its committees, including consideration of controls, assurances and mitigating actions.

The principal risks are set out below, aligned to the Trust’s strategic priorities. Further detail on the governance, controls and assurance framework is provided in the Annual Governance Statement (AGS).

Strategic priority 1: Deliver high-quality, patient-centred care

- **Principal risk:** Failure to ensure the application of clinical and operational processes within an increasingly complex environment could compromise the delivery of outstanding, high-quality, safe and patient-centred care.
  Key controls and mitigations: Established clinical governance frameworks including clinical guidelines, audit programmes, Patient Safety Incident Response Framework (PSIRF), quality deep dives and ward accreditation, with oversight through executive and Board governance structures.

- **Principal risk:** Failure to innovate and coproduce quality improvements with our staff, patients, carers and stakeholders/partners could drive health inequalities in outcomes and patient experience.

  Key controls and mitigations: Quality Improvement programme, patient and public involvement arrangements, and structured governance through Trust committees and improvement boards, supported by training and established methodologies.

- **Principal risk:** Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.

  Key controls and mitigations: Research and innovation governance structures, including the Research Strategy Board, academic partnerships and executive oversight through executive and Board governance structures.

- **Principal risk:** Risk that the population's continuously changing need for services exceeds the Trust's capability and capacity to respond in a timely way—where there are instances of demand outstripping supply, there is a risk that quality and safety of care will be compromised, the needs of service users could be insufficiently met, and this will lead to poorer health outcomes and experiences.

  Key controls and mitigations: Demand and capacity planning, integrated performance reporting, system-wide coordination through the Integrated Care System (ICS) and provider collaborative, and oversight through executive and Board governance structures.

Strategic priority 2: Be the employer of choice

- **Principal risk:** Insufficient or ineffective planning for current and future workforce requirements (including number of staff, skill mix and training) may lead to impaired ability to deliver the quantity of healthcare services to the required standards of quality, and inability to achieve the business plan and strategic objectives.

  Key controls and mitigations: People Strategy, workforce planning processes, Workforce Development Committee oversight, and system-level coordination through North West London (NWL) and wider National Health Service (NHS) governance structures.

- **Principal risk:** Failure to look after our staff's physical and mental wellbeing could lead to reduced retention of staff, increased sickness levels, pressure on staff and decreased resilience, poor staff morale, over-reliance on agency staffing at high cost/premiums, potential impairment in service quality, and loss of the Trust's strategic ambition to be the employer of choice.

  Key controls and mitigations: Health and wellbeing programmes, People Promise initiatives, workforce performance monitoring, and targeted interventions overseen through executive and Board governance structures.

- **Principal risk:** Failure to maintain a coherent and coordinated structure and approach to succession planning, organisational development and leadership development may jeopardise the development of robust clinical and non-clinical leadership to support service delivery and change, staff being supported in their career development and to maintain competencies and training attendance, staff retention, and the Trust being a 'well-led' organisation under the Care Quality Commission (CQC) domain.

  Key controls and mitigations: Organisational development and leadership programmes, People Strategy delivery structures and oversight through executive and Board governance structures.

- **Principal risk:** A failure to develop and maintain our culture in line with the Trust values and the NHS People Promise, which includes being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety and wellbeing of staff, working flexibly, supporting learning and development, promoting equality, diversity and inclusivity and fostering a team culture—the absence of this could result in harm to staff, an inability to recruit and retain staff, a workforce which does not reflect Trust and NHS values, and poorer service delivery.

  Key controls and mitigations: People Promise programme, equality, diversity and inclusion (EDI) initiatives, staff engagement mechanisms, workforce performance reporting and oversight through executive and Board governance structures.

Strategic priority 3: Delivering better care at lower cost

- **Principal risk:** Failure of the integrated care systems and provider collaboratives in which we work to deliver transformation, reduce health inequalities, integrated care, maintain financial equilibrium and share risk responsibly may impact adversely compromising service delivery and the quality of patient care.

  Key controls and mitigations: System governance arrangements across the Integrated Care System (ICS) and Acute Provider Collaborative, joint planning forums and oversight through executive and Board governance structures.

- **Principal risk:** Failure to deliver a fit for purpose digital and physical estate to deliver the Trust's clinical strategy and strategic objectives through ineffective business planning arrangements and/or inadequate mechanisms to track and control delivery of plans and programmes.

  Key controls and mitigations: Capital programme governance, estates and digital strategies, and programme oversight through executive and Board governance structures.

- **Principal risk:** Failure to deliver the financial plan and maintain financial sustainability, including, but not limited to non-delivery of cost improvement programme (CIP) savings, budget overspends, underfunding and constraints of block contracts in the context of increasing levels of activity and demand—this could lead to an inability to deliver core services and health outcomes, financial deficit, intervention by NHS England, NWL ICS constraints, and insufficient cash to fund future capital programmes.

  Key controls and mitigations: Financial planning processes, grip and control framework, cost improvement programme (CIP) governance, and oversight through executive and Board governance structures.

- **Principal risk:** Failure to protect the integrity and security of our information could lead to cyberattacks which could compromise the Trust's infrastructure and ability to deliver services and patient care, data loss or theft affecting patients, staff or finances, reputational damage and/or personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions).

  Key controls and mitigations: Cyber security controls including monitoring systems, disaster recovery arrangements, staff training, and oversight through information governance and audit structures within the Trust.

- **Principal risk:** Failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and sustain improvements in line with national targets and 'For a Greener NHS' ambitions could lead to failure to meet Trust and system objectives, reputational damage, loss of contracts and missed opportunities.

  Key controls and mitigations: Sustainability strategy, Green Plan delivery structures and governance oversight through executive and Board governance structures.

- **Principal risk:** Failure to maintain adequate business continuity and emergency planning arrangements to sustain core functions and deliver safe and effective services during a widespread and sustained emergency or incident, for example a pandemic.

  Key controls and mitigations: Emergency planning, resilience and response arrangements, business continuity plans, training and testing programmes, with oversight through executive and Board governance structures.

Going concern

The Trust has submitted a breakeven plan for 2026/27. As at 31 March 2026 the Trust holds £118m of cash reserves and has a forecast cash balance of £123m at 31 March 2027.

The directors are confident that there is a reasonable expectation that the Trust will continue to have adequate cash resources to service its operational activities in cash terms for the next 12 months and into 2027/28. The NHS clinical payment structures for the Trust have remained largely unchanged, with fixed and variable elements to the contract. The impact of any changes to funding and the cash regime has been taken into account for the Trust's plans and projections, including cash flows, liquidity and income base.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's *Financial Reporting Manual*.

PERFORMANCE ANALYSIS

How the Trust measures performance

The work of the Trust Board of Chelsea and Westminster Hospital NHS Foundation Trust is underpinned by six key committees—namely the Trust Standing Committee, Quality Committee, People and Workforce Committee, Audit and Risk Committee, Finance and Performance Committee and the Nominations and Remuneration Committee.

Board level

The Trust Standing Committee, Quality Committee, People and Workforce Committee and Finance and Performance Committee receive the integrated performance report comprising a number of key performance indicators (KPIs) with associated commentary to explain variances and detail the actions in place to deliver improvement.

The KPIs cover a range of contractual and internally determined metrics, providing a balanced scorecard for the Trust's performance across the four domains of regulatory compliance, quality, efficiency and workforce. Each KPI, where appropriate, has a target based on either the contractual performance standard or an internally set target, based on benchmarking information from a peer group of other NHS organisations.

The integrated performance report presents the KPIs for both hospital sites independently, as well as the combined Trust performance. Trend data is also provided for the last 12 months to enable the Trust Board to track progress over time.

The Trust Board receives a quarterly integrated performance and quality report which enables triangulation of outcomes and performance across the domains of access, quality, people and finance. This report includes comparator information of performance across the other three trusts in the North West London Acute Provider Collaborative while also giving nationally benchmarked performance positions. These arrangements complement a rigorous regime of internal and external audit and accountability to the Trust Board, the North West London Acute Provider Collaborative, the North West London Integrated Care Board, NHS England and our regulatory bodies. The Board also receives a summary of the Trust's financial performance, with more detailed information provided to and scrutinised by the Finance and Performance Committee.

Divisional level

Performance at the divisional level is scrutinised through monthly divisional performance review meetings, providing an opportunity for executive directors to have a more detailed discussion with divisional teams to support performance improvement initiatives, and to celebrate good performance while also challenging underperformance. Divisional performance reviews are supported with the relevant division's performance information against the committee and Board-level KPIs, supplemented by additional performance information relevant to the priorities of the division concerned.

A comprehensive programme of specialty-based deep dives has been fully embedded across the organisation for a number of years. These reviews are executive-led and held with the specialty multidisciplinary teams to review their quality, workforce and efficiency metrics.

Additionally, a weekly performance meeting led by the Managing Directors is in place to monitor the key performance metrics across both sites and to monitor data quality. Performance against the elective recovery plan is also shared on a frequent basis through the Executive Management Board and all-staff webinars.

To support effective operational performance, the Trust employs a team of specialist information professionals who provide analytical support to all parts of the organisation and service the Trust's internal and external reporting obligations.

Performance information is provided to the organisation routinely through a combination of desktop self-service tools, automated routine reports, refreshed periodical scorecards and ad hoc reporting on request. Trust performance is scrutinised and supported through a range of daily, weekly and monthly meetings, with the necessary information available for discussion.

Operational performance

Throughout 2025/26, the Trust has continued to see growth in demand for both elective and non-elective care. Progress on reducing long waits for elective treatment has been challenged by funding arrangements for the year, which required a planned reduction in elective activity in the year and a corresponding planned reduction in performance against elective access standards. Despite this challenging plan, good progress has been made in the second half of the year following the release of additional funding, and the Trust has maintained high levels of quality and performance, treating patients in the best way that it has been able to.

Our urgent and emergency care services have seen high and increasing levels of demand throughout the year, with over 318,000 attendances to our Emergency Departments and Urgent Treatment Centres. During 2025/26, the Trust achieved 78.8% of patients being admitted, transferred or discharged within four hours, surpassing the national standard of 78%, with plans to improve this performance further over the coming year.

Performance against the Referral to Treatment (RTT) waiting time target, the percentage of patients receiving treatment within 18 weeks from referral, has improved in the second half of the year, with the Trust having achieved 66% against the national target of 65% by the end of March 2026. We continued to have no patients waiting over 78 weeks for treatment and eliminated patients waiting over 65 weeks at the end of March 2026. 958 patients were waiting over 52 weeks for treatment at the end of the year. While this is an increase compared to 2024/25 as a result of reduced activity in 2025/26, it is a reduction from a peak of 1,700 during the year. Plans are now in place in line with increased funding to eliminate waits over 52 weeks in 2026/27 and to further increase RTT performance to 72%.

Performance against cancer care standards has remained strong. The 28-day Faster Diagnosis Standard (FDS) measures the number of patients who are referred for suspected cancer and are diagnosed or have cancer ruled out within 28 days. This standard was exceeded in all months across the year. The 31-day target, which measures the time from cancer diagnosis to treatment, was also achieved throughout the year.

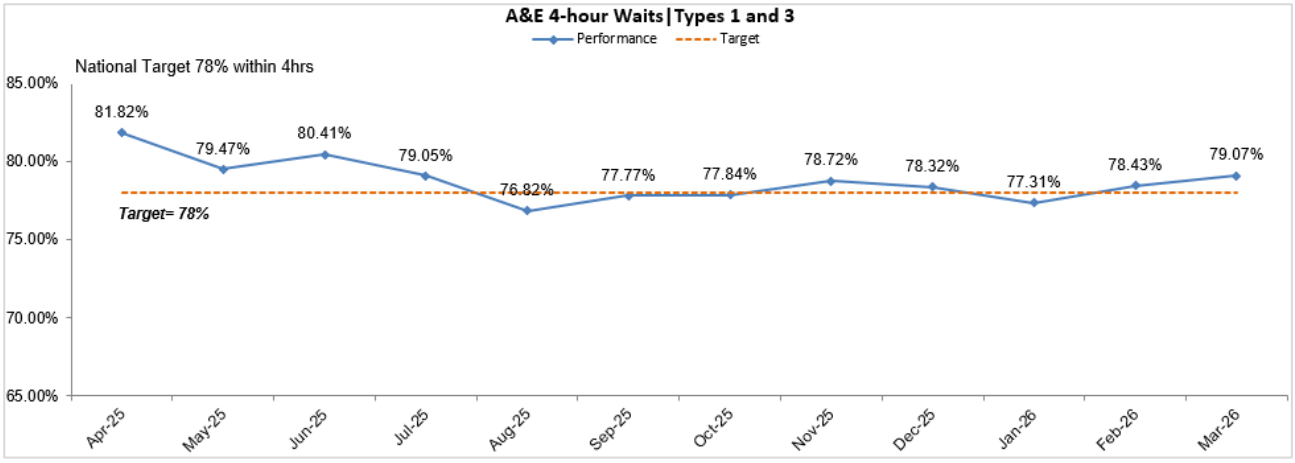
Performance against the 62-day standard, which measures the overall time from referral to treatment for those patients who are diagnosed with cancer, did not achieve the Trust target of 85% in all months but has seen improvement in the second half of the year as a

result of focused work on streamlining pathways and ensuring sufficient capacity in challenged tumour sites. The Trust did consistently meet the national standard of 75% throughout the year.

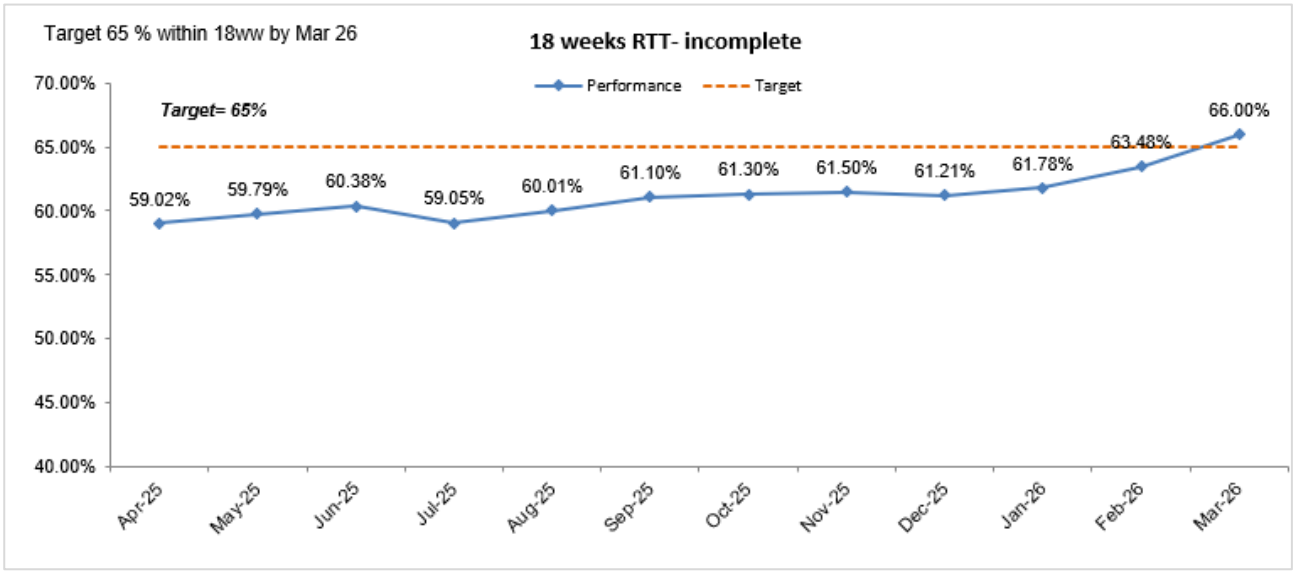
Performance against the national 95% diagnostics standard has been particularly challenging during the year as a result of the agreed reduction in funded activity. While the Trust has performed above its agreed performance trajectory, a recovery plan is now in place and we are expecting to return to compliance with the standard by the end of March 2027.

The following graphs illustrate the Trust's performance against each of the key national standards of A&E four-hour performance for types 1 and 3, 18-week Referral to Treatment (RTT) performance, 28-day Faster Diagnosis Standard performance, cancer 31-day wait performance, cancer urgent 62-day GP referral to first treatment performance, and diagnostic waiting times performance.

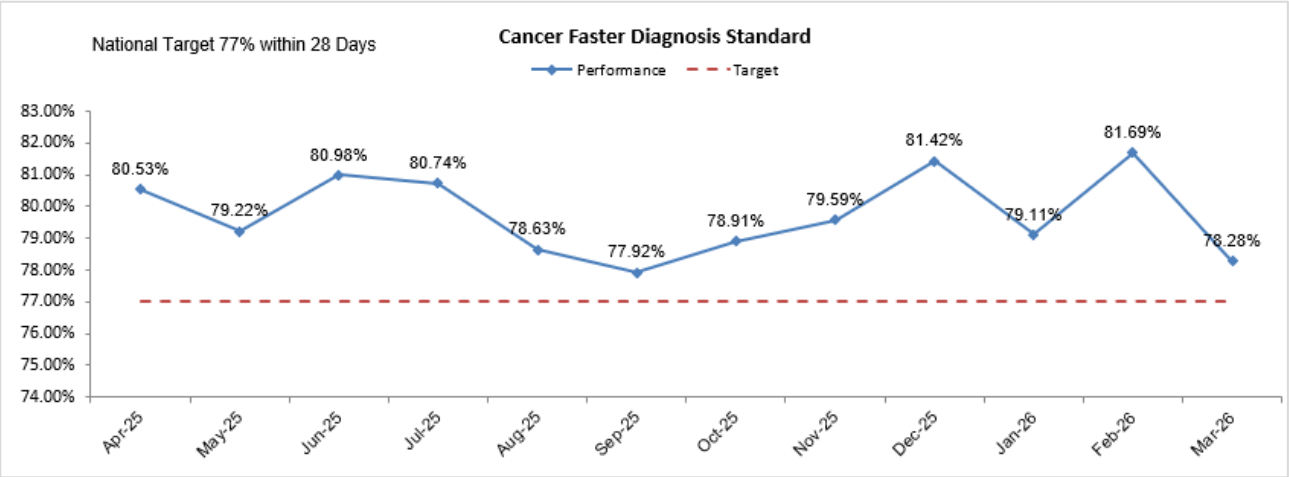
A&E four-hour performance—types 1 and 3



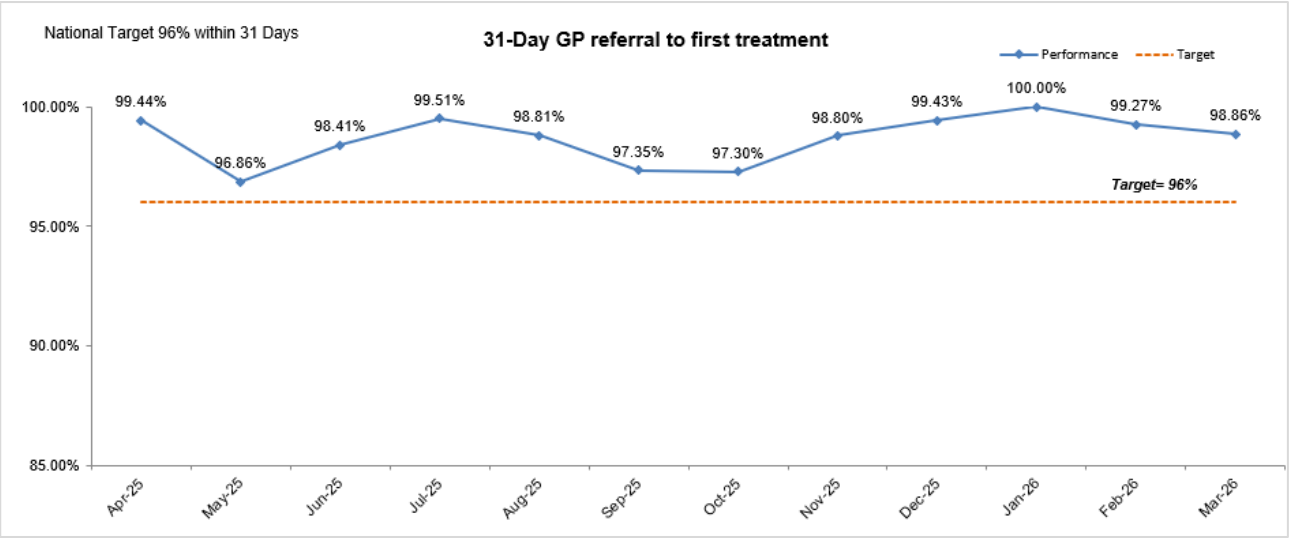
18-week Referral to Treatment (RTT) performance



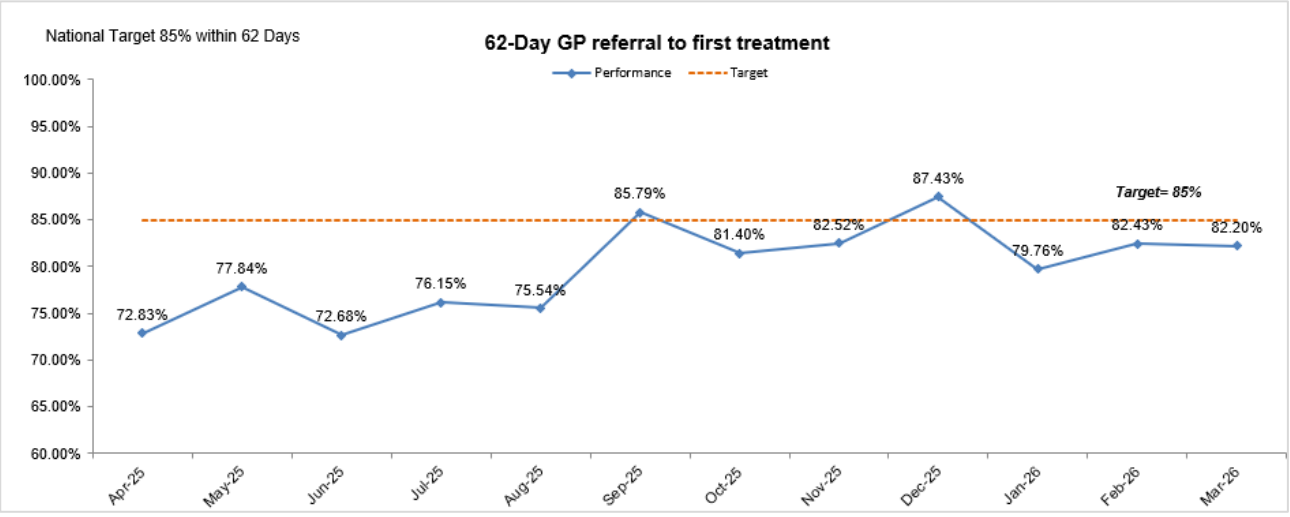
28-day Faster Diagnosis Standard performance



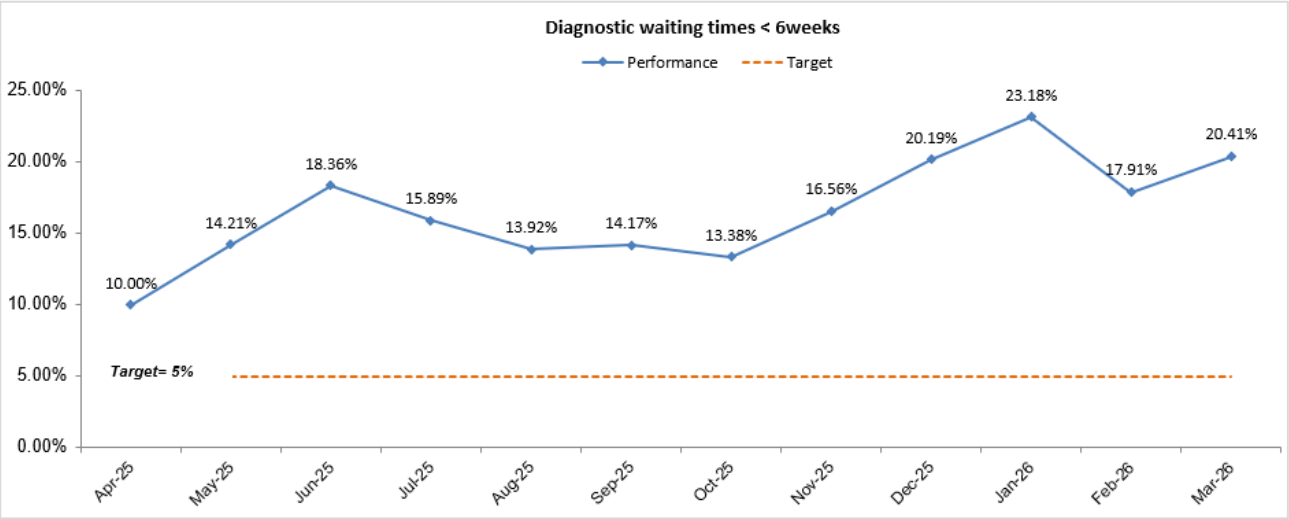
Cancer 31-day wait performance



Cancer urgent 62-day GP referral to first treatment performance



Diagnostic waiting times performance



Quality priorities

During 2025/26, the Trust set a range of quality priorities aimed at improving the clinical effectiveness, safety and experience of care received by our patients. Priorities were identified through engagement with multiple stakeholder groups:

- Engagement and feedback from our Council of Governors and Engagement Forum, which included external stakeholders
- Engagement and feedback from our Board's Quality Committee
- Review of incident reporting and feedback from complaints and claims

As a Trust, we are proud of the progress we have made against our 2025/26 quality priorities. Although not all of our ambitions were realised, the Trust has continued to deliver year-on-year improvements to our services, thereby promoting better quality of care. A brief progress update for each quality priority is provided below.

Priority 1: Feeling Safe at Work

Why we chose this as a quality priority

Violence and aggression (V&A) directed at NHS staff remains a significant issue, with a direct impact on staff wellbeing, retention and the ability to deliver safe, compassionate care. In December 2024, NHS England published an updated Violence Prevention and Reduction Standard, strengthening expectations on organisations to take proactive steps to prevent and manage violence and abuse against staff. In line with this national guidance and the Trust's commitment to the NHS People Promise, the Trust selected Feeling Safe at Work as a quality priority for 2025/26, recognising that a safe working environment is fundamental to high-quality patient care and positive staff experience.

Aims

The aim of this quality priority is to reduce the incidence and impact of violence and aggression experienced by staff by strengthening prevention, early identification and response. This includes improving staff capability through conflict resolution training,

building local leadership through Staff Safety Champions and Guardians, and embedding consistent Trustwide processes and systems to identify, manage and learn from incidents of V&A. The work also aims to promote a culture of kindness and respect, supporting staff wellbeing while ensuring robust systems are in place to protect both staff and patients.

Update on progress

During 2025/26, good progress has been made across several key areas, supported by measurable improvement in training compliance and workforce capability. Level 1 Conflict Resolution Training compliance increased from a baseline of 84% to 95% by Q3, consistently exceeding the Trust target of 90%. Level 2 Conflict Resolution Training also demonstrated sustained improvement, rising from 20% at baseline to 46% by Q3, nearing the year-end target of 50%.

Training of Staff Safety Champions commenced, with steady growth in numbers across the year, increasing from 44 in Q1 to 61 in Q3, strengthening local leadership and visibility of this agenda across clinical areas. In parallel, the Trust maintained compliance with the NHS Violence Prevention and Reduction Standard baseline requirements, with preparatory work underway to support full alignment with the expanded 2024 standard.

A refreshed Trustwide Kindness Campaign was developed and approved, alongside the identification of key stakeholders to refresh policies relating to violence and aggression. Level 2 Conflict Resolution Training content was updated, and preparatory work commenced to support consistent alerting for violence and aggression within the electronic patient record.

Forward plan

In 2026/27, the Trust will build on this progress by launching the refreshed Kindness Campaign alongside staff engagement activity, aligned to the annual staff survey. Training of Staff Safety Guardians will commence, strengthening escalation, support and oversight arrangements across divisions. Policy refresh work will continue, alongside the rollout of a multidisciplinary team (MDT) review process for serious incidents where sanctions may be required. This MDT process brings together relevant clinical and operational staff to review incidents of violence and aggression, agree appropriate next steps, including consideration of sanctions or referral to other services, and ensure that affected staff have received appropriate support. Collectively, these actions will support a safer working environment, stronger staff confidence and continued improvement against the national Violence Prevention and Reduction Standard.

Priority 2: Reducing medication incidents with moderate harm or above

Why we chose this as a quality priority

Medication safety is a core component of patient safety and a key determinant of patient outcomes. While a high volume of incident reporting reflects an open and learning culture, reducing medication-related incidents is crucial to patient safety, helping to reduce prolonged hospital admissions and improve the quality and safety of care and patient outcomes. The Trust therefore selected reducing medication incidents with moderate harm or above as a quality priority to strengthen oversight, learning and prevention, and to ensure continued focus on the highest-risk areas of medicines management, including omitted doses and anticoagulant safety.

Aims

To improve patient safety by reducing avoidable harm related to medicines, through strengthening medication safety practices across the Trust. This includes increasing staff awareness and learning through consistent education and communication, improving the timely administration of critical medicines, and reducing risks associated with high-risk medications. A particular focus is on identifying and addressing missed doses of critical medicines using enhanced digital monitoring, and promoting safe prescribing and management of anticoagulants, to ensure patients receive the right medicines at the right time.

Update on progress

During 2025/26, the Trust maintained strong performance in reducing medication-related harm, with incidents resulting in moderate harm or above held at 0.5% year to date, consistently below the Trust target of ≤1%. This reflects sustained control in high-risk areas of medicines management and provides assurance that processes to identify, manage and mitigate risk are effective. Oversight of medication safety continued through regular review of incident trends by the Medication Safety Group, with shared learning disseminated via Trustwide medication safety bulletins and divisional meetings.

A key development was the implementation of a real-time Omitted Doses Dashboard, supporting earlier identification and action where critical medications have been missed. Continued assurance was provided through monthly review of anticoagulant incidents, root cause analysis of hospital-associated thrombosis events, and updates to VTE guidelines and prescribing systems to support safer practice.

Forward plan

In 2026/27, the Trust will continue to embed medication safety improvements by maintaining robust governance through the Medication Safety Group and ongoing reporting to the Patient Safety Group. Trustwide medication safety bulletins will remain a key mechanism for sharing learning from incidents with moderate harm. Further work will focus on strengthening cross-site analysis of reporting trends, continued optimisation of electronic prescribing and decision support systems, and sustained education and stewardship around high-risk medications, including anticoagulants and VTE prevention. Collectively, these actions will support continued reduction in avoidable harm and ongoing improvement in medication safety for patients.

Priority 3: Single Delivery Plan

Why we chose this as a quality priority

The Single Delivery Plan (SDP) is a national programme to improve the safety, quality, personalisation and equity of maternity and neonatal care. Given the complexity of maternity services and the need for consistent, system-wide assurance, the Trust selected delivery of the SDP as a quality priority to ensure sustained focus on the actions required to improve outcomes for women, babies and families. The priority reflects the Trust's commitment to listening to service users, supporting staff, strengthening governance and improving outcomes, while ensuring alignment with regional and national maternity safety ambitions.

Aims

The aim of this quality priority was to deliver all actions within the Three-Year Single Delivery Plan (2023–2026), ensuring that improvements were embedded across four nationally defined themes. The Trust sought to provide assurance that required standards were met, risks were appropriately managed and that improvements translated into safer, more equitable care for women and babies, supported by robust reporting and oversight arrangements.

Update on progress

By Quarter 4 of 2025/26, strong progress had been achieved across the Single Delivery Plan, with all 43 deliverables completed, providing full assurance of delivery against national expectations. Throughout the year, delivery remained on track, with no actions assessed as off-track or without delivery plans at any point. The number of fully completed deliverables increased from 28 in Q1 to 30 by Q3, with all remaining actions progressing as planned and subsequently closed by year-end.

Across all four themes, deliverables were embedded into routine service delivery, with assurance provided through regular review of safety outcomes, workforce initiatives and governance processes. Midwifery Continuity of Carer continued across both sites, supported by enhanced analysis of outcomes by ethnicity and deprivation. Workforce development actions were completed, including progress on mentorship and preceptorship frameworks. Collectively, this provides assurance that improvements have been delivered, embedded and aligned to national maternity safety ambitions.

Forward plan

Although the Single Delivery Plan programme has formally concluded, the Trust will focus on sustaining and embedding improvements into business-as-usual practice. Key areas of ongoing focus include maintaining robust surveillance of maternal and neonatal outcomes, using real-time data tools to support early identification of safety signals, and strengthening the systematic use of patient feedback to inform service improvement. Governance and escalation arrangements will continue to be refreshed, and work will progress to enhance data capture and assurance through the new incident management system. This will ensure that the improvements delivered through the Single Delivery Plan remain embedded, sustainable and responsive to emerging risks and inequalities.

Priority 4: Dementia

Why we chose this as a quality priority

Dementia is a growing challenge for health and care services, with increasing numbers of people living with dementia and many remaining undiagnosed. Patients with dementia are at higher risk of adverse outcomes during hospital admission, particularly when delirium is not recognised and managed promptly. The Trust chose Dementia as a quality priority to strengthen early identification, improve person-centred care, and ensure staff are supported with the skills, knowledge and systems needed to deliver safe, compassionate care for people living with dementia. This priority also reflects the Trust’s commitment to improving patient experience and reducing unwarranted variation in care for older people.

Aims

The aim of this quality priority was to improve the early identification and management of dementia and delirium in hospital, while enhancing staff capability and confidence in caring for patients. This included maintaining high levels of dementia screening for older patients following emergency admission, embedding the use of evidence-based screening tools, expanding Tier 2 dementia training for frontline staff, and strengthening multidisciplinary approaches to care and communication with patients and carers.

Update on progress

During 2025/26, the Trust maintained strong performance across key dementia care measures, with sustained high levels of staff training and screening compliance. Tier 1 dementia training remained consistently high at 96% throughout the year, exceeding the Trust target of 90% and providing assurance of a well-informed workforce. Progress was also demonstrated in Tier 2 dementia training for frontline staff, increasing from a baseline of 50% to 65% by Q3, reflecting continued expansion of enhanced skills and capability, though further improvement is required to meet the 75% target.

Performance in dementia screening for patients aged 75 and over following emergency admission remained above the 90% target overall, with improvement from 94.6% in Q1 to 96.6% in Q3 following targeted action to address a dip in Q2 (83.7%). This demonstrates effective recovery and sustained focus on early identification. Over 50 Dementia Champions were trained across both sites, with further training planned, supporting local leadership and awareness. The Trust also strengthened patient and carer engagement through partnership working, refreshed carer resources and increased meaningful activity on wards to improve patient experience and wellbeing.

Forward plan

In 2026/27, the Trust will focus on sustaining and embedding improvements in dementia care. This includes further rollout of face-to-face Tier 2 dementia training aligned to the updated national Core Skills Framework, continued expansion of the Dementia Champion network, and ongoing education to reinforce the consistent use of approved screening tools. Work will continue to strengthen carer involvement, improve communication and ensure best practice in one-to-one care and cohorting arrangements. These actions will support earlier identification of delirium and dementia, improve patient outcomes and experience, and ensure high-quality, compassionate care for people living with dementia remains embedded as business-as-usual practice.

Priority 5: Implementation of NatSSIPs2

Why we chose this as a quality priority

The implementation of the National Safety Standards for Invasive Procedures 2 (NatSSIPs2) will strengthen patient safety and reduce the risk of avoidable harm associated with invasive procedures. Following the publication of updated national guidance in 2023, NatSSIPs2 places greater emphasis on organisational standards and consistent safety behaviours, rather than checklist compliance alone. This priority also reflects learning from previous never events and incidents linked to variable compliance with local safety standards, highlighting the need for greater standardisation, oversight and assurance across the Trust.

Aims

The aim of this quality priority was to implement NatSSIPs2 by strengthening organisational governance, standardising local safety standards (LocSSIPs), and embedding the updated sequential steps to safer surgery across relevant services. This included reducing unwarranted variation in safety processes, supporting teams to adopt a consistent and proportionate approach to risk and progressing the digitisation of safety checklists to improve reliability, auditability and learning. Ultimately, the priority sought to improve patient safety during invasive procedures and reduce the risk of never events.

Update on progress

During 2025/26, the Trust established key foundations for the implementation of NatSSIPs2, with progress focused on governance, standardisation and preparation for system-wide change. Baseline assessments identified approximately 150 LocSSIPs in use across the organisation, highlighting significant variation and informing the need for a structured harmonisation programme, with an ambition to reduce this by 30–50% over time.

While full digital integration within the electronic patient record has not yet been achieved (baseline 0%, target 25%), the year has focused on enabling this transition through the development and agreement of a standardised baseline LocSSIP checklist template and alignment with the Acute Provider Group. This preparatory work provides a clear trajectory towards digitisation and improved auditability.

The LocSSIP/Surgical Safety Group strengthened oversight and commenced a structured review of LocSSIPs by specialty, ensuring alignment with the eight sequential steps to safer surgery and agreeing where standardisation or bespoke approaches are required. Collectively, this progress establishes a robust platform for delivery in 2026/27, with clear priorities for harmonisation, digitisation and strengthening assurance processes.

Forward plan

In 2026/27, the Trust will focus on completing the next phase of NatSSIPs2 implementation. This includes securing approval of the baseline checklist through the APG NatSSIPs Implementation Group, progressing digitisation within the electronic patient record, and advancing a harmonisation programme to reduce the overall number of LocSSIPs where appropriate.

Development of a Trustwide standard operating procedure and a sustainable training programme will remain priorities, alongside the introduction of more systematic qualitative and quantitative auditing in high-risk areas. These actions will support more consistent safety practices, improved assurance and continued reduction of procedural risk.

Priority 6: Deteriorating Patient—Sepsis

Why we chose this as a quality priority

Building on the work from last year, key focuses were to fully implement Martha’s Rule and expand our work on Recognition and Escalation of Deteriorating Patients (REDP) and sepsis. Early recognition, timely escalation and rapid response are critical to improving outcomes and preventing serious complications. The Trust selected Deteriorating Patient

as a quality priority to strengthen a consistent, systemwide approach to identifying and managing deterioration, aligned to national guidance and the Acute Provider Collaborative programme. This priority reflects the Trust's commitment to improving patient safety through reliable processes, effective escalation and robust clinical oversight.

Aims

The aim of the North West London Deteriorating Patient and Sepsis Pathway programme is to deliver a consistent, systemwide approach to the early recognition, escalation and management of deteriorating patients and sepsis. This will be achieved by implementing a shared pathway within Cerner across all NWL Acute Provider Collaborative trusts, standardising education and training so staff can apply the pathway confidently and consistently, strengthening internal and external communications to support staff, patients and carers, and using shared data and dashboards to track pathway use, support learning and drive continuous improvement across the system.

Update on progress

Good progress was made against the 2025/26 Deteriorating Patient quality priority, with the overall aims largely achieved across Martha's Rule, sepsis, and Recognition and Escalation of Deteriorating Patients (REDP). Delivery focused on embedding sustainable systems, strengthening clinical insight and establishing robust arrangements for ongoing monitoring beyond the formal quality priority period.

For sepsis, performance was consistently strong across most areas, with screening rates for patients with a high NEWS score remaining at or above the 90% target in AMU/AAU (Q3 93.6%) and wards (Q3 91%). Performance in ED showed some variation, improving above target in Q1 (93%) but stabilising below target in Q2 and Q3 (84% and 84.3%), highlighting a continued focus for improvement.

For REDP, initial dashboard data suggested variable performance against some process metrics, particularly around timeliness of observations and SBAR completion within 60 minutes. However, clinician review within 60 minutes consistently met or exceeded the 80% target in ED (Q3 92%), indicating strong clinical response where escalation occurred. Detailed manual audits confirmed that, despite variability in recorded process measures, underlying clinical practice remained strong and appropriate, demonstrating the importance of triangulating digital data with clinical review.

Implementation of Martha's Rule is well advanced, with two of the three components fully delivered, including consistent staff escalation routes and patient, family and carer access to escalation pathways. Since launch, 175 calls have been received up to December 2025, with 15% resulting in a change in treatment or clinical intervention, providing evidence of appropriate escalation and clinical impact. The majority of calls related to non-clinical concerns, which were appropriately redirected, demonstrating effective system navigation and patient engagement.

The development and optimisation of digital dashboards for sepsis and REDP has enabled improved oversight and learning, including greater scrutiny of data quality and refinement of metrics to better reflect meaningful clinical outcomes.

Forward plan

During 2026/27, the Trust will continue to review the programme and systematically track the benefits achieved. Further work will focus on strengthening the links between deterioration metrics and incident reporting, ensuring that learning is consistently captured and used to inform improvement. Targeted quality improvement activity will be directed towards areas where performance remains variable, supporting sustained improvement in the early recognition and timely treatment of sepsis and other causes of patient deterioration.

Priority 7: Deteriorating Patient—PEWS

Why we chose this as a quality priority

Early recognition and timely response to clinical deterioration in children is critical to improving patient safety and outcomes. National guidance requires all NHS trusts to implement a standardised Paediatric Early Warning Score (PEWS) to support consistent identification, escalation and management of deterioration. This priority was selected in response to this national requirement and as part of the North West London Acute Provider Collaborative (NWL APC) approach to strengthening paediatric safety across organisations. The Trust aims to reduce unwarranted variation in practice, improve escalation reliability, and ensure that deteriorating children receive prompt and appropriate care.

Aims

The overarching aim of this quality priority was to implement a nationally standardised PEWS across paediatric services, supported by digital systems, aligned policies and workforce training. Specific objectives included delivering a safe and reliable Cerner build and integrating PEWS with monitoring equipment.

Update on progress

The National PEWS and Sepsis Cerner build went live across the North West London sector in June 2025 and is now embedded within paediatric services, representing full delivery of the core technical build against programme milestones. Following go-live, further technical development was completed to achieve full integration with Welch Allyn monitoring equipment across all Trust sites, strengthening reliability of physiological observations and supporting safer escalation processes. Post-go-live audit activity has been undertaken and continues to provide assurance on system adoption, data quality and compliance, confirming that National PEWS is embedded within routine clinical practice. Delivery of key enabling actions has been completed, including alignment of policies, development of education and training materials, and implementation of communication plans to support staff. Progress is now focused on embedding consistent use and strengthening assurance through ongoing audit, recognising that this phase is critical to demonstrating sustained impact on the recognition and escalation of deterioration in children.

Forward plan

During 2026/27, the focus will shift from implementation to embedding, assurance and continuous improvement. This will include establishing a North West London Paediatric

Deteriorating Patient Group to provide system leadership and shared learning, implementing routine monitoring of PEWS compliance and associated clinical outcomes, and reviewing the alignment of sepsis pathways, escalation processes and Emergency Department triage. Audit activity and learning from PSIRF will be used to evidence improvement, support learning across the system and demonstrate impact on safety and outcomes for children.

Financial performance

The Trust reported an adjusted surplus of £4.97m against the control total of a breakeven plan, thus reporting a £4.97m positive variance against plan. This surplus only materialised at year-end as NHS England decided to redistribute any Deficit Support Funding (DSF) foregone by systems that did not deliver their plans in 2025/26 to those providers that did, as long as those providers were part of a system that delivered plan and had also submitted a balanced plan for 2026/27. The Trust was thus eligible for this funding, £4.915m. As the funding from which this bonus is paid was originally intended to fund system deficits, the money has to flow to the NHS bottom line to make sure that the NHS overall meets its financial targets and so cannot be spent. This DSF bonus is cash-backed, so provides the Trust with additional cash, to be paid in 2026/27. Also included within these figures are industrial action costs and income, where the Trust incurred costs of £3.2m and received associated funding from NHS England of £3.2m in 2025/26 and a non-recurrent release of unutilised provisions.

The overall reported position is a deficit of £3.6m for the year, before adding back all reversals of impairments relating principally to land and buildings of £16.0m and other adjustments of £7.5m. The Trust delivered £33.4m of cost improvement programmes during the year. The following table shows the 2025/26 financial outturn against the 2024/25 position under NHS England's reporting definitions.

	2025/26 outturn (£m)	2024/25 outturn (£m)
Operating revenue	£1,076.5	£1,036.3
Employee expenses	(£643.6)	(£612.9)
Other operating expenses	(£424.1)	(£416.7)
Non-operating income/expenses	(£11.7)	(£12.0)
Other gains/(losses) including disposal of assets	(£0.6)	£0.01
Net reversal of impairments and other non-current asset gains/(losses)	£16.0	£5.0
Corporation tax expense	£0	(£0.02)
Removal of donated assets/PPE consumables	(£6.2)	(£0.7)
Removal of I&E impact of IFRS 16 on IFRIC 12 schemes	(£1.2)	£1.0
Adjusted surplus/(deficit)	**£4.97**	**£0.11**
Net surplus/(deficit) %	0.46%	0.01%
Total operating revenue for EBITDA	£1,068.8	£1,034.0
Total operating expenses for EBITDA	(£1,016.4)	(£990.2)
EBITDA	**£52.4**	**£43.8**
EBITDA margin %	4.9%	4.2%
Year-end cash	**£117.6**	**£143.5**

During the year, the balance of cash and cash equivalents decreased from £143.5m at 31 March 2025 to £117.6m at 31 March 2026.

In 2025/26, the Trust invested £64.2m in capital, which included £0.7m on the Treatment Centre, £43.3m on the Diagnostic, Treatment and Education Centre (DTEC) build and £2.1m on DTEC equipment, £7.8m on estates works and maintenance across both sites, £4.5m on medical equipment and £4.5m on IT goods and services. The balance of £1.1m included the impact of IFRS 16 leases.

Environmental and sustainability performance

Task Force on Climate-related Financial Disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the Task Force on Climate-related Financial Disclosures (TCFD) recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD-aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures, as interpreted and adapted for the public sector by HM Treasury, are implemented on a phased basis within sustainability reporting requirements.

The Trust has undertaken risk assessments and has plans in place that take account of the *Delivering a Net Zero Health Service* report under the Greener NHS programme, and ensure that its obligations under the Climate Change Act and the NHS adaptation reporting requirements are complied with. The Trust's Green Plan, originally approved by the Trust Board in November 2021 and refreshed in November 2025, confirms the Trust's commitment to national NHS net zero ambitions, including achieving net zero for emissions directly controlled by the Trust by 2040 and for emissions it can influence by 2045.

Overall strategy for sustainability

Chelsea and Westminster Hospital NHS Foundation Trust, along with its partners, is actively working towards the decarbonisation of our activities and a transformation to a low-carbon, sustainable healthcare system. In November 2021, the Trust implemented its Green Plan, setting out our targets to be carbon neutral for our 'core' footprint by 2040 and for our 'plus' footprint, including our supply chain, by 2045. In November 2025, the Trust reviewed and updated its Green Plan, setting out updated goals and targets to prepare the Trust for the journey ahead. The Trust has since refocused its sustainability programme in line with these recommendations, creating eight workstreams of our Sustainability Board to tackle different areas of sustainable operation, and developing plans to review and update our key operational policies to incorporate sustainability at the heart of everything we do.

We recognise that delivering sustainable healthcare involves a cross-cutting approach, working at all levels with staff, patients and partner organisations to implement our ambitions. Throughout the past year, we have been working to develop this collaborative approach through a wide number of mechanisms, including engagement with our partner organisations, staff engagement events and collaborative work across the wider North West London healthcare sector. We will continue to develop this in years to come, leveraging our position as an anchor institution to leave a positive impact on the natural world around us as well as the communities and patients we serve.

The Trust has considered the impact of climate-related risks and opportunities against a global warming pathway of 2°C or lower, over the short, medium and long term, aligned to its existing strategic and business planning horizons and in line with NHS Net Zero and

Greener NHS commitments. This includes assessing both transition risks, such as regulatory change, decarbonisation requirements and supply chain impacts, and physical risks, including extreme weather, heat and infrastructure resilience, and the need for sustained investment to reduce carbon emissions, embedding these considerations into operational and strategic planning. Actions include strengthening estate resilience, supporting service continuity and accelerating lower-carbon models of care through digital and community-based delivery.

These risks have also been reflected in the Trust's financial planning through scenario-based assumptions, including capital investment required for estate decarbonisation, potential cost pressures linked to adaptation and compliance, and opportunities for efficiency savings through energy optimisation and redesigned clinical pathways. This approach ensures that the Trust's strategy, operations and financial plans remain resilient and aligned to a 2°C or lower pathway, while supporting delivery of high-quality, sustainable care and system-wide sustainability goals.

The Trust does not currently apply a formal internal carbon pricing mechanism as part of its financial planning or investment appraisal processes. However, environmental sustainability considerations are taken into account in business cases, procurement tenders and capital investment decisions in line with the Trust's Green Plan and NHS Net Zero requirements.

The Trust's response to climate-related risks and opportunities is delivered primarily through its Green Plan and associated programmes of work, which set out prioritised actions for mitigation and adaptation and are aligned to national NHS policy and the Delivering a Net Zero Health Service programme.

Governance pillar

The Trust Board has oversight of climate-related issues via the quarterly NWL Acute Provider Group Strategic Estates, Infrastructure and Sustainability Group Committee, which provides quarterly updates to the Board in Common. The Committee monitors progress against goals and targets for addressing climate-related issues.

The Trust's programme is overseen by the Sustainability Board, which is chaired by the Chief Financial Officer as the Executive Sustainability Lead. The Sustainability Board meets every quarter. The Sustainability Board acts as the assurance group for sustainable change and climate-related issues across the Trust and submits regular reports to the Improvement Board, Finance and Performance Committee, and the Trust Board.

The Sustainability Board has eight supporting workstreams:

- Workforce and System Leadership
- Models of Care
- IT and Digital
- Estates and Facilities
- Travel and Transport
- Medicines
- Procurement, Supply Chain and Social Value
- Adaptation

The Board also considers climate-related issues through business cases and procurement processes.

Risk management pillar

The Trust's process for identifying and assessing climate-related risks is in line with the Trust's risk management process. Further details are provided in the Annual Governance Statement. The Trust has also identified a strategic risk in relation to environmental sustainability on its Board Assurance Framework. BAF reference 3.5 is: "Failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in environmental sustainability in line with national targets and 'For a Greener NHS' ambitions." This could lead to a failure to meet Trust objectives, reputational damage and loss of cost-saving opportunities.

During 2025/26, no climate-related events resulted in material financial impact or significant disruption to service delivery. However, the Trust recognises the potential for climate-related risks, such as extreme heat, flooding or severe weather events, to impact service delivery, infrastructure resilience and patient demand. These risks are considered through the Trust's risk management and emergency preparedness arrangements.

Climate-related risks are reviewed and monitored in line with the Trust's Risk Assurance Framework and Board Assurance Framework, with ongoing oversight to ensure that emerging risks and potential impacts are identified and managed appropriately.

Performance

Projects

Significant progress has been made by the Trust on individual sustainability projects throughout the past year.

Pharmacy, Estates, Medical Engineering and Theatre teams have worked in collaboration to decommission the nitrous oxide manifolds on both sites. The CO_2e savings are estimated to be as much as 30,000kg CO_2e per month, with an associated saving on cylinders and rental. These figures will be verified as the new systems settle in but look to be on track based on the first six weeks of the programme.

Inhaler emissions are decreasing through work aligned with the NWL ICB and rollout of the Medicines Optimisation Enhanced Service. Our monthly average compared to 2024/25 shows an 8% reduction, 9,180kg per month using NICE CO_2e equivalence recommendations, in CO_2e emissions from dispensed inhalers through switches to dry powder alternatives. The Trust has participated in and advertised the NW London ICS 'Only order what you need' initiative to save re-dispensing of medicines that patients may already have at home. This may be difficult to measure but sends a positive message for the Trust. Future plans include inhaler recycling, which will be rolled out across the whole of NW London primary and secondary care.

Significant progress over the last 12 months has been made in advancing sustainable procurement and social value across Chelsea and Westminster Hospital NHS Foundation Trust. Key achievements include the continued implementation of a minimum 10% social value weighting in tenders where applicable, alongside strengthened requirements for Carbon Reduction Plans and net zero commitments within procurement processes. North

West London Procurement Services (NWLPS) also delivered four workshops for procurement teams focusing on sustainability, social value and the new compliance requirements introduced through the Procurement Act 2023. In addition, dedicated workshops were provided to sustainability leads across trusts to support alignment with system-wide priorities.

Practical sustainable procurement initiatives were progressed, including the digitisation of patient records across the wider Acute Provider Collaborative, as well as projects aimed at reducing theatre consumable waste, delivering both environmental benefits and financial savings. The Trust calculates Scope 3 emissions annually using nationally recognised methodologies. Due to data availability and processing timelines, the most recent completed assessment relates to 2024/25. Reporting for 2025/26 will be completed in line with national reporting requirements and timelines.

Over the past year, the Trust's IM&T has also delivered a strong set of environmental and sustainability successes that tangibly support the Trust's Green Plan and wider NHS Net Zero ambitions. Key achievements include the adoption of Ecosia as the default web search engine, contributing to the planting of over 33,000 trees globally, and the implementation of automated PC power management solutions that significantly reduced energy consumption and avoided approximately 200,000 kg CO_2e of emissions. We also strengthened our circular approach to IT asset management, recycling 485 items of IT equipment and preventing an estimated 66 tonnes of CO_2 emissions while reducing e-waste and supporting reuse and recycling principles.

Alongside these operational gains, IM&T established clearer sustainability governance through defined workstream leadership and reporting into the Sustainability Board, embedding environmental considerations into digital lifecycle management, procurement and programme delivery. Collectively, these initiatives demonstrate IM&T's leadership in delivering greener digital services while maintaining resilience, efficiency and high-quality support for clinical and corporate services across the Trust.

Emergency Preparedness, Resilience and Response (EPRR)

EPRR within the Trust has made strong and tangible progress in supporting the Trust's Adaptation Plan by embedding climate resilience and adverse weather preparedness within emergency planning and business continuity arrangements. Adverse Weather Incident Response Plans for heat, cold, flooding and drought are established, routinely reviewed and informed by learning from real-time alerts and incidents, with assurance evidenced through positive assessment against NHS EPRR Core Standards, including Domain 3 (Duty to Maintain Plans) and Domain 9 (Business Continuity).

EPRR has ensured that climate and weather-related risks are reflected within service-level continuity planning, supported effective warning and informing arrangements in line with the Civil Contingencies Act 2004, and strengthened organisational readiness for severe weather events. From 2026, the EPRR team has taken back direct assurance of external contractors' Business Continuity Plans, reintroducing a structured review process to ensure plans are proportionate, risk-based and aligned with the principles of ISO 22301, thereby strengthening supply chain resilience and supporting the Trust's wider adaptation and continuity objectives.

This integrated approach provides a robust foundation for continued improvement in climate resilience across Trust sites and services.

While the Trust has not formally applied the NHS Climate Change Risk Assessment Tool, equivalent considerations are incorporated through EPRR, business continuity planning and the Trust's risk management framework.

Engagement

The Trust recognises that delivering sustainable healthcare involves working with staff, patients and partner organisations at all levels to implement our ambition to deliver a health system that supports social and environmental ambitions while remaining financially efficient, putting our organisation on a path to a cleaner, greener and healthier future.

We have continued to embed the SusQI principles, developed by the Centre for Sustainable Healthcare, as part of our improvement programme to support sustainability-focused projects. Sustainability is also a core principle highlighted within the Trust's induction process.

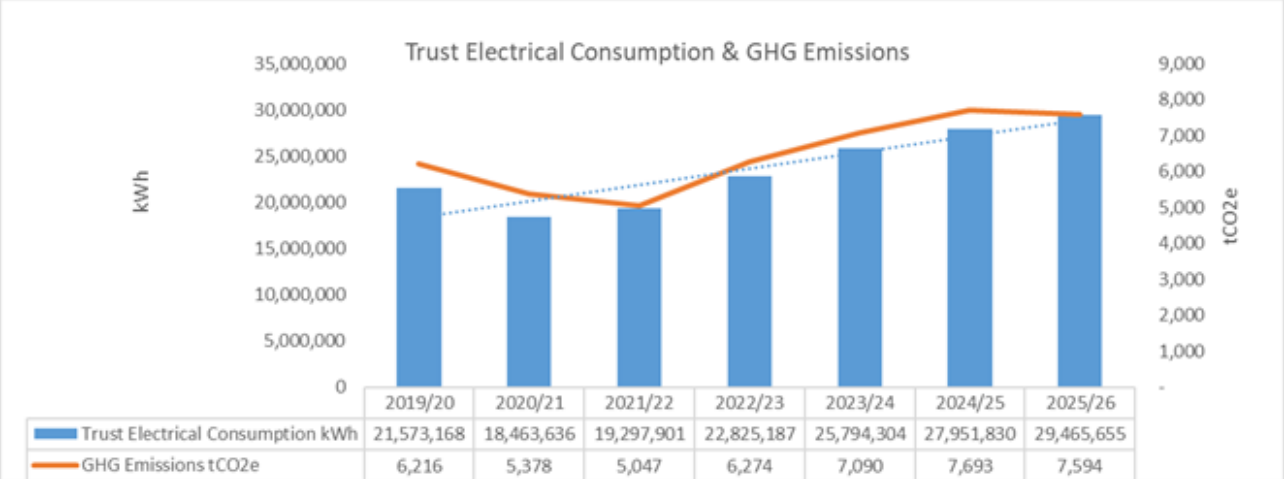
Furthermore, engagement with the local economy was strengthened through participation in two "meet the buyers" events, supporting local SMEs to access procurement opportunities.

The Trust remains committed to providing quality healthcare across its estate. This commitment is reflected in ongoing refurbishment and capital projects designed to improve energy efficiency, reduce waste and consumption and reduce cost. Key initiatives include large-scale transitions to LED lighting, decarbonisation and capital construction programmes, which helped to mitigate increased non-energy costs and wholesale water charges during 2025/26.

Metrics and target pillar

Electricity

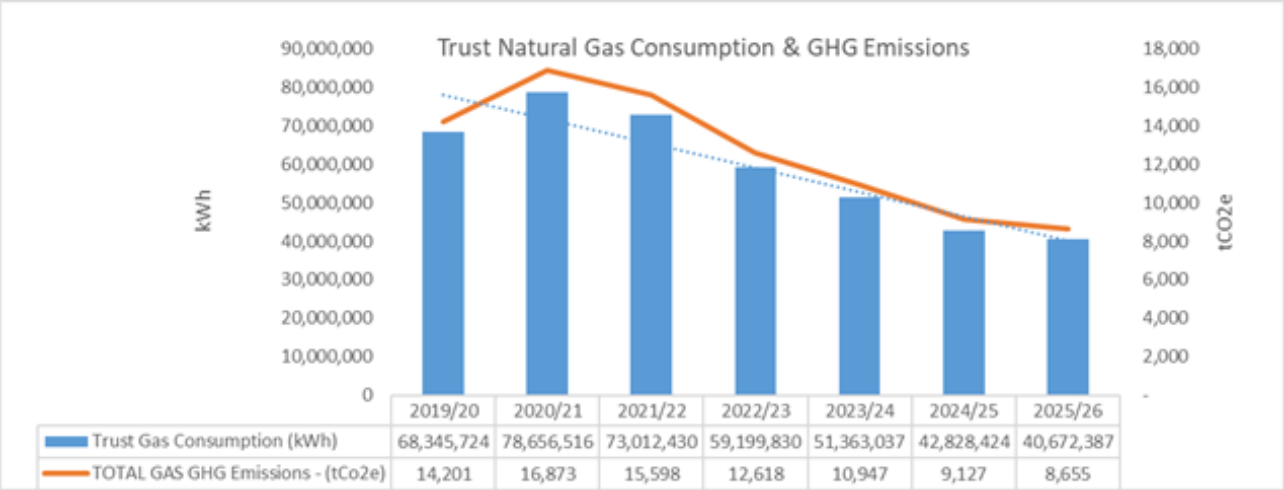
Electricity consumption from the grid rose by 5%, reaching 29.47 GWh compared to the previous year, 2024/25. Our three Combined Heat and Power (CHP) units supplied 43% of the total electrical demand to our West Middlesex Hospital (WMH) site, amounting to 10.9 GWh. Efforts continue to restore the two CHP engines at the CWH site to operational status.



	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Trust Electrical Consumption kWh	21,573,168	18,463,636	19,297,901	22,825,187	25,794,304	27,951,830	29,465,655
GHG Emissions tCO2e	6,216	5,378	5,047	6,274	7,090	7,693	7,594

Natural gas consumption

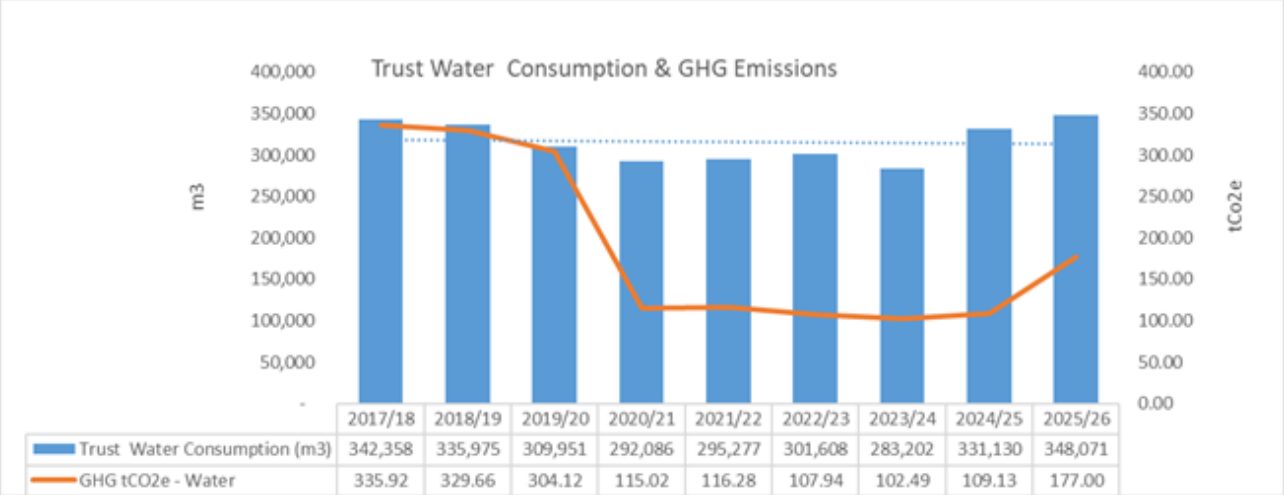
The Trust's natural gas consumption was approximately 40.67 GWh, reflecting a 5% decrease compared to 2024/25. This reduction can be attributed to a warmer winter period and the ongoing requirement to operate only one of the three CHP engines, due to capital works on the two engines serving the CWH site.



	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Trust Gas Consumption (kWh)	68,345,724	78,656,516	73,012,430	59,199,830	51,363,037	42,828,424	40,672,387
TOTAL GAS GHG Emissions - (tCo2e)	14,201	16,873	15,598	12,618	10,947	9,127	8,655

Water

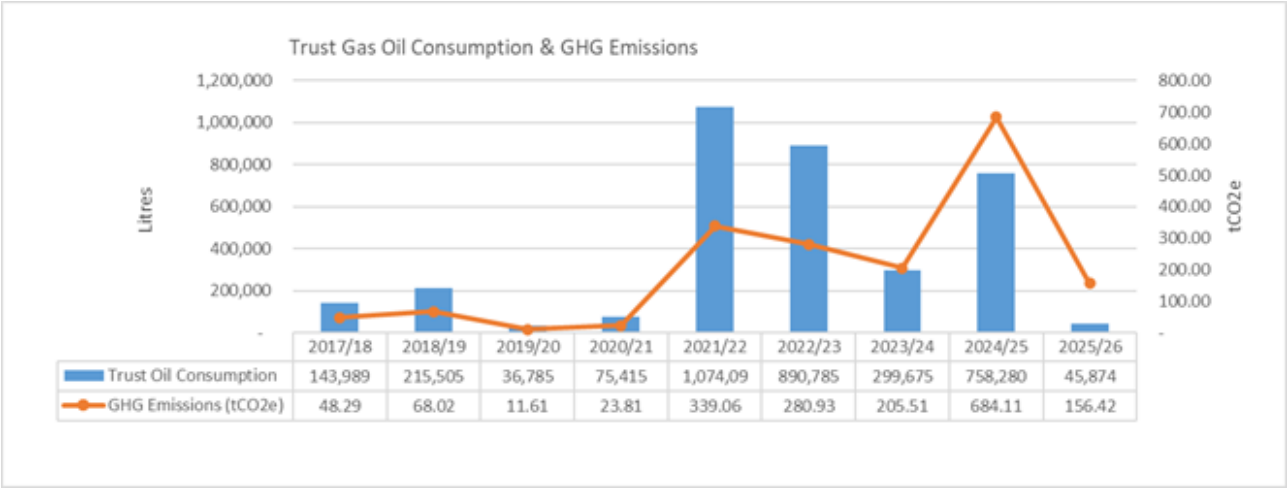
Retail water contracts have been transitioned to a new provider, resulting in improved administration of services. During the period, wholesale consumption increased by 5%. The Trust continues to collaborate with water providers to upgrade infrastructure, monitor usage and enhance the detection of leakages.



	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Trust Water Consumption (m3)	342,358	335,975	309,951	292,086	295,277	301,608	283,202	331,130	348,071
GHG tCO2e - Water	335.92	329.66	304.12	115.02	116.28	107.94	102.49	109.13	177.00

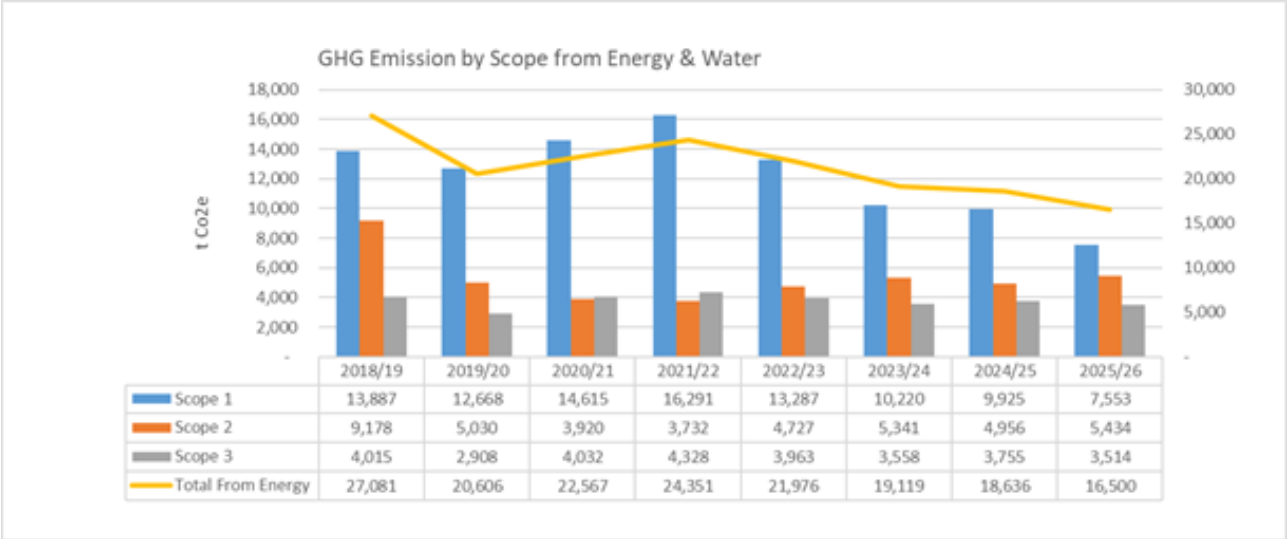
Generator gas oil

Capital replacement of oil-fired heating systems has contributed to a 94% reduction in gas oil consumption to 45,874 litres and a 77% reduction in GHG emissions compared to 2024/25. We will continue to review the use of greener alternative fuel sources for our emergency generators.



Greenhouse gas emissions from energy and water

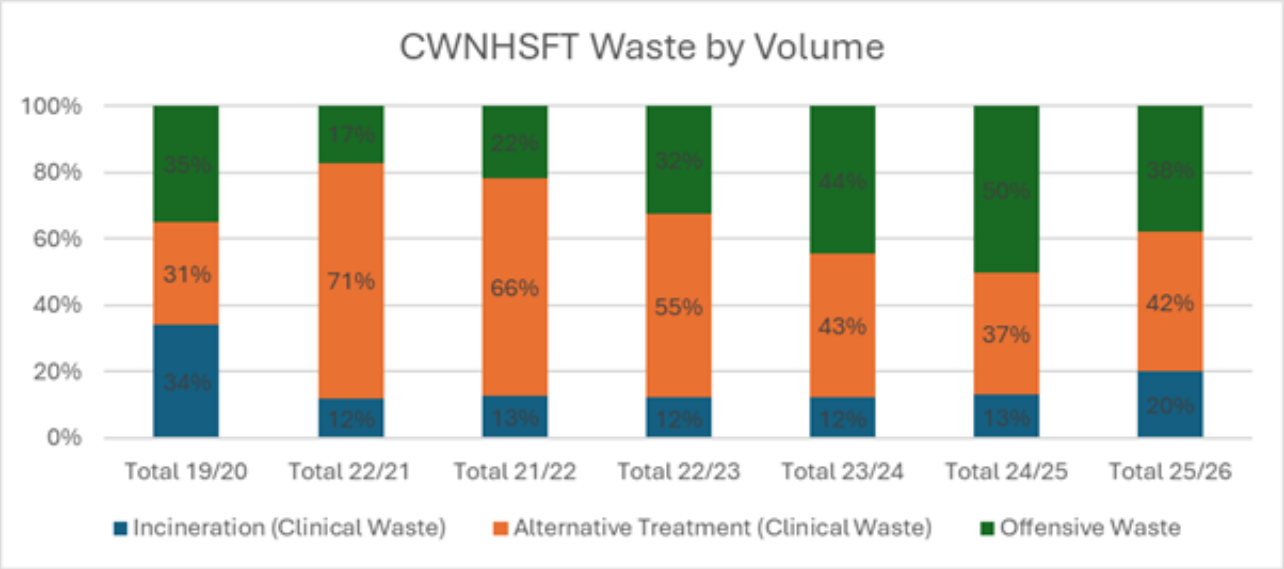
Greenhouse gas emissions from our energy and water sources experienced an 11% reduction compared to 2024/25, totalling 16,508 tCO_2e. This represents a 57% reduction relative to the Trust's 2019/20 baseline.



Waste

The Trust works closely with its staff, contractors, Infection Prevention and Control Leads and wider community to improve the segregation and reduction of waste. The Trust has a wide multidisciplinary waste group, which supports the overall Sustainability Waste workstream.

The Trust continues to monitor activity against the revisions in the Health Technical Memorandum 07-01 and overall NHS Clinical Waste Strategy. The Trust is working towards the targets of 20% incineration, 20% alternative treatment and 60% offensive waste (20:20:60), with developed contract management.



Offensive waste has not fully increased to the targeted level by the NHS of 60% of clinical waste, partly due to the need for infectious waste and partly due to a segregation issue which affected two clinical areas for two months.

With a focus on waste segregation during 2025/26, there were some sub-optimal practices identified and, as a result of this, the Trust has been able to target training and support to the areas where it is most needed.

The food waste bio-digester continues to be well used, turning 15.6 tonnes of food waste into 4.7 tonnes of usable ‘soil conditioner’ material.

Additionally, going forward at Chelsea and Westminster Hospital, the Trust is rolling out reusable sharps bins which will further reduce single-use plastic by approximately 30 tonnes, as well as changing the route of disposal where sharps will go for alternative treatment.

Medicines

The desflurane usage shown, which has a zero-usage target, relates to stock that has expired. As this needs to be removed from our system, it will show as use. No desflurane has been used for patients. This pattern is also shown at Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust, so the reported figure does not reflect patient use.

The nitrous oxide and Entonox reference information has only been updated to 1 December 2025. Figures extrapolated from the monthly average to annual estimates are also included below.

Extrapolated figures for nitrous oxide and Entonox are included because NHS Greener Dashboard data was only available up to 1 December 2025 at the time of reporting. Full data is expected by July 2026.

When full data is available, the expectation is for nitrous oxide emissions to be lower than the extrapolated figure due to the decommissioning of manifolds across Trust sites in Q4 2025/26.

Trust emissions	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26[1]
Desflurane	301.7	164.9	106	20.8	35.3	13.4	39.2[2] ↑
Sevoflurane	138.6	70.6	114.4	119.1	114.5	99.8	92.2 ↓
Isoflurane	3.7	9.1	5.2	1.4	5.8	1.9	1.8 ↓
All volatiles	**444**	**244.6**	**225.6**	**141.3**	**155.6**	**115.1**	**133.2 ↑**
Nitrous oxide: manifold	627.5	300.2	353.6	401.8	269.6	413.9	365.5[1] ↓
Nitrous oxide: portable	33.3	8.1	18	7.2	19.8	6.3	8.4[1] ↑
All nitrous oxide	**660.8**	**308.3**	**371.6**	**409**	**289.4**	**420.2**	**373.9[1] ↓**
Gas-air (Entonox): manifold	1,270	1,613	1,427	1,237	1,289	1,338	1,657[1] ↑
Gas-air (Entonox): portable	480	234	379	416	388	357	332[1] ↓
All gas-air (Entonox)	**1,750**	**1,847**	**1,806**	**1,653**	**1,677**	**1,695**	**1,989[1] ↑**

Data for the reporting period has been requested from the supplier, along with confirmation of submission timelines to NHS England for inclusion within the national dashboard to support completion of the 2025/26 return. A response was awaited at the time of writing.

Based on previous reporting cycles, the national dashboard typically reflects a lag of approximately three months. Therefore, availability of updated data is anticipated shortly.

While it would be possible to extrapolate data up to 1 December 2025 to provide an indicative position, this would not be representative due to the decommissioning of nitrous oxide manifolds during the year. Data to 1 December 2025 has therefore been included for contextual purposes, with this limitation noted.

Information technology (IT)

The digital maturity assessment is the NHS measure of progress towards digitising, connecting and transforming healthcare. In the 2025 results, the Trust ranked 8th out of 134 acute trusts. All four trusts in the North West London Acute Provider Group are in the top ten. This shows we have a strong foundation to build on, and a focus of the digital strategy going forward is to make it easier for our patients, communities and staff to interact with the digital tools that we make available.

Staff engagement and wellbeing

This year, the Trust was proud to launch its flagship staff-facing Sustainability, Health and Wellbeing platform, ‘PROUD to be Green’, in collaboration with CW+. The platform uses principles of gamification and reward to encourage positive behaviour change. It also provides the branding to visibly bring all sustainability initiatives at the Trust together under one umbrella, enabling staff to better recognise the sustainability programme as a whole.

The PROUD to be Green platform provides a framework to drive the behaviour change that will be needed among all staff if we are to succeed in our green ambitions.

Since launching in May 2024, there are now around 500 PROUD to be Green members at the Trust, many of whom are engaging in green projects and initiatives. In addition, the Trust is able to monitor CO_2e emissions avoided as a result of members’ activities. This is

1 Extrapolated to full year
2 Expired stock

the first time the Trust has been able to measure these emissions: our staff have avoided over 60,000kg CO_2e through their sustainable actions.

The transition to a net zero NHS will be driven by its people, and supporting staff to learn, innovate and embed sustainability into everyday actions at home and at work is integral to achieving the Trust's sustainability goals. To that end, sustainability modules are now embedded within existing quality improvement and leadership training programmes. This capitalises on existing structures and reinforces the understanding that sustainability is an integral part of gold-standard work.

Partnerships

The Trust continues to play an active role in sharing its learning and progress with other NHS organisations. We are proud to be among the founding members of the Circular Economy Healthcare Alliance: a group of forward-thinking trusts leading the way towards greener, more efficient care.

Procurement

In line with national guidelines, a 10% weighting for net zero and social value is included for all new contracts. Over the last year, the Sustainability Manager has supported our procurement colleagues at NWL Procurement in delivering training on this requirement to NHS suppliers.

Patient-led assessments of the care environment (PLACE)

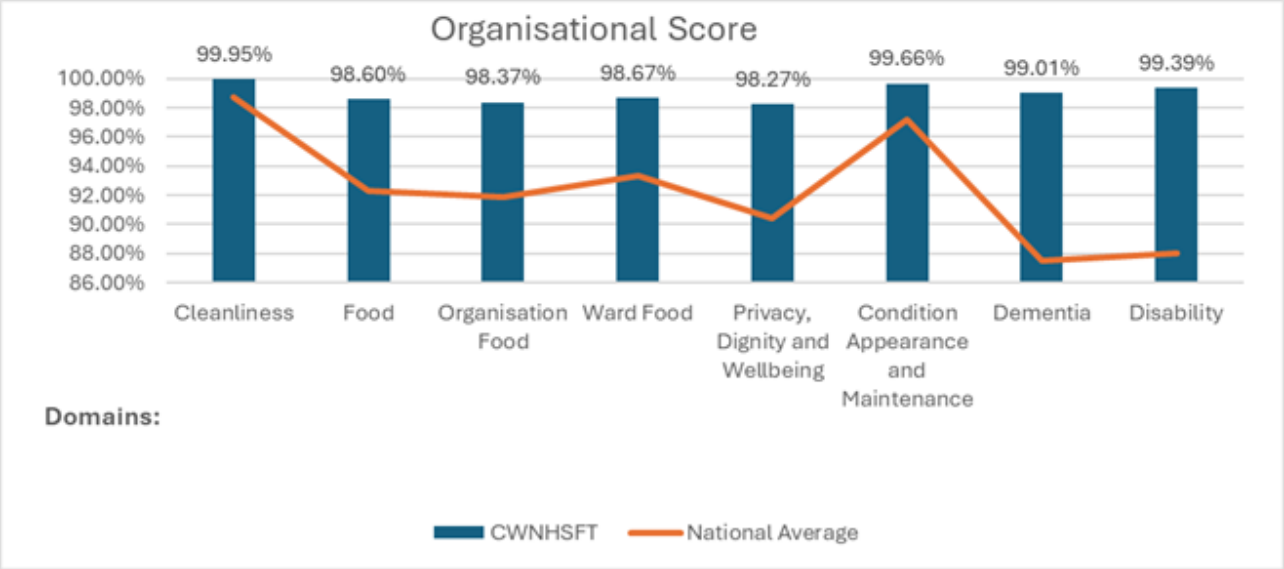
PLACE assessments were conducted at both main hospital sites during September and October 2025. Although all areas are included in the formal PLACE assessments, the Trust also undertakes regular "PLACE-light" local assessments throughout the year to continue to monitor and improve patient experience across the Trust.

Assessments were undertaken at each site in:

- 10 wards
- 10 outpatient departments
- Accident and Emergency departments
- Communal areas
- External areas
- Four food tasting sessions in each hospital

The scores achieved at both Chelsea and Westminster Hospital and West Middlesex University Hospital show further improvements from previous years and are above the national average in all domains scored. The outstanding scores and positive feedback achieved highlight the ongoing commitment to providing a safe environment that is conducive to our patients' recovery. This places the Trust among the top five peer hospitals in London, as well as one of the highest-scoring trusts nationally.

The following graphs illustrate the Trust's scores.



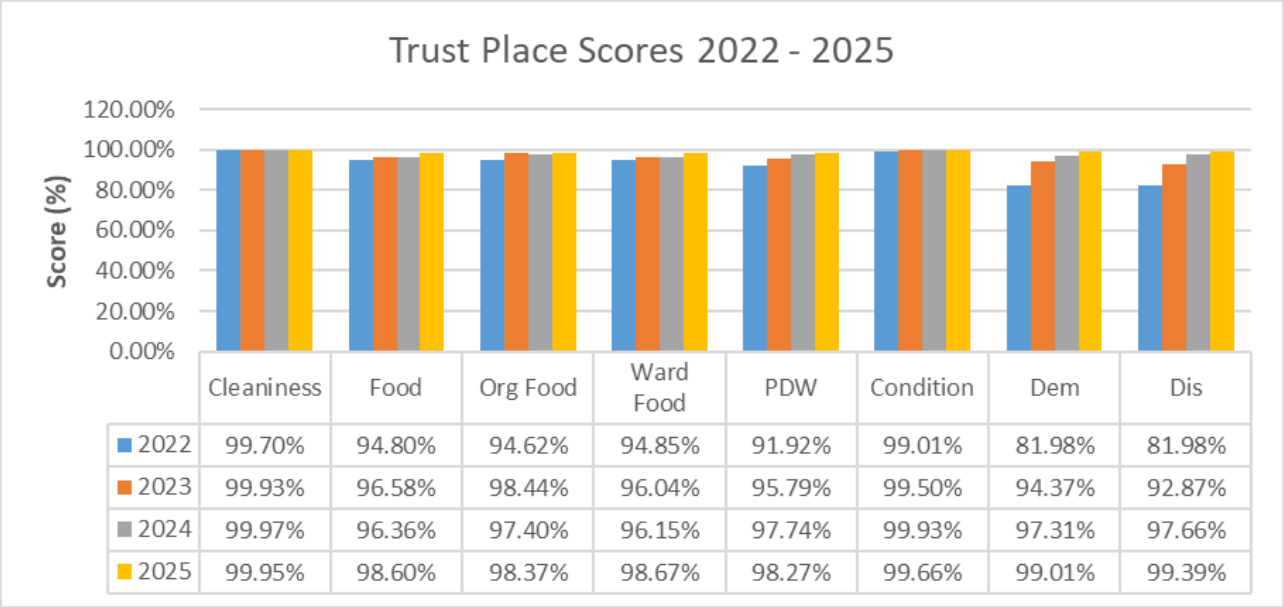
Overall, both hospitals scored extremely well compared both nationally and across the Acute Provider Group.

The Trust ranks on average 20th against all 225 NHS trusts, and 6th when ranked against NHS acute trusts.

This includes ranking 1st for Dementia and Privacy, Dignity and Wellbeing, 2nd for Disability, 3rd for Overall Food and 4th for Cleanliness against all acute trusts.

	All trusts		All acute trusts	
	Trust national rank	Total n° of Trusts	Trust national rank	Total n° of Trusts
Cleanliness	27	225	4	125
Overall food	11	225	3	125
Organisation food	22	225	20	125
Ward food	37	225	9	125
Privacy, dignity and wellbeing	11	225	1	125
Condition, appearance and maintenance	32	225	10	125
Dementia	14	225	1	125
Disability	4	225	2	125
Average ranking	**20**	**225**	**6**	**125**

There is an improving picture over the last four years across all eight domains, which reflects the work and investment made in these areas across the Trust. This is particularly evident around Dementia and Disability, where the Trust has invested in dementia-friendly clocks, automatic opening doors, new and improved wayfinding, consistent dementia-friendly toilet and wet room signage and portable hearing loops in key locations.



	Cleaniness	Food	Org Food	Ward Food	PDW	Condition	Dem	Dis
2022	99.70%	94.80%	94.62%	94.85%	91.92%	99.01%	81.98%	81.98%
2023	99.93%	96.58%	98.44%	96.04%	95.79%	99.50%	94.37%	92.87%
2024	99.97%	96.36%	97.40%	96.15%	97.74%	99.93%	97.31%	97.66%
2025	99.95%	98.60%	98.37%	98.67%	98.27%	99.66%	99.01%	99.39%

Note: Food is defined in three domains. Ward Food is scored from observations on the day and food tasting. Organisation Food is scored from the structure of the catering arrangements in place, for example the number of hot meals per day, whether the hot meal is made up of three courses and whether every patient receives a hot breakfast. Food is the combined average score of the two.

Patient environment

The estates capital plan continues to strategically invest in the hospital environment and critical infrastructure to improve patient experience and service resilience.

Highlights of successfully completed schemes in 2025 include:

- Chelsea site redevelopment of Treatment Centre: Two new theatres, recovery and short stay ward space
- West Mid and CWH paediatric ED waiting areas
- Chelsea X-ray Rooms 3 and 4: Two new specialist X-ray machines and rooms refurbished
- Chelsea Interventional Radiology recovery: Increasing capacity from three to four bed spaces
- West Mid CT Scanner: New CT scanner and room refurbished

Over the next financial year, investment continues with the following schemes currently in construction or planning stages:

- West Mid Diagnostic, Treatment and Education Centre (DTEC): Planned opening in Q4 2026
- Chelsea new Endoscopy Procedure Room
- Chelsea creation of paediatric LTV sleep study spaces
- Building energy efficiency, critical infrastructure and air handling schemes
- Main Theatre refurbishment: Theatres to be refurbished in the Main Theatre area with work planned to begin in 2027

Social, community, anti-bribery and human rights issues

There have been no anti-bribery or human rights issues to escalate throughout the year. The Trust's modern slavery statement was approved by the Audit and Risk Committee and demonstrates full compliance. The statement is available at www.chelwest.nhs.uk/corporate-publications.

Community

The Trust continued to work closely with our NHS and community partners throughout the year to ensure effective care was provided to residents.

Equality, diversity and inclusion

The 2025/26 Belonging Action Plan was further streamlined to outline clear priorities, objectives and responsibilities for areas within the People and Organisational Development teams. The plan focuses on addressing discrimination, improving staff experience, embedding inclusive leadership and strengthening accountability across the organisation.

Some of the highlights from 2025/26 include:

- Improved scores in the Promise Element of the NHS Staff Survey "We are compassionate and inclusive". Our scores increased in the EDI section with a score of 8.19 from 8.14 in 2025 and an improved score in the Inclusion section with a score of 6.93 from 6.90 in 2024
- An improved position in relation to staff experiencing discrimination from a manager, team leader or colleague at 10.04%, down from 11.53% in 2024
- Launched the Domestic Abuse and Sexual Safety People Policy
- Established the Just and Learning Panel to consider and agree a recommendation on whether formal disciplinary investigations should be initiated in employee relations cases
- Launched the Inclusive Recruitment Action Plan
- Established the Armed Forces Family Network
- Our five staff networks, ENRICH, Women's, Disabled, LGBTQ+ and Armed Forces Family, each have an Executive Sponsor and chairs or co-chairs
- Published the 2024/25 Ethnicity Pay Gap Report
- Continued to grow our Diversity and Inclusion Champions (DIC) programme of work, increasing numbers and maintaining compliance with DIC representatives on interview panels
- Participated in the Healthcare Leaders' Fellowship regional leadership development programme for clinical colleagues from Black, Asian and minority ethnic backgrounds

Disabled employees

We published our 2024/25 Workforce Disability Equality Standard (WDES) report on 31 October 2025. It is available at www.chelwest.nhs.uk/equalityinfo.

The table below shows the number of staff who have declared that they have a disability. The declaration rate has been at around the same level of 3% for several years and efforts continue to improve declaration rates.

Staff declaring disability status on ESR, March 2026	Total	% of workforce
Declared that they have a disability	253	3.2%
Declared that they do not have a disability	6,198	79.6%
Not stated if they do or do not have a disability	1,332	17.2%

Our 2025 staff survey results show a slight change in the staff engagement score for disabled staff, at 6.67 from 6.78 in 2024. Our Disabled Staff Network continues to grow in visibility across the organisation, reflecting the commitment to creating an inclusive and supportive workplace.

The network has expanded to include dedicated subgroups that focus on the specific needs and experiences of our colleagues, including those with dyslexia and other neurodivergent conditions. These groups provide tailored peer support, raise awareness and help shape policies and practices that remove barriers and enable all staff to thrive. Their ongoing work is strengthening our culture and ensuring that diverse voices are heard and valued.

We published our Workforce Disability Equality Standard action plan as part of our wider Trustwide EDI plan, setting out the steps we will take to address the key areas of focus, working with the Disabled Staff Network.

Learning disabilities

Project SEARCH is now in its seventh year with the Trust, with interns who have autism and/or a learning disability placed within the Trust to gain work experience and progress to future employment within the organisation. The facilitators of Project SEARCH, with support from the People and Organisational Development team, agreed to use their expertise to support staff who require additional support in completing online mandatory training.

The pilot was introduced to address challenges with traditional NHS mandatory eLearning, including accessibility barriers, learning fatigue and excessive time away from frontline duties.

The Inclusive Working eLearning Pilot was a one-year pilot introducing a new, inclusive design approach to online core mandatory training across the Trust. It covered five core compliance topics, including health and safety, infection prevention, fire safety, data protection and safeguarding, and was designed to better support different learning styles, visual learners and accessibility needs.

Over the one-year period starting in May 2025, the pilot tested an inclusive design approach across five core compliance modules. By February 2026, 3,780 individual courses had been completed, with 395 staff feedback responses collected. The purpose was to assess whether inclusive, accessible eLearning could act as a reasonable adjustment at scale while improving learning quality and staff experience.

The outcomes demonstrate clear benefit. 97% of staff reported increased confidence in doing the right thing at work, 94% found the training easy to understand, and 86% want this approach adopted Trustwide.

Compared to standard eLearning, staff learned more in less time, returned to work faster and experienced reduced stress. Importantly, no staff rated the pilot as worse than existing Trust eLearning across speed, engagement or accessibility. The pilot provides strong evidence that inclusive eLearning improves confidence, efficiency and wellbeing, and supports a recommendation to move from pilot to Trustwide adoption.

Safeguarding

The Trust actively engages with local safeguarding adult and safeguarding children boards. The Trust has a dedicated team of professionals who work to protect vulnerable adults and children. There are named leads for both safeguarding children and adults who report regularly through the governance structure to the Trust's Quality Committee. The Trust has a team of independent domestic violence advisors to support patients and staff who are affected by domestic abuse, an increasing issue over recent years.

The Trust also has a team of mental health nurse leads and mental health nurses (RMNs) to support the care of patients with mental health issues while they are in our hospitals. This team works alongside our partner providers and delivers extensive training programmes throughout the organisation to enable staff to provide care and support to those in need. The Trust offers a range of mandatory and additional training in all areas of safeguarding for both children and adults.

Anti-bribery

The Trust does not tolerate any form of fraud, bribery or corruption by employees, partners or third parties acting on behalf of the organisation. We investigate allegations fully and apply sanctions to those found to have committed a fraud, bribery or corruption offence.

RSM has continued working with the Trust during 2025/26 to provide local counter-fraud specialist services in accordance with Secretary of State directions. The Trust Board's Audit and Risk Committee formally approves the counter-fraud annual work plan and the policy for counter-fraud and corruption, and progress reports are provided to the Committee at each meeting.

Volunteers

In 2025/26, volunteers contributed over 41,100 hours, in line with the previous year, supported by a stable cohort of 270 active volunteers. This consistency demonstrates that our volunteering programme has now stabilised.

As highlighted in last year's annual report, we streamlined volunteer roles and focused recruitment, induction and training around these priorities to maximise impact for our patients. Since implementing this approach, we have seen significantly positive outcomes on our wards. Volunteers supported over 11,000 patients at mealtimes, including approximately 1,000 who required direct feeding support, and provided companionship to around 17,000 patients. As a result, 86% of patients reported an improvement in their mood.

Volunteer roles continue to span the entire hospital, including support in A&E, infant feeding on the maternity ward, responder roles meeting departmental needs, Pets as Therapy, Butterfly Volunteers, meet-and-greet services accompanying patients to appointments, among others, and, more recently, outpatient volunteer roles. Over a three-month period, outpatient volunteers helped improve DNA rates by 2% among some of our most socially deprived patients.

Our volunteer workforce continues to reflect our local community, something we value greatly and continue to build on. Volunteering also provides meaningful opportunities for individuals, with many going on to further training, careers, or using volunteering as a way to give back, build relationships and develop skills.

The Butterfly Volunteer Service continues to have a profound impact on patients and families during some of the most difficult moments of their lives. The service supported over 1,000 patient visits, with volunteers spending more than 500 hours at the bedside, delivered by a dedicated team of 26 volunteers.

Charity matters—CW+

CW+, our official charity, works with the Trust to create world-class facilities, drive innovation and research, and enhance patient and staff wellbeing. The Trust is committed to actively promoting and supporting CW+, and several directors of the Trust Board are CW+ trustees. This shared governance arrangement is designed to ensure clear alignment between the strategic priorities of both organisations.

Throughout the past year, CW+ and its generous community continued to support our patients, families and staff, for which we are incredibly grateful.

Fundraising

CW+ anticipates raising approximately £5.7m in the 2025/26 financial year, subject to final audit and Board approval. This includes income associated with the strategic merger with Paintings in Hospitals, supporting the development of a national art collection across multiple hospitals in England, and a significant gift towards research following the merger of the Westminster Medical School Research Trust into CW+.

This year, fundraising activity has continued to focus on key Thirty at Thirty appeal targets. £1m was raised for the new Day Surgery Unit at Chelsea and Westminster Hospital, and engagement with fundraising for the Diagnostic, Treatment and Education Centre at West Middlesex University Hospital increased. Both projects have enabled CW+ to involve the local community, along with our networks of valued philanthropic supporters and large grant givers.

In a challenging fundraising landscape, the charity continues to focus on deepening and diversifying its audience base to offer the best possible chance of raising the funds our hospitals need. New initiatives this year included the delivery of Walking West, a 13-mile walk between Chelsea and West Mid to mark the 10-year anniversary of the merger of our two hospitals into one Trust. More than 150 people took part. CW+ also hosted an interfaith Iftar at West Mid during Ramadan, celebrating the hospital’s role as a pillar of the local community.

The charity has continued to secure funding for specific clinical areas, including NICU, HIV and GUM, and remains committed to working collaboratively with colleagues across the Trust to identify funding opportunities, increase engagement and strengthen support for its work.

CW Innovation

Led jointly by CW+ and Chelsea and Westminster Hospital NHS Foundation Trust, CW Innovation paves the way for new ideas, and new ways of using existing ideas, that will improve patient care, patient experience and the way our hospitals and clinics are run.

A major milestone this year was the new partnership with La Roche-Posay to expand the use of DERM AI, the world's first autonomous AI for skin cancer diagnosis. Initially introduced through CW Innovation, DERM AI is already speeding up assessment for patients with benign lesions and enabling earlier skin cancer detection.

In partnership with the Behavioural Insights Team, the CW Innovation Team's work with La Roche-Posay focuses on understanding patients' attitudes towards autonomous AI in diagnosis, and on improving communication about these innovations. A further strand of this partnership centres on helping patients to protect their skin, with the aim of reducing future skin cancer cases. CW Innovation is also working with La Roche-Posay to engage dermatology services nationally and support wider adoption of the Skin Analytics DERM AI platform, enabling more patients to benefit.

With support from CW Innovation and through the CW Innovation Fellowship, Dr Richard Lee evaluated the impact of Ufonia's Dora AI on patients who were referred to the Trust for cataract surgery. The automated telephone system supports patients before and after surgery, improving efficiency, enhancing patient experience and reducing the need for in-person appointments. Dora AI is now fully embedded as business-as-usual.

Now in its fourth year, the CW Innovation Fellowship programme continues to support Trust staff to develop and deliver their innovative project ideas. Projects in Cohort 4 are progressing well, with several already moving into early deployment, demonstrating the programme's impact in enabling staff-led innovation.

This year also saw the appointment of the first CW Innovation Associate. Aglaia Gantzopoulou, Maternity Lead Immunisation Midwife and former CW Innovation Fellow, undertook a part-time secondment as Innovation Associate in VR/AR. During this time, she developed the programme's VR portfolio and supported delivery of the first CW+ VR/AR Funding Call, which generated a strong response and showcased innovative uses of immersive technology across the Trust.

Additionally, CW Innovation projects were showcased during a visit by Peter Kyle MP, Secretary of State for Science, Innovation and Technology. CW Innovation also remains a national partner on the NHS CEP InSites Programme and continues to support Cohort 9 of the DigitalHealth.London Accelerator, further strengthening its role in driving innovation across the NHS.

Arts in health

In this financial year, the charity's Arts Team continued working with the Trust to support capital projects and design new spaces across both hospital sites.

A key achievement was the completion of major enhancements to the Day Surgery Unit (DSU) at Chelsea and Westminster Hospital. The scheme included commissioning a sculptural entrance canopy by architectural metalsmith Heather Burrell, and an integrated series of biophilia-inspired artworks on the window glazing throughout the new unit. Bespoke lightboxes by leading botanical photographer Jonathan Buckley bring nature, light and colour into the interior rooms and corridor spaces. The planter next to the DSU entrance was relandscaped as part of the works to support patient wayfinding.

The waiting room in the Paediatric Emergency Department at Chelsea underwent a full refurbishment, led by award-winning architects White Arkitekter.

CW+ significantly improved the patient and staff experience at West Middlesex University Hospital through a major refresh of its art collection, commissioning a striking series of artworks that bring colour, calm and creativity into clinical spaces. Three new installations—Hannah Lim's *Winged Archway* sculpture, Lucia Pizzani's corridor work *Healing Flows* and Joy Labinjo's large-scale painting *Isleworth Riverside*—were developed in close collaboration with hospital staff, patients and visitors, ensuring each piece reflects and celebrates the local community it serves. Lucia's commission for the Intensive Care Unit won Gold at the 2025 Building Better Healthcare Awards, and *Winged Archway* has been nominated for a PSSA Marsh Award.

The CW+ Arts for All (AfA) programme creatively engaged patients and staff in ward sessions, classes and workshops. In total, AfA artists made over 500 visits to the hospitals, reaching more than 12,000 patients and 5,000 staff. A highlight was a new writing residency based in the Haematology and Oncology unit at West Middlesex University Hospital. The Writer in Residence, Rebecca Goss, has shared her experience in *The Lancet*.

In the CW+ Studio at Chelsea and Westminster Hospital, the Kobler Rehabilitation Group shared the work of their creative physiotherapy classes, designed in partnership with staff and the English National Ballet School, in a performance for friends, family and the public at the Royal Opera House.

The CW+ GreenUP project at West Middlesex University Hospital engaged 15 new partners, including Royal Botanic Gardens, Kew, to deliver the seasonal participation programme. From April to November, 170 activities provided opportunities for participants to learn new skills in growing, biodiversity and sustainability, and to take part in wellbeing and creative sessions.

Following the merger of CW+ and Paintings in Hospitals in July, the Arts Team has been working with new colleagues to shape the development of an ambitious programme called NHS Arts, which will make use of a collection of around 2,500 artworks as part of a broader national creative health infrastructure.

Grants

The CW+ Grants programme provides funding to Trust staff to support projects that improve patient care, staff wellbeing and service development. The Grants team continued to see strong engagement from staff, awarding 307 grants in the 2025/26 financial year.

This year, grants included piloting EMPOWER, an endometrial cancer pathway for obesity management in women, and upgrading the pharmacy satellite dispensary on David Evans

Ward, allowing it to dispense all eligible TTOs for a wider range of wards within the Planned Care Division at the point of care.

The final round of the first CW+ virtual and augmented reality funding call was held in March. The winning project, 'Ophthalmology by the bedside—VR in stroke', based at West Middlesex University Hospital, uses VR to assess vision problems in stroke patients at the bedside. This enables patients to be seen quickly and comfortably at the bedside, reducing the need for transport to ophthalmology services at Chelsea and Westminster Hospital.

Alongside these larger-scale projects, CW+ awarded just under £50,000 in small grants to staff across the Trust to support fast-track projects that improve patient care and experience. These included a booklet explaining the serial casting journey for autistic children, exercise equipment to support paediatric patients' recovery, patient support groups and awareness stalls for the public.

More than £73,000 was awarded to support staff training and development, including funding for staff to attend national and international conferences to represent their work and the Trust. In addition, the Joint Research Committee (JRC) awarded one PhD, one Fellowship and eight small grants to support staff with postgraduate education and research projects.

This year, CW+ also awarded over 85 grants totalling £28,000 to support staff morale and wellbeing. The grants supported staffroom enhancements and team-building activities that helped support better communication and collaboration. Staff fed back that the support made a meaningful difference to the wellbeing of the team.

The CW+ Grants programme is open to all occupational groups, and the team continues to promote the Booster scheme, specifically targeting staff in junior and non-clinical roles. The team awarded 24 grants totalling £3,000 for items to improve patient experience, such as tools to reduce stress in clinics, resources for dementia patients and distraction devices.

Regional and national programmes

While the charity's priority focus remains local, it is building on these successes by supporting neighbouring trusts and national programmes wherever it can add value, expertise and leadership.

Best For You

Best For You is an innovative approach to mental health care designed for, and in consultation with, young people and their families. It is run in partnership by Central and North West London NHS Foundation Trust, Chelsea and Westminster Hospital NHS Foundation Trust, West London NHS Trust and CW+, and is evaluated by experts at Imperial College.

In May 2025, Best For You celebrated the end of its first phase. An event at Chelsea and Westminster Hospital featured a discussion with a young person with lived experience, highlighting how the programme's work across the trusts, in the community and online supports young people experiencing similar challenges. The event also launched the next phase of the programme, during which the founding partner organisations will continue to

build on these achievements while driving adoption across north west London, the UK and beyond.

The Best For You website, which brings together mental health resources for young people, welcomed over 47,000 visitors in 2025/26. In response to feedback, the Best For You team redeveloped the site, working with more than 75 young people and 13 clinicians to improve navigation, expand content and develop interactive signposting tools.

In February 2026, Imperial College London hosted an event to share findings from the programme's evaluation. Best For Us, the programme's Danish partner, also presented its learnings at the event.

National Neonatal Palliative Care Programme

Over the past year, the National Neonatal Palliative Care Programme has made significant progress in expanding training, strengthening national influence and supporting the neonatal workforce across England.

Training has now been completed in the South East and Northern Operational Delivery Networks (ODNs), bringing the total to seven of the ten Neonatal Networks in England. National education sessions have continued to grow, reaching 787 unique users and 1,860 total attendees, with representation from all regions of England and participation from the devolved nations.

The next phase of delivery is already underway in the East of England Neonatal Network, with training in the East and West Midlands due to begin in spring 2026.

The programme is also helping shape the future of neonatal palliative care at a national level. This includes advising on NHS England-funded training for all ODNs, contributing to e-learning content for the NHS England Learning Hub and leading national guidance work. Programme Lead Alex Mancini serves as Co-chair of the British Association of Perinatal Medicine (BAPM) scoping exercise reviewing implementation of the 2024 framework, and is contributing to the Modern Service Framework for palliative care.

The programme also continues to run peer support and specialist interest groups nationally, helping to develop skills and confidence across specialist and associated palliative care roles.

Volunteering for Health

Volunteering for Health is a £10m programme that is testing and building volunteering infrastructure through 15 partnerships across England. By empowering communities, as volunteers, to improve health and wellbeing in ways that matter most to local people, and connecting VCSE community partners with Trusts to enhance health volunteering across the system, the programme's aims align with the ambitions for neighbourhoods articulated in the 10-Year Plan.

Partnership successes include the transfer of volunteers between hospital and community settings, widening participation of CORE20PLUS5 groups, improved accessibility and flexibility of volunteer roles, and the streamlining of volunteering recruitment. Several partnerships are running pilot projects to test specific approaches to volunteering for priority groups in new roles.

The programme community meets monthly for learning days, and self-led ‘community conversations’ have taken off around passporting, volunteer-to-career pathways, evaluation and person-centred approaches.

The programme is starting to gather evidence for the far-reaching health benefits of volunteering to individuals, the NHS and wider communities. The first year’s evaluation highlighted the importance of the national programme in strengthening the case for investment in volunteering infrastructure and influencing policy as the health landscape continues to evolve.

HIV, sexual health and gender

CW+ is proud to support the Trust’s HIV Sexual Health Directorate across four key areas: education, awareness, community engagement and research. Over the past year, the charity has contributed to a wide range of initiatives, including sourcing funding and providing project management for several PrEP programmes funded by ViiV Healthcare. CW+ also helped deliver a ‘lost to HIV care’ project in partnership with other hospital trusts and community organisations through Fast Track Cities London.

The Directorate continues to welcome clinicians from across Europe through the CW+-administered Clinical Observation Programme, funded by MSD. This year, nine delegates joined the team to exchange knowledge and explore the latest approaches in HIV treatment and care. CW+ also supports a Project Manager post, funded by ViiV Healthcare, which focuses on improving care for older people living with HIV.

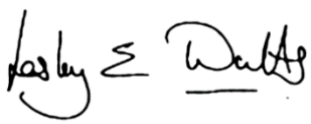
The charity’s Arts for All team continues to work closely with the HIV Physiotherapy team, English National Ballet School and other partners to offer wellbeing activities for older people living with HIV who attend the Kobler Clinic.

In addition, CW+ grants have part-funded an Independent Domestic and Sexual Violence Advisor role, providing vital support to survivors of domestic and sexual violence through the integrated Sexual Health London online platform. The charity also continues to invest in staff development by funding training and conference opportunities.

Important events after the reporting period

Integrated Care Board changes

Following the year-end, from 1 April 2026, NHS England implemented changes to Integrated Care Board (ICB) structures, including the merger of North Central London (NCL) and North West London (NWL) ICBs into a single organisation. This has been accompanied by changes in leadership arrangements across the system.



p.p. Lesley Watts
Chief Executive

for Prof Tim Orchard
Group Chief Executive and Single Accountable Officer

SECTION 2

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

Governance arrangements in the North West London Acute Provider Collaborative, 2025/26

During 2025/26, the four acute trusts in North West London continued to operate under the Acute Provider Collaborative (APC) governance model established in 2022. Each trust remained a separate statutory entity with its own Board, working together through a Board in Common and aligned committee structures. The trust boards of the four acute trusts are:

- Chelsea and Westminster Hospital NHS Foundation Trust
- The Hillingdon Hospitals NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- London North West University Healthcare NHS Trust

The governance arrangements have been developed based on core principles of corporate governance in a collaborative system, including adhering to the principle of subsidiarity (meaning decision-making should be local where possible) while ensuring collaborative decision-making and holding each other to account and ensuring the continuation of public accountability and stakeholder involvement and engagement at trust level as well as at the level of the collaborative.

In practice, the Board in Common (comprising all four trust boards meeting together) provided strategic direction for the collaborative and made joint decisions on shared priorities. The Board in Common met quarterly in public and remained collectively responsible for setting collaborative strategy and overseeing delivery across the trusts.

Each trust also maintained its own Trust Standing Committee (a committee of the whole local board) to ensure robust local oversight and assurance. These standing committees, established in the prior year in response to an internal audit recommendation, met quarterly and were composed of all board members of the respective trust.

They reviewed trust-specific issues including quality, finance and operational performance, workforce, and key risks through regular reports (e.g. quality and safety metrics, financial performance, Board Assurance Framework updates, and outputs from each trust's specialist committees). The Chair of each Trust Standing Committee reported key matters and risks up to the Board in Common, ensuring that local issues requiring collaborative action could be escalated appropriately.

In parallel, several collaborative (APC-level) committees continued to operate across the four trusts. These included committees for Quality, Workforce (People), Finance and Performance, Digital and Data, and Strategic Estates, Infrastructure and Sustainability. These cross-trust committees focused on developing joint strategic priorities and they provided a consolidated view of performance and risks in their domains across the collaborative. They reported summary updates to the Board in Common, supporting group-wide assurance and strategy development.

Additionally, each trust maintained its own statutory committees—for example, individual Audit and Risk Committees and Nominations and Remuneration Committees—to fulfil regulatory requirements and uphold each Board's responsibilities for internal control, risk management, and executive appointments. The four Audit and Risk Committees remained

independent in each trust (reflecting that each trust must maintain its own system of internal control), coordinating where necessary, and provided assurance reports into their respective Trust Standing Committees.

Likewise, two trusts in the collaborative (Chelsea and Westminster and Hillingdon, as foundation trusts) continued to operate Councils of Governors during 2025/26, preserving foundation trust accountability in line with national requirements.

Governance developments during 2025/26 (transition to group model)

Importantly, during 2025/26 the trusts made several key governance decisions to prepare for the next stage of collaboration, the planned transition from the APC model to a formal Acute Provider Group (APG) governance model effective from 1 April 2026. These decisions did not alter the operational governance for 2025/26, but set the future direction and were documented and approved through the Board in Common and other relevant bodies over the course of the year.

This year saw the North West London acute trusts maintain their established collaborative governance arrangements while laying the groundwork for the new Group model. Notably, the appointment of a Group Chief Executive and the approval of a revised committee structure and Scheme of Delegation were key milestones in this transition. Further detail on the Group governance model approved by the Board in Common on 20 January 2026 is available on the Acute Provider Group website.

Names of Trust directors during 2025/26

The table below lists the names of directors during 2025/26 and up until the time of writing this annual report.

Name	Title	Period	Unexpired term	Notice period
Matthew Swindells	Chair in Common	1 Apr 2022–31 Mar 2026	n/a	3 months
Patricia Gallan[3]	Non-Executive Director	1 Jul 2023–present	16 months	3 months
Aman Dalvi	Non-Executive Director	1 Dec 2019–31 Mar 2026	n/a	3 months
Ajay Mehta	Non-Executive Director	1 Dec 2019–31 Mar 2026	n/a	3 months
Carolyn Downs	Non-Executive Director	1 Sep 2023–31 Mar 2026	n/a	3 months
Dr Syed Mohinuddin	Non-Executive Director	1 Jul 2023–present	12 months	3 months
Mike O'Donnell	Non-Executive Director	1 Nov 2025–present	17 months	3 months
Catherine Williamson	Non-Executive Director	20 Jan 2025–present	18 months	3 months
Vineeta Manchanda	Non-Executive Director	1 May 2025–present	10 months	3 months
Helen Stephenson	Non-Executive Director	1 Oct 2025–31 Dec 2025	n/a	3 months
Bob Alexander	Interim Group Chair	1 Apr 2026–present	4 months	3 months
Baljit Ubhey	Non-Executive Director	1 Apr 2026–present	36 months	3 months
Tanaka Chiimba	Non-Executive Director	1 Apr 2026–present	33 months	3 months
Lesley Watts	Chief Executive Officer	14 Sep 2015–present	n/a	6 months
Robert Bleasdale	Chief Nursing Officer	4 Apr 2022–present	n/a	6 months
Dr Roger Chinn	Chief Medical Officer	4 Apr 2020–present	n/a	6 months
Virginia Massaro	Chief Financial Officer	1 Oct 2019–present	n/a	6 months

[3] Became Vice Chair from 1 November 2025 for a further three years

Register of interests

Board members are required to declare their interests annually and as they change, in addition to confirming they meet the fit and proper person condition as set out in Regulation 5 of the *Health and Social Care Act 2008 (Regulated Activities) Regulation 2014*.

Members of the public can view the register of directors' interests on the Trust website at www.chelwest.nhs.uk/bod, by emailing chelwest.corporategovernance@nhs.net or by writing to:

Corporate Governance Team
Chelsea and Westminster Hospital NHS Foundation Trust
369 Fulham Road
London
SW10 9NH

Well-led framework

Ensuring that the Trust is well-led is key to our commitment that services are safe and patient-centred. In November 2019, we welcomed the Care Quality Commission (CQC) to inspect our services, which included a well-led inspection, and a use of resources inspection by NHS England. The Trust maintained the rating of 'good' overall, with the well-led rating improving to 'outstanding', and maintained a use of resources rating of 'outstanding'. The Chelsea site improved from 'good' to 'outstanding', and the West Middlesex site maintained a rating of 'good'.

The organisation undertakes periodic self-assessments against the CQC and NHS England Well-led framework to support continuous improvement. While the Trust has not undertaken a standalone externally facilitated Well-led review during the reporting period, it has drawn on a range of sources of assurance. This includes a North West London Acute Provider Collaborative governance review during 2023/24, facilitated by Internal Audit, which considered leadership and governance arrangements across partner organisations.

The Trust also continues to use internal self-assessments against the Well-led framework and other sources of assurance to review the effectiveness of its governance arrangements. An overview of the arrangements in place to govern service quality is included in the annual governance statement and will be included in the Quality Report, published separately in accordance with the Health Act 2009 and associated regulations. These arrangements include a clear 'ward to board' assurance framework covering quality, workforce, performance and finance. The Quality Committee seeks assurance on systems, processes and outcomes relating to quality (safety, clinical effectiveness and patient experience) on behalf of the Trust Board.

The Trust underwent an announced routine inspection of the Nuclear Medicine department at Chelsea and Westminster Hospital in May 2025 under the IR(ME)R regulations as part of CQC's proactive inspection programme. No enforcement action was required, and a detailed action plan addressing two recommendations for improvement was submitted to, and accepted by, the CQC.

The Trust's leadership team has regular meetings with its CQC relationship manager and remains in regular contact to respond to any queries. To the best of the directors' knowledge, there are no known material inconsistencies between:

- the annual governance statement
- the corporate governance statement and annual report

In 2026/27, the Trust will continue to develop its governance arrangements as part of the North West London Acute Provider Group, including further alignment of committee structures, reporting and assurance processes. A further internally facilitated review of governance arrangements, aligned to the principles of the Well-led framework, is planned during 2026/27.

Compliance with cost allocation and charging guidance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political donations

The Trust did not make any political donations during 2025/26 (none in 2024/25).

The Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier. The Trust's compliance with the code is set out in the following table.

Measure of compliance	2025/26 n°	2025/26 £000	2024/25 n°	2024/25 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	88,303	333,654	92,682	334,651
Total non-NHS trade invoices paid within target	83,792	313,491	88,557	318,475
Percentage of non-NHS trade invoices paid within target	**94.9%**	**94.0%**	**95.5%**	**95.2%**
NHS payables				
Total NHS trade invoices paid in the year	2,846	73,028	3,041	76,742
Total NHS trade invoices paid within target	2,432	59,840	2,684	67,729
Percentage of NHS trade invoices paid within target	**85.5%**	**81.9%**	**88.3%**	**88.3%**
Totals				
Total trade invoices paid in the year	91,149	406,683	95,723	411,394
Total trade invoices paid within target	86,224	373,331	91,241	386,204
Percentage of total trade invoices paid within target	**94.6%**	**91.8%**	**95.3%**	**93.9%**

The reduction in performance during the year was partly due to the insourcing of some facilities contracts and the associated requirement to set up new suppliers, which delayed some payments. Increased purchase order compliance practices have been put in place and this should lead to improved performance in 2026/27.

In 2025/26, there were late payment charges of £2k (2024/25: £14k).

Disclosure of information to Trust auditors

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

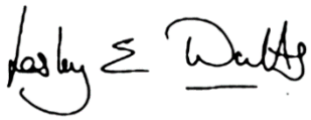
Fees and Charges (income generation)

There was no income or costs associated with fees and charges levied by the Trust where the full cost exceeds £1 million or the service is otherwise material to the accounts.

Income disclosures

The Trust has met the requirement of *Section 43(2A) of the NHS Act 2006*, as amended by the *Health and Social Care Act 2012*, in that its income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for other purposes.

The impact of other income which the Trust has received has been invested in the provision of goods and services for the purposes of the health service in England.



p.p. Lesley Watts
Chief Executive

for Prof Tim Orchard
Group Chief Executive and Single Accountable Officer

REMUNERATION REPORT

Annual statement on remuneration

The Nominations and Remuneration Committee is a committee of the Trust Board which is appointed in accordance with the constitution of the Trust to determine the remuneration, allowances, pensions and gratuities or terms of service of the executive directors, and rates for the reimbursement of travelling and other costs and expenses incurred by directors.

In 2025/26, the Committee met on three occasions to consider a number of matters within its terms of reference, including making decisions on the remuneration and terms of service of the executive directors' and very senior managers' pay. When making decisions on the salaries of executive directors, the Committee considered benchmarking data for comparable positions, particularly to ensure that salaries remained appropriate where responsibilities of senior managers were amended in line with national guidance. Changes made to the salaries of executive directors during 2025/26 were in line with national pay recommendations and benchmarking.

The Committee does not determine the terms and conditions of office of the Chair and non-executive directors. These are decided by the Council of Governors at a general meeting.

Patricia Gallan
Vice-Chair and Chair of the Nominations and Remuneration Committee

25 June 2026

Senior managers' remuneration policy

The Nominations and Remuneration Committee sets pay and employment policy for the executive directors and other senior staff designated by the Trust Board. The Trust's policy is for all executive directors to be on permanent Trust contracts with six months' notice.

Remuneration consists mainly of salaries, which are subject to satisfactory performance, and pension benefits in the form of contributions to the NHS Pension Fund. There were nine senior managers whose pay exceeded £150,000 during 2025/26, an increase of two compared to the previous year.

Remuneration is set with due regard to benchmarking information from other NHS organisations and public sector bodies as appropriate, and survey data. Experience, performance and portfolio are also taken into account.

Salaries are awarded on an individual basis, taking into account the skills and experience of the post-holder and comparable salaries for similar posts elsewhere. Pay is also compared with that of other staff on nationally agreed Agenda for Change terms and conditions, and medical and dental staff terms and conditions.

Increases in pay can be withheld where it is considered, through the annual appraisal process, that individual or Trust performance does not warrant an increase, but is also subject to affordability and labour market conditions.

There are provisions within the directors' contracts of employment for recovery of sums, should performance fall below the required standard. Trust employees were not specifically consulted on the policy and procedure for determining the remuneration of directors, however the policy was developed with full consideration given to the terms and conditions of other staff groups within the Trust and in accordance with national guidance. The policy is aligned in many ways to the terms and conditions of other staff groups.

The Council of Governors determines the terms of appointment for non-executive directors based on benchmarking data for similar posts elsewhere in the NHS. Typically, non-executive directors are appointed for three-year terms of office and do not have access to the NHS pension scheme.

The Trust has complied with the requirements of the NHS Very Senior Manager (VSM) pay framework issued by the Department of Health and Social Care and NHS England. Where required, appropriate national approvals for senior pay arrangements were sought and received during the reporting period. The Trust has not made any material departures from the framework.

Information on the salaries and pensions of directors is included within the senior manager remuneration tables in the annual report on remuneration section.

Diversity

The Trust recognises that it has a legal obligation to ensure that its practices through service provision and its employees do not discriminate. The Trust is committed to promoting equality of opportunity and equity of opportunity for all its employees. Individuals will be treated fairly in all aspects of their employment at the Trust. The gender and ethnicity of the Trust Board during 2025/26 is provided below:

Role	First name	Last name	Gender	Ethnicity
Non-Executive Director	Matthew	Swindells	Male	White
Non-Executive Director	Patricia	Gallan	Female	BME
Non-Executive Director	Ajay	Mehta	Male	BME
Non-Executive Director	Aman	Dalvi	Male	BME
Non-Executive Director	Carolyn	Downs	Female	White
Non-Executive Director	Michael	O'Donnell	Male	White
Non-Executive Director	Vineeta	Manchanda	Female	BME
Non-Executive Director	Helen	Stephenson (left Oct 2025)	Female	White
Non-Executive Director	Catherine	Williamson	Female	White
Non-Executive Director	Syed	Mohinuddin	Male	BME
Executive Director	Robert	Bleasdale	Male	White
Executive Director	Virginia	Massaro	Female	White
Executive Director	Lesley	Watts	Female	White
Executive Director	Rodger	Chinn	Male	White

The Workforce Race Equality Standard indicator 9 reflects the difference between BME representation on the Board and in the workforce. This will be reflected in the upcoming Workforce Race Equality Standard report. The Trust has an Equality, Diversity and Equal Opportunities Policy which details the guiding principles to remove any barriers, bias or discrimination that prevent individuals or groups from realising their potential and contributing fully to the Trust's performance. This policy and associated documents, such as the gender pay gap plan, are implemented in accordance with statutory requirements. This policy supports the work of the Nominations and Remuneration Committee.

Future policy table

	Salary/fees	Taxable benefits	Annual performance-related bonus	Long term-related bonus	Pension-related benefits
Support for the short- and long-term strategic priorities of the Foundation Trust	Ensure the recruitment/retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	n/a	n/a	Ensure the recruitment/retention of directors of sufficient calibre to deliver the Trust's objectives
How the component operates	Paid monthly	None disclosed	n/a	n/a	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme
Maximum payment	As set out in the remuneration table, salaries are determined by the Trust's Nominations and Remuneration Committee	None disclosed	n/a	n/a	Contributions are made in accordance with the NHS pension scheme
Framework used to assess performance	Trust appraisal system	None disclosed	n/a	n/a	n/a
Performance measures	Based on individual objectives agreed with line manager	None disclosed	n/a	n/a	n/a
Performance period	Concurrent with the financial year	None disclosed	n/a	n/a	n/a
Amount paid for minimum level of performance and any further levels of performance	No performance-related payment arrangements	None disclosed	n/a	None paid	n/a
Explanation of whether there are any provisions for recovery of sums paid to directors or provisions for withholding payments	Any sums paid in error may be recovered	None disclosed	Any sums paid in error may be recovered	None paid	n/a

Service contracts

Information relating to directors' service contracts is included within the section *Names of Trust Directors during 2025/26* above. The Trust has assessed only directors as senior managers for the purpose of this disclosure.

Policy on payments for loss of office

Payments for loss of office in a compulsory redundancy situation are made under the nationally negotiated compensation scheme. The Nominations and Remuneration Committee has the authority to consider compensation in relation to exit arrangements for directors. In the event of early termination, executive director contracts provide for compensation in line with contract. Notice periods are subject to contract and are between three and six months. The Committee may consider non-contractual compensation payments in line with NHS England guidance and subject to NHS England and Treasury approvals. There were no payments for loss of office made in 2025/26. Comparatively, there were no payments for loss of office in 2024/25.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

When setting the remuneration policy for senior managers, consideration is given to pay rates within NHS Agenda for Change conditions and the new national VSM pay framework.

The Trust utilises information available via NHS England and peer benchmarking information from comparative local trusts within London, as recommended for use by NHS England to allow the Committee to assess where the Trust's senior pay benchmarks.

Nominations and Remuneration Committee

The Board Nominations and Remuneration Committee is chaired by the Trust Vice-Chair, and membership comprises three other non-executive directors.

The Trust's Chief Executive may be invited to attend all or part of the Committee meetings provided that they are not present when their executive role is subject to Committee discussion/decision-making.

The Committee is supported by the Chief People Officer and Director of Corporate Governance. Details of Committee attendance in 2025/26 may be found in the section *NHS Foundation Trust Code of Governance Disclosures*.

Disclosures required by Health and Social Care Act

The Trust is governed by a Board of Directors. At 31 March 2026, the Board comprised ten non-executive directors, including the Chair, and four executive directors, including the Chief Executive.

There are 31 governor positions, 24 of which were in post as at year-end, comprising:

- **8 patient governors (elected):** patients treated at the hospital in the last three years, or their carers
- **14 public governors (elected):** two each from seven local boroughs, except for one borough having one representative and a 'Rest of England' constituency
- **6 staff governors (elected):** two non-clinical staff members, one allied health professional, scientific and technical staff member, one medical and dental staff member, and two nursing and midwifery staff members
- **3 stakeholder governors (appointed):** nominated from partnership organisations

Expenses paid to governors and directors are outlined in the following table.

	Total n° in post	N° receiving expenses	Total sum of expenses £00
2025/26			
Governors	24	0	0.00
Directors	14	3	54.17
2024/25			
Governors	24	0	0.00
Directors	18	5	59.52

Annual Report on Remuneration

Senior manager remuneration 2025/26 [Audited]

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash equivalent transfer value at 1 April 2025 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2026 £000
Executive directors												
Lesley Watts, Chief Executive[1]	180-185	0	0	0	180-185	0	0	0	0	0	0	0
Roger Chinn, Chief Medical Officer[2]	250-255	0	0	0	250-255	0	0	0	0	0	0	0
Virginia Massaro, Chief Financial Officer[3]	105-110	0	0	130-132.5	235-240	7.5-8	10-12.5	65-70	155-160	1,125	110	1,286
Robert Bleasdale, Chief Nursing Officer[4]	190-195	0	0	65-65.5	255-260	2.5-5	0-2.5	55-60	125-130	977	50	1,068
Non-executive directors												
Matthew Swindells, Chair in Common[5]	20-25	0	0	0	20-25	0	0	0	0	0	0	0
Aman Dalvi, Non-Executive Director[6]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Patricia Gallan, Non-Executive Director/Vice Chair[7]	15-20	0	0	0	15-20	0	0	0	0	0	0	0
Ajay Mehta, Non-Executive Director[8]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Syed Mohinuddin, Non-Executive Director[9]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Dame Helen Stephenson, Non-Executive Director[10]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Mike O'Donnell, Non-Executive Director[11]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Vineeta Manchanda, Non-Executive Director[12]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Catherine Williamson, Non-Executive Director[13]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Carolyn Downs, Non-Executive Director[14]	5-10	0	0	0	5-10	0	0	0	0	0	0	0

[1] Lesley Watts is the Joint CEO for the Trust and Hillingdon Hospitals NHS Foundation Trust. Her total salary for the current year fell in the £360k-£365k salary banding, of which the banding of £180k-£185k is attributable to the Trust. Figures for Pension and CETV are not available/£0 as the individual is no longer part of the NHS pension scheme; salary excludes £10k-£15k for the selling of annual leave and this would cover both Trusts.

[2] The remuneration of the Chief Medical Officer includes £180k-£185k in respect of their clinical role; salary excludes £0k-£5k for the selling of annual leave. Figures for Pension and CETV are not available/£0 as the individual is no longer part of the NHS pension scheme.

[3] Virginia Massaro is the Joint CFO for the Trust and Hillingdon Hospitals NHS Foundation Trust. Her total salary for the current year fell in the £210k-£215k salary banding, of which the banding of £105k-£110k is attributable to the Trust.

[4] Salary excludes £0k-£5k for the selling of annual leave.

[5] Matthew Swindells is Chair in Common for all Trusts within the Acute Provider Collaborative. His total salary for the current year fell in the £80k-£85k salary banding, of which the banding of £20k-£25k is attributable to the Trust.

[6] Aman Dalvi held the position of Non-Executive Director of the Trust. His directorship extended to cover Imperial College Healthcare Trust. His total salary for the current year for both directorships fell in the £15k-£20k salary banding, of which the banding of £5k-£10k is attributable to the Trust.

[7] Patricia Gallan held the position of Non-Executive Director and Vice Chair of the Trust. Her directorship extended to cover Hillingdon Hospitals NHS Foundation Trust. Her total salary for all of the current year for both directorships fell in the £25k-£30k salary banding, of which the banding of £15k-£20k is attributable to the Trust.

[8] Ajay Mehta held the position of Non-Executive Director of the Trust. His directorship extended to cover London Northwest University Healthcare NHS Trust. His total salary for the current year for both directorships fell in the £15k-£20k salary banding, of which the banding of £5k-£10k is attributable to the Trust.

[9] Syed Mohinuddin held the position of Non-Executive Director of the Trust and was hosted by London Northwest University Healthcare NHS Trust, his salary banding of £5k-£10k is attributable to the Trust.

[10] Left the Trust Board in December 2025.

[11] Mike O'Donnell held the position of Non-Executive Director of the Trust. His directorship extended to cover Hillingdon Hospitals NHS Foundation Trust. His total salary for all of the current year for both directorships fell in the £15k-£20k salary banding, of which the banding of £5k-£10k is attributable to the Trust.

[12] Vineeta Manchanda held the position of Non-Executive Director of the Trust and was hosted by Hillingdon Hospitals NHS Foundation Trust, her salary banding of £5k-£10k is attributable to the Trust.

[13] Catherine Williamson held the position of Non-Executive Director of the Trust and was hosted by Imperial College Healthcare Trust, her salary banding of £5k-£10k is attributable to the Trust.

[14] Carolyn Downs held the position of Non-Executive Director of the Trust and was hosted by Hillingdon Hospitals NHS Foundation Trust, her salary banding of £5k-£10k is attributable to the Trust.

For all non-executive directors, figures for Pension and CETV are not available/£0 as these individuals are not part of the NHS pension scheme.

The Accounting Officer has reviewed which officers act as 'senior managers' for the purposes of the remuneration report, and considers that for 2025/26, this only includes the chair and executive and non-executive directors of the Trust.

Senior manager remuneration 2024/25 [Audited]

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash equivalent transfer value at 1 April 2025 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2026 £000
Executive directors												
Lesley Watts, Chief Executive[1]	285-290	0	15-20	0	305-310	0	0	0	0	0	0	0
Roger Chinn, Chief Medical Officer[2]	230-235	0	0	0	230-235	0	0	0	0	0	0	0
Virginia Massaro, Chief Financial Officer	195-200	0	0	122.5-125	320-325	5-7.5	10-12.5	55-60	140-145	930	103	1,125
Robert Bleasdale, Chief Nursing Officer[3]	185-190	0	0	32.5-35	215-220	2.5-5	0	50-55	120-125	873	22	977
Non-executive directors												
Matthew Swindells, Chair in Common[4]	20-25	0	0	0	20-25	0	0	0	0	0	0	0
Steve Gill, Vice Chair[5]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Aman Dalvi, Non-Executive Director[6]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Carolyn Downs, Non-Executive Director[7]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Patricia Gallan, Non-Executive Director/Vice Chair[8]	10-15	0	0	0	10-15	0	0	0	0	0	0	0
Ajay Mehta, Non-Executive Director[9]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Catherine Jervis, Non-Executive Director[10]	0-5	0	0	0	0-5	0	0	0	0	0	0	0
Neville Manuel, Non-Executive Director[11]	0-5	0	0	0	0-5	0	0	0	0	0	0	0
Nena Modi, Non-Executive Director[12]	0-5	0	0	0	0-5	0	0	0	0	0	0	0
Syed Mohinuddin, Non-Executive Director[13]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Dame Helen Stephenson, Non-Executive Director[14]	0-5	0	0	0	0-5	0	0	0	0	0	0	0
Mike O'Donnell, Non-Executive Director[15]	0-5	0	0	0	0-5	0	0	0	0	0	0	0
Vineeta Manchanda, Non-Executive Director[16]	5-10	0	0	0	5-10	0	0	0	0	0	0	0
Catherine Williamson, Non-Executive Director[17]	0-5	0	0	0	0-5	0	0	0	0	0	0	0

[1] Lesley Watts took up the role of Joint CEO for the Trust and Hillingdon Hospitals NHS Foundation Trust from 13th Jan 2025. Her total salary for the current year fell in the £325k-£330k salary banding, of which the banding of £285k-£290k is attributable to the Trust. Figures for Pension and CETV are not available/£0 as the individual is no longer part of the NHS pension scheme; salary excludes £10k-£15k for the selling of annual leave.

[2] The remuneration of the Chief Medical Officer includes £170k-£175k in respect of their clinical role; salary excludes £5k-£10k for the selling of annual leave. Figures for Pension and CETV are not available/£0 as the individual is no longer part of the NHS pension scheme.

[3] Salary excludes £0k-£5k for the selling of annual leave.

[4] Matthew Swindells is Chair in Common for all Trusts within the Acute Provider Collaborative. His total salary for the current year fell in the £80k-£85k salary banding, of which the banding of £20k-£25k is attributable to the Trust.

[5] Left the Trust Board in Oct 2024.

[6] Aman Dalvi held the position of Non-Executive Director of the Trust. His directorship extended to cover Imperial College Healthcare Trust. His total salary for the current year for both directorships fell in the £15k-£20k salary banding, of which the banding of £5k-£10k is attributable to the Trust.

[7] Carolyn Downs held the position of Non-Executive Director of the Trust and was hosted by Imperial College Healthcare Trust and Hillingdon Hospitals NHS Foundation Trust, her salary banding of £5k-£10k is attributable to the Trust.

[8] Patricia Gallan held the position of Non-Executive Director and then Vice Chair of the Trust from Nov 2024. Her directorship extended to cover Hillingdon Hospitals NHS Foundation Trust. Her total salary for all of the current year for both directorships fell in the £20k-£25k salary banding, of which the banding of £10k-£15k is attributable to the Trust.

[9] Ajay Mehta held the position of Non-Executive Director of the Trust. His directorship extended to cover London Northwest University Healthcare NHS Trust. His total salary for the current year for both directorships fell in the £15k-£20k salary banding, of which the banding of £5k-£10k is attributable to the Trust.

[10] Left the Trust Board Sep 2024.

[11] Left the Trust Board Apr 2024.

[12] Left the Trust Board in July 2024.

[13] Syed Mohinuddin held the position of Non-Executive Director of the Trust and was hosted by London Northwest University Healthcare NHS Trust, his salary banding of £5k-£10k is attributable to the Trust.

[14] Appointed to the Trust Board in Oct 2024. Dame Helen Stephenson held the position of Non-Executive Director of the Trust and was hosted by Imperial College Healthcare Trust, her salary banding of £0k-£5k is attributable to the Trust.

[15] Appointed to the Trust Board in Nov 2024. Mike O'Donnell held the position of Non-Executive Director of the Trust. His directorship extended to cover Hillingdon Hospitals NHS Foundation Trust. His total salary for all of the current year for both directorships fell in the £5k-£10k salary banding, of which the banding of £0k-£5k is attributable to the Trust.

[16] Appointed to the Trust Board in May 2024. Vineeta Manchanda held the position of Non-Executive Director of the Trust and was hosted by Hillingdon Hospitals NHS Foundation Trust, her salary banding of £0k-£5k is attributable to the Trust.

[17] Appointed to the Trust Board in Jan 2025. Catherine Williamson held the position of Non-Executive Director of the Trust and was hosted by Imperial College Healthcare Trust, her salary banding of £0k-£5k is attributable to the Trust.

For all non-executive directors, figures for Pension and CETV are not available/£0 as these individuals are not part of the NHS pension scheme.

The Accounting Officer has reviewed which officers act as 'senior managers' for the purposes of the remuneration report, and considers that for 2024/25, this only includes the chair and executive and non-executive directors of the Trust.

Fair pay disclosures [Audited]

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce. Per the updated GAM requirements, non-executive directors are no longer included in the fair pay disclosures for the current year, however the prior year comparatives still include remuneration of the NEDs. For this reason, and the fact that prior year comparisons do not need adjusting, the year-on-year comparisons will not fully align.

Percentage change in remuneration [Audited]

The banded remuneration of the highest-paid director in the organisation in the financial year 2025/26 was £250,000 to £255,000 (2024/25: £285,000 to £290,000). This is a change between years of -12% (2024/25: -5%). This is the result of the highest-paid director being a different individual in 2025/26 due to the changes in executive roles and remuneration being shared by some of the trusts within the APG.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £25,000 to £30,000 to £270,000 to £275,000 (2024/25: £15,000 to £20,000 to £285,000 to £290,000). The percentage change in average employee remuneration, based on total for all employees on an annualised basis divided by full-time equivalent number of employees, between years is 5% (2024/25: 8%). This 5% is largely reflective of the following:

Agenda for Change (AfC) staff received a 3.6% pay award across all bands, and medical and dental staff received a 4% pay award, plus, for doctors in training, a £750 increase to pay points.

Two employees received remuneration in excess of the highest-paid director in 2025/26 on an annualised basis (nil in 2024/25).

Performance pay and bonuses [Audited]

The banded remuneration of the highest-paid director in the organisation in the financial year 2025/26 was £0k to £0k (2024/25: £15,000 to £20,000). This is a 100% decrease from the prior year as there was no value paid for this category in 2025/26 (2024/25: 0%).

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £15,000 to £20,000. The percentage change in average employee remuneration, based on total for all employees on an annualised basis divided by full-time equivalent number of employees, between years in 2024/25 was 0%. No employees received remuneration in excess of the highest-paid director in 2024/25.

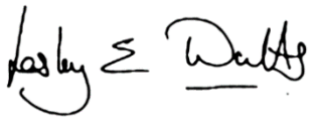
Pay ratio information [Audited]

The remuneration of employees at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest-paid director, excluding pension benefits, and each point in the remuneration range for the organisation's workforce.

2025/26	25th percentile	Median	75th percentile
Salary component of pay	£41,082	£53,442	£66,981
Pay and benefits excluding pension: pay ratio for highest paid director	6.14:1	4.72:1	3.76:1

2024/25	25th percentile	Median	75th percentile
Salary component of pay	£39,213	£51,230	£63,995
Pay and benefits excluding pension: pay ratio for highest paid director	7.84:1	6.00:1	4.80:1

Changes in the ratios between the current and prior financial years reduced in 2025/26 from 2024/25 in the remuneration range of the organisation's workforce, compared to the highest-paid director. This is largely due to the fact that the highest-paid director is a different individual in 2025/26, as noted above.



p.p. Lesley Watts
Chief Executive

for Prof Tim Orchard
Group Chief Executive and Single Accountable Officer

25 June 2026

STAFF REPORT

Analysis of staff costs (subject to audit)

	2025/26 £000	2024/25 £000
Salaries and wages	493,144	473,663
Social security costs	65,313	52,921
Apprenticeship levy	2,336	2,299
Employer's contributions to NHS pensions	83,798	77,853
Pension costs other	45	32
Temporary staff (including agency)	1,861	8,766
Total gross staff costs	**646,497**	**615,534**
Of which		
Costs capitalised as part of assets	2,874	2,666

Operating expenses (group)

	2025/26 £000	2024/25 £000
Staff and executive directors' costs	626,932	597,173
Difference	**19,595**	**18,361**
Rec		
Costs capitalised as part of assets	2,874	2,666
Research and development	9,719	8,850
Education and training	6,972	6,845
	19,565	**18,361**

Analysis of average staff numbers (subject to audit)

Average numbers are spread over the year and include bank and agency staff.

Average number of employees (WTE basis)	Permanent n°	Other n°	2025/26 total n°	2024/25 total n°
Medical and dental	1,511	107	1,618	1,623
Ambulance staff	-	-	-	-
Administration and estates	1,376	25	1,401	1,402
Healthcare assistants and other support staff	959	168	1,127	1,182
Nursing, midwifery and health visiting staff	2,692	269	2,961	2,985
Scientific, therapeutic and technical staff	700	63	763	721
Healthcare science staff	31	-	31	-
Total average numbers	**7,269**	**631**	**7,900**	**7,913**
Of which:				
N° of employees (WTE) engaged on capital projects	36	0	36	41

Breakdown of employees

The following chart provides information on the gender split between the different staff groups as at 31 March 2026. Numbers are for substantive staff only.

Payscale	Male	Female	% Male	% Female
Under Band 1	0	0	-	-
Band 1	0	0	-	-
Band 2	65	153	29.82%	70.18%
Band 3	256	828	23.62%	76.38%
Band 4	119	371	24.29%	75.71%
Band 5	275	1,293	17.54%	82.46%
Band 6	226	1,129	16.68%	83.32%
Band 7	178	785	18.48%	81.52%
Band 8A	91	249	26.76%	73.24%
Band 8B	42	90	31.82%	68.18%
Band 8C	23	38	37.70%	62.30%
Band 8D	17	20	45.95%	54.05%
Band 9	7	7	50.00%	50.00%
VSM	9	11	45.00%	55.00%
Consultant	355	529	40.16%	59.84%
Career/staff grade	30	45	40.00%	60.00%
Trainee grade/Trust grade	301	373	44.66%	55.34%
Total	**1,994**	**5,921**	**25.19%**	**74.81%**

Sickness absence

The chart below details the Trust's sickness absence data for 2025/26.

Sickness absence	2024/25 n°	2025/26 n°
Total days lost (FTE days lost)	102,588	114,117
Total staff	7,192	7,303
Average working days lost per whole-time equivalent	14.26	15.63

Staff health and wellbeing

We are delighted to be able to deliver an inclusive and wide-ranging staff health and wellbeing programme. The Trust is aware that without such a comprehensive offer in place for staff we could see higher turnover and increased long-term sickness. Our staff health and wellbeing programme engages in all elements and stages of life to ensure all staff can access our offers, ranging from family planning to retirement. We are very proud to have established a health and wellbeing programme which meets the varying needs of our diverse workforce.

Our staff health and wellbeing programme is broken into four main elements:

- **Healthy Mind:** Enhanced psychological and mental wellbeing support for staff
- **Healthy Body:** Programme to support our staff to be physically well
- **Healthy Living:** Programme to support our staff to live well
- **Feeling Safe:** Ensuring our staff feel safe at home and in the workplace

During the year, our health and wellbeing programme has been accessed by staff, with a total of 9,927 engagements. Our network of 190 Mental Health First Aiders and 120 Wellbeing Champions continues to grow to support our staff across the Trust.

Our programme focuses on supporting staff with their physical and mental health. Our Staff Psychology Service continues to grow and support the organisation to be trauma-informed. Staff are supported 24/7 with access to a dedicated support line and, with our NHS England partners, staff have access to a variety of wellbeing apps and health programmes.

Our colleagues at CW+ continue to offer a programme of activities for staff across the sites, with yoga sessions being a favourite.

Our monthly menopause group continues to grow in numbers and provides a helpful forum for staff to seek peer-to-peer support and hear from expert speakers from within the Trust on key menopause topics. Together with our Acute Provider Collaborative partners, we hosted our second annual World Menopause Day conference.

Our Back-up Care offer supported staff with 788 days of emergency care booked, enabling staff to come to work when care broke down at home.

In partnership with our Sustainability Manager, the team ran a joint project for staff to encourage staff to think green as well as supporting their wellbeing. The app-based project had over 500 active users, creating sustainable behaviour change as well as actively taking part in step challenges.

The 2025 National Staff Survey score for Health and Wellbeing saw a decline from 62.35% in 2024 to 57.45% in 2025. However, we do remain above the acute sector average for supporting staff with their wellbeing, which is reflected in the number of engagements we have had with the programme.

Throughout 2025/26, we continued to engage our staff through a variety of means including All Staff webinars, team brief, senior visits to wards and departments, weekly communications such as the Bulletin and the CEO newsletter, quarterly Wellfest events, and recognition events such as our PROUD Awards and Long Service Awards. We also delivered our third Great Big Thank You in December 2025, thanking staff for their continued commitment to outstanding patient care. As part of the People Promise programme, we have focused efforts on staff safety, particularly violence and aggression from patients and visitors towards staff. Helpful weekly ward visits between the sites are providing a supportive listening space for staff to speak about the challenges they face.

We continue to invest in our staff networks to provide protected time and funding to promote network activities. Our Staff Networks reached staff via a series of meetings and network events across the Trust, including being part of Pride in London.

National NHS Staff Survey 2025

The NHS Staff Survey is conducted annually. In 2025, our survey response rate was 52%, with 3,981 surveys completed, which is a small increase from 3,913 in 2024. This was a total increase of 68 responses. The median response rate across all acute trusts was 47%. Our Bank Staff Survey had a 22% response rate, with 148 surveys completed. The median response rate across all acute trusts was 15%.

Headlines

The latest NHS Staff Survey results show that our Trust continues to perform strongly, ranking us as one of the leaders for staff engagement in London and above the national average across all areas of the survey.

More than 4,000 colleagues—over 52% of our workforce—completed the survey, providing valuable insight into the experience of working at our Trust. We ranked as leaders in learning and development, with the 'We are always learning' theme ranked 2nd in London.

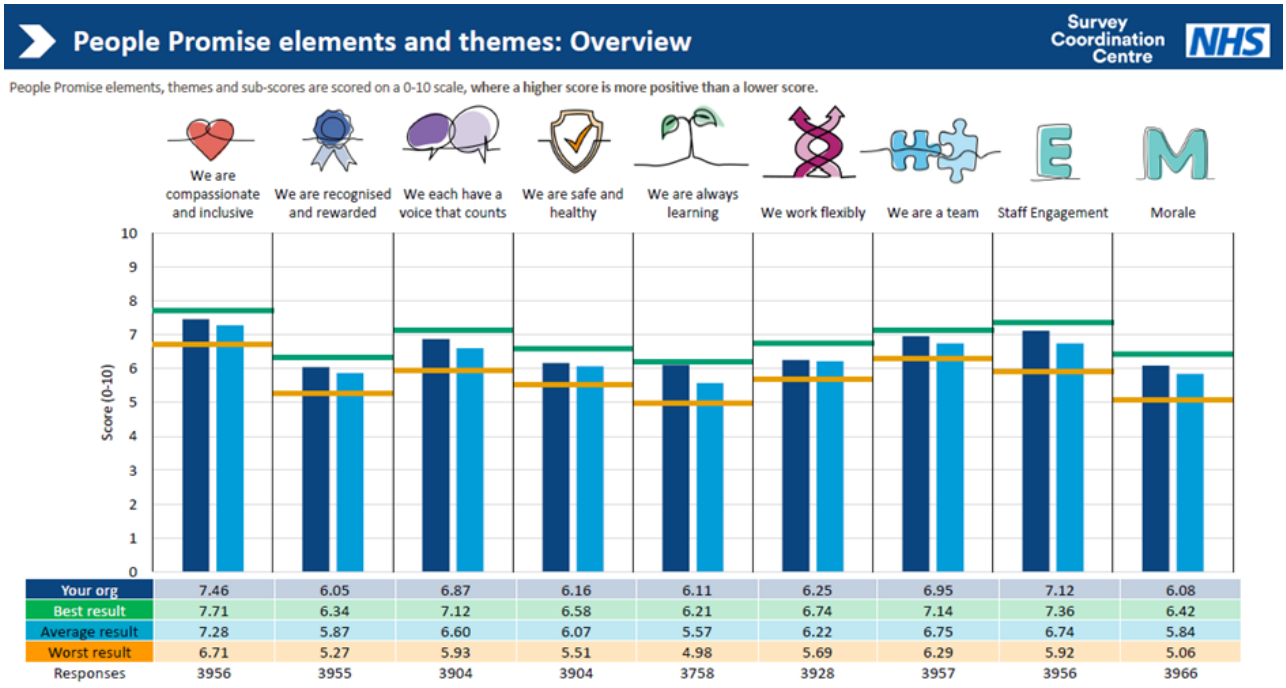
We also ranked above the national average on a range of measures, including staff voice, raising concerns, team working, advocacy, health and safety climate and appraisals, reflecting the continued commitment and professionalism of colleagues across our organisation.

Within the north west London acute sector, the Trust ranked 1st in a number of key areas, including staff engagement, morale, staff involvement, learning and development, flexible working, support for work-life balance and appraisals.

The survey also shows improvement in the number of staff reporting that they received an appraisal, reflecting the introduction of Performance Development Review (PDR) windows over the past year to support meaningful performance and development conversations.

Colleagues also reported positively on the availability of nutritious and affordable meals at work, following improvements made in partnership with our ISS and Estates teams to enhance food provision and accessibility across our sites.

Despite the financial pressures facing the NHS and the challenges of the past year, the results also show that colleagues continue to view the Trust positively as a place to work and would recommend our services to friends and family.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.46	6.05	6.87	6.16	6.11	6.25	6.95	7.12	6.08
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	3956	3955	3904	3904	3758	3928	3957	3956	3966

Where we will continue to focus

The survey also highlights areas where further work is needed, particularly around workload pressures and staff experience at work.

While the Trust performed strongly overall, scores relating to burnout, negative experiences and motivation ranked lower than other areas, highlighting the continued importance of supporting staff wellbeing and reducing pressure in the workplace.

More staff also reported incidents involving physical or verbal abuse at work. Increased reporting helps ensure we maintain a safe culture where colleagues feel confident speaking up, while also giving the organisation a clearer understanding of what staff experience and supporting action to improve safety.

Work is continuing with ward managers and teams across the Trust to better understand patient-to-staff violence and aggression and ensure incidents are consistently recorded and addressed.

2025 Staff Survey scores and across three years

2024 staff survey scores and across three years

Themes overview	2023	2024	2025	Best	Average	Worst
People Promise 1: We are compassionate and inclusive	7.35	7.37	7.46	7.71	7.28	6.71
People Promise 2: We are recognised and rewarded	5.99	6.06	6.05	6.34	5.87	5.27
People Promise 3: We each have a voice that counts	6.83	6.89	6.87	7.12	6.60	5.93
People Promise 4: We are safe and healthy	6.07	6.15	6.16	6.58	6.07	5.51
People Promise 5: We are always learning	5.92	6.05	6.11	6.21	5.57	4.98
People Promise 6: We work flexibly	6.13	6.26	6.25	6.74	6.22	5.69
People Promise 7: We are a team	6.89	6.90	6.95	7.14	6.75	6.29
Theme—Staff Engagement	7.13	7.17	7.12	7.36	6.74	5.92
Theme—Morale	5.95	6.10	6.08	6.42	5.84	5.06

In terms of the three staff engagement questions:

Question/score	2023	2024	2025	Best	Average	Worst
Q25a Care of patients/service users is my organisation's top priority	83.45%	84.20%	82.34%	87.31%	71.63%	49.59%
Q25c I would recommend my organisation as a place to work	70.07%	72.13%	71.44%	79.40%	57.77%	34.20%
Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	77.08%	77.37%	76.79%	88.41%	60.83%	34.73%

The full Staff Survey report is published at www.nhsstaffsurveyresults.com.

Gender pay

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

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

The Trust's gender pay gap report for 2024/25 is published at www.chelwest.nhs.uk/genderpaygap.

Workforce gender split

Gender	N° of staff	% split of the workforce
Female	5,837	75%
Male	1,946	25%

Board of Directors 2024/25

Gender	N° of staff	% split of the workforce
Female	7	50%
Male	7	50%

Executive team, excluding Board members, 2024/25

Gender	N° of staff	% split of the workforce
Female	3	60%
Male	2	40%

Senior management team 2024/25

Gender	N° of staff	% split of the workforce
Female	21	51.2%
Male	20	48.8%

Average and median hourly rates 2024/25

Gender	Average hourly rate	Median hourly rate
Male	£32.20	£27.59
Female	£27.13	£24.56
Difference	£5.07	£3.03
Pay gap %	**15.7%**	**10.9%**

In 2024/25, the mean average was 15.7%, compared to 15.9% the previous year. In 2024/25, this mean average equates to a difference of £5.07 per hour in favour of male staff compared to female staff.

The median average was 10.9%, compared to 12.2% the previous year. In the reporting year, both mean and median averages improved over last year by 0.2% and 1.3% respectively. While the overall trend is positive, continued focus is needed as progress has not been steady and challenges remain.

Average bonus gender pay gap by hourly rate

For the purpose of reporting, the bonus payments referred to are those made to consultants in the form of National Clinical Impact Awards. For a consultant to be eligible for a National Clinical Impact Award, they have to:

- have been, and continue to be, a permanent NHS consultant or academic GP in a permanent clinical academic role in higher education at the same level as a senior lecturer or above
- meet the above condition for at least one year, on 1 April in the award year in the year of application
- the year does not usually include time spent as a locum or on other fixed-term consultant contracts

From our medical consultant workforce, the conditions above set out those who are eligible to apply for National Clinical Impact Awards. This then determines the “relevant employees”.

As of 31 March 2025, there were 1,585 consultants at the Trust, of which 42% were female, compared to 1,495 consultants at 31 March 2024, of which 51.58% were female.

Gender	Total relevant employees	%	Employees paid bonuses in 2024/25	% of those paid a bonus
Female	666	42%	67	48%
Male	919	58%	74	52%
Total	**1,585**	**100%**	**141**	**100%**

Mean average bonus pay

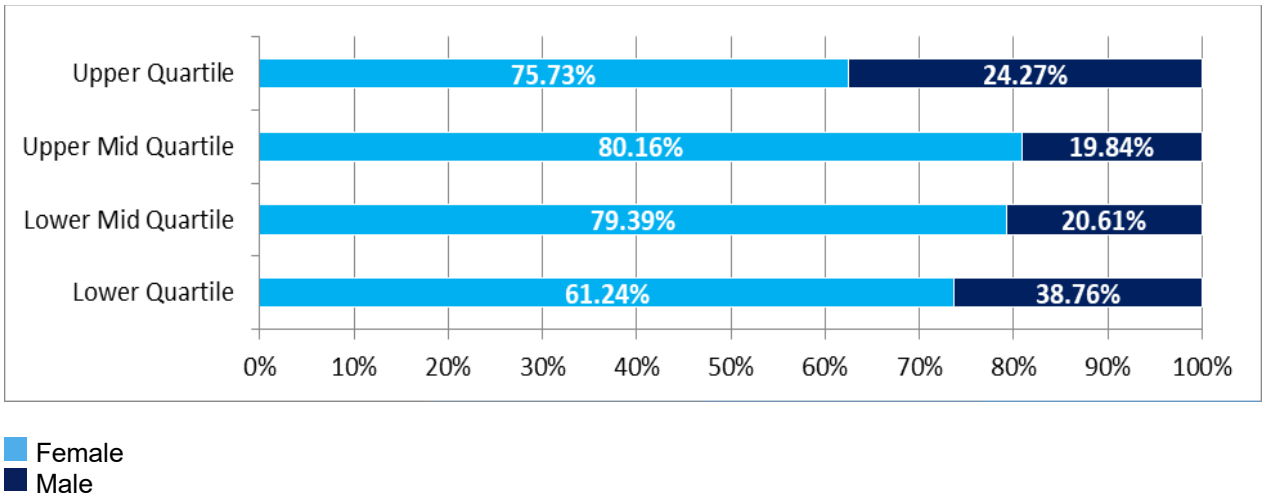
When comparing mean bonus pay, women’s mean bonus pay is 22.7% lower than men’s, a difference of £2,856.10 per annum.

Median average bonus pay

When comparing the 2024/25 median bonus pay, women’s bonus pay is 1.23% lower than men’s, a difference of £91.23 per annum. In 2023/24, the median average was the same for males and females at £3,421. There was no bonus gap differentiation between genders.

Our women’s mean bonus pay gap has increased from 13.7% in 2024 to 22.7% in 2025. This means a difference in bonus pay for men from £748.55 per annum to £2,856.10 per annum, an increased gap of £2,107.55.

Proportion of males and females when divided into four groups ordered from lowest to highest pay



For the 2025/26 Gender Pay Gap reporting, we committed to taking action to help close the gender pay gap. Actions will be monitored through our Belonging sub-group. Further details of key actions are detailed in the Trust's Gender Pay Gap report for 2024/25, which can be accessed using the link at the start of this section.

Workforce improvement activity

Recruitment and retention

Over the last 12 months, the Trust has maintained a low vacancy rate, closing the year at 4.38%. Recruitment time to hire has fluctuated across all non-medical staff groups, reflecting pressure on operational services, but reduced to 7.98 weeks at the close of year and seven weeks as an average over the year. We have maintained pace with local recruitment and continue to benchmark our time to hire across the North West London Acute Provider Group. We continue to work closely with colleagues across the APG for all recruitment-related activity, including streamlining and process re-engineering, to ensure our service is right-sized and provides an excellent user experience. We also continue to work with other sectors and national partners to tackle hard-to-recruit roles.

Our retention work has been driven forward this year again by our Trust being part of the People Promise Exemplar Programme and formally embedding the post of the People Promise Manager as part of an NHS England programme specifically targeting retention. During 2025/26, we concluded our pilot of self-rostering and we are now rolling this project out across the Trust. We aim to have all inpatient wards completed by summer 2026. We continue to promote our Employee Value Proposition (EVP), which we have called the ChelWest People Promise, so staff can access all their benefits in one place via a dedicated People Promise page on our intranet.

Much focus has been on patient-to-staff violence and aggression. During the year, we have managed to increase the number of staff reporting incidents, so we understand exactly what our staff are dealing with on a daily basis. We have introduced weekly ward drop-ins so staff can speak openly about their experiences and get the support they need. We continue to host stay questionnaires throughout the year so we can improve staff

experience at our Trust in order to support staff retention. For 2026/27, we will be introducing Cultural Intelligence to support team working, which ultimately will lead towards improved patient care.

We are extremely proud that we were able to achieve our target of reducing voluntary turnover to below 10% during 2025/26. Retention remained a key area of focus and, at the end of March 2026, we recorded an in-year reduction in voluntary turnover from 9.17% to 7.85%. This is a significant achievement, with the stretch target of 10% achieved and maintained from December 2024 onwards. This compares favourably with the sector position.

Performance and development reviews (PDRs)

Staff continued to have their Performance and Development Reviews (PDRs) throughout the year and, as part of plans to improve the experience and value of these annual conversations, the Trust Executive decided in the autumn to move to a dedicated annual PDR window for 2026, from 1 April to 30 June. Manager webinars have taken place to support the transition and ensure each conversation supports colleague wellbeing, reviews both the what and how of individual objectives, ensures alignment with values and includes a focus on development needs to deliver objectives. A new system to record PDRs and a suite of supporting resources to help make the process more meaningful and accessible for both staff and managers is also now available.

Mandatory learning

Mandatory learning was at the 90% target at the end of 2025/26. Work is continuing in line with the NHS England National Review of Mandatory Training, with the Trust ready to implement the outcomes when available. Continuous improvement activities are continuing with our new Learning Management System for an enhanced learner experience.

Leadership and management development

Throughout 2025/26, our commitment to supporting leaders and managers continued. The offer included leadership apprenticeships, targeted half-day topic-based sessions for managers, our Emerging Leaders programme, coaching and bespoke activity. These sessions provide essential skills and knowledge, equipping staff with the tools necessary for effective team leadership and operational management. A revised offer for leaders and managers has also been created following engagement and will be available in 2026.

Medical education

Over 657 doctors across various specialties were inducted at our Trust through a structured Doctors' Induction Programme. Local inductions were prioritised, supported by a comprehensive checklist to ensure all steps were completed. Welcome packs were distributed with key information on ID badges, IT access, smartcards and resources. A virtual induction was held in the morning, featuring talks from CEO Lesley Watts and Directors of Medical Education, Dr Orhan Orhan and Miss Christina Cotzias, covering essential topics such as safety protocols, study leave, wellbeing and mandatory training. Cerner training was also provided as needed. The programme was jointly delivered across both sites of the Trust, improving collaboration and reducing duplication.

Study leave continues to be processed via a digital platform for all doctors. Doctors seek approval from their Educational or Clinical Supervisors via email and upload it to Microsoft Forms. This streamlined process ensures all required information is accurately captured and easily accessible across the two sites. We have processed 3,560 claims across both sites using this platform.

The GMC survey serves as a vital tool for gathering valuable feedback and insights from our trainees, thereby enabling us to continuously refine and enhance the quality of their educational experiences and support systems. We have satisfactorily addressed all outstanding actions from NHS England, though some actions remain under surveillance on both sites: O&G at the West Middlesex site and Neonatology at the Chelsea site.

An in-house survey has been distributed across all specialties, ensuring thorough insight collection directly from our trainees. This proactive measure allows us to identify and address potential issues before the release of the GMC survey results. The findings from our in-house survey have been shared with respective leads. This proactive approach will mean that we are able to gain insight into what the results may be from the GMC.

We run regular robust local faculty group meetings to support and respond to feedback from our resident doctors. Our clinical and educational supervisors are supported to keep up to date with their educational appraisals and we run courses to facilitate learning of the seven domains of the framework. We have excellent RTT champions on both sites and run programmes to help resident doctors returning to work after a break re-adapt to clinical practice as effectively as possible. Our SAS champions are in post and advocate for this workforce group, coordinating courses specifically to meet their needs. Our simulation team, facilitated by PG Education Fellows, deliver high-fidelity and in-situ simulation for our resident doctors at all levels.

The West Middlesex site is one of the two London providers for Leading through Education for Excellent Patient Care (LEEP)—the NHS England Leadership programme. 1,106 candidates have attended our LEEP programme in the last year with overwhelmingly positive feedback.

The North West London (NWL) International Medical Graduate (IMG) Hub is hosted at the West Middlesex site of the Trust. The Hub delivers the Clinical Attachment Training Programme (CATP), with a total of 649 candidates participating in the programme to date. 35% of these candidates have since successfully secured employment within the NHS. A monthly International Medical Graduate (IMG) Induction Programme is also facilitated by the Hub for IMGs starting employment in NWL, with 412 doctors participating in the programme since November 2022. An online Education Programme has also been developed which is attended by IMGs working all over the NHS, not just in London, as well as those aspiring to from overseas.

Regular Postgraduate and IMG Education Governance Meetings are held at both sites.

Further to LEEP and the IMG work, we offer a wide variety of courses in Postgraduate Medical Education. These include Make Me a Medic Course, Practical Assessment of Clinical Examination Skills teaching for Internal Medicine Training doctors, Educational Supervisor Update Courses, Medical Registrar Ready Simulation Course, Supporting Colleagues and Managing Workplace Friction Course, mock Internal Medicine Training interviews, mock Core Surgical Training interviews, RCS-accredited laparoscopic surgical skills courses, Specialty and Specialist Doctors Development Days, Digital Literacy

Course, Simulation Champion Instructor Course, Simulation Educator Course, Teach the Teacher Course and Train the Trainer, Basic Surgical Skills courses and College Tutor update days.

In addition, our team organises and runs two national annual conferences, Hot Topics in Global Health and Advancing Medical Education Conference (AMEC). Our team remains active in research, dissemination and academic collaboration, with multiple abstracts accepted or submitted to national and international conferences: Royal College of Physicians Med+ Conference, British Thoracic Oncology Group (BTOG) Conference, Medical Education Leaders Conference, Association for Medical Education in Europe (AMEE) Conference and Association for the Study of Medical Education (ASME) Conference.

Chelsea and Westminster Hospital NHS Foundation Trust continues to deliver a dynamic and forward-thinking Undergraduate Education programme, with several recent developments. As one of the largest teaching sites affiliated with Imperial College London, and now the second largest host of medical students within the Trust network, we play a central role in undergraduate clinical education. We have further expanded our global partnerships, increasing the number of student rotations with medical schools in Singapore. At West Middlesex Hospital, there has been an increase in specialty placements in collaboration with the American University of the Caribbean and a new partnership with the University of Bologna has also recently been formalised, with the first placement expected later this year. We are also now the primary host site for PACES examinations, supporting the delivery of these key clinical assessments at scale. As the only site affiliated with Imperial College London to deliver simulation-based learning for Pre-Foundation students, we continue to lead in this area. In addition, we have successfully developed and implemented the Palliative Care Simulation Course across both sites, ensuring students gain essential experience in end-of-life care.

We are also advancing the integration of innovative technologies, including AI and virtual reality, to enhance student learning and clinical engagement. Each year, we proudly host OSCEs and Year 5 PACES examinations, and in 2026 we are planning to lead the large-scale recruitment of over 800 doctors to support the delivery of these vital assessments.

Recognition schemes

The CW+ PROUD Awards is a monthly recognition scheme in which staff are nominated for above-and-beyond demonstration of our PROUD values. During April 2025 to March 2026, 356 nominations were received, from which 296 individuals and 39 teams were recognised. The winners are invited to an award ceremony where the Chief Executive presents them with a signed certificate and special pin badge.

There were 126 Excellence Reporting nominations during the last financial year. There are plans to reinforce these and encourage more participation. Out of the 126 nominations, 124 were individual nominations and two were team nominations.

Apprenticeships

Investment and growth in apprenticeships remain central to the Trust’s agenda. The Trust continues to expand its apprenticeship offerings through partnerships with reputable training providers, ensuring a diverse range of opportunities and high-quality delivery.

During the financial year 2025/26, the Trust delivered 48 distinct apprenticeship programmes, with an average of 4.1% of its workforce, 320 staff, participating as apprentices.

The Trust has successfully maintained its Main Provider Status, demonstrating its commitment to quality and compliance. It achieved a 'Good' grade following the most recent Ofsted inspection, which took place in April 2025. As a main provider, the Trust continues to deliver the Healthcare Support Worker Apprenticeship and is actively exploring further expansion of its provision as an Apprenticeship Main Provider. The Trust's achievement rate as a Main Provider is 84%, which is higher than the national average of 64%.

In November 2025, during the NHS England London Capital Clinical Support Workers (CSW) Awards, the Trust was recognised as the winner in the Widening Access and Supporting Diversity category. Additionally, the Head of Apprenticeships received a high commendation in the CSW Lead of the Year category, reflecting the Trust's commitment to inclusion and leadership in the sector.

The Growth and Skills Levy was formally introduced in April 2025, replacing the Apprenticeship Levy, with full reforms implemented from April 2026. These funding changes have significantly reshaped NHS workforce development, including the December 2025 restriction on Level 7 apprenticeships, which curtailed a key levy-funded route for senior clinical and leadership development. This has increased reliance on employer-funded alternatives, with limited mitigation for critical roles such as Advanced Clinical Practitioner.

The Trust utilised £1,856,510 of levy this year, demonstrating an increase in apprenticeship activity. The average levy utilisation for the year is 79%, significantly higher than the previous year's 54%.

There were 111 completions across 22 different apprenticeship programmes this year, compared to 94 completions last year. The five apprenticeship standards with the highest number of completions are detailed below:

Apprenticeship standard	N° of completers
Level 2 Healthcare Support Worker	36
Level 5 Nursing Associate	14
Level 7 Senior Leader	11
Level 3 Data Technician	9
Level 6 Registered Nurse Degree	9

Apprenticeships have played a significant role in developing talent, especially in entry-level and hard-to-fill positions. They have supported the introduction of new roles to address workforce gaps and have been instrumental in delivering key aspects of the People Strategy, particularly within the "growing for future" and "new ways of working" sub-groups. Moreover, apprenticeships contribute to staff retention by offering career development pathways.

The Trust provides monthly face-to-face careers clinics, accessible on site, where staff can discuss their career aspirations and opportunities available through the apprenticeship route. Additionally, online information sessions are held throughout the year to ensure staff are well-informed about apprenticeship opportunities.

This year's National Apprenticeships Week celebration featured the Annual Apprenticeship Recognition event, which highlighted apprentices who successfully completed their programmes. Apprentices were joined by their managers and mentors during the ceremony. A representative from the Department for Education attended as a guest speaker, and 111 apprentices were formally recognised for their achievements. Executives and senior leaders from People and Organisational Development and Nursing attended the week-long event, highlighting the Trust's ongoing support for apprenticeship and staff development.

Health and safety and occupational health

The Trust continues to maintain and update its core health and safety and occupational health policies, ensuring they remain applicable across both main hospital sites and satellite locations. Incident, complaint, claim, risk register and occupational health data are recorded within Datix, the Trust's integrated safety learning system. Ongoing enhancements to Datix, including improved dashboards and key performance indicators, are supporting a more robust reporting culture and enabling clearer oversight of safety performance across the organisation.

During 2025/26, the Trust reported 58 incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) to the Health and Safety Executive. Of these, 35 related to Chelsea and Westminster Hospital and 22 to West Middlesex Hospital, with one further incident arising from community nursing and clinic services. A total of 21 staff-related body fluid exposures, including sharps and splash injuries, were recorded during the reporting period.

Ward accreditation processes continue to assess compliance with safe sharps management, including appropriate disposal practices and auditing staff awareness of safety practices. The Trust's Safer Sharps Group provides oversight and champions improvement, working in partnership with clinical leads and key services such as procurement, health and safety and occupational health. Risks within its remit are proactively identified, recorded on the risk register and monitored through local divisional processes and the Health, Safety and Environmental Risk Group.

During 2025/26, the Safer Sharps Group led a number of targeted safety initiatives. These included further promoting the replacement of non-safety sharps with safety-engineered devices, undertaking risk assessments where required, strengthening training provision and reinforcing safe disposal practices. The Trust also further embedded the use of the Occupational Health hotline for reporting sharps injuries during working hours, reducing reliance on Emergency Department attendance and improving staff experience.

The Health and Safety team continues to work with clinical and corporate departments to support a structured programme of self-assessment, supplemented by independent, risk-based spot checks and audits. Areas of focus are identified through analysis of risk, incident trends and organisational priorities. Occupational Health led the consultation and update of the Trust's Prevention and Management of Body Fluid Exposure policy. The revised guidance strengthens alignment with national recommendations, including the testing of source patients, with informed consent, for hepatitis B, hepatitis C and HIV following a confirmed exposure.

Policies and procedures in respect of countering fraud and corruption

The Trust has an approved counter-fraud and corruption policy and does not tolerate any form of fraud, bribery or corruption by its employees, partners or third parties acting on its behalf. We investigate allegations fully and apply sanctions to those found to have committed a fraud, bribery or corruption offence. RSM continues to be contracted by the Trust during 2025/26 to provide local counter-fraud specialist services in accordance with Secretary of State directions. The Trust Board's Audit and Risk Committee formally approves the counter-fraud annual work plan and progress reports are provided to the Committee at each meeting.

Expenditure on consultancy

In 2025/26, the Trust incurred £0.19m (£0.58m in 2024/25) of consultancy expenditure. Overall, this is a decrease from the previous financial year and includes specialist advice to support procurement saving opportunities and estates and facilities projects.

Off-payroll arrangements

The Trust's policy is that off-payroll arrangements should only be used on rare occasions where recruitment to key/specialist roles has not been possible. The use of any off-payroll arrangements is regularly reviewed to ensure that they are used for the shortest period of time possible.

Highly paid off-payroll worker engagements as at 31 March 2026 earning £245 per day or greater

	Total
Number of existing engagements as of 31 Mar 2026	0
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater

	Total
Number of off-payroll workers engaged during the year ended 31 Mar 2026	0
Of which:	
Not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in-scope of IR35	0
Subject to off-payroll legislation and determined as out-of-scope of IR35	0
Number of engagements reassessed for compliance/assurance purposes during the year	0
Of which number of engagements that saw a change to IR35 status following review	0

For any off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026

	Total
Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	0

Exit packages

Reporting of compensation schemes—exit packages 2025/26

Exit package cost band (including any special payment element)	N° of compulsory redundancies	N° of other departures agreed	Total n° of exit packages
≤£10,000	1	4	5
£10,001–25,000	6	2	8
£25,001–50,000	1	-	1
£50,001–100,000	-	-	-
£100,001–150,000	2	-	2
£150,001–200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**10**	**6**	**16**
Total resource cost (£)	£369,508	£50,234	£419,742

Reporting of compensation schemes—exit packages 2024/25

Exit package cost band (including any special payment element)	N° of compulsory redundancies	N° of other departures agreed	Total n° of exit packages
≤£10,000	1	9	10
£10,001–25,000	4	3	7
£25,001–50,000	4	1	5
£50,001–100,000	-	-	-
£100,001–150,000	-	-	-
£150,001–200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**9**	**13**	**22**
Total resource cost (£)	£224,940	£129,501	£353,441

Exit packages—other (non-compulsory) departure payments

	2025/26		2024/25	
Exit package cost band (including any special payment element)	**N° of payments agreed**	**Total value of agreements (£000)**	**N° of payments agreed**	**Total value of agreements (£000)**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARs) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	6	50	10	124
Exit payments following employment tribunals or court orders	-	-	3	4
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**6**	**50**	**13**	**129**

	2025/26		2024/25	
Exit package cost band (including any special payment element)	**N° of payments agreed**	**Total value of agreements (£000)**	**N° of payments agreed**	**Total value of agreements (£000)**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

Awards and achievements

Internal recognition

CW+ PROUD Awards

The CW+ PROUD Awards recognise the outstanding achievements of members of staff or teams. Each month, winners are recognised with a certificate, a special gold PROUD to Care pin badge and a voucher, while other nominees receive a letter advising them of their nomination.

From April 2025–March 2026, 356 nominations were received, of which 296 individuals and 39 teams across the Trust were recognised. The winners are listed below. In addition, as part of Great Big Thank You Week, we invited nominations for a Great Big Cheer award, holding two ceremonies for our winners.

PROUD Award winners

April 2025
Felix Barry
Dionne Kelly Jellow
Nicola Miles
Beaven Mawoza
Hannah Murphy
Grace McCarthy

May 2025
SAR Team
Bincy Jobin
Anna Miklen
Chloe Cruickshank
Jin Jin Chen
Emily Nolan
Julian Litter
Challa Rai

June 2025
Matthew Robinson
Annamaria Guban
Marie Jaenette Licunan
Bilal Hassan
Emma Bhuva
Caoimhe Hatch
Shez Naqvi
Muhammed Choudhry

July 2025
Rafina Yarde
Caroline Day
Charlie Gibbons
Simpson Unit Staff Nurses and MSWs
Priyanka Patel
Ama Nkrumah
Debora Lopes and the L&OD team

August 2025
Julia Hillier
Catriona Davies
Ioanna Papadopalou
Deepika Arora
Paul Bulusan
Debra Jackson
Rhianne Woodfine
Khawar Hussain
Resourcing Team
Helder Fernandes

September 2025
Rachel Boucher
Zandie Chakunda
Jennifer Simpson
Raffaella Tate
Emily Hodgkinson
Yash Soni

October 2025
Hathi Siddique
Eldric Siron
Sophie Hicks
Michael Hanna
Monika Kucinska
Madiou Elhadj

November 2025
Kiran Keshvala
Jonathan Kershaw
Tanya Maric
West Middlesex Clinical Site Team
Larissa Hamlet
Thelma Flammia
Joanna Thomas
Rona Davies
Alan Lonsdale

December 2025
WM Reporting Radiographer Team
Aleck Dalrymple
Queenne Moralidad-Paredes
Rafrucinni Nellas
Monica Borrello
Lailani Pablo
Mariana Noy
Katie Woodason
Olivia Lambert
Edmund Desouza
Calum Woodward
Aidan Graham
Melissa Byam
Sally Garling

January 2026
John Foster
Alice Sisson
Miti Rach
Ruby Zordok
Aibhin Burke

February 2026
Kiya-Jade Luison-Spenceley
Anna Kamocka
Michael Wride
Jeanilyn Amistoso
Rhian Bull

March 2026
Amanpreet Banga
Courtney Heathcote
Lisa Clarke-Luis
Leah de Leon
Claire Dyer
Gwen Makosana
Patience Okyere
Sarah Rickett
Buen Chester Maranan
Agnieszka Malachowska

Great Big Cheer winners 2025/26

Chelsea	West Middlesex
• Alice Egerton, Occupational Therapist • IT Department Team • Richelle Lewton, Medical Photographer • Dr Imane Boughazi, Senior Clinical Fellow • Irina Stankeviciute, Clinical Hysteroscopist Nurse Specialist • Nitrous Oxide Decommissioning Group • Klarissa Naegler, Healthcare Assistant • Emily Quintana, Practice Educator • Becky Ford, Sister • Manpreet Kaur, Rota Coordinator • Ilona Kouame, Nursing Associate • Ali Aghabeigi, Highly Specialist Pharmacy Clinical Trials Manager • CW PATCH Team • Benjamin Mansfield, Capital Projects Manager • Acute Assessment Unit • Carl Stockley, Volunteer • Infant Feeding Volunteers	• Helen Orridge, Occupational Therapist • David Shackleton, ED Consultant • Sexual Health Hounslow Team • Dr Sara Zafar, Foundation Year 2 • Kathlyn Cubos, Specialist Nurse • Jino Orcullo, Clinical Support Worker • Maternity Bereavement Team • Arvel Alea, Staff Nurse • Clare Cahill, Senior Patient Administrator • Alam Choudhury, Assistant Practitioner • Clarissa Pui, Clinical Anticoagulant Pharmacist • Brandon Mitchell, Patient Administrator Gastroenterology • Hina Hussain, HATS Transport Manager • Margaret Hogan, Volunteer

External recognition

Across the year, colleagues secured 29 award wins, with further recognition through highly commended and shortlisted/finalist positions at prominent national award programmes.

Notable achievements included:

- Harold Thimbleby Award for Digital Transformation at the Royal College of Physicians Excellence in Patient Care Awards (July 2025)
- Chief Allied Health Professional's Gold Award for Excellence from NHS England (November 2025), including recognition as the first Music Therapist nationally to receive a Gold Award
- Gold and Silver Awards at the Building Better Healthcare Awards for collaborative arts and wellbeing projects (November 2025)
- BAFTA Award at the EXTEND Study Awards for excellence in surgical research (July 2025)
- Multiple Black Healthcare Awards wins recognising leadership in stroke care and women's health (July 2025)
- Radiology Quality Improvement Awards from the Royal College of Radiologists, achieving first and second prizes nationally (December 2025)
- NHS England Safeguarding Star Award recognising advocacy for women and families at risk (February 2026)

In addition, Trust teams were shortlisted and finalists at the Royal College of Physicians Excellence in Patient Care Awards (June 2025), Nursing Times Awards (July–September

2025), HSJ Digital Awards (January 2026), National Technology Awards (March 2026) and the International Forum on Quality and Safety in Healthcare (March 2026).

Internal recognition programmes also continued throughout the year, with regular PROUD Awards and Great Big Cheer Awards, celebrating peer-nominated excellence and patient-led recognition.

Media profile

The Trust achieved a strong national media presence during 2025/26, with coverage in outlets including The Sunday Times, The Guardian, ITV, Sky News, Channel 4 News, Radio Jackie and BBC Breakfast.

Highlights included:

- National coverage of the Cancer 360 digital pathway (May 2025)
- BBC Breakfast features on breastfeeding research and neonatal care (March 2026)
- Trust participation in London-wide NHS campaigns on flu vaccination, maternity and workforce diversity (November 2025)

NHS FOUNDATION TRUST CODE OF GOVERNANCE DISCLOSURES

Code of Governance compliance statement

An updated Code of Governance for NHS provider trusts, setting out an overarching framework for the corporate governance of trusts, was published by NHS England in October 2022 and came into effect in April 2023. The Code covers both foundation trusts and NHS trusts and is based on the principles of the UK Corporate Governance Code issued in 2012. Chelsea and Westminster Hospital NHS Foundation Trust has applied the principles of this Code on a 'comply or explain' basis.

The purpose of the Code of Governance is to assist trusts in improving governance practices by bringing together the best practice of public and private sector corporate governance.

During the year, we completed a 'comply or explain' self-assessment exercise in relation to the Code, which was reviewed and considered by the Audit and Risk Committee. Our assessment has not identified any material issues of non-compliance.

As a Trust, we are committed to effective, representative and comprehensive governance which secures organisational capacity and the ability to deliver mandatory goods and services.

Governance arrangements

The Trust is led by a Board of Directors whose key responsibilities are to:

- Provide leadership to the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed
- Ensure the Trust complies with its licence, its constitution, requirements set by NHS England, and relevant statutory and contractual obligations
- Set the Trust's vision, values and standards of conduct
- Set the Trust's strategic aims and ensure that the necessary human and financial resources are in place to deliver these
- Ensure the quality and safety of the healthcare services provided by the Trust
- Ensure the Trust exercises its functions effectively, efficiently and economically

The Trust Board undertakes its responsibilities through a set business cycle which includes approving strategies and receiving monitoring reports on areas such as key risks and financial, operational, quality and safety performance. The Trust Audit and Risk Committee approves standing financial instructions, scheme of delegation and reservation of powers policies, which outline the decisions that must be taken by the Board and the decisions that are delegated to the management of the hospital. These include contracts, tendering procedures, security of the Trust's property, monitoring and ensuring compliance with Department of Health and Social Care directions on fraud and corruption, delegated approval limits, budget submission, annual reports and accounts, banking arrangements, payroll, borrowing and investment, risk management and insurance arrangements.

The Trust Board of Directors, collectively and individually, has a legal duty to promote the success of the Trust to maximise the benefits for the populations that it serves. They also have a duty to avoid conflicts of interest, not to accept any benefits from third parties and to declare interests in any transactions that involve the Trust.

Throughout the reporting period, the Nominations and Remuneration Committee has kept under review the overall size of the Trust Board and the balance of skills, experience and expertise of its members.

The Council of Governors represents the interests of local communities, patients, the public and staff, and shares information about key decisions with Foundation Trust members. The Council of Governors is not responsible for the day-to-day management of the organisation, which is the responsibility of the Trust Board.

The role of the Council of Governors includes:

- Appointment or removal of the Chair and other non-executive directors
- Approving the appointment, by non-executive directors, of the Chief Executive
- Deciding the remuneration, allowances and other terms and conditions of office of non-executive directors
- Appointment or removal of the Foundation Trust's financial auditors
- Reviewing and developing the Trust's membership strategy

A formal procedure is in place should there be a dispute between the Board and Council of Governors. During 2025/26, no issues of dispute arose, and the governors therefore did not exercise their power under paragraph 10(c) of schedule 7, NHS Act 2006.

Board of Directors

During 2025/26, the Board had four executive directors, including the Chief Executive, and ten non-executive directors, including the Chair in Common. The skills, expertise and experience of each Trust Board director as at 31 March 2026 are detailed below.

Executive directors during 2025/26

- **Lesley Watts CBE, Chief Executive Officer:** Lesley is joint Trust Chief Executive of Chelsea and Westminster Hospital NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust. In addition to her current role, Lesley was Chief Executive of the North West London Integrated Care System until November 2021. A nurse and midwife by training, Lesley has extensive executive managerial experience, having led the Trust since 2015, and was previously Chief Executive for East and North Hertfordshire Clinical Commissioning Group. In 2020, under her leadership, the Trust was awarded a CQC rating of Outstanding for well-led and use of resources.

- **Dr Roger Chinn, Chief Medical Officer:** Roger Chinn was appointed as Chief Medical Officer in December 2020. He is a clinical radiologist who has been a consultant with the Trust since 1996. Previously, he has held senior leadership roles as Deputy Medical Director and Chief Clinical Information Officer in the Trust and was the Medical Director at West Middlesex University Hospital for the year prior to its acquisition by the Trust.

- **Robert Bleasdale, Chief Nursing Officer:** Robert joined the Trust in April 2022. He was previously Chief Nurse and Director of Infection Prevention and Control at St George's University Hospital and has held a number of senior nursing leadership roles in the NHS. He played a key role in the Covid-19 response, leading the vaccination programme and establishing one of the first clinics in the country. He has led a range of quality improvement programmes, including accreditation systems to raise standards of care, and contributed to St George's exit from CQC special measures. He is passionate about partnership working and the role of staff and patient involvement in service development. Robert became Deputy Chief Nurse at St George's in 2017 and began his career in acute medicine before moving into emergency care. He is an advanced trauma nursing instructor and holds a nursing degree from Oxford Brookes University and a Master's in Senior Healthcare Leadership from the University of Birmingham.

- **Virginia Massaro, Chief Finance Officer:** Virginia is joint Chief Financial Officer of Chelsea and Westminster Hospital NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust. Virginia joined CWFT in 2010 as Head of Financial Planning before progressing to Assistant Director of Finance and Deputy Director of Finance, having previously worked in finance teams across other NHS organisations in North West London. She has been Chief Financial Officer since October 2019 and is a qualified chartered management accountant.

Non-executive directors during 2025/26

- **Matthew Swindells, Chair:** Matthew joined the Trust in April 2022. He has over 30 years' experience in healthcare. He is the former Deputy Chief Executive and Chief Operating Officer for the NHS in England. He also runs his own consultancy, through which he provides strategic advice on digital transformation and global healthcare to a small number of innovative companies.

  Matthew's NHS career started as an NHS supplies management trainee and includes a series of operational management roles in the NHS up to Chief Executive at the Royal Surrey County Hospital and as the NHS's first Chief Information Officer. He then worked in government, firstly as Head of the Health Team in the Prime Minister's Office of Public Service Reform and then as Special Policy Adviser to the Secretary of State for Health. Matthew is President of the Health Care Supply Association and holds a Visiting Professorship at Imperial College Institute of Global Health Innovation.

  Matthew is joint Chair, responsible for 12 hospitals across four NHS trusts in North West London: Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust.

- **Patricia Gallan, Vice Chair and Senior Independent Director:** Patricia is a Non-Executive Director for HMRC and the Trade Remedies Authority, and serves on the Council of Queen Mary University of London. A former chief police officer, she had a distinguished career in the Metropolitan Police Service, retiring in 2018 after more than 13 years at executive board level. She has held a range of senior operational and leadership roles and is a qualified barrister. Patricia joined the Trust Board in July 2023.

- **Carolyn Downs CB:** Carolyn is a recently retired Chief Executive of the London Borough of Brent and was previously Chief Executive of the Local Government Association. Prior to that, she was Deputy Permanent Secretary in the Ministry of Justice, Chief Executive of the Legal Services Commission and Chief Executive of Shropshire County Council. She has worked in local government in numerous councils for almost 40 years.

- **Aman Dalvi:** Aman has held chief executive roles across multiple organisations and brings extensive experience in planning, regeneration and development. He has served on national boards and chaired several housing and development organisations. He is currently Chair of the Audit and Risk Committee and Lead Non-Executive Director for Estates and Facilities. He also serves on the Board of Imperial College Healthcare NHS Trust.

- **Mike O'Donnell:** Mike is an experienced non-executive director, CEO and CFO with a proven track record in financial services, the public sector and other regulated industries. He has a strong network in pensions and local government and is skilled in building collaborative teams and relationships. Mike has chaired various board committees, including audit, risk and remuneration, and has served on investment oversight committees.

  With experience as CEO of an FCA-regulated investment company and Corporate Director in local government, Mike is a qualified accountant with expertise in public sector financial management. He has led corporate functions such as ICT, property, HR and strategy and communications and has significant experience in complex stakeholder and governance environments.

  As a strategic thinker, Mike excels in working with both executive and non-executive teams to develop strategies focused on improvement and customer outcomes. His current NED roles include positions with Public Sector Audit Appointments Ltd, XTP Ltd and Local Pensions Partnership Administration. Previous roles include executive board member at London CIV, NED and Chair at Homes for Lambeth, and Chair of Audit and Risk and Remuneration Committees at London Pension Fund Authority. Mike has also served as President of the Society of London Treasurers.

- **Catherine Williamson:** Catherine is Professor of Women's Health at Imperial College London and a consultant in obstetric medicine. She is a Fellow of the Academy of Medical Sciences and an honorary fellow of the RCOG. Her research focuses on maternal and fetal health conditions and she leads major national and international clinical guideline work.

- **Ajay Mehta:** Ajay is an organisational development specialist working globally to support civil society organisations. He has extensive experience in strategy, governance and community engagement. He currently chairs the People and Workforce Committee and serves as Wellbeing Guardian, with previous board experience in the NHS and charity sector.

- **Dr Syed Mohinuddin:** Dr Mohinuddin is a Consultant Neonatologist with more than 25 years' NHS experience and leads the pan-London Neonatal Transfer Service. He is a Fellow of the Royal College of Paediatrics and Child Health and holds a Master's in Medical Leadership. He has expertise in clinical education, digital innovation and patient safety, and currently chairs the Quality and Safety Committee.

- **Vineeta Manchanda:** Vineeta is Audit Chair of The Hillingdon Hospitals NHS Foundation Trust and a Non-Executive Director of Chelsea and Westminster Hospital NHS Foundation Trust. Her non-executive director and advisory career has spanned the private, public and voluntary sectors covering med-tech, software as a service, local government, adult and children's social services, education, debt advice, as well as previous NHS roles. Currently, she is Audit Chair at Bedfordshire, Luton and Milton Keynes ICB and RTOP PLC, and a member of the Audit Committee at Worcester College, Oxford University.

  Vineeta's executive career was in investment banking, where she had experience of working in large multinationals such as Merrill Lynch and Unilever, as well as leading the growth of start-up emerging market investment banks. She brings extensive experience of helping companies raise funds, financial analysis, stakeholder management, organisational development, mergers and acquisitions and risk management.

Directors who left during 2025/26

- Helen Stephenson, Non-Executive Director, left 31 December 2025.

Directors and others in regular attendance at Board meetings 2025/26

- Laura Bewick, Managing Director, Chelsea and Westminster Hospital
- Sheena Basnayake, Managing Director, West Middlesex Hospital
- Peter Jenkinson, Director of Corporate Governance
- Kevin Croft, Chief People Officer
- Emer Delaney, Director of Communications
- Alexia Pipe, Chief of Staff to the Chair in Common

Board of Directors at the time of writing

At the time of writing this Annual Report, the Board had five executive directors and eight non-executive directors, including the Chair in Common, as full members. The Board's composition had changed following the end of the reporting period, reflecting the developing North West London Acute Provider Group arrangements. The skills, expertise and experience of the Trust Board are appropriate to meet the requirements of an NHS foundation trust.

Executive directors at the time of writing

- **Professor Tim Orchard, Group Chief Executive of the North West London Acute Provider Group:** Tim is Group Chief Executive, a consultant gastroenterologist, and was appointed Chief Executive of Imperial College Healthcare NHS Trust in 2018. He was previously Divisional Director for Medicine and Integrated Care at the Trust, which he joined as a registrar in 2000.

  Having taken his undergraduate medical degree at the University of Cambridge, he trained at Charing Cross and Westminster Medical School and was a research fellow at the University of Oxford, before completing his training as a gastroenterologist in the hospitals of North West London. He was appointed Professor of Gastroenterology at Imperial College London in 2012. He is a recognised expert in inflammatory bowel disease (IBD), having been Chair of the IBD section of the British Society of Gastroenterology and national representative on the European Crohn's and Colitis Organisation. He is also an accomplished educator and Fellow of the Higher Education Academy (FHEA).

  Tim has a particular focus on developing a collaborative, inclusive and kind organisational culture. During his time as Chief Executive, Imperial has seen significant improvements in its CQC ratings, staff engagement scores, and operational and financial performance. The trust has recently achieved excellent NHS Oversight Framework rankings as one of the top-performing acute trusts in the country and the top teaching trust for the last two quarters.

  Tim has also prioritised the development of strategic partnerships with Imperial College London and others to bring research and innovation to the forefront in healthcare, supporting the creation of a new life sciences partnership at St Mary's Hospital and an increased five-year funding award of £105m for the NIHR Imperial Biomedical Research Centre.

  Tim has previously been Chair of The Shelford Group, a collaboration between ten of the largest teaching and research NHS hospital trusts in England, for whom he currently sits on the Board of the Office for Strategic Coordination of Health Research. He has also worked at a national level, chairing the Statutory and Mandatory Training Assurance Board, aiming to streamline training and focus it on effectively reducing harm.

  After the formation of the North West London Acute Provider Collaborative in 2022, Tim became Lead CEO, working with colleagues to support a range of initiatives across the collaborative, including clinical, workforce, digital and data developments. As Group CEO, Tim is looking forward to building on the excellent performance across the group to deliver more benefits for patients, communities and staff across north west London.

- **Lesley Watts CBE, Chief Executive Officer:** Lesley is joint Trust Chief Executive of Chelsea and Westminster Hospital NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust. In addition to her current role, Lesley was Chief Executive of the North West London Integrated Care System until November 2021. A nurse and midwife by training, Lesley has extensive executive managerial experience, having led the Trust since 2015, and was previously Chief Executive for East and North Hertfordshire Clinical Commissioning Group. In 2020, under her leadership, the Trust was awarded a CQC rating of Outstanding for well-led and use of resources.

- **Dr Roger Chinn, Chief Medical Officer:** Roger Chinn was appointed as Chief Medical Officer in December 2020. He is a clinical radiologist who has been a consultant with the Trust since 1996. Previously, he has held senior leadership roles as Deputy Medical Director and Chief Clinical Information Officer in the Trust and was the Medical Director at West Middlesex University Hospital for the year prior to its acquisition by the Trust.

- **Robert Bleasdale, Chief Nursing Officer:** Robert joined the Trust in April 2022. He was previously Chief Nurse and Director of Infection Prevention and Control at St George's University Hospital and has held a number of senior nursing leadership roles in the NHS. He played a key role in the Covid-19 response, leading the vaccination programme and establishing one of the first clinics in the country.

  He has led a range of quality improvement programmes, including accreditation systems to raise standards of care, and contributed to St George's exit from CQC special measures. He is passionate about partnership working and the role of staff and patient involvement in service development.

  Robert became Deputy Chief Nurse at St George's in 2017 and began his career in acute medicine before moving into emergency care. He is an advanced trauma nursing instructor and holds a nursing degree from Oxford Brookes University and a Master's in Senior Healthcare Leadership from the University of Birmingham.

- **Virginia Massaro, Chief Finance Officer:** Virginia is joint Chief Financial Officer of Chelsea and Westminster Hospital NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust. Virginia joined CWFT in 2010 as Head of Financial Planning before progressing to Assistant Director of Finance and Deputy Director of Finance, having previously worked in finance teams across other NHS organisations in North West London. She has been Chief Financial Officer since October 2019 and is a qualified chartered management accountant.

Non-executive directors at the time of writing

The Board's composition had changed following the end of the reporting period, reflecting the developing North West London Acute Provider Group arrangements. The Board members at the time of writing are listed below.

- **Bob Alexander OBE, Interim Chair:** Bob is Interim Chair of the North West London Acute Provider Group (APG), responsible for 12 hospitals across four NHS trusts in North West London: Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust.

  Bob brings more than 30 years of board-level experience across the NHS and wider public sector, including senior executive NHS roles at regional and national level and, more recently, a portfolio of non-executive positions currently including London Ambulance Service and South West London ICB. Bob has extensive leadership experience in finance, governance and system working. Bob has an MBA and is a Fellow of both the Chartered Institute of Public Finance and Accountancy and the Healthcare Financial Management Association.

- **Patricia Gallan, Vice Chair and Senior Independent Director:** Patricia is Vice Chair of Chelsea and Westminster Hospital NHS Foundation Trust and a non-executive director of Imperial College Healthcare NHS Trust. Patricia is a member of the following Board Committees:

  • Quality Committee, Group (Chair)
  • Digital and Data Committee, Group
  • Nomination and Remuneration Committee, Group
  • Audit and Risk Committee, CWFT
  • Trust Standing Committee, CWFT (Chair)
  • Trust Standing Committee, ICHT
  • Lead for Quality and Maternity Champion, CWFT

  She is an external member of the Council of Queen Mary University of London, Chair of Governors at an east London infant and junior school and a member of the Drapers' Multi-Academy Trust.

  A former chief police officer, she began her police career as a graduate entrant in east London, rising to Assistant Commissioner Specialist Crime and Operations of the Metropolitan Police Service, retiring in 2018 with more than 13 years' executive board experience in policing. Patricia was a detective and hostage negotiator, and is a qualified barrister. She previously served as Deputy Assistant Commissioner, Specialist Operations—Security and Protection, and Deputy Assistant Commissioner, Professionalism, in the Met.

  In addition, she has served in Merseyside Police and the National Crime Squad as a chief police officer, as well as completing a secondment to the Home Office. In July 2023, Patricia joined the respective boards of Chelsea and Westminster Hospital NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust within the NHS North West London Acute Provider Collaborative as a non-executive director.

- **Mike O'Donnell, Non-Executive Director:** Mike is a non-executive director of Chelsea and Westminster Hospital NHS Foundation Trust and a non-executive director of The Hillingdon Hospitals NHS Foundation Trust. Mike is a member of the following Board Committees:

  • Finance and Performance Committee, Group
  • Strategic Estates, Infrastructure and Sustainability Committee, Group
  • Audit and Risk Committee, CWFT
  • Trust Standing Committee, CWFT
  • Trust Standing Committee, THHFT
  • Lead for Finance and Performance, LNWH

  He is an experienced non-executive director, CEO and CFO with a proven track record in financial services, the public sector and other regulated industries.

  He has a strong network in pensions and local government and is skilled in building collaborative teams and relationships. Mike has chaired various board committees, including audit, risk and remuneration, and has served on investment oversight committees. With experience as CEO of an FCA-regulated investment company and Corporate Director in local government, Mike is a qualified accountant with expertise in public sector financial management. He has led corporate functions such as ICT, property, HR and strategy and communications, and has significant experience in complex stakeholder and governance environments. As a strategic thinker, Mike excels in working with both executive and non-executive teams to develop strategies focused on improvement and customer outcomes.

  His current NED roles include positions with Public Sector Audit Appointments Ltd, XTP Ltd and Local Pensions Partnership Administration. Previous roles include executive board member at London CIV, NED and Chair at Homes for Lambeth, and Chair of Audit and Risk and Remuneration Committees at London Pension Fund Authority. Mike has also served as President of the Society of London Treasurers.

- **Vineeta Manchanda, Non-Executive Director:** Vineeta is a non-executive director of The Hillingdon Hospitals NHS Foundation Trust and a non-executive director of Chelsea and Westminster Hospital NHS Foundation Trust. Vineeta is a member of the following Board Committees:

  • Finance and Performance Committee, Group
  • Strategy Committee, Group
  • Audit and Risk Committee, ICHT
  • Trust Standing Committee, ICHT
  • Trust Standing Committee, CWFT
  • Lead for Finance and Performance, ICHT
  • Redevelopment Committee, ICHT

  Her non-executive director and advisory career has spanned the private, public and voluntary sectors, covering med-tech, software as a service, local government, adult and children's social services, education, debt advice, as well as previous NHS roles. Currently, she is Audit Chair at Bedfordshire, Luton and Milton Keynes ICB and RTOP PLC, and a member of the Audit Committee at Worcester College, Oxford University.

Vineeta's executive career was in investment banking, where she had experience of working in large multinationals such as Merrill Lynch and Unilever, as well as leading the growth of start-up emerging market investment banks. She brings extensive experience of helping companies raise funds, financial analysis, stakeholder management, organisational development, mergers and acquisitions and risk management.

- **Dr Syed Mohinuddin, Non-Executive Director:** Syed is a non-executive director of Chelsea and Westminster Hospital NHS Foundation Trust and London North West University Healthcare NHS Trust. Syed is a member of the following Board Committees:

  • Quality Committee, Group
  • Strategic Estates, Infrastructure and Sustainability Committee, Group
  • Audit and Risk Committee, LNWH
  • Trust Standing Committee, LNWH
  • Trust Standing Committee, CWFT
  • Lead for Quality and Maternity Champion, LNWH

  Syed has worked in the NHS for more than 20 years and is a consultant neonatologist for the London Neonatal Transfer Service, Barts Health NHS Trust. He is also the Training Programme Director, London Specialty School of Paediatrics, Health Education England, and Innovation and Clinical Lead for the NeoMate smartphone app programme.

  Syed is a member of the Harrow Muslim community and Harrow Central Mosque, and previously worked as a specialist registrar at Northwick Park and Central Middlesex hospitals between 2004 and 2007. He graduated from the Armed Forces Medical College, Pune, India, in 1995 and was awarded the prestigious Colonel Malhotra Memorial Gold Medal in medicine. He subsequently moved to the UK and completed his core and higher specialist training in paediatrics.

- **Catherine Williamson, Non-Executive Director:** Catherine is a non-executive director of Imperial College Healthcare NHS Trust, Professor of Women's Health at Imperial College London and a consultant in obstetric medicine at Queen Charlotte's, St Thomas' and King's College Hospitals. Catherine is a member of the following Board Committees:

  • Quality Committee, Group
  • Strategy Committee, Group
  • Trust Standing Committee, ICHT
  • Trust Standing Committee, CWFT

  She is a Fellow and Council Member of the Academy of Medical Sciences and is an honorary fellow of the RCOG. She is the maternal medicine representative on the RCOG Genomics Committee. Her research focuses on the maternal and fetal aetiology, outcomes and management of intrahepatic cholestasis of pregnancy, gestational diabetes mellitus and severe hyperemesis gravidarum. Professor Williamson was Chair of the writing group for the EASL Clinical Practice Guideline for Liver Disorders in Pregnancy and is currently writing the FIGO Guidelines on Management of Liver Disorders in Pregnancy. As Director of the Tommy's National Centre for Preterm Birth

Research, she coordinates a research portfolio that aims to understand the aetiology of preterm birth, develop research-informed interventions and provide improved support for women affected by preterm birth, a complication that affects the pregnancies of many women with obstetric medical disorders.

- **Baljit Ubhey, Non-Executive Director:** Baljit is a non-executive director of London North West University Healthcare NHS Trust and a non-executive director on the Board of The Hillingdon Hospitals NHS Foundation Trust. Baljit is a member of the following Board Committees:

  • People Committee, Group
  • Strategy Committee, Group
  • Nomination and Remuneration Committee, Group
  • Audit and Risk Committee, CWFT (Chair)
  • Trust Standing Committee, CWFT
  • Trust Standing Committee, LNWH
  • Lead for People, Wellbeing and Freedom to Speak Up (FTSU) Champion, CWFT

  Baljit joined the Crown Prosecution Service (CPS) as a legal trainee in 1992, later qualifying as a prosecutor in London. Baljit has since held many roles, including Chief Crown Prosecutor of CPS London. In January 2017, Baljit was appointed as Director of Prosecution Policy and Inclusion, leading a policy team within the CPS's operations directorate while leading on equality and inclusion across the service. In September 2019, Baljit became Director of the Strategy and Policy Directorate. In addition to her career with the CPS, Baljit has held a number of external roles, including as a non-executive director for Barts and The London Hospital, and has worked with a number of charities. She was also a member of the National Fire Chiefs Council Culture and Inclusion Challenge and Support Panel. In 2011, she was awarded an OBE for services to criminal justice.

- **Tanaka Chiimba, Non-Executive Director:** Tanaka is a non-executive director of The Hillingdon Hospitals NHS Foundation Trust and Chelsea and Westminster Hospital NHS Foundation Trust. Tanaka is a member of the following Board Committees:

  • People Committee, Group
  • Strategy Committee, Group
  • Nominations and Remuneration Committee, Group
  • Audit and Risk Committee, THHFT (Chair)
  • Trust Standing Committee, THHFT
  • Trust Standing Committee, CWFT
  • Lead for People, Wellbeing and Freedom to Speak Up (FTSU) Champion, THHFT
  • Charitable Funds Committee, THHFT

  She is a Chartered Accountant with more than 25 years' experience working at board level across healthcare, education and public interest organisations. She has held senior leadership roles in large-scale strategy, transformation and performance improvement, with a focus on governance, workforce and financial stewardship in complex, regulated environments. She currently holds a number of non-executive and trustee roles across the charitable and education sectors, and is the founder of a social investment venture focused on sustainable, community-based care models.

Directors who left on or after 31 March 2026

- Matthew Swindells, Chair in Common, served until 31 March 2026
- Aman Dalvi, Non-Executive Director, served until 31 March 2026
- Ajay Mehta, Non-Executive Director, served until 31 March 2026
- Carolyn Downs, Non-Executive Director, served until 31 March 2026

Key responsibilities of non-executive directors

For all non-executive directors, key responsibilities include:

- Challenging and supporting the executive directors in decision-making and on the Trust's strategy
- Holding collective accountability with the executive directors for the exercise of their powers and for the performance of the Trust

Independence of non-executive directors

The Trust Board has evaluated the circumstances and relationships of individual non-executive directors which are relevant to the determination of the presumption of independence and determines all its non-executive directors to be independent in character and judgement.

We extend our sincere appreciation to our three dedicated non-executive directors, Ajay Mehta, Carolyn Downs and Aman Dalvi, who concluded their extended terms of office during the year. Their contribution, leadership and steadfast commitment to the Trust have been greatly valued.

The Chair meets frequently with the Vice Chairs for separate NED briefing sessions.

Performance evaluation of the Board

The annual appraisal of the Chair was led by the Senior Independent Director. The views of non-executive directors, executive directors, external partners and governors were sought and contributed to the process. The performance of non-executive directors is evaluated annually by the Vice Chair, who also seeks the views of colleagues and stakeholders. Executive directors have an annual appraisal with the Chief Executive. All Trust Board committees reviewed their effectiveness during 2025/26 and provided assurance reports to the Committees on their reported effectiveness and associated improvement actions.

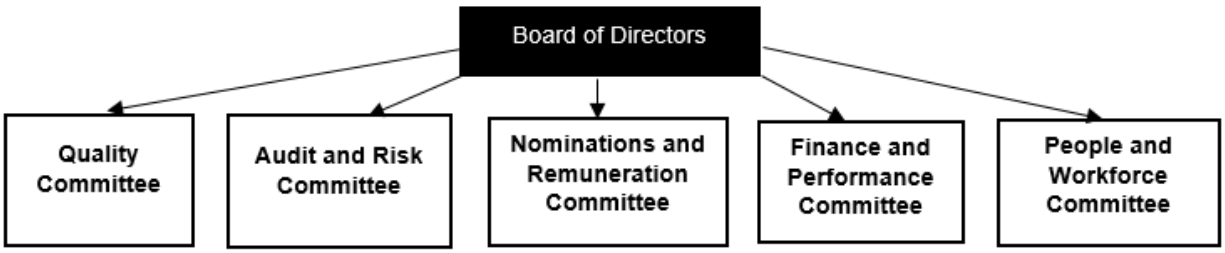
Board meetings

The Trust Board meets in public no fewer than four times per year. Special meetings are organised as and when required. There were four meetings in public held in 2025/26. These were meetings of the Chelsea and Westminster Hospital NHS Foundation Trust Board of Directors, meeting as part of the Board in Common with the other North West London Acute Provider Collaborative trusts. Director attendance is detailed below.

	Public Board meeting attendance	
	Required to attend	Attended
Executive directors		
Lesley Watts	4	4
Robert Bleasdale	4	3
Roger Chinn	4	4
Virginia Massaro	4	4
Non-executive directors		
Matthew Swindells	4	4
Aman Dalvi	4	2
Patricia Gallan	4	4
Carolyn Downs	4	3
Ajay Mehta	4	4
Syed Mohinuddin	4	4
Helen Stephenson	2	2
Vineeta Manchanda	3	2
Mike O'Donnell	1	1
Catherine Williamson	1	0

Committees of the Board of Directors

The Trust Board committee structure is set out below. Terms of reference detail the responsibilities of each committee. This structure monitors and provides assurance to the Board on the delivery of our objectives and other key priorities.



Nominations and Remuneration Committee of the Board of Directors for the appointment of executive directors

The Nominations and Remuneration Committee is a committee of the Trust Board of Directors. It is appointed in accordance with the constitution of the Trust to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors. The Committee comprises the Chair and four other non-executive directors. The Committee met on three occasions during the year and at these meetings it:

- Approved executive director pay and very senior management pay
- Approved the terms of reference of the Committee
- Approved the annual business cycle of the Committee
- Reviewed the effectiveness of the Committee

Nominations and Remuneration Committee members and attendees	Attendance	
	Required to attend	Attended
Patricia Gallan (Chair of Committee)	3	3
Matthew Swindells, Chair	3	2
Aman Dalvi	3	2
Ajay Mehta	3	2
Mike O'Donnell	3	2
In attendance		
Lesley Watts, Chief Executive Officer	3	3
Kevin Croft, Chief People Officer	3	3
Marie Price, Deputy Director of Corporate Governance	3	3

Nominations and Remuneration Committee of the Council of Governors for the appointment of non-executive directors

A separate Nominations and Remuneration Committee of the Council of Governors is responsible for the nomination, appointment and remuneration of the Chair, Vice Chair and non-executive directors. The Committee is chaired by the Trust Chair and includes the Lead Governor and five public and patient elected governors.

In relation to appointments, the Committee oversees a structured and transparent process in line with the Trust's constitutional requirements and NHS best practice. This includes agreeing role specifications, determining the skills and experience required by the Board, overseeing the recruitment approach, including the use of external search where appropriate, shortlisting, stakeholder and formal interview panels involving governors, and making recommendations to the Council of Governors for approval.

The Committee also has oversight of succession planning for the Chair and non-executive directors. This includes regular consideration of Board composition, tenure, skills mix and anticipated vacancies to ensure continuity and effective leadership. Succession planning is informed by the Trust's strategic priorities and aims to maintain an appropriate balance of skills, experience and independence.

In carrying out its role, the Committee is mindful of the importance of equality, diversity and inclusion. Recruitment processes are designed to be fair and open, with a focus on attracting a broad and diverse field of candidates. Consideration of Board diversity forms part of the Committee's discussions on both appointments and succession planning, supporting the development of a diverse pipeline of potential candidates over time.

Appointments and reappointments

During 2025/26, on recommendation by the Committee and agreement of the Council of Governors, it was agreed:

22 October 2025

- Appointment of the Group Chief Executive/Single Accountable Officer. The recommendation of Tim Orchard as Group Chief Executive was supported by the Nominations and Remuneration Committee and presented to the Council of Governors for approval.
- Approval of the extension to the term of office for non-executive directors Ajay Mehta and Aman Dalvi.

21 January 2026

- Group non-executive director changes for transition to the Group Governance Model, effective from 1 April 2026. The Committee agreed to the recruitment process for the shared NEDs and the proposed changes to the composition of the NEDs, which were presented to the Council of Governors for approval.
- Extension of the Chair's term of office as Chair of the Chelsea and Westminster Board for two years. This was agreed by the Committee and presented to the Council of Governors for approval. For the other trusts in the collaborative that are not foundation trusts, approval would be sought from NHS England.

17 March 2026

- Approval of the appointment of a non-executive director following recruitment, and approval of the appointment of an Interim Chair following the resignation of the previous APC Chair.

Council of Governors Nominations and Remuneration Committee attendees	Attendance	
	Required to attend	Attended
Matthew Swindells, Chair	3	3
Pat Gallan, Vice-Chair	3	3
Richard Ballerand, Public Governor	3	3
Minna Korjonen, Patient Governor	3	3
Nigel Clarke, Public Governor	3	3
Nina Littler, Public Governor	3	3
Ian Dalton, Patient Governor	3	3
In attendance		
Lesley Watts, Chief Executive Officer	3	3
Peter Jenkinson, Director of Corporate Governance (deputy attended)	3	3

Trust Standing Committee

The purpose of the Trust Standing Committee is to oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that related Trust risks and issues are being managed. The Trust Standing Committee also oversees and provides assurance to the Trust Board, via the Board in Common, on operational, finance, quality and workforce performance; the corporate risk register and Board Assurance Framework; Board committee chair's reports and statutory reports that are reported on at the Board in Common.

Quality Committee

The Quality Committee is mainly responsible for issues of quality and patient safety. It seeks assurance on systems, processes and outcomes relating to the safety and effectiveness of care which we deliver to our patients. This includes monitoring regulatory compliance with the standards set out by the Care Quality Commission.

People and Workforce Committee

The People and Workforce Committee is responsible for reviewing Trust performance on key workforce metrics, including turnover, mandatory training and appraisal rates, while also reviewing key workforce and organisational development strategies on behalf of the Trust Board.

Finance and Performance Committee

The Finance and Performance Committee is responsible for seeking assurance as to the satisfactory management of the Trust's finances, cost improvement programme, cash management and capital programme. The Committee also reviews and recommends to the Trust Board for approval those business cases with high-level strategic significance.

Audit and Risk Committee

The Audit and Risk Committee assures the Trust Board that probity and professional judgement are exercised in all financial matters. It advises on the adequacy and effectiveness of the Trust's internal control systems, risk management arrangements, counter-fraud measures and governance processes, and on ways of maximising efficiency and effectiveness. In doing this, the Audit and Risk Committee primarily utilises the work of internal audit, provided by BDO in 2025/26, external audit, provided by Deloitte in 2025/26, and other external bodies. The Committee approves the annual work plans of internal and external audit, as well as the local counter-fraud specialist, provided by RSM in 2025/26.

The Chief Executive is the Trust's designated accounting officer, who has the duty of preparing the accounts in accordance with the NHS Act 2006. Aman Dalvi chaired the Audit and Risk Committee, which includes two other non-executive directors. The Committee met four times in 2025/26. Following the year-end, Baljit Ubhey was appointed Chair of the Audit and Risk Committee from 1 April 2026 and will chair the Committee for the approval of the 2025/26 annual report and accounts.

Audit and Risk Committee attendees	Attendance	
	Required to attend	Attended
Aman Dalvi (Chair)	4	4
Dr Syed Mohinuddin	4	2
Carolyn Downs	2	3

Significant issues considered by the Audit and Risk Committee in relation to the financial statements, operations and compliance

During the year, the Audit and Risk Committee received several reports from the internal auditors, BDO. These covered several areas, including data quality—RTT waiting times, fit and proper persons, IT asset management, cyber in supply chain, use of electronic consent, medical devices management, consultant job planning benchmarking, Mental Health Act compliance, nurse rostering, Patient Safety Incident Response Framework (PSIRF) and patient transport services. For the period 1 Apr 2025–31 Mar 2026, three high-risk recommendations were identified by our internal auditors, primarily relating to Mental Health Act compliance, nurse rostering controls and patient transport eligibility assurance.

Following the year-end, the Committee considered the draft annual report and accounts 2025/26 and received the ISA 260 report from the Trust's external auditors.

During 2025/26, in addition to non-executive directors and those executive directors in attendance, the Trust's internal and external auditors and counter-fraud specialist attended the Committee meetings. When relevant, other senior managers attended meetings to provide a deeper level of insight into certain key issues within their respective areas of

expertise, including all areas of significant risk, cyber security, risk management, Board Assurance Framework and information governance.

The Committee has engaged regularly with the external auditors over the financial year. External audit matters discussed have included consideration of the external audit plan, matters arising from the audit of the Trust's financial statements, implementation and adoption of international reporting standards and any recommendations on control and accounting matters proposed by the auditor.

The Committee assesses the external auditor's quality and value of work, timeliness, reporting and fees on an annual basis. This assessment includes the review and monitoring of the external auditor's independence, objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards. The Committee will discuss and agree with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan, including consideration of their local evaluation of audit risks. The Committee reviews all external audit reports, including the report to those charged with governance, agreement of the annual auditor's report and the appropriateness of management responses and progress on implementation of recommendations received by the Trust's external auditor. In addition, the Committee received and considered the significant risks identified by the Trust's internal auditor in the end-of-year report.

Policy for safeguarding the external auditors' independence

The Trust carried out an Official Journal of the European Union (OJEU) tender for statutory audit services in October 2016 and reappointed Deloitte LLP on a three-year contract, with an option to extend for a further two years. It was agreed by the Audit and Risk Committee during 2019/20 to extend the contract for two years. Following an unsuccessful procurement process in 2022/23, it was agreed by the Audit and Risk Committee to extend the contract with Deloitte LLP for a further two years.

As part of the initial procurement process, the independence of applicants was assessed. The external auditor has not provided non-audit services in the year. This is the one area of non-compliance, albeit not material as stated earlier in this report, regarding the Code of Governance, whereby trusts should not retain the same auditors in excess of 20 years.

A further procurement was attempted in 2024/25, which again did not result in the appointment of a new auditor and therefore the contract with Deloitte has been extended further for two years. As described above, the Trust has tried to address this and plans to retender during 2026/27.

Internal audit

From June 2021, following a competitive tender, the Trust awarded the contract to provide internal audit to BDO on a three-year contract, with an option to extend for a further two years. The internal audit plan covered the Trust's risk management, governance and internal control processes, both financial and non-financial, across the Trust.

Through detailed examination, evaluation and testing of the Trust's systems, internal audit plays a key role in the Trust's assurance processes. The Audit and Risk Committee signs off the annual internal audit plan and reviews the findings of internal audit's work against the annual plan at each of its meetings. The Head of Internal Audit reports to the Committee and has a right of direct access to Committee members. The internal audit function is managed by the Chief Financial Officer.

Council of Governors

The role, powers and composition of the Council of Governors was outlined earlier in this report and is also set out within the Trust's constitution. The Council of Governors meets at least quarterly and held four meetings in 2025/26. Executive and non-executive directors of the Trust Board are invited to attend these meetings.

Both elected and appointed governors normally hold office for a period of three years and are eligible for re-election or reappointment at the end of that period. The details of the governors holding office as at 31 March 2026 are provided within the table below:

Last name	First name	Constituency	Borough/Organisation	Date elected or appointed	Term	Attendance at council meetings 2025/26 (required to attend)	Attendance at council meetings 2025/26 (attended)
Ballerand	Richard	Public	Royal Borough of Kensington and Chelsea	Nov 2017	3	4	4
Boulliat Moulle	Caroline	Patient	-	Feb 2023	2	4	3
Cass-Horne	Cass J	Public	City of Westminster	Feb 2023	2	4	4
Chatterley	Maureen	Public	Richmond upon Thames	Nov 2023	1	4	4
Clarke	Nigel	Lead/Public Governor	Hammersmith and Fulham	Feb 2023	1	4	4
Dacanay	Rodelix	Staff	Non-Clinical	Nov 2024	1	4	4
Dalton	Ian	Patient	-	Nov 2023	1	4	4
Daubeney	Nara	Public	Wandsworth	Feb 2023	1	4	1
Digby-Bell	Christopher	Patient	-	Nov 2017	3	4	2
Fleming	Stuart	Public	Wandsworth	Nov 2021	2	4	3
Folkson	Jerry	Public	Hounslow	Nov 2024	1	4	3
Singh Garcha	Parvinder	Public	Hounslow	Nov 2021	2	4	3
Korjonen	Minna	Patient	-	Nov 2018	3	4	4
Littler	Nina	Deputy Lead Governor/Public Governor	Royal Borough of Kensington and Chelsea	Feb 2023	1	4	4
Mansfield[4]	Simon	Public Governor	Hammersmith and Fulham	Nov 2024	1	4	4
Martin	Ras I	Public	Rest of England	Feb 2023	1	4	4
Nelson	Mark	Staff	Medical and Dental	Nov 2020	3	4	3
O'Farrell	Fiona	Patient	-	Nov 2024	2	4	3
Pascal	Will	Local Authority	Kensington and Chelsea	May 2022	2	4	4
Podder	Nathalie	Public	Ealing	Nov 2024	1	4	2
Sharpe	Lucinda	Staff	Nursing and Midwifery	Nov 2023	1	4	3

[4] This post is for two years as the governor who was re-elected for this constituency in November 2023 resigned after one year in post and, in accordance with the election guidelines, the appointment in this constituency would only be for two years. After this period has passed and this post is up for re-election, the appointment would be for three years.

Last name	First name	Constituency	Borough/Organisation	Date elected or appointed	Term	Attendance at council meetings 2025/26 (required to attend)	Attendance at council meetings 2025/26 (attended)
Vassallo	Linda	Staff	Non-Clinical	Nov 2024	1	4	1
Walsh	Dr Desmond	University	Imperial College	Oct 2018	2	4	4
Winterbottom	Jo	Public	City of Westminster	Feb 2023	1	4	2
Vacant		Patient	-				
Vacant		Patient	-				
Vacant		Patient	-				
Vacant		Public	Richmond upon Thames				
Vacant		Staff	Allied Health Professionals, Scientific and Technical				
Vacant		Staff	Nursing and Midwifery				
Vacant		Appointed/ Local Authority	Hounslow				

There were no disputes between the Council of Governors and the Board of Directors during the year. Should any such dispute or disagreement arise, governors are able to contact the Lead Governor or Senior Independent Director.

Council of Governors' register of interests

Governors are required to sign a code of conduct, declare any interests that are relevant annually and confirm they meet the fit and proper person condition as set out in Regulation 5 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*.

The register of governors' interests is published annually. A copy can be downloaded from the Trust website at www.chelwest.nhs.uk/cog, requested by emailing chelwest.corporategovernance@nhs.net or requested by calling 020 3315 6716/6725.

You can also request a hard copy by writing to:

Corporate Governance Team
Chelsea and Westminster Hospital NHS Foundation Trust
369 Fulham Road
London
SW10 9NH

Contacting the governors

Governors welcome the views and suggestions of members and the wider public. Please see www.chelwest.nhs.uk/cog for governors' details and biographies. If you would like to contact any of the governors, email chelwest.corporategovernance@nhs.net or call 020 3315 6716/6725.

How the Board of Directors and Council of Governors have acted to understand the views of governors and Foundation Trust members

The Trust Board interacts regularly with the Council of Governors to ensure that it understands their views and those of members. Governors can attend the Trust's public Board meetings and at least five governors usually take this opportunity. Non-executive directors attend the public Council of Governors meetings.

Governors and non-executive directors also meet twice a year to discuss a range of topics in an open and informal manner. A rolling programme of non-executive director chairs of Trust Board committees presenting at each Council of Governors meeting takes place to enable governors to hold the non-executive directors to account. In addition, we hold regular governor briefing sessions on topics of strategic or operational interest to governors, to enable them to develop their knowledge around the range of information presented to them for assurance purposes and to seek their views on how we can improve aspects of our business.

Foundation Trust membership

As a Foundation Trust, we are accountable to our local community, patients and staff, who all have the right to become members. Trust members play an active role in helping us to understand the views and needs of the population we serve. Membership is open to anyone aged 16 years or older. The membership has three constituencies—patient, public and staff—as defined in the Trust constitution and summarised below.

Patient membership

Anyone who has attended any of the Trust's hospitals as either a patient or as the carer of a patient within the last three years.

Public membership

Any member of the public over the age of 16 who lives in the area the Trust serves, divided into six constituencies based on local government boundaries:

- City of Westminster
- London boroughs of Ealing, Hammersmith and Fulham, Hounslow, Richmond upon Thames and Wandsworth
- Royal Borough of Kensington and Chelsea

Staff membership

All staff automatically become members unless they choose to opt out of membership. Individuals employed by the Trust under a contract of employment with the Trust are divided into four constituencies as follows:

- Non-clinical staff, two positions
- Allied health professionals, scientific and technical staff, one position
- Medical and dental staff, one position
- Nursing and midwifery staff, two positions

Membership engagement strategy

The Trust's membership engagement strategy focuses on recruitment, communication and engagement with members. In 2025/26, the Trust continued to make positive progress in delivering its Membership Engagement Strategy to ensure that it diversified its approach to facilitate engagement with a more representative group of members. The actions that have been implemented include:

- Members' News—a monthly newsletter that provides up-to-date information about the Trust and is distributed via email to all Trust members

- Meet a Governor sessions—face-to-face meetings between governors and members of the public and patients, which take place at both the Chelsea and Westminster and West Middlesex sites

- A QR code has been implemented to simplify the process of becoming a member of the Trust. This is on display in various departments throughout the Trust and satellite areas, and also appears on screens at both the Chelsea and Westminster and West Middlesex sites

Governors participated in public and member engagement events organised by the Trust throughout the year. The Meet a Governor sessions have been held regularly since August 2023, and this has seen a healthy representation of governors, with more governors becoming involved in running these sessions. Governors have also been involved in the recruitment of non-executive directors (NEDs) and on stakeholder panels.

Our overall membership as of 31 March 2026 is 18,939 members, a change from 18,996 last year. New members have joined, but the change is largely attributed to a comprehensive update of the membership list.

The majority of our members are aged over 40 years, and we continue to encourage greater representation of the under-40s age range. Just over 5% of our members are in the 22 to 29 age category.

We have a very successful youth volunteering platform that is being explored to encourage and share the benefits of membership, and we are developing targeted work with colleges, universities and workplaces. We continue to use alternative media to reach these populations, as well as provide in-person interaction.

It is imperative that the membership of the Trust is representative of the population we serve. Socioeconomically and, as expected, the majority of our membership sits within the AB and C1 categories.

These are listed as 'metropolitan professionals' and 'multi-ethnic, purpose-built estates' and cover more than 25% of the area. The next highest proportion of our membership is defined as those residing in 'younger professionals in smaller flats', which is more than 9% of the area.

Directors' responsibilities for preparing the accounts

The directors have undertaken their responsibility for preparing the accounts under directions issued by NHS England, and as detailed in the *Statement of Accounting Officer's Responsibilities* section of this Annual Report.

The Trust has ensured that the annual accounts of the organisation have met the accounting requirements of the NHS Foundation Trust Annual Reporting Manual and the Department of Health and Social Care Group Accounting Manual.

The directors consider that the Annual Report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

The directors are responsible for the maintenance and integrity of the corporate and financial information included on the Trust's website. Legislation in the UK governing the preparation and dissemination of financial statements differs from legislation in other jurisdictions.

NHS OVERSIGHT FRAMEWORK

NHS Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems, including providers. It promotes transparency and improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains, segment 1, to low performance across a range of domains, segment 4. An organisation assessed as segment 4, combined with low capability to improve, is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) its segment, derived from scored metrics under five performance domains: access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity

b) consideration of a financial override, which may limit a segment to no better than 3

c) contextual metrics, which are not scored, for example those under the sixth domain of improving health and reducing inequality

d) capability assessments, which consider the organisation's leadership and governance

Segmentation

The Trust has been placed into Segment 1.

This segmentation information is the Trust's position as at 31 March 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables. The Trust is included on the acute hospital trust dashboard.

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the Chief Executive's responsibilities as the accounting officer of Chelsea and Westminster Hospital NHS Foundation Trust

The *NHS Act 2006* states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given accounts directions which require Chelsea and Westminster Hospital NHS Foundation Trust to prepare, for each financial year, a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the Department of Health and Social Care's *Group Accounting Manual* and, in particular, to:

- Observe the accounts direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

- Make judgements and estimates on a reasonable basis

- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual and the Department of Health and Social Care Group Accounting Manual have been followed, and disclose and explain any material departures in the financial statements

- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance

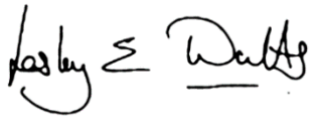
- Confirm that the Annual Report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy

- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



p.p. Lesley Watts
Chief Executive

for Prof Tim Orchard
Group Chief Executive and Single Accountable Officer

25 June 2026

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically, and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the Trust's policies, aims and objectives, evaluate the likelihood of those risks being realised and assess the impact should they be realised. This enables us to manage them efficiently, effectively and economically. The system of internal control has been in place in Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the Annual Report and accounts.

As part of our system of internal control, it is of paramount importance to ensure that the Trust is well-led in accordance with NHS England and NHS England's Well-Led Framework, so that services are safe and patient-centred. In November 2019, we welcomed the Care Quality Commission (CQC) to inspect our services, which included a well-led inspection and a use of resources inspection by NHS England. The Trust maintained the rating of 'good' overall, saw an improvement in the well-led rating from 'good' to 'outstanding' and maintained the use of resources rating of 'outstanding'. The Chelsea site improved the overall rating from 'good' to 'outstanding', and the West Middlesex site maintained the overall rating of 'good'.

Within our system of internal control, we have a range of approaches and methodologies to continually assess our performance against the Well-Led Framework. This includes the use and analysis of data, including quality, effectiveness, financial and access times, board-to-floor visibility, our ward accreditation scheme and our governance arrangements from Board to local service. The Trust remains fully compliant with the registration requirements of the Care Quality Commission.

Capacity to handle risk

The Trust is committed to a comprehensive, integrated, Trustwide approach to the management of risk based upon the support and leadership offered by the Board of Directors and the committees of the Board. The Trust's risk management process is designed to provide a systematic method of identifying risks and determining the most effective means to minimise or remove them following risk analysis and evaluation. Practice is supported through the maintenance of an organisation-wide risk register. The

register is a management tool that promotes visibility and escalation, and provides a repository from which assurance can be offered that risks are being identified and appropriately managed.

The Risk Management Strategy describes the roles and responsibilities of all staff in relation to the identification, management and control of risk, and encourages the use of risk management processes as a mechanism to highlight areas they believe require improvement.

The executive directors have responsibilities for the management and coordination of strategic and operational risk within their areas of control. These responsibilities include the maintenance of risk registers, the promotion of risk management activity, the development of strategic and business plans required to address risk, and the escalation of principal risks and associated assurance to the Trust Board.

Responsibility for the implementation of risk management activity has been delegated to the executive directors as follows:

- The Chief Nursing Officer has responsibility for the professional standards and revalidation of the nursing workforce and allied health professionals, clinical governance, patient safety, staff safety, regulatory compliance and associated risks.

- The Chief Medical Officer has responsibility for the professional standards and revalidation of the medical workforce, research and development, service development, clinical effectiveness, public health and associated risks.

- The Chief Finance Officer has responsibility for financial governance, physical estate and associated risks.

- The Chief People Officer has responsibility for learning and development, equality, diversity and inclusion, workforce management, staff wellbeing and associated risks.

- The Hospital Managing Directors have responsibility for site development, operational performance and associated risks.

- The Chief Information Officer is responsible for information management, information technology, information security and associated risks.

Executive and non-executive directors receive training as part of a scheduled risk and Board Assurance Framework development session. All staff receive risk management training on various aspects of risk as part of the Trust's induction programme. This training forms part of the mandatory courses provided by the Trust, which all staff undertake on a regular basis. The organisation's Quality and Clinical Governance directorate also provides one-to-one and group risk management training.

The risk assurance framework is scrutinised by the following committees of the Board:

- Audit and Risk Committee (ARC)
- Quality Committee (QC)
- People and Workforce Committee (PWC)
- Finance and Performance Committee (FPC)

The Board Assurance Framework (BAF) is reviewed by the Audit and Risk Committee and Trust Standing Committee.

The committees and their sub-groups ensure risks and the associated mitigation actions are recognised and good practice is supported across all areas. The scrutiny given by these Committees also assures learning from excellence.

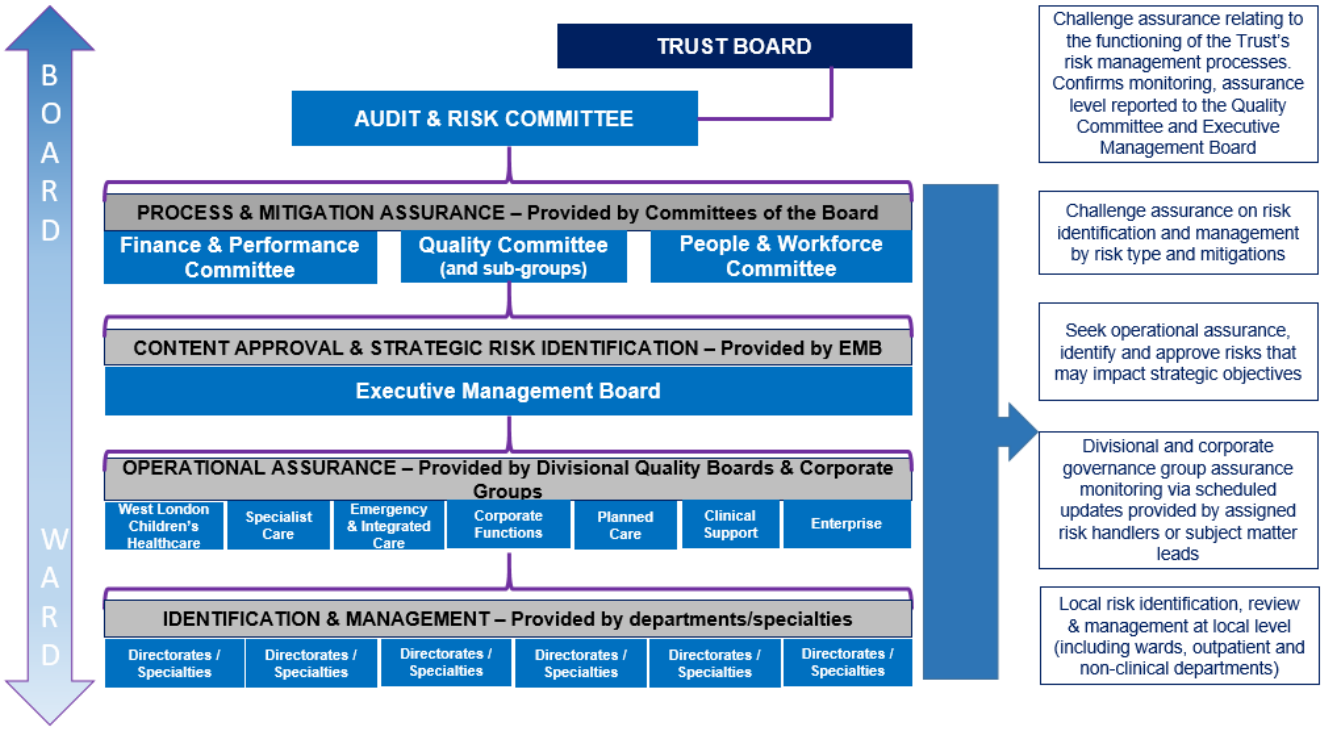
The Trust risk management policy is accessible to all staff via the intranet and aims to provide guidance on the process of risk identification, assessment and escalation, as appropriate, in accordance with each staff member's level of authority and duties.

Risk and Control Framework

The Trust's risk management process is designed to provide a systematic method of identifying risks and determining the most effective means to minimise or remove them. Practice is supported through the maintenance of an organisation-wide risk register.

Operational risk assurance is provided via the Divisional Quality Boards within the clinical divisions. These groups ensure the risk register process is embedded and mitigation actions are undertaken within appropriate timescales. Within the corporate functions/non-clinical division, individual management teams undertake this responsibility with executive oversight.

Management and mitigation assurance is provided via the committees of the Board. All items recorded within the risk register are categorised according to the risk 'subject'. Each categorisation is aligned to an executive director and a committee or sub-group who are responsible for measuring risk assurance and supporting mitigation action where required.



While the Trust Board retains overall responsibility, detailed scrutiny of specific areas of the Trust's work, including relevant risks, is provided by Board sub-committees:

- **Quality Committee** assures the Board that quality and safety within the organisation is being delivered to the highest possible standards, and that there are appropriate policies, processes and governance in place to continuously learn and improve care.

- **People and Workforce Committee** assures the Board on matters related to staff, considering the following work areas: people and organisational development strategy and planning, leadership development and talent management, education, skills and capability, clinical and non-clinical, statutory and mandatory training, performance, reward and recognition, culture, inclusion, equality and diversity, values and engagement, and health and wellbeing. The Committee ensures that there are robust processes in place to identify risks and issues and manage them accordingly. The Committee oversees the development and governance of short, medium and long-term workforce strategies to ensure that staffing systems are in place to assure the Board that staffing processes are safe, sustainable and effective and oversees compliance with Developing Workforce Safeguards standards. The Committee receives regular reports on workforce and people-related key performance indicators and metrics alongside other hard and soft intelligence.

- **Finance and Performance Committee** assures the Board on financial and investment policy, capital, information management and technology, estates management and commercial development issues, ensuring the Trust operates in an economic and efficient manner against agreed income and expenditure positions.

- **Audit and Risk Committee** assures the Board that probity and professional judgement are exercised by providing independent and objective review of financial and corporate governance, assurance processes, risk management across the Trust's clinical and non-clinical activities, and fraud and corruption. The Committee is also responsible for measuring assurance in the process for the identification and response to potential conflicts of interest relating to commercial partnership working. In addition, the Committee scrutinises the output of all audits undertaken by the Trust's internal and external auditors, reporting any risks identified to the Board accordingly, and has an explicit role to assure the Board on the appropriateness and effectiveness of the Trust's Risk Assurance Framework.

- **Nominations and Remuneration Committee** oversees all aspects of the appointment process for executive directors and very senior managers, including the approval of arrangements for the termination of directorships, determining the remuneration, allowances, pensions, gratuities and other major contractual terms, and evaluating the performance of individual executive directors.

The Trust control framework ensures the transmission of risk information from ward to Board. This process is supported by:

- **Risk appetite statement:** Describes the amount of risk the Board is prepared to take in the pursuit of its objectives and is detailed in our Board Assurance Framework. The Trust's risk appetite varies between objectives and risk type.

- **Risk management strategy:** Describes the systems of internal control in place to oversee, monitor and manage risk within the Trust.

- **Risk register:** Documents risks at each level of the Trust, alongside actions to control, mitigate or resolve each risk.

- **Board Assurance Framework (BAF):** Records the principal risks that could substantially impact on the achievement of the Trust's strategic objectives.

The risk management framework informs objective setting, business planning, service delivery and the routine functioning of the organisation, and ensures risk management is an integral part of routine management.

The last overall internal audit of the organisation's risk management framework took place in January 2020. The report concluded that significant assurance with minor improvements required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. Auditors completed a risk maturity report in 2021, which demonstrated a positive level of risk maturity.

In June 2025, there was an internal audit on the organisation's level of 'cultural maturity', which included review of the BAF. The audit was advisory, so did not provide a control design, operational effectiveness or assurance opinion. There were two recommendations arising from the audit relating to the BAF, which were enacted within the required timescale by the governance team, leading to a strengthened BAF and process.

Engagement with patients and the public in risk management

The Trust recognises the importance of involving patients, governors and the wider public in identifying and managing risks that impact on service delivery. Feedback from patients and the public is gathered through a range of mechanisms, including the Friends and Family Test, complaints, Patient Advice and Liaison Service (PALS), and engagement with the Council of Governors.

This information is regularly reviewed at divisional and corporate governance forums, including quality and risk committees, to identify emerging risks and themes relating to patient safety, experience and access. Where appropriate, this feedback informs risk assessments, the development of mitigating actions and service improvements.

The Council of Governors also provides a formal mechanism for public and stakeholder input into the Trust's governance, offering insight and challenge on issues affecting patients and the communities served.

Identification of risk

There are four principal methods of risk identification used by the Trust:

- Known ongoing inherent risks of which the Trust is aware, which are controlled and managed
- Foreseeable local risks which are inherent and identified proactively by competent persons

- Strategic risks identified by the Board, including the risks associated with complying with the Trust's foundation trust licence
- Retrospectively realised risks from risk sources

As per the fourth method of risk identification detailed above, risks can be identified from a number of sources, including but not restricted to:

- Recommendations from learning responses, patient safety investigations and themes/trends arising from cumulative analysis of incident data
- Risks arising as a result of external review or inspections
- Recommendations from internal audit reports or other internal or external monitoring reviews, audits, assessments or reports
- Clinical risk assessments
- Non-clinical risk assessments, including security, health and safety, and health and wellbeing
- Patient surveys
- Staff surveys
- PALS and complaints key themes
- Risks shared by other NHS organisations and/or other stakeholders, duty holders or authorities

In some cases, through the processes described above, the Trust Board may identify complex risks that affect or involve external organisations, such as local stakeholders within the local healthcare community, including the ICB, NWL Acute Provider Collaborative and local authorities. Where this is the case, the Trust adopts a collaborative approach to its risk mitigation plans, ensuring a transparent and joined-up approach to managing risk, recognising that in some cases the Trust will be limited in the degree of risk mitigation it can achieve as an individual organisation.

Risk assessment

The purpose of undertaking risk assessments is to effectively manage and control significant risks which are, or have been, identified or inherited, or which are foreseeable in nature, as required by health and safety legislation. Risks are evaluated in order to determine the level of exposure and provide input to decisions on where responses to reduce, accept or avoid risks are necessary, acceptable or likely to be worthwhile.

The evaluation of the risk assessment will involve the analysis of the individual risk to identify the consequences/severity and likelihood of the risk being realised. Within the Trust, the severity and likelihood of risk is given a numeric score based on the following matrix.

Likelihood	Consequence				
	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1 Rare	1 (Low)	2 (Low)	3 (Low)	4 (Medium)	5 (Medium)
2 Unlikely	2 (Low)	4 (Medium)	6 (Medium)	8 (High)	10 (High)
3 Possible	3 (Low)	6 (Medium)	9 (High)	12 (High)	15 (Extreme)
4 Likely	4 (Medium)	8 (High)	12 (High)	16 (Extreme)	20 (Extreme)
5 Almost certain	5 (Medium)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)

In addition, the risk register process involves a set of risk metrics pertaining to risk impact and likelihood, which helps to improve the robustness of the calculation of risk assessments taking place within the Trust.

Impact level	Descriptor	Risk type			
		Injury	Service delivery	Financial	Reputation/publicity
1	Insignificant	No injuries or injury requiring no treatment or intervention	Service disruption that does not affect patient care	Less than £10,000	Rumours
2	Minor	Minor injury or illness requiring minor intervention <7 days off work if staff	Short disruption to services affecting patient care or intermittent breach of key target	Loss of between £10,000 and £100,000	Local media coverage
3	Moderate	Moderate injury requiring professional intervention RIDDOR reportable incident	Sustained period of disruption to services/ sustained breach of key target	Loss of between £100,001 and £500,000	Local media coverage with reduction in public confidence
4	Major	Major injury leading to long-term incapacity requiring significant increased length of stay	Intermittent failures in a critical service Significant under-performance of a range of key targets	Loss of between £500,001 and £5m	National media coverage and increased level of political/public scrutiny, total loss of public confidence
5	Catastrophic	Incident leading to death Serious incident involving a large number of patients	Permanent closure/ loss of a service	Loss of >£5m	Long term or repeated adverse national publicity Removal of chair/ CEO or executive team

Likelihood level	Descriptor	Range
5	Almost certain	>50%
4	Likely	10–50%
3	Possible	1–10%
2	Unlikely	0.1–1%
1	Rare	<0.1%

Alongside the general risk assessment process the Trust employs, there are also patient and staff-specific risk assessment forms used at ward/department level in relation to particular risk domains.

The risk register record is structured in a way that requires the recording of a ‘current risk rating’ and a ‘target risk rating’. This allows the Trust to track changes in risk, from risk recognition through to an assessment of the risk post-mitigating actions. In each case, the Trust’s risk ‘appetite’ is determined by the target risk rating—i.e. once the mitigating actions have been implemented successfully and the risk has reduced to the target, the Trust accepts this residual level of risk. However, each time a risk is reviewed and updated, the determination of the Trust’s risk appetite is also reviewed, particularly after new mitigating actions have been identified.

Principal risks

The Trust’s principal risks are set out in the Performance Report. These are derived from the Board Assurance Framework (BAF), which records the risks that could materially impact the achievement of the Trust’s strategic objectives and compliance with the NHS provider licence.

The BAF provides a structured framework for the identification and management of principal risks, including:

- the key controls in place to mitigate risks
- the sources of assurance regarding the effectiveness of those controls
- any gaps in control or assurance and the actions in place to address these

The BAF is reviewed on a regular basis through executive and Board governance structures to ensure that principal risks remain current, reflect the operating environment and are being appropriately managed.

Principal risks are aligned to the Trust’s strategic priorities and are supported by clear executive ownership and defined governance routes for oversight, including alignment to relevant Board committees. Each risk is subject to regular review through executive and Board governance structures, with progress against mitigating actions monitored and escalated where required.

Overview of principal risks

The principal risks reported during the year reflect the main challenges facing the Trust and can be summarised across the following key areas:

- **Quality and patient safety:** Risks relating to the ability to consistently deliver safe, high-quality and patient-centred care within a complex and evolving operational environment, including increasing demand and the need to embed continuous improvement and innovation.

- **Workforce and culture:** Risks associated with workforce capacity, capability and wellbeing, including recruitment and retention, leadership development and maintaining a positive organisational culture aligned to the NHS People Promise and regulatory expectations.

- **System working and service delivery:** Risks arising from the Trust's role within the Integrated Care System (ICS) and provider collaborative arrangements, including the delivery of transformation, management of demand and capacity, and reliance on system-wide performance.

- **Financial sustainability and use of resources:** Risks relating to the delivery of the financial plan, including cost improvement programme requirements, funding constraints and the need to maintain financial stability while meeting increased activity and demand.

- **Digital, estates and infrastructure:** Risks associated with the delivery of a fit-for-purpose digital and physical estate, including capital planning, programme delivery and maintaining resilient infrastructure to support clinical services.

- **Information governance and cyber security:** Risks relating to the protection of information assets, including cyber threats, data security and compliance with legal and regulatory requirements.

- **Sustainability and environmental impact:** Risks associated with meeting national sustainability targets and delivering the Trust's Green Plan, including reducing environmental impact and supporting system-wide objectives.

- **Business continuity and resilience:** Risks relating to the Trust's ability to maintain critical services during emergency or major incidents, supported by emergency planning, resilience and response arrangements.

Governance and assurance

The Trust operates a 'three lines of assurance' model to support robust risk management. This includes:

- operational management and internal controls
- oversight through executive and Board governance structures
- independent assurance from internal audit and external bodies

The Audit and Risk Committee receives regular reports on the BAF and provides assurance to the Board on the adequacy and effectiveness of the risk management framework and internal control environment.

Compliance with NHS Foundation Provider Licence Section 4 (Governance)

Compliance with the NHS provider licence is routinely monitored through the NHS Oversight Framework.

The previous licence requirement for NHS foundation trusts to prepare and submit a forward-looking 'corporate governance statement' was removed in the March 2023 update to the NHS provider licence.

However, the Trust has continued to follow the principles contained within the aforementioned ‘corporate governance statement’ in order to assess and assure its compliance, particularly in relation to:

- the effectiveness of governance structures
- the responsibilities of directors and subcommittees
- reporting lines and accountabilities between the Board, its subcommittees and the executive team
- the submission of timely and accurate information to assess risks to compliance with the Trust’s licence
- the degree and rigour of oversight the Board has over the Trust’s performance

Assurances to support the validity of the conditions have been reviewed by the Trust Audit and Risk Committee and no principal risks to compliance were identified.

Information governance

Data Security and Protection Toolkit

Each year, the Trust is required to submit a return to NHS England through the Data Security and Protection Toolkit. This assesses the Trust’s compliance with national data security standards, which are aligned to the National Cyber Security Centre’s Cyber Assessment Framework.

The Toolkit is independently audited each March by the Trust’s internal auditors against minimum attainment levels set by NHS England. The most recent review, undertaken in March 2026 in support of the 2025/26 submission, concluded an overall risk rating of ‘moderate’, with a ‘high’ level of assurance in the Trust’s self-assessment.

The audit provides assurance to the Board, ahead of the June submission deadline, that the Toolkit has been completed appropriately. It also identifies any gaps in current arrangements so that remedial action can be taken where necessary.

Further information on the Data Security and Protection Toolkit is available at Further information on the Data Security and Protection Toolkit is available at www.dsptoolkit.nhs.uk.

Data security incidents

All data security incidents are assessed in line with the NHS England Data Security and Protection Incident Breach reporting criteria. Incidents that meet the reporting threshold are notified to the Information Commissioner’s Office and the Department of Health and Social Care.

During the previous financial year, two incidents met the reporting threshold and were reported accordingly. No incidents have met the reporting threshold in the current financial year. All incidents are subject to internal investigation.

Freedom of information

A Freedom of Information (FOI) request is a formal request made by the public to access information held by public authorities, aimed at promoting transparency and accountability.

In the 2025/26 financial year, we received 884 FOI requests. The Act says we must respond within 20 working days. The Trust achieved this in 88% of cases, against the ICO minimum acceptable requirement of 90%.

Subject Access Requests

A Subject Access Request (SAR) is a request made by an individual to access the personal data an organisation holds about them under UK GDPR and the Data Protection Act 2018.

In the 2025/26 financial year, we received 6,987 SARs. The Act says we must respond within one calendar month. The Trust achieved this in 99.2% of cases.

General Data Protection Regulation (GDPR)

The GDPR came into force on 25 May 2018, along with the UK interpretation of this legislation, the Data Protection Act 2018. As required by law, we have appointed a Data Protection Officer and are compliant with the core aspects, led in part by work on the DSPT and various other workstreams.

Quality governance and performance

The Annual Safe Staffing Assurance Report was considered by the Executive Management Board in November 2025 and the Quality Committee in November 2025, providing assurance on the Trust's approach to safe, effective and sustainable staffing. Safe staffing metrics are reported monthly through the Integrated Quality and Performance Report to the Executive Management Board, the Trust Board and its committees, and are submitted in line with national reporting requirements.

The Trust remains compliant with national requirements for safe staffing as set out by the National Quality Board and NHS England's Developing Workforce Safeguards guidance. Staffing decisions continue to be informed by a triangulated approach using evidence-based tools, where available, professional judgement and patient outcomes, supported by robust governance, escalation and assurance arrangements.

Following a comprehensive review of safe staffing across nursing and midwifery, allied health professionals, pharmacy and the medical workforce, the Chief Nursing Officer and Chief Medical Officer have confirmed that they are satisfied that staffing levels are safe and appropriate and meet national workforce safeguard standards. While the Trust demonstrates strong overall compliance, some services remain partially compliant with specific elements of national guidance. These areas are subject to ongoing monitoring and targeted improvement plans, and are captured on divisional risk registers with agreed mitigations.

The report identified a clear set of priorities for 2025/26, including:

- Implementation of demand management measures within maternity services to support compliance with the Birthrate Plus 2024 review
- Continued review and phased investment in the neonatal nursing workforce to address identified staffing gaps
- Sustained focus on recruitment and retention, particularly within therapies and pharmacy

- Ongoing establishment reviews and job planning to ensure medical tier 3 cover aligns with service need and available resources
- Continued triangulation of acuity and dependency data with clinical outcomes, patient experience and professional judgement to inform business planning
- Further reduction in reliance on temporary staffing, including agency and enhanced care provision, while maintaining patient safety

Overall, the Trust continues to demonstrate a strong and improving position on safe staffing, underpinned by transparent governance, regular reporting and a sustained commitment to workforce stability, quality and patient safety.

Data assurance

The Trust assures the quality and accuracy of elective waiting times data through a combination of regular daily and weekly meetings, and review and sign-off procedures for performance data. The review and sign-off process includes review at the Elective Access Group, Trust Executive Team meetings, Finance and Performance Committee and Trust Standing Committee.

We have an advanced feed from the patient administration system (PAS), which is available throughout the Trust and updated daily. Divisional staff and the Information Team regularly review a suite of reports, including more advanced information for elective waiting times and patient-level information. The Trust has a set of training modules available to support staff and is currently undertaking an assessment to further improve staff adoption.

A manual data validation process is undertaken by the Information Team to review the information entered into the PAS and to investigate the data that underlies reported performance. Identified data issues are logged by the Performance Team, then investigated and corrected. Recurring issues are subject to root cause analyses, from which corrective action plans are developed to support the relevant services to improve the quality of inputted and reported data.

We have invested significantly in data quality improvement via the electronic patient record (EPR) system. A Trustwide Data Quality Group is in place, which provides oversight of data quality policies, strategies and reviews. The Data Quality Group reports into the Information Governance Steering Group, which in turn provides reports to the Executive Management Board and the Audit and Risk Committee to enable prompt escalation of emerging issues to the Trust Board when required.

All Trust sites use the Datix database system for reporting incidents, which provides a unified approach to aid the review of the information governance (IG) incident management process. Information governance incidents are summarised and reported to the Information Governance Steering Group. The IG team assists IG incident investigations as required and advises on lessons learned from these incidents at departmental meetings and/or via Trustwide communication tools.

Corporate governance

Details of the corporate governance structure can be found within the Accountability Report. It is a fundamental part of our Trust’s governance structure that all material risks and issues are scrutinised and monitored by the Executive Management Board, in addition

to being reported to Board committees. This includes the key areas of quality, workforce, performance and finance, giving further assurance that the Trust is fully compliant with the Care Quality Commission registration requirements.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure compliance with all employer obligations contained within the scheme regulations. This includes ensuring that deductions from salary, employer contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

There are control measures in place to ensure that the organisation complies with obligations under equality, diversity and human rights legislation. The Trust has implemented a number of equity and diversity programmes to support openness, honesty and transparency. The policy and procedure is maintained by the Human Resources team and compliance is monitored by the People and Workforce Committee.

Conflicts of interest

The Trust maintains a Register of Interests for decision-making staff as required by 'Managing Conflicts of Interest in the NHS'. The register can be viewed at www.chelwest.nhs.uk/bod.

Climate change and Greener NHS programme

The Trust, with its partners, will continue to pursue its ambition to reduce the impact of our activities on the environment while providing leading sustainable healthcare. This means that the way the Trust operates today must meet the needs of the present, while collaboratively building on a cleaner, healthier environment for future generations.

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust's Green Plan was approved by the Trust Board in November 2021 and refreshed in November 2025. It confirms our commitment to the NHS *Delivering a Net Zero Health Service* report and Greener NHS programme, which outlines the NHS's ambition to become the world's first carbon net zero national health service by 2045. For further information on our progress over 2025/26, please see the more detailed section on environmental and sustainability performance.

Review of economy, efficiency and effectiveness of the use of resources

The Trust Board keeps a regular review of the Trust's use of resources through the Integrated Quality and Performance Report, in addition to the finance report, which is reviewed at the Board in Common, Trust Standing Committee and both the Trust and Acute Provider Collaborative Finance and Performance Committee. This allows the Trust Board to maintain oversight of financial and operational performance and productivity, and allows the triangulation of quality, performance, workforce and financial data.

During 2025/26, the Trust has continued to use various benchmarking sources and the Improvement Board to identify efficiency and productivity opportunities. Productivity, efficiency and benchmarking data is also reviewed at regular specialty-level deep dives.

The oversight roles of the Trust Board and Finance and Performance Committee are supplemented by the annual internal audit programme, which includes a comprehensive annual review of the Trust's financial systems and controls.

The governance structure below the Executive Management Board provides opportunities through the divisional boards for divisional quality, financial and operational performance to be reviewed. Monthly reviews with the executive and divisional triumvirate teams allow for regular oversight of performance within the respective clinical services they provide. The cost improvement programme is monitored through the Improvement Board, and this is further supplemented by productivity work programmes, such as bed productivity, theatre productivity and outpatient pathway optimisation, and specialty deep dives, in addition to the internal audit work undertaken throughout 2025/26.

The detail of the key actions of the internal audit programme can be found in the *Review of effectiveness* section below.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The clinical audit programme also supports my review of the effectiveness of the system of internal control. A full internal review of each clinical audit is undertaken, and actions are taken to address any identified risks and improve the quality of healthcare that is provided.

The role of the Board, Audit and Risk Committee, Quality Committee, Finance and Performance Committee and People and Workforce Committee in maintaining and reviewing the Trust's systems of internal control is described above. The internal audit programme provides a further mechanism for doing this. BDO, the Trust's internal auditors, identify high, medium and low-priority recommendations within their audit reports, which are monitored in an internal audit recommendations tracker and reviewed regularly by the executive team.

In 2025/26, there were three high-risk recommendations identified by our internal auditors.

The Head of Internal Audit Opinion for the period 1 April 2025 to 31 March 2026 is 'generally satisfactory with improvements required in some areas'. This indicates that there

is a sound system of internal control designed to meet the Trust's objectives, with controls generally applied consistently.

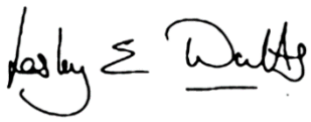
Overall, the controls in the areas reviewed were suitably designed and operating effectively to support risk management, governance and value for money. However, some weaknesses and areas of non-compliance were identified which could, if not addressed, impact the achievement of objectives. Management actions are in place to address these findings and further strengthen the effectiveness of the control environment.

During the year, a range of assurance processes, including internal audit, regulatory inspections, data quality reviews and routine governance reporting, identified a number of control weaknesses at points during the financial period. These related to specific processes or services and were addressed through established management actions and oversight arrangements.

Actions taken in response were monitored through the Trust's governance structures, including divisional governance, executive review and the committees of the Board, to ensure that issues were appropriately managed and improvements embedded.

Conclusion

In conclusion, to the best of my knowledge, no significant internal control issues have been identified within 2025/26.



p.p. Lesley Watts
Chief Executive

for Prof Tim Orchard
Group Chief Executive and Single Accountable Officer

25 June 2026

SECTION 3

AUDITOR'S REPORT

Independent auditor's report to the Board of Governors and Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Chelsea and Westminster Hospital NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2026 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the consolidated statement of comprehensive income;
- the group and foundation trust statements of financial position;
- the group statement of changes in equity;
- the foundation trust statement of changes in equity;
- the group and foundation trust statement of cash flows; and
- the related notes 1 to 35.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the foundation trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

We considered the nature of the group and its control environment and reviewed the group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit and local counter fraud about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

We obtained an understanding of the legal and regulatory framework that the group operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations and IT specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address these are described below:

- determination of whether expenditure is capital in nature is subjective: we tested a sample of expenditure to assess whether it meets the relevant accounting requirements to be recognised as capital in nature.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006 in all material respects; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1)(d) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of this matter.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1)(d) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Delay in the certification of completion of the audit

As at the date of this audit report, we have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Chelsea and Westminster Hospital NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Chelsea and Westminster Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Kate Waite

Kate Waite
For and on behalf of Deloitte LLP
Appointed Auditor
London, United Kingdom

25 June 2026

Independent auditor's statement to the directors of Chelsea and Westminster Hospital NHS Foundation Trust on the NHS foundation trust consolidation schedules

We have examined the consolidation schedules of Chelsea and Westminster Hospital NHS Foundation Trust, version 1.25.12.0C, for the year ended 31 March 2026, which have been prepared by the Chief Financial Officer and acknowledged by the Chief Executive. Our examination of the consolidation schedules covers the following:

- Designated TAC02 to TAC29 for tables outlined in red, excluding TAC05A, TAC014B and TAC23.

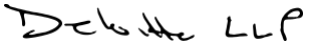
This statement is made solely to the Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust in accordance with paragraph 24(4A) of Schedule 7 of the National Health Service Act 2006 (the Act) and paragraph 4.12 of the Code of Audit Practice, and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the consolidation schedules which are also included in the audited financial statements.

Auditors are required to report on any differences over £1,000,000 between the audited financial statements and the consolidation schedules, with the following exceptions:

- For the parliamentary accountability disclosures, remote contingent liabilities not within the scope of IAS 37 but disclosed for accountability purposes on TAC 22, and losses and special payments and gifts on TAC 29, any differences over £300,000 between the audited financial statements and the consolidation schedules should be reported.
- Centrally-procured inventory: as set out in NHS England TAC completion instructions and financial reporting guidance, where trusts do not recognise consumables in inventory on the grounds of materiality, and inventory remains immaterial, the receipt and utilisation may be omitted from the inventory note in local accounts. However, trusts should record the receipt of items in inventory with an equivalent figure in utilisation within the TAC form (footnote on page 58 of the TAC-Completion-Instructions-M12-202526-26-March-2026.pdf).

Unqualified audit opinion on the audited financial statements; no differences identified: The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.



Kate Waite
for and on behalf of Deloitte LLP, Appointed Auditor
1 New Street Square
London EC4A 3BZ United Kingdom

25 June 2026

SECTION 4

FINANCE

ANNUAL ACCOUNTS 2025/26

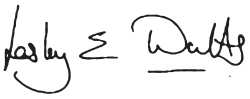
Chelsea and Westminster Hospital NHS Foundation Trust

Annual accounts for the year ended 31 Mar 2026

Foreword to the accounts

Chelsea and Westminster Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Chelsea and Westminster Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed	pp 
Name	**Lesley Watts**
Job title	**Chief Executive Officer** **For Professor Tim Orchard, Group Chief Executive and Single Accountable Officer**
Date	**25 June 2026**

Consolidated Statement of Comprehensive Income

		Group	
		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	955,360	930,131
Other operating income	4	121,123	106,188
Operating expenses	7,9	(1,067,746)	(1,029,549)
Operating surplus from continuing operations		**8,738**	**6,770**
Finance income	11	6,471	8,203
Finance expenses	12	(4,378)	(6,914)
PDC dividends payable		(13,830)	(13,291)
Net finance costs		**(11,737)**	**(12,002)**
Other gains / (losses)	13	(594)	8
Corporation tax expense		-	(22)
(Deficit) for the year from continuing operations		**(3,594)**	**(5,246)**
(Deficit) for the year		**(3,594)**	**(5,246)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairment reversal	8	3,401	3,881
Total other comprehensive income for the period		**3,401**	**3,881**
Total comprehensive (expense) / income for the period		**(193)**	**(1,365)**

The figures below outline the adjusted financial performance on a control total basis as reported to NHSE. This is part of NHSE's control purposes, rather than set by the Trust.

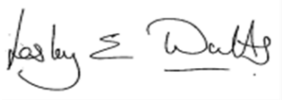
Adjusted financial performance (control total basis):		
(Deficit) for the period	(3,594)	(5,246)
Add back all I&E impairments / (reversals)	16,025	5,035
Surplus / (Deficit) before impairments and transfers	**12,432**	**(211)**
Remove capital donations / grants I&E impact	(6,243)	(747)
Remove PFI revenue costs on an IFRS 16 basis	29,765	30,002
Add back PFI revenue costs on a UK GAAP basis	(30,983)	(29,016)
Remove net impact of DHSC centrally procured inventories	-	81
Adjusted financial performance surplus	**4,971**	**109**

Statements of Financial Position

		Group		Trust	
	Note	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Non-current assets					
Intangible assets	14	25,213	28,025	25,213	28,025
Property, plant and equipment	16	624,546	605,146	624,546	605,146
Right of use assets	20	6,824	7,767	6,824	7,767
Investments in subsidiary	21	-	-	3,200	3,200
Receivables	23	926	1,032	926	1,032
Total non-current assets		**657,509**	**641,970**	**660,709**	**645,170**
Current assets					
Inventories	22	8,624	9,704	7,359	8,437
Receivables	23	48,353	49,878	47,822	48,778
Cash and cash equivalents	24	117,590	143,460	116,984	142,369
Total current assets		**174,567**	**203,042**	**172,165**	**199,584**
Current liabilities					
Trade and other payables	25	(112,196)	(115,037)	(113,011)	(114,812)
Borrowings	27	(9,047)	(9,138)	(9,047)	(9,138)
Provisions	28	(13,444)	(22,801)	(13,417)	(22,745)
Other liabilities	26	(27,108)	(29,469)	(27,108)	(29,469)
Total current liabilities		**(161,795)**	**(176,445)**	**(162,583)**	**(176,164)**
Total assets less current liabilities		**670,282**	**668,568**	**670,291**	**668,590**
Non-current liabilities					
Borrowings	27	(71,155)	(79,578)	(71,155)	(79,578)
Provisions	28	(9,785)	(10,283)	(9,785)	(10,283)
Total non-current liabilities		**(80,940)**	**(89,861)**	**(80,940)**	**(89,861)**
Total assets employed		**589,342**	**578,707**	**589,351**	**578,729**
Financed by					
Public dividend capital		334,381	323,554	334,381	323,554
Revaluation reserve		155,737	153,757	155,737	153,757
Income and expenditure reserve		99,223	101,396	99,233	101,418
Total taxpayers' equity		**589,342**	**578,707**	**589,351**	**578,729**

The notes on pages 160–215 form part of these accounts.

Name **pp**



Position **Chief Executive Officer**
For Professor Tim Orchard, Group Chief Executive and Single Accountable Officer

Date **25 June 2026**

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**323,554**	**153,757**	**101,396**	**578,707**
Surplus/(deficit) for the year	-	-	(3,594)	**(3,594)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,421)	1,421	**-**
Impairments	-	3,401	-	**3,401**
Public dividend capital received	10,827	-	-	**10,827**
Taxpayers' and others' equity at 31 March 2026	**334,381**	**155,737**	**99,223**	**589,342**

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**302,160**	**150,468**	**106,050**	**558,678**
Taxpayers' and others' equity at 1 April 2024 - restated	**302,160**	**150,468**	**106,050**	**558,678**
Surplus/(deficit) for the year	-	-	(5,246)	**(5,246)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(592)	592	**-**
Impairments	-	3,881	-	**3,881**
Public dividend capital received	21,394	-	-	**21,394**
Taxpayers' and others' equity at 31 March 2025	**323,554**	**153,757**	**101,396**	**578,707**

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**323,554**	**153,757**	**101,418**	**578,729**
Surplus/(deficit) for the year			(3,606)	**(3,606)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,421)	1,421	**-**
Impairments	-	3,401	-	**3,401**
Public dividend capital received	10,827	-		**10,827**
Taxpayers' and others' equity at 31 March 2026	**334,381**	**155,737**	**99,233**	**589,351**

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**302,160**	**150,468**	**105,952**	**558,580**
Surplus/(deficit) for the year	-	-	(5,126)	**(5,126)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(592)	592	**-**
Impairments	-	3,881	-	**3,881**
Public dividend capital repaid	21,394	-	-	**21,394**
Taxpayers' and others' equity at 31 March 2025	**323,554**	**153,757**	**101,418**	**578,729**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statements of Cash Flows

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		8,738	6,770	8,725	6,815
Non-cash income and expense:					
Depreciation and amortisation	7.1	35,283	34,372	35,283	34,372
Net impairments	8	16,025	5,035	16,025	5,035
Income recognised in respect of capital donations	4	(7,698)	(2,304)	(7,698)	(2,304)
Decrease in receivables and other assets		1,169	2,500	601	2,644
Decrease in inventories		1,080	627	1,078	430
(Decrease) in payables and other liabilities		(1,948)	(6,999)	(909)	(7,224)
(Decrease) in provisions		(9,856)	(2,211)	(9,826)	(2,268)
Other movements in operating cash flows		-	159	-	159
Net cash flows from operating activities		**42,793**	**37,949**	**43,279**	**37,660**
Cash flows from investing activities					
Interest received		6,633	8,412	6,633	8,412
Purchase of intangible assets		(3,285)	(4,554)	(3,285)	(4,554)
Purchase of PPE and investment property		(62,989)	(55,807)	(62,989)	(55,807)
Sales of PPE and investment property		23	1	23	1
Initial direct costs or up front payments in respect of new right of use assets (lessee)		(167)	(120)	(167)	(120)
Receipt of cash donations to purchase assets		7,698	2,304	7,698	2,304
Net cash flows (used in) investing activities		**(52,087)**	**(49,764)**	**(52,087)**	**(49,764)**
Cash flows from financing activities					
Public dividend capital received		10,827	21,394	10,827	21,394
Repayment on loans from DHSC		(2,893)	(3,673)	(2,893)	(3,673)
Repayment on other loans		(1,444)	(1,409)	(1,444)	(1,409)
Capital element of lease liability repayments		(1,979)	(2,045)	(1,979)	(2,045)
Capital element of PFI, LIFT and other service concession payments		(3,941)	(1,045)	(3,941)	(1,045)
Interest on loans		(669)	(766)	(669)	(766)
Other interest		(49)	(115)	(49)	(59)
Interest paid on lease liability repayments		(242)	(323)	(242)	(323)
Interest paid on PFI, LIFT and other service concession obligations		(2,656)	(5,266)	(2,656)	(5,266)
PDC dividend (paid)		(13,530)	(13,091)	(13,530)	(13,091)
Net cash flows (used in) financing activities		**(16,576)**	**(6,339)**	**(16,576)**	**(6,283)**
(Decrease) in cash and cash equivalents		**(25,871)**	**(18,154)**	**(25,385)**	**(18,388)**
Cash and cash equivalents at 1 April - brought forward		**143,460**	**161,614**	**142,369**	**160,756**
Cash and cash equivalents at 31 March	24	**117,590**	**143,460**	**116,984**	**142,369**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

We have taken the exemption of preparing a statement of comprehensive income for the trust as allowed in the GAM and in line with the requirements of Section 408 of the Companies Act. The deficit for the trust in the current year was £0.1m (2024/25: £1.3m). The adjusted surplus for the trust in the current year was £5.0m (2024/25: £0.1m).

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

Other subsidiaries
Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

These consolidated financial statements incorporate the financial statements of the Trust and its wholly owned subsidiary, CW Medicine Ltd. CW Medicines Ltd began trading in April 2022, with Its primary activity being the dispensing of medicines to outpatients of the Trust.

All intragroup assets and liabilities, reserves, income, expenses and cash flows relating to transactions between members of the group are eliminated on consolidation.
Profit or loss and each component of other comprehensive income are attributed to the Trust in full.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care Board (ICB) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

Specifically in 2025/26 the 5 London ICBs and NHS England blocked the ERF element of the contract, therefore any over/under performance were not traded.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England and ICBs based on actual usage against an agreed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other NHS clinical income' in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

In 2025/26, the Trust recognised total income from grants and donations of £7,698k, comprising £4,413k in grant income and £3,285k in donations.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust. The last full valuation of land and buildings was performed by Montagu Evans, Chartered Surveyors, as at 31 December 2024. A desktop review was performed in the current year.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

The Trust utilises its PFI scheme to deliver healthcare infrastructure and services. Given the long term nature of PFI contracts, future changes in the Retail Price Index (RPI) will significantly impact the inflation-linked unitary charge, directly affecting the Trust's future cash flow.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	1	60
Dwellings	10	32
Plant & machinery	3	15
Information technology	3	10
Furniture & fittings	5	10

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as ‘deemed cost’ and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	2	10
Software licences	3	10

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit losses is recognised in line with IFRS 15. Injury costs recovery (ICR) credit losses are recognised as advised by the Compensation Recovery Unit (CRU) at 24.62% for 2025-26. The credit losses for receivables are recognised in line with IFRS 9 of the simplified approach, based on the age and type of each debt. The percentages applied reflect an assessment of the recoverability of each class of debt provisions are charged to operating expenditure. In some cases a specific credit losses applied consider the relevant credit quality of relevant financial assets. Write off of debt will be undertaken only where the Trust has exhausted all means of recovery, this includes on the recommendation of a debt collection agency.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 28.3 but is not recognised in the Trust's accounts.

The Trust participates in the Maternity Incentive Scheme (MIS), which forms part of the Clinical Negligence Scheme for Trusts (CNST) administered by NHS Resolution. The MIS is designed to incentivise improvements in maternity safety by linking a proportion of CNST contributions to the achievement of specified safety actions.
Under the scheme, Trusts are required to pay an initial CNST contribution based on their risk profile. Subject to successful demonstration of compliance with the MIS safety actions, a rebate may subsequently be received from NHS Resolution.

In line with Department of Health and Social Care guidance, CNST contributions are recognised as expenditure within the Statement of Comprehensive Net Expenditure in the year to which they relate. Any income receivable in respect of MIS rebates is recognised only when there is sufficient evidence that the Trust has met the required criteria and the rebate is confirmed by NHS Resolution.

Where a trust has successfully demonstrated compliance against the 10 safety actions, it will recover its element of CNST contribution that went in to the maternity incentive fund, plus a share of any unallocated funds. The Trust demonstrated compliance against the 10 safety actions for 2025/26 and hence recovered the element of CNST contribution that went in to the maternity incentive fund; in addition the Trust also received a share of unallocated funds from other Trusts in 2025/26.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 29.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

The trust has determined that it has a corporation tax liability based on the nature of the Trust's business through its Wholly Owned Subsidiary CW Medicines.

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £506m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £506m at 31 March 2026. The withdrawal of this assumption is expected to have a material impact on future asset valuations; however, the financial effect cannot be quantified reliably at this time.

Note 1.23 Critical judgements in applying accounting policies

Management do not believe that there are critical judgements to disclose.

Note 1.24 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Independent valuers Montagu Evans were instructed to carry out an enhanced desk-top valuation of all land and buildings at the Chelsea and West Middlesex sites as at 31 December 2025 as disclosed at Note 16.1, as part of the three year contract with the Trust. The valuation was prepared under the requirements of the DHSC Group Accounting Manual and the RICS Valuation – Global Standard 2021 and the national standards and guidance set out in the UK national supplement (January 2019), the International Valuation Standards, and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM). Specialised assets such as hospitals for which no market exists are valued at Depreciated Replacement Cost (DRC) valuation method to arrive at the Modern Equivalent Asset. Other assets are valued at Existing Use Value (EUV) in Current Use.

A majority of the buildings owned by the Trust are specialised assets which have been valued on a Modern Equivalent Asset basis. This requires assumptions to be made about the design of a modern asset with equivalent service potential to the existing asset:

- reviewing the Useful Economic Life of the asset and the residual value at the end of that life;
- revising the areas excluded from the valuation of the Chelsea site (as used by Imperial College rather than the Trust) to reflect current usage, and reassessing the overall layout of an equivalent modern asset;
- excluding recoverable VAT when revaluing PFI buildings on the West Middlesex site reflecting the cost at which the service potential would be replaced by the PFI operator; and
- adopting an “alternative site” basis of valuation for the Chelsea site, and at West Middlesex reducing the area of the site required for the modern equivalent asset on the basis that it would be more efficiently arranged as part of a single holistic design.

Non-specialised assets and land such as the Trust’s residential staff accommodation have been valued on an Existing Use Value basis with assessed in line with the Group Accounting Manual.

Per Note 16.1 the carrying amount as at 31 March 2026 of the Trust's land and building valled at £508.65m. In determining the Modern Equivalent Asset (MEA) valuation, the Trust uses a range of inputs, including construction cost data derived from the Royal Institution of Chartered Surveyors (RICS) Building Cost Information Service (BCIS) indices. The valuation is therefore sensitive to movements in these indices. A change in BCIS indices of +/-5% would result in an increase or decrease in the Trust’s land and buildings valuation of approximately +/-3.76%.

Note 2 Operating Segments

The Trust has determined that it operates as a single reporting segment. Accordingly, no separate segmental analysis is presented, as the Trust’s activities are considered to form one operating segment.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2025/26	2024/25
	£000	£000
Income from commissioners under API contracts - variable element*	185,903	201,201
Income from commissioners under API contracts - fixed element*	577,077	533,988
High cost drugs income from commissioners	82,970	77,933
Other NHS clinical income	7,395	10,786
Income from commissioners under API contracts*	2,393	2,919
Private patient income	24,122	24,153
National pay award central funding***	-	2,394
Additional pension contribution central funding**	33,078	30,789
Other clinical income	42,422	45,968
Total income from activities	**955,360**	**930,131**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised. Nothing to report in 2025/26 as the pay awards was reflect in contracts and national tariffs.

Note 3.2 Income from patient care activities (by source)

	2025/26	2024/25
Income from patient care activities received from:	**£000**	**£000**
NHS England	135,391	214,390
Integrated care boards	760,134	653,896
Other NHS providers	283	484
NHS other	284	667
Local authorities	29,833	31,139
Non-NHS: private patients	24,122	24,153
Non-NHS: overseas patients (chargeable to patient)	3,321	3,348
Injury cost recovery scheme	1,523	1,514
Non NHS: other	469	540
Total income from activities	**955,360**	**930,131**
Of which:		
Related to continuing operations	955,360	930,131

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	3,321	3,348
Cash payments received in-year	2,093	1,738
Amounts added to provision for impairment of receivables	1,493	1,134
Amounts written off in-year	753	953

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	6,788	2,861	**9,649**	6,652	2,551	**9,203**
Education and training	35,852	1,853	**37,705**	33,544	1,213	**34,757**
Non-patient care services to other bodies	7,951	-	**7,951**	13,734	-	**13,734**
Income in respect of employee benefits accounted on a gross basis	14,469	-	**14,469**	12,841	-	**12,841**
Receipt of capital grants and donations and peppercorn leases	-	7,698	**7,698**	-	2,304	**2,304**
Charitable and other contributions to expenditure	-	299	**299**	-	490	**490**
Revenue from operating leases	-	284	**284**	-	108	**108**
Other income	43,068	-	**43,068**	32,751	-	**32,751**
Total other operating income	**108,128**	**12,995**	**121,123**	**99,522**	**6,666**	**106,188**
Of which:						
Related to continuing operations			121,123			106,188

Other income of £43.1m (2024/25 £32.8m) includes, car parking income £3.6m (2024/25 £3.3m), CW Medicines £1.8m (2024/25 £1.8m), staff accommodation rental £2.2m (2024/25 £2.5m), Sexual Health E-Services £2.0m (2024/25 £2.1m), Royal Marsden Partners £0.8m to improve cancer pathways (2024/25 £0.3m), Clinical Excellence awards £0.7m (2024/25 £0.8m), Pathology facilities £3.4m (2024/25 £3m), Facilities recharges £0.8m (2024/25 £1.2m), BBV (blood borne virus) - ED opt out testing £1m (2024/25 £1m), funding for PDC depreciation capital charges of £0.5m (2024/25 £0.9m), industrial action funding £3.2m (2024/25 £1m), funding for staffing in Maternity and Sexual Health £0.4m (2024/25 £1m). Items that are specific to 2025/26, NHS England reallocation of Deficit Support Funding £4.9m, Sprint funding £1.5m, Screening & Vaccination programmes £0.7m, Salary Sacrifice £0.6m, RTT funding £4.1m account for the increase from 2024/25 and various other smaller departmental schemes.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	11,843	14,786

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2026	31 March 2025
	£000	£000
within one year	9,267	15,681
Total revenue allocated to remaining performance obligations	**9,267**	**15,681**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	895,525	868,286
Income from services not designated as commissioner requested services	59,835	61,845
Total	**955,360**	**930,131**

Note 6 Operating leases - Chelsea and Westminster Hospital NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where the trust is the lessor.

Note 6.1 Operating leases income (Group)

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	284	108
Variable lease receipts / contingent rents	-	-
Total in-year operating lease income	**284**	**108**

Note 6.2 Future lease receipts (Group)

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	284	108
Total	**284**	**108**

Note 7.1 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,981	2,961
Purchase of healthcare from non-NHS and non-DHSC bodies	15,158	23,210
Staff and executive directors costs	626,932	597,173
Remuneration of non-executive directors	191	179
Supplies and services - clinical (excluding drugs costs)	113,123	108,404
Supplies and services - general	48,011	42,335
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	97,599	93,430
Inventories written down	360	419
Consultancy costs	198	584
Establishment	3,333	4,110
Premises	22,454	27,180
Transport (including patient travel)	4,294	3,894
Depreciation on property, plant and equipment	28,526	26,993
Amortisation on intangible assets	6,757	7,379
Net impairments	16,025	5,035
Movement in credit loss allowance: contract receivables / contract assets	2,471	1,479
Movement in credit loss allowance: all other receivables and investments	(6)	22
Increase/(decrease) in other provisions	(5,590)	(204)
Change in provisions discount rate(s)	67	(8)
Fees payable to the external auditor		
audit services- statutory audit	674	530
Internal audit costs	213	192
Clinical negligence	34,240	38,370
Legal fees	283	216
Insurance (as a policy holder)	359	433
Research and development	10,352	9,913
Education and training	10,881	10,188
Expenditure on low value leases	4	3
Variable lease payments not included in the liability	232	242
Redundancy	802	231
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	24,067	22,220
Car parking & security	1,364	1,211
Hospitality	31	66
Losses, ex gratia & special payments	377	512
Other services, eg external payroll	640	621
Other	343	26
Total	**1,067,746**	**1,029,549**
Of which:		
Related to continuing operations	1,067,746	1,029,549

The Group's appointed external auditors are Deloitte LLP. The auditors carry out the statutory audit of the Trust's Annual Accounts. The cost of this service in 2025/26 was £674k including CW Medicines subsidiary (2024/25 £530k). All audit fees are presented inclusive of VAT due. Under VAT Contracted out services, the VAT is non-recoverable on the Trust's audit fees.

Note 7.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2,000k (2024/25: £2,000k), with the exception for liability in the event of death, injury or fraud which is unlimited.

Note 8 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	16,025	5,035
Total net impairments charged to operating surplus / deficit	**16,025**	**5,035**
Impairments charged to the revaluation reserve	(3,401)	(3,881)
Total net impairments	**12,624**	**1,154**

The position includes net impairment charge of £18.65m (2024/25 £9.89m) and reversal of Impairments credit of £2.62m (2024/25 £4.85m) arising from the annual valuation exercise of the Trust's estate (based on industry standard indices). This has deteriorated the Trust financial performance, but the loss does not impact the control total, which the Trust is measured against.

Note 9 Employee benefits (Group)

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	493,144	473,663
Social security costs	65,313	52,921
Apprenticeship levy	2,336	2,299
Employer's contributions to NHS pensions	83,798	77,853
Pension cost - other	45	32
Temporary staff (including agency)	1,861	8,766
Total gross staff costs	**646,497**	**615,534**
Recoveries in respect of seconded staff	-	-
Total staff costs	**646,497**	**615,534**
Of which		
Costs capitalised as part of assets	2,874	2,666

Note 9.1 Retirements due to ill-health (Group)

During 2025/26 there were 2 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £201k (£418k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

NEST is the workplace pension set up by the Government. The Trust offers employees the NEST pension scheme alongside the two NHS Pension Schemes. NEST is a defined contribution workplace pension scheme backed by the UK Government. In 2025/26 the Trust paid £28k into NEST. Staff are automatically enrolled into the NHS pension scheme or the NEST scheme unless staff opt out.

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	6,470	8,121
Other finance income	1	82
Total finance income	**6,471**	**8,203**

Note 12.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	605	667
Interest on other loans	58	92
Interest on lease obligations	242	324
Interest on late payment of commercial debt	2	14
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	2,657	4,861
Contingent finance costs	-	-
Remeasurement of the liability resulting from change in index or rate	767	856
Total interest expense	**4,331**	**6,814**
Unwinding of discount on provisions	47	100
Total finance costs	**4,378**	**6,914**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	212	156
Amounts included within interest payable arising from claims made under this legislation	2	14

Note 13 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	-	8
Losses on disposal of assets	(594)	-
Total (losses)/ gains on disposal of assets	**(594)**	**8**
Total other (losses)/ gains	**(594)**	**8**

Losses on disposal recognised during the year relate primarily to the disposal of non-current assets. These comprised losses of £196k on IT assets, £32k on medical equipment and £366k on intangible assets.

Note 14.1 Intangible assets - 2025/26

Group	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**5,178**	**53,699**	**3,734**	**62,611**
Additions	-	-	4,311	**4,311**
Reclassifications	2,769	489	(3,258)	**-**
Disposals / derecognition	(296)	(814)	-	**(1,110)**
Cost at 31 March 2026	**7,651**	**53,374**	**4,787**	**65,812**
Amortisation at 1 April 2025 - brought forward	**2,847**	**31,739**	**-**	**34,586**
Provided during the year	1,613	5,144	-	**6,757**
Disposals / derecognition	(221)	(523)	-	**(744)**
Amortisation at 31 March 2026	**4,239**	**36,360**	**-**	**40,599**
Net book value at 31 March 2026	**3,412**	**17,014**	**4,787**	**25,213**
Net book value at 1 April 2025	**2,331**	**21,960**	**3,734**	**28,025**

During 2025/26, the Trust continued its programme of asset verification to ensure that intangible assets which are no longer in use are appropriately identified and recorded as disposed. As a result of this review, intangible assets with a gross costs of £1,110k were disposed of during the year, giving rise to a net disposal loss of £366k recognised in the Statement of Comprehensive Income.

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 14.2 Intangible assets - 2024/25

Group	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**9,880**	**68,751**	**2,717**	**81,348**
Valuation / gross cost at 1 April 2024 - restated	**9,880**	**68,751**	**2,717**	**81,348**
Additions	-	-	3,297	**3,297**
Reclassifications	810	1,470	(2,280)	**-**
Disposals / derecognition	(5,512)	(16,522)	-	**(22,034)**
Valuation / gross cost at 31 March 2025	**5,178**	**53,699**	**3,734**	**62,611**
Amortisation at 1 April 2024 - as previously stated	**7,310**	**41,931**	**-**	**49,241**
Amortisation at 1 April 2024 - restated	**7,310**	**41,931**	**-**	**49,241**
Provided during the year	1,049	6,330	-	**7,379**
Disposals / derecognition	(5,512)	(16,522)	-	**(22,034)**
Amortisation at 31 March 2025	**2,847**	**31,739**	**-**	**34,586**
Net book value at 31 March 2025	**2,331**	**21,960**	**3,734**	**28,025**
Net book value at 1 April 2024	**2,570**	**26,820**	**2,717**	**32,107**

Note 15.1 Intangible assets - 2025/26

Trust	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**5,178**	**53,699**	**3,734**	**62,611**
Additions	-	-	4,311	**4,311**
Reclassifications	2,769	489	(3,258)	**-**
Disposals / derecognition	(296)	(814)	-	**(1,110)**
Cost at 31 March 2026	**7,651**	**53,374**	**4,787**	**65,812**
Amortisation at 1 April 2025 - brought forward	**2,847**	**31,739**	**-**	**34,586**
Provided during the year	1,613	5,144	-	**6,757**
Disposals / derecognition	(221)	(523)	-	**(744)**
Amortisation at 31 March 2026	**4,239**	**36,360**	**-**	**40,599**
Net book value at 31 March 2026	**3,412**	**17,014**	**4,787**	**25,213**
Net book value at 1 April 2025	**2,331**	**21,960**	**3,734**	**28,025**

During 2025/26, the Trust continued its programme of asset verification to ensure that intangible assets which are no longer in use are appropriately identified and recorded as disposed. As a result of this review, intangible assets with a gross costs of £1,110k were disposed of during the year, giving rise to a net disposal loss of £366k recognised in the Statement of Comprehensive Income.

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 15.2 Intangible assets - 2024/25

Trust	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**9,880**	**68,751**	**2,717**	**81,348**
Valuation / gross cost at 1 April 2024 - restated	**9,880**	**68,751**	**2,717**	**81,348**
Additions	-	-	3,297	**3,297**
Reclassifications	810	1,470	(2,280)	**-**
Disposals / derecognition	(5,512)	(16,522)	-	**(22,034)**
Valuation / gross cost at 31 March 2025	**5,178**	**53,699**	**3,734**	**62,611**
Amortisation at 1 April 2024 - as previously stated	7,310	41,931	-	**49,241**
Amortisation at 1 April 2024 - restated	**7,310**	**41,931**	**-**	**49,241**
Provided during the year	1,049	6,330	-	**7,379**
Disposals / derecognition	(5,512)	(16,522)	-	**(22,034)**
Amortisation at 31 March 2025	**2,847**	**31,739**	**-**	**34,586**
Net book value at 31 March 2025	**2,331**	**21,960**	**3,734**	**28,025**
Net book value at 1 April 2024	**2,570**	**26,820**	**2,717**	**32,107**

Note 15.3 Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	2	10
Software licences	3	10

Note 16.1 Property, plant and equipment - 2025/26

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**98,066**	**395,165**	**21,222**	**52,426**	**64,600**	**18,009**	**825**	**650,313**
Additions	-	-	-	58,709	-	-	-	**58,709**
Impairments	-	(21,802)	-	-	-	-	-	**(21,802)**
Reversals of impairments	967	6,243	1,968	-	-	-	-	**9,178**
Revaluations	-	(14,157)	(686)	-	-	-	-	**(14,843)**
Reclassifications	-	29,270	-	(36,994)	6,266	1,425	33	**-**
Disposals / derecognition	-	-	-	-	(550)	(1,879)	-	**(2,429)**
Valuation/gross cost at 31 March 2026	**99,033**	**394,719**	**22,504**	**74,141**	**70,316**	**17,555**	**858**	**679,126**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**7,044**	**172**	**-**	**28,658**	**8,811**	**482**	**45,167**
Provided during the year	-	15,027	703	-	7,334	3,275	95	**26,434**
Revaluations	-	(14,157)	(686)	-	-	-	-	**(14,843)**
Disposals / derecognition	-	-	-	-	(495)	(1,683)	-	**(2,178)**
Accumulated depreciation at 31 March 2026	**-**	**7,914**	**189**	**-**	**35,497**	**10,403**	**577**	**54,580**
Net book value at 31 March 2026	**99,033**	**386,805**	**22,315**	**74,141**	**34,819**	**7,152**	**281**	**624,546**
Net book value at 1 April 2025	**98,066**	**388,121**	**21,050**	**52,426**	**35,942**	**9,198**	**343**	**605,146**

In 2025/26 the Trust invested £64,168k on capital, which included £43,333k on the Diagnostic, Treatment and Education Centre (DTEC) build, £8,564k on estates works and maintenance across both sites, £6,594k on medical equipment and £4,529km on IT goods and services. The balance of £1,148k included the impact of IFRS16 leases.

During 2025/26, the Trust continued its programme of asset verification to ensure that assets which are no longer in use are appropriately identified and recorded as disposed. As a result of this review, assets with a gross costs of £2,429k were disposed of during the year, giving rise to a net disposal loss of £251k recognised in the Statement of Comprehensive Income.

Note 16.2 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**98,609**	**381,207**	**21,289**	**33,985**	**103,708**	**121**	**30,913**	**3,719**	**673,551**
Additions	-	-	-	60,195	-	-	-	-	**60,195**
Impairments	(531)	(14,897)	-	-	-	-	-	-	**(15,428)**
Reversals of impairments	75	13,710	489	-	-	-	-	-	**14,274**
Revaluations	-	(13,614)	(671)	-	-	-	-	-	**(14,285)**
Reclassifications	(87)	28,759	115	(41,754)	9,197	-	3,508	262	**-**
Disposals / derecognition	-	-	-	-	(48,305)	(121)	(16,412)	(3,156)	**(67,994)**
Valuation/gross cost at 31 March 2025	**98,066**	**395,165**	**21,222**	**52,426**	**64,600**	**-**	**18,009**	**825**	**650,313**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**6,346**	**171**	**-**	**70,186**	**121**	**22,283**	**3,552**	**102,659**
Provided during the year	-	14,312	672	-	6,777	-	2,940	86	**24,787**
Revaluations	-	(13,614)	(671)	-	-	-	-	-	**(14,285)**
Disposals / derecognition	-	-	-	-	(48,305)	(121)	(16,412)	(3,156)	**(67,994)**
Accumulated depreciation at 31 March 2025	**-**	**7,044**	**172**	**-**	**28,658**	**-**	**8,811**	**482**	**45,167**
Net book value at 31 March 2025	**98,066**	**388,121**	**21,050**	**52,426**	**35,942**	**-**	**9,198**	**343**	**605,146**
Net book value at 1 April 2024	**98,609**	**374,861**	**21,118**	**33,985**	**33,522**	**-**	**8,630**	**167**	**570,892**

Note 16.3 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	99,033	306,551	22,315	71,062	32,299	7,152	281	**538,693**
On-SoFP PFI contracts and other service concession arrangements	-	62,564	-	-	-	-	-	**62,564**
Owned - donated/granted	-	17,690	-	3,079	2,520	-	-	**23,289**
NBV total at 31 March 2026	**99,033**	**386,805**	**22,315**	**74,141**	**34,819**	**7,152**	**281**	**624,546**

Note 16.4 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	98,066	309,025	21,050	52,415	32,992	9,198	343	**523,089**
On-SoFP PFI contracts and other service concession arrangements	-	62,254	-	-	-	-	-	**62,254**
Owned - donated/granted	-	16,842	-	11	2,950	-	-	**19,803**
NBV total at 31 March 2025	**98,066**	**388,121**	**21,050**	**52,426**	**35,942**	**9,198**	**343**	**605,146**

Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	99,033	386,805	22,315	74,141	34,819	7,152	281	**624,546**
NBV total at 31 March 2026	**99,033**	**386,805**	**22,315**	**74,141**	**34,819**	**7,152**	**281**	**624,546**

Note 16.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	98,066	388,121	21,050	52,426	35,942	9,198	343	**605,146**
NBV total at 31 March 2025	**98,066**	**388,121**	**21,050**	**52,426**	**35,942**	**9,198**	**343**	**605,146**

Note 17.1 Property, plant and equipment - 2025/26

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**98,066**	**395,165**	**21,222**	**52,426**	**64,600**	**-**	**18,009**	**825**	**650,313**
Additions	-	-	-	58,709	-	-	-	-	**58,709**
Impairments	-	(21,802)	-	-	-	-	-	-	**(21,802)**
Reversals of impairments	967	6,243	1,968	-	-	-	-	-	**9,178**
Revaluations	-	(14,157)	(686)	-	-	-	-	-	**(14,843)**
Reclassifications	-	29,270	-	(36,994)	6,266	-	1,425	33	**-**
Disposals / derecognition	-	-	-	-	(550)	-	(1,879)	-	**(2,429)**
Valuation/gross cost at 31 March 2026	**99,033**	**394,719**	**22,504**	**74,141**	**70,316**	**-**	**17,555**	**858**	**679,126**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**7,044**	**172**	**-**	**28,658**	**-**	**8,811**	**482**	**45,167**
Provided during the year	-	15,027	703	-	7,334	-	3,275	95	**26,434**
Revaluations	-	(14,157)	(686)	-	-	-	-	-	**(14,843)**
Disposals / derecognition	-	-	-	-	(495)	-	(1,683)	-	**(2,178)**
Accumulated depreciation at 31 March 2026	**-**	**7,914**	**189**	**-**	**35,497**	**-**	**10,403**	**577**	**54,580**
Net book value at 31 March 2026	**99,033**	**386,805**	**22,315**	**74,141**	**34,819**	**-**	**7,152**	**281**	**624,546**
Net book value at 1 April 2025	**98,066**	**388,121**	**21,050**	**52,426**	**35,942**	**-**	**9,198**	**343**	**605,146**

In 2025/26 the Trust invested £64.168k on capital, which included £43,333k on the Diagnostic, Treatment and Education Centre (DTEC), £8,564k on estates works and maintenance across both sites, £6,594k on medical equipment and £4,529km on IT goods and services. The balance of £1,148k included the impact of IFRS16 leases.

During 2025/26, the Trust continued its programme of asset verification to ensure that assets which are no longer in use are appropriately identified and recorded as disposed. As a result of this review, assets with a gross costs of £2,429k were disposed of during the year, giving rise to a net disposal loss of £251k recognised in the Statement of Comprehensive Income.

Note 17.2 Property, plant and equipment - 2024/25

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**98,609**	**381,207**	**21,289**	**33,985**	**103,708**	**121**	**30,913**	**3,719**	**673,551**
Additions	-	-	-	60,195	-	-	-	-	**60,195**
Impairments	(531)	(14,897)	-	-	-	-	-	-	**(15,428)**
Reversals of impairments	75	13,710	489	-	-	-	-	-	**14,274**
Revaluations	-	(13,614)	(671)	-	-	-	-	-	**(14,285)**
Reclassifications	(87)	28,759	115	(41,754)	9,197	-	3,508	262	**-**
Disposals / derecognition	-	-	-	-	(48,305)	(121)	(16,412)	(3,156)	**(67,994)**
Valuation/gross cost at 31 March 2025	**98,066**	**395,165**	**21,222**	**52,426**	**64,600**	**-**	**18,009**	**825**	**650,313**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**6,346**	**171**	**-**	**70,186**	**121**	**22,283**	**3,552**	**102,659**
Provided during the year	-	14,312	672	-	6,777	-	2,940	86	**24,787**
Revaluations	-	(13,614)	(671)	-	-	-	-	-	**(14,285)**
Disposals / derecognition	-	-	-	-	(48,305)	(121)	(16,412)	(3,156)	**(67,994)**
Accumulated depreciation at 31 March 2025	**-**	**7,044**	**172**	**-**	**28,658**	**-**	**8,811**	**482**	**45,167**
Net book value at 31 March 2025	**98,066**	**388,121**	**21,050**	**52,426**	**35,942**	**-**	**9,198**	**343**	**605,146**
Net book value at 1 April 2024	**98,609**	**374,861**	**21,118**	**33,985**	**33,522**	**-**	**8,630**	**167**	**570,892**

Note 17.3 Property, plant and equipment financing - 31 March 2026

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	99,033	306,551	22,315	71,062	32,299	7,152	281	**538,693**
On-SoFP PFI contracts and other service concession arrangements	-	62,564	-	-	-	-	-	**62,564**
Owned - donated / granted	-	17,690	-	3,079	2,520	-	-	**23,289**
Total net book value at 31 March 2026	**99,033**	**386,805**	**22,315**	**74,141**	**34,819**	**7,152**	**281**	**624,546**

Note 17.4 Property, plant and equipment financing - 31 March 2025

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	98,066	309,025	21,050	52,415	32,992	9,198	343	**523,089**
On-SoFP PFI contracts and other service concession arrangements	-	62,254	-	-	-	-	-	**62,254**
Owned - donated / granted	-	16,842	-	11	2,950	-	-	**19,803**
Total net book value at 31 March 2025	**98,066**	**388,121**	**21,050**	**52,426**	**35,942**	**9,198**	**343**	**605,146**

Note 17.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	99,033	386,805	22,315	74,141	34,819	7,152	281	**624,546**
Total net book value at 31 March 2026	**99,033**	**386,805**	**22,315**	**74,141**	**34,819**	**7,152**	**281**	**624,546**

Note 17.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	98,066	388,121	21,050	52,426	35,942	9,198	343	**605,146**
Total net book value at 31 March 2025	**98,066**	**388,121**	**21,050**	**52,426**	**35,942**	**9,198**	**343**	**605,146**

Note 18 Donations of property, plant and equipment

The Trust recognised donation and grant income of £7,698k in the year.
- £3,380k cash grant from NHS North West London ICB for the development of Federated Data Platform (FDP).
- £2,748k cash donation from CW+ for projects, including contributions to the Paediatrics Emergency Department, Treatment Centre and the Diagnostic, Treatment & Education Centre redevelopment and equipment.
- £537k cash donation from Imperial College Healthcare Trust towards the Diagnostic, Treatment & Education Centre redevelopment.
- £1,033k cash grant from the London Borough of Hounslow, including a £1m contribution to the Diagnostic, Treatment & Education Centre redevelopment.

CW+ is the affiliated charity of the Trust. The Trust does not exercise control over CW+ as defined by IFRS 10 and the Department of Health and Social Care Group Accounting Manual (GAM). CW+ is not consolidated into the Trust's annual accounts.

Note 19 Revaluations of property, plant and equipment

The Trust instructed Montagu Evans to carry out a revaluation of its property portfolio as at 31 December 2025. The revaluation was predominantly based on modern equivalent asset values using the alternative site approach where appropriate. This exercise resulted in a decrease in the value of the relative assets of £12,623k, this represents £16,025k impairment charged to the I&E and £3,401k decrease in revaluation reserves in accordance with the Trust's accounting policies and NHSE guidance.

Given that the financial year-end is 31 March 2026, the valuer has subsequently provided an assessment to consider whether there have been any material changes in value between the revaluation date and the reporting date. Based on this review, the valuer concluded that any movement in value over this period would not be material to the financial statements.

Note 20 Leases - Chelsea and Westminster Hospital NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%, where 4.81% discount rate has applied for newly commenced leases.

Note 20.1 Right of use assets - 2025/26

Group	Property (land and buildings)	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**13,438**	**-**	**13,438**	**1,209**
Additions	-	761	**761**	-
Remeasurements of the lease liability	387	-	**387**	(40)
Movements in provisions for restoration / removal costs	1	-	**1**	-
Valuation/gross cost at 31 March 2026	**13,826**	**761**	**14,587**	**1,169**
Accumulated depreciation at 1 April 2025 - brought forward	**5,670**	**-**	**5,670**	**601**
Provided during the year	2,092	-	**2,092**	189
Accumulated depreciation at 31 March 2026	**7,762**	**-**	**7,762**	**790**
Net book value at 31 March 2026	**6,063**	**761**	**6,824**	**379**
Net book value at 1 April 2025	**7,767**	**-**	**7,767**	**608**

Net book value of right of use assets leased from other DHSC group bodies 379

Note 20.2 Right of use assets - 2024/25

Group	Property (land and buildings)	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**13,746**	**-**	**13,746**	**1,201**
Additions	843	-	**843**	-
Remeasurements of the lease liability	(535)	-	**(535)**	8
Movements in provisions for restoration / removal costs	35	-	**35**	-
Disposals / derecognition	(651)	-	**(651)**	-
Valuation/gross cost at 31 March 2025	**13,438**	**-**	**13,438**	**1,209**
Accumulated depreciation at 1 April 2024 - brought forward	**3,816**	**-**	**3,816**	**398**
Provided during the year	2,206	-	**2,206**	203
Disposals / derecognition	(352)	-	**(352)**	-
Accumulated depreciation at 31 March 2025	**5,670**	**-**	**5,670**	**601**
Net book value at 31 March 2025	**7,767**	**-**	**7,767**	**608**
Net book value at 1 April 2024	**9,929**	**-**	**9,929**	**803**

Net book value of right of use assets leased from other DHSC group bodies 608

Note 20.3 Right of use assets - 2025/26

Trust	Property (land and buildings)	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**13,438**	**-**	**13,438**	**1,209**
Additions	-	761	**761**	-
Remeasurements of the lease liability	387	-	**387**	(40)
Movements in provisions for restoration / removal costs	1	-	**1**	-
Valuation/gross cost at 31 March 2026	**13,826**	**761**	**14,587**	**1,169**
Accumulated depreciation at 1 April 2025 - brought forward	5,670	-	**5,670**	601
Provided during the year	2,092	-	**2,092**	189
Accumulated depreciation at 31 March 2026	**7,762**	**-**	**7,762**	**790**
Net book value at 31 March 2026	**6,063**	**761**	**6,824**	**379**
Net book value at 1 April 2025	**7,767**	**-**	**7,767**	**608**

Net book value of right of use assets leased from other DHSC group bodies 379

Note 20.4 Right of use assets - 2024/25

Trust	Property (land and buildings)	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**13,746**	**-**	**13,746**	**1,201**
Additions	843	-	**843**	-
Remeasurements of the lease liability	(535)	-	**(535)**	8
Movements in provisions for restoration / removal costs	35	-	**35**	-
Disposals / derecognition	(651)	-	**(651)**	-
Valuation/gross cost at 31 March 2025	**13,438**	**-**	**13,438**	**1,209**
Accumulated depreciation at 1 April 2024 - brought forward	**3,816**	**-**	**3,816**	**398**
Provided during the year	2,206	-	**2,206**	203
Disposals / derecognition	(352)	-	**(352)**	-
Accumulated depreciation at 31 March 2025	**5,670**	**-**	**5,670**	**601**
Net book value at 31 March 2025	**7,767**	**-**	**7,767**	**608**
Net book value at 1 April 2024	**9,929**	**-**	**9,929**	**803**

Net book value of right of use assets leased from other DHSC group bodies 608

Note 20.5 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 27.1.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	**7,796**	**9,958**	**7,796**	9,958
Transfers by absorption	-	-		
Lease additions	594	723	594	723
Lease liability remeasurements	387	(535)	387	(535)
Interest charge arising in year	242	324	242	324
Early terminations	-	(306)	-	(306)
Lease payments (cash outflows)	(2,221)	(2,368)	(2,221)	(2,368)
Carrying value at 31 March	**6,798**	**7,796**	**6,798**	**7,796**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 20.6 Maturity analysis of future lease payments at 31 March 2026

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,328	209	2,328	209
- later than one year and not later than five years;	4,657	209	4,657	209
- later than five years.	330	-	330	-
Total gross future lease payments	**7,315**	**418**	**7,315**	**418**
Finance charges allocated to future periods	(517)	(20)	(517)	(20)
Net lease liabilities at 31 March 2026	**6,798**	**398**	**6,798**	**398**
Of which:				
Leased from other DHSC group bodies		398		398

Note 20.7 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,192	224	2,192	224
- later than one year and not later than five years;	5,557	447	5,557	447
- later than five years.	726	-	726	-
Total gross future lease payments	**8,475**	**671**	**8,475**	**671**
Finance charges allocated to future periods	(679)	(47)	(679)	(47)
Net finance lease liabilities at 31 March 2025	**7,796**	**624**	**7,796**	**624**
Of which:				
Leased from other DHSC group bodies		624		624

During 2025/26, the Trust entered into a new lease arrangement for a neutral host Distributed Antenna System (DAS). The contract has a non-cancellable term of five years, with an option to extend for a further two years.

In accordance with IFRS 16, the Trust has recognised a lease liability and corresponding right-of-use asset based on the five-year lease term, as the extension option has not been assessed as reasonably certain to be exercised at commencement.

If the extension option were to be exercised, this would result in an increase to the lease liability of approximately £852k. The extension period also includes a payment in advance of £167k, which would be recognised at the commencement of the extended term.

Note 21 Investments in subsidiary

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**-**	**-**	**3,200**	**3,200**
Carrying value at 31 March	**-**	**-**	**3,200**	**3,200**

The £3.2m relates to the Wholly Owned Subsidiary CW Medicines. The primary activity of the company is dispensing medications to outpatients of the Trust.

Note 22 Inventories

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Drugs	6,018	5,840	4,753	4,573
Work In progress	-	-	-	-
Consumables	2,469	3,679	2,469	3,679
Energy	54	72	54	72
Other	83	113	83	113
Charitable fund inventory	-	-	-	-
Total inventories	**8,624**	**9,704**	**7,359**	**8,437**

Inventories recognised in expenses for the year were £113,953k (2024/25: £112,707k). Write-down of inventories recognised as expenses for the year were £360k (2024/25: £419k).

Note 23.1 Receivables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Contract receivables	41,672	39,018	41,672	39,018
Allowance for impaired contract receivables / assets	(8,505)	(7,304)	(8,505)	(7,304)
Allowance for other impaired receivables	(560)	(608)	(560)	(608)
Prepayments (non-PFI)	9,205	11,320	9,205	11,320
Interest receivable	500	662	500	662
PDC dividend receivable	152	452	152	452
VAT receivable	2,126	2,888	1,607	1,796
Other receivables	3,763	3,450	3,751	3,403
Total current receivables	**48,353**	**49,878**	**47,822**	**48,778**
Non-current				
Other receivables	926	1,032	926	1,032
Total non-current receivables	**926**	**1,032**	**926**	**1,032**
Of which receivable from NHS and DHSC group bodies:				
Current	16,276	19,091	16,276	19,091
Non-current	926	1,032	926	1,032

Non-current receivables includes Clinician Pension tax of £926k (2024/25 £1,032k) provided by NHSE, using information provided by the Government Actuaries Department and NHS Business Services Authority. A separate provision is recognised in Payables.

Note 23.2 Allowances for credit losses - 2025/26

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2025 - brought forward	**7,304**	**608**	**7,304**	**608**
New allowances arising	3,440	23	3,440	23
Reversals of allowances	(969)	(29)	(969)	(29)
Utilisation of allowances (write offs)	(1,270)	(42)	(1,270)	(42)
Allowances as at 31 Mar 2026	**8,505**	**560**	**8,505**	**560**

The total balance for allowances for contract credit losses includes £3,375k for Overseas patients credit losses (2024/25 £2,582k), £1,425k for NHS (2024/25 £1,489k), £574k for Local Authorities (2024/25 £431k), £1,060k for Private Patients (2024/25 £1,019k), £1,288k for Road Traffic Accident (RTA) (2024/25 £1,129k) and £793k for Others (2024/25 £654k). Each year the Compensation Recovery Unit (CRU) advises a percentage probability of not receiving the RTA income, for 2025/26 this figure is 24.62% (2024/25 24.45%). The total balance for allowances for non-contract credit losses is for salary overpayment of £560k (2024/25 £608k).

Amounts written off in the year that are still subject to enforcement activity is zero.

Note 23.3 Allowances for credit losses - 2024/25

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2024 - as previously stated	**7,179**	**601**	**7,179**	**601**
New allowances arising	3,243	39	3,243	39
Reversals of allowances	(1,764)	(17)	(1,764)	(17)
Utilisation of allowances (write offs)	(1,354)	(15)	(1,354)	(15)
Allowances as at 31 Mar 2025	**7,304**	**608**	**7,304**	**608**

Note 24.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**143,460**	**161,614**	**142,369**	**160,756**
Net change in year	(25,870)	(18,154)	(25,385)	(18,387)
At 31 March	**117,590**	**143,460**	**116,984**	**142,369**
Broken down into:				
Cash at commercial banks and in hand	645	1,136	39	45
Cash with the Government Banking Service	116,945	142,324	116,945	142,324
Total cash and cash equivalents as in SoFP	**117,590**	**143,460**	**116,984**	**142,369**
Total cash and cash equivalents as in SoCF	**117,590**	**143,460**	**116,984**	**142,369**

Note 25.1 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	22,548	24,826	21,918	22,609
Capital payables	15,038	18,292	15,038	18,292
Accruals	48,792	48,806	50,266	50,850
Social security costs	7,378	6,255	7,365	6,242
Other taxes payable	8,581	8,025	8,569	8,013
PDC dividend payable	-	-	-	-
Pension contributions payable	7,586	6,939	7,586	6,936
Other payables	2,273	1,894	2,269	1,869
Total current trade and other payables	**112,196**	**115,037**	**113,011**	**114,811**
Of which payables from NHS and DHSC group bodies:				
Current	11,423	12,654	11,423	12654

As of March 31 2026, the Trust's Trade payables includes the amount of £3,949k (2024/25 £2,968k) owed to its subsidiary, dispensing drugs to the Trust's outpatients.

Note 26 Other liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Deferred income: contract liabilities	27,108	29,469	27,108	29,469
Total other current liabilities	**27,108**	**29,469**	**27,108**	**29,469**

Within the £29,469k contract liability balance at the beginning of the year, £11,843k (2024/25 £14,786k) of revenue was recognised during the year as the related performance obligation were satisfied.

Note 27.1 Borrowings

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Loans from DHSC	2,160	2,964	2,160	2,964
Other loans	1,481	1,446	1,481	1,446
Lease liabilities	2,328	2,190	2,328	2,190
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	3,078	2,538	3,078	2,538
Total current borrowings	**9,047**	**9,138**	**9,047**	**9,138**
Non-current				
Loans from DHSC	28,498	30,593	28,498	30,593
Other loans	-	1,479	-	1,479
Lease liabilities	4,470	5,606	4,470	5,606
Obligations under PFI, LIFT or other service concession contracts	38,187	41,900	38,187	41,900
Total non-current borrowings	**71,155**	**79,578**	**71,155**	**79,578**

Note 27.2 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**33,557**	**2,925**	**7,796**	**44,438**	**88,716**
Cash movements:					
Financing cash flows - payments and receipts of principal	(2,893)	(1,444)	(1,979)	(3,941)	**(10,257)**
Financing cash flows - payments of interest	(611)	(58)	(242)	(2,656)	**(3,567)**
Non-cash movements:					
Additions	-	-	594	-	**594**
Lease liability remeasurements	-	-	387	-	**387**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				767	**767**
Application of effective interest rate	605	58	242	2,657	**3,562**
Carrying value at 31 March 2026	**30,658**	**1,481**	**6,798**	**41,265**	**80,202**

Group - 2024/25	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**37,236**	**4,335**	**9,958**	**44,874**	**96,403**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,673)	(1,409)	(2,045)	(1,045)	**(8,172)**
Financing cash flows - payments of interest	(673)	(93)	(323)	(5,266)	**(6,355)**
Non-cash movements:					
Additions	-	-	723	-	**723**
Lease liability remeasurements	-	-	(535)	-	**(535)**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				856	**856**
Application of effective interest rate	667	92	324	4,861	**5,944**
Early terminations	-	-	(306)	-	**(306)**
Other changes	-	-	-	158	**158**
Carrying value at 31 March 2025	**33,557**	**2,925**	**7,796**	**44,438**	**88,716**

Note 27.3 Reconciliation of liabilities arising from financing activities

Trust - 2025/26	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**33,557**	**2,925**	**7,796**	**44,438**	**88,716**
Cash movements:					
Financing cash flows - payments and receipts of principal	(2,893)	(1,444)	(1,979)	(3,941)	**(10,257)**
Financing cash flows - payments of interest	(611)	(58)	(242)	(2,656)	**(3,567)**
Non-cash movements:					
Additions	-	-	594	-	**594**
Lease liability remeasurements	-	-	387	-	**387**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	-	767	**767**
Application of effective interest rate	605	58	242	2,657	**3,562**
Carrying value at 31 March 2026	**30,658**	**1,481**	**6,798**	**41,265**	**80,202**

Trust - 2024/25	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**37,236**	**4,335**	**9,958**	**44,874**	**96,403**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,673)	(1,409)	(2,045)	(1,045)	**(8,172)**
Financing cash flows - payments of interest	(673)	(93)	(323)	(5,266)	**(6,355)**
Non-cash movements:					
Additions	-	-	723	-	**723**
Lease liability remeasurements	-	-	(535)	-	**(535)**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	-	856	**856**
Application of effective interest rate	667	92	324	4,861	**5,944**
Early terminations	-	-	(306)	-	**(306)**
Other changes	-	-	-	158	**158**
Carrying value at 31 March 2025	**33,557**	**2,925**	**7,796**	**44,438**	**88,716**

Note 28.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	**1,062**	**808**	**957**	**1,710**	**28,547**	**33,084**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	35	16	-	-	(58)	**(7)**
Arising during the year	-	-	493	-	6,935	**7,428**
Utilised during the year	(171)	(81)	(219)	(142)	(3,736)	**(4,349)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	(39)	-	(754)	(1,568)	(10,675)	**(13,036)**
Unwinding of discount	26	19	-	-	64	**109**
Movement in charitable fund provisions	-	-	-	-	-	**-**
At 31 March 2026	**913**	**762**	**477**	**-**	**21,077**	**23,229**
Expected timing of cash flows:						
- not later than one year;	166	81	477	-	12,720	**13,444**
- later than one year and not later than five years;	595	325	-	-	7,167	**8,087**
- later than five years.	152	356	-	-	1,190	**1,698**
Total	**913**	**762**	**477**	**-**	**21,077**	**23,229**

There has been an overall movement of £9.9m (reduction) in provisions held in year, with the main movements in relation to contractual disputes, VAT and CNST MiS achievement.

Pensions; early departure and Injury benefits. The Trust is responsible for meeting additional costs arising from early departure and injury benefits awards in respect of claims made by employees. The amount disclosed here is discounted to their present value.

Legal claims; this relates to outstanding legal cases, mainly in relation to Employment cases, with the amount provided subject to outcomes.

Other provisions include Contractual disputes, this relates to challenges from Commissioners on pricing, charging and penalties, £2,931k (2024/25 £6,524k); NHS Resolution LTPS Claims of £111k (2024/25 £96k); Dilapidations £1,428k (2024/25 £1,409k); Contractual pay claims £3,961k (2024/25 £2,880k): Clinician pension tax £975k (2024/25 £1,071k); Liability for Sphere Joint Venture £433k (2024/25 £867k); Outsourced record management £6,003k (2024/25 £6,230k); Covid and Vaccination overpayment £1,575k (2024/25 £525k); Benefit in Kind schemes £633k (2024/25 £1,723); car parking claims £128k (2024/25 £1,385k); and other Contractual claims £2,899k (2024/25 £5,837k).

Note 28.2 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	**1,062**	**808**	**957**	**1,710**	**28,491**	**33,028**
Transfers by absorption						**-**
Change in the discount rate	35	16	-	-	(58)	**(7)**
Arising during the year	-	-	493	-	6,935	**7,428**
Utilised during the year	(171)	(81)	(219)	(142)	(3,736)	**(4,349)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	(39)	-	(754)	(1,568)	(10,646)	**(13,007)**
Unwinding of discount	26	19	-	-	64	**109**
At 31 March 2026	**913**	**762**	**477**	**-**	**21,050**	**23,202**
Expected timing of cash flows:						
- not later than one year;	166	81	477	-	12,693	**13,417**
- later than one year and not later than five years;	595	325	-	-	7,167	**8,087**
- later than five years.	152	356	-	-	1,190	**1,698**
Total	**913**	**762**	**477**	**-**	**21,050**	**23,202**

Pensions; early departure and Injury benefits. The Trust is responsible for meeting additional costs arising from early departure and injury benefits awards in respect of claims made by employees. The amount disclosed here is discounted to their present value.

Legal claims; this relates to outstanding legal cases, mainly in relation to Employment cases, with the amount provided subject to outcomes.

Other provisions include Contractual disputes, this relates to challenges from Commissioners on pricing, charging and penalties, £2,931k (2024/25 £6,524k); NHS Resolution LTPS Claims of £111k (2024/25 £96k); Dilapidations £1,428k (2024/25 £1,409k); Contractual pay claims £3,961k (2024/25 £2,880k): Clinician pension tax £975k (2024/25 £1,071k); Liability for Sphere Joint Venture £433k (2024/25 £867k); Outsourced record management £6,003k (2024/25 £6,230k); Covid and Vaccination overpayment £1,575k (2024/25 £525k); Benefit in Kind schemes £633k (2024/25 £1,723); car parking claims £128k (2024/25 £1,385k); and other Contractual claims £2,899k (2024/25 £5,837k).

Note 28.3 Clinical negligence liabilities

At 31 March 2026, £322,990k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Chelsea and Westminster Hospital NHS Foundation Trust (31 March 2025: £369,051k).

Note 29 Contingent assets and liabilities

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	58	58	58	58
Gross value of contingent liabilities	**58**	**58**	**58**	**58**
Net value of contingent liabilities	**58**	**58**	**58**	**58**
Net value of contingent assets	**-**	**-**		

NHS Resolution clinical negligence claims are not provided for in the Trust's annual accounts. Under the NHS Resolution schemes (e.g. CNST), the financial risk of clinical negligence claims is transferred to NHS Resolution, which settles claims on behalf of member organisations.

Note 30 Contractual capital commitments

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Property, plant and equipment	3,473	68,462	3,473	68,462
Intangible assets	103	-	103	
Total	**3,576**	**68,462**	**3,576**	**68,462**

Note 31.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**55,595**	**60,239**	**55,595**	**60,239**
Of which liabilities are due				
- not later than one year;	5,705	5,431	5,705	5,431
- later than one year and not later than five years;	22,354	22,135	22,354	22,135
- later than five years.	27,536	32,673	27,536	32,673
Finance charges allocated to future periods	(14,330)	(15,801)	(14,330)	(15,801)
Net PFI, LIFT or other service concession arrangement obligation	**41,265**	**44,438**	**41,265**	**44,438**
- not later than one year;	3,078	2,538	3,078	2,538
- later than one year and not later than five years;	14,007	12,466	14,007	12,466
- later than five years.	24,180	29,434	24,180	29,434

Note 31.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**199,958**	**213,214**	**199,958**	**213,214**
Of which payments are due:				
- not later than one year;	19,245	19,358	19,245	19,358
- later than one year and not later than five years;	80,896	78,867	80,896	78,867
- later than five years.	99,817	114,989	99,817	114,989

Note 31.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Unitary payment payable to service concession operator	**32,805**	**30,580**	**32,805**	**30,580**
Consisting of:				
- Interest charge	2,657	4,861	2,657	4,861
- Repayment of balance sheet obligation	3,941	1,045	3,941	1,045
- Service element and other charges to operating expenditure	24,067	22,220	24,067	22,220
- Capital lifecycle maintenance	2,140	2,454	2,140	2,454
Total amount paid to service concession operator	**32,805**	**30,580**	**32,805**	**30,580**

The Trust paid £33,026k in the year which represents £6,354k in excess of the contractually committed amount. A significant amount of this excess relates to volume adjusters, that were not included in the initial contractual commitment. The Trust expects to incur a comparable spend in addition to the contractual liability presented above in the coming year.

Note 32 Financial instruments

Note 32.1 Financial risk management

The Trust's financial risk management activities are undertaken by the Treasury function, operating within parameters formally defined in approved policies and procedures and overseen by the Board of Directors. Treasury activities are subject to regular reporting and review, including scrutiny by internal and external auditors.

The Trust's financial instruments comprise cash and cash equivalents, borrowings, and routine operating balances such as trade receivables and payables. These instruments arise directly from the Trust's day-to-day activities. The Trust does not hold or issue complex financial instruments, nor does it engage in speculative trading.

Due to the nature of its funding arrangements and its ongoing service relationships with NHS commissioners, the Trust is not exposed to the same level of financial risk typically encountered by non-NHS entities.

The Trust has limited authority to borrow or invest surplus funds. Accordingly, financial assets and liabilities are generated through operational activity rather than being used to manage or alter the underlying financial risks associated with the Trust's core activities.

Liquidity Risk

The Trust's net operating costs are mainly incurred under legally binding contracts with commissioners, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long-term capital requirements through continuous monitoring of forecast and actual cash flows. The Trust currently has substantial cash balances and is not currently exposed to any liquidity risk associated with inability to pay creditors.

In addition to internally generated resources the Trust finances its capital programme through agreed loan facilities with the Independent Trust Financing Facility. The Trust has a working capital facility as at 31 March 2026 but has not drawn down against it.

Credit Risk

Credit risk exists where the Trust can suffer financial loss through default of contractual obligations by a customer of counterparty.

The policy reflects the position on the causes of debt, the implications of compliance and the need to identify trading counterparties correctly and the varied level of risk associated with them along with the requirement to maintain an adequate bad debt provision. The Trust maintains a bad debt provision rule set which is flexible and reflects the monthly movements on the sales ledger, however it also requires that a line by line review of items to be provided is carried out regularly.

Trade debtors consist of high value transaction with NHS England and ICB commissioners under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health and local authorities under contractual terms although these are subject to individual negotiation. Other trade debtors include private and overseas patients, spread across diverse geographical areas.

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

The majority of the Group’s revenue comes from contracts with other public sector bodies, thus the Trust has low exposure to credit risk. The maximum exposure of the Trust to credit risk is equal to the total trade and other receivables within Note 22.1.

The Trust reviews its exposure to credit risk on an annual basis, assessing historical recovery experience across different debtor categories. An allowance for expected credit losses is recognised for contract receivables that are more than 30 days past due. The level of provision is determined using management judgement, informed by historic recovery rates and the specific characteristics of the debtor population.

The increase in expected credit losses during the year is primarily driven by a rise in outstanding debtor balances, which have increased by 28% to £27.72m compared to the prior year at £26.96m. In comparison, expected credit losses have increased by 23% to £8.93m (2024/25 £7.91m), indicating an overall improvement in collection performance.

The Trust’s expected credit loss rates have improved across a number of debtor categories in 2025/26, including other non-NHS debtors, staff debtors (salaries), and private patient receivables. Notwithstanding these improvements, the Trust continues to experience challenges in the recovery of debts relating to overseas visitors, reflecting the higher level of credit risk associated with this debtor group.

Interest rate risk

The Trust's borrowings comprise fixed rate loans or interest free loans; the Trust is not therefore exposed to interest rate risk.

Note 32.2 Carrying values of financial assets (Group)

Carrying values and fair value of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	36,768	**36,768**
Cash and cash equivalents	117,590	**117,590**
Total at 31 March 2026	**154,358**	**154,358**

Carrying values and fair value of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	35,179	**35,179**
Cash and cash equivalents	143,460	**143,460**
Total at 31 March 2025	**178,639**	**178,639**

Note 32.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	36,756	**36,756**
Cash and cash equivalents	116,984	**116,984**
Total at 31 March 2026	**153,740**	**153,740**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	35,172	**35,172**
Cash and cash equivalents	142,369	**142,369**
Total at 31 March 2025	**177,541**	**177,541**

Note 32.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	30,658	**30,658**
Obligations under leases	6,798	**6,798**
Obligations under PFI, LIFT and other service concessions	41,265	**41,265**
Other borrowings	1,481	**1,481**
Trade and other payables excluding non financial liabilities	81,234	**81,234**
Provisions under contract	12,217	**12,217**
Total at 31 March 2026	**173,653**	**173,653**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	33,557	**33,557**
Obligations under leases	7,796	**7,796**
Obligations under PFI, LIFT and other service concessions	44,438	**44,438**
Other borrowings	2,925	**2,925**
Trade and other payables excluding non financial liabilities	85,874	**85,874**
Provisions under contract	13,562	**13,562**
Total at 31 March 2025	**188,152**	**188,152**

Note 32.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	30,658	**30,658**
Obligations under leases	6,798	**6,798**
Obligations under PFI, LIFT and other service concessions	41,265	**41,265**
Other borrowings	1,481	**1,481**
Trade and other payables excluding non financial liabilities	82,075	**82,075**
Provisions under contract	12,217	**12,217**
Total at 31 March 2026	**174,494**	**174,494**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	33,557	**33,557**
Obligations under leases	7,796	**7,796**
Obligations under PFI, LIFT and other service concessions	44,438	**44,438**
Other borrowings	2,925	**2,925**
Trade and other payables excluding non financial liabilities	85,676	**85,676**
Provisions under contract	13,562	**13,562**
Total at 31 March 2025	**187,954**	**187,954**

Note 32.6 Fair values of financial assets and liabilities

The book value of financial liabilities represents 81% of fair value. The difference is due to future interest costs for loan arrangements.
DH Loans book value £30,657k (fair value £34,947k), Commercial Loan book value £1,481k (fair value £1,502k), PFI book value £41,265k (fair value £55,594k) and lease book value £6,798k (fair value £7,315k)

Note 32.7 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	105,944	112,065	106,785	111,867
In more than one year but not more than five years	37,261	39,601	37,261	39,601
In more than five years	49,903	57,939	49,903	57,939
Total	**193,108**	**209,605**	**193,949**	**209,407**

Note 33 Losses and special payments

Group and trust	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	545	1,101	839	1,348
Stores losses and damage to property	25	344	50	342
Total losses	**570**	**1,445**	**889**	**1,690**
Special payments				
Ex-gratia payments	35	32	52	81
Total special payments	**35**	**32**	**52**	**81**
Total losses and special payments	**605**	**1,477**	**941**	**1,771**
Compensation payments received				

Losses and special payments are charged to the relevant headings on an accrual basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risk.

There were no individual cases over £300k in the year (2024/25 none).

Note 34 Related parties

The Trust is a public benefit corporation and has been authorised pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003. The Department of Health and Social Care is the parent department and the ultimate controlling party.

During the year none of the Trust board members or member of the key management staff, has undertaken any material transactions with the Trust other than receipts of employment benefits and accrual of entitlement to post-employment benefits. Remuneration of board members is disclosed in the remuneration report.

During the year the Trust has had a significant number of material transactions with the following Whole Government bodies. These entities are listed below for the year ending 31 March 2026. Further information on the extent of related party transactions contained in the income (Note 3.2), expenditure (Note 7.1), receivables (Note 23.1) and payables notes (Note 25.1). This list is indicative and not exhaustive:

– Department of Health and Social Care NHS England (Parent)

– NHS England

– NHS Integrated Care Boards including:
NHS North West London ICB
NHS South East London ICB
NHS South West London ICB

– NHS Foundation Trusts and NHS Trusts including:
Imperial College Healthcare NHS Trust

– Other NHS bodies including:
NHS Pension Scheme
NHS Resolution

– Other non-NHS entities:
HM Revenue and Customs

During the year an entity (Travill Construction Ltd) related to a Trust Board member had transactions with the Trust to the value of £98k (£464k 2024/25).

In addition to the above the Trust has a number of transactions with CW+ (the official charity partner of the Trust) and Imperial College Health Partners {Academic Health Science Network for North West London} (ICHP).

	Revenue	Expenditure	Revenue	Expenditure
	2025/26	2025/26	2024/25	2024/25
	£000s	£000s	£000s	£000s
Value of balances with other related parties:				
Charitable Funds	2,165	196	2,129	403
Other bodies or person outside of the whole government bodies	6,005	282	5,649	614
	8,170	**478**	**7,778**	**1,017**

	Receivables	Payables	Receivables	Payables
	2025/26	2025/26	2024/25	2024/25
	£000s	£000s	£000s	£000s
Value of balances with other related parties:				
Charitable Funds	333	1	-	60
Other bodies or person outside of the whole government bodies	808	6	833	23
	1,141	**7**	**833**	**83**

Note 35 Events after the reporting date

None

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