



QUALITY ACCOUNT

2025/26



**PROUD
TO CARE**



Chelsea and Westminster Hospital
NHS Foundation Trust

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PART 1

WELCOME AND OVERVIEW

Statement from the Chief Executive

It is with great pride that I present the 2025/26 Quality Account 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, 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, with long waits continuing to fall. 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, development has progressed on the Diagnostic, Treatment and Education Centre (DTEC), a major new facility scheduled to open later in 2026. 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:

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

Our vision

The Trust is committed to consistently delivering the highest quality of care and outcomes for our patients.

Our priorities

Our Trust strategic priorities have remained the same as the previous year:

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

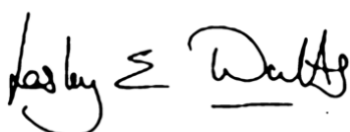
Patients, their friends, family and carers will be treated with unfailing kindness and respect by every member of staff in every department, and their experience and quality of care will be second to none.

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: financial and human, including staff, partners, stakeholders, volunteers and friends.



Lesley Watts
Chief Executive Officer

Our Trust

Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) is one of the top ranked and top performing hospital trusts in the UK. We employ over 7,000 staff across our two main hospital sites, Chelsea and Westminster Hospital (CW) and West Middlesex University Hospital (WM), including a number of community-based clinics within North West London.

The Trust delivers specialist and general hospital care at Chelsea and Westminster Hospital and West Middlesex University Hospital. Both hospitals have major A&E departments, and the Trust provides one of the largest maternity services in England.

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

We are active partners in the North West London Integrated Care System (ICS), which brings together all parts of the NHS and local authorities to focus on improving the health of the local population. We have exercised our functions in accordance with the plans of the Integrated Care Board (ICB) that governs the ICS and have worked in partnership in developing any joint capital resource plans in accordance with NHS England's guidance on good governance and collaboration.

Within the ICS, we are part of the North West London Acute Provider Group (APG), formerly the North West London Acute Provider Collaborative (APC), along with Imperial College Healthcare NHS Trust (ICHT), The Hillingdon Hospitals NHS Foundation Trust (THH) and London North West University Healthcare NHS Trust (LNWUH). The group is focused on reducing health inequalities for patients accessing acute care across North West London by developing joint clinical pathways and providing mutual aid.

The Trust serves a catchment area in excess of one million people in the following areas:

- Brent
- Central London
- Ealing
- Hammersmith and Fulham
- Harrow
- Hillingdon
- Hounslow
- Kensington and Chelsea
- Richmond
- Wandsworth
- West London

The Trust also serves wider populations in London and nationally who use some of the national services that we provide.

We also have a series of contractual, system management and other partnership arrangements with respective local authorities. This includes membership and reporting arrangements to health and wellbeing boards and overview and scrutiny committees.

We have established our partnership duties through a series of accountability and reporting mechanisms to local Healthwatch groups, the statutory patient representative organisations.

Building on our existing strategic partnerships, the APC formally came together as the North West London Acute Provider Group (APG), with Professor Tim Orchard taking on the role of Group Chief Executive and accountable officer across all four trusts from 1 April 2026. The new leadership model aims to increase joined-up decision making for local people, improve care, share best practice and expertise, and make better use of NHS resources.

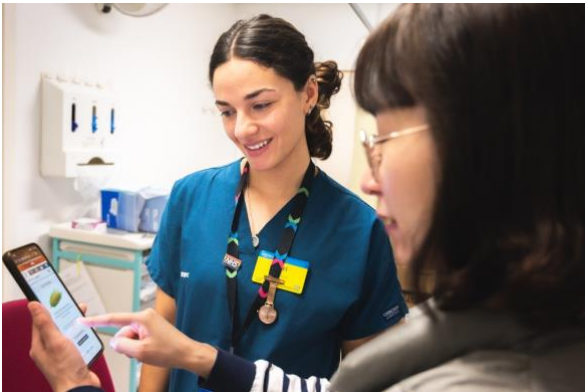
Key facts and figures

	2021/22	2022/23	2023/24	2024/25	2025/26
Outpatient attendances (excluding sexual health and private patients)	795,583	777,916	806, 884	859,639	839,624
Emergency Department (A&E) attendances	335,374	348,754	269,256	314,005	319,595
Inpatient admissions	138,448	153,670	164,721	164,448	158,708
Babies delivered (excluding private patients)	10,066	9,740	10,458	9,839	9,608
Patients operated on in our theatres	13,526	25,102	30,457	29,779	29,824
X-rays, scans and procedures carried out by clinical imaging (excluding private patients)	450,240	455,334	457,364	514,614	544,909
Total average number of employees (WTE basis)	7,174	7,365	7,510	7,168	7,756

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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

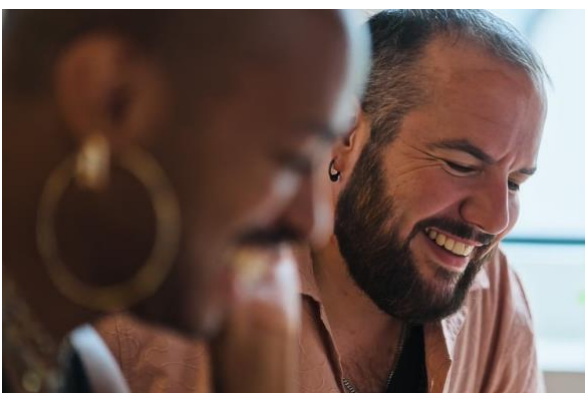


We were recognised nationally as an AI exemplar supporting patient care during a government visit.



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.

Achievements to highlight

Cardiac virtual ward

A project to transform care for cardiac patients using digital technology won national recognition for Chelsea and Westminster Hospital NHS Foundation Trust through being awarded the Harold Thimbleby Award for Digital Transformation at the Royal College of Physicians' Excellence in Patient Care Awards.

The Trust's pioneering "virtual ward" programme was recognised for its success in improving outcomes and inclusion for patients with chronic cardiac conditions, while easing hospital pressures and improving efficiency.



Team members said the award "represents a huge amount of work with patients, staff and other trusts."

The project used digital tools—including smartphone apps, remote monitoring systems and digital health records—to manage patients with atrial fibrillation, heart failure and chest pain safely at home. The model, co-designed with patients, staff and local partners, has improved therapy optimisation, reduced length of stay and supported access to care via digital literacy programmes in the community.

This recognition highlights the innovation demonstrated in reshaping care for patients with cardiac conditions. By utilising digital technology, the project has enabled the delivery of safer, more personalised care to thousands of patients, supporting them to stay well at home.

Thrombosis Prevention and Management

The cross-site, multidisciplinary anticoagulation and thrombosis team achieved the highly commended Thrombosis UK VTE (venous thromboembolism) award for their 'Excellent quality improvement programme advancing practice in thrombosis prevention and management', which was presented to the team at the House of Commons in May 2025.



Anticoagulation and Thrombosis Team at the House of Commons

Some highlights of the QI programme include:

- Compliance with national VTE performance metrics
- Monthly feedback on VTE risk assessment performance with quarterly audits on the prescribing and administering of appropriate thromboprophylaxis, and a VTE dashboard to disseminate actions, key messages and shared learning
- Monthly feedback on anticoagulant incidents with shared learning for each staff user group
- A dashboard for hospital-associated VTE events, and implemented actions to prevent potentially preventable hospital-associated VTE events
- Optimisation of the Trust digital system for safe anticoagulant prescribing, administration, monitoring and documentation across North West London
- Anticoagulation system-wide changes across healthcare settings
- More than 45 user-friendly, functional VTE clinical guidelines, including infographics and pocket guides
- Specific patient information leaflets for various blood clot conditions, supporting education and awareness
- VTE stewardship delivering a local VTE prevention programme
- National recognition via 'VTE Exemplar Centre' status

Furthermore, following an external assessment, which the Trust passed, we are now a 'Centre of Excellence' for anticoagulation.

The rigorous assessment gave us the chance to measure our clinical practice against five key areas of patient care. Participation in this programme demonstrates the Trust's ongoing ambition to achieve the highest level of care and the best possible outcomes for our patients on anticoagulation.

Augmented Reality for endometriosis care

The hospital has become the first NHS trust to deploy augmented reality technology, enabling patients and clinicians to view large-scale, anatomically precise 3D models. This innovative approach helps clinicians explain diagnoses and disease progression more clearly, while supporting patients to better understand what is happening inside their bodies.

Developed by Medical iSight, the technology is intended to improve patient understanding of complex women's health conditions, including deep infiltrating endometriosis, endometrioma (ovarian cysts due to endometriosis) and uterine fibroids.

Offering exceptional visual quality, it provides patients with a clear, detailed view of internal organs—making complex information feel approachable and supporting confident, informed decision-making. By guiding patients through a sequence of advanced 3D anatomical models, clinicians can illustrate the structural changes caused by various conditions with meticulous clarity.



Augmented Reality in endometriosis

During a pre-surgery appointment, patients can explore a spatial representation of internal anatomy, including key areas affected by inflammation and scar tissue such as the ovaries, bowel or uterus. At the same time, clinicians can view and interact with the same model from their computer, highlighting and enlarging specific regions to show the impact of the disease. This allows them to show precisely which areas of endometriosis will be excised during surgery.

Funded by the Trust's official charity, CW+, and the Friends of Chelsea and Westminster Hospital, the project was first piloted in 2025 and has now been introduced as standard practice to support clinicians during consultations.

Cardiology Physiologist-Led Valve Clinic

We also launched a new physiologist-led valve clinic, offering patients faster access to specialist assessment and earlier diagnosis for heart valve disease. The service, which opened in February 2026, is expected to benefit 200–250 patients across both hospital sites in its first year, increasing to 400–500 patients annually as capacity grows.

Heart valve disease is common, affecting around 2.5% of adults and more than 10% of people over 75. This equates to over 1.6 million people over 65 currently living with the condition nationally, with numbers projected to double by 2046 and rise further to 3.3 million by 2056.

Until now, many patients faced long waiting times, fragmented investigations and variable follow-up. The Trust's new Valve Clinic creates a streamlined, guideline-driven pathway, ensuring patients receive earlier assessment, structured surveillance and timely referral for intervention when needed.

First-in-Human Trials for Ebola, Marburg and Lassa Vaccines

The Trust, alongside Imperial College London, launched a first-in-human clinical trial, EML-Vac, to test three new vaccines targeting Ebola, Marburg and Lassa fever. The study is led by Professor Robin Shattock (Imperial) and Dr Marta Boffito (Chelsea and Westminster). The study aims to check whether these vaccines are safe and whether they trigger an immune response.

The vaccines use self-amplifying RNA (saRNA) technology, which can be developed and manufactured more rapidly than traditional approaches. Each vaccine targets the glycoproteins of the respective viruses and is delivered using lipid nanoparticles. The trial will assess safety and immune responses, with vaccines being tested both individually and in combination.

Recruitment is currently underway for healthy volunteers aged 18–50, with the study taking place at Chelsea and Westminster Hospital and sponsored by Imperial.

Quality Awards and Recognition 2025/26

HSJ Digital Awards

Our teledermatology team were awarded the Digital Clinical Safety Award at the HSJ Digital Awards in June 2025 for Demonstrating the Clinical Safety of AI-powered Teledermatology: Transitioning from Pilot to Sustainable Standard Practice. The pathway has safely discharged 2,600 patients and helped the Trust to avoid 95 per cent of urgent face-to-face appointments, freeing up dermatology capacity for those with skin cancer.



Trust colleagues at the HSJ awards

The Trust was also recognised as a finalist across multiple categories:

- **James Bird:** Finalist, Digital Leader of the Year
- **Best For You (CNWL, CWFT, West London and CW+):** Finalist, Improving Mental Health Through Digital
- **NWL APC:** Finalist, Improving Medicines Management and Pharmacy for work on Therapeutic Duplicate Prescribing Alerts for Analgesia and Anticoagulants
- **Teledermatology team:** Finalist, Unlocking Productivity and Efficiency Through Digital

This is a true testament to the innovation, collaboration and impact we're delivering through digital. This recognition highlights the strength of our partnerships and our teams' commitment to safe, effective and transformative digital healthcare.

HSJ Patient Safety Awards

West London Children's Healthcare (WLCH) brings together acute and specialist services for almost 500,000 children across Chelsea and Westminster Hospital NHS Foundation Trust and Imperial College Healthcare NHS Trust.

The project, using Dosium's Touchdose solution, is funded through NHS England's first-of-type scheme and will allow prescribers to access detailed patient-specific dosing recommendations instead of manually working them out—a stressful and error-prone process.

West London Children's Healthcare and Dosium were shortlisted as finalists at the HSJ Patient Safety Awards 2025 in recognition of their outstanding commitment to improving patient safety. This came after a rigorous judging process by a panel of healthcare leaders and patient safety experts. WLCH has been recognised in the "Safety improvement through technology" category for its work, together with Dosium, which has reduced prescribing errors by an average of 83%—from 7.1% to 1.2%.

London Maternity and Neonatal Excellence Awards

Our maternity service was recognised in three categories at the London Maternity and Neonatal Excellence Awards in October 2025. The Maternity and Neonatal Voices Partnership (MNVP) was Highly Commended in the Service User Partnership category for its commitment to inclusive engagement and innovative feedback methods, which have amplified service user voices.

Their work has contributed to nationally shared resources, enhanced postnatal support and service improvements that prioritise compassion, quality and patient safety.



Trust maternity colleagues at the LMNS awards

The service was also shortlisted in the Excellence in Quality and Safety category for the Escalation Toolkit project. This initiative has empowered maternity and neonatal staff to escalate clinical concerns with confidence, supporting safer care across our services.

In addition, as part of the North West London Local Maternity and Neonatal System, the Trust was shortlisted in the Innovation in Care category for the North West London Maternity Trauma and Loss Care (MTLC) service.

This trauma-informed specialist service provides collaborative, multidisciplinary support for perinatal mental health, ensuring compassionate care for those experiencing trauma and loss.

Capital CSW Awards—celebrating excellence

In November 2025, the Trust joined the Capital Clinical Support Worker (CSW) Awards, which saw over 600 nominations across London, including 50 from Chelsea and Westminster.

We are thrilled to share that our teams and individuals were recognised in several categories:

- **CSW Innovator of the Year:** Tatiana Nadeena and Tamanna Karim
- **Allied Health Professions:** Marie Felix
- **Maternity Support Worker:** Amanda Brewster
- **Apprentice CSW of the Year:** Sokhna Diop, Daniel Nicholas Rabonos, Velencia Barreto, Wing Sze Yui
- **Healthcare Support Worker:** Daniel Rabino, Catie-Dee Perkins, Kendie Steele
- **CSW Team of the Year:** 56 Dean Street

Our Apprenticeships Team also won the award for Widening Participation & Collaboration, and Cess Quiambao was named Highly Commended Leader. A special mention goes to Gloria Soares, who received a Chief Nursing Officer Award for her outstanding contribution to patient care and for being an inspiring role model for HCSWs across the Trust

Global Top 30 Improvers Award

In December 2025, the North West London Acute Provider Collaborative (APC) introduced a unified guideline for recognising and responding to patient deterioration and sepsis across four acute trusts. The initiative has been shortlisted in the Best Cross-Organisation Collaboration category of the Global Top 30 Improvers Awards.

Launched to mark the 30th anniversary of the International Forum on Quality and Safety in Healthcare, the Global Top 30 Improvers Awards recognise individuals and teams leading meaningful change and shaping the future of healthcare improvement worldwide.

The Best Cross-Organisation Collaboration category celebrates projects that work across organisational, sector and geographical boundaries to improve quality and safety.

Previously, there were variations between hospitals in how deteriorating patients were identified, how quickly care was escalated and how patients and families were involved. These differences reflected local systems and processes rather than clinical need.

In December 2025, the APC launched a unified, system-wide pathway across all four trusts. The new approach:

- Sets clear and consistent escalation thresholds
- Defines expected clinical response times
- Is embedded directly into the shared electronic health record
- Supports structured assessment and time-bound senior review
- Enables consistent reporting, monitoring and audit

These changes ensure patients receive the same high standard of care wherever they are treated in North West London. Most importantly, the system helps identify the sickest patients quickly and supports faster access to higher levels of care, reducing the risk of preventable harm. Trusts aligned policies, workflows and governance arrangements to move beyond individual organisational approaches and deliver system-wide improvement.

Arts programme in The Lancet

Congratulations to Rebecca Goss, whose account of her CW+ Writer-in-Residence role based at West Middlesex University Hospital has been published in The Lancet. In her article, Rebecca describes how poetry opened the door to conversations about love, family, memory and everyday life—offering patients a moment away from treatment and worry. Her residency is part of the charity’s wider ‘Arts for All’ programme, bringing creativity and arts into our hospitals to support and enhance patient wellbeing.

PART 2.1

PRIORITIES FOR IMPROVEMENT

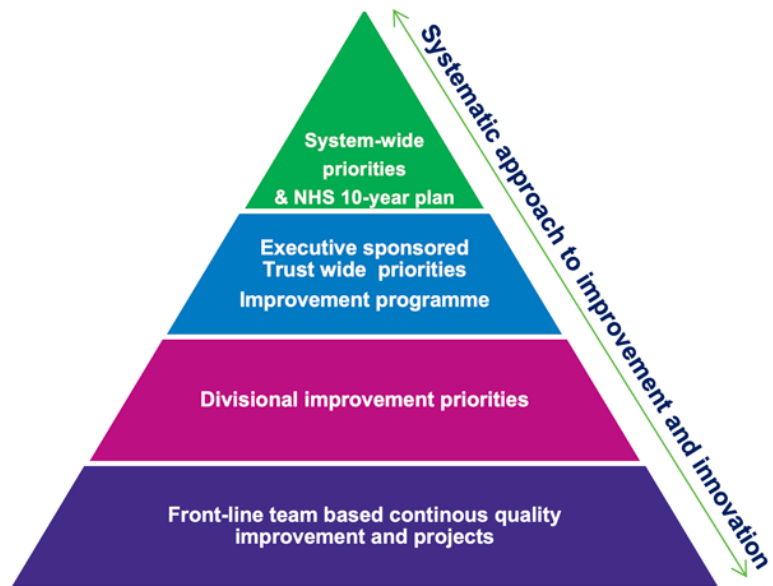
This section provides an overview of our approach to quality improvement, our improvement priorities for the upcoming year and a review of our performance over the last year. We are proud of our quality and safety culture and our ongoing focus on improvement and innovation to drive best practice.

Our culture of improvement and innovation

The Trust operates an ambitious quality improvement programme. Our well-embedded improvement process is based around the Trust PROUD values and an improvement framework.

We have a dedicated quality improvement team that works to support colleagues to develop ideas, grow their skills and deliver change to improve patient care.

We want all staff to feel part of a culture where new ideas and ways of thinking are encouraged and supported.



RIQI

During the last financial year, we have focused on growing collaboration between research, innovation and quality improvement (RIQI).



RIQI is a shared approach to working with colleagues and services to improve health outcomes, increase clinical effectiveness, enhance patient experience and translate learning into better outcomes for everyone.

We want all staff to get involved with RIQI, and some of the ways we support our organisation to continue developing include:

- Running a comprehensive RIQI learning and development programme to grow skills and capabilities across the organisation at all levels.
- Creating opportunities for staff to share learning, ideas and successes through a range of communication channels and events. For example, we hold an annual RIQI event where staff showcase their work and publish a regular bulletin for all staff to celebrate achievements and inspire future projects.
- Working with our patients and communities to co-produce improvements and research projects, leading to better outcomes for all who use our services.

Alongside the RIQI programme, the annually set quality priorities help deliver the Trust's quality strategy: 'quality priorities delivered and supported by a systematic improvement method', and are agreed as part of business planning each year.

They align with one or more of the Trust's three strategic objectives and triangulate with areas where the greatest opportunities for improvement exist, based on a review of improvement opportunities using sources including Getting It Right First Time (GIRFT), Model Hospital, and themes from claims, incidents, complaints and Friends and Family Test (FFT) data.

Getting It Right First Time (GIRFT) Programme

Getting It Right First Time (GIRFT) is a clinically led national improvement programme that supports trusts to reduce unwarranted variation, improve patient outcomes and make better use of NHS resources. During 2025/26, Chelsea and Westminster Hospital NHS Foundation Trust has continued to strengthen its GIRFT delivery model, moving from engagement and planning to demonstrable implementation and impact. GIRFT is now firmly embedded within divisional governance and quality improvement arrangements, supporting the Trust's priorities around elective recovery, high-quality patient-centred care and delivering better care at lower cost.

The Trust has delivered sustained progress across medical, surgical and cross-cutting specialties, with over half of all GIRFT recommendations now either completed or actively implemented, demonstrating tangible changes in clinical practice rather than intention alone. GIRFT peer, gateway and system reviews have been used systematically to benchmark services, identify variation and prioritise opportunities for improvement. Actions arising from these reviews are now routinely tracked and reviewed through structured divisional governance, supporting consistency and accountability across the Trust.

Growth in active GIRFT workstreams compared with the previous year reflects both increased maturity and broader clinical engagement, enabling a more comprehensive and coordinated response to national best practice recommendations. GIRFT plays a central role in driving quality, supporting elective recovery and strengthening financial and operational sustainability, with a strong platform in place to build on improvements in the year ahead.

CW Innovation is a partnership jointly led by CW+ (the Trust's charity) and Chelsea and Westminster Hospital NHS Foundation Trust. It supports the development of a culture of innovation across the Trust, incubates new ideas and ways of working, and provides a testbed for innovative technologies developed by digital health companies.

The programme comprises two Innovation Business Partners, both experienced clinicians—a respiratory physiologist and a musculoskeletal physiotherapist—as well as a Head of Innovation. The team is managed directly by the Director of Digital Operations and Innovation.

CW Innovation is now in its seventh year of partnership with the Trust and continues to:

- **Support and embed a culture of innovation:** During 2025/26, we recruited a fourth cohort of 15 CW Innovation Fellows, bringing the total number of Fellows across all cohorts to over 90. More than 75% of Fellows have completed their projects, which have included the development of a virtual atrial fibrillation pathway for cardiology patients, a voice AI post-operative follow-up programme for cataract patients, and a home-based sleep apnoea diagnostic service. In addition, we delivered our first CW Innovation Associate, a graduate of the CW Innovation Fellowship programme and a Trust midwife, who led a programme of work to develop and deploy VR and AR projects across services. Over a 12-month period, the Associate identified more than 26 potential projects.
- **Deploy projects and programmes:** AI remained a major theme for the Trust and CW Innovation during 2025/26. An evaluation of Dora AI, a voice-enabled AI agent supporting waitlist validation, pre-assessment, post-operative follow-up and the collection of patient-reported outcome measures, demonstrated a saving of over 200 hours of clinician time per year. We also initiated a multi-Trust evaluation of ambient voice AI scribe technology involving Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust and London North West University Healthcare NHS Trust. This nine-month evaluation involved more than 100 clinicians and 18,000 consultations. A procurement process is now underway to secure an ambient voice solution for the benefit of clinical teams across the Acute Provider Group.
- **Build productive partnerships:** Our partnership with the NHS InSites programme continued to provide opportunities to raise awareness of innovation work delivered at the Trust. In November, a presentation at BMJ Future Health focused on the implementation of Skin Analytics dermatology AI at the Trust and, in March, the team presented at Rewired on the challenges of rolling out AI in busy clinical services. Our partnership with GE Healthcare continued to support the development of new research activity, including projects on wireless ECG technology. In addition, partnerships with early-stage digital health companies enabled a fully funded evaluation of home-based lipid diagnostic testing across the London Borough of Hounslow.

In the coming year, the team's focus will be on supporting the Trust to deliver the ambitions set out in the NHS 10-Year Plan. We will continue to invest in our Culture of Innovation workstream and, by leveraging existing and emerging partnerships, seek out transformative new technologies and drive performance.

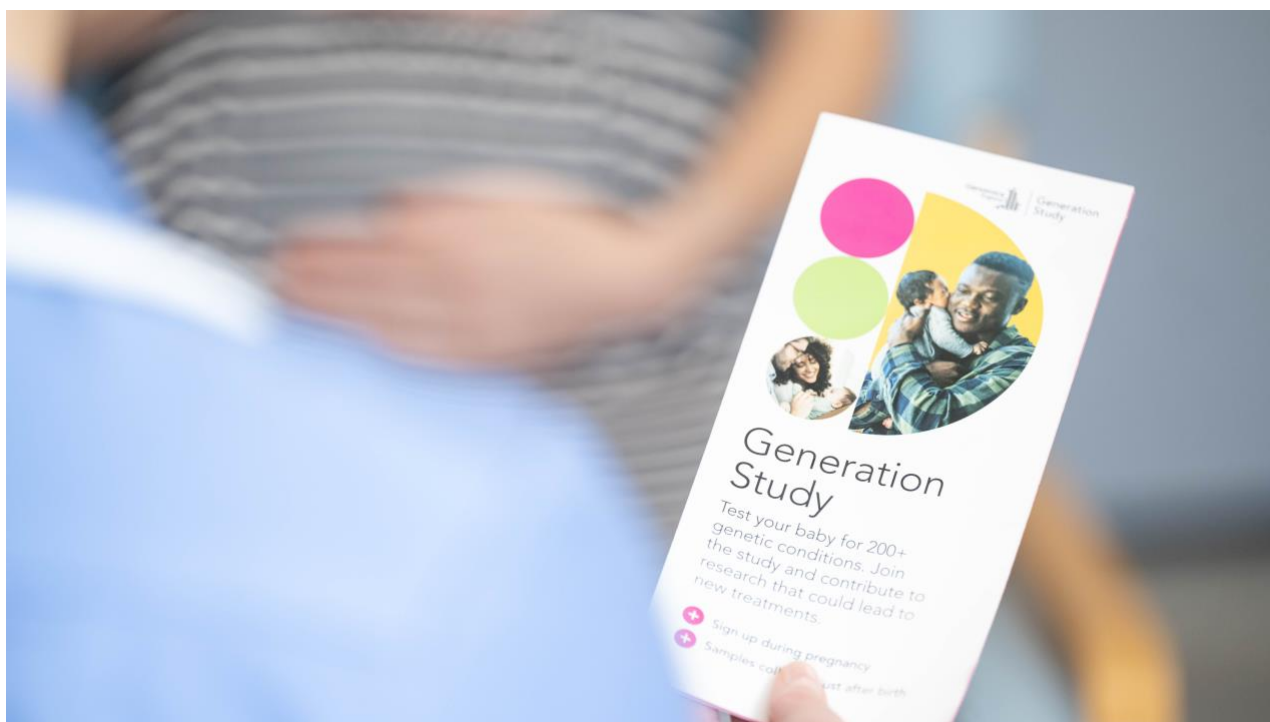
Research and Development

Research is essential in gaining a clearer understanding of disease and how it is best managed. New treatments, technologies, care approaches and devices all need to be carefully and safely tested in real-life healthcare environments. The Trust delivers a wide portfolio of research studies covering the breadth of our clinical practice.

A Clinical Research Oversight Committee (CROC) was established in April 2025 and meets quarterly. The purpose of the CROC is to ensure that the Trust Executive is informed of any issues relating to the conduct of clinical trials.

The Research Department is responsible for the management, support and leadership of all aspects of research across the Trust. It facilitates access to Trust resources and infrastructure for research by internal and external researchers, sponsors, patients and the public.

Below is one example of the team's involvement in supporting preventative healthcare:



The Generation Study

The study, led by Genomics England in partnership with NHS England, remains open for recruitment until the end of 2026, aiming to screen up to 100,000 newborns in England for more than 200 rare but treatable conditions.

At the end of the 2025/26 financial year, the Trust had enrolled 2,440 babies into the study—1,528 at Chelsea and Westminster Hospital and 912 at West Middlesex University Hospital. More than 1,721 samples had already been collected across the Trust from blood taken from newborns' umbilical cords shortly after birth. This pioneering research aims to identify rare conditions earlier, enabling timely diagnosis and treatment that could slow disease progression or improve—and in some cases extend—a child's life.

Research activity in 2025/26

The number of patients receiving relevant health services provided or subcontracted by Chelsea and Westminster Hospital NHS Foundation Trust in 2025/26 who were recruited during that period to participate in research approved by a research ethics committee was 4,384. Of these, 3,992 were recruited into National Institute for Health and Care Research (NIHR) non-commercial portfolio-adopted studies and 392 into commercial studies.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer, making our contribution to wider health improvement, and ensuring our clinical staff stay abreast of the latest treatment possibilities. Through the Participant Research Experience Survey (PRES), the Trust also gathers feedback from research participants. This is used to support high-quality participant safety and data integrity. In 2025/26, 185 PRES responses were completed.

The Trust recruited participants into 110 NIHR portfolio-adopted research studies in 2025/26 across multiple specialties. Over the last year, 506 publications have resulted from our involvement in research and audits, reflecting our commitment to transparency and our desire to improve patient outcomes and experience across the NHS.

In line with the Trust's ambition to broaden access to research and embed research activity across the full patient pathway, a Community Research Centre (CRC) at the Meadows Health Centre in Hounslow was established in 2025/26. The CRC has successfully begun delivering its first clinical trial, which is progressing well, demonstrating early proof of concept for community-based research delivery and effective partnership working with primary care. This marks a transition from strategic planning to tangible delivery and supports the Trust's longer-term objective to expand research activity beyond the acute hospital setting into community and primary care environments.

Our Quality Priorities for 2026/27

In establishing the Trust Quality Priorities for the year, consideration was given to the definition of quality and the requirement to address health inequalities. Therefore, in addition to the Trust strategic priorities and objectives, quality priorities also align to one or more of the following:

- Patient safety
- Patient experience
- Clinical effectiveness
- Addressing health inequalities

The Quality Priorities have been selected through a review of improvement opportunities, looking at triangulation of data sources such as GIRFT, Model Hospital, top themes from claims, complaints and incidents, and national audit data. Additional consideration was given to the improvement work that is happening as a collaborative, national priorities and existing locally identified improvements within the divisions.

Each priority has been aligned to a division to act as the lead for implementation of the quality priority, in addition to local improvement initiatives within the divisions. Progress on the delivery of the Trust's quality priorities will be monitored on a quarterly basis through reporting to the Executive Management Board and the Trust Standing Committee. We are

committed to focusing on these priorities to best improve the quality of care, patient experience, and the environment and culture within which our staff work.

In addition to our quality priorities, we are also working with our partner trusts in the North West London Acute Provider Group (APG), including Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundation Trust, on a number of priority areas where there is an opportunity to improve care.

The APG 2026/27 quality priorities focus firstly on optimising antimicrobial selection, route and clinical appropriateness, and delivering the requirements of the national action plan for antimicrobial resistance.

The priority to implement the joint reporting and management system is continuing from 2025/26. This programme will be delivered by July 2026, when the new system will go live, and will thereafter be stepped down as a priority. The next priority seeks to support system-wide delivery of the national HCAI reduction programmes through the effective use of a shared electronic surveillance platform. The final priority focuses on improving the safety and timeliness of inter-hospital transfers.

Progress against these priorities will be reported monthly to the APG Executive Management Board and quarterly to the APG Quality Committee for assurance.

For Chelsea and Westminster Hospital NHS Foundation Trust, we have set seven Quality Priorities for 2026/27.

1. Infection Prevention and Control (IPC)

Why we have chosen this as a quality priority

Infection Prevention and Control remains fundamental to patient safety and staff wellbeing. Analysis of Trust data shows higher-than-expected rates of healthcare-associated infections, including *Clostridioides difficile* and MRSA, with variation across sites and performance in the lower national quartile. Preventing avoidable infection reduces patient harm, length of stay and risk of mortality, while also improving experience and operational resilience. This priority aligns with national patient safety expectations and addresses unwarranted variation across the Trust.

What we aim to achieve in 2026/27

During 2026/27, we aim to reduce hospital-acquired infections through strengthened prevention, surveillance and assurance. This will include consistent application of evidence-based IPC practices, improved grip on variation between sites, and enhanced learning from incidents. The focus will be on delivering sustainable improvement rather than short-term reductions.

Key Deliverable	Due Date
Implement site-specific IPC improvement plans targeting HCAI reduction	Q1 2026/27
Strengthen surveillance and reporting of MRSA and <i>C. difficile</i>	Q2 2026/27
Deliver refreshed IPC training and compliance monitoring	Q3 2026/27
Demonstrate sustained reduction in HCAI rates and variation	Q4 2026/27

2. Pressure Ulcer Prevention

Why we have chosen this as a quality priority

Pressure ulcers are largely preventable and remain a significant cause of avoidable patient harm. They contribute to pain, infection risk, delayed recovery and increased length of stay. Reducing hospital-acquired category 3 and 4 pressure ulcers is a national patient safety priority and an indicator of fundamental nursing care quality.

What we aim to achieve in 2026/27

The Trust aims to eliminate hospital-acquired category 4 pressure ulcers and significantly reduce category 3 pressure ulcers. This will be achieved through consistent risk assessment, evidence-based prevention, improved documentation and strengthened learning from incidents to embed best practice across all inpatient areas.

Key Deliverable	Due Date
Refresh Trustwide pressure ulcer prevention standards	Q1 2026/27
Improve compliance with risk assessment and repositioning documentation	Q2 2026/27
Targeted ward-level improvement in high-risk areas	Q3 2026/27
Achieve zero hospital-acquired category 4 pressure ulcers	Q4 2026/27

3. Antimicrobial Stewardship

Why we have chosen this as a quality priority

Optimising antimicrobial prescribing is essential to patient safety, clinical effectiveness and tackling antimicrobial resistance. Inappropriate antimicrobial use exposes patients to avoidable harm and contributes to resistance. This priority aligns with the UK Antimicrobial Resistance Action Plan and focuses on safer, more standardised prescribing practice.

What we aim to achieve in 2026/27

In 2026/27, the Trust aims to reduce unnecessary antimicrobial exposure by improving appropriate antibiotic selection, including a shift towards first-line ('Access') antibiotics—narrower-spectrum agents used for common infections and associated with lower resistance risk—where clinically appropriate, increasing IV-to-oral step-down, and reducing inappropriate broad-spectrum use. Standardised management of key invasive infections will improve outcomes and consistency of care.

Key Deliverable	Due Date
Increase proportion of 'Access' antibiotic use	Q2 2026/27
Improve compliance with IV-to-oral step-down criteria	Q2 2026/27
Standardise treatment pathways for key invasive infections	Q3 2026/27
Reduce inappropriate broad-spectrum prophylactic prescribing	Q4 2026/27

4. Reducing Noise at Night

Why we have chosen this as a quality priority

Patient feedback from the CQC National Inpatient Survey has highlighted night-time noise as a significant detractor from rest and recovery. Poor sleep negatively affects patient experience, healing and wellbeing. Addressing noise at night demonstrates responsiveness to patient feedback and supports compassionate, patient-centred care.

What we aim to achieve in 2026/27

We aim to improve patient-reported sleep quality by reducing avoidable noise at night through environmental, behavioural and process changes. Improvement will focus on sustainable ward-level practice and measurable experience outcomes.

Key Deliverable	Due Date
Identify key sources of night-time noise across wards	Q1 2026/27
Implement ward-based “quiet at night” interventions	Q2 2026/27
Embed staff awareness and behavioural standards	Q3 2026/27
Improve patient-reported sleep measures and CQC survey results	Q4 2026/27
Monitor feedback from FFT survey questions	All quarters

5. Reducing Inequalities in Early Antenatal Booking

Why we have chosen this as a quality priority

Black and Brown women are more likely to book later in pregnancy, limiting access to early screening, risk assessment and personalised care. Late booking contributes to inequality in maternal and neonatal outcomes. Improving early antenatal engagement supports the Maternal Care Bundle and Core20PLUS5 ambitions.

What we aim to achieve in 2026/27

The Trust aims to increase the proportion of women from target groups booking by 9+6 weeks, reducing unwarranted variation and improving early access to appropriate maternity care. This will be achieved through community engagement, partnership working and targeted service improvement.

Key Deliverable	Due Date
Analyse barriers to early booking in target populations	Q1 2026/27
Strengthen community outreach and referral pathways	Q2 2026/27
Improve timely access to screening and personalised care	Q3 2026/27
Demonstrate reduction in late booking among target groups	Q4 2026/27

6. NatSSIPs2 Implementation

Why we have chosen 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.

What we aim to achieve in 2026/27

Variation in Local Safety Standards for Invasive Procedures (LocSSIPs) and limited digital integration present risks to patient safety. Continuing this programme for a second year will support safer care, learning and alignment across the Acute Provider Group. We aim to harmonise and digitise LocSSIPs, improving compliance, assurance, oversight and consistency across services, and strengthening safety during invasive procedures.

Key Deliverable	Due Date
Review and standardise Trust LocSSIPs	Q1 2026/27
Progress digitalisation and IT integration	Q2 2026/27
Strengthen assurance and compliance monitoring	Q3 2026/27
Demonstrate improved procedural safety outcomes	Q4 2026/27

7. Paediatric Deteriorating Patients (NPEWS)

Why we have chosen this as a quality priority

Following implementation of the National Paediatric Early Warning Score (NPEWS), system-wide oversight is required to ensure it delivers improved recognition and response to deterioration. This aligns with national patient safety initiatives, including Martha's Rule, and addresses learning from incidents, audits and PSIRF investigations.

What we aim to achieve in 2026/27

In 2026/27, we aim to embed NPEWS consistently, strengthen escalation and response to deterioration, and reduce unwarranted variation. Shared learning across North West London will improve safety and outcomes for children.

Key Deliverable	Due Date
Establish NWL Paediatric Deteriorating Patient Group	Q1 2026/27
Monitor NPEWS compliance and clinical outcomes	Q2 2026/27
Review sepsis, escalation and ED triage alignment	Q3 2026/27
Use audit and PSIRF learning to demonstrate improvement	Q4 2026/27

Our Quality Priority achievements in 2025/26

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. These focused on the following areas:

- Feeling Safe at Work
- Reducing medication incidents with moderate harm or above
- Single Delivery Plan
- Dementia
- Implementation of NatSSIPs2
- Deteriorating Patient (SEPSIS)
- Deteriorating Patient (PEWS)

Priorities were identified through engagement with multiple stakeholder groups, including:

- Engagement and feedback from our Council of Governors and 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 made against our 2025/26 quality priorities. Although not all ambitions were fully realised, the Trust has continued to deliver year-on-year improvements to services, promoting better quality of care. A 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 was to reduce the incidence and impact of violence and aggression experienced by staff by strengthening prevention, early identification and response. This included 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 aimed 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 the number of champions 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 an MDT review process for serious incidents where sanctions may be required. 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 ensuring patient safety, reducing prolonged hospital admissions, improving the quality and safety of care provided and improving patient health outcomes.

The Trust therefore selected reducing medication incidents with moderate harm and 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 included 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 was 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 and above held at 0.5% year to date, consistently below the Trust target of $\leq 1\%$. 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 Trust-wide 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 had 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.

A key development was the implementation of a real-time Omitted Doses Dashboard, supporting earlier identification and action where critical medications had 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 quality priority helped 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.

More than 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.

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 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 implementation. This includes securing approval of the baseline checklist through the APG NatSSIPs2 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 2024/25, key focuses were the full implementation of Martha's Rule and expanding our work on the 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, system-wide approach to identifying and managing deterioration, aligned to national guidance and the Acute Provider Group 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 was to deliver a consistent, system-wide approach to the early recognition, escalation and management of deteriorating patients and sepsis. This was achieved by implementing a shared pathway within Cerner across all North West London Acute Provider Group trusts, standardising education and training so staff could 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 a 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 had 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 deterioration.

Priority 7: Deteriorating Patient – NPEWS

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 National Paediatric Early Warning Score (NPEWS) 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 Group (NWL APG) approach to strengthening paediatric safety across organisations. The aim was to reduce unwarranted variation in practice, improve escalation reliability and ensure deteriorating children receive prompt, 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 NPEWS 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 NPEWS 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.

PART 2.2

STATEMENTS OF ASSURANCE FROM THE BOARD OF DIRECTORS

This section includes mandatory statements about the quality of services that we provide, relating to financial year 2025/26. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. The statements are designed to provide assurance that the Board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

Review of services

During 2025/26, Chelsea and Westminster Hospital NHS Foundation Trust provided and/or subcontracted 80 relevant health services.

The Trust has reviewed all the data available on the quality of care in these NHS services through our performance management framework and assurance processes.

The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by the Trust for the year.

Participation in clinical audits and national clinical outcome review programmes

Clinical audits drive improvement through a cycle of service review against recognised standards. We use audits to benchmark our care against local and national guidelines, so we can allocate resources to areas requiring improvement and as part of our commitment to ensure the best treatment and care for our patients. National confidential enquiries investigate areas of healthcare and recommend ways to improve.

During 2025/26, 61 national clinical audits and 11 clinical outcome review programmes covered health services provided by the Trust. During that period, we fully participated in 85% of the national clinical audits¹ and 70% of the national confidential enquiries² applicable to the Trust.

The national clinical audits and clinical outcome review programmes the Trust was eligible to participate in during 2025/26 are listed within Annex 1 on page 73.

National clinical audit

Outcome reports from 40 national clinical audits were reviewed by the Trust during 2025/26. Annex 2 on page 77 provides a summary of some of the actions the Trust intends to take to improve quality, safety and clinical effectiveness arising from participation in national clinical audit—this is not intended to be a comprehensive reflection of the action plans.

Actions are ongoing and are monitored via divisional quality boards and the Clinical Effectiveness Group (CEG).

Local clinical audit

A total of 304 local clinical audits were registered by the Trust via the Clinical Governance Team during 2025/26 as per the following table.

¹ The Trust partially participated in 10% of national clinical audits and did not participate in 5% owing to issues with digital capability and resources.

² The Trust partially participated in 30% of national confidential enquiries.

Division	Local clinical audits registered 2025/26	Local clinical audits completed 2025/26 ³
Clinical Support Services	49	53
Planned Care Division	91	76
Emergency & Integrated Care	65	39
Specialist Care Division	74	24
West London Children's Healthcare	25	10
Trust Total	304	202

202 local audits were reviewed (logged as completed with the Clinical Governance Team) during 2025/26. They have been presented at various forums including Divisional Boards, Directorate Meetings, Patient Safety Group, Clinical Effectiveness Group and Clinical Governance Half Days to discuss key findings, recommendations and action plans to support improvements. The following 15 audits are examples of local clinical audit projects undertaken across our divisions during 2025/26, demonstrating actions taken to improve the safety and effectiveness of our services.

Local clinical audit (title/objectives)	Summary/agreed actions arising from local clinical audits
<p>1. Patient Access–External Letters Workflow</p> <p>External letter flows were reviewed following a Learning Response where a patient's clinical information was uploaded to the Electronic Patient Record (Evolve) without being reviewed by a clinician. A new process was implemented to address this and build a more robust flow. The audit aimed to ensure the new process for managing external letters was being followed correctly.</p> <p><i>This audit was presented and discussed at the Patient Access Governance Group, Clinical Support Division Quality and Risk Group and the Patient Safety Group.</i></p>	<p>Recommendations:</p> <ul style="list-style-type: none"> • Instead of waiting for clinicians to sign off correspondence before scanning, consider emailing the clinician a PDF and scanning it into Evolve simultaneously, preventing loss of correspondence. Once correspondence is emailed to clinicians and uploaded to Evolve, the responsibility for actioning the document lies with the clinician. Admin staff must ensure there is evidence that the correspondence was sent. The directorate has discussed the need for a tracking mechanism, such as a spreadsheet, to log correspondence sent to clinicians, ensuring an audit trail exists. • Escalate audit findings to highlight the issue of clinical teams not following the current correct process. <p>Actions:</p> <ul style="list-style-type: none"> • The SOP has been updated and published on the Trust intranet, in line with recommendations. • The directorate plans to conduct a follow-up audit to assess improvements and adherence to the process. This will be included in the Clinical Support Division 2026/27 Audit Forward Plan.
<p>2. Outpatients–Virtual Fracture Clinic</p> <p>The audit focused on the Virtual Fracture Clinic pilot at CWH, comparing it to the established service at WMH and measuring efficiency against British Orthopaedic Association (BOA) standards.</p> <p><i>This audit was presented and discussed at the Patient Access Governance Group and Clinical Support Division Quality and Risk Group.</i></p>	<p>Key issues identified:</p> <ul style="list-style-type: none"> • Emergency Department (ED) colleagues were unclear about the 72-hour referral window, leading to delayed bookings. • Non-clinical teams booked the next available appointment without flagging capacity issues. • Patients often missed their scheduled virtual clinic calls because they misunderstood the service and believed they could call back at any time, not realising they needed to be available at a specific time for the appointment. The patient leaflet lacked clarity about appointment times and how the virtual service operates, contributing to this misunderstanding. • Appointments were previously allocated by sub-specialty, causing delays; now, all consultants can see all sub-specialties. • It was noted as a related process issue that some clinicians handed slips to patients instead of entering orders in Cerner, leading to potential missed follow-ups. This issue had improved at Chelsea but was still more prevalent at West Mid. <p>Actions:</p> <ul style="list-style-type: none"> • Improvement actions already underway include clarifying the referral process, updating patient leaflets, increasing clinic frequency and standardising consultant coverage. • Re-audit planned to assess the impact of changes.

³ Some audits carried over from the previous financial year were completed in 2025/26.

Local clinical audit (title/objectives)	Summary/agreed actions arising from local clinical audits
<p>Dietetics–Nasogastric (NG) Tube</p> <p>The audit aims to prevent incidents related to feeding through incorrectly placed NG tubes.</p> <p><i>This audit was presented at Clinical Support Division Quality and Risk Group.</i></p>	<p>The audit was conducted in July as part of the quality round with the senior nursing team, covering adult and paediatric wards across both sites. The audit examined:</p> <ul style="list-style-type: none"> • pH documentation • Staff knowledge and training <p>Results (documentation):</p> <ul style="list-style-type: none"> • 76% had pH recorded in Cerner, with some missing documentation. • 68% of those with pH documented had consistent entries. Where entries were not in the expected section, 86% were found in nursing notes. Two wards lacked documentation entirely. <p>Results (knowledge):</p> <ul style="list-style-type: none"> • 91% correctly identified the safe pH threshold (≤ 5.5) for feeding. • 91% had received training, and 88% had been assessed in tube placement and confirmation. • 100% knew the correct protocol for checking tube position and the next steps if pH was too high. • 59% could identify medications, such as PPIs, that might affect pH readings. <p>Actions:</p> <p>Dietitian teams were tasked with providing additional training to underperforming wards. Ongoing enteral feeding training will be included within the induction of new band 5 staff by senior nursing staff and dietitians. The Clinical Skills Team and senior nursing team will continue ensuring this is a mandatory training component for all adult nurses. The audit will be repeated annually, with a focused re-audit in six months for targeted wards.</p>
<p>4. An audit of Fast Track Pathway (FTP) GA cases in paediatric dentistry for neurodiverse children with severe autism</p> <ul style="list-style-type: none"> • To ascertain the total number of Fast Track Pathway patients completed since September 2024 • To discuss the pathway and lessons learnt from each case • To recommend improvements and amendments to the pathway and re-audit • To disseminate to all teams involved 	<p>Recommendations:</p> <ul style="list-style-type: none"> • Disseminate to all teams involved. • Formulate a checklist to be undertaken by all dental clinicians. • Take paper feedback from patients on the day. <p>Actions:</p> <ul style="list-style-type: none"> • Email for FTP to be sent to clinical, bookings, anaesthetics, recovery, Saturn nurses and theatre scrub team. • FTP patient to be added to dental, scrub and theatre nurses' diaries. • Take paper feedback from patients on the day. <p><i>Presented at directorate team meeting.</i></p>
<p>5. Can washout outcome predict segment length in Hirschsprung disease?</p> <p>To determine whether washout outcome (success vs failure) can be used to predict Hirschsprung segment length.</p> <p><i>Presented at directorate team meeting.</i></p>	<p>Findings:</p> <ul style="list-style-type: none"> • High sensitivity (87–88%) means short segments usually succeed in washouts. • Low specificity (46–50%) means long segments do not always fail in washouts. <p>Recommendations:</p> <ul style="list-style-type: none"> • Washouts remain valuable for decompression and bridging to pull-through. • Do not use washout outcome to infer segment length: biopsy/imaging remain essential. • Standardise recording of reasons for stoma formation in the database to avoid misclassification. • Consider a prospective study across multiple centres for validation. <p>Actions:</p> <ul style="list-style-type: none"> • Improve database capture of stoma reasons. • Present audit findings. • Share learning with the network.

Local clinical audit (title/objectives)	Summary/agreed actions arising from local clinical audits
<p>6. Accuracy of discharge documentation for Nurse Led Discharge on Saturn Ward as per Standard Operating Policy (SOP)</p> <p>A new SOP was implemented in March 2025 (approved by the WLCH Guidelines Committee) to support the process of Nurse Led Discharge from Saturn Ward at the Chelsea site after a period of consultation with stakeholders. Two snapshot audits were carried out approximately four and eight weeks after implementation of the SOP.</p> <p><i>Presented at directorate team meeting.</i></p>	<p>Findings:</p> <ul style="list-style-type: none"> • Some improvements were seen after the first audit but were not consistent. • Improvement was more noticeable in teams where the surgeons were engaged with the process. • Lack of consistency with documentation correlated with changeover of surgical staff and visiting surgeons from other trusts within WLCH. <p>Recommendations:</p> <ul style="list-style-type: none"> • Continue monthly snapshot audits. • Maintain direct communication with relevant teams until 100% of children have clear documentation supporting nurse led discharge. <p>Actions:</p> <ul style="list-style-type: none"> • Continue monthly snapshot audits.
<p>7. Quality of Neonatal Intensive Care Unit (NICU) portable chest X-rays (CXRs)</p> <p>Portable CXRs are essential for critically ill neonates who cannot be moved to the radiology department. High-quality images are crucial for accurate diagnosis, device placement confirmation and reducing repeat imaging. NICU imaging is challenging due to patient size, fragility and environment.</p>	<p>Recommendations:</p> <ul style="list-style-type: none"> • Provide targeted training on neonatal positioning, centring and collimation. • Introduce a 'last look' quality check before exposure. • Reinforce rotation checks in NICU portable imaging. • Improve NICU–radiographer communication on patient preparation. • Re-audit three to six months after interventions. <p>Actions:</p> <ul style="list-style-type: none"> • Immediate: share results with NICU and radiography teams. • Within one month: deliver targeted training sessions. • Within three to six months: re-audit to assess improvements. • Ongoing: maintain quality through continuous feedback from reporting radiologists.
<p>8. Dietetic input pre Lower Feminisation Surgery (LFS)</p> <p>The dietetic service within the Lower Feminisation Surgery service has been in place for the last 14 months to help patients achieve their target BMI for surgery. It is important to assess patient outcomes in relation to weight management before surgery.</p>	<p>Findings:</p> <p>A total of 38 patients who were referred for weight management before LFS were audited, with 27 patients having completed care.</p> <ul style="list-style-type: none"> • 63% achieved their target weight loss. • No patients with BMI ≥ 40 achieved target weight loss. • Mean weight loss was 7.1%. <p>Recommendations:</p> <ul style="list-style-type: none"> • Continue to monitor outcomes of weight management before LFS. • Include additional information relating to barriers to change and physical activity, and work on ways of addressing these to increase the percentage of patients achieving their target weight. • Implement stricter referral criteria for weight management. <p>Actions:</p> <ul style="list-style-type: none"> • Collect additional information. Add barriers to change and specific details of physical activity to the clinical template. • Introduce stricter referral criteria, limiting weight management to patients in obesity category I or below. • Disseminate to the referring team and keep a record of data. • Record weight loss data for all referrals.
<p>9. Maternity–Neurological monitoring associated with obstetric regional block</p> <p>To assess data regarding neurological monitoring following epidural insertion on the labour ward.</p>	<p>Analysis:</p> <ul style="list-style-type: none"> • The sample size was 372. Of these, 211 had a positive SLR test and 81 had a negative SLR test. 80 patients had no anaesthetic review completed. A small percentage of women had no epidural review documented on K2. This could be improved further to support patient safety. <p>Conclusion:</p> <ul style="list-style-type: none"> • Anaesthetic review and SLR test reminders should be included during the huddle when all members of the team are present. <p>Benefits:</p> <ul style="list-style-type: none"> • Early attention to patients who have dense motor block and follow-up.

Local clinical audit (title/objectives)	Summary/agreed actions arising from local clinical audits
<p>10. Acute care bundle: REDCOAT</p> <ul style="list-style-type: none"> To identify how often REDCOAT is completed in the PTWR of patients admitted to Chelsea and Westminster Acute Assessment Unit (AAU). Completion rates pre- and post-intervention will be measured and compared through re-auditing. Educational and awareness-based interventions are feasible and low-cost. We can increase awareness through weekly departmental teaching and engaging posters. We will aim for a compliance rate of 90% to allow for small unavoidable omissions while ensuring meaningful improvement. 	<p>Recommendations:</p> <ul style="list-style-type: none"> Complete REDCOAT for every post-take ward round (PTWR). We will continue to reintroduce this concept after changeover, but we require your input. Re-audit to be completed in the next couple of months. More work needs to be done to spread awareness of REDCOAT and the importance of its completion at the start of admission. We aim to create a poster with the ideal process. This will standardise the PTWR, improving documentation efficiency in line with the relevant guidelines. <p><i>This audit was presented at the Divisional Board meeting in March 2026.</i></p>
<p>11. Ambulatory Emergency Care (AEC) Syncope Pathway Audit</p> <p>Compare current year practice (2025) regarding syncope pathway referral to AEC with the previous year (2024), to check for any improvement following teaching.</p> <p><i>This audit was presented at the Divisional Board meeting in January 2026.</i></p>	<p>There was significant improvement in safety/health advice and ECG documentation, but still a high burden of inappropriate referrals to AEC: 73% of patients, compared with 67% previously.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> Stress the importance of discharging patients with clear evidence of uncomplicated syncope with no/low-risk features to the GP, with a copy of the ECG. Increase awareness among doctors about the syncope pathway. Disseminate posters in targeted clinical areas. Send a communication email about the audit findings and recommendations.
<p>12. A retrospective audit on pre-operative pain management for patients with neck of femur (NOF) fractures admitted to ED/AAU</p> <p>Assess compliance with NICE guidelines for pre-operative pain management in patients presenting with neck of femur fractures. Scope: all surgically managed NOFs in March 2025.</p> <p><i>This audit was presented at the Divisional Board meeting in November 2025.</i></p>	<p>Areas of good practice:</p> <ul style="list-style-type: none"> Regular paracetamol prescribed (90%). PRN opioids/pain relief prescribed (80%). Nerve block considered and given (100%). NSAIDs are generally avoided (87%). <p>Areas for improvement:</p> <ul style="list-style-type: none"> Pain assessment on admission and pain score documentation. Pain reassessment post-analgesia. Regular pain reassessment. <p>We achieved 100% compliance in prescribing regular paracetamol alongside PRN analgesia, and there was complete avoidance of NSAIDs in both cycles, meeting our prescribing targets.</p> <p>Recommendations:</p> <p>The areas in need of greatest improvement are regular pain assessment and assessment post-analgesia. Therefore:</p> <ul style="list-style-type: none"> Include pain reassessment as part of regular observations done on AMU. Repeat teaching sessions when changeover happens with new staff. Ensure the NOF checklist is used by new members of staff.
<p>13. Standardising Documentation of Microbiology Results and Antimicrobial Therapy in ITU Clinical Notes</p> <p>To audit current ICU documentation of microbiology results and antibiotics against a proposed template for microbiology summaries, with the goal of improving documentation quality and accuracy.</p>	<p>Findings:</p> <ul style="list-style-type: none"> Microbiology ward rounds still lacked detail, including culture results and sensitivities. Microbiology summaries had started to be introduced and generally had more detail. However, summaries rarely mentioned discussions with microbiology. SOS antibiotics were poorly documented. Only 20% of patients had a separate microbiology summary note documented. There was variability in the information documented depending on the type of note created, as there was no standard format. Microbiology summaries, either as a separate note or as part of a ward round, contained more information than microbiology ward round notes.

Local clinical audit (title/objectives)	Summary/agreed actions arising from local clinical audits
	<ul style="list-style-type: none"> Separate microbiology summary notes were easier to find in the notes. <p>Recommendations:</p> <ul style="list-style-type: none"> Encourage use of the Microbiology Summary template. Re-audit.
<p>14. Re-excision rates after breast-conserving surgery</p> <ul style="list-style-type: none"> To audit the re-excision rates in patients undergoing breast-conserving surgery (BCS) at West Middlesex University Hospital. To assess adherence to NICE margin guidelines and identify areas for improvement in surgical practice. 	<p>Findings: Sample size: 50 patients (January–July 2025). Re-excisions required: 7 patients (14%), which is:</p> <ul style="list-style-type: none"> Within the national benchmark range Slightly above the ideal target of <10% <p>Surgical techniques used:</p> <ul style="list-style-type: none"> Pintuition seed: 1 case Wire-guided excision: 2 cases Wide local excision (WLE): 4 cases <p>Recommendations:</p> <ul style="list-style-type: none"> Although the re-excision rate is acceptable, it exceeds the ideal threshold. Contributing factors may include: <ul style="list-style-type: none"> Close surgical margins Larger tumour sizes <p>Action plan:</p> <ul style="list-style-type: none"> Review and potentially revise surgical margin policies and pathology protocols. Promote more consistent use of localisation techniques, such as Pintuition seeds. Conduct a repeat audit after implementing changes to assess improvement.
<p>15. Audit on Consent Form Quality in Ankle ORIF</p> <p>A locally conducted audit within the Orthopaedics Department was undertaken to evaluate compliance with national standards for informed consent among patients undergoing ankle open reduction and internal fixation (ORIF).</p> <p>The audit specifically assessed the quality and completeness of consent forms against established guidance set out by the British Orthopaedic Association (BOA), the General Medical Council (GMC) and the National Institute for Health and Care Excellence (NICE), with the aim of identifying areas of good practice and opportunities for improvement in documentation and patient consent processes.</p>	<p>Findings: The audit reviewed 39 consent forms, demonstrating an overall compliance rate of 84.6%, with most completed on paper-based forms (60.6%), followed by electronic forms (27.3%) and both formats (12.1%). Written clarity was variable, with only 37.5% considered clear, while the remainder were unclear or partially clear.</p> <p>Paper forms frequently lacked the time of signature, whereas electronic forms consistently included the date and time through automatic time-stamping. Although the right to refuse was documented in all paper forms, it was absent from electronic forms, and there was no documentation of the risks associated with refusing treatment.</p> <p>Evidence of consent was missing in 15.4% of cases, and while common side effects were usually recorded, significant risks such as amputation, compartment syndrome and skin damage were rarely mentioned, with alternative treatments often omitted.</p> <p>Overall, electronic forms were more complete but still inconsistent, highlighting the need for an updated, preferably electronic, ankle ORIF-specific consent template that clearly states benefits, the right to refuse, diagnosis and procedure details, and includes rare but serious risks.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> Develop an updated ankle ORIF consent template. Deliver training sessions on consent form documentation. Standardise consent using electronic documentation. Re-audit in three months.

Commissioning for Quality and Innovation (CQUIN) schemes

Commissioning for Quality and Innovation (CQUIN) is a quality framework that allows commissioners to agree annual payments to hospitals based on the number of schemes implemented.

For the financial year 2025/26, there was a pause on traditionally established CQUIN schemes. This was to allow the Trust to have additional focus on established Quality Priorities.

Registration with the Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care in England. It registers, and therefore licenses, providers of care services if they meet essential standards of quality and safety. It monitors licensed organisations on a regular basis to ensure that they continue to meet these standards.

The Trust is required to register with the CQC, and its current registration status is 'fully registered'. The Trust has no conditions on its registration. The CQC did not take enforcement action against the Trust during 2025/26.

The Trust underwent an announced routine inspection of the Nuclear Medicine Department at Chelsea and Westminster Hospital in May 2025. This inspection was undertaken under the IR(ME)R regulations as part of the CQC's proactive inspection programme—it was not prompted by any specific concerns.

The inspectors did not identify any breaches under IR(ME)R that met the threshold for enforcement action. However, they did identify two recommendations for improvement. A detailed action plan was submitted by the Trust to the CQC and accepted, with no further regulatory action required.

Trust overall CQC rating

The Trust's overall CQC rating is 'Good'. The Trust's Well-led rating and Use of Resources rating remain 'Outstanding'.

By hospital site, Chelsea and Westminster Hospital's CQC rating is 'Outstanding' and West Middlesex University Hospital's CQC rating is 'Good'.



Secondary Uses Service (SUS) information

The Trust submitted records during 2025/26 to the Secondary Uses Service (SUS) for inclusion in Hospital Episode Statistics, which are included in the latest published data. Best and worst figures were unavailable for NHS number completeness and General Medical Council (GMC) practice code completeness.

Data security and protection toolkit

Information governance is the way organisations process and handle information. It covers information relating to patients and staff, as well as corporate information, and helps to ensure information is handled appropriately and securely, with particular emphasis on managing personal data in line with data protection legislation.

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that all organisations must use if they have access to NHS patient data and systems. It provides assurance that organisations are practising good data security and that personal information is handled correctly. The DSPT is audited prior to submission by our internal auditors.

For 2024/25, the Trust achieved 'Standards Met', and the organisation believes it will again achieve this standard for 2025/26.

ODS	Organisation name	Status	Published
RQM	<u>Chelsea and Westminster Hospital NHS Foundation Trust</u>	2024/25 (version 6) - Standards Met	28 Jun 2026

NHSE Organisation Data Service

Clinical coding error rate

The Trust was not subject to a Payment by Results clinical coding audit during 2025/26 by the Audit Commission.

Data quality

The Trust is taking the following actions to improve data quality:

- **Validation of referral to treatment (RTT) data:** The Trust utilises a standard operating procedure for the validation of referral to treatment data. Findings are shared with service managers and divisional leads to ensure robust actions are taken in response to learning.
- **Information Governance Steering Group (IGSG):** The Information and Data Quality Policy has been updated, with the next review date set for April 2027. This has been shared with the IGSG via the Data Quality Steering Group (DQSG) to ensure oversight and assurance.
- **Data quality (DQ) monitoring:** A number of dashboards have been built within Qlik Sense to monitor data quality from Cerner EPR systems against agreed DQ measures. The Foundry tool is also used to manage data quality on inpatient and outpatient waiting lists. Outputs are shared and monitored by the Data Quality Steering Group, at weekly elective access meetings and, where applicable, the Clinical and Operational Innovation Steering Group.

Learning from deaths

During 2025/26, 1,310 adult and child deaths occurred within the Trust's hospital sites. This comprised the following number of deaths that occurred in each quarter of the reporting period: 297 in Q1, 299 in Q2, 348 in Q3 and 366 in Q4.

By 31 March 2026, 1,258 cases had been screened for potential learning and 535 full case record reviews had been undertaken by consultants. This represents case screening of 96% of total deaths, with comprehensive reviews completed for 41% of cases.

The impact of problems in care provision is graded using the classification system initially developed within the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI).

CESDI outcome grading system:

- **Grade 0:** Unavoidable death, no suboptimal care
- **Grade 1:** Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome
- **Grade 2:** Suboptimal care, but different care might have affected the outcome (possibly avoidable death)
- **Grade 3:** Suboptimal care, where different care would reasonably be expected to have affected the outcome (probable avoidable death)

Where case record reviews identified potential areas for improvement, individual action plans are developed to support and monitor delivery of change. Learning from case record reviews is scrutinised monthly at the organisation's Mortality Surveillance Group (MSG), where learning is also cascaded through divisional and specialty mortality and morbidity groups.

During the reporting period, there was one case identified where suboptimal care might have affected the outcome for the patient (CESDI 2). There was also one reported CESDI 3 case where different care would reasonably have been expected to affect the outcome. Both cases had an appropriate safety learning response in addition to the mortality review.

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q1 2025/26	107	16	0	0
Q2 2025/26	83	22	1	0
Q3 2025/26	108	19	0	1
Q4 2025/26	84	9	0	0
Total	382	66	1	1

Closed mortality cases by CESDI grade, Apr 2025–Mar 2026

The Trust is committed to delivering a just, open and transparent approach to investigations that reduces the risk and consequence of recurrence. Key themes from incident investigations linked to mortality review are submitted to the Patient Safety Group and the Executive Management Board for shared learning and consideration of whether further quality improvement projects, deep dives or targeted action are required.

The organisation publishes learning from safety learning responses on a monthly basis, and outcomes and learning are received by the Patient Safety Group, local Quality Committee and Executive Management Board each month (with case outlines and

associated actions). The following themes and issues were flagged to the Mortality Surveillance Group between April 2025 and March 2026:

Theme	Key learning	Key actions
Escalation and Patient Flow	Delays in escalation and transfer result in patients being managed in inappropriate settings.	<ul style="list-style-type: none"> Strengthen escalation pathways and oversight, and review SOP criteria Ensure treatment is initiated irrespective of bed availability
Treatment Escalation Plans (TEPs) and End-of-Life Care (EoLC)	TEPs are often delayed, not reviewed or poorly documented, leading to care misaligned with patient wishes.	<ul style="list-style-type: none"> Embed early and dynamic TEP completion Improve documentation of escalation decisions Promote early palliative care involvement
Documentation Quality	Inaccurate, inconsistent documentation (including copy-and-paste) is a recurring safety and medico-legal risk.	<ul style="list-style-type: none"> Reinforce standards for contemporaneous documentation Reduce copy-and-paste practices Standardise documentation of clinical reasoning and procedures
Communication	Poor communication with patients and families, including inconsistent interpreter use and NOK documentation issues.	<ul style="list-style-type: none"> Mandate use of professional interpreters Introduce structured family communication processes Improve recording of next of kin (NOK) details and discussions
Medication Safety	Errors include opioid duplication and delays in time-critical medications, particularly out of hours.	<ul style="list-style-type: none"> Strengthen prescribing and administration processes Reinforce end-of-life medication guidance Improve reliability of time-critical prescribing
Recognition of Deterioration	Delays in recognising and responding to deterioration, including delayed investigations and escalation.	<ul style="list-style-type: none"> Improve escalation protocols and training Ensure timely diagnostics (e.g. imaging) Clarify monitoring guidance (e.g. telemetry)
Risk Assessment	Inconsistent documentation (e.g. falls) impacts early recognition of deterioration.	<ul style="list-style-type: none"> Reinforce falls prevention and pressure care standards
Procedural Safety	Harm arising from routine procedures (e.g. catheterisation) due to poor practice.	<ul style="list-style-type: none"> Deliver targeted training on procedural safety Standardise procedural documentation (who, when and complications)
Operational/System Factors	Bed pressures, ward moves and staffing impact continuity of care and escalation.	<ul style="list-style-type: none"> Escalate systemic risks via Trust governance forums Mitigate impact through improved planning and oversight

Learning themes summary table, Apr 2025–Mar 2026

Learning and actions identified above were shared with the patient's named consultant and divisional mortality review groups, and feedback on actions taken to improve quality of care is provided monthly to the Trustwide Mortality Surveillance Group.

Learning and positive feedback identified through the Medical Examiner scrutiny process, which includes discussions with patients' relatives, is routinely shared at the Trustwide Mortality Surveillance Group. Some of this feedback is summarised below:

- Quick issue of MCCD:** Expressions of gratitude for the prompt issuance of the Medical Certificate of Cause of Death (MCCD) by the Medical Examiner's Office, allowing families to proceed with urgent burials in accordance with their faith.

- **Compassionate and supportive staff:** Feedback often mentions the compassionate and supportive nature of hospital staff, including doctors, nurses and palliative care teams.
- **Clear communication:** Appreciation for the clear and empathetic communication from medical teams, helping families understand treatment decisions and processes.
- **Comfort and dignity:** Recognition of how hospital staff ensured patients were comfortable and their dignity was maintained throughout their stay.
- **Teamwork and professionalism:** Feedback frequently highlights the excellent teamwork and professionalism of hospital staff, who worked seamlessly together to provide the best care possible.

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) to monitor the relative risk of mortality. SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on patient characteristics. The metric is calculated by NHS England using information submitted by all acute providers.

The Trust continues to have one of the lowest relative risks of mortality within NHS England, providing strong assurance regarding the quality of care and services we provide.

Reporting against core indicators

The following data outlines the Trust’s performance against a selected core set of indicators. Comparative data shown is sourced from the former Health and Social Care Information Centre (HSCIC), now NHS Digital, where available.

Where data is not available from NHS Digital, other sources have been used as indicated. Data that has not been published is indicated as ‘data not published’ (dnp).

Core indicators

Summary Hospital-level Mortality Indicator (SHMI)

	2021/22	2022/23	2023/24	2024/25	2025/26 ⁴
Trust SHMI	0.72	0.71	0.72	0.70	0.75
National Performance: highest	1.22	1.22	1.25	1.23	1.31
National Performance: lowest	0.72	0.71	0.72	0.70	0.71
National Performance: mean	1	1	1	1	1

Data source: digital.nhs.uk/data-and-information/publications/statistical/shmi

⁴ The reporting period for 2025/26 is December 2024 to November 2025

The Trust considers that this data is as described for the following reasons:

- The Trust maintains excellent performance in terms of relative risk of mortality and has seen sustained improvement in this national indicator since March 2017.
- The Trust submits data as part of the Secondary Uses Statistics (SUS) return, which is then used by NHS Digital to compile the national SHMI.

The Trust intends to take the following actions to improve this indicator, and therefore the quality of its services, by:

- Maintaining the mortality surveillance and assurance provided by scrutinising and analysing information from mortality reviews, serious incidents, external datasets and triggers/indicators associated with the SHMI.
- Promoting further clinical engagement and use of the organisation’s safety learning systems, which provide a platform for recording and analysing consultant-led reviews.
- Undertaking patient-level clinical and coding reviews of any specialties or conditions that show as mortality outliers when compared with national data.
- Presenting key themes and learning from the SHMI data for all four NWL Acute Provider Group (APG) trusts to the APG Quality Committee and then Board in Common for assurance.

Percentage of patient deaths with palliative care coding

	2021/22	2022/23	2023/24	2024/25	2025/26 ⁵
Percentage of patient deaths with palliative care coded	47%	48%	54%	52%	55%
National performance: Lowest	11%	13%	16%	17%	8%
National performance: Highest	64%	66%	67%	66%	63%
National performance: Mean	39.7%	40%	42%	44%	35%

Data source: digital.nhs.uk/data-and-information/publications/statistical/shmi

The Trust considers that this data is as described for the following reasons:

- The Trust End of Life Care (EoLC) Steering Group meets quarterly and reviews trends relating to all aspects of end-of-life care across adults, paediatrics and maternity to provide assurance and analysis of Trustwide improvements.
- Progress is demonstrated by the improved access to the Universal Care Plan via Cerner, the education and training that has taken place with staff to improve awareness and knowledge of the Universal Care Plan system, the redesign of the Fast Track discharge process and the breadth of training that has been delivered to staff around the new process.

⁵ The reporting period 2025/26 is December 2024 to November 2025

The Trust intends to take the following actions to improve this indicator, and therefore the quality of its services, by:

- Rolling out the new digital process for fast-track discharge, which received significant input from the EoLC Steering Group to support education, simulation training and implementation across the Trust.
- Participating in the National Audit of Care at the End of Life (NACEL)—findings from the 2025 audit are used to triangulate and monitor this metric.
- Delivering more integrated, person-centred care to patients in their last months of life.
- Continuing the Butterfly Volunteering programme, which provides companionship to patients in the last days of life and those important to them, following successful launch and evaluation demonstrating the positive impact of the service.
- Improving communication with families to ensure their understanding of the Universal Care Plan and to manage family expectations.

Patient reported outcome measures (PROMs)

Patient reported outcome measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of two clinical procedures: hip replacement or knee replacement. The Trust has not participated in PROMs since 2022. It was removed from the NHS England Quality Accounts list in 2024/25 and is no longer monitored through this report.

Readmission within 28 days

	2021/22	2022/23	2023/24	2024/25	2025/26
Readmission (28 days) age 0-15 years	9.0%	6.20%	6.8%	6.57%	5.10%
National performance: Worst	17.5%	19.6%	22.3%	21.8%	dnp
National performance: Best	0.0%	0.0%	0.0%	0.0%	dnp
National performance: Mean	8.1%	9.8%	10.1%	9.6%	dnp

	2021/22	2022/23	2023/24	2024/25*	2025/26
Readmission (28 days) age 16+ years	9.7%	10.2%	10.6%	9.93%	5.09%
National performance: Worst	13.1%	21.2%	17.0%	21.3%	dnp
National performance: Best	4.4%	0.0%	0.0%	0.0%	dnp
National performance: Mean	8.7%	7.5%	8.5%	7.3%	dnp

National Performance: <https://www.hed.nhs.uk/portal/Module.aspx?ReportID=516>

Readmission rates have decreased compared with previous years and are now below the national mean. These indicators are routinely reviewed as part of the organisation's standard governance procedures and anomalies are investigated.

The Trust intends to take the following actions to continue improving this indicator, and therefore the quality of its services, by:

- Enhanced monitoring of readmissions through the bed productivity programme, ensuring there is an overarching and coordinated approach to monitoring quality indicators relating to flow through our hospitals, including safe discharge. Oversight and assurance are provided by the Improvement Board and the Quality Committee (QC).

- Maintaining and improving workstreams around demand, capacity and patient flow as part of the bed productivity programme.
- Ensuring timely and safe discharges, reducing readmissions, and providing patients with the support they need to manage their conditions at home, as identified through the quality priority work completed in relation to Fast Track discharge.

Responsiveness to personal needs

The national inpatient survey asks five questions focusing on responsiveness and personal care.

NHS England stopped publishing data in relation to this indicator three years ago. Therefore, we have included the following data from the inpatient survey to demonstrate the Trust's performance against some of the respective domains of the survey.

Section	Themes	2021	2022	2023	2024 ⁶
Admission to hospital	Did not mind waiting as long as did for admission	60%	71%	61%	69%
	Did not have to wait a long time to get to a bed on the ward	78%	66%	68%	67%
Overall	Treated with respect and dignity	98%	89%	89%	91%
	Rated overall experience as 7/10 or more	85%	79%	80%	80%
	Asked to give views on quality of care during stay	26%	17%	41%	33%

The patient survey results are overseen and acted upon by the Patient and Public Experience and Engagement Group, which reports to the Quality Committee. The Patient Experience Team triangulates feedback alongside the Friends and Family Test (FFT), drawing themes from the national patient survey, Trust complaints and Patient Advice and Liaison Service (PALS) enquiries.

The Trust has taken the following actions to improve this indicator, and therefore the quality of its services, by:

- Undertaking significant work focused on improving the inpatient experience for our patients. Early results for 2025 indicate that, overall, we are on a positive trajectory across several survey domains, supported by local survey data gathered throughout the year.
- Making improvements in how we care for patients while they are on the ward, how we communicate and involve them in their care journey, and how we provide a supportive environment. This has included extensive education and awareness initiatives with clinical teams responsible for patient care.
- Continuing efforts to reduce waiting lists for elective surgery, successfully eliminating 78-week waits last year and making significant progress in reducing waiting times for patients waiting 65 weeks and 52 weeks.

⁶ The data period is up to 2024 as the sample month is November. For the 2025 iteration of the survey, patients admitted in November 2025 are currently being surveyed.

Staff recommending our Trust

	2021/22	2022/23	2023/24	2024/25	2025/26
Staff are happy with the standard of care that would be provided to a friend or relative	76.1%	72.1%	77.1%	77.4%	76.8%
National performance: Worst	43.6%	39.2%	44.3%	39.7%	34.7%
National performance: Best	89.5%	86.4%	88.8%	89.6%	88.4%
National performance: Mean	66.9%	61.9%	63.3%	61.5%	60.8%

Date source: <https://cms.nhsstaffsurveys.com/app/reports/2025/RQM-benchmark-2025.pdf>

The Trust considers that this data is as described for the following reasons:

- The indicator is part of the nationally reported and validated Staff Survey dataset.

The Trust is above the national average and has taken the following actions to further improve this indicator, and therefore the quality of its services, by:

- Engaging all staff in the delivery of the Trustwide Quality Priorities.
- Improving the number of staff appraisals completed through the introduction of meaningful performance and development conversations.
- Strengthening support for staff experiencing violence and aggression at work, including introducing a new policy and continuing conflict management training.
- Expanding work within equality, diversity and inclusion, including introducing cultural intelligence to support better understanding of colleagues and patients.
- Launching a sexual safety policy alongside awareness training for staff.

Venous thromboembolism risk assessment

Venous thromboembolism (VTE) occurs when a deep vein thrombosis (blood clot in a deep vein, most commonly in the legs) and pulmonary embolism (where a blood clot travels in the bloodstream and lodges in the lungs) causes substantial long-term health complications or death.

Risk assessment for VTE ensures identification of patient- and hospital-related risks, prompting appropriate preventative measures at the earliest opportunity to help reduce the risk of VTE developing.

	2021/22	2022/23	2023/24	2024/25	2025/26
Percentage of admitted patients risk assessed for VTE	93.2%	92.7%	95.0%	95.4%	95.8%

Data source: Trust Qlik Analytics

The Trust considers that this data is as described for the following reasons:

- The Trust achieved the national VTE risk assessment target ($\geq 95\%$) for 2025/26.
- The Thrombosis and Thromboprophylaxis Group includes VTE risk assessment performance as a standing agenda item as part of ongoing work to monitor performance and support divisions with improvement.

- Performance is tabled in monthly divisional quality board reports.
- Performance is overseen by the Executive Management Board via the monthly performance and quality report.
- Performance is tabled in the quarterly Thrombosis and Thromboprophylaxis subgroup report to the Patient Safety Group for governance and assurance.
- Monthly VTE risk assessment performance reports are disseminated to divisional and clinical leads for feedback, identification of areas for improvement and wider awareness.
- Optimisation of Cerner VTE risk assessment and digital data reporting has supported processes, including real-time monitoring and feedback on performance.
- Cerner includes a VTE risk assessment status on handover lists and Care Organiser, providing a visual indication of whether VTE risk assessment has been completed for inpatients.
- VTE risk assessment performance and prescribing of appropriate pharmacological and mechanical thromboprophylaxis (where clinically indicated and no contraindications are present), by clinical area and ward for each hospital site, are audited quarterly, with a summary of key messages, shared learning and actions disseminated through a quarterly VTE performance report.
- A specific VTE risk assessment for patients in lower limb immobilisation was developed and implemented across North West London acute trusts.
- Cohorting arrangements for VTE risk assessments were reviewed and updated for groups of patients undergoing procedures considered low risk for VTE, using Department of Health and NICE risk assessment categories.
- An annual Trustwide VTE bulletin is disseminated to support shared learning and key messages on World Thrombosis Day.
- The Thrombosis and Thromboprophylaxis Group has developed and introduced specific patient information leaflets on blood clot conditions, such as deep vein thrombosis, pulmonary embolism and atrial fibrillation, to increase patient education, awareness and support counselling.
- VTE education is delivered through multiple platforms, including induction programmes, clinical governance meetings, grand rounds and departmental updates.

The Trust intends to take the following actions for this indicator, and therefore the quality of its services, by:

- Continuing to disseminate monthly VTE risk assessment performance reports to divisional and clinical leads for feedback on performance, areas for improvement and wider awareness.

- Performing biannual audits of inpatients at risk of VTE to assess the prescribing of pharmacological and/or mechanical thromboprophylaxis (where clinically indicated and no contraindications are present), with feedback provided to divisional clinical leads and pharmacy staff. Actions taken to address contributory factors may include management of omitted medication, staff education and awareness, and review and update of clinical guidelines.
- Hospital-associated VTE events undergo a learning response (PSIRF investigation). Shared learning and actions to reduce the risk of recurrence are disseminated to clinical teams, divisional boards and the Thrombosis and Thromboprophylaxis Group.

***Clostridium difficile* (C. diff) occurrence**

Public Health England changed the surveillance definitions for *C. diff* in April 2019. Before this date, cases of *C. diff* detected four or more days after admission to hospital were classified as healthcare-associated.

Following the April 2019 change, the classification of hospital-onset healthcare-associated (HOHA) was given to all cases identified two or more days post-admission (where the day of admission is counted as day 1).

Patients diagnosed as positive for *C. diff* within two days of admission, but with a history of an inpatient stay at CWFT within 28 days of the positive result, are classified as community-onset healthcare-associated (COHA) and are Trust-apportioned, even if the previous admission was unrelated to the current presentation.

	2021/22	2022/23	2023/24	2024/25	2025/26
Count: Hospital-onset, healthcare-associated	36	27	35	61	58
Rate: Hospital-onset, healthcare-associated per 100,000 bed days	11.5	9.3	12.1	21	19.4
National performance: Worst	dnp	dnp	92.5	97.2	dnp
National performance: Best	dnp	dnp	0	0	0
National performance: Mean	dnp	dnp	27.6	27.6	19.8

Data source: <https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-statistics#hcai-annual-data-sets>

During 2025/26, there were 58 Trust healthcare-associated *C. diff* cases against an apportioned Trust target of 33.

A PSIRF learning response for each Trust-apportioned case was initiated by the Infection Prevention and Control Team and involved senior medical and nursing staff caring for each patient. Action plans were subsequently developed to address learning and are monitored through Trust quality and risk meetings.

The Trust considers that this data is as described for the following reasons:

- The dataset is nationally reported and locally validated.
- Performance is monitored through the Trust Infection Prevention and Control Group (IPCG) and reported to the North West London Integrated Care System and Acute Provider Collaborative (APC) groups respectively.

- Performance is overseen by the Executive Management Board and Trust Board via the monthly performance and quality report.

The Trust has taken the following actions to improve this indicator, and therefore the quality of its services, by:

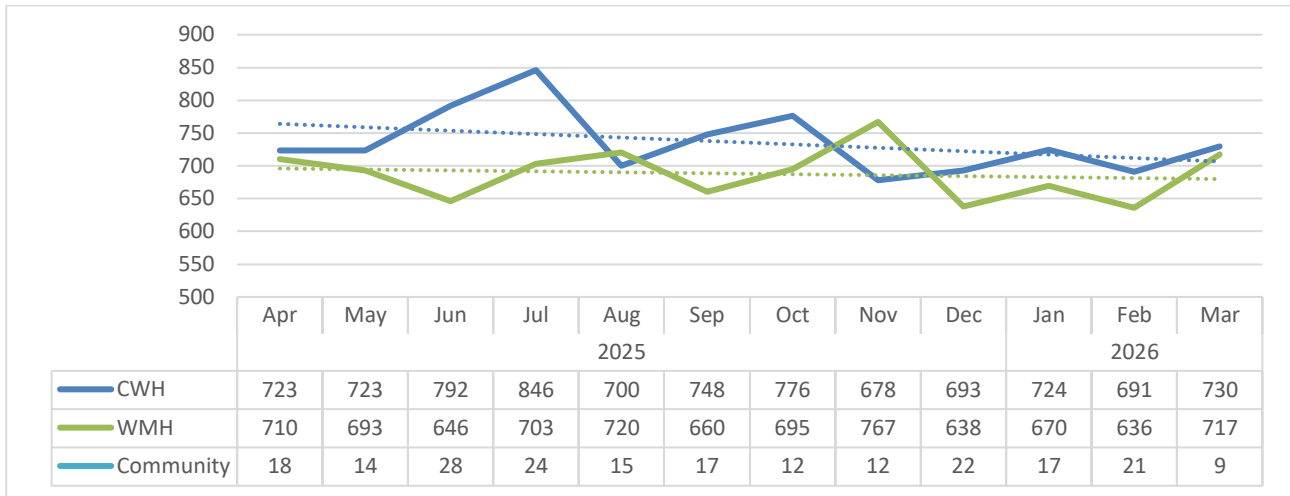
- **Clinical engagement:** Ongoing education for all staff on the early recognition of *C. diff* symptoms and appropriate sample testing, alongside attendance, discussion and feedback at clinical learning response meetings to improve clinical management and divisional oversight.
- **Antibiotic stewardship:** Facilitated by the introduction of the ICNET clinical surveillance system, a web-based software platform, at West Middlesex University Hospital in July 2021. Use of this system across both hospital sites has improved antimicrobial prescribing, monitoring and auditing, with ongoing review to identify inappropriate prescribing and review prescribing in known cases of *C. diff*.
- **Environmental decontamination:** Ongoing high levels of environmental hygiene, monitored at IPCG and through ward accreditation.
- **Isolation nursing:** Prompt recognition and isolation of patients with suspected infectious diarrhoea, and suspected or confirmed *C. diff*.
- **Documentation and communications:** *C. diff* checklist on Cerner, with an additional poster devised to support staff on appropriate testing.
- **Hand hygiene:** Supporting high levels of hand hygiene compliance through a monthly audit programme with Trustwide feedback and data availability.
- **Hand hygiene compliance:** Areas with lower compliance produced divisional action plans, with compliance monitored at the Infection Prevention and Control Group and through monthly divisional dashboards.
- **Testing for *C.diff*:** Clinical teams leading local education, with support from the Infection Prevention and Control Team, to improve the appropriateness of testing and management.
- **Collaboration:** Learning from *C. diff* cases shared at North West London APC and Integrated Care System level to improve local and sector management, review practice and support reduction of hospital-associated infections.

Number of patient safety incidents that resulted in severe harm or death

Patient safety incidents can have a devastating impact on our patients and staff. The Trust is committed to continuously improving the quality of the care and services provided to our patients. This improvement process is supported by a system for reporting, responding to and learning from patient safety incidents.

A key indicator of an organisation's safety culture is its willingness to report safety events that could have, or did, affect patient safety and to embed the changes required to reduce the risk of recurrence. A high incident reporting rate reflects a positive reporting culture.

The implementation of PSIRF has supported safety learning, compassionate engagement and safety improvement, and resulted in a gradual decrease in the number of investigations required.



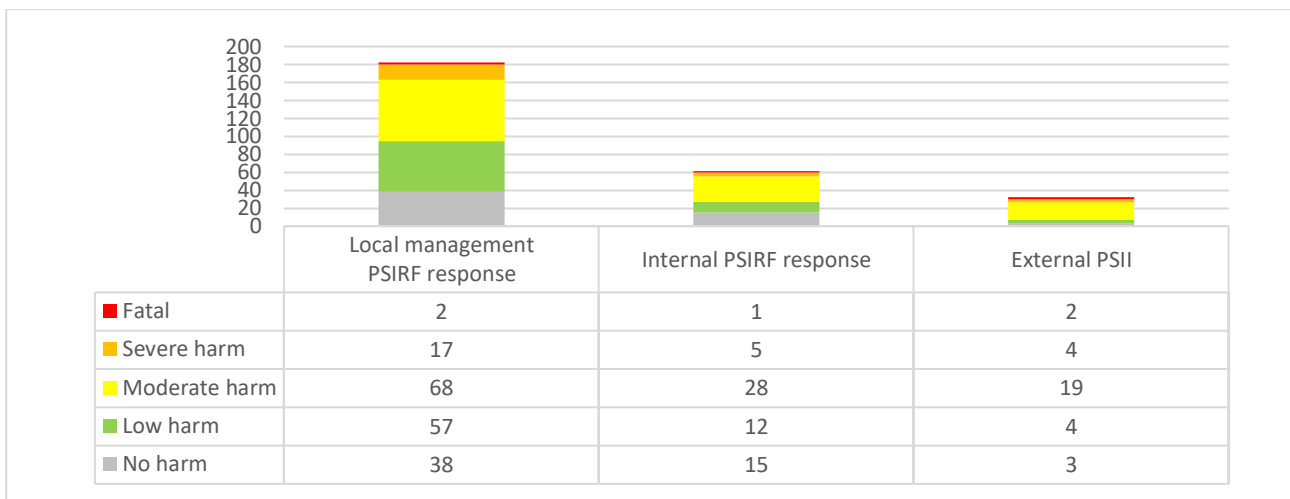
Number of Patient Safety Incidents reported by month, April 2025–March 2026

During 2025/26, 17,288 patient safety incidents were reported by staff across all our departments and services. This is a 4.4% increase on the number of patient safety incident reports made during the previous financial year (n=16,557).

A significant proportion of reported incidents did not require a PSIRF learning response, accounting for 98.4% of incidents (n=17,013). PSIRF advocates for a proportionate response to harm, where the severity and impact of an incident guide both the investigation and learning process.

Even incidents involving low harm can offer valuable learning opportunities. The focus should extend beyond the severity of harm to include identifying key lessons that can enhance patient safety and improve care processes.

The chart below shows that 47% of incidents requiring a further learning response were low or no-harm events, 42% were moderate-harm events and 11% were severe-harm events or resulted in death. This highlights that learning is not solely driven by the severity of harm, but also by the opportunity to improve safety processes across all levels of harm.



Breakdown of harm and level of investigation/oversight, April 2025–March 2026

The number of investigations previously reported externally has decreased due to changes in national definitions and the criteria for Patient Safety Incident Investigations (PSIIs). Additionally, the increased use of alternative PSIRF learning response tools, such as After Action Reviews (AARs), thematic reviews and multidisciplinary team (MDT) reviews, which are managed at Trust level and do not require external reporting, has contributed to this reduction.

Indications for PSIIs are grouped as follows:

- Nationally defined priorities—reviews by another body, e.g. MNSI, Child Death Review, LeDeR and safeguarding
- Nationally defined incidents requiring a local PSII, e.g. Never Events, learning from deaths, suicide/self-harm
- Locally defined incidents requiring a local PSII, e.g. cases with significant learning or incidents predefined in the Trust PSIRF Plan

The number of learning responses initiated under the PSIRF framework during 2025/26 included:

- 32 PSIIs, comprising 10 Maternity and Newborn Safety Investigations (MNSI) and 22 locally defined PSIIs
- 61 internal PSIRF responses, including 42 AARs, 9 MDT reviews and 5 incidents featured in 3 thematic reviews
- 182 locally managed PSIRF responses, including 130 IIRs only, 32 AARs, 8 mortality reviews and 12 incidents featured in 3 thematic reviews

Never Events

Never Events are serious, preventable patient safety incidents that should never occur in healthcare settings. These events typically involve situations where there are clear and well-established safety protocols that, if followed, would prevent the event from happening.

All Never Events are reported externally and the Integrated Care Board (ICB) is notified upon submission of the incident. A closure meeting is held with the ICB to review the actions taken, assess their effectiveness and ensure that the necessary steps have been implemented by the Trust to prevent recurrence.

The Trust reported no Never Events in 2025/26.

Duty of Candour

Patient safety incidents can have emotional and physical consequences for patients, their families and carers, and can be distressing for the professionals involved. The Trust is committed to being open and transparent when there are issues or errors in care. When patient safety incidents are identified, we aim to discuss the event with those involved promptly, fully and compassionately so that patients and professionals are best supported to cope with the after-effects.

As a CQC-regulated provider of healthcare services, the Trust has a legal requirement under Regulation 20: Duty of Candour to ensure that patients and their families are informed when a notifiable safety incident occurs. These are cases assessed as having led to moderate harm, severe harm or death. The Trust's duties include:

- Making an immediate verbal disclosure to the patient and apologising
- Providing a written post-investigation explanation of the causes of the incident and the improvement actions being taken as a result

During 2025/26, a total of 196 incidents were reported across all divisions where the Duty of Candour applied. At the time of writing this report, Trust performance, once adjusted for exclusions and exceptions, was as follows:

- 92% of incidents were explained and discussed with the relevant person
- 98% of incidents had a written outcome letter issued to the relevant person

In relation to the 196 notifiable patient safety incidents identified:

- Verbal notification and apologies were given for 169 cases:
 - In 16 cases, there was no documented evidence that a verbal notification and apology had been given at the time of the incident. These incidents include cases where contact with the patient or appropriate person has not yet been established, for example due to complexities or sensitivities identified during the investigation process.
 - In the remaining 11 cases, it was not possible to complete the verbal Duty of Candour because the patient was deceased with no identified next of kin, or the patient and/or next of kin was uncontactable.
- Written outcome letters were provided for 92 cases:
 - 80 cases are still awaiting completion of learning responses.
 - In 21 cases, a written outcome letter was not sent and a rationale was recorded, for example where the patient was deceased and no next of kin could be identified.

All efforts are made to identify and engage with the relevant person (the person who was harmed or someone acting lawfully on their behalf). Unfortunately, this was either not possible or was declined in three cases.

This is identified as an exception under Regulation 20: Duty of Candour, section 5. The Trust includes these cases for transparency.

PART 3

OTHER INFORMATION AND ANNEXES

This section provides further information on the quality of care we offer, based on our performance against the NHS Oversight Framework indicators, national targets, regulatory requirements and other metrics we have selected.

Performance indicators

During 2025/26, the NHS saw particular challenges in the achievement of key regulatory and contractual performance metrics, including quality and workforce key performance indicators (KPIs). The Trust performed well in comparison with peers within an extremely challenging operating environment.

Below is a summary of some of our KPIs for 2025/26. These should be read in conjunction with the main narrative of the Annual Report and Accounts for a better understanding of the context of these performance measures. Details of our current performance, updated monthly, are available on our website: www.chelwest.nhs.uk.

NHS Oversight Framework metrics

The table below summarises the performance indicators for the Trust.

	National Operational Plan 2025/26	Trust target	Performance
Incidents of C. diff (hospital-associated infections)	n/a	33	58
18 weeks Referral to Treatment (RTT) incomplete pathways	65%	92%	66%
All cancers: 31-day wait from diagnosis to first treatment	65%	96%	98.6%
All cancers: 62-day combined target	75%	85%	79.8%
Cancer: two-week wait from referral to date first seen (breast symptomatic)	80%	93%	90.1%
Cancer: two-week wait from referral to date first seen (comprising all cancers)	80%	93%	95.4%
Cancer: 28-day Faster Diagnosis Standard (FDS)	80%	75%	79.7%
A&E: total time waiting in A&E ≤4 hours	78%	95%	78.8%
Emergency care pathway–length of stay	7	4.5	5
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	n/a	compliant	compliant

Local quality indicators

Local quality indicators provide us with an opportunity to review the KPIs that are important to us and the quality of care our patients receive. The following indicators are tracked by the Executive Management Board and the Quality Committee to ensure we remain focused on where improvements can be embedded and sustained, and where learning can be shared.

Indicator		2021/22	2022/23	2023/24	2024/25	2025/26
Patient Safety	Patients with hospital-acquired MRSA infections (target 0)	6	7	4	5	6
	Hand hygiene compliance (target >90%)	92.1%	95.3%	96.3%	97.0%	96.7%
	Number of Patient Safety Incident Investigations	75	69	33	44	31
	Number of Never Events (target 0)	2	1	5	3	0
	Incident reporting rate per 100 admissions (target >8.5%)	9.3%	9.2%	9.5%	10.5%	11.4%
	Percentage of patient safety incidents resulting in severe harm or death	0.02%	0.02%	0.01%	0.02%	0.02%
	Medication-related safety incidents per 100,000 FCE bed days (target ≥280)	358.4	376.1	446.7	496.3	478
	Medication-related safety incidents with harm (target ≤12%)	8.4%	9.8%	9.7%	7.8%	4.0%
	Summary Hospital-level Mortality Indicator (SHMI) (target <100)	71	72	72	70	74

Indicator		2021/22	2022/23	2023/24	2024/25	2025/26
Clinical Effectiveness	Dementia screening case findings (target >90%)	94.0%	94.7%	94.4%	93.8%	92.8%
	Fractured neck of femur time to theatre <36 hours for medically fit patients (target 100%)	78.4%	75.1%	81.3%	81.5%	87.2%
	Stroke care: time spent on dedicated stroke unit (target >80%)	93.8%	89.6%	89.8%	84.9%	91.1%
	VTE: hospital-acquired	26	58	44	61	61
	VTE risk assessment (target >95%)	93.1%	92.7%	95.0%	95.6%	95.8%
	Sepsis: inpatient wards percentage of patients with a high NEWS score screened for sepsis (target >90%)	88.5%	93.2%	95.7%	90.1%	95.6%

Indicator		2021/22	2022/23	2023/24	2024/25	2025/26
Patient Experience	FFT: inpatient satisfaction (target >90%)	95.5%	95.6%	95.8%	96.0%	95.9%
	FFT: A&E satisfaction (target >90%)	82.2%	79.3%	82.0%	81.4%	79.5%
	FFT: maternity satisfaction (target >90%)	88.0%	89.1%	89.7%	90.0%	87.3%
	Complaints: number of formal complaints received	448	476	479	451	712
	Complaints: number of formal complaints responded to within 25 working days	341 (76%)	401 (84%)	269 (56%)	361 (80%)	598 (84%)
	Complaints: number of formal complaints responded to within 45 working days	100%	100%	100%	100%	100%
	Complaints: number of formal complaints referred to and upheld by the Ombudsman	3	1	6	2	2

Other quality improvement indicators

Top performer for patient environment

We have been recognised as a top performer in the February 2026 Patient-Led Assessments of the Care Environment (PLACE). PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to

quantify the facility's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

The Trust was one of the only acute providers to rank among the highest scorers for cleanliness, food quality and privacy. PLACE is a national assessment carried out by patients and members of the public to evaluate the quality of the care environment.

The assessment helps us understand how clean our hospitals are, the standard of the food we serve, the dignity and privacy we provide, and the overall condition of our facilities so that we may improve the overall patient journey through our organisation.

Divisional safety improvement highlights

Each division has an established structure for continuous quality improvement in the Trust to improve quality of care, reduce variation in a sustained manner and support an improvement culture across the organisation. During 2025/26, in addition to the Trust quality priorities, each division led a set of local priorities. Examples of their achievements are as follows:

Clinical Support Division

- **Removal of Nitrous Oxide Pipelines:** The Trust has removed piped nitrous oxide supplies from both main hospital sites and replaced them with a more sustainable and cost-effective alternative. Decommissioning the three manifolds required extensive planning to ensure no impact on patient care.

Supported by NHS England funding and collaboration across Pharmacy, Anaesthetics, Sustainability, Estates and Clinical Engineering, the project is expected to reduce greenhouse gas emissions by approximately 391 tonnes CO₂e per year—equivalent to the annual energy use of around 254 UK homes. This initiative contributes significantly to the Trust's Green Plan, particularly in reducing emissions from medicines, equipment and anaesthetic gases.

Emergency & Integrated Care Division

- **Fit to Sit:** West Middlesex Hospital Accident and Emergency (A&E) has replaced its short-stay ward with a 10-chair 'Fit to Sit' area and a 2-bed Rapid Assessment and Treatment (RAT) space to support winter demand.

Approximately 25% of A&E attendances are now managed through 'Fit to Sit', resulting in quicker assessments, faster treatment and improved four-hour performance compared with the same period last year. Staff report that the dedicated area improves workflow for patients not requiring cubicle care, and patient feedback indicates appreciation for being treated away from the main waiting room.

The RAT space enables faster senior clinical assessment and earlier initiation of investigations and treatment.

Planned Care Division

- **Neck of Femur—Time to Surgery:** Improvement work was undertaken to reduce time to theatre for patients presenting with fractured neck of femur, ensuring that all medically optimised patients undergo surgery within 36 hours, seven days a week. This work aimed to minimise avoidable delays to theatre, reducing the risk of post-operative complications and supporting improved patient outcomes.

Key elements of the improvement included:

- Implementation of a standardised pathway across both acute sites
 - Timely surgical intervention to support early post-operative recovery and mobilisation
 - A resulting reduction in length of stay
- **Enhanced recovery arthroplasty (knee and hip):** A multidisciplinary team (MDT) approach is in place to optimise outcomes and minimise surgical stress for patients undergoing elective hip and knee procedures. The pathway focuses on comprehensive pre-operative assessment, patient education and proactive discharge planning. Intra-operatively, modern anaesthetic techniques are used to support enhanced recovery.

Post-operatively, patients follow an agreed pain management plan, including the use of ice therapy, with an emphasis on early mobilisation. Discharge planning supports safe early discharge, with home environments assessed in advance and necessary equipment in place.

Key elements of the improvement included:

- Improved patient experience
 - Education and information provided to patients
 - Decrease in length of stay
- **Community Breast Pain Clinic:** A nurse-led community breast pain clinic is now being delivered to provide timely, high-quality assessment and reassurance for patients with breast pain, the majority of whom have benign symptoms that do not require secondary care investigation. The service supports care closer to home, reduces unnecessary referrals into specialist breast clinics, and ensures that patients with concerning features are identified promptly and escalated appropriately. This model improves patient experience, uses the workforce more effectively, and supports system-wide efficiency while maintaining patient safety.

Three key benefits:

- Reduced pressure on secondary care by diverting appropriate benign referrals from one-stop breast clinics
- Improved patient experience and reassurance through timely assessment in a community setting
- More efficient use of clinical resources through a cost-effective, protocol-driven, nurse-led model

Specialist Care Division

- **Clinical Immersion Programme:** One key innovation delivered was our first Clinical Immersion Programme in Conscious Sedation and Ambulatory Gynaecology. Welcoming 12 delegates, including members of the British Society for Gynaecological Endoscopy (BSGE), this milestone reinforces Chelsea and Westminster Hospital's leadership in this field. Since 2022, we have been the first hospital in the UK to offer conscious sedation for hysteroscopy, and we remain the only sedation immersion hub in the country providing dedicated training for gynaecology.

The programme, which offered hands-on training to clinicians from both the UK and internationally, highlighted a transformative model of care. By offering women more choice in pain relief, we have helped close the gender pain gap. By avoiding the need for general anaesthesia and anaesthetic support while delivering procedures in an outpatient setting, and enabling discharge after just one hour of monitoring, this approach improves patient experience while also being cost-effective, freeing up theatre capacity and reducing our carbon footprint.

This success reflects the dedication of our clinical teams and the support of our partners Medtronic and Kebomed in delivering innovative and equitable care.

West London Children's Healthcare

- **Paediatric Delirium Screening Tool:** West London Children's Healthcare has embedded the Cornell Assessment of Paediatric Delirium (CAPD) screening tool into Cerner, enabling faster and safer detection of paediatric delirium across Chelsea and Westminster Hospital and Imperial College Healthcare.

The tool went live after 16 months of development and is the first paediatric delirium screening tool integrated into the Trust's electronic patient record. The nurse-led project was initiated by Senior Recovery/PACU Nurses and Non-Medical Research Champions for Planned Care Recovery with support from multidisciplinary teams and partner organisations. The launch coincided with World Delirium Day on 11 March 2026.

Additional quality highlights

People and Workforce

The 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. During 2025/26, we ranked as leaders in learning and development, with the 'We are always learning' theme ranked second 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.

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

Pathology Savings

In 2024/25, the Trust experienced a 10% increase in pathology expenditure that deviated from sector trends, despite no significant change in activity. To address this, the Pathology Team within the Clinical Support Division was tasked with identifying underlying causes and exploring potential efficiencies during 2025/26.

One major contributor to the elevated costs was respiratory PCR testing, which became the focus of pathology services. A multidisciplinary team, comprising pathology operations, BI resources, a Finance Business Partner, the Chief Registrar and Hospital Directors, conducted an initial audit to better understand test-ordering pathways and processes across outpatient, inpatient and emergency care settings.

This investigation clarified where targeted improvements were needed and generated a number of initial actions:

- **Improve visibility of data, spending and test ordering:** A Pathology App and data-cleansing programme were developed to eliminate unnecessary tests, with care sets on the Electronic Patient Record (EPR) realigned and pathology costs integrated into divisional budgets to improve transparency and accountability.
- **Identify quick-win solutions:** Blood test cards and posters reduced specimen haemolysis, while care-set optimisation reduced unwarranted variation. Enhanced EPR access for allied health professionals also helped minimise test duplication.
- **Enhance education and training:** Ongoing sessions for clinical staff increased awareness of pathology processes, costs and environmental impacts, including the carbon footprint associated with duplicated tests such as Vitamin D testing.
- **Launch smaller quality improvement projects within services:** The Emergency Department reduced unnecessary coagulation testing by more than 70%, saving approximately £30,000 per month, while the Acute Medical Unit reduced respiratory viral swabs by more than 10,000 tests per month through audits and behavioural interventions.

As a result, the Trust reduced pathology expenditure by £2.86 million and test volumes by more than 520,000 within 12 months, improving patient care by reducing unnecessary risks and enabling faster clinical decision-making.

Next steps for 2026/27 include focusing on sustainability, developing champions within services, embedding pathology discussions within Performance and Deep Dive meetings to ensure engagement at all levels, further EPR refinement, continued care-set reviews, and closer collaboration on improvement initiatives with North West London Pathology.

Leading an Empowered Organisation (LEO) Programme

The Leading an Empowered Organisation (LEO) programme is designed to empower healthcare professionals to become transformational leaders, creating environments that support high-performing teams and professional practice.

The Trust launched the programme initially for nurse leaders from Bands 6–8b. It has since been expanded to include allied health professionals and midwives, with more than 450 staff attending the programme.

Key outcomes include encouraging ownership, accountability, teamwork, quality improvement and an inclusive, engaging leadership style. Each participant completes an improvement project to help embed learning and presents this back to their cohort at a follow-up session three months later.

Feedback has been overwhelmingly positive, with 100% of participants recommending the programme to others. National research also demonstrates the effectiveness of the training and retention of learning.

Shared Decision-Making

Shared decision-making, or shared governance, is defined as: ‘Staff having collective ownership to develop and improve practice to ensure patients receive caring, safe and confident care. It places staff at the heart of the decision-making process and sees managers having a facilitative leadership role’ (Taylor, 2016). The significant impact that shared decision-making can have is based on the principles that:

- Front-line staff have the greatest insight into improvements that will enhance patient experience and outcomes, as they work closest to patients and spend the most time with them.
- Involving staff in shared decision-making increases engagement and wellbeing, which in turn positively influences patient satisfaction and outcomes.

There are currently 20 active councils across the Trust. During the last financial year, they delivered a range of projects under three main improvement themes:

Patient Experience

- Cardiac discharge information leaflet
- Television in side rooms
- Patient information in the admissions lounge
- Improved seating in the admissions lounge and day surgery
- Frailty ward leaflet
- Improved storage of hearing aids
- Nail care on the diabetic ward
- Access to snack boxes for patients whose surgery is cancelled
- Reduction in noise on wards



Clinical Outcomes

- Bedside emergency equipment storage
- Improved infection prevention and control signage and staff guidance
- Storage of medicines to take home on discharge
- Introduction of a checklist for respiratory equipment
- Nurses joining bedside medical rounds
- Tracheostomy care
- Ensuring comfort rounds are implemented

Staff Wellbeing

- Staff Digital Pocket Guide
- Student welcome pack
- Refurbishment of staff rooms
- Employee of the Month initiative
- Team-building events
- Preceptorship pack for new starters

Ward Manager Development Programme



Ward managers on completion of the PROUD programme

The Trust has continued to invest in ward leadership through delivery of the Ward Manager PROUD Programme, with the initial cohort now having completed the first phase over a 12-month period. The programme brought together ward managers from inpatient wards across both hospital sites, providing a structured opportunity to share learning, strengthen leadership capability and build supportive peer networks across services.

Feedback from participants has been positive, highlighting strong engagement and the value of cross-site collaboration and shared learning. The final session focused on leadership development, supporting ward managers to reflect on their leadership approach, influence and impact within their teams and clinical areas.

Learning from the programme will inform future leadership development activity and support continued collaboration across inpatient services. This work supports the Trust's ongoing commitment to developing capable ward leaders who play a central role in delivering safe, high-quality and compassionate care.

Electronic Ward and Department Accreditation

The Trust continues to strengthen assurance of the quality and safety of care through its electronic ward and department accreditation programme. This programme provides a systematic, transparent and consistent method for assessing standards across all clinical areas, aligned to Care Quality Commission (CQC) domains and Trust quality priorities.

Since the introduction of the revised electronic accreditation framework in June 2023, all clinical areas have been assessed using a standardised digital tool. Accreditation visits are undertaken by a core team of trained subject matter experts to ensure consistency and reduce assessor bias. Inspections are unannounced and reflect a short-notice regulatory approach, providing a robust and realistic assessment of day-to-day practice.

In December 2025, the ward accreditation application moved into the Federated Data Platform (FDP), enabling centralised data collection. This transition has introduced enhanced reporting functionality, providing detailed analysis of accreditation results and compliance trends that can be filtered by site, division, ward and time period. The reporting tool also helps identify priority areas for improvement at site, divisional and ward level.

The electronic accreditation tools assess performance across key domains including infection prevention and control, health and safety, environment, medicines management, harm-free care, safeguarding and mental health, patient experience, end-of-life care and governance. Data is captured digitally at the point of inspection and triangulated with wider intelligence, including training compliance, patient feedback, incident reporting and complaints. Scoring is automated, producing a clear overall rating and enabling timely feedback to wards and departments.

Use of an electronic system has improved the reliability and timeliness of assurance information, supporting greater oversight at ward, divisional and Trust level. Results are shared transparently, with accreditation outcomes displayed within clinical areas and used to inform improvement priorities, action plans and reinspection schedules.

The programme continues to drive improvement, support learning and recognise areas of good and outstanding practice. Where accreditation identifies opportunities for development, targeted support and follow-up reviews are put in place to ensure sustained improvement. The Trust remains committed to further developing the digital accreditation system, including enhanced reporting and benchmarking capabilities, to strengthen assurance and improve patient outcomes.

AI-Assisted Discharge Summaries

The AI-Assisted Discharge Summarisation (AADS) product uses large language models (LLMs) to generate a first draft of a discharge summary from clinical notes, based on a best-practice clinical standard developed by clinicians at Chelsea and Westminster Hospital NHS Foundation Trust. This draft is then reviewed and edited by clinicians before being sent to patients and their care providers.

AADS has been co-designed and co-developed with clinical colleagues. The product is currently in live use across a small number of specialties at both hospital sites, with the aim of achieving full adoption across all in-scope specialties by the end of 2026. Plans are also underway to expand use of AADS to partner trusts over the coming months. Expansion to new specialties and sites will be phased, with safety and quality remaining key factors in determining the pace of deployment.

The tool is hosted on the NHS Federated Data Platform (FDP), providing a secure and tightly governed environment for AI-enabled medical devices. AADS is the first AI-enabled medical device developed on the FDP, and significant effort has been invested to ensure full compliance with all relevant regulatory and governance requirements.

Discharge summaries are a critical but time-consuming part of clinical workflow. Delays and inconsistency can compromise patient safety and increase administrative burden. AADS reduces this burden by automating the drafting process, freeing clinical time for patient care. It also improves adherence to best-practice standards for discharge summaries, increasing the completeness and consistency of information provided to patients and healthcare professionals.

As a pathfinder project, AADS has addressed regulatory questions for which there were no established precedents. Relevant regulatory bodies, including the Medicines and Healthcare products Regulatory Agency (MHRA) and the Health Research Authority (HRA), have engaged constructively with the programme and are using the learning generated to help create a more enabling environment for future innovations.

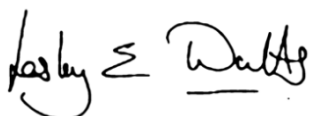
Declaration

It is important to note, as in previous years, that there are a number of inherent limitations in the preparation of quality accounts which may impact the reliability or accuracy of the data reported. Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance or included in the internal audit programme of work each year.

National data definitions do not necessarily cover all circumstances and local interpretations may differ. Where any local interpretations of national data definitions are applied, the Trust will ensure that variations are taken through appropriate governance to ensure the intent of the definition is achieved.

Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

Notwithstanding these inherent limitations, to the best of my knowledge, the information in this report is accurate.



Lesley Watts
Chief Executive Officer

Annex 1: National clinical audit and clinical outcome review programmes

National clinical audit participation 2025/26

N°	National clinical audits/quality improvement programmes	Trust eligible	Trust participated	% submitted
1	RCEM: Adolescent Mental Health (AMH)	Yes	Yes	Data collection in progress
2	BAUS: British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	Yes	No	0%
3	BAUS: Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Yes	Yes	100%
4	Breast and Cosmetic Implant Registry	Yes	Yes	Rolling data submission
5	British Spine Registry	No	No	n/a
6	BTS UK Interstitial Lung Disease (ILD) Registry	Yes	Yes	100%
7	RCEM: Care of Older People Year 3	Yes	Yes	100%
8	RCEM: Care of Older People Year 4	Yes	Yes	Data collection in progress
9	Case Mix Programme (CMP)	Yes	Yes	Rolling data submission
10	Cleft Registry and Audit Network (CRANE) Database	No	No	n/a
11	LeDeR - Learning from Lives and Deaths of People with a Learning Disability and Autistic People	Yes	Yes	Rolling data submission
12	RCEM: Mental Health (Self Harm): Year 3	Yes	Yes	100%
13	National Acute Kidney Injury Audit	Yes	Yes	Rolling data submission
14	National Audit of Cardiac Rehabilitation	No	No	n/a
15	National Audit of Cardiovascular Disease Prevention in Primary Care: CVD Prevent Workstream 3	No	No	n/a
16	National Audit of Care at the End of Life	Yes	Yes	100%
17	National Audit of Dementia: Service Mapping Exercise in Dementia Diagnostic Services	Yes	Yes	CW: Yes WM: n/a to site
18	National Audit of Eating Disorders	No	No	n/a
19	National Audit of Pulmonary Hypertension (NAPH)	No	No	n/a
20	National Bariatric Surgery Registry (NBSR)	Yes	Yes	Rolling data submission
21	NATCAN: Breast Cancer, Metastatic (NAoMe)	Yes	Yes	Rolling data submission
22	NATCAN: Breast Cancer, Primary (NAoPri)	Yes	Yes	Rolling data submission
23	NATCAN: Kidney Cancer (NKCA)	Yes	Yes	Rolling data submission
24	NATCAN: National Bowel Cancer Audit (NBOCA)	Yes	Yes	Rolling data submission
25	NATCAN: National Lung Cancer Audit (NLCA)	Yes	Yes	Rolling data submission
26	NATCAN: National Oesophagogastric Cancer Audit (NOGCA)	Yes	Yes	Rolling data submission
27	NATCAN: National Prostate Cancer Audit (NPCA)	Yes	Yes	Rolling data submission
28	NATCAN: Non-Hodgkin Lymphoma (NNHLA)	Yes	Yes	Rolling data submission
29	NATCAN: Ovarian Cancer (NOCA)	Yes	Yes	Rolling data submission
30	NATCAN: Pancreatic Cancer (NPaCA)	Yes	Yes	Rolling data submission

N°	National clinical audits/quality improvement programmes	Trust eligible	Trust participated	% submitted
31	National Cardiac Arrest Audit (NCAA)	Yes	Yes	Rolling data submission
32	NCAP: Left Atrial Appendage Occlusion (LAAO)	No	No	n/a
33	NCAP: Myocardial Ischaemia National Audit Programme (MINAP)	Yes	Partial	WM: No data submitted CW: Participated
34	NCAP: National Adult Cardiac Surgery Audit (NACSA)	No	No	n/a
35	NCAP: National Audit of Cardiac Rhythm Management (NACRM)	Yes	Yes	Rolling data submission
36	NCAP: National Audit of Percutaneous Coronary Interventions (NAPCI)	Yes	Partial	Applicable to WM site only
37	NCAP: National Congenital Heart Disease Audit (NCHDA)	No	No	n/a
38	NCAP: National Heart Failure Audit (NHFA)	Yes	Yes	Rolling data submission
39	NCAP: Percutaneous Foramen Ovale Closure (PFOC)	No	No	n/a
40	NCAP: Transcatheter Aortic Valve Implantation (TAVI)	No	No	n/a
41	NCAP: Transcatheter Mitral and Tricuspid Valve Procedure (TMTV)	No	No	n/a
42	National Child Mortality Database (NCMD)	Yes	Yes	Rolling data submission
43	National Clinical Audit of Psychosis	No	No	n/a
44	National Clinical Audit of Seizures and Epilepsies for Children and Young People: Epilepsy12	Yes	Partial	Rolling data submission
45	NCABT: 2025 Major Haemorrhage Audit	Yes	Yes	100%
46	NDA: Diabetes Prevention Programme (DPP) Audit (primary care)	No	No	n/a
47	NDA: National Core Diabetes Audit	Yes	Yes	Rolling data submission
48	NDA: National Diabetes Foot Care Audit (NDFA)	Yes	Yes	Rolling data submission
49	NDA: National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	Rolling data submission
50	NDA: National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	Rolling data submission
51	NDA: National Gestational Diabetes Audit	Yes	Yes	Automatic data upload
52	NDA: Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Yes	Rolling data submission
53	NDA Integrated Specialist Survey	Yes	No	Closed until further notice
54	National Early Inflammatory Arthritis Audit	Yes	Yes	Rolling data submission
55	NELA: Laparotomy (Lap)	Yes	Partially	Rolling data submission
56	NELA: No Laparotomy (NoLap)	Yes	No	No data submitted
57	FFFAP: Fracture Liaison Service Database	Yes	Yes	Rolling data submission
58	FFFAP: National Audit of Inpatient Falls	Yes	Yes	100% submission
59	FFFAP: National Hip Fracture Database	Yes	Yes	Rolling data submission
60	National Joint Registry	Yes	Yes	Rolling data submission
61	National Major Trauma Registry Network [Note: Previously The Trauma Audit & Research Network (TARN)]	Yes	Yes	Rolling data submission
62	National Maternity and Perinatal Audit	Yes	Yes	Rolling data submission
63	National Neonatal Audit Programme	Yes	Yes	Rolling data submission
64	National Obesity Audit	Yes	Yes	Rolling data submission

N°	National clinical audits/quality improvement programmes	Trust eligible	Trust participated	% submitted
65	NOD: Age-related Macular Degeneration (AMD) Audit	Yes	No	No data submitted
66	NOD: Cataract Audit	Yes	No	No data submitted
67	National Paediatric Diabetes Audit	Yes	Yes	Rolling data submission
68	NRAP: Asthma Secondary Care	Yes	Yes	Rolling data submission
69	NRAP: Children and Young People Asthma	Yes	Yes	Rolling data submission
70	NRAP: COPD Secondary Care	Yes	Yes	Rolling data submission
71	NRAP: Pulmonary Rehabilitation	No	No	n/a
72	National Vascular Registry	No	No	n/a
73	Out of Hospital Cardiac Arrest Outcomes (OHCAO)	No	No	n/a
74	Paediatric Intensive Care Audit Network (PICANet)	No	No	n/a
75	Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	Rolling data submission
76	POMH: Improving the quality of valproate prescribing in adult mental health services	No	No	n/a
77	POMH: The use of clozapine	No	No	n/a
78	POMH: The use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	No	No	n/a
79	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Rolling data submission
80	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	Yes	Rolling data submission
81	RCEM: Time Critical Medications (TCM) Year 2	Yes	Yes	100% submission
82	RCEM: Time Critical Medications (TCM) Year 3	Yes	Yes	Data collection in progress
83	UK Cystic Fibrosis Registry	No	No	n/a
84	UK Parkinson's Audit	Yes	Partial	WM: No data submitted CW: Participated
85	UK Renal Registry Chronic Kidney Disease Audit	No	No	n/a

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National clinical outcome review programmes 2025/26

N°	Programme Title	Trust eligible	Trust participated	% submitted
1	Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry—annual topic-based serious maternal morbidity	Yes	Yes	100%
2	Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality confidential enquiries	Yes	Yes	100%
3	Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance	Yes	Yes	100%
4	Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality and serious morbidity confidential enquiry	Yes	Yes	100%
5	Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality surveillance	Yes	Yes	100%
6	Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Review Tool	Yes	Yes	100%
7	Medical and Surgical Clinical Outcome Review Programme: Emergency surgery in children and young people	Yes	Yes	70%
8	Medical and Surgical Clinical Outcome Review Programme: Stabilisation of the critically ill child	Yes	Yes	Data collection in progress
9	Medical and Surgical Clinical Outcome Review Programme: Managing acute illness in people with learning disabilities	Yes	Yes	100%
10	Medical and Surgical Clinical Outcome Review Programme: Pleural procedures	Yes	Yes	Data collection in progress
11	Medical and Surgical Clinical Outcome Review Programme: Rib fractures	Yes	Yes	Data collection in progress
12	Mental Health Clinical Outcome Review Programme (NCISH)	No	No	Not eligible, but Trust reviews annual NCISH recommendations

Annex 2: National clinical audits reviewed by the Trust

The table below provides a summary of actions and examples of good practice identified following the publication of these national reports during 2025/26. The actions are monitored through local governance meetings.

Programme	Summary
<p>1. National Maternity and Perinatal Audit: Multiple births report 2023 data</p> <p>Speciality: Maternity</p> <p>Publication date: 12 Mar 2026</p>	<p>Cross-site gap analysis in progress.</p>
<p>2. National Paediatric Diabetes Audit: Care and Outcomes 2024–2025 report</p> <p>Speciality: WLCH</p> <p>Publication date: 12 Mar 2026</p>	<p>WLCH gap analysis in progress.</p>
<p>3. UK Parkinson’s Audit: Transforming care: report of 2025</p> <p>Speciality: Neurology</p> <p>Publication date: 9 Mar 2026</p>	<p>The audit identified five improvement themes across participating services and will use these themes to develop and facilitate a national priority improvement programme, for those who sign up to it, to address gaps identified.</p> <p>The improvement themes, links to useful resources and learning to support development were emailed to cross-site audit teams, along with details of the Audit and Service Improvement portal for signing up to the national service improvement project when it launches, and for recording local improvement projects.</p>
<p>4. National Comparative Audit of Blood Transfusion: 2025 Audit of Compliance with Major Haemorrhage Protocols</p> <p>Speciality: Blood Transfusion</p> <p>Publication date: 23 Feb 2026</p>	<p>Cross-site gap analysis is in progress and will be presented at the Hospital Transfusion Team Safety Subgroup meeting in May 2026.</p>
<p>5. NATCAN: National Lung Cancer Audit: State of the Nation (2024 data)</p> <p>Speciality: Cancer</p> <p>Publication date: 12 Feb 2026</p>	<p>Good practice</p> <p>Every patient who has advanced lung cancer is seen by our oncology colleagues for a full assessment of their performance status and any therapy that might be suitable for them, including clinical trials. We do not rely solely on performance status at MDT. We have 62 days to manage and care for a patient, so performance status is revisited at multiple MDTs and adjusted where appropriate. More than one clinician is involved in assessing the patient.</p> <p>Cases are brought back to MDT where there is concern that performance status differs from that previously discussed, allowing treatment decisions to be reviewed and ratified.</p>
<p>6. NCMD: Thematic Report: Understanding consanguinity-related child deaths (April 2019–March 2023)</p> <p>Speciality: WLCH</p> <p>Publication date: 12 Feb 2026</p>	<p>WLCH gap analysis is in progress and will be presented at the Imperial and Chelsea joint quality and safety meeting.</p>

<p>7. FFFAP: FLS-DB: Annual Report (2024 data)</p> <p>Speciality: Musculoskeletal, falls, older people</p> <p>Publication date: 8 Jan 2026</p>	<p>Good practice</p> <p>There is currently no formal collaboration with ICBs. However, GP practices are improving awareness of the Fracture Liaison Service (FLS) and actively increasing referrals. Current national guidelines are being followed to support the implementation of KPI 7. The service works closely with community bone health teams, maintaining proactive communication regarding patient follow-up. Pharmacists are also engaged, and intolerance to oral therapies is usually communicated promptly to ensure appropriate alternative management.</p>
<p>8. National Heart Failure Audit (NHFA): 2nd Edition 2025 Annual Report (2024–2025 data)</p> <p>Speciality: Cardiology</p> <p>Publication date: 15 Dec 2025</p>	<p>Good practice</p> <p>Both sites are above the national average for prescribing all appropriate medications unless contraindicated. The team plans to build on this good practice. The team will look at using non-core data to indicate contraindications to see if this helps with data for next year.</p>
<p>9. National Audit of Cardiac Rhythm Management (NACRM): 2nd Edition 2025 Annual Report (2024–2025 data)</p> <p>Speciality: Cardiology</p> <p>Publication date: 15 Dec 2025</p>	<p>Good practice</p> <p>West Middlesex University Hospital reviews waiting lists and local practice against guidelines. The hospital undertakes sufficient procedure numbers at the site.</p> <p>The hospital works with industry and supports the team, including AHPs, to attend conferences and study days.</p>
<p>10. Myocardial Ischaemia National Audit Project (MINAP): 2nd Edition 2025 Annual Report (2024–2025 data)</p> <p>Speciality: Cardiology</p> <p>Publication date: 15 Dec 2025</p>	<p>Good practice</p> <ul style="list-style-type: none"> • Inter-hospital transfer pathways for patients in non-interventional hospitals are met by CWFT via the network policy. • CWFT has been unable to submit complete and accurate data to the NAPCI. A process is being scoped to address this. • Use of the database and scanning system in the lab is undertaken to ensure implant identifiers and relevant clinical fields are completed and submitted within agreed timelines.
<p>11. National Audit of Percutaneous Coronary Intervention (NAPCI): 2nd Edition 2025 Annual Report (2024–2025 data)</p> <p>Speciality: Cardiology</p> <p>Publication date: 15 Dec 2025</p>	<p>Good practice</p> <ul style="list-style-type: none"> • CWFT is not a primary PCI centre. There is a pathway for patients who need transfer to the tertiary centre. Some cases are performed within our centre during daytime hours to avoid delay. • All operators follow best practice.
<p>12. SSNAP: State of the Nation Report 2025 (April 2024–March 2025 data)</p> <p>Speciality: Neurology/Stroke</p> <p>Publication date: 13 Nov 2025</p>	<p>No recommendations for acute trusts.</p> <p>National recommendations linked to findings were emailed to the Trust Stroke Lead to discuss with the clinical team and ensure the findings are taken into consideration when reviewing services or benchmarking practice.</p>
<p>13. NMPA: Induction of Labour Snapshot Audit (2023 data)</p> <p>Speciality: Gynaecology, Maternity and Midwifery</p> <p>Publication date: 13 Nov 2025</p>	<p>No recommendations for acute trusts.</p> <p>The report and findings were emailed to clinical audit leads to discuss with their clinical teams and ensure the findings are taken into consideration when reviewing services or benchmarking practice.</p>
<p>14. NCEPOD: Risking Life and Limb: A review of the quality of the care provided to adults with acute limb ischaemia</p> <p>Speciality: Vascular</p> <p>Publication date: 13 Nov 2025</p>	<p>CWFT is a “spoke” hospital where patients with acute limb ischaemia may present, for example to an emergency department, before being referred or transferred to a specialist “hub” hospital for treatment (ICHT).</p> <p>ICHT is in the process of completing a gap analysis against the report recommendations and will share this with CWFT once completed for discussion at the Clinical Effectiveness Group.</p>

<p>15. NJR: 22nd Annual Report: Surgical data to 31 Dec 2024</p> <p>Speciality: Musculoskeletal</p> <p>Publication date: 5 Nov 2025</p>	<p>No recommendations in report.</p> <p>The report was disseminated to audit leads to share across their teams.</p>
<p>16. NATCAN: National Bowel Cancer Audit: State of the Nation Report (Jan 2023–Dec 2023 data)</p> <p>Speciality: Cancer</p> <p>Publication date: 9 Oct 2025</p>	<p>Good practice</p> <p>Robust pathways are in place to provide timely genomic assessment where clinically appropriate, to inform personalised treatment options and/or identify patients.</p> <p>Continue to improve data completeness of key items in the English cancer registration and Wales Cancer Network datasets to allow risk adjustment of performance indicators.</p>
<p>17. NELA: 10th Patient Report (April 2023–April 2024 data)</p> <p>Speciality: Surgery</p> <p>Publication date: 9 Oct 2025</p>	<p>Recommendations are for national bodies.</p> <p>The national report, key messages and recommendations were emailed to cross-site leads to disseminate across their teams.</p>
<p>18. NCEPOD: A Balanced Solution: A review of the quality of the care in hospital provided to adults with abnormal levels of blood sodium</p> <p>Speciality: Endocrinology/blood biochemistry</p> <p>Publication date: 9 Oct 2025</p>	<p>Improvement actions identified:</p> <ul style="list-style-type: none"> • Develop a local care bundle with defined responsibilities and checklist documentation. • Standardise the investigation protocol, aligned with NICE and endocrinology guidance. • Provide targeted teaching sessions on fluid assessment. • Develop/review the local protocol, including escalation pathways. • Standardise medication review, recording and communication at diagnosis of abnormal sodium.
<p>19. NEIAA: State of the Nation Summary Report 2025 (April 2024–March 2025 data)</p> <p>Speciality: Musculoskeletal</p> <p>Publication date: 9 Oct 2025</p>	<p>Improvement actions identified:</p> <ul style="list-style-type: none"> • Dashboard data is used to direct improvement. There is inadequate time allocation for data entry by doctors, and more patients need to be entered into the database. • Patients are not routinely assessed using PROMs. Patients are asked about mental health status if indicated during routine rheumatology appointments. GPs are asked to review if concerns are raised and refer to mental health services if appropriate.
<p>20. NRAP: Clinical Outcomes (2021–2023) and Outliers: Summary Report</p> <p>Speciality: Respiratory</p> <p>Publication date: 9 Oct 2025</p>	<p>No recommendations in report.</p> <p>The report and resources are to be used by service providers, commissioners and clinical teams to identify areas of success or those requiring improvement to facilitate and influence change. These were disseminated to cross-site clinical teams.</p>
<p>21. NAIF: Stepping towards improvement (2024 data)</p> <p>Speciality: Falls, older people</p> <p>Publication date: 9 Oct 2025</p>	<p>Recommendations and QI actions were discussed at the Falls Steering Group, which reports on workstream activity on a quarterly basis to the Patient Safety Group.</p>

<p>22. NATCAN: National Oesophago-Gastric (OG) Cancer Audit: State of the Nation Report (Jan 2022–Dec 2023 data)</p> <p>Speciality: Cancer</p> <p>Publication date: 11 Sep 2025</p>	<p>Good practice</p> <p>Of the 232 patients diagnosed with OG cancer between October 2021 and September 2024, which are the report parameters, 16 (7%) were referred via emergency admission. Missed cancers at endoscopy within three years continue to be reviewed on a case-by-case basis in EUG, and the Trust took part in the National PEUGIC study.</p> <p>Any missed imaging is reviewed in the Radiology Discrepancy Meeting. Learning from these cases is shared with the UGI MDT, Endoscopy and Imaging teams. There is a continued action plan to monitor emergency presentations and monitor for any recurrent themes delaying diagnosis. This will be reviewed at the time of MDT discussion if there is any delay in the referral pathway.</p> <p>Of the 232 patients, 100 referred from a GP for suspected cancer were treated on the 62-day pathway. The median wait from referral to first treatment was 44.5 days.</p>
<p>23. NATCAN: National Kidney Cancer Audit: State of the Nation Report 2025 (Jan 2019–Sep 2024 data)</p> <p>Speciality: Cancer and Urology (CW site)</p> <p>Publication date: 11 Sep 2025</p>	<p>Good practice</p> <p>In conjunction with ICHT, clinical management will review pathways for higher-risk renal cell carcinoma (RCC) to understand system-level delays, and patients are treated within 31 days.</p> <p>Patients with kidney cancer, stage T1aN0M0 RCC, are discussed in specialist multidisciplinary team meetings and offered nephron-sparing treatment where appropriate.</p> <p>Patients diagnosed with metastatic RCC are evaluated by a medical or clinical oncologist with expertise in renal cancer management and considered for receipt of systemic anti-cancer therapy (SACT).</p>
<p>24. MBRRACE-UK: State of the Nation Report (2021–2023 data)</p> <p>Speciality: Gynaecology, Maternity and Midwifery</p> <p>Publication date: 11 Sep 2025</p>	<p>The majority of recommendations arise from existing national guidance.</p> <p>National recommendations to improve care were emailed to leads with a request to discuss these with their clinical teams and ensure they are taken into consideration when reviewing services or benchmarking practice.</p>
<p>25. NHFD: Room for improvement: hip fracture care in 2024 (Jan–Dec 2024 data)</p> <p>Speciality: Older people, surgery, rehabilitation, falls</p> <p>Publication date: 11 Sep 2025</p>	<p>Recommendations for Integrated Care Boards (ICBs) were disseminated to audit leads to discuss with their clinical teams and ensure they are taken into consideration when reviewing services or benchmarking practice.</p>
<p>26. NMPA: State of the Nation Report (2023 data)</p> <p>Speciality: Gynaecology, Maternity and Midwifery</p> <p>Publication date: 11 Sep 2025</p>	<p>Recommendations for national bodies were disseminated to audit leads to discuss with their clinical teams and ensure they are taken into consideration when reviewing services or benchmarking practice.</p>
<p>27. LeDeR Annual Report (2023 data)</p> <p>Speciality: Learning Disability</p> <p>Publication date: 3 Sep 2025</p>	<p>Improvement actions identified:</p> <ul style="list-style-type: none"> • Inform the team of admissions involving patients with a learning disability and autistic people. • Ensure the patient has a hospital passport at their bedside. • Involve the team in best-interest and discharge planning meetings. • Use correct terminology in records. • Present data annually to the Safeguarding Board and relevant committees.

<p>28. NACEL: State of the Nation Report 2024 (2024 data)</p> <p>Speciality: End of Life Care</p> <p>Publication date: 14 Aug 2025</p>	<p>Actions form part of the End of Life Care Steering Group work programme, with quarterly progress updates provided to the Clinical Effectiveness Group.</p>
<p>29. BAUS Data & Audit Programme: Environmental Lessons Learned and Applied (ELLA) to the Bladder Cancer Care Pathway</p> <p>Speciality: Urology</p> <p>Publication date: 24 Jul 2025</p>	<p>Good practice</p> <p>Recommendations relating to the use of advice and guidance to optimise secondary care referrals, performing flexible cystoscopy in a clinic setting, optimising anaesthesia for bladder tumour resection, and decarbonising the bladder tumour resection surgical field have all been met by the Trust.</p>
<p>30. National Ophthalmology Database (NOD) Audit: 8th Annual Report: National Cataract Audit (April 2023–March 2024)</p> <p>Speciality: Ophthalmology</p> <p>Publication date: 25 Jul 2025</p>	<p>Good practice</p> <p>An all-cause estimate of risk over the course of treatment and recovery from cataract surgery showed a 0.46% risk of vision loss and a 0.17% risk of severe vision loss. These findings were cascaded to all cataract surgeons within the department.</p>
<p>31. Serious Hazards of Transfusion (SHOT): Annual Report (2024 data)</p> <p>Speciality: Haematology</p> <p>Publication date: 11 Jul 2025</p>	<p>Good practice</p> <p>Trust policy clearly promotes labelling at the bedside. This is supported through Transfusion Sampling Competencies, with bedside labelling as a key aspect of the competency.</p> <p>A bedside checklist is embedded within Cerner and has a paper counterpart on compatibility tags in the event of Cerner downtime.</p> <p>The Trust has Adult, Paediatric, Neonatal and Maternity Major Haemorrhage (MH) policies, all aimed at ensuring a timely response to the provision of blood products. Training is delivered at induction for doctors. New local in-situ simulations have been undertaken to reinforce major haemorrhage processes. Maternity services deliver major haemorrhage training as part of annual maternity updates for all staff. The Emergency Department undertakes local training and simulation programmes addressing major haemorrhage.</p> <p>There is a mandatory field within the Cerner prescription process that must be completed before transcribing blood. This includes information on providing information to the patient and obtaining informed consent from the patient, although not necessarily written consent. Patient information leaflets are available on the intranet for printing and distribution.</p>
<p>32. NCMD: Thematic Report: Learning from child death reviews on palliative and end-of-life care provision (April 2019–March 2022 data)</p> <p>Speciality: Child and Adolescent</p> <p>Publication date: 10 Jul 2025</p>	<p>Good practice</p> <p>All families of children who die in North West London are referred to Shooting Star Children's Hospices for bereavement support. The service offers ongoing support for three years and three months following death and includes support for wider family members and siblings. Local bereavement support is also offered across all sites by child death key workers and bereavement midwives.</p> <p>WLCH has strong links with palliative care teams across North West London, predominantly those at Great Ormond Street Hospital. These teams prepare the ReSPECT documentation. There is currently no specific training package in place for staff within the Trust.</p>

<p>33. NCEPOD: Recovery Beyond Survival: A review of the quality of rehabilitation care provided to patients following an admission to an intensive care unit</p> <p>Speciality: Rehabilitation</p> <p>Publication date: 12 Jun 2025</p>	<p>Good practice</p> <p>Across both sites, a named rehabilitation care coordinator is in place at patient level to oversee rehabilitation needs within the ICU, on the ward and in the community. On the wards, responsibility is team-specific and is most likely undertaken by the clinical lead therapist. A named person or role is allocated from the therapy team within each division.</p> <p>ICU teams and the Psychology Team undertake and document a comprehensive, holistic assessment of the rehabilitation needs of patients admitted to intensive care who are at risk of physical and/or non-physical morbidity.</p>
<p>34. NRAP: Catching Our Breath: Time for change in respiratory care (April 2023–March 2024 data)</p> <p>Speciality: Respiratory</p> <p>Publication date: 12 Jun 2025</p>	<p>No recommendations for acute trusts.</p> <p>Recommendations for national bodies were disseminated to audit leads to discuss with their clinical teams and ensure they are taken into consideration when reviewing services or benchmarking practice.</p>
<p>35. RCEM: Care of Older People (Year 2)</p> <p>Speciality: Emergency Medicine</p> <p>Publication date: 19 May 2025</p>	<p>Good practice</p> <ul style="list-style-type: none"> • All patients aged over 70 are streamed to majors to facilitate improved screening. An Acute Frailty Service continues to operate within departmental hours to support screening and assessment. • Teaching for resident doctors is ongoing and is highlighted during induction. • Falls risk assessments are completed in Cerner by nursing staff. • A proforma is available within Cerner. Regular reminders are provided through daily morning handovers, teaching sessions and induction programmes.
<p>36. MBRRACE-UK: Perinatal Mortality Surveillance: State of the Nation Report (2023 data)</p> <p>Speciality: Gynaecology, Maternity and Midwifery</p> <p>Publication date: 08 May 2025</p>	<p>Good practice</p> <ul style="list-style-type: none"> • The Trust has adopted and uses the BAPM Perinatal Optimisation Pathway to improve preterm outcomes. This is embedded within clinical practice and supported by accompanying clinical guidance. • To support the reduction of direct and indirect health inequalities, CWFT is a MRICB pilot site. A Cultural Safety Team and Continuity of Carer Working Group are in place to support delivery of equitable and personalised maternity care.
<p>37. RCEM: Time Critical Medications (TCM) Year 1</p> <p>Speciality: Emergency Medicine</p> <p>Publication date: 22 Apr 2025</p>	<p>Good practice</p> <ul style="list-style-type: none"> • Time Critical Medications are discussed during induction, with a new locum induction pack being introduced. • Electronic prescribing is in place. • Staff have access to the Summary Care Record (SCR). • Posters within the department encourage patients to inform staff if they are taking time critical medications, and nursing staff are aware that patients should be supported to self-administer where appropriate. • A local process is in place to identify time critical medications on all wards.

<p>38. RCEM: Mental Health (Self Harm) Year 2</p> <p>Speciality: Emergency Medicine</p> <p>Publication date: 22 Apr 2025</p>	<p>Good practice</p> <ul style="list-style-type: none"> • Eligible patients are identified at triage and streamed to an appropriate mental health majors cubicle, with early involvement of the Psychiatric Liaison Nursing (PLN) team by triage staff or the nurse in charge. • The culture of parallel assessment within the Emergency Department has continued to develop positively over the last 6–12 months. • A mental health proforma is in use and reinforced through daily morning handovers, clinical governance meetings, induction programmes and resident training. • Regular safety rounds are undertaken, with escalation and liaison with Mental Health Teams for long-stay patients, supported by daily psychiatric ward round reviews. • Referrals to community services and third-sector organisations are completed by the Psychiatric Liaison Nursing team.
<p>39. NATCAN: National Lung Cancer Audit: State of the Nation Report (2023 data)</p> <p>Speciality: Cancer</p> <p>Publication date: 10 Apr 2025</p>	<p>Improvement actions identified</p> <ul style="list-style-type: none"> • Additional diagnostic capacity is required and an audit has been undertaken to assess this need. • Further work with Clinical and Medical Oncology teams is required to identify opportunities to increase the proportion of patients with stage 3B–4 non-small cell lung cancer (NSCLC) and performance status 0–1 who receive systemic anti-cancer therapy (SACT) in line with NICE guidance, including supporting patients to maintain fitness for treatment throughout the care pathway.
<p>40. NPDA: Type 2 Diabetes Mellitus (T2DM) Spotlight Audit (2023/24 data)</p> <p>Speciality: Child and Adolescent, Long-Term Conditions, Diabetes</p> <p>Publication date: 10 Apr 2025</p>	<p>Good practice</p> <ul style="list-style-type: none"> • A Children and Young People Type 2 Diabetes forum for North London has been established. The forum includes multidisciplinary team representatives and champions, including clinical nurse specialists, dietitians and consultants. The North West London network has also introduced quarterly Type 2 Diabetes meetings to discuss education, management and complex cases. Several WLCH team members have received training in poverty proofing. • Patients with Type 2 Diabetes receive multidisciplinary care within the service in line with NICE guidance. Psychology support is available through referral, and dietitians lead on lifestyle modification. The frequency of support will increase in line with new network guidance. • A West London Children’s Healthcare-wide clinical guideline is currently being developed.

Annex 3: Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations (amended in 2020) to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS foundation trust boards on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the Quality Account. In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

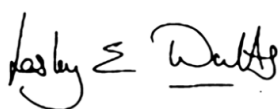
- The content of the Quality Account is not inconsistent with internal and external sources of information, including:
 - Board minutes and papers for the period Apr 2025–Mar 2026
 - Papers relating to quality reported to the Board over the period Apr 2025–Mar 2026
 - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
 - The latest national patient survey
 - The latest national staff survey
 - CQC inspection reports
- The Quality Account presents a balanced picture of Chelsea and Westminster Hospital NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26 (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the Quality Account

The directors confirm, to the best of their knowledge and belief, that they have complied with the above requirements in preparing the Quality Account.

By order of the board:



Bob Alexander OBE
Interim Group Chair
8 Jun 2026



Lesley Watts
Chief Executive Officer
8 Jun 2026

Annex 4: Statement from the Council of Governors

Governors' comments on the Quality Account 2025/26

As Council of Governors, we are pleased to comment on this year's Quality Report, which reflects the Trust's continued commitment to delivering safe, high-quality and patient-centred care. We extend our sincere thanks to all staff, volunteers and partners for their dedication and resilience throughout another demanding year, and for all that they have achieved to maintain and improve services over that time.

The Trust continues to make significant progress in key areas, including wider deployment of digital records and analysis supporting reducing waiting times, further focus on maternity services, and improving cancer diagnosis and treatment. We are encouraged by the Trust's proactive approach to innovation and collaboration with local communities and partners. The commitment to improved use of data to inform management and drive better and more effective care is matched by some very exciting innovation, encapsulated by the Virtual Cardiac Ward, the developments in thrombosis prevention and the augmented reality work in endometriosis. We look forward to the opening of the Diagnostic, Treatment and Education Centre at West Middlesex later in the year as another step on that road.

As elected representatives of patients, the public and staff, we are accountable to our wider membership. We fulfil this role through regular engagement activities, including 'meet the governor' sessions, community feedback, and formal and informal meetings with Trust leadership. We continue to hold Non-Executive Directors to account, play a role in the appointment of new directors, and maintain constructive relationships with the Trust's leadership team. We also provide constructive challenge and input where we believe the Trust could do more to improve services and patient experience, always with the aim of achieving the best outcomes for our communities.

Over the past year, we have focused on several quality priorities and initiatives. Below are some examples:

- **Quality Priorities 2025/26:** We endorsed the Trust's quality priorities, which included improving care for deteriorating and frail patients, and welcomed the launch of the Same Day Emergency Care frailty pilot at West Middlesex, critical to avoiding unnecessary admissions and reducing pressure on services. That benefit was echoed by the new Day Surgery Unit at Chelsea and Westminster. These developments show the gains that are made by a relentless focus on the quality of care. The Trust continues to invest in infrastructure and associated services with improvement at the core.
- **Outpatient communications:** The Governors have been concerned that the outpatient booking arrangements are too frequently suboptimal, both in terms of communication and putting patients' interests foremost. The further development of, and integration with, the NHS app looks very promising and this will remain a focus in the coming year.
- **Lessons learned:** The Governors continue to work with the Non-Executive Directors to ensure that where Prevention of Future Deaths reports have been issued, these are acted upon in a constructive way, and processes are amended where needed. The Governors are grateful to Patricia Gallan, the Trust's Vice Chair and Chair of the North West London Acute Provider Group Quality Committee, for her commitment to openness and to a collaborative approach to these issues.

- **Single Delivery Plan:** The Trust's performance in maternity and neonatal care as part of the national programme has been very encouraging; the new incident management system is an essential assurance mechanism and has been welcomed by the Governors.
- **Patient experience:** The Trust continues to receive positive feedback in the national inpatient experience and Urgent and Emergency Care (UEC) surveys, being a positive outlier for type 1 UEC performance. We note, however, that the Trust always strives for even better performance, so will focus on areas requiring improvement. The priorities set out for 2026/27 have a strong focus on patient safety, which the Governors welcome.
- **End-of-Life Care:** The Trust remains committed to supporting patients' preferences for their final days, ensuring timely and compassionate transitions from hospital to home or other preferred settings. The Governors are very encouraged by and supportive of the Trust involving the voluntary sector to improve patient care and experience. During 2025/26 we have seen an increase in support for end-of-life patients. Our Butterfly Volunteers from within our communities work every day across both sites to provide support to patients and their families.
- **Dementia:** The performance over the last year in dementia screening, and the training of dementia champions, has demonstrated in practice the Trust's commitment to care of the elderly.
- **Compliance with regulators and maintaining high standards:** We received updates on how we meet our regulatory standards and best practice.
- **Research and Development:** The Trust continues to expand access to research opportunities, and the year's focus on connecting innovation and quality improvement is a vital part of that. Investment in R&D helps attract good staff, so the developments are very encouraging.

As the North West London Acute Provider Group has continued to evolve, Governors have been concerned to make sure that the interests of the patients and communities served by the Chelsea and Westminster Trust's two hospitals continue to be promoted as change occurs. As the Group develops, the changes that follow will need to be communicated to the public well to ensure continued support.

We believe that listening to and engaging with patients is essential to improving services and reducing inequalities. Despite the considerable uncertainty over the future of patient and community work in the Trust caused by the changes which may result from the current legislation, the Governors remain committed to making sure that subsequent arrangements support patients and staff to maintain the high standards of care that the Trust maintains.

The report demonstrates again that the Trust is a high-quality and safe provider. To maintain that, the Governors recognise that, as always, continuous improvement is essential. We remain committed to working in partnership with the Trust's leadership and our communities to make that so.

Nigel Clarke
Lead Governor
8 Jun 2026

Annex 5: Stakeholder statements

Healthwatch Richmond Commentary to Chelsea and Westminster Hospital NHS Foundation Trust 2025/26 Quality Account

We are pleased to review and offer our commentary on Chelsea and Westminster Hospital NHS Foundation Trust's 2025/26 Quality Account. We commend the Trust's ongoing commitment to patient and staff safety, patient experience and clinical effectiveness.

We are pleased to see baseline measures, targets and achieved results presented throughout the Quality Account. We support the Trust's engagement with staff and patient experience data, and encourage the ongoing use of these insights to ensure initiatives are effective and contribute to tangible improvements in patient care.

2025/26 Quality Priorities

Priority 1: Feeling Safe at Work

We are pleased to see a range of approaches towards ensuring staff feel safe at work, from training to refreshing policies relating to violence and aggression. The Trust's progress in Level 2 Conflict Resolution Training compliance, increasing from 20% to 46%, is an impressive improvement, as is exceeding the Level 1 target.

Nonetheless, we would appreciate more insight into whether these initiatives led to staff actually feeling safer. During recent work on inpatient wards at West Middlesex University Hospital, Healthwatch Richmond collected positive feedback from staff regarding safety and hospital support, despite an increase in aggression. While our findings align with the progress outlined in this Quality Priority, we would welcome greater consideration of the outcome, i.e. staff experiences, when assessing the Trust's success.

Priority 2: Reducing Medication Incidents with Moderate Harm or Above

It is encouraging to see the Trust maintained its strong performance in keeping medication incidents with moderate and above harm at 0.5%. We are interested in how the raw number of reported incidents changed throughout the year. Nevertheless, we are impressed with the Trust's progress and support the outlined future learning tools, including cross-site analysis of reporting trends and medication safety bulletins.

Priority 3: Single Delivery Plan

We are pleased to see all deliverables have been completed for the Single Delivery Plan. We support the Trust's plans to strengthen the use of patient feedback to inform service improvements and provide quality assurance. We commend the Trust for delivering the Single Delivery Plan within the three-year goal.

Priority 4: Dementia

Tier 1 dementia training exceeded the Trust's target, achieving an impressive 96% completion rate. We support the decision to continue rolling out Tier 2 training to achieve its initial 75% target and would appreciate further detail on how the Trust is working towards this. This intention is supported by the findings of our inpatient visits, which suggest that despite high Tier 1 completion rates, further work is needed to ensure training translates into safe, compassionate care for people living with dementia. We also encourage measuring staff performance beyond training.

Priority 5: Implementation of NatSSIPs2

We are pleased to see the Trust's progress towards implementing the National Safety Standards for Invasive Procedures 2 (NatSSIPs2). It is positive to see that developing a standard operating procedure and training programmes remain Trust priorities. The need for this is supported by our work, which identified a small number of patients who had not received adequate information before an invasive procedure.

Priority 6: Deteriorating Patient—Sepsis

It is encouraging to see the Trust's progress towards implementing Martha's Rule, demonstrated by the 175 calls received since its December 2025 launch. It is also positive to see calls relating to non-clinical concerns being appropriately redirected.

It is concerning to see that sepsis targets in the Emergency Department stabilised below target and it would be helpful to explain the cause of this. However, we are pleased to see that REDP Emergency Department targets were met or exceeded.

Priority 7: Deteriorating Patient—NPEWS

We are impressed with the Trust's progress in implementing the National Paediatric Early Warning Score (NPEWS).

We also note the aim to ensure the NPEWS implementation is supported by workforce training. We would welcome the inclusion of the Trust's plan to roll out the training.

Priorities for 2026/27

We support the Trust carrying forward the NatSSIPs2 and NPEWS priorities, given their need for further implementation. We are particularly pleased to see reducing noise at night as a 2026/27 priority for the Trust, as this emerged as an area of improvement during Healthwatch Richmond's work on inpatient wards.

Healthwatch Richmond

hello@healthwatchrichmond.co.uk

25 Jun 2026

Royal Borough of Kensington and Chelsea Statement on the Chelsea and Westminster Hospital NHS Foundation Trust Quality Account 2025/26

We welcome the opportunity to comment on the draft Quality Account and were extremely pleased that Robert Bleasdale, Chief Nursing Officer, and Laura Bewick, Managing Director, attended select committee on 17 June 2026 to answer members' questions. As the Quality Account is a published document, it has an important role in demonstrating publicly to our residents the Trust's commitments to patient safety, effective treatment and care, and improving quality standards in clinical services.

Chelsea and Westminster Hospital is a key institution in our local NHS and we greatly value the work of staff and its partnership with the local authority in providing health and care to our communities.

Priorities

Overall, the seven priorities selected for 2026/27 are rightly identified as significant challenges and are high-risk areas.

In terms of improving patient safety and reducing avoidable harm, the select committee was particularly interested in Priority 1, Infection Prevention and Control, and Priority 3, Antimicrobial Stewardship, because infections such as MRSA are significant issues facing the NHS and acute hospital trusts in London and nationally.

However, the Quality Account noted that healthcare-associated infections, for example *C. difficile*, exceeded targets, although performance is better than national figures. The targets are set by NHS England.

The Trust acknowledged at select committee that for *C. difficile* there is an increasing number of infections. Furthermore, members learned that the four trusts in the North West London Acute Provider Group are increasingly working together, for example through testing and flagging infectious patients as they move between the trusts, and using electronic systems to communicate. We also learned that there has been an emphasis on environmental control of infections, for example by campaigns to improve hand hygiene and reduce dust in clinical settings. On MRSA, there is work on care of lines.

The select committee's feedback is that reports on infections such as *E. coli*, which are reported to the Integrated Care Board (ICB), could also be included in the Quality Account going forward.

Priority 5, Reducing Inequalities in Early Antenatal Booking, is also important as part of a commitment to reducing health inequalities. Members of the select committee asked about the different outcomes experienced by Black and Minority Ethnic (BME) women, particularly in maternity services. We were assured that the Trust is committed to monitoring those outcomes using the Whole Systems Integrated Care (WSIC) data platform, as well as incorporating demographic data on deprivation, and we were pleased to learn that in complaints reports staff were asked to present data on outcomes for BME patients and based on multiple deprivation.

Quality improvement

The Quality Account clearly demonstrates a culture of quality improvement and continuous learning at the Trust.

Select committee members heard the Trust has a developed system for learning from reviews and audits. This includes cascading information through a patient safety bulletin and local newsletters, and shared governance days to bring teams and ward leaders together to review incidents and carry out mortality reviews.

On learning from deaths, the information in the report on page 49 could have more context provided to help understanding.

While there were no Never Events last year, there is a structured process in place involving sharing incidents of a Never Event across the four trusts in the local provider collaborative. There is also a group among the trusts to learn from deaths.

However, the Quality Account could say more, if possible, to show if there is a measurable impact on outcomes for patients from quality improvement and learning.

Workforce

The challenge of workforce recruitment and retention is perhaps one of the main challenges faced by the NHS. A well-motivated, relatively stable workforce is also key to quality improvement and learning. Therefore, it was welcome to learn at select committee that in key workforce areas such as midwifery and nursing the turnover rate at the Trust is less than five per cent, and that the leadership at the Trust reviews national workforce standards every year and monitors key staffing statistics at least monthly.

In delivering the 2026/27 priorities, the offer of training and strong take-up by staff will be important. For example, to deliver Priority 1, refreshed infection prevention and control training is identified.

The Quality Account highlights staff awards and provides recognition for innovation and achievements. Furthermore, the issue of staff safety was an important area of activity last year and identified as a priority in the Quality Account for 2025/26.

At select committee members were also told that there was positive feedback from staff, and that in last year's staff survey 91 per cent reported that they were treated with respect. The Quality Account may want to report how the figure of 91 per cent is broken down by profession or job role, as well as ethnicity within the workforce, to provide further insight into equalities and outcomes.

Digital and AI

The shift to digital is one of the three commitments in the 10 Year Health Plan for England. The Quality Account demonstrates digital innovations at the Trust, including a scheduling tool to maximise surgical theatre capacity and an AI-powered tool to enhance dermatology analysis of possible skin cancers. It was also pleasing to learn that the Trust is developing digital initiatives to better communicate with patients, particularly for appointment scheduling. Poor communication is an issue complained of by too many NHS patients, so digital improvements are a good investment.

The development of virtual wards is highlighted in the Quality Account, including national recognition for the Trust's cardiac virtual ward programme using digital tools to shift care settings into patients' homes. As virtual wards continue to grow, the Quality Account may wish in future to say more about how quality assurance is done. Similarly, at select committee the Trust was asked about the potential of using AI systems to help register patients to support triage and produce discharge summaries, and the Trust is working with the national team to develop AI in this area. AI will be an area for greater comment in Quality Accounts in the future.

Urgent and emergency care

Increasingly urgent and emergency care, particularly A&E departments, are a high-pressure area for the NHS. It is unsurprising that the Trust reported increasing demand, particularly in the emergency department, and it is now one of the busiest providers of urgent and emergency care nationally, recording approximately 318,000 patient visits a year.

Furthermore, A&E waiting times are an issue for too many patients. The Quality Account acknowledges that the patient satisfaction rating is around 80 per cent, although this is a similar figure to other London acute trusts and in line with the national picture.

For both elective and emergency care, the Trust is not able at present to meet the performance standards set out in the NHS Constitution, which it has been asked to achieve by 2028/29. While the Trust said it was confident it could meet constitutional standards for emergency care, we also learned that it will be challenging because the 'flow' of patients out of the system is constrained by bottlenecks in other parts of the health and care system, which it is working with other partners to address.

It has to be acknowledged that it was confirmed at the select committee that Chelsea and Westminster does not have corridor care of patients in the emergency departments. Furthermore, the environment of emergency and urgent care departments is being improved to improve the experience of patients who are waiting, and the Trust is working to implement a pre-registration and screening-triage system.

Nonetheless, the Quality Account may want to say if there is an improvement plan for emergency and urgent care, and A&E, or set out more details about steps to improve performance and patient experience.

National Context

Finally, we would like to end by commenting on the national picture as the context for the Quality Account. Financial pressures are growing on the NHS and demand is rising. Following the pandemic, there has been a backlog in elective care and the Trust said at select committee the longer waiting times are in surgical specialties such as ear, nose and throat, orthopaedics and plastic surgery. There are still approximately 1,000 patients waiting 52 weeks or more for treatment, although the aim is to eliminate this by the end of the year.

The select committee welcomes the aim to clear the 52-week backlog by year-end, but the Quality Account may want to state what assurance process will track progress against this target.

It should also be acknowledged that there have been improvements in planned and elective care, including a seven per cent improvement for patients waiting 18 weeks, and the Trust has also exceeded cancer diagnosis targets. Service improvements include a diagnostic treatment centre at the West Middlesex site and investments in a day surgery unit at the Chelsea hospital site.

The Quality Account is being produced during a period of NHS reorganisation and transition, with changes to the Integrated Care Boards and the new NHS plan.

One of the shifts in the national NHS plan is from hospital to community services. This will mean that the Trust will have to manage a planned one per cent shift in funding from acute hospital services into community and neighbourhood health programmes while maintaining the high-quality care and performance that patients expect.

At the same time, acute trusts are facing unsustainable demand on services, so a shift to community will help to manage this and reduce pressure on hospital services. The Bi-borough Place Based Partnership was recently selected as one of the pilot places

nationally for accelerating integrated neighbourhood teams and developing a neighbourhood NHS.

We hope that this will help the Trust and other acute providers to maintain quality standards in the future.

Councillor Anne Cyron, Chair

Councillor Dr Max Chauhan, Vice-Chair

Adult Social Care and Health Select Committee

Royal Borough of Kensington and Chelsea

26 June 2026

NHS North West and North London Integrated Care Board Statement on the Chelsea and Westminster Hospital NHS Foundation Trust Quality Account 2025/26

On behalf of NHS North West London Integrated Care Board, I would like to thank the Trust for the opportunity to review the Quality Account for 2025/26. It is clear that this represents a year of sustained effort and commitment from colleagues across the organisation, working to deliver safe, high-quality care in a demanding and evolving system context.

There is much to recognise and value in the Trust's progress. The continued emphasis on innovation, quality improvement and safety is evident, alongside strong operational delivery and a positive organisational culture. Achievements in digital transformation, sustained performance in cancer pathways, and high levels of staff engagement all reflect a workforce that is committed to improvement and to delivering for patients.

We particularly welcome the Trust's focus on areas that matter most to patients and staff. This includes ongoing work to reduce harm, embed learning, and strengthen improvement approaches. Progress in pressure ulcer prevention, antimicrobial stewardship and paediatric early warning systems demonstrates a clear commitment to safer care.

There are several areas where the Trust continues to demonstrate strong practice. A well-established reporting culture, low rates of severe harm and robust mortality review processes provide assurance on patient safety. Alongside this, sustained performance in infection prevention and patient experience, and active contribution to system working, are all positive indicators of a mature and collaborative organisation.

As with all organisations, there remain areas where continued focus will be important. Reducing healthcare-associated infections, particularly *C. difficile*, remains a priority, and we support the Trust's approach to strengthening surveillance and targeted improvement. Delivering more consistent elective access and improving patient flow will also be key to maintaining performance.

We also welcome the Trust's focus on reducing health inequalities and improving experience for all patients. Continued work to address variation in outcomes, particularly for Black and Brown women, alongside improvements in the inpatient experience at night, will be important measures of progress.

The Trust's investment in digital systems and data quality is a positive step, and we would encourage continued focus on strengthening data completeness and use of information to support assurance and improvement.

Overall, we are assured by the transparency of reporting, the strength of governance, and the clear commitment to learning and continuous improvement. The Trust's contribution to system working is essential, and we value the collaborative approach taken with partners across North West London.

We look forward to continuing to work in partnership with the Trust in the year ahead to support delivery of shared priorities and to ensure the best possible outcomes for the population we serve.

Yours sincerely,

Jennifer Roye

Chief Nurse Officer

NHS West and North London

25 Jun 2026

Glossary of Terms

A&E (Accident & Emergency): The part of the hospital that treats urgent and emergency conditions.

Acute Provider Group (APG): A partnership of local hospitals working together to improve care.

Acute Trust: A hospital organisation that provides emergency and specialist care.

Ambulatory Diagnostic Centre (ADC): A facility where patients can have tests and scans without staying overnight.

Antimicrobial stewardship: Careful use of antibiotics to prevent resistance.

Audit: A structured review of how services are delivered to improve care.

Call 4 Concern/Martha's Rule: A service that allows patients, families or staff to request an urgent medical review if they are worried about a patient.

Cerner (Electronic Patient Record): A digital system used to store and manage patient information.

Clinical audit: A check to make sure care meets agreed standards and to identify improvements.

Clinical coding: Turning diagnoses and treatments into standard codes for records and planning.

Clinical effectiveness: How well treatments and services improve patients' health.

Core indicators: National measures used to assess how well hospitals are performing.

CQC (Care Quality Commission): The independent regulator that checks NHS services are safe and high quality.

CQUIN (Commissioning for Quality and Innovation): A scheme that rewards hospitals for improving quality.

Data Security and Protection Toolkit: A system to ensure patient information is handled safely and securely.

Dementia training (Tier 1 / Tier 2): Training for staff to support patients with dementia (basic and more advanced levels).

Duty of Candour: A legal duty to be open and honest with patients when something goes wrong.

Early Warning Score (NEWS/PEWS): A scoring system used to identify if a patient is becoming seriously unwell.

Elective surgery: Planned (non-emergency) operations, such as hip or knee replacements.

Electronic Patient Record (EPR): A digital system for storing patient information.

Emergency Department (ED): See A&E (Accident & Emergency).

Friends and Family Test (FFT): A survey asking patients if they would recommend NHS services.

GIRFT (Getting It Right First Time): A national programme to improve care and reduce differences between hospitals.

HCAI (Healthcare-associated infection): An infection that a patient develops while in hospital.

Healthwatch: An independent organisation that represents patients' views.

Inpatient: A patient who stays in hospital overnight or longer.

Integrated Care System (ICS): Local NHS organisations and councils working together to improve health services.

MDT (Multidisciplinary team): A group of healthcare professionals from different specialties working together.

Mortality Surveillance Group: A team that reviews patient deaths to identify learning and improve care.

MRSA: A type of bacteria that is resistant to some antibiotics.

National Health Service (NHS): The publicly funded healthcare system in the UK.

NatSSIPs/LocSSIPs: National and local safety rules for procedures such as surgery.

Never Event: A serious mistake in healthcare that should never happen if proper procedures are followed.

NPEWS (National Paediatric Early Warning Score): A system used to detect if a child's condition is getting worse.

Outpatient: A patient who attends hospital for an appointment but does not stay overnight.

Patient experience: How patients feel about their care, including communication and comfort.

Patient safety: Preventing harm to patients during care.

Patient safety incident: Any event that caused or could have caused harm to a patient.

Preceptorship: A support programme for newly qualified healthcare staff.

Pressure ulcer: Damage to the skin caused by prolonged pressure (sometimes called a bedsore).

PROMs (Patient Reported Outcome Measures): Patient feedback on how their health improves after treatment.

Protected mealtimes: Designated times where patients can eat without interruptions.

PSIRF (Patient Safety Incident Response Framework): A system used to learn from safety incidents and improve care.

Quality priorities: Key areas the Trust focuses on improving each year.

Readmission: When a patient returns to hospital within a set time after being discharged.

RIQI (Research, Innovation and Quality Improvement): A programme that supports new ideas, research and improvements in care.

RTT (Referral to Treatment): The time from being referred for care to starting treatment.

Sepsis: A serious condition caused by the body's extreme response to infection.

SHMI (Summary Hospital-level Mortality Indicator): A measure comparing the number of deaths in a hospital with what would be expected.

Trust: An organisation that manages NHS hospitals or services.

Virtual ward: Care provided at home using technology and regular monitoring instead of staying in hospital.

VTE (Venous thromboembolism): Blood clots in veins, such as deep vein thrombosis or pulmonary embolism.

West London Children's Healthcare (WLCH): A partnership providing specialist healthcare for children.

WTE (Whole Time Equivalent): A way of counting staff based on full-time hours.

Epilogue

About the Trust website

The maintenance and integrity of the Trust's website is the responsibility of the directors. The work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Your comments are welcome

We hope that you have found our Quality Account interesting and easy to read. We would like to hear your thoughts about it, so please let us have your comments by using the contact details below.

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You can receive our newsletter to stay up to date and get involved in improving quality at our hospitals by becoming a member of our foundation trust—please see www.chelwest.nhs.uk/membership for details.



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