QUALITY REPORT

2024/25

PROUD TO CARE

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

TABLE OF CONTENTS

PART 1: OVERVIEW AND WELCOME

PART 2.1: PRIORITIES FOR IMPROVEMENT

PART 2.2: STATEMENTS OF ASSURANCE FROM THE BOARD OF DIRECTORS

PART 3: OTHER INFORMATION AND ANNEXES

PART 1:

OVERVIEW AND WELCOME

Statement from the Chief Executive

It is with great pride that I present the 2024/25 Quality Account Report for Chelsea and Westminster Hospital NHS Foundation Trust.

This past year has been one where we have demonstrated our resilience, while continuing to ensure we transform our services in line with national best practice. We have remained steadfast in our commitment to delivering outstanding care to our patients, supported by innovation, collaboration, and the unwavering dedication of our staff. Amid the pressures facing the wider NHS, our teams have demonstrated exceptional adaptability and compassion.

It has been a very busy 12 months for our Trust, during which we sustained our performance in all areas despite increasing pressures on the system. We have made meaningful progress in serving those in our community who need us most—particularly the most vulnerable and those with complex needs. A key focus has been on improving frailty care, ensuring that older patients receive personalised, compassionate support tailored to their individual circumstances. At the same time, we have worked hard to optimise our emergency department performance, recognising its vital role in responding to the most acute cases. By streamlining patient flow throughout the hospital and strengthening links between acute and community services, we are not only enhancing outcomes but also ensuring that patients receive timely, effective care. These efforts reflect our continued commitment to delivering safe, high-quality services to all those who rely on us.

We have concentrated relentlessly on the recovery of our elective care programme, ensuring we treat our cancer and urgent patients first, and then treating our longest waiting patients. I am immensely proud of the work that we have achieved, particularly in utilising our technology and the use of robotic surgery. Many of our clinical services have proactively led on super surgery weekends to ensure we can see and treat more patients. By performing a record number of surgeries, we are helping to tackle the waiting list backlog and improve patient outcomes.

We have made important strides in digital innovation, research, and integrated care—delivering on our strategic ambition to be a national and global leader in digitally-enabled healthcare. By embedding digital innovation across every stage of the patient journey, we are not only improving the quality, safety and personalisation of care, but also fundamentally reshaping how healthcare is delivered. This year, we have expanded the reach of our artificial intelligence (AI)-driven diagnostic tools in dermatology, ophthalmology and lung cancer pathways, enabling earlier, faster and more accurate clinical decisions, and freeing up specialist time for patients who need it most.

We have scaled one of London’s largest virtual ward programmes, empowering patients to manage their health at home across a growing number of specialties, while virtual consultations, robotic surgery, mobile health apps and digital platforms have enhanced access, efficiency, and patient engagement. Our commitment to innovation—from virtual reality (VR)-based training to pioneering digital consenting and patient-held record systems—is driving measurable improvements in outcomes and experience.

One of our most significant digital innovation milestones was becoming the first hospital globally to deploy an autonomous AI-driven teledermatology service for skin cancer assessments. Launched at our Chelsea and Westminster Hospital site in December 2024,

this ground-breaking technology, developed by Skin Analytics and supported by CW Innovation, discharges benign cases without dermatologist input, freeing up over 35% of specialist appointments. With 99.9% accuracy in ruling out melanoma, it is reducing patient anxiety, cutting wait times, and setting a new standard for integrating AI into clinical pathways across the NHS.

It's through this culture of innovation, continuous improvement, and collaboration, we are building a truly digital-first hospital for the future, setting a new standard for healthcare delivery in the NHS and beyond.

This year, we have also made significant strides in expanding and modernising our on-site facilities to better serve our communities. Construction continues on our state-of-the-art Ambulatory Diagnostic Centre (ADC) at West Middlesex University Hospital. This new five-storey facility will double our capacity for vital cancer, renal and imaging services, helping to address major health needs in Hounslow, Richmond and Ealing. Designed as an all-electric building, the ADC demonstrates our commitment to sustainability while also enhancing staff development with a modern education space. Once completed, it will play a crucial role in reducing health inequalities, improving patient outcomes, and providing care closer to home.

In parallel, our enhanced Day Surgery Unit at Chelsea and Westminster Hospital is set to officially open in June 2025. The new unit will significantly increase our day recovery capacity and will incorporate cutting-edge technologies, including surgical robotics, to improve surgical outcomes and patient experience. This major upgrade will not only boost our elective surgery capacity but will also strengthen our efforts to reduce waiting lists and deliver exceptional, efficient care for our patients.

While our achievements in patient care delivery, digital innovation and major capital developments have been transformational this year—none of this would be possible without the dedication, skill, and passion of our people. Our staff are the foundation of everything we do, and we are proud to have celebrated their outstanding contributions throughout the year. The 2024 NHS Staff Survey results reflected this strength, with the Trust ranking above the national average for staff engagement and as a great place to work and receive care. Among many positive results, 84% of colleagues agreed that patient care is our top priority, and we scored significantly above the national benchmark in eight out of nine NHS People Promise themes.

We also saw important improvements in well-being, development opportunities, and the support provided by managers. While we recognise there is more work to do, particularly in ensuring a safe and inclusive workplace, we remain deeply committed to ensuring every colleague feels valued, supported, and empowered to deliver exceptional care.

Looking ahead, our focus will remain on recovery, reform, and equity—building a healthier future for all our communities. We will continue to strengthen our partnerships, invest in our people, and lead with purpose to deliver excellence in everything we do.

Thank you to all our staff, partners, patients, and supporters for your trust and collaboration. Together, we will keep striving to improve lives.

Our values

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

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

Our vision

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

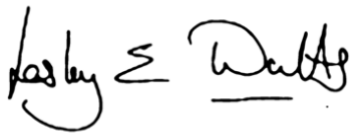
Our priorities

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 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). Our collaborative is focused on reducing health inequalities to 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, systems 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 organisation).

Building on our existing strategic partnership, CWFT and THH appointed a Joint Chief Executive Officer to further strengthen partnership working and importantly, ensure both Trusts continue to deliver high quality care. 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

	2020/21	2021/22	2022/23	2023/24	2024/25
Outpatient attendances (excluding sexual health and private patients)	651,567	795,583	777,916	806, 884	859,639
Emergency department (Accident & Emergency) attendances	215,438	335,374	348,754	269,256	314,005
Inpatient admissions	100,221	138,448	153,670	164,721	164,448
Babies delivered (excluding private patients)	9,959	10,066	9,740	10,458	9,839
Patients operated on in our theatres	13,643	13,526	25,102	30,457	29,779
X-rays, scans and procedures carried out by clinical imaging (excluding private patients)	357,932	450,240	455,334	457,364	514,614
Total average number of employees (WTE basis)	6,821	7,174	7,365	7,510	7,168

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The year in photos

April 2024

Sexual health team wins a BHIVA 2024 award for a Desi POV campaign improving HIV awareness

We marked Trans Day of Visibility with a panel event and celebrated our 1,000th TransPlus patient

May 2024

We delivered our first robotic hernia Super Saturday, treating 11 patients and reducing surgical wait times

West Mid maternity team featured in *The Times* ahead of International Day of the Midwife

June 2024

We marked Pride month with a Ride for Pride fundraiser in partnership with SoulCycle UK

We won an MJ Award for our collaborative digital inclusion project tackling health inequalities

July 2024

We marked the start of building our new £80m ADC at West Mid with a ground-breaking ceremony

Our critical care teams were shortlisted for two HSJ Patient Safety Awards for the REDP project

August 2024

We opened our newly refurbished Therapy Outpatients Department at our Chelsea site

Our AI skin cancer pathway was shortlisted for an HSJ Award for driving efficiency through technology

September 2024

We cut waiting lists with a record 59 robotic surgeries during our latest super surgery weekend

We welcomed the Minister for Public Health to 56 Dean Street for a tour and roundtable

October 2024

We joined the world-leading Generation Study to screen newborns for more than 200 rare genetic conditions

We celebrate Dr Shweta Gidwani's Churchill Fellowship medallion for her work on global healthcare workforce wellbeing

November 2024

We won an HSJ Award for the AcuPebble Project, transforming sleep apnoea diagnosis across North West London

We were recognised at the London HCSW Awards for outstanding staff contributions and inclusive healthcare

December 2024

We expanded our AI skin cancer service, speeding up diagnosis and freeing up dermatology capacity

We celebrated staff and patients with festive fayres, awards and special visits from local sports teams

January 2025

We welcomed DHSC, UKHSA and NHSE to Dean Street to support the new HIV Action Plan

Sexual Health London was shortlisted for two HSJ Awards for innovation in online sexual healthcare

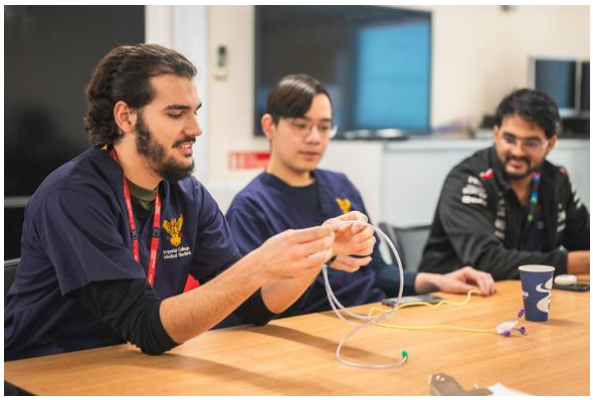
February 2025

Cormack won the MyPorter Newcomer of the Year Award for his outstanding work as a porter

We celebrated CW+ MediCinema's BAFTA win, recognising its outstanding contribution to patient care

March 2025

We celebrated success at the HSJ Partnership Awards 2025, winning two awards for SHL and AI skin cancer services



We ranked first in London for learning culture in the NHS Staff Survey, with high scores across all People Promise themes

Achievements to highlight

Improving the recognition and escalation of deteriorating patients (REDP)

The Critical Care Outreach Team (CCOT) for Advanced Clinical Practice won the HSJ Patient Safety Team of the Year award on the 16th of September 2024 for their impact in improving the recognition and escalation of deteriorating patients (REDP) in adult in-patient wards at the Trust.

The REDP project, a Horizon Fellowship scheme supported by CW Innovation, supports early recognition and escalation when a patient's condition is deteriorating, helping to increase the chances of survival and recovery.

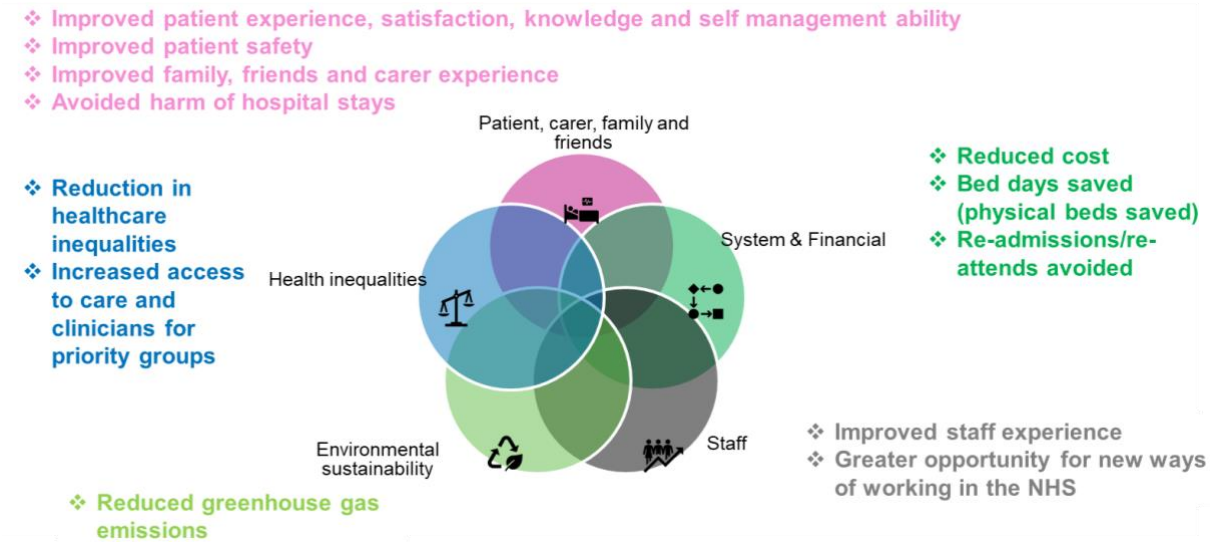
Celebrating the CCOT team's achievement during the 12 days of Staffmas

This award is testament to the incredible work that the entire team has been doing to support vulnerable patients and in taking the initiative to make early, lifesaving interventions.

In September 2024 we also launched Martha's Rule as a Trustwide pilot—a 24/7 escalation route to CCOT to provide a rapid review of care. This service is available for patients, carers and staff to use when concerned about a patient's condition. Thank you to the CCOT team for their support in making this pilot initiative a success.

Using the newest diabetes technology for our patients

To optimise patient care and support our patients with diabetes to live their best lives, the cross-site diabetes team have been supporting colleagues Trustwide with using the newest diabetes technology including wearable technology, to empower their patients. The team has been able to upskill colleagues, improve patient experience, increase pump starts and participate in national audits. This led to them being presented a 'Highly Commended Achievement' by Diabetes UK and NHS England.



Benefits of Virtual Wards

As noted in the chart above, the new financial year will be just as exciting when the diabetes team start to be directly involved in the Virtual Wards improvement programme which will enhance our patient care even further.

Mortuary Team Gold Accreditation

With expertise in end-of-life care and grief support, the mortuary team ensures that the deceased are treated with dignity and compassion. Their work goes beyond caring for patients—they also support grieving families, educate colleagues, while maintaining high standards of care. The Mortuary Team's role is a crucial part of the patient journey, providing a dignified and respectful transition for the deceased, which helps bring closure to families.

The Chelsea team achieved gold department accreditation in 2024

The team also hold teaching sessions and encourage student nurses to shadow them in the mortuary, increasing understanding of their vital role in patient care. They actively invite staff to visit the mortuary, helping to dispel myths and normalise the environment.

The level of care in death is not always visible but is such an important aspect to both the bereaved families and to our staff. The team is made up of highly compassionate individuals who make a tangible difference into how individuals manage grief at one of the most vulnerable times of their lives. They ensure our patients are always presented with dignity and respect.

Artificial Intelligence (AI) pathway for skin cancer

The Trust partnered with Skin Analytics in 2022 to implement regulated, AI driven teledermatology, a service which involves taking specialist dermoscopic images of moles or lesions, to classify 11 different lesion types including the most common malignant, pre-malignant, and benign (harmless) skin lesions.

The Trust was shortlisted in the HSJ Awards 2024 *Driving Efficiency Through Technology* category, for our innovative AI pathway to help diagnose and treat patients with skin cancer more quickly at Chelsea and Westminster Hospital. The teledermatology service has been recognised as a pioneering NHS initiative, harnessing the latest digital advancements to bring positive change, by accelerating the diagnosis and management of skin cancer.

The technology supports the specialist dermatology team in speeding up discharge for those with benign skin lesions, releasing over 35% of dermatologist appointments for more urgent cases. The majority of Trust referrals for suspected skin cancer do not result in an urgent skin cancer diagnosis so this will enable teams to reduce consultant time spent reviewing benign (harmless) conditions that do not need urgent treatment and prioritise patients with greatest need.

Teledermatology service team

Quality Awards and Recognition 2024/25

Nursing and Midwifery Excellence

- **Royal College of Nursing Rising Stars:** Three nurses—Blessing Bello, Arvin Vinas, and Gwen Makosana—were recognised as Rising Stars by the Royal College of Nursing. This national recognition celebrates outstanding contributions to patient care and professional development.

- **Mariposa Award for Midwife of the Year:** Navi Fernandes, Bereavement Midwife, received the prestigious Mariposa Award for her compassionate and skilled support of families experiencing pregnancy loss.

- **National Preceptorship Quality Mark:** The Trust received the National Preceptorship Interim Quality Mark in recognition of its strong support for newly registered nurses. Over 160 new nurses took part in the Adult Nursing Preceptorship Programme, which emphasised multidisciplinary learning, wellbeing, and retention.

Maternity and Neonatal Care

- **CQC Maternity Survey:** The Trust scored above the national average on several indicators, reflecting improvements in communication, postnatal care and patient involvement.

- **Maternity Incentive Scheme (MIS):** The Trust achieved full compliance with the NHS Resolution's MIS Year 6 safety actions, including the Saving Babies' Lives Care Bundle. The Trust has been compliant with all actions for the MIS since its launch.

- **Maternity and Neonatal Voices Partnership (MNVP):** This service-user-led group was highlighted for its role in shaping improvements in maternity and neonatal care, including the introduction of Neonatal Intensive Care Unit (NICU) admission packs and enhanced postnatal information.

Broader Clinical and Patient Experience Recognition

- **National Thrombosis UK VTE 'Highly Commended' Award:** Our cross-site anticoagulation and thrombosis team was Highly Commended at the Thrombosis UK VTE Awards for an outstanding quality improvement programme in thrombosis prevention and management. The team continues to drive local VTE prevention efforts, supporting our status as a 'VTE Exemplar Centre' and 'Anticoagulation Centre for Excellence'. This achievement reflects the dedication of a multidisciplinary team committed to delivering safer, high-quality care.

- **HSJ Partnership Awards 2025:** The Trust won an award for its work in Sexual Health London, showcasing innovation in care pathways.

- **CW+ MediCinema BAFTA Win:** The MediCinema programme, supported by CW+, was recognised for its contribution to patient wellbeing and experience.

- **MyPorter Awards 2025:** Cormack Mylchreest was named Newcomer of the Year, reflecting the Trust's culture of valuing all staff who contribute to patient care.

PART 2.1:

PRIORITIES FOR IMPROVEMENT

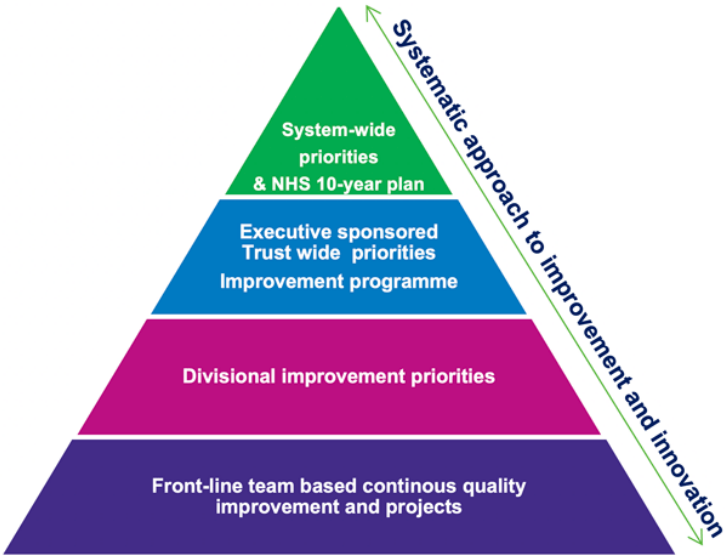
This section provides an overview of our approach to quality improvement, our improvement priorities for the upcoming year and a review of our performance over the last year. We are proud of our quality and safety culture and ongoing focus to improve and innovate to drive best practice.

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 changes to improve patient care.

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



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

RIQI is a shared approach to work with colleagues and services to improve health outcomes, increase clinical effectiveness, enhance patient experience and translate our 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 to develop 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 number of communications channels and events. For example, we hold an annual RIQI event where staff showcase their work and send out a regular bulletin to 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 to 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 are triangulated against areas with the greatest opportunity for improvement, identified through a review of data sources including Getting It Right First Time (GIRFT), Model Hospital, and themes emerging from claims, incidents, complaints and Friends and Family Test (FFT) feedback.

Getting It Right First Time (GIRFT) Programme

GIRFT is a national programme designed to improve medical care by reducing unwarranted variations in the way services are delivered across the NHS, and by sharing best practice guides between Trusts. GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies, such as the reduction of unnecessary procedures, and cost savings. GIRFT engages integrated care systems and regions to work at pace to agree standardised pathways and adopt best practice, as well as pooling capacity and resources, to achieve top decile performance in clinical outcomes and equity of access to care for their population.

The success of the GIRFT program at the Trust has relied heavily on effective stakeholder engagement. The Trust recognised the importance of involving key stakeholders, including clinical staff and administrative personnel in the planning and implementation stages. The programme covers 58 specialities (Medical, Surgical and Cross cutting) and is designed to improve treatment and care by reviewing health services.

GIRFT Successes 2024/25

- **Gynaecology recommendations:** The implementation of 'elective enhanced recovery' pathways for hysterectomy and cystectomy procedures has led to a service efficiencies and highlights the division's commitment to optimising care pathways while driving financial sustainability.

- **Treatment Centre (day surgery unit) accredited as GIRFT elective surgical hub:** By enhancing efficiency, patients benefit from shorter wait times, same-day discharges, and reduced need for post-operative interventions. The segregation of emergency services ensures that surgical beds remain available for patients awaiting planned procedures, minimising the risk of last-minute cancellations. The Trust has also been recognised as a top performer among national hubs.

- **Pancreatic cancer peer review:** The Trust was recognised by GIRFT as exemplary in multidisciplinary team (MDT) processes and patient pathways, notably implementing a dedicated pathway for complex benign pancreatic conditions to enhance MDT efficiency.

CW Innovation

CW Innovation is a partnership led jointly by CW+ (the Trust's Charity) and the Trust to drive the development of a culture of innovation, incubate new ideas and ways of working and create a testbed for innovative technologies developed by entrepreneurial digital health companies.

The programme comprises three Innovation Business Partners, all experienced clinicians—a respiratory physiologist, a musculoskeletal (MSK) physiotherapist and a nurse—as well as a Head of Innovation. The team is managed directly by the Director of Digital Operations and Innovation.

CW Innovation celebrated its fifth anniversary in Oct 2024 with a series of events that culminated in a showcase of the programme's achievements, attended by NHS and industry leaders, companies, partners and innovators. As part of the celebrations, CW+ unveiled the new CW Innovation Hub at Chelsea and Westminster Hospital—an inclusive, flexible space dedicated to inspiring creativity and driving tangible improvements in patient care, operations and staff engagement.

Their work is focused around three themes:

1. **Culture of Innovation:** The team has a range of programmes to support colleagues to engage fully with innovation at the Trust, and offer training to support staff to take forward their own innovations. During 2024/25 they launched a third cohort of the CW Innovation Fellowship, a 12-month programme of thematic training, action learning and peer support for staff to develop their own projects. Twenty-five fellows were recruited from all parts of the Trust, including clinical and non-clinical areas, and all staff groups.

   Recruitment of a CW Innovation Associate was completed to help scale up the adoption of virtual and mixed-reality technologies across the Trust. The Innovation Associate builds on the skills developed in the CW Innovation Fellowship programme, by working across multiple services to further develop expertise and to drive the adoption of transformational technologies.

2. **Testing and adopting transformational technologies:** The team work with services to identify high potential technologies ranging from artificial intelligence (AI) and automation to remote monitoring and wearable devices. This year delivered notable milestones including successful deployment of an automated AI-enabled teledermatology service for triaging images of skin lesions for patients referred to the Trust on the urgent suspected skin cancer pathway. This was the culmination of a four-year partnership between the dermatology service and Skin Analytics.

   CW Innovation provided a wide range of support including partnership building, contracting, governance, programme management and implementation. The transition to autonomous operation represents a national first for AI technologies.

The team worked with the sleep service at the Trust and with colleagues at Imperial College Healthcare Trust to evaluate AccuPebble remote sleep apnoea service, enabling a fully remote sleep assessment service for patients on bariatric surgical pathways. This programme won an HSJ Award in November 2024 for Modernising Diagnostics.

Dr Natalie Nunes and her team in the Early Pregnancy Unit won the Mitchell-Jones prize for their innovative app, SIPS, which supports women with hyperemesis. The award, presented at the Association of Early Pregnancy Units (AEPU) Annual Scientific Meeting, recognises exceptional initiatives that enhance patient care in early pregnancy settings. The SIPS app was supported by CW Innovation, which provided funding and helped identify the right technology to deliver the service.

3. **Building partnerships:** The model of innovation championed at the Trust is predicated on quickly translating best-in-class innovations into service. CW Innovation is one of 18 designated national partners on the NHS CEP InSites (Innovation Sites) Programme, working with NHS England and the NHS Clinical Entrepreneur Programme to trial and scale the best in UK medical innovation. CW+ is also a founding partner of the DigitalHealth London Accelerator, with CW Innovation supporting its eighth cohort.

   At the end of 2024 the team secured £252,000 from L'Oréal to cement a partnership with the dermatology service at the Trust to scale up our teledermatology AI work. This involves building a virtual tissue bank to support research into skin cancers, particularly among darker skinned patients, and to improve education given to patients.

   They also secured funding of £590,000 from GE Healthcare to deepen partnership working with the cardiology service at West Middlesex University Hospital site, and to further evaluate a novel ward-based wireless vital signs technology. This was to support the early identification of deteriorating patients on general medical wards, enabling early intervention and improving patient care and outcomes. The partnership is now four years old and goes from strength to strength.

Looking ahead to the coming year, the team's focus will be on developing a Culture of Innovation workstream to build the Trust's capacity to innovate, adopt technology and drive performance. The CW Innovation Hub will continue to evolve and become a place where staff can come along anytime and share their ideas with the CW Innovation Team. It will also be a place where they can find out more about innovation at the Trust or get help with their ideas.

Our Quality Priorities for 2025/26

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 below:

- 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/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 a lead for the implementation of the quality priority, this is in addition to local improvement initiatives for 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 Quality 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.

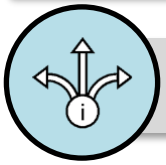
In addition to our quality priorities, we are also working with the other three acute trusts in the North West London Acute Provider Collaborative (APC) including Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundation Trust,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

The APC 2025/26 quality priorities focus on enhancing the quality of care and minimising harm associated with patient deterioration. A comprehensive approach known as PIER (Prevention, Identification, Escalation, and Response) is being implemented. This strategy aims to improve the overall system coordination, ensuring that acute physical deterioration is addressed promptly and effectively as part of safe and reliable care pathways. The new guidance emphasises the importance of transitioning from screening to continuous targeted observation of patients who are identified at risk of deteriorating, using the National Early Warning Score (NEWS). By doing so, teams can intervene at an earlier stage, potentially preventing further complications. This proactive approach broadens the scope of patients who are monitored and allows for timely escalations to appropriate care levels.

Progress will be monitored through APC Quality Meetings, attended by the Chief Medical Officers and Chief Nurses from each Trust, and reported quarterly to the Acute Provider Collaborative Quality Committee. CWFT is the most closely aligned with the Acute Physical Deterioration and Sepsis Guidelines within the APC, requiring only minor refinements including digital consistency and improved communication with patients.

For Chelsea and Westminster Hospital NHS Foundation Trust, we have set the following Quality Priorities for 2025/26:

Quality Priorities 2025/26



Priority 1: **Deteriorating Patient (PEWS)**
(West London Children's Healthcare)

Priority 2: **Implementation of NatSSIPs2**
(Planned Care)

Priority 3: **Violence and Aggression**
(Emergency & Integrated Care)

Priority 4: **Reducing medication incidents with moderate harm or above**
(Clinical Support Division)

Priority 5: **Single Delivery Plan**
(Specialist Care Division)

Priority 6: **Dementia**
(Corporate)

1. Deteriorating Patient (PEWS)

Why have we chosen this as a Quality Priority?
The implementation of the NHSE-required Digital Paediatric Early Warning System (PEWS) aims to enhance the quality of healthcare provided to children in West London.

Continuing from last year's quality priority, this initiative remains a focus to ensure digital monitoring systems align with the latest national healthcare standards. Success will be measured through various metrics, including completion of testing, successful rollout of the system, and an effectiveness audit.

Key guidance and supporting documents can be found in NHSE's comprehensive *Case for Change* documentation.

What do we aim to achieve during 2025/26?
Initial implementation was expected to commence in August 2024, with metrics outlined and monitored by October 2024. However, this has been delayed due to ongoing issues with the PEWS Cerner build (the Trust's electronic patient record), which is part of a wider national issue. End-to-end testing has therefore not yet started, and the following table has been updated to reflect revised timeline expectations:

Key deliverable	Due Date
Workflow/Alignment of Policies	May 2025
Education and Training/Communication	May 2025
Technical build (integration, system testing)	Jun 2025
Post go-live Audit	Jul 2025

2. Implementation of NatSSIPs2

Why have we chosen this as a Quality Priority?
The National Safety Standards for Invasive Procedures (NatSSIPs) were originally published in 2015 and revised in 2023, introducing two interrelated sets of standards:

- **Organisational standards** set clear expectations for Trusts and external bodies to support teams in delivering safe invasive care

- **Sequential standards** outline the procedural steps to be taken, where appropriate, by individuals and teams for every patient undergoing an invasive procedure

The focus of NatSSIPs2 has shifted from a tick-box approach to one that incorporates cautions, priorities, and a balanced use of checklists, taking into account clinical risk. This change supports teams in standardising practices across specialties within the Trust and the wider APC.

What do we aim to achieve during 2025/26?
The implementation of NatSSIPs2 aims to standardise safety behaviours, processes, and policies for invasive procedures, ensuring consistency across specialties through the adoption of LocSSIPs (Local Safety Standards for Invasive Procedures). This initiative is driven by the occurrence of a never event involving a wrong-site injection in 2024/25, as well as a notable number of incidents in previous years linked to LocSSIPs.

How will we measure our success?
Success will be measured using data from incident reports and checklist audits, aligned with the National Safety Standards for Invasive Procedures as outlined by the Centre for Perioperative Care (CPOC). Key deliverables include:

- A Trustwide Standard Operating Policy (SOP) for the management of LocSSIPs
- Creating a training programme for APC healthcare colleagues on NatSSIPs2
- Introducing a quarterly audit programme for LocSSIPs in targeted high-risk areas

Metric	Baseline	Ambition
IT integration/digitalisation (CERNER)	0%	25%
Harmonisation of existing Trust LocSSIPs	150	30–50% reduction

3. Violence and Aggression

Why have we chosen this as a Quality Priority?
In December 2024, NHS England published an updated version of its *Violence Prevention and Reduction Standard*. This version supports organisations in taking action to prevent and reduce violence and abuse against staff. In line with the revised guidance and the need to protect colleagues' safety and wellbeing under the NHS People Promise, this quality priority focuses on supporting staff and patients in managing workplace violence and aggression. The goal includes initiatives covering violence reduction standards, psychological impact, prevention and de-escalation, support and intervention, and community and social impact.

What do we aim to achieve during 2025/26?
Aims include expanding the number of safety champions and ensuring there is a safety guardian in each division to support teams in managing violence and aggression more effectively.

These measures—alongside de-escalation techniques, wellbeing support and addressing root causes—are essential to reducing incidents and improving staff safety and patient care.

How will we measure our success?
Potential success metrics include Level 2 conflict resolution training for high-risk areas and lone-working staff, improved staff survey responses, and adherence to national guidance such as the *Violence Prevention and Reduction Standard v2 (2024)*. This updated national framework, issued by NHS England in December 2024, is designed to help NHS organisations reduce violence and abuse against staff and supports the NHS People Promise to ensure staff feel 'safe and healthy'. Key deliverables are as follows:

- Multidisciplinary team review process for all serious incidents where a potential sanction is required for a visitor or patient
- Increase the number of staff safety Guardians and Champions
- New Trustwide communications campaign

Metric	Baseline	Ambition
Level 1 Conflict Resolution Training	84%	90%
Level 2 Conflict Resolution Training	20%	50%
NHS Violence Prevention and Reduction Standard 2024	8	43

4. Reducing medication incidents with moderate harm or above

Why have we chosen this as a Quality Priority?
Reducing medication-related incidents with moderate harm and above is crucial in ensuring patient safety through the reduction of prolonged hospital admissions, improved quality and safety of care provided, and improved patient health outcomes. A high reporting rate of incidents with low harm suggests a culture of 'greater openness' and safety within NHS organisations. Staff are encouraged to report all medication-related incidents of any degree of harm, with focal themes and trends reviewed by the Medication Safety Group for wider learning and shared awareness.

Oversight in the reduction of moderate harm and above to patients will be monitored monthly via the Trust Performance and Quality Report, to determine whether the Trust

target has been met, with review and commentary as appropriate. Learning from these incidents will be addressed by the Medication Safety Group with review of preventative actions and changes to practice/process where applicable, to prevent recurrence. Medication safety stewardship includes delivery of medication safety training—eg induction programmes, monthly medication safety bulletins for Trustwide staff education and awareness, education on medication safety focal themes, and implementing actions and strategies to prevent future recurrence.

What do we aim to achieve during 2025/26?
A key component of this initiative includes addressing the omission of critical medication doses, and ensuring that patients receive their medications on time and as prescribed. This will involve the development and implementation of an 'Omitted Doses Dashboard', a real-time electronic dashboard to identify current inpatients with omitted medication doses from a pre-defined list of therapeutic drug classes—eg anticoagulants, anti-epileptics, anti-parkinsonian, antimicrobials etc.

Additionally, the promotion of safe prescribing practices for anticoagulants is essential to minimise the risks associated with this high-risk medication group to ensure patient safety and reduce avoidable harm.

How will we measure our success?
The proposed quality priority includes enhancing medication safety awareness to reduce the percentage of incidents resulting in moderate harm or above to less than or equal to 1% of all incidents. This will involve the development and implementation of a Critical Omitted Doses Dashboard and the promotion of safer anticoagulant prescribing practices.

Metric	Baseline	Ambition
Medication-related (NRLS reportable) safety incidents % with moderate harm and above	≤2%	≤1%

5. Single Delivery Plan (for maternity and neonatal services)

Why have we chosen this as a Quality Priority?
The *Single Delivery Plan*, published in 2023, sets out a clear agreement on the key areas of focus for maternity and neonatal services over the next three years. It highlights four core themes: listening and collaborating with women and families, developing a sustainable workforce, supporting a culture of safety and continuous learning, and delivering more personalised and equitable care.

What do we aim to achieve during 2025/26?
The Three-Year Delivery Plan is a national ambition to make maternity and neonatal care safer, more personalised and more equitable for women, babies and families.

Over three years (2023–26) services are asked to focus on four high level themes:

- Listening to and working with women and families with compassion
- Growing, retaining and supporting our workforce
- Developing and sustaining a culture of safety, learning and support
- Standards and structures that underpin safer, more personalised, and more equitable care

How will we measure our success?
The plan outlines 43 specific actions to be completed. As of the Q3 2024/25 reporting period, 17 actions remain open (16 categorised as amber, and one as red). The goal is to complete all 43 actions by the end of the financial year.

Metric	Baseline	Ambition
Meet all standards in the Three-Year Delivery Plan	26	43

6. Dementia

Why have we chosen this as a Quality Priority?
There are currently an estimated 982,000 people living with dementia in the UK, but more than a third remain undiagnosed. This number is expected to rise to 1.4 million by 2040.

Dementia as a quality priority focuses on several areas, the first being dementia screening and onward referrals. This involved a shift from the Abbreviated Mental Test Score (AMTS) to the 4AT (4 A's Test) as a single process to assess patients. Some patients may require a 4AT, which is effective in identifying both delirium and potential cognitive impairment. It is imperative that we recognise the signs and symptoms early, to provide treatment for the underlying cause. The impact of delirium on a person living with dementia is greater than that of a person with no cognitive impairment and without rapid identification and treatment, the delirium can have a long-term effect, leading to poorer outcomes on discharge.

Quality Priority for dementia care includes transitioning from AMTS to 4AT for screening, enhancing admission avoidance and readmission rates, and improving downstream conversion rates.

What do we aim to achieve during 2025/26?
We aim to improve identification of and collaboration with carers, initiate advance care planning, and better recognise end-of-life stages.

Staff education is a key focus, alongside establishing integrated care pathways through partnership working and introducing a dementia care framework.

How will we measure our success?
Success metrics include achieving 75% Tier 2 dementia training compliance in the first year and 95% by the second year; screening 90% of patients over the age of 75 within 72 hours; and alignment with national guidance—including *Challenge on Dementia 2020* and the 10-year plan for dementia.

Metric	Baseline	Ambition
Number of staff with Tier 1 Dementia Training	96%	90%
Number of staff with Tier 2 Dementia Training	50%	75%
Maintain screening patients aged 75+ following emergency admission to hospital within 72 hours	90%	90%

Our Quality Priority Achievements in 2024/25

During 2024/25, 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:

- Transitional care for children
- Deteriorating patient—PEWS
- Deteriorating patient—Call 4 Concern
- Improving frailty care
- Tobacco and smoking reduction
- Implementation and embedding of PSIRF
- Patient experience (Nutrition and Hydration)

Priorities were identified through engagement with multiple stakeholder groups:

- 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 2024/25 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 brief progress update for each Quality Priority is provided below.

Priority 1: Transitional Care

Why we chose this as a Quality Priority
Transition is defined as a planned process of supporting young people to move from children's to adults' services. It is not a single act, but rather a process that begins around age 12 and involves engaging children and young people in discussions and decisions about all elements of their care. Transition can be a difficult and anxious time for young people and their families. Without proper support, there is a risk of disruption to care provision during the already vulnerable adolescent period.

This project operates across Imperial College Healthcare NHS Trust (ICHT) and Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) to deliver shared approaches across both Trusts. The following summarises progress toward the project objectives in 2024/25, supported through:

- Re-launch of the Transition Steering Group to include adult representation (previously West London Children's Healthcare only)

- Recruitment to a project manager post to support delivery of the project

Aims
- To ensure young people who move from children's to adults' service have a coordinated transition plan

- To provide a safe, effective, and developmentally appropriate process for transition and transfer (handover) from children's services to adult services for all young people within acute care

- To ensure young people and/or carers are equipped with the knowledge and skills needed to manage in adult services

Update on progress
Implementation of the Adolescent and Young Adult Healthcare Transition Policy across both trusts has been completed. Standard operating procedures (SOPs) for adolescent admissions and checklists for adult wards were piloted. A service-level audit tool and condition-specific transition pathways (e.g. diabetes and asthma) were developed.

Training workshops were delivered, and a core education module was drafted. Data tracking via QlikView (a data analytics platform) was initiated for the diabetes team. Engagement with NHS England (NHSE) and internal forums helped raise awareness.

Opportunities for innovation
The project continues to benefit from strong leadership within paediatric services, with an opportunity to increase engagement from adult care teams to align outcomes across the full age spectrum.

Enhanced data insights—particularly through refined QlikView tools—will support better planning and delivery of transition services for young people aged 12–25. A coordinated communications approach across both trusts will be important for ensuring awareness of upcoming policies and training requirements. Recent improvements to digital systems, including Cerner reporting and electronic documentation, have contributed to more efficient fast track discharge processes, demonstrating the value of ongoing collaboration and process optimisation.

Forward plan
The programme is focused on embedding key policies, tools, and resources to support effective healthcare transition for adolescents and young adults. This includes ensuring visibility of core policies and checklists, developing a standardised framework and resource toolkit for transition pathways, and promoting the use of the 'Ready, Steady, Go, Hello' tool across both trusts. Finalisation and delivery of an education module, alongside dedicated intranet pages, will support training and signposting.

Additionally, work is underway to optimise data systems—such as QlikView—for identifying transition-age patients and informing service planning, with efforts to finalise audit tools and explore digital solutions for tracking key metrics.

The project also continues to work with our partners across North West London to support improvements and consistency (where appropriate) across the sector. We are liaising with colleagues from London North West University Healthcare NHS Trust (LNWH) and The Hillingdon Hospitals NHS Trust to explore this further.

Priority 2: Deteriorating Patient (PEWS)

Why we chose this as a Quality Priority
Improving the identification and management of deteriorating patients is one of the improvement work streams across the acute provider collaborative. Nationally there is a

requirement for Trusts to implement the Paediatric Early Warning Score (PEWS), which will be complimented with a programme of training for staff.

Aim
The initial implementation was expected to commence in August 2024 with metrics outlined and being monitored by October 2024. This was delayed due to some issues with the digital build work nationally.

Update on progress
The Trust has made steady progress in preparing for the rollout of the Paediatric Early Warning Score (PEWS) system. Weekly steering group meetings have resumed to support the go-live. Most technical changes—called Requests for Change (RfCs)—have been approved and completed, including updates to the PEWS chart, electronic documentation (iView), and assessment tools. All paediatric Welch Allyn (medical monitoring equipment) monitors now run the required firmware version. However, the digital build for the paediatric sepsis tool requires further work with the go-live date changed from 20 May to 10 June 2025.

Opportunities for innovation
Good progress has been made noting some challenges due to availability of testing resources. Further engagement with clinical divisions will be a focus in the next stage of rollout. The sepsis tool and Welch Allyn configuration are due to receive further support from Cerner. Key next steps include completing the technical build and testing in June, with policies, training and communications to follow with a post-launch audit in August 2025.

Forward plan

Actions	Target date
Technical build key deliverables—build, integration, system testing	Jun 2025
Workflow/alignment of policies	May 2025
Education and training/communication	May 2025
Post ‘go live’ audit	Aug 2025

Priority 3: Deteriorating Patient (Call 4 Concern)

Why we chose this as a Quality Priority
The ‘Call for Concern’ is linked to the national announcement in February 2024 for Trusts to implement Martha’s Rule. This follows the family of Martha Mills campaigning to help improve the care of patients experiencing acute deterioration. Martha Mills sadly died aged 13 in 2021 from sepsis at King’s College Hospital, after her family’s concerns about Martha’s deteriorating condition were not responded to promptly. In 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

The concept builds on critical care outreach teams (CCOT) and allows patients, families, careers and advocates to have access to the same 24/7 rapid review from a critical care outreach team which they can contact via mechanisms advertised around the hospital and more widely if they are worried about the patient’s condition.

Aim
As part of the national implementation of Martha’s Rule, the Trust implemented a mechanism to enable all inpatients, their families, carers, and advocates to initiate a 24/7 rapid review from a critical care outreach team via a centralised phone number.

Implementation for all inpatient wards across both sites was completed as of 30 September 2024. Data reporting on the pilot to NHSE is also underway.

Update on progress
The Trust implemented a single point of contact in autumn 2024, escalating to the critical care outreach team 24 hours a day. Since implementation in autumn 2024, the service has handled 128 calls, with over 88% successfully answered. Call volumes varied, with the Chelsea site experiencing higher activity, although not all calls led to documented cases—due to duplication, misdirected calls, or external queries. Notably, most calls were initiated by relatives (92% at Chelsea, 82% at West Middlesex). The team responded to the majority of calls within the target of one hour, providing appropriate and timely advice or changes in management, demonstrating improved support for patient care.

Opportunities for innovation
Since implementation in autumn of 2024, the majority of calls have been received from medical wards or surgical wards, with none from paediatric wards.

Of those calls received, only 18 to date have been considered appropriate for review by a CCOT team member, due to clinical deterioration and need for support in clinical management. Most calls received have related to non-clinical concerns (e.g. communications issues) and have been referred to the most appropriate group for management. CCOT's interventions have largely focused on documenting advice for the parent team. Of the 18 calls reviewed by CCOT, six have resulted in a change in treatment.

Volumes varied over the span of the implementation period but began to drop off after the first few months of implementation. While calls at the Chelsea site were more likely to be considered appropriate for review, this fluctuated at both sites over implementation—likely as staff gained more familiarity and confidence with managing calls.

Forward plan
As part of participation in the national pilot, the team is continuing to work towards implementation of an approach to ensure that patients/families are asked daily about their clinical condition, with this documented and acted upon.

Next steps for this work include the following:

- **Preparation of technical requirements:** To leverage existing bedside technology such as observation machines to enable automated collection. Explore what would be required to make changes within the Cerner electronic health record to include this question.

- **Pilot implementation:** To confirm the clinical process for pilot teams and engage proposed wards to discuss implementation, next steps and evaluation criteria.

Priority 4: Improving Frailty Care

Why we chose this as a Quality Priority
Frailty is a loss of resilience, meaning people with frailty are unable to bounce back quickly after an illness, accident or other stressful event. People with frailty are also at risk of developing conditions such as anxiety and depression, and are more likely to have unplanned hospital admissions. Due to our aging population, an increasing number of

people are at risk of developing frailty. Early recognition and timely intervention can save lives, prevent harm, improve patient experience and reduce unwarranted variation in care.

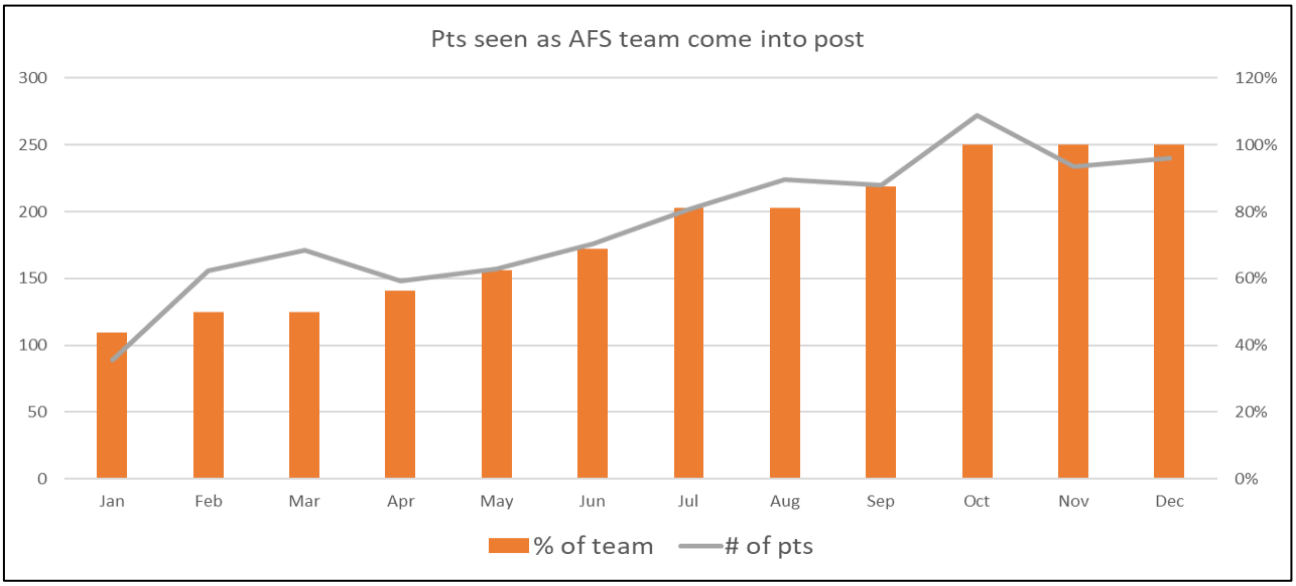
It is, therefore, the Trust's ambition to improve how we recognise frailty, assess patient needs and intervene to best support patients and reduce risk. In order to achieve this we will utilise comprehensive assessments and targeted interventions to support early discharge from hospital. By adopting this front door approach, patients who meet the criteria can be triaged for an admission avoidance pathway, treatment in the community, or home monitoring.

Aim

To improve identification, management and prevention of frailty through evidence-based interventions, multidisciplinary team reviews and data-driven approaches earlier within a patient's pathway and within the emergency care pathway. To further embed the Acute Frailty Service (AFS) with community services, while aiming to increase delivery of Same Day Emergency Care (SDEC), virtual, or telephone clinics to establish and improve all acute in-reach services.

Update on progress

A primary aim was to implement the practitioner (MDT) front door element of the AFS and recruit to outstanding roles. As the team expanded and finalised recruitment, the AFS was able to expand to further areas within the hospital, extend opening hours, and also initiate seven day working. As these goals were achieved, the service was able to see on average 240 eligible patients per month.



	2024-Jan	2024-Feb	2024-Mar	2024-Apr	2024-May	2024-Jun	2024-July	2024-Aug	2024-Sept	2024-Oct	2024-Nov	2024-Dec
Cross site	89	156	171	148	157	176	202	224	220	272	234	240

The frailty quality priority continued to meet and exceed the 35% national CQUIN (Commissioning for Quality and Innovation) target set in 2023/24 for completing a clinical frailty assessment (CFS) and ensuring appropriate follow up care was received through a Comprehensive Geriatric Assessment (CGA), reaching 99.9% and 65% on average, respectively.

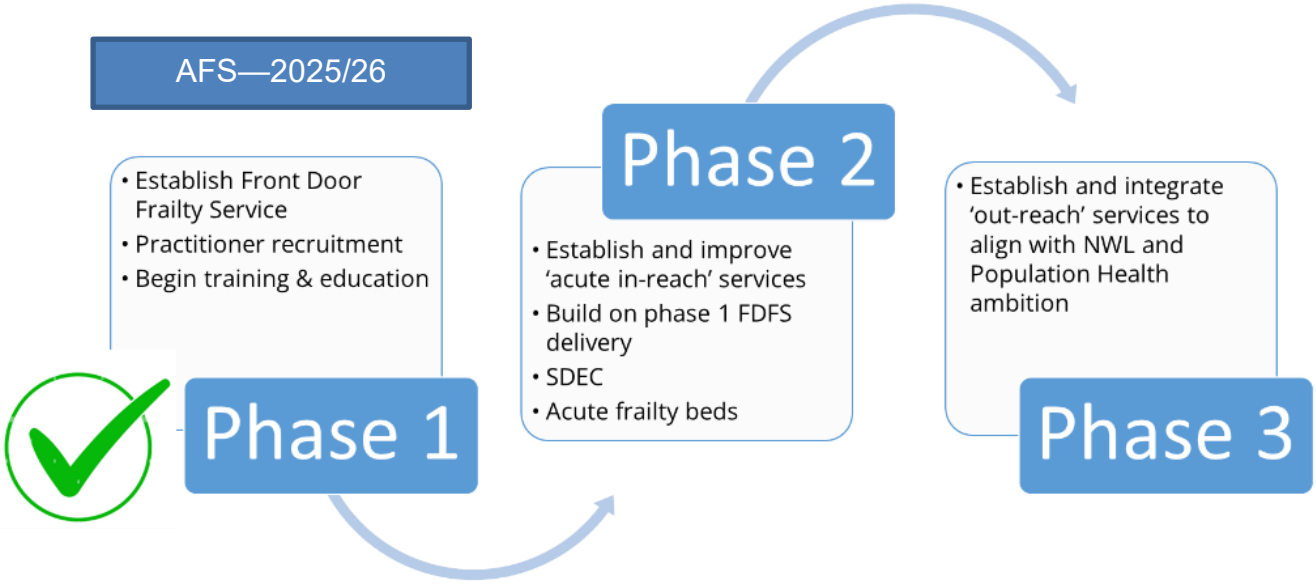
Patient impact was demonstrated throughout the year but particularly in the last six months, with a steady reduction in length of stay (LoS) notably for those who were 65 years old and above with a CFS of >5 when compared to those who were not seen by the service. The LoS improvement and associated bed day saving was seen in the second half of the year when both teams were fully recruited to and offering a seven-day service.

The team were also able build and deploy a frailty specific Friends and Family Test with the patient experience team to gather insights into how the new AFS teams were appraised cross-site, with consistent and frequent positive feedback.

Despite the success of the quality priority as a whole, there were some key challenges that the team encountered including:

- Patients referred to AFS have a higher acuity and therefore higher chance of admission which is reflected in clinical frailty score of patients being seen by the team.
- It can be difficult to assess a frailty related admission as a single entity, as other confounding initiatives can impact the admission profile (virtual wards, SDEC, or redirection).
- The Acute Frailty Unit (AFU) opened July 2024 (separate to original AFS plans), which required significant input from the West Middlesex team to provide support developing the standard operating procedure (SOP), triaging appropriate patients, initiating the CGA, and staff training.

Forward plan



After the successful delivery of phase 1, work is underway to build on all the work to date and identify the key drivers to achieve phase 2 and move into phase 3, which involves establishing and improving acute in-reach services and integrating outreach services.

Several development pieces are underway, including identifying a dedicated frailty area, increased community engagement and integration, developing training models to increase expertise within the frailty team, and creating a frailty link role to enable a link worker between the emergency department and acute assessment areas to increase joint ways of working.

Priority 5: Tobacco and smoking reduction

Why we chose this as a Quality Priority
The NHS Long Term Plan links key priorities such as improving population health, preventing illness, and reducing health inequalities. Approximately 64,000 people die from smoking-related illnesses in England every year. While smoking is most commonly associated with lung cancer, it also causes 15 other types of cancer and more than 100 other diseases. As a result, two out of every three smokers will die from a smoking-related disease.

Being in hospital is a significant event in someone's life and people can be more open to making healthier choices. The Long Term Plan commits to providing NHS funded tobacco dependency treatment to all inpatients who smoke, with everyone admitted overnight being able to access services.

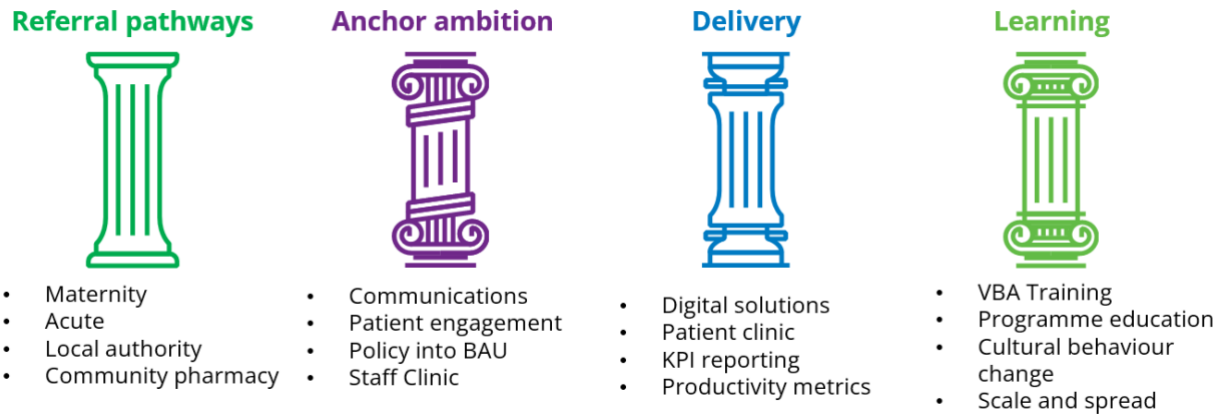
Campaigning at both Trust sites

Aim
This quality priority focussed on the delivery of the NHSE Long Term Tobacco Control Plan for smoking across acute inpatient settings. This focused on the identification of smokers, offering intervention advice and nicotine replacement therapy, as well as referral to stop smoking services. This was supported through an education programme and

establishing a network of Smokeless Champions. Our recent 'PROUD to be Smoke Free' campaign launched on national 'No Tobacco Day' in March 2025, as a result of the enabling work undertaken through the year. Activities completed as a result of the campaign included a trolley-dash on inpatient wards, the team received a number of new self-referrals from staff smokers and 150+ new Smokeless Champions were recruited.

Update on progress
The programme continues to embed smokeless care into routine practice across acute and maternity services, with Phase 2 focused on strengthening staff ownership and engagement. Monthly delivery group meetings support Trustwide alignment on the PROUD to be Smoke Free ambition, underpinned by data insights into health inequalities. Key initiatives include enhancements to Cerner workflows, smoking status screenings through pharmacy engagement, and incentives for pregnant smokers. Educational efforts—such as medical inductions and nurse training—are aligned with NICE guidance, while successful tools like the Smokeless Screening Champions Leaderboard and cross-site communications are helping drive consistent implementation and recognition.

The delivery across the 2024/25 financial year can be summarised by the Smokeless pillars:



Opportunities for innovation
The team are continuing to explore the embedding of electronic tools to support the identification and monitoring of this initiative.

Forward plan
Smoking has been identified as a significant risk factor impacting five critical clinical areas: hypertension, cancer, chronic respiratory disease, mental illness, and maternity. The Trust continues to work with primary care services and the local integrated care board (ICB) to ensure sustainability of the service in supporting patients and staff, and to recognise the impact of these interventions on wider health promotion initiatives.

Priority 6: Patient Safety Incident Response Framework (PSIRF)

Why we chose this as a Quality Priority
The Patient Safety Incident Response Framework (PSIRF) is a national contractual requirement aimed at developing and maintaining effective systems and processes for responding to patient safety incidents to foster learning and improve patient safety. It helps

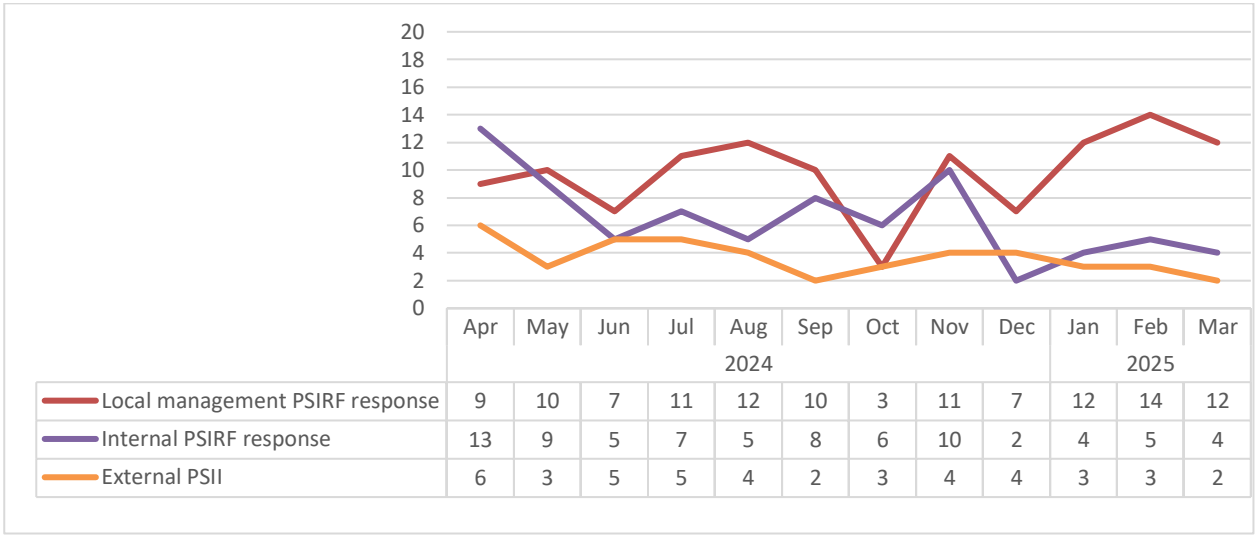
identify key areas of concern that can be monitored within a robust and strategically aligned system, ensuring that the patient voice is at the core of our safety agenda.

The Trust began implementing PSIRF in Apr 2023 and fully phased out the previous Serious Incident (SI) framework in Mar 2024. This included publication of the North West London Integrated Care Board (ICB) approved PSIRF Policy and Plan for the Trust in March 2024.

While delivering much of the year one quality priority work, including the rollout of new methodology and making online training accessible to all staff, further work was needed to improve training compliance, develop a safety education programme and embed new approaches to learning responses and patient safety investigations.

Aim
To empower and enable our staff to respond to patient safety events through the implementation of the patient safety incident response framework in collaboration with the North West London Acute Provider Collaborative.

The Trust launched their implementation of PSIRF plan at the end of the 2023/24 financial year and have a better understanding of the safety culture of the organisation and areas for improvement given the experience of running of this priority over the past two years.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2024									2025		
Local management PSIRF response	9	10	7	11	12	10	3	11	7	12	14	12
Internal PSIRF response	13	9	5	7	5	8	6	10	2	4	5	4
External PSII	6	3	5	5	4	2	3	4	4	3	3	2

Breakdown of patient safety Incidents requiring a PSIRF response by incident level (Reported 1 Apr 2024 to 31 Mar 2025)

Update

- A review of Trust performance against the PSIRF Plan was completed in February and approved at the Patient Safety Group. The findings will be used to inform the improvements in the plan and further adoption for the year ahead.

- Level 1 and 2 training moved successfully to the new Learning Management System and the Training Needs Analysis for Level 2 was updated in February 2025.

- Timelines for Initial Incident Reviews (IIRs) have improved during Q4 owing to divisions working with governance colleagues to meet the two week turnaround time and active monitoring by the IIR Group.

Metric	Ambition	Baseline	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
All staff: • Level 1—Essentials for patient safety • Level 1—Essentials of patient safety for boards and senior leadership team	90%	29%	53%	73%	85%	90%
Band 6 and above and medical professionals: • Level 2—Access to Practice	90%	29%	23%	42%	49%	76%

Opportunities for innovation

- While the level 2 training target compliance improved over the year, it was missed. However the time taken to deliver 76% compliance and engage staff in training over the last two financial years has led to positive engagement with PSIRF methodology and embedded it into the working practices of Trust staff.

- Timelines for After Action Reviews (AARs) and Patient Safety Incident Investigations (PSIIs) remain a focus for the Trust to ensure timely investigation and learning

- Develop a bespoke training programme as part of the APC for new investigators to support understanding of learning responses and review tools.

- The Trust will continue to recruit to the Patient Safety Partner roles for both sites, noting this is now a requirement of the NHS Standard contract 2025/26.

Forward plan

While an enhanced staff training package is being designed alongside APC colleagues, internal training is being offered ad hoc, with PSIRF added to the new consultant induction programme in 2025 and a permanent feature of the resident safety training course.

The Trust will continue work to enhance and assure safety improvement plans via sub-groups of Patient Safety Group and Clinical Effectiveness Group to ensure PSIRF is embedded into the culture of the Trust. The Trust will also analyse the Safety Culture survey results once it is closed (running Feb-Apr 2025) to see where staff feel we can improve.

Work is ongoing to develop the quality of our learning responses as leads gain SEIPS (Systems Engineering Initiative for Patient Safety) maturity and there is better uptake of systems approaches across the Trust—ie when considering risk. The PSIRF steering group has been stood down and a new Patient Safety Specialist Group is due to commence meetings in May 2025 in order to continue the wider National Patient Safety Strategy work in the Trust.

Priority 7: Patient experience (Nutrition and Hydration)

Why we chose this as a Quality Priority

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services. The NPSP is commissioned by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England.

As part of the NPSP, the Adult Inpatient Survey has been conducted annually since 2002. In 2022, the survey results highlighted several themes that were not as favourable as hoped. The Adult Inpatient Survey benchmarks the Trust against 11 themes. Across these, the Trust scored ‘about the same’ for 8 themes and ‘worse’ for 3.

While the Patient Experience Group is monitoring an improvement plan, actions regarding nutrition and hydration should be implemented Trustwide across all services. Ensuring good nutrition and hydration is vital to promote healing and recovery.

Aim
Through this quality priority, the Trust aimed to ensure patients were appropriately assessed for nutritional risk and, where needed, referred for specialist dietetic support. In addition, patients requiring help at mealtimes should receive dedicated support to ensure their nutritional needs are met.

In July 2024, additional questions were added to the FFT feedback system, including: ‘Did you get enough help and support with your meals?’ The baseline for this metric, taken from the NPSP, was 54.29%. A target of 75% was set, supported by a series of interventions including: relaunching and refocusing on protected mealtimes, pre-mealtime huddles, consistent feedback from patients, and the creation of a mealtime champion/support role within the Trust’s volunteer service.

Update on progress
The Nutrition and Hydration Steering Group has been meeting monthly. Following process mapping of a patient’s nutrition and hydration care during an inpatient stay, the group initially focused on timely completion of the MUST screening tool and re-launching protected mealtime principles. This was supported through policy reviews, staff education, and the introduction of a dedicated mealtime champion/buddy role, with volunteers assisting with meal services on wards.

Compliance with MUST screening has exceeded the initial target of 80%, and the group is now working towards a stretch target of 90%, which was consistently surpassed in Q4.

For FFT results, both sites have exceeded the 75% target. West Middlesex generally compares favourably with the Chelsea site, although in Mar 2025, Chelsea scored 90%.

Opportunities for innovation
- Referral processes for dietitians have been reviewed to support electronic referrals for all patients at risk

- Protected mealtime principles will be audited through the Trust’s quality programme

- Access to out-of-hours hot food and provision of hot finger food will be explored as part of the dementia group and monitored through the Nutrition and Hydration Group

Forward plan
Separate from protected mealtimes, a targeted piece of work has taken place at the Chelsea site to explore barriers to providing excellent nutritional care. An associated action plan has had a positive impact. Progress has been made in terms of MUST screening and patient experience, and an ongoing work plan is in place to continue driving standards.

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 2024/25. 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 2024/25, 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 2024/25 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 an area of healthcare and recommend ways to improve.

During 2024/25, 63 national clinical audits and 10 clinical outcome review programmes covered health services provided by the Trust. During that period, we participated in 82.5% of the national clinical audits and 80% of national confidential enquiries applicable to the Trust.

The national clinical audits and clinical outcome review programmes the Trust was eligible to participate in during 2024/25 are listed within Annex 1 (page 83).

National clinical audit

Outcome reports from 33 national clinical audits were reviewed by the Trust during 2024/25. Annex 2 (page 89) 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 287 local clinical audits were registered by the Trust via the Clinical Governance Team during 2024/25 as per the table below.

Division	Local clinical audits registered 2024/25	Local clinical audits completed 2024/25
Clinical Support Services	46	41
Planned Care Division	80	78
Emergency & Integrated Care	42	44
Specialist Care Division	84	33
West London Children's Healthcare	35	13
Trust Total	**287**	**209**

209 local audits were reviewed (logged as complete with the Clinical Governance Team) during 2024/25. 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 are examples of local clinical audit projects undertaken across the organisation, demonstrating actions to improve the safety and effectiveness of our services:

Local clinical audit (title/objectives)	Summary and agreed actions from local clinical audits
Audit: CPR (cardiopulmonary resuscitation) & TEP (Treatment Escalation Plan) Decision CW/WM **Aim:** To understand proportion of patients admitted to Chelsea and Westminster Hospital and West Middlesex Hospital, who have CPR and TEP decisions completed and compare this to trust standards (snapshot, one day audit.) **Objectives:** • To identify the proportion of all adult inpatients on 1 May 2024 who have a CPR and TEP decision completed • To review the completion of Cerner CPR and TEP forms identified and compare these to the Gold Standards • To investigate if patients with CPR decision place have an adequate TEP recorded • To identify areas where practice does not meet the standards and to propose strategies to improve practice • To compare this year's data to previous data from earlier years and audit cycles **Standards:** • Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing • 20160123 Decisions Relating to CPR - 2016.pdf (resus.org.uk)	**Observations:** • Continues to be an increase in absolute numbers of CPR and TEP decisions completed on Cerner form year on year with increase in number of 'For CPR' decisions recorded this year on both sites • 100% of patients had capacity assessed and documented • Continued reduction in number of patients with 'Review prior decision' resus status, now 5% of all patients • Lower incidence of CPR and TEP decisions on surgical wards • Reduction in decisions endorsed by Consultant within 48hrs from 89% to 79% • Improvement in quality of TEP decisions **Actions Identified:** • Present audit at EOLC steering group and Planned Care division governance meeting • Cerner CPR & TEP decision—plan for NWL review of current documentation and CPR and TEP decision policy • Cerner support bundle form with added focus on clear TEP and CPR decision for patients started on these treatments to support improvements in quality of TEP • New simulation course planned in Jan 2025 to support surgical trainees with conversations regarding CPR and TEP decisions and direction of care. **Audit standards for completion of CPR and TEP decisions at CWHFT, all decisions must:** • Be documented on Cerner (100%) • Document capacity assessment prior to making a 'CPR and TEP' decision (100%) • Document adequate clinical reason for the decision (100%) • All 'No CPR' decisions should be accompanied by a TEP (100%) • Be discussed with patients with capacity (100%) • Be discussed with NOK (next of kin) where a patient lacks capacity to make decision (100%) • Be completed by ST3 (residents) and above in line with trust policy (100%) • Be endorsed by consultant within 48 hours of completion (100%) • Not contain Learning difficulty or autism as sole documented reason for 'No CPR decision' (100%) **Target:** To re-audit current practice in the Trust around decision-making, discussion and documentation of CPR and Treatment Escalation Plans (TEP) for the adult in-patient population.

Local clinical audit (title/objectives)	Summary and agreed actions from local clinical audits
Audit: Implementation of a geriatric checklist on a Care of the Elderly Ward to improve patient outcomes **Objectives and aims:** Our elderly patient population often have multiple comorbidities and acute issues which need to be addressed. High volumes of patients with quick turnover means that at times it can be easy to miss or forget to look at certain aspects of care. However, some patients on the ward with longer stays need constant reviewing. • Aim is to create a complete checklist to address multiple co-morbidities and care needs of the elderly population, to avoid things being overlooked on busy ward rounds. • To complete this checklist for all patients 65 years and over admitted to Rainsford Mowlem Ward to assess impact on patient outcomes and length of stay. **Standards:** • NICE Best Practice • British Geriatric Society • NHS England Guidelines	**Observations:** • We are good at establishing TEPs for patients 65 years and over • Mobility and medication review are well documented both before and after admission to Rainsford Mowlem. • The checklist improved our documentation of catheterisation of patients and oxygen prescription, although significant improvement can still be made. • There is notable room for improvement in updating NOKs and ensuring this is documented. • 4AT and Frailty scores are poorly documented across admission. • Length of Stay was improved post intervention **Actions identified:** • Repeat audit collecting data across all care of the elderly wards (COTE) in CWH • Present intervention to acute & emergency teams to ensure continuity across the hospital • Ensure checklist is reviewed at least weekly on COTE wards, for example can be discussed at board round • Can consider inclusion of further aspects to manage frailty such as nutritional assessment or bone health • Can consider inclusion of mood assessments
Re-Audit of the management of acute pancreatitis against the NICE guidelines *(Presented and Discussed at Planned Care Quality Board Meeting: September 2024)* **Context:** Evaluate if patients admitted to the hospital with acute pancreatitis are appropriately scored Undergo ultrasound imaging in a timely manner Undergo ERCP (Endoscopic Retrograde Cholangio-Pancreatography) within 72 hours if deemed necessary Have cholecystectomy within same admission or within 2 weeks of presentation if required. **Standards/Target:** Compare the findings with the NG104 NICE guidelines for Acute Pancreatitis **Audit Sample:** Retrospective data collection of patients diagnosed with acute pancreatitis during the 6-month span from Jan–Jun 2024.	**Target Standard = Partially met** • 100% acute pancreatitis diagnosed within 24 hrs of admission, with aetiology confirmed in 85% • Glasgow score calculated in 50% of patients—achieving a 5% Improvement since first Audit • 60% of patients with severe pancreatitis were reviewed by CCOT/ICU—achieving a 100% improvement • Median time from admission to ERCP 5 days—achieving a 1.5-day improvement • 100% cholecystectomies within 2 weeks/same admission—achieving a 25% Improvement • 50% non-gallstone pancreatitis pts were transferred to gastroenterology ward—achieving a 22% improvement **Areas for Improvement:** Share findings of the audit with surgical team to improve awareness and implementation NICE guidelines for Acute Pancreatitis and re audit in 6 months.
Audit: HIV rates of late cervical cytology test in women attending a GUM clinic—is there an unmet need in our service? (Presented and discussed at departmental meeting) **Aim:** To identify how many individuals attending 10 Hammersmith Broadway are due for a cervical screening test. **Audit Objective:** To establish if there is a high demand for implementing this service within the GUM setting. **Data Source:** Lilie patient records.	**Quality Improvement** • The project identified an unmet need and supports implementing this service within our clinic. • Improved documentation regarding previous compliance is required. • Increased patient awareness and education on the importance of screening are necessary. **Sampling** • Included the last 100 female or trans male patients over 25 years old, living in Hammersmith and Fulham, seen at 10 Hammersmith Broadway. • Data reviewed by clinicians over one month. • 96 patients were included after excluding duplicates.

Local clinical audit (title/objectives)	Summary and agreed actions from local clinical audits

Audit: Inpatient hypoglycaemia management
 	
Objectives and Aim:
• Inpatients with diabetes mellitus are increased risk of harm, most commonly an increased risk of hypoglycaemia.
• Hypoglycaemia is associated with increased length of hospital stay and mortality in patients with diabetes mellitus.
• Therefore, appropriate management of hypoglycaemia in inpatients is essential.
• Severe inpatient hypoglycaemia events (BM <2.2 mmol/L) are harms reported in the national diabetes inpatient safety audit
 	
Aim: To review cases of hypoglycaemia (threshold blood glucose measurement <4 mmol/L) recorded by point of care blood glucose meters for Trust inpatients across Oct/Nov 2023.
 	
To identify adherence to the trust hypoglycaemia management guidelines across all adult inpatients
 	
Standards:
• 100% blood glucose readings reviewed in records from point of care blood glucose meters should have a correct patient identifier recorded alongside the measurement.
• 100% of hypoglycaemic blood glucose readings (using a threshold of <4mmol/L) will have an appropriate intervention in keeping with the trust hypoglycaemia management guidelines (which are based on Joint British Diabetes Society guidelines).
• <20% of glucose readings <4 mmol/L will have been in patients where testing not indicated (ie not diabetes, liver failure or suspected hypoglycaemic disorder) and no patients outside these criteria with glucose <4 mmol/L received inappropriate treatment of hypoglycaemia.
	Observations:
	Incorrect identification:
	• The majority of hypoglycaemic results recorded by the point-of-care glucose meters did not have a corresponding patient identifier recorded
	• In these cases, adherence to the trust guidelines for hypoglycaemia could not be assessed.
	
	Documentation regarding hypoglycaemia events is not consistent:
	• Detail and location of documentation varies between events
	• Separate note vs within nursing shift documentation vs comment on recorded result
	
	Management decisions often not in keeping with guidelines for the patient's clinical condition:
	• Using IV glucose when oral route suitable not sufficiently trialled
	
	BMs often not rechecked at an appropriate interval post-treatment for hypoglycaemia:
	• Often rechecked more than 10-15 minutes post-intervention
	
	Identifying hypoglycaemic episodes and intervening when not indicated and no risk of harm:
	• ie End of Life care with limited oral intake
	• BM <4 can be normal if no underlying condition/medication that can reduce blood glucose
	• Threshold of <2.2 mmol/L is more appropriate in these cases
	
	Actions identified:
	• Implementation of new glucose meters that will link with the Cerner EPR
	  • Ensure that all blood glucose measurements recorded are linked to patient identifier and transferred to that patient's record.
	  • Would limit transcription errors and support future re-audit.
	  • New meters being implemented from 7 Jul 2024—readings matched to hospital numbers through scanning patient barcodes
	
	• Introducing a power form on Cerner EPR that will pop-up if BM<4 is recorded
	  • Allow the episode to be documented formally—ensure consistent documentation
	  • Provide guidance on the appropriate management which could then be selected.
	  • Support the user with determining the appropriate management of these episodes.
	
	• Encourage use of hypo box to treat hypoglycaemia episodes
	  • Contains the guidelines to support management decisions
	
	• Develop a glucose monitoring policy
	  • Guidelines for glucose monitoring and when to check ketones
	  • Support staff to determine appropriate monitoring
	
	• Review end of life guideline with palliative care team
	  • Ensure inappropriate BM checks are stopped

Local clinical audit (title/objectives)	Summary and agreed actions from local clinical audits
Re-Audit: Evaluation of current discharge protocol for stable Weber B fractures (Presented and discussed at Orthopaedics Clinical Governance Half day meeting Sep 2024) **Aim:** To optimise follow-up protocols for patients with stable Weber B fractures, specifically aiming to reduce unnecessary 6-week follow-up appointments, thereby improving patient satisfaction and resource allocation within the orthopaedic department. **Standards:** The audit will benchmark practices against established guidelines and literature on the management and follow-up of stable Weber B fractures. The criteria for assessing follow-up necessity will be derived from best practice recommendations within orthopaedic and fracture management literature, focusing on optimising patient outcomes and resource allocation.	**Conclusions and next steps after first cycle:** Discharging patients with stable Weber B fractures at 2 weeks is safe • Saving 1.4 unnecessary fracture clinic appointments per patient • Avoiding 1.2 XR ankle serious per patient • Pathway introduction -> Weber B fractures get discharged when first deemed stable. • Patients get an information leaflet and patient initiated follow up. **Conclusions after second cycle:** • 1/12 (8.3%) patients were discharged on first clinic appointment • Of remaining patients, 2/3 were discharged after one additional clinic • The remaining patients were all discharged by the second additional clinic appointment • Prior to the pathway intervention 14% of patients had three are more additional clinic appointment times • If we followed pathway we would save 1.4 clinic appointments and XRs **Next Steps:** • Email pathway to team members seeing patients in VFC and fracture clinic. • Encourage discharges with patient lead follow up at the initial two week appointment if fracture deemed stable. • Re-audit compliance to pathway.
Re-audit: Urology—reliable triage to allow a fast-track pathway for haematuria patients (Presented and discussed at Urology Clinical Governance Half Day Jun 2024) **Context:** National cancer waiting times (CWT) (two week, 31 days and 62 days) have been useful levers to speed the diagnostic and treatment process. Diagnostic stage for haematuria should be ideally done within 14 days (Imaging and flexible cystoscopy). Initial treatment as Cystoscopy +/- TURBT within 31 days. **Standards/Target:** GIRFT pathway Updated August 23 Images should be requested prior to Flexi clinic attendance. Once date is confirmed. The flexi clinic is arranged after. This will enable the CNS/clinician to update the patient about the results and possibly discharge patients at the time of clinic. If images indicates bladder tumours, they can be booked into TURBT directly	**Summary:** • The arrangement of images before Flexi clinic and hence the rate of discharge at the time of Flexi decreased compared to the first audit. • There is improvement in the number of days till discharge or decision for TURBT (Transurethral Resection of a Bladder Tumor) or General Anaesthsia (GA) procedure. **Recommendations:** • There is overall improvement in the pathway in terms of decreased days till discharge or decision. • Increase the images slots for haematuria patients **Audit Sample:** Retrospective Audit. The data was collected from Patients Electronic records. 230 patients included.

Local clinical audit (title/objectives)	Summary and agreed actions from local clinical audits
Audit: Medication reviews and HIV drug-drug interactions (Presented and discussed at Clinical Support Quality and Risk Group Sep 2024 **Context:** Medication Safety for Patients. There is increasing potential for drug-drug interactions due to Aging Populations, Comorbidities and Polypharmacy. **Standards/Target:** BHIVA British HIV Association—90% of individuals must have a documented medication review within the past 15 months by a HCP. **Method:** Identify the number of documented interactions between Antiretroviral Therapy (ART) drugs and non-ART drugs through use of Liverpool HIV Interactions Database. Identify how many 'Amber' and how many 'Red' interactions had a documented management plan.	**Summary:** Target Standard = Met On Audit 92.9% of individuals had a documented medication review within the past 15 months by a Health Care Professional. 99 Interactions identified, just over 50% of interactions have been documented with plans: Spacing (62.9%), Monitoring (20.4%), Stopping co-medications (9.3%), Capping dosages of co-medications (5.5%), Switching ARVs (1.8%). Audit has highlighted a shift in ART drug classes implicated for drug-drug interactions: 2019 Protease inhibitors were the highest (~50%) and Integrase inhibitors lowest. 2024 Integrase inhibitors were highest (>90%) and Protease inhibitors the lowest. **Areas for Improvement:** A universal pre-clinic questionnaire on co-medications could be uploaded onto medical records to further improve the medication review process. **Audit Sample:** Retrospective case note review of 282 individuals.
Re-audit: Completion rate of staging following a cancer diagnosis (Presented and discussed at CSD Quality and Risk Group Oct 2024) **Context:** In Oct 2022 the Trust was notified the Royal Marsden Partners standard for Cancer Staging had not been met. This standard is for 80% staging to be captured and recorded on the Somerset Cancer Registry. The Trust subsequently implemented a package of improvement to address data capture.	**Summary:** This programme examined Patients over a two-year period from 2021 to 2022 who had missing staging data on Somerset Cancer Registry. Q1 2022 (start of the improvement programme): Trust = 32%. Following the staging project the percentage improved to 81.6% making CWFT 3rd in the Cancer Alliance. This position continues to be maintained with 80.8% completeness Jan–Jun 2024. **Quality Improvement:** Programme of Quality Improvement has shown that the Cancer Performance Service are compliant with national best practice, demonstrating a high standard of data capture and completeness which has been recognised formally via 2 letters of congratulations (NHSE NHSI Head of Cancer Datasets.) The Trust continues to maintain a focus on Staging via: Bespoke 1:1 training for the MDT coordinators and Cancer Trackers with the NHSE team so they are able to ensure data entry is being made in real time. Liaison with consultants to ensure the staging data is being documented in correspondence or captured live in the MDT meetings. Monthly list being sent to each individual tumour site with missing staging data that needs to be entered into the cancer data base.

Local clinical audit (title/objectives)	Summary and agreed actions from local clinical audits
Re-audit: Urgent spinal imaging in suspected CES & MSCC *Presented and Discussed at Radiology Clinical Governance Half Day (November 2024)* **Context:** Patient Safety and Prompt Diagnosis—Cauda Equina Syndrome (CES) and Metastatic Spinal Cord Compression (MSCC) are a diagnostic and neurosurgical emergency requiring prompt diagnosis and treatment via specialist urgent neurosurgical decompression to avoid severe and permanent disability. **Actions Implemented:** Ring-fenced slots for CES at both sites. Standard operating protocols. Improved communications between ED and radiology. CES scan sequences were updated in line with GIRFT to include a screening whole spine MRI. **Standards/Target:** MRI of the Lumbar spine is the gold standard diagnostic study to confirm a diagnosis of CES/MSCC. Royal College of Radiologists February 2023 guidance: 24/7 Emergency MRI should be available on-site in all acute hospitals by June 2024, where a local service is unable to provide this service then there should be an agreed networked service. **Nice Guidance:** Carry out MRI as soon as possible (always within 24 hours) at the local hospital or appropriate centre with direct access imaging facilities if MSCC is suspected.	**Summary:** • Improvement in scans occurring within 4 hours (49% in 2023. 74% in 2024.) • Improvement in scans being reported within 1 hour (34% in 2023. 66% in 2024.) • Improvement in scans performed within 24 hours, MSCC with neurology (37% in 2023. 70% in 2024.) • Improvement in scans performed within 24 hours, MSCC without neurology (87% in 2023. 89% in 2024.) **Audit Sample:** Review of urgent MRI spine requests between 1st-30th September 2024 at CWH and WMH. 93x Query CES/MSCC (73 query CES and 20 query MSCC.)
Community Paediatrics—Evidence of children with concerns about Foetal Alcohol Syndrome within Cheyne CDS *Presented and discussed at departmental meeting* **Aim:** To review documentation of information related to alcohol exposure and its potential consequences across CCDS clinic and report types. To use this information to consider if any modification or updates are required to improve this. To use this information as part of consideration into a new FASD pathway. **Audit Standards:** This audit as compared against criteria created after review of the following guideline: SIGN 156: Children and young people exposed prenatally to alcohol guidelines will be used to compare clinical documentation with relation to foetal alcohol syndrome. Letters reviewed against set criteria with regards to presence/lack of documentation about these criteria. If it was not documented in the letter, for the purposes of this audit it is assumed that it was not asked/not considered.	**Observations:** Questions regarding alcohol consumption during pregnancy are not being asked very often, even in situations where a child is presenting with known or suspected developmental delay. Dysmorphic features (or lack of) are not being well documented in clinic letters. Poor review of birth measurements in letters. Poor review of head circumference in clinic (with only 2/3 of those <5 years old having this documented when this is accounted for). Together these findings may represent potential missed opportunities to review if a diagnosis of FASD should be considered. **Recommendations:** Review of clinic letter templates for each clinic type. Add in sections regarding alcohol consumption during pregnancy as this may encourage increased asking and documentation. Ongoing consideration if FASD pathway is needed within CCDS. Repeat analysis following change to templates.

Local clinical audit (title/objectives)	Summary and agreed actions from local clinical audits
Paediatric Emergency—Concussion recognition: how good are the PEM team at recognising concussion and providing appropriate advice *Presented and Discussed departmental meeting* **Aim:** The primary objective was to investigate, in children with concussion prone injuries: the proportion of children who meet criteria for concussion vs those diagnosed with concussion by Paediatric Emergency Medicine (PEM) team members. To identify mechanisms of injury and symptoms that were associated with a diagnosis of a concussion by PEM team. **Audit standards:** Compared against the Zurich International Criteria for Concussion.	**Key finding:** A total of 80 CT heads were done in the 2-year period for head injury. 72 children had a normal CT head. 56 meet the criteria for concussion as per the Zurich Fourth International Consensus. Of those 56 children, only 18 children (36%) were diagnosed with concussion by the PEM Team. Concussions were more likely to be diagnosed by the PEM team if the injury took place during sport with 83.3% of sports related cases diagnosed with concussion in the emergency department, followed by fall in playground (57%). Headaches and nausea/vomiting were the most regularly documented symptoms when a diagnosis of concussion was made by the PEM team. **Recommendations:** Better education needed for Paediatric Emergency team about concussions **Sampling:** Which patients: all children <16 y.o presenting with a head injury requiring neuroimaging. What timeframe: 1 Sep 2022–31 Aug 2024 inclusive Sample size/population: 80. How sample was identified: advanced search on Data source (e.g. health records, CDR, radiology reports etc.): health records and radiology reports.
Paediatric Dentistry—An audit to monitor and record the turnover of dental instruments in the paediatric dental unit at Chelsea and Westminster Hospital *Presented and Discussed departmental meeting* **Aims:** To ascertain the effectiveness of using 'Fingerprint' application to locate or monitor the hand-pieces used in Paediatric Dental Unit from after use in clinical work to sterilisation (TSSU) and back to Paediatric Dental Unit. To assess the efficacy of scanning the packed instruments ready to be stored in storage room. To determine the effectiveness and safety of the practice (transportation and utilisation of dental instruments) and to recommend implementing the practice to scan and monitor additional dental instruments. **Sampling:** A Retrospective audit from years 2020 till 2024 for missing hand-pieces used in Paediatric Dental Unit. Data was collected by all dental nurses in the paediatric dental unit	**Key Finding:** The utilisation of 'Fingerprint' application for scanning and monitoring of dental hand-pieces has been a successful endeavour in recording and locating hand-pieces. This practice has generated a 100% successful outcome since its implementation in 2023. Since the use of 'Fingerprint' application to scan and monitor the transfer of dental hand-pieces for the use of Paeds Dental Unit (including Orthodontics, OMFS, A&E), no dental hand-pieces have been misplaced or lost during transfer from sterilisation. **Recommendations:** To maintain the practice of scanning dental hand-pieces 'in' and 'out'. For all dental nurses to update training and refresh the process of using the application. To discuss adding more dental instruments to the list for scanning and monitoring (e.g. Orthodontics SARPE keys, forks, surgical driver, scalers). Fingerprint system was introduced in September 2023 to scan dental hand-pieces. Data was collected over the CW Paediatric Dentistry Unit only. Manual records were available from 2020 (in the dental nurses shared drive) before the Fingerprint system was introduced. Records were collected and analysed from the Fingerprint software on the storage dental nurse's laptop and analysed manually.

Local clinical audit (title/objectives)	Summary and agreed actions from local clinical audits
Maternity—Management of P-PROM at West Middlesex hospital in accordance with trust and national guidelines *Presented and discussed at Governance half day November 2024* **Background**: Preterm pre-labour rupture of membranes (PPROM) complicates up to 3% of pregnancies and is associated with 30-40% of preterm births. PPROM can lead to significant neonatal morbidity due to prematurity, chorioamnionitis, sepsis, cord prolapse, placental abruption, and fetal lung hypoplasia. Our Trustwide guideline for managing PPROM in pregnancies of 23+6 to 36+6 weeks gestation was updated in April 2023. The lack of audit was noted in a significant event. **Methodology:** A retrospective audit was conducted as a local cross-site study. The pre-existing 2023 audit reviewed PPROM cases from April to September 2024. Compliance with the administration of antibiotics, steroids, MgSO4, and neonatal counselling were evaluated.	**Key Results:** Both sites are not meeting the recommended targets for the administration of antibiotics, steroids, and MgSO4. Additionally, neonatal counselling requires improvement. **Recommendations:** Conduct training for all clinicians on the administration of antibiotics, MgSO4, steroids, and neonatal referral and transfer. • Ensure that prescribed drugs are recorded in Cerner. • Consider modifications to K2 templates. • Place a poster in the midwifery office in ANW to remind staff to refer to neonatologists for prematurity counselling. • Reaudit in six months.
Gynaecology- VTE assessment and thromboprophylaxis in patients undergoing surgical management of miscarriage **Re-Audit** *Presented and discussed at departmental meeting departmental meeting*. **Aim:** To re-audit if Antenatal VTE risk assessment is being performed in women undergoing SMM at WMUH after implementation of the changes and compare the data from the previous audit. To highlight its importance in preventing maternal morbidity and mortality. **Standards/Target:** Memorandum: Antenatal Venous Thromboembolism (VTE) Risk Assessment and Management for Patients in Early Pregnancy Having a Surgical Procedure under General Anaesthesia (cross-site) 4 October 2022. Royal College of Obstetricians and Gynaecologists. Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium. Green-top Guideline No. 37a. April 2015	**Comparison to previous audit:** 100% of patients admitted for SMM had VTE assessment, and 85.7% had maternity VTE done, whereas the first audit showed only 66.7% had any VTE assessment, and 13.3% had the correct maternity VTE. **Areas for improvement:** Documentation for pre-SMM and post-SMM review, as currently only 64.3% of patients had appropriate documentation. Ensure that all patients scoring above 3 in maternity VTE are prescribed LMWH. **Audit Sample:** All women who underwent SMM from 01/01/2024 to 31/01/2024, identified from EPU SMM booking notes. Data collected from electronic patient records (Cerner). Compared with the initial audit performed in June 2023.

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 2024/25 was a pause on traditionally established CQUINs. This was to allow the Trust to have additional focus on established Quality Priorities.

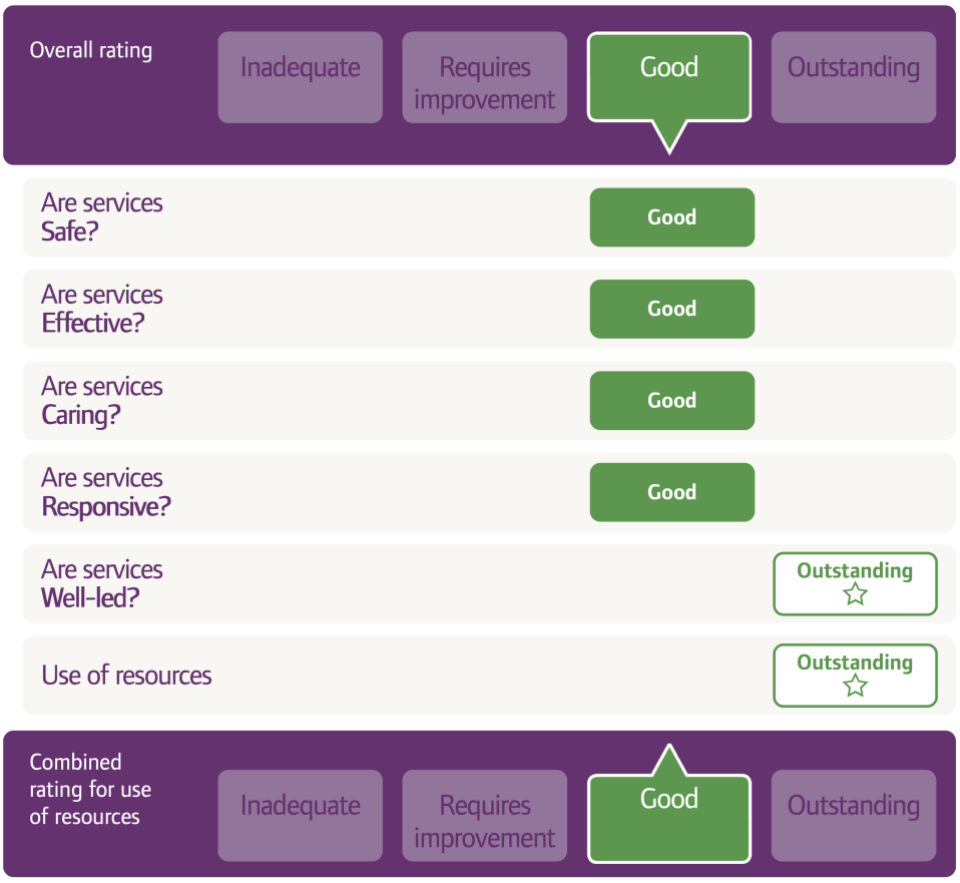
Registration with the Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care in England. They register, and therefore licence, providers of care services if they meet essential standards of quality and safety. They monitor licenced 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 registration. The CQC has not taken enforcement action against the Trust during 2024/25.

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'.



Secondary Uses Service (SUS) information

The Trust submitted records during 2024/25 to the SUS for inclusion in the hospital episode statistics which are included in the latest published data. Best/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 or handle information. It covers information relating to patients and staff, as well as corporate information, and helps to ensure the information is handled appropriately and securely with particular emphasis on managing personal data within the 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 to provide assurance that they are practicing good data security and that personal information is handled correctly. The DSPT is audited pre-submission by our internal auditors.

For 2023/24 the Trust achieved 'standards met' and the organisation believes it will again achieve this standard for 2024/25. https://www.dsptoolkit.nhs.uk/

ODS	Organisation name	Status	Published
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	2023-24 (version 6)— Standards met	28/06/2024

NHSE Organisation Data Service

Clinical coding error rate

The Trust was not subject to the payment by results clinical coding audit during 2024/25 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 of April 2027. This has been shared with the IGSG via the DGSG (Data Quality Steering Group) to ensure oversight and assurance.

- **Data quality (DQ) monitoring:** A number of dashboards have been built on the QlikSense app to monitor data quality from Cerner EPR systems with regards to agreed DQ measures. The Foundry tool is also used to manage data quality on inpatient/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 2024/25, 1,309 adult and child deaths occurred within the Trust's hospital sites. This comprised the following number of deaths which occurred in each quarter of that reporting period—317 in Q1, 272 in Q2, 340 in Q3 and 380 in Q4.

By 31 Mar 2025, 1,199 cases had been screened for potential learning and 560 full case record reviews had been undertaken by consultants—this represents case screening of 92% of total deaths with comprehensive reviews completed for 43% of cases.

The impact of problems in care provision is graded using the classification system initially developed within the confidential enquiry into stillbirth 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, different care would reasonably be expected to have affected the outcome (probable avoidable death)

Where case record reviews identified potential areas for improvement, individual actions plans are developed to support and monitor change delivery. Learning from case record reviews are 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 were five cases identified whereby suboptimal care might have affected the outcome for the patient. All five cases had an appropriate safety learning response in addition to the mortality review. There were no CESDI 3 cases reported.

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q1 2024/25	130	13	2	0
Q2 2024/25	98	20	3	0
Q3 2024/25	116	17	0	0
Q4 2024/25	94	9	0	0
Total	**438**	**59**	**5**	**0**

Closed mortality cases by CESDI grade, Apr 2024–Mar 2025

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 Group for shared learning and consideration of whether further Quality Improvement Projects, deep-dives, or targeted action is required.

The organisation publishes a learning from Safety learning responses on a monthly basis and outcomes/learning is received by the Patient Safety Group, local Quality Committee and Executive Management Board on a monthly basis (with case outlines and associated actions). The following themes and issues were flagged to the Mortality Surveillance Group between April 2024 and March 2025:

- **End of life care/symptom control:** Opportunities to enhance staff knowledge, confidence and practice regarding symptom control.

- **Documentation issues:** opportunities to improve the accuracy and timeliness of documentation, including the need for chronological recording.

- **Concise handovers:** The need for concise handovers between doctors and nursing teams, with suggestions to modify CERNER training to allow the use of free text.

- **Consultant reviews:** Opportunity to review and increase the frequency of consultant reviews and strengthen the process for patients who may be outliers.

- **Falls prevention:** Recommendations for improving adherence to guidelines for fall prevention, including monitoring of lying and standing blood pressure.

- **Communication with families:** The importance of clear communication with families, particularly regarding prognosis and treatment plans.

- **Advanced care planning:** The need for earlier and more consistent advanced care planning discussions with patients and their families.

Learning identified above was shared with the patient's named consultant and divisional mortality review groups and feedback on actions taken to improve quality of care is provided on a monthly basis to the Trustwide Mortality Surveillance Group. The following themes of good practice or commendation were identified during the Medical Examiner process which includes discussions with the patients' relatives:

- **Brilliant care and treatment:** Multiple entries highlight the exceptional care and treatment provided by the hospital staff, often described as brilliant, marvellous, and exceptional.

- **Quick issue of MCCD:** expressions of gratitude for the quick issuance of the Medical Certificate of Cause of Death (MCCD) by the Medical Examiner's Office, which allowed families to proceed with urgent burials according to their faith.

- **Compassionate and supportive staff:** feedback often mentions the compassionate and supportive nature of the hospital staff, including doctors, nurses, and palliative care teams.

- **Clear communication:** appreciation for the clear and empathetic communication from the medical teams, which helped families understand the treatment decisions and processes.

- **Comfort and dignity:** how the hospital staff ensured that patients were comfortable and their dignity was maintained throughout their stay.

- **Teamwork and professionalism:** feedback frequently mentions the excellent teamwork and professionalism of the 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. The 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 the characteristics of the patient. The metric is calculated by NHS England using information submitted by all acute providers.

The Trust has one of the lowest relative risks of mortality within NHS England—this provides excellent assurance regarding the provision of our care and services.

Reporting against core indicators

The following data outlines the Trust performance on 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 the data is not available from NHS Digital, other sources have been used as indicated. Data which has not been published is indicated as ***'data not published' (dnp)***.

Core indicators

Summary Hospital-level Mortality Indicator (SHMI)

	2020/21	2021/22	2022/23	2023/24	2024/25[1]
Summary hospital level mortality indicator (SHMI)	0.75	0.72	0.71	0.72	0.70
National Performance: highest	1.20	1.22	1.22	1.25	1.23
National Performance: lowest	0.69	0.72	0.71	0.72	0.70
National Performance: mean	1	1	1	1	1

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 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 that is then used by NHS Digital to compile the national SHMI

[1] The reporting period for 2024/25 is Jan–Dec 2024

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 provides a platform for recording and analysing consultant led-reviews

- Undertaking patient level clinical and coding reviews of any specialties or conditions which show as mortality outliers when compared with national data

Percent of patient deaths with palliative care coding

	2020/21	2021/22	2022/23	2023/24	2024/25[2]
Percentage of patient deaths with palliative care coded	55%	47%	48%	54%	52%
National performance: Lowest	8%	11%	13%	16%	17%
National performance: Highest	63%	64%	66%	67%	66%
National performance: Mean	35%	39.7%	40%	42%	44%

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 National Audit of Care at the End of Life (January-December 2024) identified that 75% of case notes audited recorded an individualised care plan

- The specialist palliative care team support 50% of the total deaths that occur annually in the Trust

- 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 re-design of the Fast Track discharge process and the breadth of training that has been delivered to staff around the new process.

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

- The Trust participating in the National Audit of Care at the End of Life (NACEL)— findings from the 2024 audit are used to triangulate and monitor this metric

- The Trust's ambition to deliver more integrated, person-centred care to patients in their last months of life

- The Butterfly Volunteering programme providing companionship to patients in the last days of life, and those important to them, has been successfully launched with evaluation demonstrating the positive impact of the service

[2] The reporting period for 2024/25 is Jan–Dec 2024

- 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, which are hip replacement or knee replacement.

The Trust has not participated in PROMs since 2022 and as PROMS was recently removed from the NHS England Quality Accounts List 2024/25, it is now no longer monitored through our annual accounts.

Readmission within 28 days

	2020/21	2021/22	2022/23	2023/24	2024/25[3]
Readmission (28 days) age: 0-15 years	5.7%	9.0%	6.20%	6.8%	6.57%
National performance: Worst	17.7%	17.5%	19.6%	22.3%	21.8%
National performance: Best	3.0%	0.0%	0.0%	0.0%	0.0%
National performance: Mean	9.1%	8.1%	9.8%	10.1%	9.6%

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

	2020/21	2021/22	2022/23	2023/24	2024/25[4]
Readmission (28 days) age: 16+ years	9.4%	9.7%	10.2%	10.6%	9.93%
National performance: Worst	15.8%	13.1%	21.2%	17.0%	21.3%
National performance: Best	5.2%	4.4%	0.0%	0.0%	0.0%
National performance: Mean	10.7%	8.7%	7.5%	8.5%	7.3%

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

Re-admission rates have increased on those in previous years and are now above 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 improve 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 is provided by the Improvement Board and the Quality Committee (QC)

- Maintain and improve workstreams around demand, capacity and patient flow as part of the bed productivity programme

- It is the Trust's ambition to ensure timely and safe discharges, reduce readmissions, and provide patients with the support they need to manage their conditions at home as identified by the quality priority work completed in relation to Fast Track discharge

[3] Data available from Apr 2024–Dec 2025
[4] Data available from Apr 2024–Dec 2025

Responsiveness to personal needs

The national inpatient survey asks five questions focussing 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 inpatient survey.

Section	Themes	2020	2021	2022	2023[5]
Admission to hospital	Did not mind waiting as long as did for admission	61%	60%	71%	61%
	Did not have to wait a long time to get to a bed on the ward	85%	78%	66%	68%
Overall	Treated with respect and dignity	99%	98%	89%	89%
	Rated overall experience as 7/10 or more	84%	85%	79%	80%
	Asked to give views on quality of care during stay	25%	26%	17%	41%

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), pulling themes from the national patient survey, Trust complaints and Patient Advice and Liaison Service (PALS) queries.

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

- Significant work focused on improving the inpatient experience for our patients. Early results for 2024 indicate that, overall, we are on a positive trajectory across several survey domains, supported by local survey data gathered throughout the year.

- Establishment of a Trust flow board, with an improvement programme for Urgent and Emergency Care pathway to ensure patients are seen in a timely manner and improve discharge and bed availability

- Established leadership development programmes for nursing staff focusing on fundamentals of care and improving patient experience

- Improvements related to how we care for patients while they are on the ward, how we communicate and involve them in that care journey, and provide a supportive environment. Undertaking extensive education and awareness initiatives with clinical teams responsible for patient care.

- Continued efforts to reduce waiting lists for elective surgeries, successfully eliminating 78-week waits last year and making significant progress in reducing waiting times for those at 65 weeks and 52 weeks.

[5] The data period is up to 2023 as the sample month is November, ie for the 2024 iteration of the survey, patients admitted in Nov 2024 are currently being surveyed now

Staff recommending our Trust

	2020/21	2021/22	2022/23	2023/24	2024/25
Staff are happy with the standard of care that would be provided to a friend or a relative	79.0%	76.1%	72.1%	77.09%	77.37%
National performance: Worst	49.7%	43.6%	39.2%	44.3%	39.72%
National performance: Best	91.7%	89.5%	86.4%	88.8%	89.59%
National performance: Mean	74.2%	66.9%	61.9%	63.3%	61.54%

Date source: www.nhsstaffsurveys.com/results/interactive-results/

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 data set

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

- Engaging all staff in the delivery of the Trustwide quality priorities

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 blood and lodges in the lungs) causes substantial long-term health complications or death. Risk assessments for VTE ensures identification of patient and hospital related risks, to prompt appropriate preventative measures at the earliest opportunity to help reduce the risk of VTE developing.

	2020/21	2021/22	2022/23	2023/24	2024/25
Percentage of admitted patients risk assessed for VTE	83.7%	93.2%	92.7%	95.0%	95.4%

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

- The Trust achieved the national VTE risk assessment target of 95.4% for 2024/25.
- The Thrombosis and Thromboprophylaxis Group includes VTE risk assessment performance as a standing agenda item as part of the ongoing work to monitor performance and support divisions with improvement.
- Performance is tabled in the 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 sub-group report to the Patient Safety Group.
- Monthly VTE risk assessment performance reports are disseminated to divisional and clinical leads for feedback, areas for improvement, and wider awareness.

- Optimisation of Cerner VTE risk assessment forms and online data reporting has supported processes, including real-time monitoring and feedback on performance.

- Cerner includes a VTE risk assessment status on handover list and care organiser, to visually indicate if VTE risk assessment has been completed or not for inpatients.

- VTE risk assessment performance and prescribing of appropriate pharmacological and mechanical thromboprophylaxis (if clinically indicated and no contraindications present), by clinical area and ward, is audited on a quarterly basis, with a summary of key messages, shared learning and actions via a quarterly VTE performance report dissemination to divisions.

- Cohorting arrangements (assessment, data capture and reporting) for VTE risk assessments was reviewed and updated for groups of patients undergoing procedures that are considered low risk of VTE using the Department of Health/NICE risk assessment categories.

- An annual Trustwide VTE bulletin to support shared learning and key messages.

- The Thrombosis and Thromboprophylaxis Group has developed and introduced specific patient information leaflets on blood clot conditions—eg deep vein thrombosis, pulmonary embolism, atrial fibrillation, to increase patient education, awareness and support counselling.

- VTE education is delivered via multiple platforms—eg inclusion in induction programmes, Trustwide clinical governance meetings, grand rounds, departmental updates.

The Trust intends to take the following actions to improve 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 quarterly audits on inpatients at risk of VTE prescribed appropriate pharmacological and/or mechanical thromboprophylaxis (if clinically indicated and no contraindications present), with feedback to divisional clinical leads and pharmacy staff—actions taken to address any contributory factors—eg management of omitted medication, staff education and awareness, 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 day of admission is counted as day 1).

Patients diagnosed as positive for *C.diff* within 2 days 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.

	2020/21	2021/22	2022/23	2023/24	2024/25
Count: Hospital onset, healthcare associated	20	36	27	35	61
Rate: Hospital onset, healthcare associated per 100,000 bed days	9.5	11.5	9.3	12.1	21
National performance: Worst	80.6	dnp	dnp	92.5	97.2
National performance: Best	0	dnp	dnp	0	0
National performance: Mean	18.2	dnp	dnp	27.6	27.6

Data source: https://hcaidcs.phe.org.uk/WebPages/GeneralHomePage.aspx

During 2024/25 there were 61 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 engaged with the senior medical and nursing staff caring for each patient. Action plans were subsequently developed to address learning which are monitored at 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
- The Trust commissioned an internal audit for the reporting and management of infection control data
- Performance is monitored through the Trust Infection Prevention and Control Group (IPCG) and reported at 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 along with clinical learning response meeting attendance and discussion and feedback at learning response meeting to improve clinical management and divisional oversight
- **Antibiotic stewardship:** Facilitated by the introduction of the ICNet clinical surveillance system (web-based software platform) at West Middlesex University Hospital in July 2021—the use of this service across both hospital sites has improved antimicrobial

prescribing, monitoring and auditing and there is ongoing review to identify inappropriate prescribing and review of 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/suspected or confirmed *C.diff*

- **Documentation and communications:** *C.diff* checklist on Cerner, and 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/data availability.

- **Hand hygiene compliance:** Areas with lower compliance produced divisional action plans—compliance monitored at Infection Prevention and Control Group and through monthly divisional dashboards.

- **Testing for *C.diff*:** Clinical teams leading with local education and support from the infection prevention and control team to improve appropriateness of testing and management.

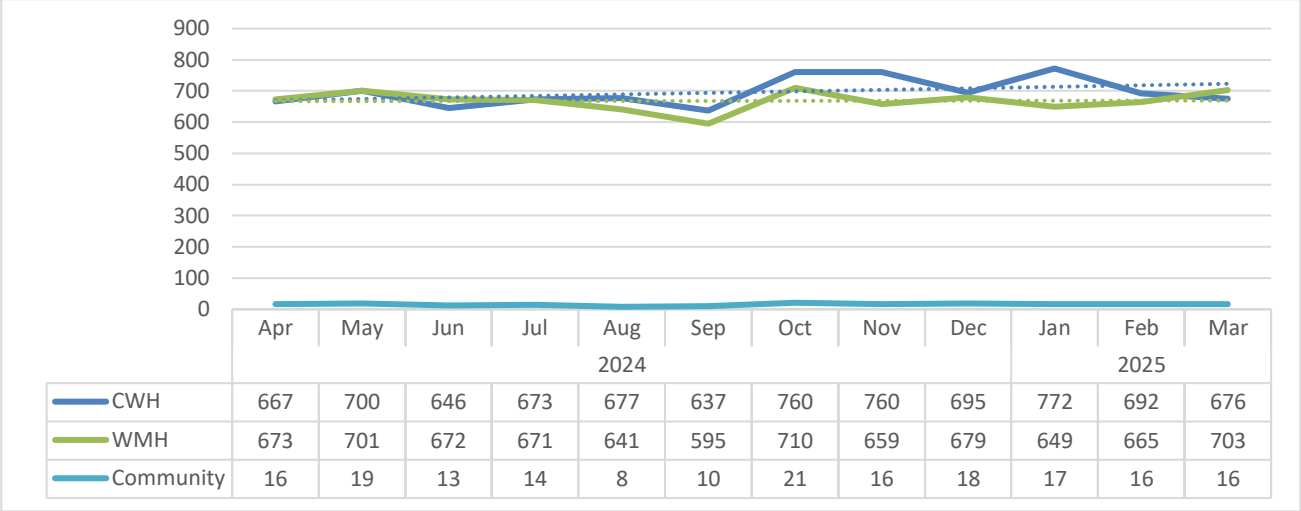
- **Collaboration:** Learning from *C.diff* cases shared at North West London APC and Integrated Care System level to improve local and sector management and review and support reduction of hospital associated infections.

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, 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 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.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2024									2025		
CWH	667	700	646	673	677	637	760	760	695	772	692	676
WMH	673	701	672	671	641	595	710	659	679	649	665	703
Community	16	19	13	14	8	10	21	16	18	17	16	16

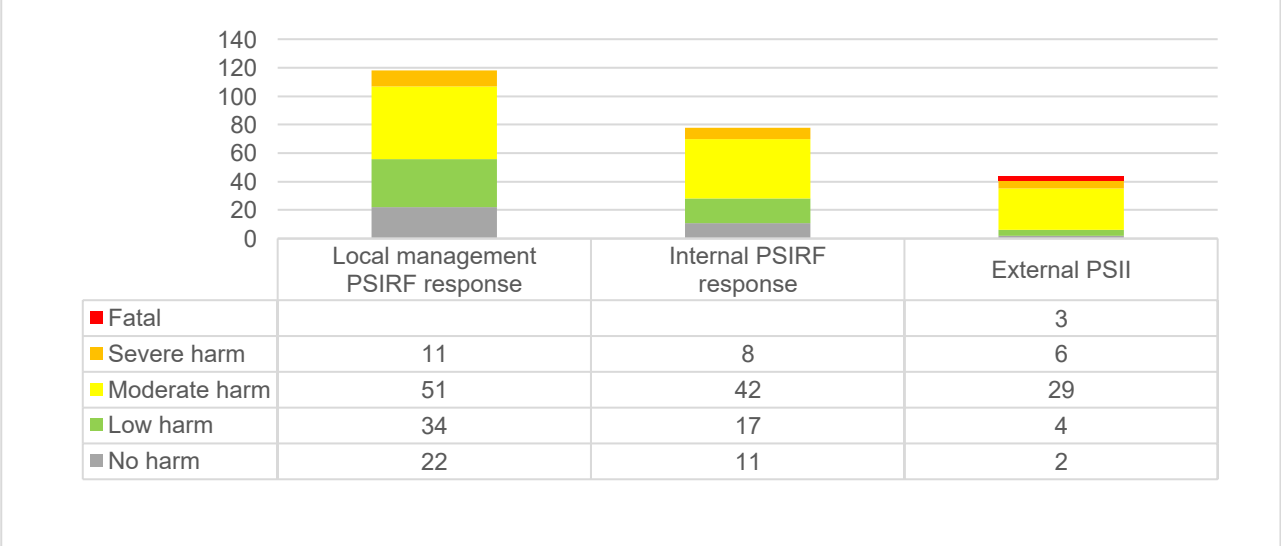
Number of Patient Safety Incidents reported by month, Apr 2024–Mar 2025

During 2024/25, 16,557 patient safety incidents were reported by staff across all our departments and services. This is a 9.5% increase on crude patient safety incident reports made during the previous financial year (n=15,119).

A significant proportion of reported incidents did not require a PSIRF learning response, accounting for 98.5% of incidents (n=16,317). PSIRF advocates for a proportionate response to harm, where the severity and impact of an incident guide both the investigation and the 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 38% of incidents requiring a further learning response were low or no harm events, 51% were moderate harm, and 11% were severe harm 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 harm levels of incidents.



	Local management PSIRF response	Internal PSIRF response	External PSII
Fatal			3
Severe harm	11	8	6
Moderate harm	51	42	29
Low harm	34	17	4
No harm	22	11	2

Breakdown of harm and level of investigation/oversight Apr 2024–Mar 2025

The number of investigations previously reported externally is expected to decrease 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 Multi-disciplinary Team (MDT) reviews, which are managed at Trust level and do not require external reporting, will contribute to this reduction.

Indications for PSIIs are grouped as follows:

- Nationally defined priority—review by another body eg MNSI, Child death, LeDeR, Safeguarding
- Nationally defined incidents requiring local PSII eg Never Events, Learning from Deaths, Suicide/Self harm
- Locally defined incident requiring local PSII eg cases with significant learning or predefined in the Trust PSIRF Plan

The number of learning responses initiated under the PSIRF framework during 2024/25 include:

- 44 PSIIs, comprising 3 Never Events, 16 Maternity and Newborn Safety Investigations (MNSI), and 24 locally defined PSIIs—Averaging 3 PSIIs a month
- 78 Internal PSIRF responses, including 51 AARs, 6 MDTs, and 20 incidents featured in 9 thematic reviews
- 118 Locally managed PSIRF responses, including 82 IIR's only, 8 AAR's, 6 MDT's, 6 mortality reviews and 16 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 on 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. A total of three Never Events have been reported in 2024/25.

Category	Incident details	Degree of harm	Key actions
Wrong site surgery	A non-targeted liver biopsy was performed rather than a targeted one resulting in the patient requiring a repeat biopsy.	Low	Ensuring ICT supports are available, and displaying necessary patient information during team brief.
Retained foreign object post-procedure	A patient who was 5 weeks post-natal found a 'cloth-like item' inside their vagina which in clinical examination was confirmed as a large swab.	Moderate	Re-inforce surgical counts processes, through training and awareness, and use of visual and technological aids.
Wrong site surgery	Intravitreal injection performed on the wrong site resulting in the patient receiving an injection in the wrong eye (right instead of left).	Low	Enhanced pre-treatment verification protocol was implemented in clinic with immediate effect.

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 to have led to moderate harm, severe harm or death). The Trust's duties include:

- Making an immediate verbal disclosure is to the patient and apologising
- Providing a written post-investigation explanation of the causes of the incident and what improvement actions we are taking as a result

During 2024/25, 202 notifiable patient incidents were identified:

- Verbal notification and apology has been given for 89% of cases (n=180)
    - All cases have now been documented within Datix that a verbal notification and apology was given at the time of the incident where possible. Incidents are reviewed at Patient Safety Group to understand why documentation has not occurred.
    - In 11% of cases (n=22) it was not possible to complete the verbal duty.
- Written outcome of investigation letters were provided for 52% of cases (n=105)
    - 29% of cases (n=59) are still pending outcomes of learning responses.
    - 15% of cases (n=30) A written outcome of investigation was not sent and a rationale as to why it could not be sent has been recorded in the Trust's system for logging such incidents (Datix)—eg patient deceased with no next of kin.
    - 4% of cases (n=8) A written outcome of investigation has not yet been sent following completion of the investigation. These incidents will be reviewed at Patient Safety Group to understand barriers to completion.

All efforts are undertaken as part of the professional duty of candour 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 for a number of cases (n=25). These were not included in the total number of notifiable incidents for 20245/25 above, as they did not trigger under the statutory duty but had relevant learning for the Trust.

This is identified as an exception for Regulation 20: Duty of Candour under 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 2024/25, the NHS has seen particular challenges in the achievement of key regulatory and contractual performance metrics, including quality and workforce key performance indicators (KPIs). The Trust has performed well in comparison to peers within the extremely challenging operating environment.

Below is a summary of some of our KPIs for 2024/25. 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, particularly in relation to treating long waiting patients, a national issue post-pandemic impacting on the referral to treatment peformance. You can find details of our current performance, updated monthly, on our website www.chelwest.nhs.uk.

NHS oversight framework metrics

The table below summarises the performance indicators for the Trust.

	Target	Performance
Incidents of *C. diff* (hospital-associated infections)	33	61
18 weeks Referral To Treatment (RTT) incomplete pathways	92%	62.73%
All cancers: 31 day wait from diagnosis to first treatment	96%	98.03%
All cancers: 62 day combined target	85%	82.90%
Cancer: Two-week wait from referral to date first seen (breast symptomatic)	93%	98.9%
Cancer: Two-week wait from referral to date first seen (comprising all cancers)	93%	98%
Cancer: 28 day Faster Diagnosis Standard (FDS)	75%	81.08%
Referral to treatment waiting times <18 weeks—incomplete	92%	62.73%
A&E: Total time waiting in A&E ≤4 hours	78%	79%
Emergency care pathway—Length of stay	4.5	5.06
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	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 patient care that our patients receive. The following indicators are tracked by the Executive Management Board and the Quality Committee to ensure we have focus on where we can embed and sustain improvements and share learning.

	Indicator	2020/21	2021/22	2022/23	2023/24	2024/25
Patient Safety	Patients with hospital-acquired MRSA infections (target 0)	4	6	7	4	5
	Hand hygiene compliance (target >90%)	92.6%	92.1%	95.3%	96.3%	97.0%
	Number of serious incidents	76	75	69	33	44
	Number of never events (target 0)	2	2	1	5	3
	Incident reporting rate per 100 admissions (target >8.5%)	11.6%	9.3%	9.2%	9.5%	10.5%
	Percentage of patient safety incidents resulting in severe harm or death	0.03%	0.02%	0.02%	0.01%	0.02%
	Medication-related safety incidents per 100k FCE bed days (target ≥280)	428.3	358.4	376.1	446.7	496.3
	Medication-related safety incidents % with harm (target ≤12%)	10.0%	8.4%	9.8%	9.7%	7.8%
	Summary Hospital Mortality Indicator (SHMI) (target <100)	77	71	72	72	70

	Indicator	2020/21	2021/22	2022/23	2023/24	2024/25
Clinical Effectiveness	Dementia screening case findings (target >90%)	74.3%	94.0%	94.7%	94.4%	93.8%
	Fractured neck of femur time to theatre <36 hours for medically fit patients (target 100%)	90.4%	78.4%	75.1%	81.3%	81.5%
	Stroke care: Time spent on dedicated stroke unit (target >80%)	87.2%	93.8%	89.6%	89.8%	84.9%
	VTE: Hospital-acquired	16	26	58	44	61
	VTE risk assessment (target >95%)	86.2%	93.1%	92.7%	95.0%	95.6%
	Sepsis: Inpatient wards percentage of patients with high NEWS score screened for sepsis (target >90%)	86.1%	88.5%	93.2%	95.7%	90.1%

	Indicator	2020/21	2021/22	2022/23	2023/24	2024/25
Patient Experience	FFT: Inpatient satisfaction (target >90%)	95.5%	95.5%	95.6%	95.8%	95.98%
	FFT: A&E satisfaction (target >90%)	89.9%	82.2%	79.3%	82.0%	81.42%
	FFT: Maternity satisfaction (target >90%)	88.8%	88.0%	89.1%	89.7%	90.0%
	Complaints: Number of formal complaints received	392	448	476	479	451
	Complaints: Number of formal complaints responded to within 25 working days	238 (61%)	341 (76%)	401 (84%)	269 (56%)	361 (80%)
	Complaints: Number of formal complaints referred and upheld by the Ombudsman	4	3	1	6	2

Other quality improvement indicators

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 2024/25, in addition to the Trust quality priorities, each division led a set of local priorities as follows:

Clinical Support Division

Adapting the environment to the patient's needs

The division aims to create an environment in the clinical areas which meets the needs of our patients. This includes responding to feedback received through our friends and family mechanisms and concerns raised by patients. Examples include improvements to a newly relocated OPD8 clinic on the WM site, where provision of porters and volunteers to support patients to find the clinic, improved signage and building adjustments, including a canopy and improvement to the walkway surface was undertaken following feedback. The area continues to be monitored to ensure it is suitable for our patients.

The phlebotomy department on the CW site has also undergone refurbishment, to improve the environment for patients and staff receiving and delivering care in the area respectively. This work aims to create additional space and increased service capacity.

Further improvement work to patient environment includes improved recovery area in the Chelsea and Westminster (CW) Interventional Radiology (IR) department and expansion of the Ultrasound room.

A Trust Patient Safety Partner (PSP) was recruited to the Trust, and worked across both hospital sites. The PSP was able to provide support to staff with methods for engaging better with patients. The role was embedded Trustwide through invitations for involvement at PSIRF investigations and sharing learning across a PSP network within the APC.

Right patient, Right test, Right Treatment

Ensuring positive patient identification has been embedded into imaging practice, through the implementation of cross site and cross modality audits. All audit results are reviewed at monthly imaging governance meeting and quarterly at the divisions' quality board, to provide assurance that patient ID is being confirmed. Additional data analysis against imaging ID related incidents is also undertaken to triangulate learning from the audits and incidents.

LocSSIPs audits have taken place in IR and endoscopy, providing assurance that safe services are being delivered to the right patient, and the patient is receiving the right test and treatment.

CQC radiation incidents are reported in line with national requirements. Two have been reported this year and reviewed at the divisional quality board where learning is shared across all directorates.

The Antimicrobial Stewardship (AMS) team continues to deliver safe, effective, and innovative antimicrobial care aligned with national guidance and local priorities. This entails:

- **Safe and Effective Use of Antimicrobials**

  Daily Reviews: AMS team reviews 150–250 patients per weekday, contributing to over 25,000 reviews (2024/25) and an average of 180 interventions per week to optimise antimicrobial prescribing.

  Targeted Interventions: AMS supports personalised treatment decisions, optimising dose and duration and reducing broad-spectrum antimicrobial use to minimise resistance and improve patient outcomes.

- **Impact and Outcomes**

  Significant Reductions in Antimicrobial Use (per 1,000 admissions):

  - Total antimicrobial prescribing ↓22% (vs NHS London ↑7.7%)
  - Broad-spectrum antimicrobials (WATCH/RESERVE) ↓24% (vs NHS London ↑7%)
  - Carbapenems (last line therapy) ↓27% (vs NHS London ↑10%)
  - Fluoroquinolones (MHRA defined high-risk) ↓35% (vs NHS London ↓9.5%)

  Improved Mortality Rates: 30-day mortality for E. coli and S. aureus bacteraemia is significantly below national averages (9.4% vs 15.9%, and 15.4% vs 21.9%, respectively).

  ***C.difficile*:** Infection rates have increased to highest level in over 10 years—the driver for this remains unclear. AMS provides individualised reviews and treatment plans for all cases to ensure optimal treatment outcomes.

- **Promoting Safe Prescribing**

  Fluoroquinolone Safety: A new decision-support tools and educational programme has reduced use by 35%, with safer alternatives promoted and patient information leaflets distributed at discharge.

  Penicillin Allergy Guidance: Our Trust is the first in the UK to safely expand access to cephalosporins in penicillin-allergic patients, increasing patient eligibility for first-line agents from 86% to >98%.

- **Efficient Care and Early Discharge**

  OPAT Service: Over 40 patients per day managed on Intravenous (IV) antibiotics in the community, supporting early discharge and admission avoidance.

  IV-to-Oral Switches: Routine AMS-led interventions promote early discharge through short-course therapies and IV-Oral switches (CQUIN compliance <15% on IVs inappropriately).

The AMS programme at the Trust exemplifies data-driven, patient-centred care contributing to improved safety, reduced resistance, and enhanced efficiency.

Improving communication across care boundaries

Regular communication with referring GPs is in place, facilitated by the Trust GP liaison officer. This has strengthened the relationships between the Trust and primary care and led to interface meetings, a workforce group and meetings with ICBs to discuss matters that affect continuity of care for patients. The meetings have supported improved understanding of GP expectations and facilitated improvement work related to discharge summaries, consolidated ICE ICT system, enhanced paediatric services, educational sessions with GPs, provision of e-RS training.

Primary care providers are invited to participate in PSIRF learning investigations, including AARs and PSIIs, to foster a collegiate approach to understanding why things go wrong and embed learning across primary and acute healthcare services.

Implementation of a new cancer upgrade process will enable clinicians to robustly refer patients to the cancer performance team for tracking. This new process is being monitored to provide assurance it is effective.

Audits have taken place within patient access to provide assurance of effective communication with patients. These include audits of the quality of telephone calls received in the call centre, including timeliness of answering calls and information provided to patients. An audit of the Patient Initiated Follow Up (PIFU) clinic demonstrated that patients were able to access and arrange appointments to suit their needs.

The emergency, preparedness, resilience and response (EPRR) emergency cascade audit is undertaken every 4 months, in line with the NHS EPRR Framework and NHS core standards. Audit results are responded to, and improvement work includes promotion of knowledge and ownership of the red phones, and training so staff are familiar with the location and phone ring tone in their departments.

Improvement work around letter flows received from external organisations has been undertaken to ensure the process for the correct clinician receiving and actioning information contained is robust.

Medication safety bulletins are published each month by the Trust pharmacy team. These focus on themes from incidents investigated under PSIRF and highlight best practice across all staff groups Trustwide.

Emergency and Integrated Care Division

Delivery of Integrated Care

This included development of integrated solutions to support appropriate management of our front door demand. Specific aims were as follows:

- Discharge pathways
- Provision of care for high intensity users

Inpatient Flow

The focus of this priority included incorporating patient flow metrics into the harm free care ward handover. Increase forward planning and reduce variability in support for patients

discharge (ward based improvement plans). Expand learning from the Discharge Ready Unit to other inpatient clinical areas to reduce inpatient deconditioning and improve length of stay. Specific aims were as follows:

- Reducing length of stay (LoS)
- Harm free care

Frailty Service (see Trust priority update)

In addition to delivering the Trustwide quality priority the division were involved in further embedding and extending the frailty service to establish and improve ‘acute in-reach’ services and establish formal alignment with surgical and End of Life pathways. Specific aims included:

- Admission avoidance
- Reduce rates of avoidable hospital re-admission

Planned Care Division

Surgical care of Frail patients

A review of services in surgical care was completed to provide specialised support for elderly and frail patients undergoing surgery. The aim was to ensure that frail patients on elective and non-elective pathways get the required input from a frailty perspective. The benefits of this priority included:

- Improved outcomes for patients
- Personalised care
- Reduced post-operative complications
- LoS improvement
- Lower re-admission rates
- Early identification of risk

Emergency Surgery Pathway

Work commenced in 2024/25 on an improved pathway for patients with emergency surgical conditions, allowing them to receive necessary care and return home on the same day. This involved collaborative working across divisions and multiple specialties. The aim was to improve flow and capacity in theatres. Benefits have included:

- Reduced inpatient admission
- Improved patient experience
- Cost efficiency
- Faster diagnosis and treatment

Specialist Care Division

Endometriosis

This priority was picked to ensure the division make progress in Endometriosis and Robotics service development at the West Middlesex site. The aim was to reduce

disparities between sites in the average wait for routine, urgent and 2 week wait appointments. The benefits include:

- Improved access to healthcare
- Better patient experience and outcomes

Genetic testing for aneuploidy

The fertility clinic at Chelsea site have been working on the development of pre-implantation genetic testing for aneuploidy (PGT-A). This will improve IVF success rates through the reduction of miscarriage rates and enhance patient outcomes.

Work has commenced to develop staff training and ensure implementation of required resources. The team are currently seeking funding for required equipment with associated pricing models and marketing requirements.

West London Children's Healthcare

Quality and Safety

Ongoing work is underway to deliver targeted service improvements in pain management, allergy and neurology.

In partnership with Division of Specialist Care, the team are hoping to progress the implementation of the Special Care Baby Unit (SCBU)/neonate/paediatrics business case to achieve sustainable models of care at West Middlesex.

Responding to feedback from the inpatient survey, the team are improving patient information available for Children and Young Persons and families particularly on discharge.

Work has commenced to draft, publish and implement phase one of 'Every Moment Matters: Our Strategy for Youth Work and Play' as part of the team's response to the national inpatient survey.

They will continue to deliver their internal CQC readiness action plan to take some services/themes from 'Requires Improvement' to 'Good', and some from 'Good' to 'Outstanding'.

Additional quality highlights

Veteran Champions Network

The Veteran Champions Network has been active this year, undertaking several fundraising events to raise a total of £3,790 for armed forces charities.

We undertook a Thames 13 Bridges Walk in June for SSAFA, a charity which supports military families, older veterans in need, advice on transition from the armed forces and housing.

A cake sale and tombola was held on National Reservists Day to raise money for Combat Stress, which supports the mental health of veterans, in the name of Trevor Post, our Veteran Champions Lead, who sadly died very suddenly in April 2024.

Our vaccination team and Armed Forces Champions have supported vaccination events at the Royal Hospital.

In March we launched a ‘Tea & Toast @ Ten’ drop in session on both sites for staff and patients, sponsored by our ISS partners.

We have drafted an information leaflet to be given to Veterans and Armed Forces Families on the front door and on the wards detailing support available to them.

Plans for 2025/26 include becoming a staff network, firming up partnership with a local sea cadet unit and reapplying for our Veteran Awareness Accreditation.

Little Journey app for patients and relatives

Founded in 2018, the App was aimed initially at children and their parents, following their elective journey through hospital. It focussed on providing engaging and interactive content designed to psychologically prepare and support patients and their families through the intensive care unit (ICU) journey.

Through their work with CWFT, Little Journey has created its first adult pathway content to support navigation of the intensive care unit pathway by providing clear and helpful information, while also giving more holistic care through the availabilty of techniques to help patients stay calm.

Pre-hospital Ambulance Support Service (PhAST)

Project Synopsis

The Pre-hospital Ambulance Support Team (PhAST) was a pilot service, hosted by members of the Borough Based Partnership including—hospital secondary care services at West Middlesex Hospital, Hounslow Primary Care Network, West London NHS Trust Community Services and the London Ambulance Service.

Together, through communication and shared decision-making, we enabled patients residing in Nursing Homes and Care Homes in the borough of Hounslow to receive the best possible care in the most appropriate place. The aim was to reduce unnecessary hospital admissions that potentially increase morbidity and mortality in this cohort of patients.

Ambition

Frailty inpatient activity costs the NHS £5.8bn annually, occupying c20% of all bed days across England. Furthermore, for the individual, there is significant morbidity and mortality for this cohort associated with inpatient admission. Supported by the Long Term Plan and Urgent and Emergency Care Recovery Plan, there has been significant work to create sustainable frailty front-door services. However, in isolation this is unlikely to provide a solution to the increasing frailty burden on NHS Trusts.

Local data collection demonstrated 1087 Care and Nursing Home (CH/NH) Emergency Department attendances over a 12-month period, of which 46% did not require overnight admission. Following engagement with local CH/NH, feedback suggested standard operating procedures advised calling London Ambulance Service (LAS) prior to exploring community-based options.

This suggested there was an opportunity to intervene prior to the front door. Thus for a specific cohort of frailty patients—there was potential to decrease unnecessary hospital admissions, decrease associated morbidity and direct care to more appropriate community services.

Outcome

A review of LAS data for the borough demonstrated increased number of calls to LAS annually. However, during the months the pilot ran there was a reduced conveyance rate to hospital—eg, in Feb 2025 61% of patients were conveyed compared to 66% in Feb 2024.

Review of Community Services data demonstrated further unintended positive outcomes of the pilot with an increase in direct referrals to community pathways (120% increase) hence improving resource utilisation within the system. As a system better use of community capacity available was thought to be directly attributable to all engagement work done for the pilot.

Qualitative feedback from partners was exclusively positive and themes focussed around benefit to patients, safety in shared decisions and improved resource utilisation. Further, it was thought that the trust and relationships developed allowed true collaborative working and would benefit future projects.

These relationships will be key as local, ICS and national level strategy are aligned towards system working and shifting care towards the community. This is a great example of integrated working that aims to support better health outcomes for patients and residents, while reducing unnecessary hospital admissions.

Federated Data Platform

Over the past year, our work on the Federated Data Platform (FDP) has positioned us as a national incubator for digital innovation. Through our local leadership within the NW London Acute Provider Collaborative, we've helped shape and deploy some of the first-of-type solutions in the country, supporting safer, faster and more efficient care.

The FDP enables secure, real-time integration of data across NHS trusts, supporting direct care, operational management and population health enabling us to shift towards a more digital healthcare. As one of the earliest adopters, we've used the platform to develop and implement the *Timely Care Hub* (TCH), now in use across our hospitals. This tool has transformed how we manage patient flow and bed allocation, replacing manual processes with real-time insights and freeing up frontline time for patient care.

In addition to the TCH, we've helped design and test several other modules now in active deployment—including *Cancer 360*, *RTT Validation*, *Patient-Led Validation*, and the *System Coordination Centre*. These tools are already driving measurable improvements: reducing unnecessary appointments, increasing theatre utilisation, accelerating cancer diagnosis, and improving operational oversight.

As a test-bed site, we are also contributing to national innovation through the FDP's *Solution Exchange*, including an AI-supported discharge summary pilot, which is set to reduce documentation time by up to 50%, releasing clinicians for direct patient care.

These developments reflect our commitment to continuous learning, system-wide collaboration, and using data as a strategic asset. We're proud of our role in shaping the future of care delivery and remain focused on scaling what works for the benefit of all patients across both trust, system and national level.

Leading and Empowering Organisations (LEO) Course

The Leading an Empowered Organisation (LEO) course is designed to empower healthcare professionals to become positive transformational leaders, focusing on creating environments for high performing teams and supporting professional practice.

The Trust launched the programme and initially targeted all nurse leaders above the ward manager level, which has subsequently been expanded to other professions.

Key outcomes of the course include encouraging ownership, accountability, teamwork, quality improvement and a healthy, inclusive, engaging leadership style.

Each participant completes an improvement project to help assimilate learning and presents this back to their group at a follow up day 3 months later.

Since November 2023 over 382 staff have received this training—feedback is extremely positive with 100% of the staff recommending the course to others.

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 better insight into improvements that would most improve patient experience and outcomes as they are the ones who are closest to the patient and spend most time with them

- Involving staff in shared decision making increases staff engagement which positively impacts on staff well-being and experience. In turn this has positive impacts on patient satisfaction and patient outcomes.

There are currently 24 active counsels in the Trust with a list of completed projects below:

Patient experience	Clinical Outcomes	Staff Wellbeing
Reducing noise at night	Reducing falls	Staff room refurbishment
Improving side room environment	Lack of bladder scanners to check if patients are retaining urine	Staff psychological support
Patient information	Post-operative delirium assessments for paediatric patients	VR headsets to help staff relax during break-time
Lack of theatre trolleys	Electronic Consent for patients before surgery	Staff induction programmes
Meal champions	Lack of poles for intravenous medication	Drinking fountains for staff
Activities and suitable crockery for patients with dementia	Mouth care	Improving storage of personal belongings
Activities for children	Improving patients' nail care	
Tea trolley for Emergency Department	Refurbishing room for increased computer station enabling timely documentation	
Improving relative room facilities		

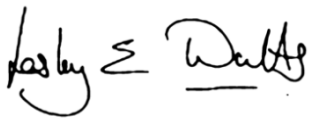
Declaration

It is important to note, as in previous years, that there are several inherent limitations in the preparation of quality reports which may impact the reliability or accuracy of the data reported. Data is derived from many 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

N°	National clinical audits/quality improvement programmes	Trust eligible	Trust participated	% submitted
1	BAUS: Environmental Lessons Learned and Applied to the Bladder Cancer Pathway (ELLA) Audit	Yes	Partial	Case Note: 0% Org. Audit: CW: 48% WM: 97%
2	BAUS: National Penile Fracture Audit	Yes	Yes	100%
3	Breast and Cosmetic Implant Registry	Yes	Yes	Rolling data submission
4	British Hernia Society Registry	Yes	Yes	Rolling data submission
5	ICNARC: Case Mix Programme (CMP)	Yes	Yes	Rolling data submission
6	Cleft Registry and Audit NEtwork (CRANE) Database	No	No	n/a
7	Emergency Medicine QIP: Time Critical Medications (Year 1)	Yes	Yes	100%
8	Emergency Medicine QIP: Care of Older People (Year 2)	Yes	Yes	100%
9	Emergency Medicine QIP: Mental Health (Self-Harm) (Year 2)	Yes	Yes	100%
10	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Partial	Rolling data submission
11	Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	Yes	Yes	Rolling data submission
12	Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Yes	Yes	100%
13	Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Yes	Yes	Rolling data submission
14	Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	Yes	Rolling data submission
15	National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	Yes	Yes	Rolling data submission
16	National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	Rolling data submission
17	National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	Rolling data submission
18	National Adult Diabetes Audit (NDA): National Diabetes Core Audit	Yes	Yes	Rolling data submission
19	National Diabetes Audit: Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Yes	Rolling data submission

N°	National clinical audits/quality improvement programmes	Trust eligible	Trust participated	% submitted
20	National Diabetes Audit: National Gestational Diabetes Audit	Yes	Yes	Rolling data submission
21	National Diabetes Audit: Diabetes Prevention Programme (DPP) Audit	No	No	n/a
22	National Respiratory Audit Programme (NRAP): Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes	Rolling data submission
23	National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation	No	No	n/a
24	National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	Yes	Yes	Rolling data submission
25	National Respiratory Audit Programme (NRAP): Children and Young People's Asthma Secondary Care	Yes	Yes	Rolling data submission
26	National Audit of Cardiac Rehabilitation	No	No	n/a
27	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	No	No	n/a
28	National Audit of Care at the End of Life (NACEL): Round 5	Yes	Yes	Data collection in progress
29	National Audit of Dementia (NAD): Round 6	Yes	Yes	100%
30	National Audit of Pulmonary Hypertension	No	No	n/a
31	National Bariatric Surgery Registry	Yes	Yes	Rolling data submission
32	NATCAN: National Audit of Metastatic Breast Cancer	Yes	Yes	Rolling data submission
33	NATCAN: National Kidney Cancer Audit	Yes	Yes	Rolling data submission
34	NATCAN: National Audit of Primary Breast Cancer	Yes	Yes	Rolling data submission
35	NATCAN: National Bowel Cancer Audit (NBOCA)	Yes	Yes	Rolling data submission
36	NATCAN: National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes	Rolling data submission
37	NATCAN: National Prostate Cancer Audit	Yes	Yes	Rolling data submission
38	NATCAN: National Lung Cancer Audit (NLCA)	Yes	Yes	Rolling data submission
39	NATCAN: National Non-Hodgkin Lymphoma (NNHLA)	Yes	Yes	Rolling data submission
40	NATCAN: National Ovarian Cancer Audit	Yes	Yes	Rolling data submission
41	NATCAN: National Pancreatic Cancer Audit (NPaCA)	Yes	Yes	Rolling data submission
42	National Cardiac Arrest Audit (NCAA)	Yes	Yes	Rolling data submission

N°	National clinical audits/quality improvement programmes	Trust eligible	Trust participated	% submitted
43	National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit (NACSA)	No	No	n/a
44	National Cardiac Audit Programme (NCAP):) National Congenital Heart Disease Audit (NCHDA)	No	No	n/a
45	National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	Yes	Rolling data submission
46	National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	Rolling data submission
47	National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Rolling data submission
48	National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes	Partial	Rolling data submission
49	National Cardiac Audit Programme (NCAP): National Audit of Mitral Valve Leaflet Repairs (MVLR)	No	No	n/a
50	National Cardiac Audit Programme (NCAP): The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	No	No	n/a
51	National Cardiac Audit Programme (NCAP): Left Atrial Appendage Occlusion (LAAO) Registry	No	No	n/a
52	National Cardiac Audit Programme (NCAP): Patent Foramen Ovale Closure (PFOC) Registry	No	No	n/a
53	National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit	No	No	n/a
54	National Child Mortality Database (NCMD)	Yes	Yes	Rolling data submission
55	National Clinical Audit of Psychosis (NCAP)	No	No	n/a
56	NCABT: Bedside Transfusion Audit	Yes	Yes	100%
57	NCABT: Audit of NICE Quality Standard QS138 (Year 2)	Yes	Yes	100%
58	National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Rolling data submission
59	NELA: Laparotomy (Lap)	Yes	Partial	Rolling data submission
60	NELA: No Laparotomy (NoLap)	Yes	No	n/a
61	National Joint Registry	Yes	Yes	Rolling data submission
62	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Rolling data submission
63	National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
64	National Obesity Audit (NOA)	Yes	Yes	Rolling data submission

N°	National clinical audits/quality improvement programmes	Trust eligible	Trust participated	% submitted
65	National Ophthalmology Database (NOD) Audit: National Cataract Audit	Yes	No	n/a
66	National Ophthalmology Database (NOD) Audit: Age-related Macular Degeneration (AMD) Audit	Yes	No	n/a
67	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Rolling data submission
68	National Vascular Registry (NVR)	No	No	n/a
69	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	No	No	n/a
70	Paediatric Intensive Care Audit Network (PICANet)	No	No	n/a
71	Perioperative Quality Improvement Programme	Yes	Yes	Rolling data submission
72	Prescribing Observatory for Mental Health (POMH): Opioid medications in inpatient mental health services	No	No	n/a
73	Prescribing Observatory for Mental Health (POMH): Rapid Tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	No	No	n/a
74	Prescribing Observatory for Mental Health (POMH): The use of melatonin	No	No	n/a
75	Quality and Outcomes in Oral and Maxillofacial Surgery: Non-melanoma skin cancers	Yes	No	n/a
76	Quality and Outcomes in Oral and Maxillofacial Surgery: Oral and Dentoalveolar Surgery	Yes	No	n/a
77	Quality and Outcomes in Oral and Maxillofacial Surgery: Orthognathic Surgery	Yes	No	n/a
78	Quality and Outcomes in Oral and Maxillofacial Surgery: Trauma	Yes	No	n/a
79	Quality and Outcomes in Oral and Maxillofacial Surgery: Oncology & Reconstruction	No	No	n/a
80	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Rolling data submission
81	Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	Yes	Rolling data submission
82	Society for Acute Medicine Benchmarking Audit	Yes	Yes	100%
83	National Major Trauma Registry Network (formerly Trauma Audit and Research Network (TARN))	Yes	Yes	Rolling data submission
84	UK Cystic Fibrosis Registry	No	No	n/a
85	UK Renal Registry Chronic Kidney Disease Audit	No	No	n/a
86	UK Renal Registry National Acute Kidney Injury Audit	Yes	Yes	100%

National clinical outcome review programmes

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: Rehabilitation following critical illness	Yes	Yes	100%
8	Medical and Surgical Clinical Outcome Review Programme: Abnormal Blood Sodium	Yes	Yes	78%
9	Medical and Surgical Clinical Outcome Review Programme: Emergency procedures in children and young people	Yes	Yes	69%
10	Medical and Surgical Clinical Outcome Review Programme: Acute limb Ischaemia	Yes	Yes	100%
11	Mental Health Clinical Outcome Review Programme (NCISH)	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. The actions are monitored at local governance meetings.

Programme	Summary
National Ophthalmology Database Audit: Age-related Macular Degeneration Audit (AMD) (3rd report) (Apr 2022–Mar 2023 data) **Publication Date:** 1 Mar 2025 **Speciality:** Ophthalmology	**Good practice** • Patients are given choice to treat both eyes on the same day to ensure the patient experience of treatment, and the immediate post- operative period, is optimal. Some patients decline bilateral treatment. • Dedicated intravitreal coordinator with cover from the failsafe officer and capacity needs met with extra weekend clinics. • Clinicians use the AMD Audit dataset and the updated NHS England Decision Support Tool to give patients with poor acuity at the start of treatment an accurate idea of the likely visual acuity outcomes after treatment. This will help them make an informed choice about starting treatment. **Identified Actions** • Admin/CERNER/IT teams to project manage streamlining of referral to triage process. • CERNER/IT expert required to design a continuous audit of this data.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Juvenile Idiopathic Arthritis Report **Publication Date:** 13 Feb 2025 **Speciality:** Paediatric Medical	**Identified Actions** • Development of WLCH wide guideline on how to refer into the service and guidance about initial investigations to be undertaken. • To review access to ancillary services across WLCH and review potential workforce gaps. • Consultant Paediatrician will undertake injection supervised by adult colleagues and review if able to join clinics at GOSH to upskill to allow them to be undertaken at ICHT.
NATCAN: National Bowel Cancer Audit Report (Apr 2022–Mar 2023 data) **Publication Date:** 9 Jan 2025 **Speciality:** Colorectal Cancer	**Comments against 10 Key Performance Indicators** • More than 95% of patients should be seen by Clinical Nurse Specialist (CNS): Around 90–100% of patients are seen by Clinical Nurse Specialists. • Annual rectal cancer resection volume greater than 20 cases per centre: 67 rectal cancer cases for Apr 2022–Mar 2023 period. • Less than 6% risk-adjusted 90-day mortality after bowel cancer resection: Both sites are at 1.8–4.2% • Less than 10% risk-adjusted 30-day unplanned return to theatre after bowel cancer resection: Under 10% despite introduction of a new technology with the robot and an inevitable learning curve during the year of this report • Less than 15% risk-adjusted 30-day unplanned readmission after bowel cancer resection: 7.5-13.7% unto 2024 • Less than 35% risk-adjusted proportion of patients with unclosed diverting ileostomy 18-months after anterior resection: High ranking in country for stoma closure rates • More than 50% of patients with Stage 3 colon cancer receiving adjuvant chemotherapy: 54-79% over Apr 2022–Mar 2023 data • n/a to the Trust. Chemotherapy is delivered at RMH. • 10% to 60% of rectal cancer patients undergoing major resection receiving neoadjuvant treatment: Met • Greater than 70% risk-adjusted 2-year overall survival rate after bowel cancer resection: Met

Programme	Summary
NATCAN: National Prostate Cancer Audit State of the Nation Report 2024 (Jan 2019–Dec 2023 data) **Publication Date:** 9 Jan 2025 **Speciality:** Urology	**Comments against 10 Key Performance Indicators** Out of the 7 Key Performance Indicators, 5 are Met with 2 n/a to CWFT. **Good practice** • 2WW and FDS targets generally adhered to Skeletal imaging requested early. • We use targeted biopsy approach with low rate of low-risk cancer diagnosis • CNS led AS clinic. • Implemented MDT review and guidance of management of men with high-risk, locally advanced disease undergoing radical prostate cancer treatment. • Implemented use of ARTA and Chemo with radical treatment is SoC unless men are not fit • MDT review of all cases • Oncology review of all suitable cases • Surgery done at Imperial • Readmission rate is <10% which is better than national average • All men are discussed in MDT for suitability of multiple treatment options and referred accordingly
National Audit of Dementia: Care in General Hospitals Round 6 (Aug 2023–Jan 2024 data) **Publication Date:** 12 Dec 2024	Recommendations form part of the Dementia Steering Group work stream which reports quarterly to the Clinical Effectiveness Group **Speciality:** Care of the Elderly
MBRRACE-UK: Perinatal Confidential Enquiry report: Perinatal care of recent migrant women with language barriers **Publication Date:** 12 Dec 2024	No recommendations for acute trusts in report. Report and recommendations emailed to cross site Maternity and Quality Safety midwives to disseminate across their teams. **Speciality:** Maternity
Paediatric diabetes—PREMS report 2024 (NPDA) **Publication Date:** 14 Nov 2024	Recommendations emailed to site leads to disseminate across their teams. **Speciality:** Paediatric diabetes
National Confidential Enquiry into Patient Outcome and Death: A review of the quality of care provided to adult patients towards the end of life **Publication Date:** 14 Nov 2024 **Speciality:** Palliative Care	• Business case submitted—case for change • Flow: Admission avoidance/early discharge/development of virtual ward—evidence • Oncology service expansion at WM • Expansion of EOLC education programme to support staff confidence/competence in recognising the last phase of life—advance care planning. • Support to expanding frailty service, re-education, ACP, symptom control and complex discharge. • Specialist Palliative care teams at both sites have good relationships with all hospices within each respective boroughs. There is near daily contact. • Seven-day face-to-face service at WM recommenced in Jan 2025. Reduced in April to 6-day service due to x3 CNS's leaving team. Recruitment in progress, will require lead in time which is dependent on experience to date for all new recruits to be competent and confident to work autonomously. May need to further reduce to 5 day service. • CW site recommenced a seven-day service July 2024 and continues to operate. Team support WM when able however this support needs to be tailored in order for CW to continue to offer this service. • SPC dashboard—referrals demonstrate year on year increase.

Programme	Summary
Fracture Liaison Service Database Report (Jan 2023–Dec 2023 data) **Publication Date:** 9 Jan 2025 **Speciality:** Trauma & Orthopaedics	**Comments against 10 Key Performance Indicators** Identification (all fragility fractures) • **CW:** Working with FLS admin to ensure uploads are accurate and submitted on time. Random audits are carried out to check that actual uploads match the database figures. • **WM:** Compliant Identification (spinal fractures) • **CW:** Compliant • **WM:** Compliant however not 100%, Occasional spinal is not referred to FLS from radiology—this is noted when a referral is made to Rheumatology by GP Time to FLS assessment (patients assessed by the FLS within 90 days of their fracture) • **CW:** Compliant • **WM:** Compliant. Use of electronic questionnaire helps with FLS within 90 days Time to DXA (patients who had a DXA ordered or recommended and were scanned within 90 days of fracture) • **CW:** Not enough capacity to cater number of patients needing DEXA scan within 90 days of fracture. Our DEXA scan team are very supportive when we needed assistance for patients requiring urgent treatments. • **WM:** DXA waiting time is around 3 months. Possibly a new DXA scanner will be available when new diagnostics centre opens, also a new urgent DXA request has been made. However this is used for patients at very high risk Falls assessment (Patients who received a falls assessment or were referred or recommended for a falls assessment): • **CW:** Compliant • **WM:** Compliant. Every patient assessed receives a simple falls assessment 70% in last years completed audit Bone therapy recommended (patients who were recommended anti-osteoporosis medication) • **CW:** Compliant • **WM:** 47% on completed audit 2023 received a bone protection. This KPI does not take into consideration, patients who do not require bone protection, patients who have sadly deceased or patients that bone protection is inappropriate—eg renal patients, poor prognosis patients or the patients who refuse bone protection. Strength and balance training (non-hip fracture patients over 75 who had started strength and balance training within 16 weeks of their fracture) • **CW:** Currently working on establishing a strong connection with community falls strength and balance exercise service • **WM:** Compliant. Patients are referred onto bone strengthening exercises. The community team have requested that all patients suitable are referred excluding very frail. Patients with normal BMDs are also referred to exercises. Monitoring contact 12-16 weeks post fracture (patients who were followed up within 16 weeks of their fracture) • **CW:** Waiting time for follow-up appointment is currently more than 4 months from the date of request. Currently using a file to track appointments for DEXA scans manually and getting in contact with patients as soon as scan is done without waiting for their allocated appointment dates (especially for those who needed treatment) • **WM:** all followed up, however this is usually delayed as the time to DXA has a delay. Commenced bone therapy within 16 weeks of fracture diagnosis (patients who had commenced (or were continuing) antiosteoporosis medication within 16 weeks of their fracture) • **CW:** Waiting time for follow-up appointment is currently more than 4 months from the date of request. Currently using a file to track appointments for DEXA scans manually and getting in contact with patients as soon as scan is done without waiting for their allocated appointment dates (especially for those who needed treatment) • **WM:** This is usually delayed as time to DXA is delayed, unless there is a pre-existing DXA already on the system or patient at very high risk and bone protection has started without the need of a DXA. Adherence to prescribed anti-osteoporosis medication at 12 months post fracture (patients who had confirmed adherence to a prescribed antiosteoporosis medication at 12 months post fracture) • **CW:** Not available yet • **WM:** Yes. Patients receive their one year follow up on time.

Programme	Summary
MBRRACE—UK: Annual Report **Publication Date:** 10 Oct 2024 **Speciality:** Maternity	Recommendations for national bodies emailed to Maternity Quality & Safety Manager on each site to disseminate across their teams.
National Early Inflammatory Arthritis Audit: State of the Nation 2024 report **Publication Date:** 10 Oct 2024 **Speciality:** Rheumatology	**Comments against Key Performance Indicators (NICE Quality Standard QS33)** Adults with suspected persistent synovitis affecting more than 1 joint, or the small joints of the hands and feet, are referred to rheumatology services within 3 working days of presenting in primary care. NB: This is for the primary care sector: • **CW:** Based on audit period 1 Jan–31 Dec 2024: 66.7% were referred within 3 days. • **WM:** GPs aware of referring patients quickly and generally do so within 3 weeks but still not getting to the 3-day target. Adults with active rheumatoid arthritis start conventional disease-modifying anti-rheumatic drug (cDMARD) monotherapy within 6 weeks of referral, with monthly monitoring until their treatment target is met: • **CW:** Based on audit period 1 Jan–31 Dec 2024: 57.1% were started on DMARDs within 6 weeks. Having the prescribing pharmacist helps significantly. There are patients who do not want to start treatment or would like to think more about the medications before starting them. • **WM:** Site compliance is 61%—the target is 80% and may have deteriorated slightly compared to previous years. Other problems encountered are that GPs, being aware that potential early arthritis patients are seen much more quickly than routine patients, are referring most patients as early arthritis—even when symptoms are not specific or typical. This is quite difficult to triage but it inevitably results in urgent slots being blocked by inappropriate patients. Clinicians do stipulate that patients who have been examined by GPs will not be seen—and this could cause a delay—but this is not likely for patients who definitely sound inflammatory. Patients do have monitoring monthly when they start a new treatment. Adults with rheumatoid arthritis are given opportunities throughout the course of their disease to take part in educational activities that support self-management: • **CW:** All patients who are diagnosed with RA are seen by the specialist nurses, who provide one to one education about their condition. They are given education packs and directed to online resources. • **WM:** All patients who start disease modifying patients through the specialist nurses are given one to one education about their condition when they first start treatment and at every follow-up appointment. They are also directed to the NRAS Right Start programme—with patient education packs, and opportunities to speak to specially trained NRAS counsellors for advice and support at any stage during the early course of the disease—this is independent to the education they receive in the department. Adults with rheumatoid arthritis and disease flares or possible treatment-related side effects receive advice within 1 working day of contacting rheumatology services. • **CW:** Our specialist nurses aim to contact all patients within 24 hours. • **WM:** Specialist nurses aim to answer calls within 1 working day- the only delay is that the admin support is limited. There is only 1 dedicated Rheumatology administrator 3 days a week and so there is a delay in the nurses receiving patients' messages. Adults with rheumatoid arthritis have a comprehensive annual review that is coordinated by rheumatology services: • **CW:** Site does not have a dedicated annual review clinic. This is performed by the clinician during the routine rheumatology clinic where the annual review criteria are addressed. This was audited by a SpR (specialist registrar). • **WM:** There is no formal 12-month review for these patients—no staff and necessary capacity. We do address most of the criteria recommended for annual review when patients are seen for their usual clinic appointment—ie this is informal and clinician dependant at present.

Programme	Summary
National Respiratory Audit Programme (NRAP): Organisational Audit Report 2024 (Apr 2022–Mar 2023 data) **Publication Date:** 14 Nov 2024 **Speciality:** Respiratory Medicine	Smokeless in house smoking cessation service has been embedded at the Trust since October 2023. The service is regularly audited. The target is for all in-patients to have a smoking status and VBA recorded on CERNER and review M-F by Smokeless team within 24 hours for advice, NRT and support as in patient and on discharge.
National Audit of Inpatient Falls: 2024 report (2023 clinical data) **Publication Date:** 10 Oct 2024 **Speciality:** Care of the Elderly	Recommendations form part of the Falls Prevention Steering Group work stream which reports quarterly to the Patient Safety Group.
Emergency Laparotomy-Ninth Patient Report (NELA) **Publication Date:** 10 Oct 2024 **Speciality:** Surgery	**Comments against 8 Key Performance Indicators** • CT scan reported by senior radiologist and communicated with the team in the correct time scale before surgery: Met by both sites. • Patients with suspected infection or sepsis have antibiotic administration within the correct clinical timeframe: Met by both sites. • Patients arrive in theatres according to correct clinical timeframe: Met by both sites. • Patients have a risk assessment documented preoperatively AND postoperatively: **CW:** Met, **WM:** No • High-risk patients (risk of death of ≥5%) have a consultant surgeon and consultant anaesthetist present in theatre: Met by both sites. • High—risk patients are admitted directly to critical care postoperatively: Met by both sites. • Patients aged 65 or older and frail, or aged 80 and older receive postoperative assessment and management by a member of a perioperative team with expertise in comprehensive geriatric assessment (CGA): Not met by both sites • A formal assessment of frailty is made in patients aged 65 or older: Not met by both sites
NATCAN: National Kidney Cancer Audit Report 2024 (Jan 2017–Dec 2021 data)	CW site meets all the key performance indicators with occasionally missing the 31-day target. **Publication Date:** 12 Sep 2024 **Speciality:** Urology
NATCAN: National Ovarian Cancer Audit Report 2024: (2021 data) **Publication Date:** 12 Sep 2024 **Speciality:** Gynaecology	Out of the 7 key performance indicators 4 are met with 3 n/a to the Trust. **Good practice:** • Direct referral pathways from ED to urgent suspected cancer are in place • Abnormal imaging is fast tracked directly to cancer services for MDT review **Actions:** • Audit last 12 months of ovarian cancers diagnosed with ovarian cancer through ED • Review data set from RMP
National Respiratory Audit Programme (NRAP): Breathing Well: An assessment of respiratory care (2022/23 data)	**Publication Date:** 11 Jul 2024 **Speciality:** Respiratory Medicine Report, recommendations and service level data files emailed to audit leads.

Programme	Summary
National Joint Registry Annual Report (Apr 2023–Mar 2024 data) **Publication Date:** 1 Oct 2024 **Speciality:** Trauma & Orthopaedics	**Compliance against Key Performance Indicators** • **Compliance:** Using the latest available HES/PEDW data, this shows the number of records submitted to the NJR by the Trust compared to those submitted to HES/PEDW in the time frame shown. The NJR target is 95% compliance—met for both sites • Consent: The number of NJR records submitted where the Patient Consent = Yes or No. The NJR target is 90%—met for both sites **Linkability:** The number of NJR records submitted where the patient demographics provided are able to be linked to a National Patient Identifier. This enables the NJR to link primary and revision procedures for outcome analysis. The NJR target is 95%. Met for both sites.
National Hip Fracture Database (Jan–Dec 2023 data) **Publication Date:** 12 Sep 2024 **Speciality:** Trauma & Orthopaedics	**Comments against 8 Key Performance Indicators** Admission to specialist ward • **CW:** Input patients who are admitted onto any of the Planned Care wards or Chelsea Wing as Orthopaedic Specialist Ward as long as Orthopaedic Team and Orthogeriatric follow up is in place. • **WM:** No action is required but team will continually improve their compliance by targeting admission to the ward within 4 hours and ensuring all patients have Nerve Block—feedback to be forwarded to the SITE and ED Team, respectively. Prompt orthogeriatric review • **CW:** Post Take Orthopaedic SHO to refer patients to Orthogeriatric Team. CNS to monitor referrals and chase if not referred to OGS • **WM:** No action is required Prompt surgery • **CW:** Anaesthetist has 3 action plans: Organise a teaching session regarding need for ECHO post operatively—anaesthetist to be bleeped by ED when Orthopaedic Doctor is bleeped for early review and assessment of patients + Reschedule electives to accommodate NOFF • **WM:** No action is required but team will continually strive to improve target times. NICE compliant surgery • **CW:** No action required. Team will continue ensuring that NICE guidelines are followed. • **WM:** Discussed in the Trauma meeting—orthopaedic team note the best intervention for patient is guided by NICE guidance CG124. Prompt mobilisation • **CW:** 'Bum off Bed' initiative is closely monitored at the divisional level, and compliance is linked with the length of stay. • **WM:** The therapy team has an action plan to mitigate prompt mobilisation. It works together with Orthogeriatricians to optimise patients' prompt mobilisation. The 'Bum off Bed' initiative is closely monitored at the divisional level, and compliance is linked with the length of stay. Not delirious post-op • **CW:** Orthogeriatric/medical team optimisation of patient post operatively to reduce risk of delirium post operatively. Ensure that pain relief is optimised. • **WM:** Ortho geriatricians are proactively working on this to further improve compliance. As per the trust's hydration policy, they are also working on improving patients' hydration before surgery by prescribing IV fluid from 6 AM on the day of the operation and cancelling the patient's operation to resume active eating/drinking early on. Return to original residence • **CW:** No action required. Some patients decide to pay for private rehab on discharge • **WM:** No action is required Bone medication • **CW:** Weekly meeting with Orthogeriatric Consultant/Registrar to commence Bone medication while patient is in hospital. Refer Patients to Fracture Liaison service if discharged prior to starting bone protection in hospital. • **WM:** No action is required.

Programme	Summary
NATCAN: National Audit of Metastatic Breast Cancer Report 2024 (2019–2021 data) **Publication Date:** 12 Sep 2024 **Speciality:** Breast Cancer	The Trust meets all but one of the 10 performance indicators. **Good practice** • All patients with new presentations are added to MDT, either oncologist/breast surgeons or breast care nurses. These patients are discussed at the weekly MDT. All additional CT/bone scans/PET CT or biopsies go through the MDT. • All patients with newly diagnosed metastatic disease, are subjected to biopsy if clinically appropriate and if accessible for biopsy, to update hormonal profile. • Palliative RT offered to all patients for symptom control if appropriate. All brain metastases are referred to Neuro-Oncology MDT at local specialist centre (Imperial College NHS Trust). • Also SABR MDT for appropriate cases of metachronous isolated or oligometastatic disease • All cases discussed at monthly Oncology Grand Round and reported to quarterly Trust CCSG (Chemo Service Group). **Action** No metastatic breast CNS and current breast care nurses only support surgical breast patients—this has been reported to Trust Tumour Board and to the Lead Cancer Nurse.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): A review of the quality of care provided to adult patients diagnosed with endometriosis. **Publication Date:** 11 Jul 2024 **Speciality:** Gynaecology	Of the 11 recommendations in the report 3 are n/a to the Trust and 3 recommendations are met. The Trust has the following action plans in place to meet the other 5 recommendations. **Actions:** • Begin use of pre-clinic digital questionnaire assessing baseline symptoms and quality of life impact, plus symptom tracking tool. • Promote discussion and clear documentation of pain management at initial consultation. Use of pre-consultation survey to discern and clearly document existing analgesia, pain scores and requirement for more. • Clear documentation of fertility implications and aspirations in context of hormonal therapy. • Define criteria for pain management referral together with pain services. Use of standardised pain surveys as part of digital data collection and symptom tracking. • Define criteria and pathway for pelvic physiotherapy referrals. • Aim for MDT 'pain/physio' clinic with practitioners on site for immediate review. Triage of patients to this clinic using prospective digital data collection. • Consider addition of medication review in endometriosis clinic smart text (Cerner notes). • Add clear descriptions of surgery detail with all points to personalised information provided by digital tool. Can be initiated through PKB care plan. • Data collection regarding patient expectations using pre-surgery surveys. This will be a key reference point in the pre-visit questionnaire for all patients. • Introduction of standardised discharge summary detail with personalisation for procedure performed, findings, and specific follow up recommendations. • Use of personalised digital information sharing discussing post-surgery and long-term implications of endometriosis and hormonal medication for each patient.
National Paediatric Diabetes Audit: Care and Outcomes Report 2022/23 data)	Report, recommendations and unit posters emailed to audit leads. **Publication Date:** 10 Apr 2024 **Speciality:** Paediatric Diabetes
NATCAN: National Lung Cancer Audit: State of the Nation report 2024 (2022 data) **Publication Date:** 10 Apr 2024 **Speciality:** Lung Cancer	Of the 8 recommendations in the report the Trust meets 4 of these and has the following action plans in place to meet the other 4. • In terms of the risk and preparation this is undertaken at NWL level. Thoracic and diagnostic capacity has been supported mainly via imperial (as RBHT also serve SEL). There are ongoing meetings with RMP regarding volume expected and need for Fellow to help. • There are delays to diagnostics due to pressures on IR, EBUS and external referrals to RBH. There is a good pathway for carrying out biomarker testing but delays in results. Action needed around IR and EBUS capacity. Communication needed with biomarker lab to speed up turn around. • Carry out ctDNA at first point of diagnostic pathway. • Discussions around recommended number of PA's ongoing and expressions of interest to be requested ASAP. • Commence Data Quality reporting to wider MDT Team.

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 reports for each financial year.

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

- The content of the quality report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period Apr 2024–Mar 2025
    - Papers relating to quality reported to the Board over the period Apr 2024–Mar 2025
    - 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 report presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, 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 report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The quality report has been prepared in accordance with the NHS foundation trust annual reporting manual 2024/25 (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board:

Matthew Swindells
Chairman
27 Jun 2025

Lesley Watts
Chief Executive Officer
27 Jun 2025

Annex 4: Statement from the Council of Governors

Governors comments on the Quality Report 2024/25

As a 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.

The Trust has made significant progress in key areas, including reducing waiting times, enhancing maternity services, and improving cancer diagnosis and treatment. We are particularly encouraged by the Trust's proactive approach to innovation and collaboration with local communities and partners, and its commitment to improving the use of data to inform management and drive better, more effective care.

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 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 2024/25:** We endorsed the Trust's quality priorities, which included improving care for deteriorating and frail patients, reducing tobacco use, enhancing patient experience (particularly nutrition and hydration), and implementing the Patient Safety Incident Response Framework (PSIRF). These priorities were selected based on their potential to address health inequalities and were aligned with divisional strategies, business planning, and investment.

- **Smoking Reduction:** In line with the NHS Long Term Plan, the Trust has committed to providing tobacco dependency treatment to all inpatients who smoke. While not all initiatives are listed as formal quality priorities, many are embedded in routine operations and continue to receive focused attention.

- **Accessibility:** The Accessibility Steering Group has made commendable progress, completing 18 of 23 actions identified through site-wide surveys. Improvements included hearing loops and automated doors.

- **Falls Prevention:** The Falls Annual Report highlighted improved performance in falls per 1000 bed days and increased compliance with risk assessments. The Trust outperformed the national average in the National Audit of Inpatient Falls and continues to prioritise fall reduction through the Falls Prevention Steering Group and PSIRF.

- **Winter Planning:** The Trust maintained its commitment to safe and dignified care by avoiding corridor care. A new ward at the West Middlesex site and a day room with bedded spaces were opened, with clear admission criteria to ensure appropriate use.

- **Patient Experience:** The Trust received positive feedback in the national inpatient experience and Urgent and Emergency Care (UEC) surveys, emerging as 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. Initiatives like Martha's Rule, which allows patients and families to request a second opinion, have been well received.

- **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.

- **Compliance with regulators and maintaining high standards:** We received updates on how we meet our regulatory standards and best practice, for example we heard that the Trust remains fully compliant following the April 2024 inspection by the Human Fertilisation and Embryology Authority (HFEA)**,** with the licence valid until November 2026.

- **Research and Development:** The Trust continues to expand access to research opportunities, supporting innovation and quality improvement. Highlights include the discharge-ready unit at West Middlesex, advancements in robotic surgery, and the learning disability and adult safeguarding team's internship programme.

We believe that listening to and engaging with patients is essential to improving services and reducing inequalities. We are excited about the direction outlined in the refreshed Trust Clinical Strategy, including developments at the Chelsea and Westminster Hospital Day Surgery Unit (formerly called the Treatment Centre) and the West Middlesex Ambulatory Diagnostic Centre.

While the report demonstrates that the Trust is a high-quality and safe provider, we recognise that continuous improvement is essential. As governors, we remain committed to working in partnership with the Trust's leadership and our communities to achieve this goal.

Nigel Clarke
Lead Governor

19 Jun 2025

Glossary of Terms

Ambulatory Diagnostic Centre (ADC)
A new five-storey building at West Middlesex Hospital that will offer tests like scans and blood work without needing an overnight stay. It will help diagnose conditions like cancer and kidney disease more quickly and closer to home.

Artificial Intelligence (AI)
Computer systems that can perform tasks that usually require human intelligence. In the Trust, AI is used to help diagnose skin cancer faster and more accurately.

Call 4 Concern/Martha's Rule
A 24/7 service that allows patients, families, or staff to request an urgent review by a senior clinical team if they are worried about a patient's condition

Care Quality Commission (CQC)
The independent regulator of health and social care in England. It checks that hospitals and other services provide safe, effective, and high-quality care.

Cerner
The Trust's electronic patient record system. It stores and manages patient information digitally, helping staff access and update records quickly and safely.

Clinical Audit
A way of checking whether healthcare is being provided in line with standards and identifying areas for improvement

Clinical Coding
The process of translating medical diagnoses and procedures into standard codes. These are used for planning, funding, and monitoring healthcare services.

Clinical Effectiveness
A measure of how well healthcare services achieve the desired health outcomes for patients

Commissioning for Quality and Innovation (CQUIN)
A national NHS scheme that rewards hospitals for improving the quality of care they provide

Dementia Tier 1 and Tier 2 Training
Training for staff to help them understand and support people with dementia. Tier 1 is basic awareness—Tier 2 is more in-depth for staff who regularly care for people with dementia

Duty of Candour
A legal requirement for NHS organisations to be open and honest with patients and families when something goes wrong with their care

Early Warning Score (NEWS/PEWS)
A scoring system used by staff to spot when a patient's condition is getting worse. NEWS is for adults, PEWS is for children

Elective Surgery
Planned surgery that is not an emergency, such as hip replacements or hernia repairs

Friends and Family Test (FFT)
A short survey asking patients whether they would recommend the Trust's services to friends and family

GIRFT (Getting It Right First Time)
A national programme that helps NHS hospitals improve care by reducing variation and sharing best practices

Integrated Care System (ICS)
A partnership of NHS organisations and local councils working together to improve health and care for people in a specific area

LocSSIPs/NatSSIPs2
Local and national safety standards for invasive procedures (like surgery or injections). These help ensure that procedures are done safely and consistently.

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

MUST/4AT
MUST is a tool to assess if a patient is at risk of malnutrition. 4AT is a quick test to check for signs of delirium or confusion, especially in older patients.

Never Event
A serious incident that should never happen if proper safety procedures are followed, such as surgery on the wrong part of the body

Patient Experience
How patients feel about the care they receive, including communication, comfort, and involvement in decisions

Patient Safety Incident Response Framework (PSIRF)
A national approach to learning from patient safety incidents. It focuses on understanding what went wrong and how to prevent it happening again.

Preceptorship
A structured support programme for newly qualified nurses and midwives to help them settle into their roles

Protected Mealtimes
Times during the day when non-urgent activity on wards is reduced so patients can eat without interruption and get help if needed

RIQI (Research, Innovation and Quality Improvement)
A programme that brings together research, new ideas, and improvement projects to make care better for patients

SHMI (Summary Hospital-level Mortality Indicator)
A measure of how many patients die following hospital treatment, compared to what would be expected. A lower number means better performance

Virtual Ward
A service that allows patients to receive hospital-level care at home, supported by technology and regular check-ins from clinical teams

West London Children's Healthcare (WLCH)
A partnership between Chelsea and Westminster Hospital and Imperial College Healthcare NHS Trust to deliver high-quality care for children and young people across West London

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 report 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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