



Trust Performance and Quality Report

January 2026



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Executive Summary



NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

Patient Safety and Experience

The Trust saw a decline in reported incidents and medication safety incidents during the month of January. This will be reviewed as part of the medication safety group, and additional focus provided to areas of low reporting. There were 5 cases of C.Difficile which have been reported in-month, with a Trust year-to-date total of 49 against a threshold of 33. 2 cases were reported at the Chelsea site 3 at West Middlesex, with 2 of the cases reported on AMU. Cases are undergoing learning response review, and additional surveillance and cleaning procedures have been instigated. Samples have been sent for ribotyping to check for cross infection. E.Coli cases are 77 year to date against a threshold of 99.

Complaints position has declined to 92.6% in-month however the year to date position improves from 80.6% to 82.6% following targeted improvement work with divisional and corporate teams and on track to maintain performance.

VTE assessments are above target, however further analysis is required on the Hospital Acquired VTE cases between the sites, and the development of an electronic detection and reporting system from the patient record is being explored. Improvement work continues with completion rates of initial assessments for patients, focusing on digital tools to support this. Further data validation is taking place to ensure inpatient areas are reported, and it is expected this will show a compliant position. There was 1 category 3 pressure ulcers and 2 severe harm falls in month. An improvement plan for falls and Pressure Ulcers has been produced based on learning responses and is monitored through Patient Safety Group. The time spent on the stroke unit remains above the target of 80% at both sites. The time to theatre for fractured NOF patients is a combined position of 95.5%, with 100% compliance at WM and 90.9% at CW. An action plan is in place to support improvement which is monitored through the divisional performance meetings. The divisional teams are reviewing the Sepsis position and improvement plan, which will be presented to EMB and include the adoption of the new digital tools in December to support this.

Patient Access and Operating Plan

The Trust reported performance of 77.3% for A&E 4-hour performance, below the 78% standard. The Emergency Care improvement plan remains in place and progress has been seen in month in reducing time to initial assessment.

All Cancer standards were met in December 2025; with 81.4% against the 28-Day Faster Diagnostics standard, 99.4% against the 31-Day standard and 87.4% against the 62 day standard.

Elective Referral to Treatment (RTT) 18-week wait performance was 61.78% for January 2026, slightly below the Operating Plan trajectory. Overall PTL size has stabilised and long waiters continue to reduce, with 1264 patients waiting over 52 weeks (-57) and 6 patients waiting over 65 weeks (-14). There were no patient waiting over 78 weeks.

Performance against the DM01 diagnostic standard (which measures the percentage of patients waiting <6 weeks) was reported at 76.8% against the 95% standard although remains ahead of the 25/26 Operating Plan trajectory.

Workforce

The Trust's Month 10 position exceeded the operating plan target level for total staffing (63WTE). Bank and agency staffing were within the operating plan target however; substantive staffing exceed the target for this month (134 WTE / 1.8%).

Finance

The adjusted YTD financial position at month 10 is a £0.12m deficit which is £0.29 m favourable against plan.

Performance Summary

Trust level



Chelsea and Westminster Hospital
NHS Foundation Trust

Section/KPI	Target	Actual	Prev. 3 Mth Trend
Patient Safety and Experience			
Incidents per 1000 FCE bed days	TBC	48.04	
Patient safety incident investigations	n/a	2	
Never Events	0	0	
Dementia screening %	90%	93.68%	
ED sepsis screening %	90%	85.47%	!
Inpatient sepsis screening %	90%	83.24%	!
C. Difficile cases	n/a	5	
E. coli cases	n/a	12	
Formal complaints received	n/a	64	
Inpatient FFT % good experience	90%	96.43%	
A&E FFT % good experience	90%	77.90%	!
Outpatient FFT % good experience	90%	91.71%	
Maternity FFT % good experience	90%	86.02%	!
Mortality			
Summary Hospital-level Mortality Index	<100	76.96	
Hospital Standardised Mortality Ratio	<100	77.41	

Section/KPI	Target	Actual	Prev. 3 Mth Trend
Patient Access			
A&E waiting times type 1&3 (4hrs)	78%	77.31%	
LAS handovers 30 mins	n/a	273	
18 week RTT incompletes	60%	61.78%	!
Diagnostic waiting times < 6 weeks	95%	76.82%	!
28 day Faster Diagnosis Standard	77%	81.42%	
31 day diagnosis to first or subsequent treatment	96%	99.43%	
62 day GP referral to first treatment combined	85%	87.43%	
Operating Plan and Capacity			
Theatre utilisation (uncapped)	85%	83.37%	
PIFU rate	5%	9.30%	
Workforce			
Medical PDR compliance	90%	85.1%	
Non-medical PDR compliance	45%	94.2%	
Core skills compliance	90%	91.9%	

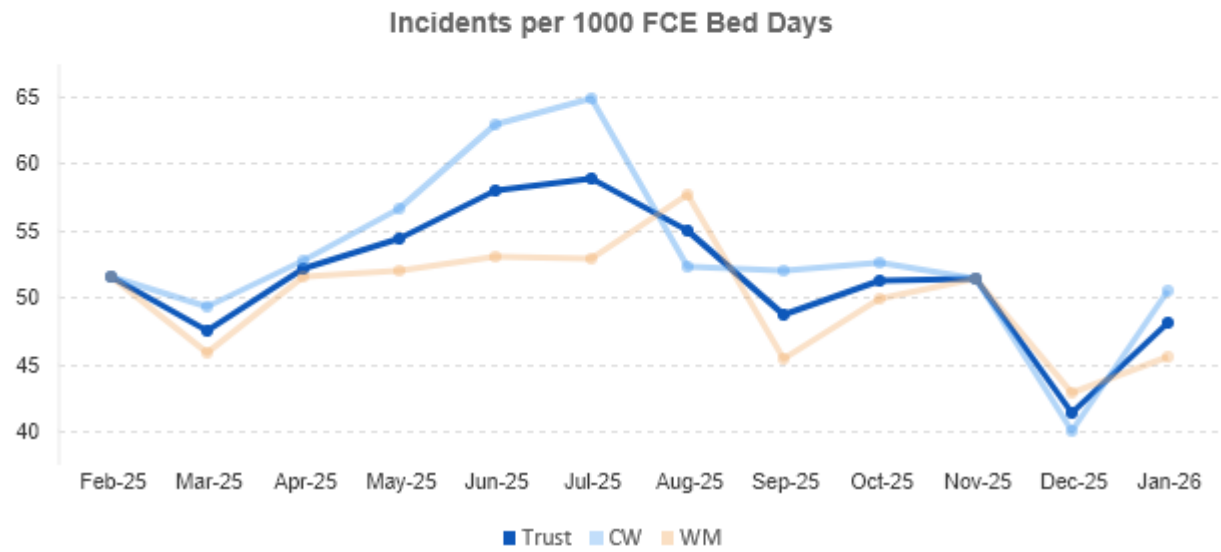


Either site or Trust overall performance red in each of the past three months



Patient Safety and Experience

Trend



Narrative

Performance: Incident reporting is a recognised indicator of an organisation’s safety culture. Higher reporting rates typically reflect a positive culture where staff feel empowered to speak up. While reporting rates have shown variability, there is an upward trend. However, we remain slightly below the national benchmark—both for the current month and on a 12-month rolling basis—where the national average is >54.9. In January, a total of 1,413 patient-related incidents were reported—160 fewer than in July, which marked the peak over the past 12months. The 12-month rolling total stands at 17,256. The trust continues to proactively identify areas for improvement in response to recurring themes and trends.

Recovery Plan: The Trust is committed to increasing incident reporting by fostering a culture of openness and psychological safety. Key initiatives include:

- Delivery of national and local training programmes aligned with PSIRF
- Enhanced identification and dissemination of learning from incidents
- Promotion of incident reporting through local team meetings, safety huddles, and divisional Quality & Safety Boards

Improvements: The implementation of a new incident management system, expected in the summer of 2026, will support the standardisation of processes across the APC and improve usability. Staff have consistently reported that the current system presents barriers to reporting, and this upgrade aims to address those concerns.

In-Month Performance

	Incidents per 1000 FCE Bed Days	Incidents Resulting in Severe Harm or Death	Incidents Resulting in Death	Incidents Resulting in Death per 1000 FCE Bed Days
CW	50.53	2	1	0.06
WM	45.50	5	1	0.07
Trust	48.04	7	2	0.07

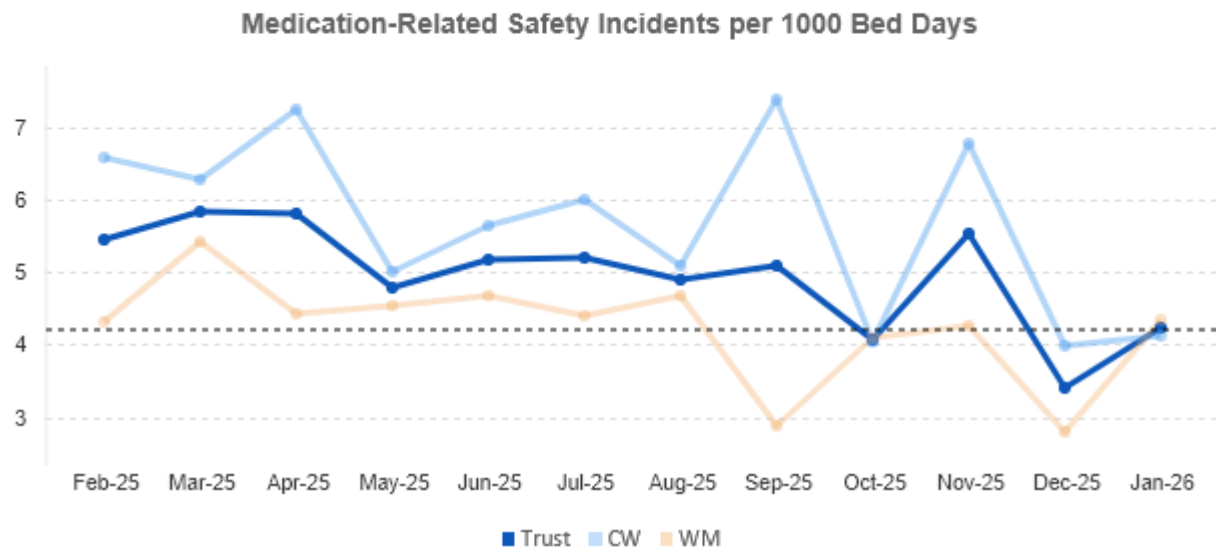
Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Incidents per 1000 FCE Bed Days (Target:)	CW	52.0	52.5	51.3	40.0	50.5	53.2
	WM	45.5	49.9	51.4	42.9	45.5	50.0
	Trust	48.6	51.2	51.4	41.4	48.0	51.6
Incidents Resulting in Severe Harm or Death (Target:)	CW	2	1	3	0	2	12
	WM	1	3	2	2	5	18
	Trust	3	4	5	2	7	30
Incidents Resulting in Death (Target:)	CW	1	0	0	0	1	3
	WM	0	1	1	0	1	4
	Trust	1	1	1	0	2	7
Incidents Resulting in Death per 1,000 FCE Bed Days (Target:)	CW	0.07	0.00	0.00	0.00	0.06	0.02
	WM	0.00	0.07	0.07	0.00	0.07	0.03
	Trust	0.03	0.03	0.04	0.00	0.07	0.02

Medication Safety Incidents

Safe

Trend



Narrative

- Performance:**
- Reporting rate targets have been met across the Trust, with increased reporting numbers at each site.
 - The target for incidents with moderate harm or above has been met.
- For noting:**
- There was one incident of moderate harm at the WM site in relation to an incorrect dose of Alteplase prescribed and administered; this incident is currently pending investigation.

In-Month Performance

	Medication Related Safety Incidents per 1000 Bed Days	Medication Related Safety Incidents With Moderate or Above Harm
CW	4.13	0.0%
WM	4.35	1.5%
Trust	4.24	0.8%

Year-to-Date Performance

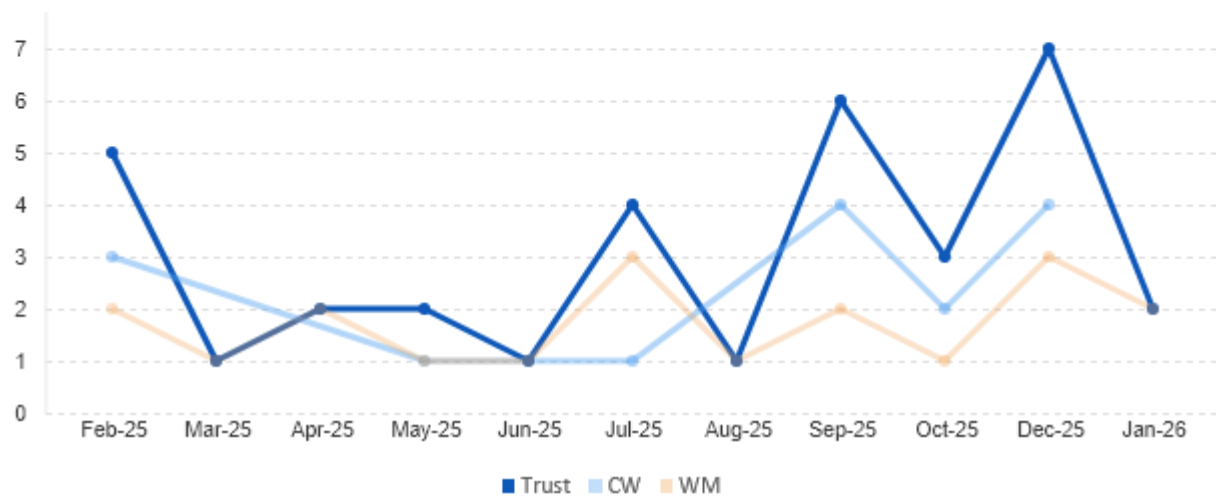
	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Medication Related Safety Incidents per 1000 Bed Days (Target: >=4.2)	CW	7.39	4.03	6.76	3.97	4.13	5.47
	WM	2.89	4.10	4.26	2.78	4.35	4.08
	Trust	5.08	4.06	5.54	3.41	4.24	4.78
Medication Related Safety Incidents % Moderate or Above Harm (Target: <1%)	CW	0.9%	1.6%	0.0%	0.0%	0.0%	0.4%
	WM	0.0%	0.0%	0.0%	0.0%	1.5%	0.5%
	Trust	0.6%	0.8%	0.0%	0.0%	0.8%	0.4%

Incidents Reported on STEIS (Sis/PSIIs)

Safe

Trend

Patient Safety Incident Investigations



Narrative

Performance: Since the implementation of PSIRF the number of incidents reported externally on StEIS has decreased. This is as expected - with PSIRF encouraging proportionate responses focused on exploring local learning opportunities more directly. Within the 12-month rolling period, the PSII indication was as follows: 62% (21) locally defined incidents requiring local PSII and 38% (13) Nationally defined priority – MNSI . There were two PSIIs declared in January. These incidents included a colonoscopy complication, and a delayed site transfer from WM to CW for an interventional radiology (IR) procedure.

Improvements: Themes are regularly reviewed and used to identify local quality and safety priorities and inform our Patient Safety Incident Response Plan (PSIRP), which has been updated for 2026/27. Safety Improvement Groups are aligned with PSIRF themes, supporting interventions in areas like falls, thrombosis, surgical safety, infection control, and medication harm. Thematic reviews have also provided insights into recurring issues.

Forecast Risks: The Trust continues to see delays in the completion of learning responses outside the timeframe outlined in the PSIRF Policy. Delays in reviewing incidents can hinder timely identification and implementation of corrective actions, potentially compromising patient safety.

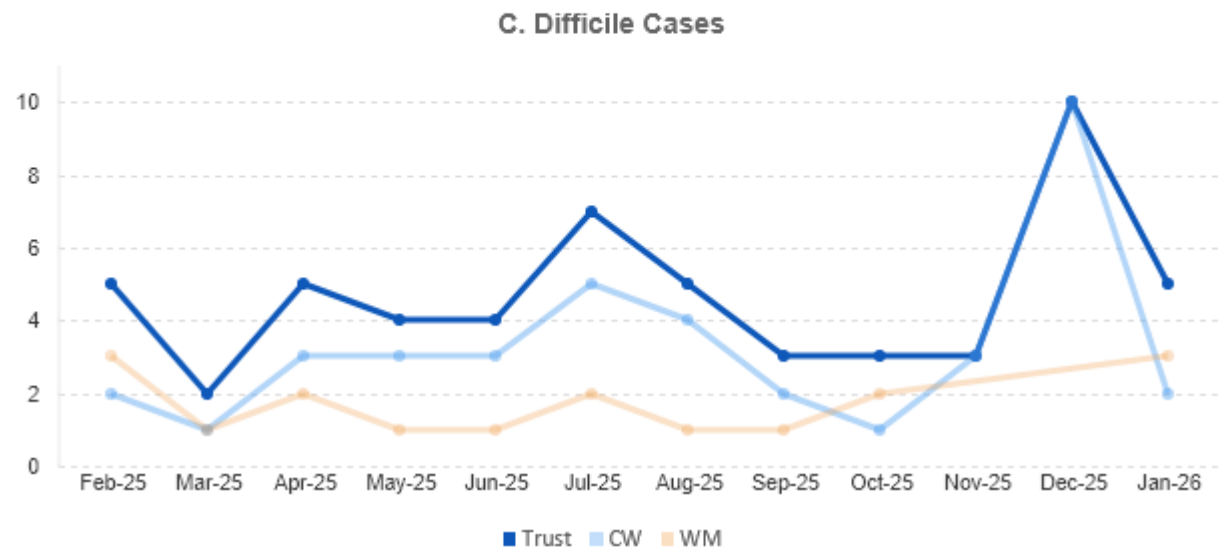
In-Month Performance

	Patient Safety Incident Investigations	Never Events	Learning Resp. Declared (AAR)	Learning Responses Declared (Thematic Review)	Learning Responses Declared (MDT)
CW	0	0	1	0	0
WM	2	0	0	0	0
Trust	2	0	1	0	0

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Patient Safety Incident Investigations	CW	4	2	0	4	0	12
	WM	2	1	0	3	2	16
	Trust	6	3	0	7	2	28
Never Events (Target: 0)	CW	0	0	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	0	0
Learning Responses Declared (AAR)	CW	2	0	0	2	1	17
	WM	2	2	5	3	0	19
	Trust	4	2	5	5	1	36
Learning Responses Declared (Thematic Review)	CW	0	0	2	0	0	2
	WM	0	0	2	0	0	3
	Trust	0	0	4	0	0	5
Learning Responses Declared (MDT)	CW	0	0	0	1	0	3
	WM	0	0	0	1	0	1
	Trust	0	0	0	2	0	4

Trend



Narrative

MRSA
There was one healthcare associated MRSA bacteraemia in January 2026 which occurred at WMH, in the specialist care division. The PSIRF meeting to review the incident has been scheduled.

CDI
There were 5 healthcare associated CDI cases in January 2026 of which x3 occurred at WMH and x2 at CWH across EIC, PC and SC Divisions. PSIRF meetings to review all 5 have been scheduled accordingly.

In-Month Performance

	C. Difficile Cases	MRSA Bacteraemia
CW	2	0
WM	3	1
Trust	5	1

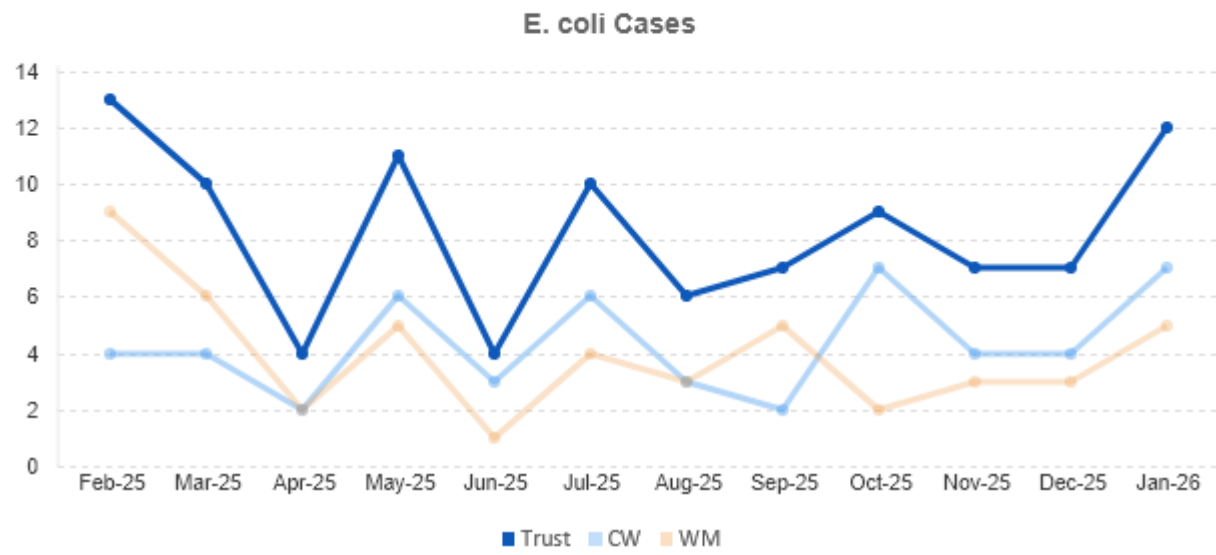
Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
C. Difficile Cases (Target: <33)	CW	2	1	3	10	2	36
	WM	1	2	-	-	3	13
	Trust	3	3	3	10	5	49
MRSA Bacteraemia (Target: 0)	CW	1	0	0	0	0	3
	WM	0	0	-	-	1	2
	Trust	1	0	0	0	1	5

Healthcare Associated E.Coli Infections

Safe

Trend



Narrative

E.coli
There were 12 healthcare associated E.coli bacteraemias in January 2026, 5 occurred at WMH and 7 at CWH across EIC, SC and PC Divisions.

The 5 cases that occurred at WMH were reviewed by the IPC and microbiology team and classified as 'non-preventable' as care was optimised and appropriate.

The CWH review meeting is scheduled. Any learning identified will be disseminated via the divisions and IPCG forum.

In-Month Performance

	E. Coli Cases	Hand Hygiene Compliance
CW	7	94.2%
WM	5	98.8%
Trust	12	96.4%

Year-to-Date Performance

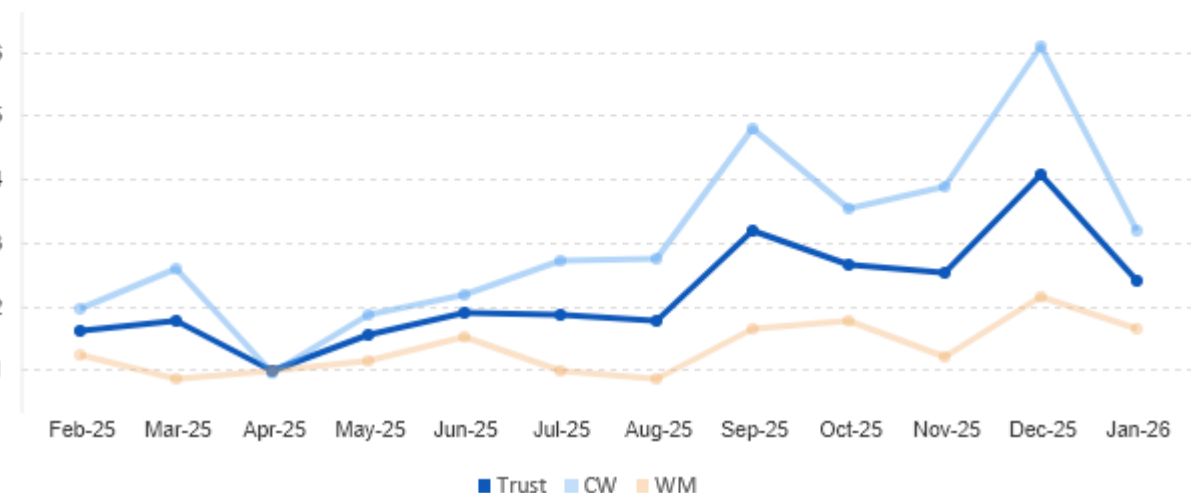
	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
E. coli Cases	CW	2	7	4	4	7	44
	WM	5	2	3	3	5	33
	Trust	7	9	7	7	12	77
Hand Hygiene Compliance (Target: >95%)	CW	96.0%	95.2%	95.8%	96.9%	94.2%	96.2%
	WM	98.0%	96.1%	97.6%	98.8%	98.8%	97.9%
	Trust	96.9%	95.6%	96.6%	97.9%	96.4%	97.0%

Formal Complaints

Responsive

Trend

Complaints Received per 1000 Bed Days



Narrative

Formal complaints – January:

- 57 received in January – decrease from 86 in December (34% decrease)
- SCD highest volume received: 17 out of 57 (30%), mainly for maternity – across maternity journey
- EIC Division received 16 mixture of ED and medical care across both sites
- WLCH received 7 new complaints, more than usual but a decrease from December – mainly for CW, mainly inpatient care and complex in nature

PALS (informal concerns) – January:

- Steep increase from 244 in December to 344 received during January.
- EIC received 105, Planned Care 98, SCD 83; CSD 29; WLCH 25, Corporate 4.
- Themes: appointments – delays and cancellations, communication with patients, access to treatment or drugs and discharges

Compliance and backlog:

- Formal complaint compliance met the KPI at 93% continued daily huddles and dedicated response writing in place, however volume of incoming correspondence continues both in PALs and Complaints.
 - PALS performance: 166 of 344 resolved in time (48%) vs 56% in December
 - Despite volume pressures, new cases are still being managed promptly.
- Rising complaints and PALS concerns continue to increase operational pressure. While formal complaint timeliness remains strong (due to recovery plan), the PALS backlog needs greater prioritisation within divisions.

In-Month Performance

	Complaints Received per 1000 Bed Days	Complaints Responded to <25 Working Days	Complaints Upheld by PHSO	Complaints Open > 90 Days
CW	3.2	92.6%	0	3
WM	1.6	92.6%	0	1
Trust	2.4	92.6%	0	4

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Complaints Received per 1000 Bed Days	CW	4.8	3.5	3.9	6.1	3.2	3.1
	WM	1.6	1.8	1.2	2.1	1.6	1.4
	Trust	3.2	2.6	2.5	4.1	2.4	2.3
Complaints Responded to <25 Working Days (Target: >90%)	CW	59.5%	90.9%	92.9%	98.1%	92.6%	83.3%
	WM	100.0%	85.0%	100.0%	95.5%	92.6%	81.0%
	Trust	65.9%	89.3%	95.0%	97.3%	92.6%	82.6%
Complaints Responded to <45 Working Days (Target: >90%)	CW	91.9%	100.0%	95.2%	98.1%	Reports a month in arrears	96.0%
	WM	100.0%	90.0%	100.0%	100.0%		94.4%
	Trust	93.2%	97.3%	96.7%	98.7%		95.5%
Complaints Upheld by PHSO	CW	0	0	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	0	0
Complaints Open > 90 Days	CW	0	1	1	0	3	5
	WM	1	0	0	1	1	5
	Trust	1	1	1	1	4	10

Inpatient Friends & Family Test

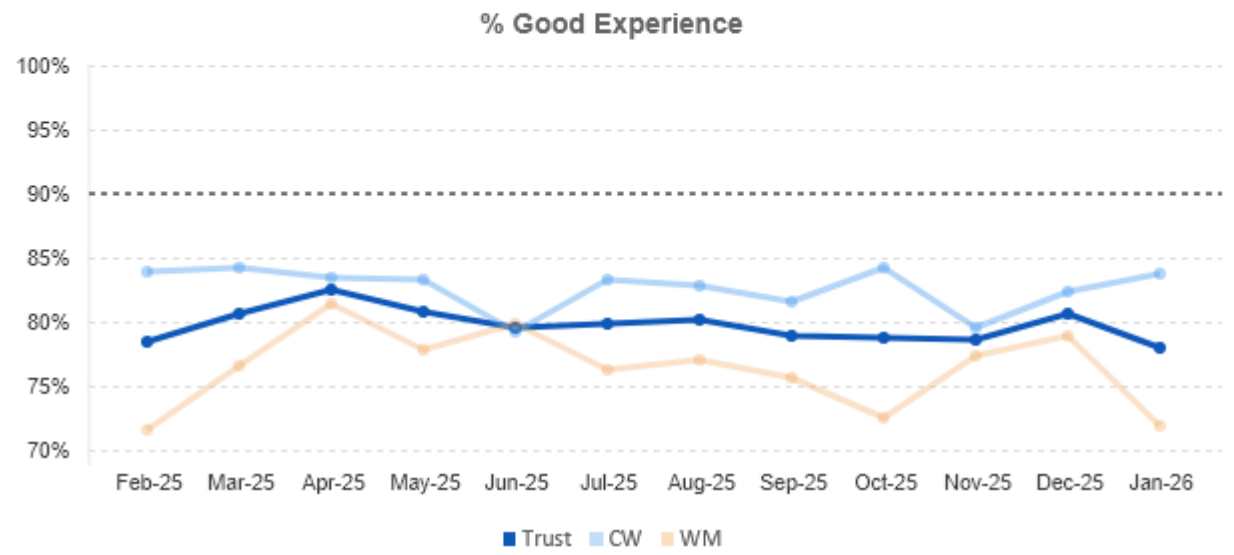
Caring

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Emergency Department Friends & Family Test

Caring

Trend



Narrative

A&E FFT

- The picture for January was mixed. CW continued to show improvement, while WM experienced a sharp decline, mainly linked to waiting times and the quality of information provided.
- Work is ongoing with PED leads to improve response rates at CW, with plans to replicate successful approaches at WM.
- In January, we engaged with UTC leads and staff to discuss the findings from the 2024 national survey alongside current FFT feedback. This focused on raising awareness of key themes and encouraging teams to consider these during clinical practice and in conversations with patients, for example, when giving discharge information.
- Themes remain largely consistent with previous months, both positive and negative, with kindness and compassion continuing to feature strongly in patient feedback.
- Response numbers remain lower than before the introduction of additional questions (June/July 2024). An end-of-year review is planned to assess whether further budget is required, particularly for paediatric areas.

Learning from A&E Complaints – January

- Safeguarding:** Families should be clearly informed at the point of care that safeguarding information may be shared with appropriate professionals, even without consent, when required by law.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	1,041	9.9%	83.8%	88.0%
WM	991	8.5%	71.7%	82.0%
Trust	2,032	9.2%	77.9%	85.1%

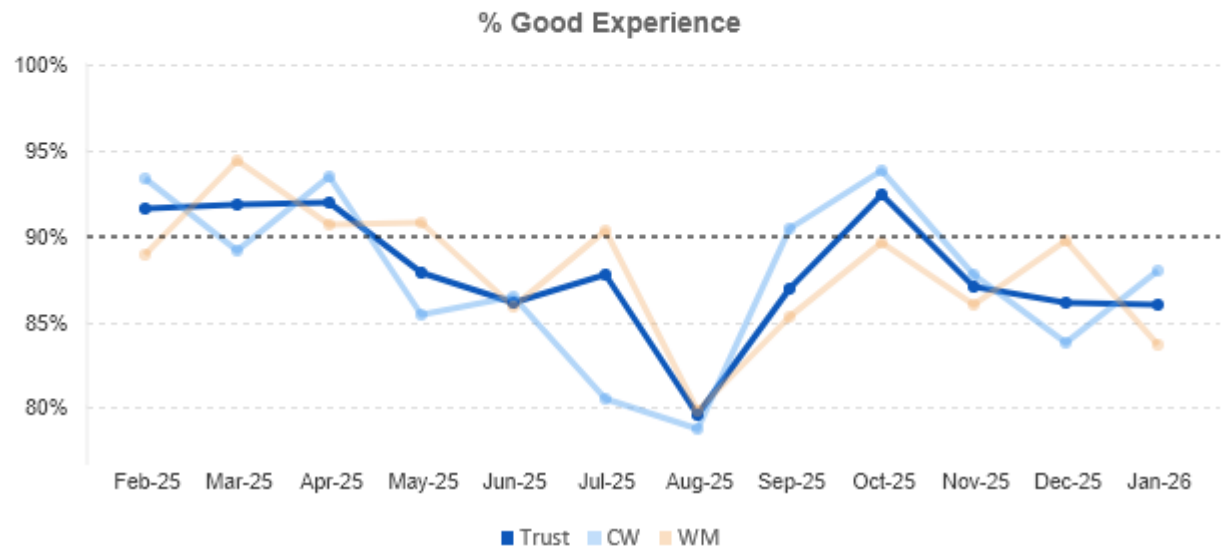
Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Responses	CW	1,009	1,008	954	935	1,041	9,709
	WM	808	882	804	820	991	8,319
	Trust	1,817	1,890	1,758	1,755	2,032	18,028
Response Rate (Target: >10%)	CW	9.9%	9.3%	9.0%	9.2%	9.9%	9.9%
	WM	8.1%	8.3%	7.5%	7.1%	8.5%	8.3%
	Trust	9.0%	8.8%	8.2%	8.1%	9.2%	9.1%
% Good Experience (Target: >90%)	CW	81.5%	84.1%	79.6%	82.2%	83.8%	82.3%
	WM	75.5%	72.4%	77.2%	78.8%	71.7%	76.6%
	Trust	78.8%	78.7%	78.5%	80.6%	77.9%	79.7%
% Treated With Dignity and Respect (Target: >90%)	CW	86.0%	89.0%	85.0%	88.0%	88.0%	86.4%
	WM	81.0%	81.0%	82.0%	84.0%	82.0%	81.4%
	Trust	83.8%	85.3%	83.6%	86.1%	85.1%	84.1%

Maternity Friends & Family Test

Caring

Trend



Narrative

Maternity – Performance Summary:
Both sites saw a decline in response numbers and experience, though overall results remain similar between Chelsea and West Mid. Consistent themes across maternity: variable information-giving, inconsistent responsiveness, and concerns about kindness and compassion. A key driver of positive experience remains giving women enough time to ask questions, both before and after birth.

Key Themes (FFT + wider feedback triangulation):
Information after birth, especially relating to mental health, has declined.
National benchmarking shows poor performance in triage and assessment, particularly listening and waiting times, and discharge processes post birth.
Rising complaints echo these issues, highlighting the need for stronger postnatal debriefing and better responsiveness during maternity triage.

Learning from December Maternity Complaints:
Obstetrics & Gynaecology – Injury During Care
Improve documentation of skin checks during and after procedures.
Address delays and communication gaps in the Maternity Assessment Unit.
Strengthen understanding and use of specialty imaging portals.
Embed postnatal pathway checks so debrief referrals are not missed.
Obstetrics & Gynaecology – Missed Diagnosis
Ensure ultrasound mandatory anatomical views (e.g., CSP) are consistently captured.
Strengthen competency assessments and provide targeted support and supervision for sonographers.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	100	18.0%	88.0%	93.0%
WM	86	18.9%	83.7%	88.0%
Trust	186	18.4%	86.0%	90.9%

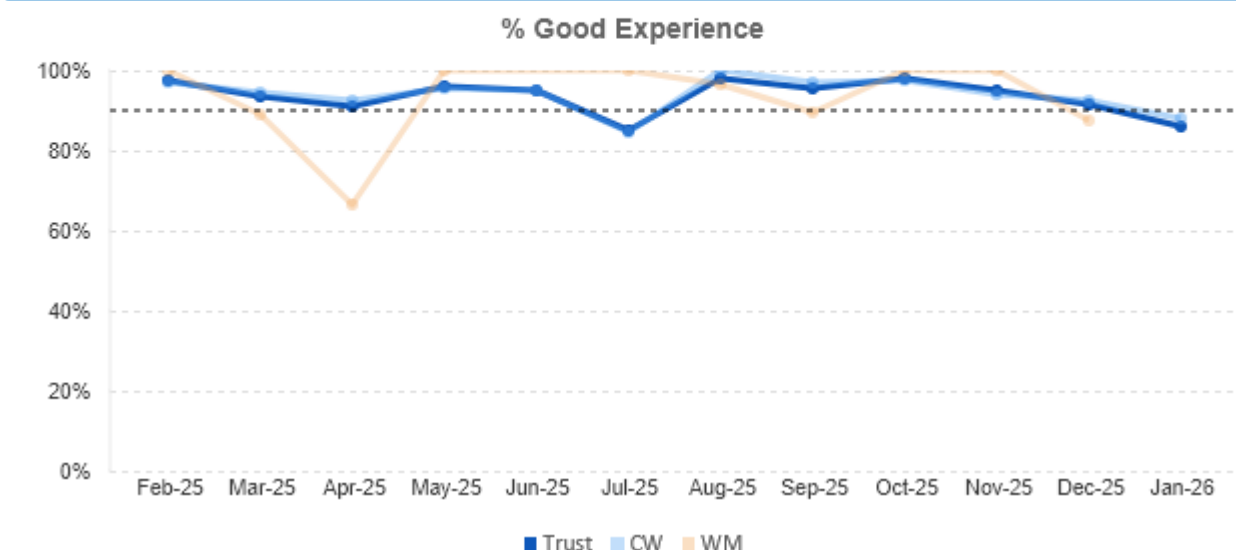
Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Responses	CW	73	193	172	136	100	1,004
	WM	156	96	121	88	86	1,065
	Trust	229	289	293	224	186	2,069
Response Rate (Target: >10%)	CW	18.2%	38.4%	31.4%	27.7%	18.0%	20.7%
	WM	5.8%	3.8%	28.5%	19.4%	18.9%	8.5%
	Trust	7.4%	9.6%	30.1%	23.7%	18.4%	11.9%
% Good Experience (Target: >90%)	CW	90.4%	93.8%	87.8%	83.8%	88.0%	88.2%
	WM	85.3%	89.6%	86.0%	89.8%	83.7%	87.0%
	Trust	86.9%	92.4%	87.0%	86.2%	86.0%	87.6%
% Treated With Dignity and Respect (Target: >90%)	CW	90.0%	97.0%	93.0%	89.0%	93.0%	92.4%
	WM	93.0%	87.0%	90.0%	90.0%	88.0%	89.0%
	Trust	92.0%	93.9%	91.8%	89.4%	90.9%	90.7%

Children and Young People Friends & Family Test

Caring

Trend



Narrative

- Response rates remain low across both sites, particularly at WM, which limits how representative the results are. However, teams continue to say they are actively promoting, and every response is still reviewed and used to inform local improvements.
- Despite the small numbers, satisfaction consistently scores above 90%, indicating broadly positive experiences among those who do respond but sample size so small.
- New CYP-specific survey questions are now in the final approval stage with the WLCH Board, with launch planned for February/March.
- These updates aim to deliver more meaningful insights and larger, more reliable sample sizes in the new financial year, supporting clearer priorities and stronger improvement planning.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	42	6.9%	88.1%	95.0%
WM	1	1.0%	0.0%	89.0%
Trust	43	6.1%	86.0%	94.5%

Year-to-Date Performance

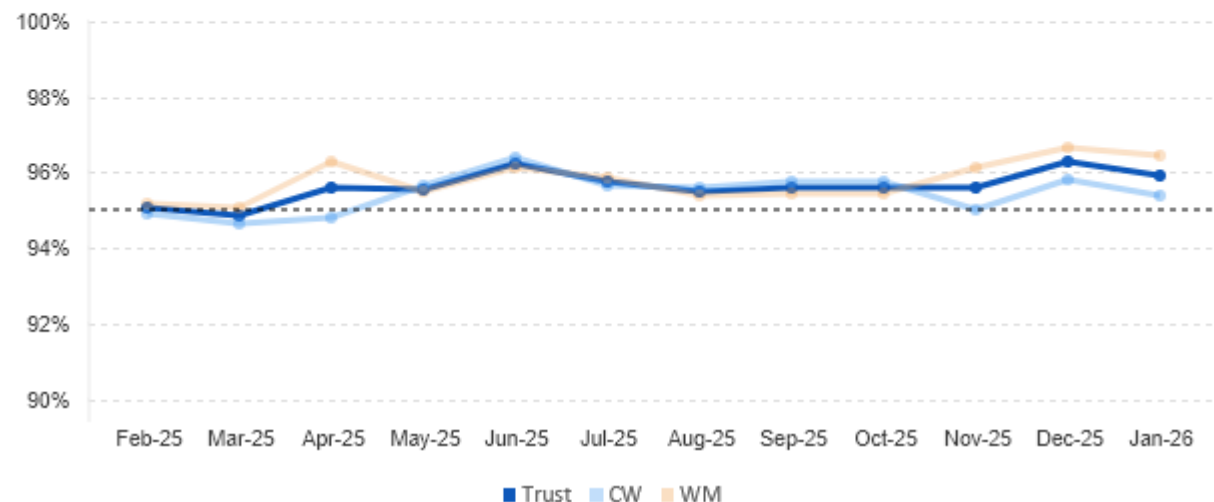
	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Responses	CW	66	39	57	39	42	415
	WM	19	9	8	8	1	78
	Trust	85	48	65	47	43	493
Response Rate (Target: >10%)	CW	11.6%	13.8%	9.5%	7.0%	6.9%	11.2%
	WM	6.2%	2.7%	2.4%	3.3%	1.0%	4.0%
	Trust	9.7%	7.9%	7.0%	5.8%	6.1%	8.7%
% Good Experience (Target: >90%)	CW	97.0%	97.4%	93.9%	92.3%	88.1%	93.9%
	WM	89.5%	100.0%	100.0%	87.5%	0.0%	92.3%
	Trust	95.3%	97.9%	95.1%	91.5%	86.0%	93.6%
% Treated With Dignity and Respect (Target: >90%)	CW	96.0%	97.0%	96.0%	99.0%	95.0%	93.9%
	WM	95.0%	100.0%	100.0%	86.0%	89.0%	76.3%
	Trust	95.8%	97.4%	96.7%	98.0%	94.5%	91.0%

VTE Risk Assessments Completed

Safe

Trend

VTE Assessments Completed



Narrative

VTE Risk Assessment: Target achieved. Monthly VTE risk assessment performance by site, division, speciality and ward disseminated for leads to review and action as appropriate.

Divisions requiring improvement: Planned Care and West London Childrens Hospital.

Specialities requiring improvement: Colorectal surgery, ophthalmology, trauma & orthopaedics, ENT, plastic surgery, general surgery, urology, elderly medicine

Hospital Associated VTE (HAT) Events:

- Cross-Site:** 'VTE alert' included in positive VTE imaging reports for identification of VTE diagnosis.
- CW Site:** HATs under-reported due to identification. Awaiting Business Analyst resource to develop and implement digital identification with auto-reporting of HATs from Cerner patient admission records.
- Cross-Site:** All reported HATs on Datix undergo investigation with VTE lead clinical review, shared learning and any actions to prevent recurrence. Timely completion of HAT investigation form is required by clinical teams.
- Quarterly review of HATs shared at Thrombosis and Thromboprophylaxis Group meeting, with appropriate action/wider dissemination and shared learning.
- Shared learning from potentially preventable HATs disseminated to specialities and departments, with action plan in progress to address contributory factors.

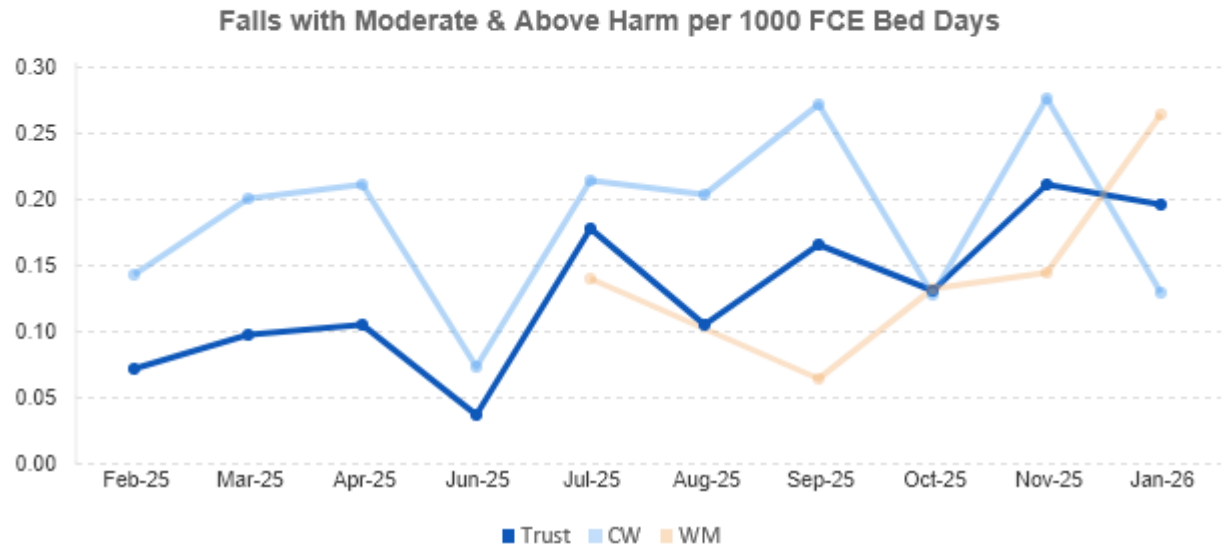
In-Month Performance

	VTE Assessments Completed	Hospital Aquired VTE Cases	Hospital Aquired VTE per 1000 FCE Bed Days
CW	95.4%	1	0.1
WM	96.5%	3	0.2
Trust	95.9%	4	0.1

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
VTE Assessments Completed (Target: >=95%)	CW	95.8%	95.7%	95.0%	95.8%	95.4%	95.6%
	WM	95.4%	95.4%	96.1%	96.6%	96.5%	95.9%
	Trust	95.6%	95.6%	95.6%	96.3%	95.9%	95.8%
Hospital Aquired VTE Cases	CW	0	0	0	0	1	4
	WM	2	6	10	5	3	49
	Trust	2	6	10	5	4	53
Hospital Aquired VTE per 1000 FCE Bed Days	CW	0.0	0.0	0.0	0.0	0.1	0.0
	WM	0.1	0.4	0.7	0.3	0.2	0.3
	Trust	0.1	0.2	0.4	0.1	0.1	0.2

Trend



Narrative

Patient falls per 1000 bed days with moderate and severe harm have risen to 6 in January.

- 2 of the moderate falls are being assessed at AAR reviews as deemed to be able to reduce to low harm.
- The 4 others have been investigated with minimal learning identified

All learnings from incidents are discussed at the falls steering group. Education regarding falls and bed rails assessments has increased from learning and a bed rail audit has been completed. All patients who fall are screened by the falls leads and patients are physical assessed as well as all notes and assessment checked.

Compliance with falls risk assessment reflected in the report currently includes all areas in the hospital and all divisions. When considering just inpatient areas compliance is above 90%.

Our pilots of new falls alarms in 3 areas, Nell Gwynne ward, Redlees ward and Rainsford Mowlem are ongoing, each area has seen a reduction in falls with moderate and severe harm. EIC and Planned Crae are preparing business proposals to expand the alarms through their wards.

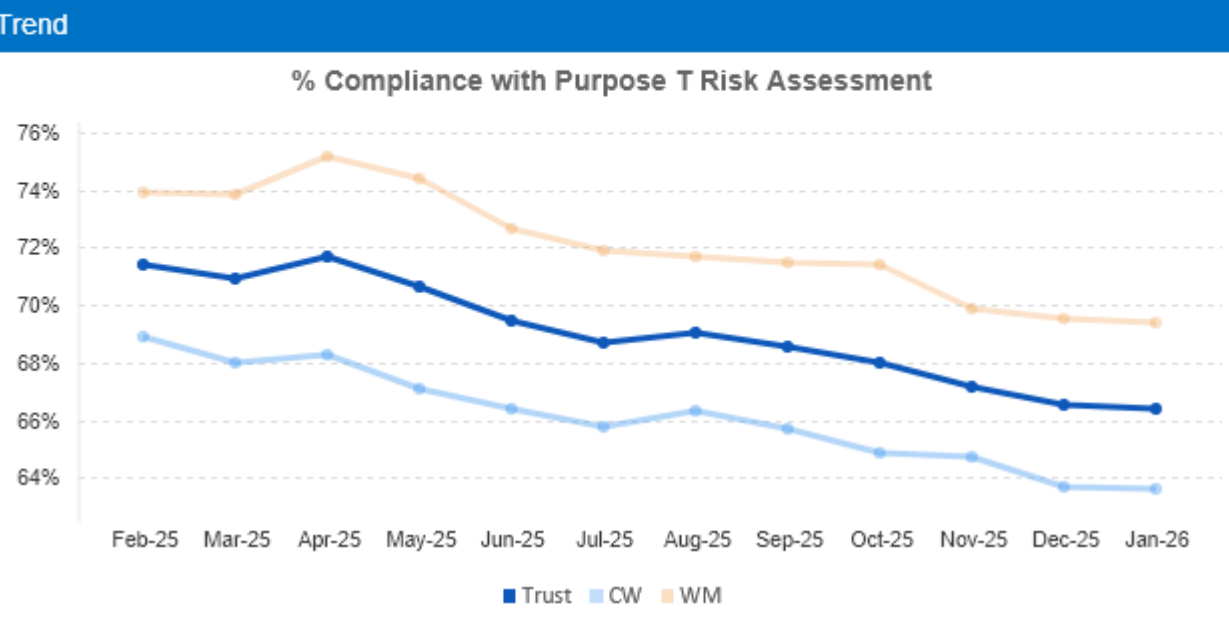
Since April 2025 the Trust has had 26 falls with moderate harm, 10 falls with severe harm and 2 falls resulting in death, a thematic review will be undertaken, from 1st April 2025-31st March 2026. The thematic review will include the time of the fall, location, pre fall interventions, staffing and frailty scores into account, this will help us to identify common themes and develop a plan for improvement.

In-Month Performance

	Inpatient Falls with Moderate & Above Harm	Inpatient Falls Resulting in Severe Harm or Death	Falls with Moderate & Above Harm per 1000 FCE Bed Days	Falls per 1000 FCE Bed Days	Compliance with Falls Risk Assessment
CW	2	0	0.13	4.78	66.1%
WM	4	2	0.26	3.96	72.2%
Trust	6	2	0.20	4.37	69.1%

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Inpatient Falls with Moderate & Above Harm	CW	4	2	4	0	2	22
	WM	1	2	2	0	4	11
	Trust	5	4	6	0	6	33
Inpatient Falls Resulting in Severe Harm or Death (Target: 0)	CW	2	1	2	0	0	8
	WM	0	1	0	0	2	4
	Trust	2	2	2	0	2	12
Falls with Moderate & Above Harm per 1000 FCE Bed Days	CW	0.27	0.13	0.28	0.00	0.13	0.15
	WM	0.06	0.13	0.14	0.00	0.26	0.08
	Trust	0.16	0.13	0.21	0.00	0.20	0.11
Falls per 1000 FCE Bed Days	CW	3.19	4.41	4.83	3.92	4.78	4.06
	WM	5.00	3.77	4.91	3.86	3.96	4.18
	Trust	4.12	4.10	4.87	3.89	4.37	4.12
Compliance with Falls Risk Assessment (Target: >=90%)	CW	67.9%	67.2%	67.1%	66.2%	66.1%	68.0%
	WM	74.3%	73.7%	72.8%	72.5%	72.2%	74.5%
	Trust	71.0%	70.3%	69.8%	69.3%	69.1%	71.2%



In-Month Performance

	Compliance with Purpose T Risk Assessment	Category 2 Pressure Ulcers	Category 3 Pressure Ulcers	Category 4 Pressure Ulcers	Category 3/4 Pressure Ulcers per 1000 FCE Bed Days
CW	63.6%	1	0	0	-
WM	69.4%	1	1	0	-
Trust	66.4%	2	1	0	-

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Compliance with Purpose T Risk Assessment (Target: >=90%)	CW	65.7%	64.8%	64.7%	63.7%	63.6%	65.6%
	WM	71.5%	71.4%	69.9%	69.5%	69.4%	71.7%
	Trust	68.6%	68.0%	67.2%	66.5%	66.4%	68.5%
Category 2 Pressure Ulcers	CW	3	0	2	0	1	11
	WM	2	1	0	1	1	15
	Trust	5	1	2	1	2	26
Category 3 Pressure Ulcers (Target: 0)	CW	0	0	0	0	0	2
	WM	0	0	4	1	1	10
	Trust	0	0	4	1	1	12
Category 4 Pressure Ulcers (Target: 0)	CW	0	0	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	0	0
Medical Device Related Pressure Ulcers	CW	2	0	1	0	0	4
	WM	0	0	0	1	0	5
	Trust	2	0	1	1	0	9

Narrative

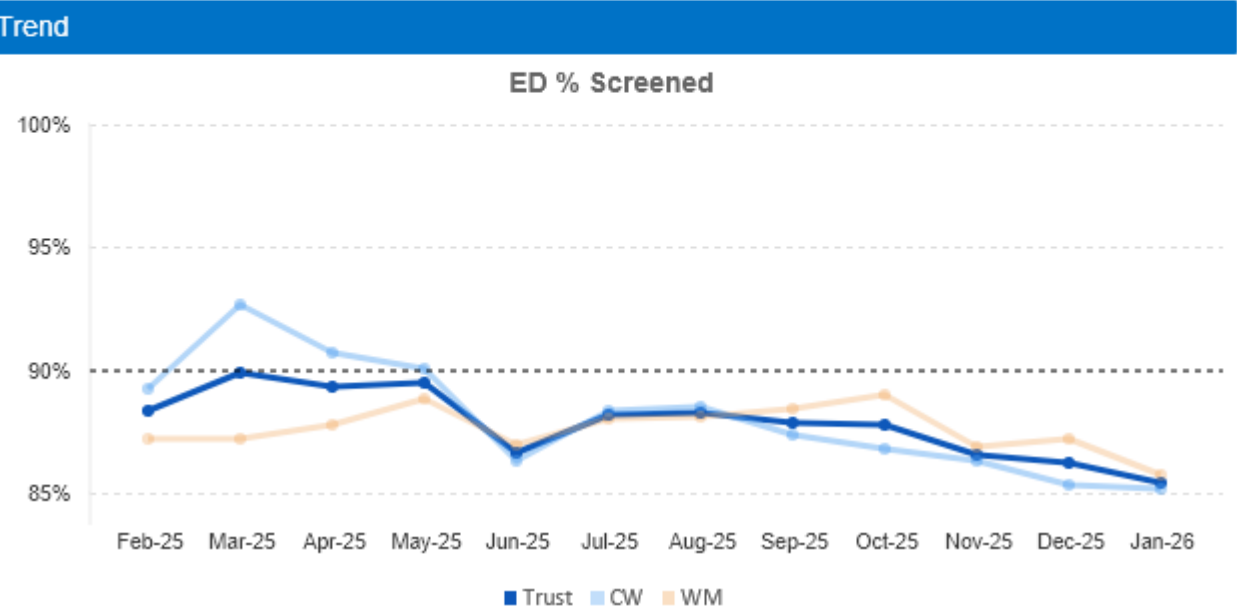
One case of hospital-acquired Category 3 pressure damage was reported at West Middlesex in January. The patient was identified at risk on admission and interventions were in place to mitigate the risk. Despite this pressure damage occurred and an IIR is being completed.

There were five Category 2 cases reported in January:

- 1 at Chelsea
- 4 at West Middlesex

Actions

- A Trust-wide action plan to reduce hospital-acquired pressure damage continues to be implemented, supported by local action plans in areas with higher incidence.
- Targeted training and focused support will be provided to the clinical teams at WMH involved in the Category 3 case.
- Learning from these incidents will be shared Trust-wide to strengthen prevention, assessment and early intervention.



Narrative

Improvement in performance across all areas, however overall performance remains non-compliant. A dedicated action plan for both Emergency Departments will be presented at FP&I and EMB in March 2024

In-Month Performance

	ED % Screened	ED % Potential Red Flags Reviewed	Ward % Screened	Ward % Potential Red Flags Reviewed
CW	85.2%	68.4%	80.6%	95.0%
WM	85.7%	94.3%	86.6%	97.4%
Trust	85.5%	79.8%	83.2%	96.1%

Year-to-Date Performance

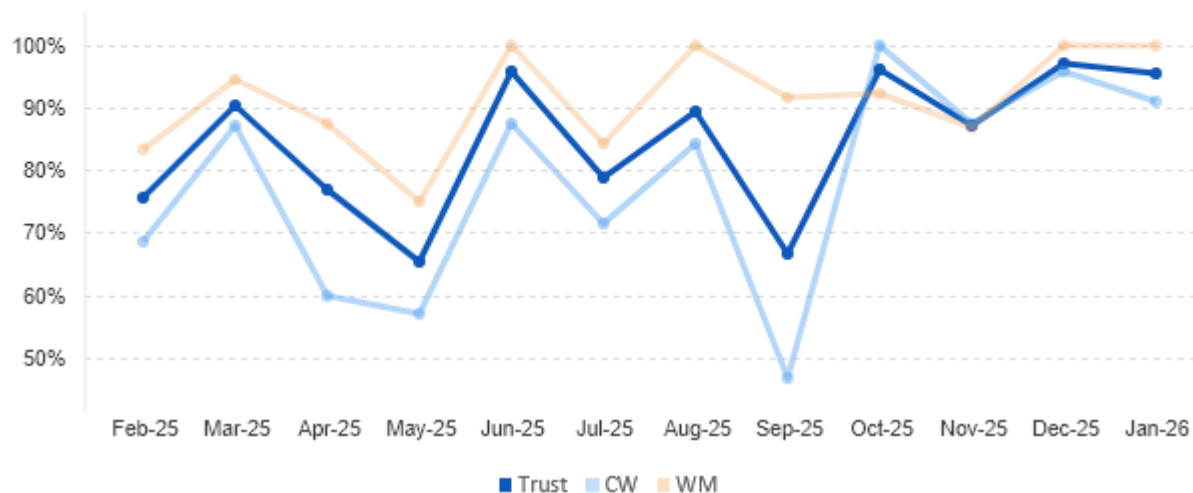
	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
ED % Screened (Target: >90%)	CW	87.4%	86.8%	86.3%	85.4%	85.2%	87.3%
	WM	88.5%	89.0%	86.9%	87.2%	85.7%	87.6%
	Trust	87.9%	87.8%	86.6%	86.2%	85.5%	87.5%
ED % Potential Red Flags Reviewed (Target: >90%)	CW	77.4%	76.5%	67.3%	63.0%	68.4%	76.6%
	WM	94.2%	94.9%	94.7%	95.1%	94.3%	93.6%
	Trust	85.0%	84.9%	78.1%	76.7%	79.8%	84.0%
Ward % Screened (Target: >90%)	CW	85.7%	83.6%	84.6%	82.8%	80.6%	84.2%
	WM	87.9%	88.6%	86.1%	86.3%	86.6%	88.7%
	Trust	86.7%	85.9%	85.3%	84.3%	83.2%	86.3%
Ward % Potential Red Flags Reviewed (Target: >90%)	CW	95.9%	93.1%	95.3%	96.9%	95.0%	95.3%
	WM	96.8%	96.3%	96.9%	97.3%	97.4%	96.4%
	Trust	96.3%	94.7%	96.0%	97.1%	96.1%	95.9%

Best Practice

Safe

Trend

NoF Time to Theatre <36hrs for Medically Fit Patients



In-Month Performance

	NoF Time to Theatre <36hrs for Medically Fit Patients	Breach of Same Sex Accommodation	Time Spent on Dedicated Stroke Unit	Dementia Screening Case Finding
CW	90.9%	0	88.9%	92.4%
WM	100.0%	38	88.0%	94.7%
Trust	95.5%	38	88.4%	93.7%

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
NoF Time to Theatre <36hrs for Medically Fit Patients (Target: 100%)	CW	46.7%	100.0%	87.5%	95.7%	90.9%	79.7%
	WM	91.7%	92.3%	86.7%	100.0%	100.0%	91.7%
	Trust	66.7%	96.0%	87.1%	97.1%	95.5%	85.5%
Breach of Same Sex Accommodation	CW	0	0	0	0	0	0
	WM	28	27	29	29	38	315
	Trust	28	27	29	29	38	315
Time Spent on Dedicated Stroke Unit (Target: >80%)	CW	83.3%	95.5%	94.1%	83.3%	88.9%	87.3%
	WM	87.0%	93.1%	92.9%	94.7%	88.0%	91.9%
	Trust	85.7%	94.1%	93.3%	89.2%	88.4%	90.0%
Dementia Screening Case Finding (Target: >90%)	CW	94.5%	93.4%	97.4%	96.8%	92.4%	94.0%
	WM	93.5%	95.3%	98.0%	98.4%	94.7%	92.1%
	Trust	94.0%	94.5%	97.8%	97.7%	93.7%	92.9%

Narrative

NOF:

Compliance across both sites has remained positive for four consecutive months. At WM, 22 out of 22 medically fit patients underwent surgery within 36 hours. At CW, 20 out of 22 medically fit patients received surgery within 36 hours. The improvement action plan continues to be implemented and this is reflected in performance.

Dementia:

We continue to meet our target of 90% and above for dementia screening since September 25. At present this remains a single point of failure, without the Dementia leads diligence this would not be met. The Dementia lead is engaging with the wider MDT as part of QI project. The focus is the completion of the 4AT within the first 24 hours of admission, this will ensure we are capturing patients with both a delirium or a possible cognitive impairment. The QI project proposal was agreed at the Senior Nurse Cabinet meeting on the 16th December and role out has begun. The project includes the compliance/non compliance rates displayed on the quality round section on TCH which will enable the ability to monitor the data.



Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Nov-25	Dec-25	Jan-26	2025-2026	Nov-25	Dec-25	Jan-26	2025-2026	Nov-25	Dec-25	Jan-26	2025-2026 Q4	2025-2026	Trend charts
Workforce	Midwife to birth ratio (Target: 1:30)	1:22	1:24	1:23	1:23	1:26	1:25	1:25	1:25	1:24	1:25	1:24	1:24	1:24	-
	Hours dedicated consultant presence on labour ward (Target 1:98)	1:98	1:98	1:98	1:98	1:98	1:98	1:98	1:98	1:98	1:98	1:98	1:98	1:98	-
Birth indicators	Total number of NHS births (Target:> CW 439 WM 392)	404	410	438	4304	339	382	390	3708	743	792	828	828	8012	-
	Total number of bookings (Target:> CW 580 WM 478)	532	488	492	5592	401	397	442	4389	933	885	934	934	9981	-
	Maternity 1:1 care in established labour (Target: >95%)	95.0%	98.0%	99.0%	98.0%	99.0%	98.0%	99.0%	98.0%	97.0%	98.0%	99.0%	99.0%	98.0%	-
Safety	Admissions >37/40 to NICU/SCBU	0	0	16	109	15	9	17	230	15	9	33	16	109	-
	Number of reported Serious Incidents	4	1	7	36	1	4	3	23	5	5	10	10	59	-
	Cases of hypoxic-ischemic encephalopathy (HIE)	1	0	0	1	0	0	0	1	1	0	0	0	2	-
	Pre-term (gestation <37 weeks) as % of mothers delivered	10.0%	6.0%	6.0%	6.3%	7.0%	8.0%	6.0%	6.4%	8.5%	7.0%	6.0%	6.0%	6.4%	-
	Number of stillbirths	2	0	1	13	1	3	3	14	3	3	4	4	27	-
	Number of Infant deaths	0	3	1	9	1	0	0	13	1	3	1	1	22	-
	Number of Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Outcomes	% of women on a continuity of care pathway	n/a	n/a	3.0%	3.0%	n/a	n/a	9.0%	9.0%	n/a	n/a	6.0%	6.0%	6.0%	-
	Spontaneous unassisted vaginal births	24.0%	24.0%	23.0%	23.8%	31.0%	28.0%	24.0%	28.2%	27.5%	26.0%	23.5%	23.5%	26.0%	-
	Vaginal Births - spontaneous & induced	39.0%	35.0%	36.0%	37.7%	47.0%	42.0%	38.0%	41.9%	43.0%	38.5%	37.0%	37.0%	39.8%	!
	Instrumental deliveries	58	58	63	592	37	42	49	430	95	100	112	112	1022	-
	Pre-labour elective caesarean sections	84	89	95	870	46	65	53	557	130	154	148	148	1427	-
	Emergency caesarean sections in labour	96	116	121	1172	97	109	135	1152	193	225	256	256	2324	-



Please note that some of the metrics require full validation and will be updated in the following months report. The above dashboard metrics covers workforce, birth indicators, safety and clinical outcomes.

Workforce: In January, the midwifery staffing ratios were reported as 1:25 at the Chelsea site and 1:23 at West Middlesex. The latest *Birthrate Plus* (2024) recommendations advise revised staffing ratios of 1:23 at Chelsea (previously 1:26) and 1:21 at West Middlesex (previously 1:22), reflecting current levels of acuity and activity. While the national birth rate continues to decline, local data indicates an increase in acuity particularly among women categorised as levels 4 and 5 (high risk) with a corresponding reduction in low-risk (category 1) cases. This evolving case mix has important implications for workforce planning and the delivery of safe maternity care. Despite significant investment a staffing shortfall of 33 WTE remains. In response, the Executive Management Board has approved demand management measures to maintain safety across both sites. These include reducing births at the Chelsea site by 509 (from 700 annual bookings) and at the West Middlesex site by 336 (from 400 annual bookings), enabling alignment with the revised staffing ratios. The service implemented the demand management initiative from 6th October 2025, with a reduction in AN activity starting from December 2025 and births in late Spring 2026. Bookings on both sites saw a decrease in December, but an increase in January was noted.

The maternity team is currently reviewing all incoming and outgoing referrals within North West London and have implemented a tiered triage process to ensure equitable access. Collaborative planning has begun with neighbouring hospitals expected to see increased activity due to these changes. Importantly, women with high-risk pregnancies or those who book later in pregnancy will not be disadvantaged by the demand management strategy.

Red flags and Birthrate Plus Compliance: All red flag events are monitored by the senior team to ensure appropriate escalation are followed and where there are delays to patient care, these are followed through with matron input.

West Middlesex Site

- **Labour Ward:** Compliance remained stable at 81% from 83% in December, with 15 red flags reported (an increase – 6 in December)
 - Delayed or cancelled time critical activity (n=3)
 - Delay in providing pain relief (n=3)
 - Delay between presentation and triage (n=2)
 - Delay between admission for induction and beginning of process (n=4)
 - Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour (n=2)
 - Co-ordinator unable to maintain supernumerary status-NOT providing 1:1 care in labour (n=1)
- **Birth Centre:** Compliance decreased to 55% from 67% in December with 3 red flags reported (an decrease – 6 in December)
 - No additional support MW available (No second MW for birth) (n=3)
- **Antenatal Ward:** Compliance remained stable at 82% from 82% in December with 30 red flags reported (an increase – 24 in December)
 - Delayed or cancelled time critical activity (n=2)
 - Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) (n=1)
 - Delay in providing pain relief (n=5)
 - Full clinical examination not carried out when presenting in labour (n=2)
 - Delay between admission for induction and start of process (n=17)
 - Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a women during established labour (n=3)
- **Postnatal Ward:** Compliance decreased to 85% from 94% in December with **6 red flags** reported (**an increase - 4 in December**)
 - Delayed or cancelled time critical activity (n=2)
 - Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) (n=2)
 - Delay between admission for induction and start of process (n=2)

Chelsea and Westminster Site

- **Labour Ward:** Compliance increased to 78% from 75% in December, with 5 red flags reported (**an increase – 1 in December**)
 - Delayed or cancelled time critical activity (n=3)
 - Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) (n=1)
 - Co-ordinator unable to maintain supernumerary status-NOT providing 1:1 care in labour (n=1)
- **Birth Centre:** Compliance increased to 65% from **53% in December** with **12 red flags reported (an increase - 2 in December)**
 - Delayed or cancelled time critical activity (n=1)
 - Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) (n=2)
 - Delay in providing pain relief (n=1)
 - Delay between presentation and triage (n=1)
 - Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour (n=4)
 - No additional support MW available (No second MW for birth) (n=3)
- **Simpson Unit (Recovery & HDU):** Compliance remained stable at 74% from 74% **in December**, with **2 red flags** reported (stable - 2 in December)
 - Delayed or cancelled time critical activity (n=2)
- **Antenatal Ward:** Compliance remained stable at 65% from **66% in December**, with 3 red flags reported (a decrease - 4 in December)
 - Delay between admission for induction and beginning of process (n=2)
 - Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman in established labour (n=1)
- **Postnatal Ward:** Compliance increased to 85% from 78% in December, with 6 red flags reported (an increase – 1 in December)
 - Delayed or cancelled time critical activity (n=4)
 - Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) (n=1)
 - Delay in providing pain relief (n=1)

Summary: Compliance decreased somewhat on the WMUH site, with the lowest rates of compliance being seen on the Birth Centre. Red flag incidents increased across all clinical areas (except the Birth centre) in January, with a significant increase seen on the Antenatal ward which has been referred to the area Matron to investigate further. Datix incidents have not been found to match the red flags raised via Birthrate Plus. A significant increase in red flag reporting was also seen on labour ward.

Compliance on the CW site showed improvement across the majority of clinical areas, with the lowest rates of compliance being seen on the Birth Centre and Antenatal Ward. Red flags saw a small increase however numbers remain overall low.

As compliance is not yet seen to regularly meet upper thresholds in all clinical areas, confidence in accuracy of data is impacted. Trajectories across both sites show positive improvements are being made towards the accurate completion of the acuity tool with the goal of consistently meeting the 80% minimum recommended compliance. An annual overview of Birthrate+ activity was at the monthly cross site Quality & Safety meeting with a plan for the year ahead discussed amongst teams.



Neonatal Staffing: The neonatal leadership team continue to strengthen the local QIS programme to optimise skill mix. At the Chelsea site, QIS compliance improved from 42% In December to 57% in January. Further improvements are expected in Spring 2026, when 7 nurses complete their consolidation of practice in ITU. Recruitment under Phase 1 and 2 of the neonatal business case has been completed, increasing establishment by 16 WTE above budgeted levels, reinforcing the Trust's commitment to achieving BAPM compliance. WMUH rates remained stable at 56%, which is mainly due to QIS dilution secondary to increase in total number of staff for the LNU re-designation. There is a plan in place to send a large cohort to QIS program in February 2026, which will boost QIS rate just in time for the expansion.

Both sites remain compliant with 98 hours of dedicated consultant labour ward presence and twice-daily ward rounds. As part of MIS Year 7, Safety Action 4, the service continues to demonstrate an effective clinical workforce in line with the RCOG 'Roles and Responsibilities of the Consultant' framework. Since February 2023, all short-term locums (<2 weeks) have been required to meet RCOG and GMC certification compliance, with details reported in the Quarterly Maternity and Neonatal Staffing Report.

At WMUH, additional paediatric locum cover is being utilised to maintain BAPM standards for a Level 2 unit. The Trust has now received ICB approval to progress with re-designating the SCBU to a Level 2 Local Neonatal Unit (LNU). Task-and-finish groups have been established to oversee project delivery, supported by guidance from a neighbouring Trust that has recently completed a successful SCBU-to-LNU transition. In October 2025, the BAPM guidance changed requiring more dedicated Tier 2 cover and Consultant cover than what is planned for in the Level 2 business case. We have a separate work stream to work towards the updated BAPM guidance.

Safety:

WM site: There were 2 patient safety incidents:

1. IIR – IUD at 30/40 – escalated for review - MDT
2. IIR – IUD at 38/40 - escalated for review – MDT
3. IIR – IUD at 40/40 – for local investigation only

Datix reporting system: There were 113 Datix incidents reported (a decrease – 123 in December)

- 16 Access to care/admissions
- 10 Staffing issues
- 10 Communication

Incidents not yet closed over 3 months old x226 (an increase from December) – the majority assigned to Obstetric Consultants. An action plan to address is in place to address this.

CWH site: There was 7 patient safety incident:

1. IIR – Maternal cardiac arrest & ITU admission – under review
2. IIR – 4th degree tear – for local investigation only
3. IIR – IUD at 32/40 – under review
4. IIR – Neonatal collapse and NICU admission – under review
5. IIR – Delay in diagnosis of PET – under review
6. IIR – Maternal ITU admission (seizure) – for local investigation only
7. IIR – Return to theatre – under review

Datix reporting system: There were 105 Datix incidents reported (a decrease – 108 in November)

- There were 130 Datix incidents reported (an increase – 105 in December)
- 16 Delay/failure in access to care/hospital
- 15 Shortage of staff
- 10 MOH

Incidents not yet closed over 3 months old x16 (an increase from December)



Neonatal Service:

Number of Datix: 48 (26 CW + 12 WM) – Down from 69 in December.

1. **PMRT (Cross site):** CW site reported 4 cases (NND 9 days of life – born 25+2 at Whipps Cross, IUD at 32+0, late loss @ 22+5 and late loss at 23+1,). WMUH reported 3 cases (IUD @ 40+0, IUD @ 38+4, and IUD @ 30+1).
2. **ATAIN (Cross site):** WMUH site reported 17 term admissions, however the term admission rate has not yet been reported for January. CW site reported 16 term admissions, with an avoidable term admission rate of 0% (4 cases identified care issues however these were not relevant to the NICU admission).
3. **Audit program:** All national and local audits have been registered and a cycle of audit and leads have been identified. An interactive audit database has been developed that provides all staff members with access to live audit data on all current programmes of work. Previous audit results/presentations will also be available in the archive.
4. **Saving Babies Lives Care Bundle v.3.2:** At the close of Q3, the service self-assessed as compliant with 96% of interventions within the care bundle. The ICB has assessed the service as compliant with 100% of interventions, and this assessment has formed part of the evidence submission for MIS SA6. The service awaits an update from the ICB on the expectations going into 2026-2027. Ongoing action plans are in place to address the areas of challenge within element 1 (smoking cessation) and element 5 (preterm birth prevention and optimisation).

Perinatal Quality Surveillance Model



Chelsea and Westminster Hospital
NHS Foundation Trust

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance				
		Nov-25	Dec-25	Jan-26	2025-2026	Nov-25	Dec-25	Jan-26	2025-2026	Nov-25	Dec-25	Jan-26	2025-2026 Q4	2025-2026
Perinatal Quality	Training compliance for all staff groups in maternity related to the core competency framework (Target: >90%)	97.0%	93.0%	93.0%	91.6%	97.0%	94.0%	92.0%	92.4%	97.0%	93.5%	92.5%	92.5%	92.0%
	Training compliance for all staff groups in maternity related to fetal monitoring (Target: >90%)	98.0%	95.0%	94.0%	94.0%	95.0%	93.0%	95.0%	94.0%	96.5%	94.0%	94.5%	94.5%	94.0%
	Service User Feedback FFT	87.8%	83.8%	88.0%	88.2%	86.0%	89.8%	83.7%	87.0%	87.0%	86.2%	86.0%	86.0%	87.6%
	Staff Feedback from board safety champion	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	9	0	0	0	0	9
	Progress in achievements of NHSR MIS (10 safety actions) Green									9	9	10	10	74
	Progress in achievements of NHSR MIS (10 safety actions) Amber									1	1	0	0	11.5
	Progress in achievements of NHSR MIS (10 safety actions) Red									0	0	0	0	10
	Ockenden compliance against 7 IEA's (49 compliance questions) (Total of 49 being 100%)									100.0%	100.0%	100.0%	100.0%	100.0%

Annual Reports	
Staff survey: Proportion of midwives responding with 'Agree or Strongly Agree' on the following: A) would recommend their trust as a place to work B) Receive treatment from the Trust (Reported Annually)	A) (Trust average 71.3%) Midwives WMUH 80.85%, CW 79.29%. B) (Trust average 72%) Midwives 83% WMUH 80.85%, CW 84.17%.
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported Annually)	A) (Trust average 71.3%) Obstetricians WMUH 71.43%, CW 66.67%. B) (Trust average 77.6%) Obstetricians WMUH 85.71%. CW 81.48%.
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported Annually)	2023 Cross-site 93.55% (WMUH 93.01%, CW 94.20%) of trainees reported excellent or good (increased from 90.54% in 2022)

Perinatal Quality Surveillance Model



NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

Perinatal Quality Surveillance Model:

Chelsea and West Middlesex are not on the national maternity safety support programme as there are no concerns regarding the quality and safety of the maternity service.

Multi-professional mandatory training and fetal monitoring training: In December, overall multi-disciplinary training compliance decreased slightly to 92% (WM) and 93% (CW). Fetal monitoring training continues to exceed the 90% compliance target, at 95% (WM) and 94% (CW). All newly appointed staff have been scheduled to attend mandatory training within the next three months. While training compliance naturally varies depending on individual staff training cycles, the Practice Development and Fetal Monitoring teams have a clear, structured plan to ensure all staff complete both training components within a rolling 12-month period.

The training needs analysis is aligned with the Core Competency Framework, and the new training year has commenced with revised content. This includes the introduction of 'Trauma-Informed Care' as a key component. Cultural safety training, which formed part of last year's curriculum, remains embedded within the current programme, reflecting the department's ongoing commitment to fostering diversity, inclusion, and culturally responsive care for both staff and service users.

Service user feedback: The maternity service collects monthly feedback via the Friends and Family Test (FFT). At the Chelsea site, positive feedback increased from 83% in December to 88% in January. Respondents were predominantly White British (35%), White Other (26%), and Asian-Asian British (9%), with most aged 35–44 years (54%) and 85% English-speaking. The lowest-scoring area remained whether concerns were taken seriously (73%) showing an improvement from December. In contrast 98% reported that they were treated with respect and dignity.

At the West Middlesex site, positive feedback decreased slightly from 89% in December to 83% in December. Respondents were predominantly Asian/Asian British (47%), White British (29%), and White Other/Other (19%), with most aged 25–34 years (62%). Lowest scores remained consistently related to concerns being taken seriously (74%). In contrast 95% reported that they were spoken to in a way they could understand.

Across both sites, recurring negative themes focus on staff attitude and behaviour, communication, discharge processes and delays in care (mainly induction of labour and caesarean section). At Chelsea, environmental issues such as temperature, space, and meals were also highlighted. These findings identify clear priorities for service improvement which are captured in the services patient experience action plan.

Board safety Champion feedback: The Deputy Chief Nurse, Chief Nurse and Non-executive Director as our board safety champions undertake rotating a monthly walkabout on both sites in the maternity and neonatal services. This feedback is captured on a survey and feedback to the maternity service safety champions. Site safety visits enable opportunity for the safety champions to meet the wider team and talk to our women and birthing people as they use our maternity and neonatal services. This feedback and improvements in the service are discussed at the 6 weekly board and maternity safety champion meetings. All maternity updates and reports are shared specifically reviewing quality, outcomes and patient experience. On-going scrutiny continues in relation to addressing health inequalities that we know are specific to patient demographic and those living in the lowest indices of deprivation.

Maternity (Perinatal) incentive Scheme year 7: MIS Year 7, Version 1.0, published on 2 April 2025 has now concluded its reporting period. The service has submitted a broad portfolio of evidence to the ICB for verification and is reporting 100% compliance with all 10 safety actions. Action plans remain in place regarding neonatal staffing. The service awaits publication of MIS Year 8, which is expected to launch on the 20th April 2026.

Interim Ockenden report (7 IEAs): The interim Ockenden was published in December 2020, and the service is fully compliant with all of the recommendations within the report.

Single Delivery Plan: The Single Delivery Plan (SDP) for maternity and neonates guides safer, more personalised, and equitable care. It aligns national priorities such as *Ockenden*, *Better Births*, and *Saving Babies' Lives* with local improvements in safety, digital innovation, workforce resilience, and health inequalities. The service is currently compliant with 30 actions and partially compliant with 13. The Trust's focus is on continuity of care, staff wellbeing, and patient experience to achieve consistently excellent outcomes for women, birthing people, babies, and families.

CQC Inspection (February 2023): The Care Quality Commission inspection in of the Maternity Service took place in February 2023 on both sites and received the final report in May 2023. Both sites have maintained their overall ratings of 'Outstanding' at WM and 'Good' at CW and the service is very proud of the continued quality and safety work that has taken place since the inspection 4 years earlier that has enabled maintaining these results with 6 areas of outstanding practice identified across the sites. The service is now compliant all must-do and should-do actions. The CQC have recently published 16 maternity recommendations, of which 7 are specifically relevant to all NHS maternity Trusts. A benchmarking piece has been undertaken to review our compliance and to demonstrate we are able to meet these standards, and as such we do not have any concerns in our ability to do so. Work is underway across both units in anticipation of a repeat inspection imminently.



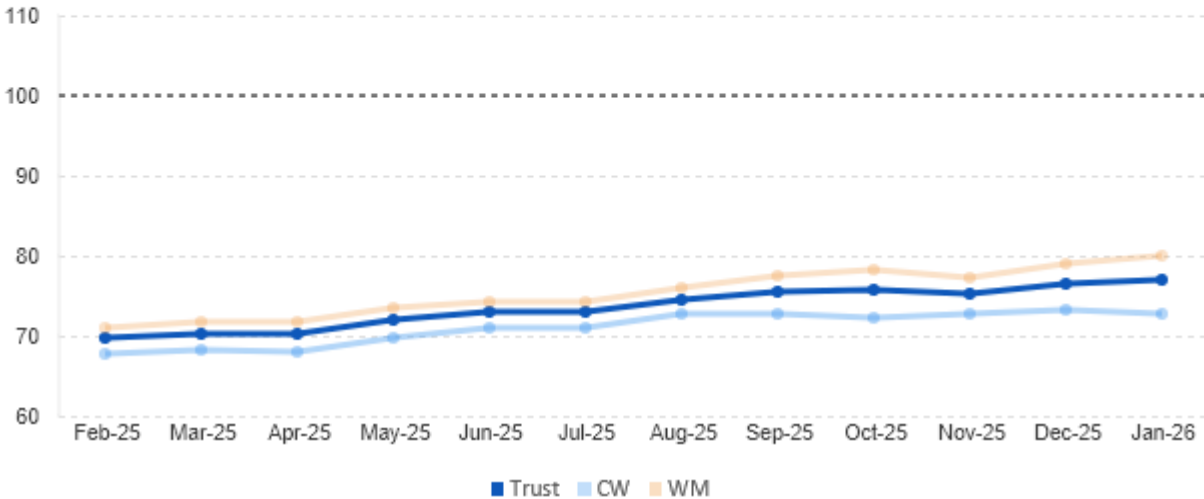
Mortality

Summary Hospital-level Mortality Index

Effective

Trend

Summary Hospital-level Mortality Index



Narrative

Seasonal variation noted in mortality which remains below expected mortality. Similar variation noted last winter. A deep dive into slightly higher crude mortality has been completed with a triangulated view from departmental mortality reviews and the Medical Examiners office. No concerns identified.

In-Month Performance

	Summary Hospital-level Mortality Index	Hospital Standardised Mortality Ratio
CW	72.8	67.0
WM	80.1	85.0
Trust	77.0	77.4

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
SHMI (Target: <100)	CW	72.8	72.3	72.8	73.3	72.8	71.6
	WM	77.5	78.2	77.1	78.9	80.1	76.1
	Trust	75.5	75.7	75.3	76.5	77.0	74.2
HSMR (Target: <100)	CW	78.4	68.2	69.5	69.1	67.0	73.7
	WM	84.3	83.7	82.3	83.9	85.0	84.1
	Trust	80.6	77.3	76.9	77.6	77.4	78.9



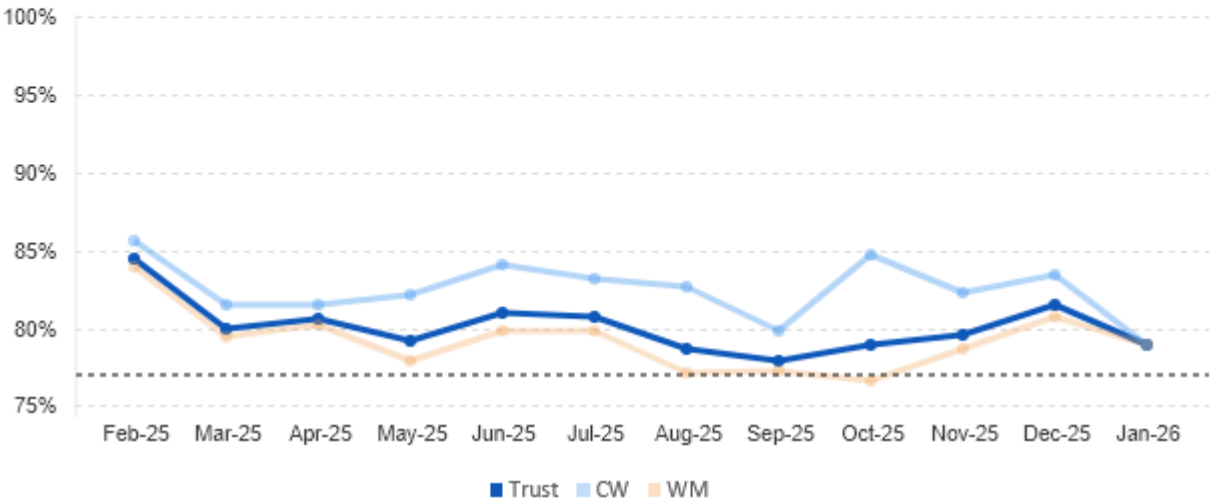
Patient Access

Access to Cancer Care (Diagnosis)

Responsive – Operating Plan

Trend

28 Day Faster Diagnosis Standard



Narrative

The Trust continues to meet the National KPI for 28 Day FDS in December 2025 at 81.4%(validated) and continues its strong performance in January 2026 at 78.9% unvalidated.

The Sarcoma service is particularly challenged and non-compliant in FDS due to continued referral demand from wider London sectors as well as outside London. This has been compounded by diagnostic challenges. Discussions are ongoing with NHS England and Royal Marsden Partners to support.

Improvement has been seen in our Haematology and Lung pathways. Head & Neck and Urology remain challenged, with continuing work within these services to improve performance.

2 week wait pathways continue to remain above the national compliance metrics with performance seeing an improvement coming out of December 2025.

In-Month Performance

	28 Days Faster Diagnosis Standard	2 Weeks from Referral to First Seen (All Urgent Referrals)
CW	78.9%	96.3%
WM	78.9%	94.8%
Trust	78.9%	95.4%

Year-to-Date Performance

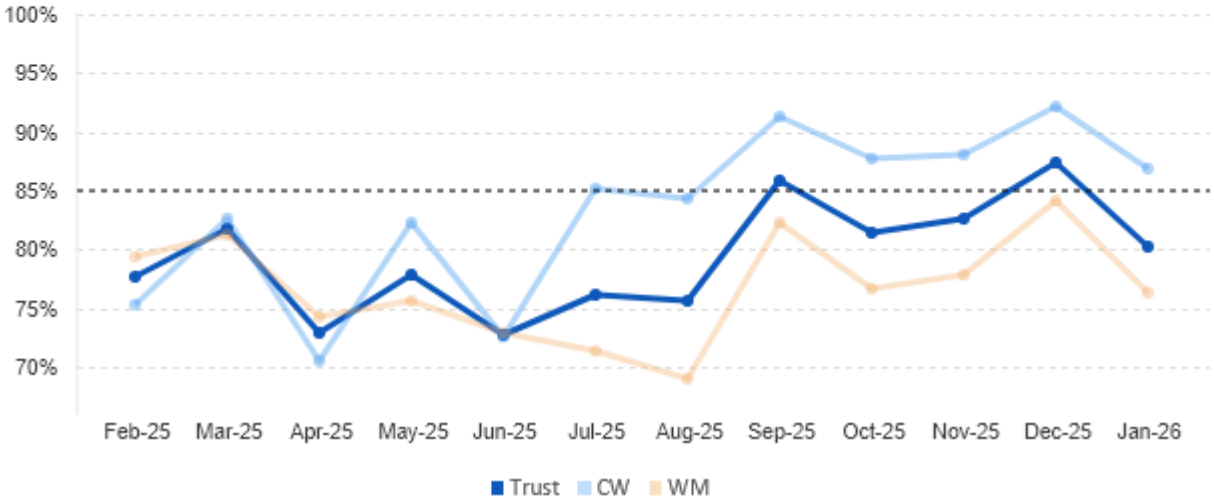
	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
28 Day Faster Diagnosis Standard (Target: >=77%)	CW	79.8%	84.7%	82.3%	83.4%	78.9%	82.2%
	WM	77.2%	76.6%	78.6%	80.7%	78.9%	78.7%
	Trust	77.9%	78.9%	79.6%	81.4%	78.9%	79.7%
2 Weeks from Referral to First Seen (All Urgent Referrals) (Target: >=96%)	CW	97.3%	95.1%	93.4%	93.4%	96.3%	94.5%
	WM	95.9%	94.3%	96.0%	96.5%	94.8%	96.0%
	Trust	96.5%	94.7%	94.9%	95.1%	95.4%	95.4%

Access to Cancer Care (Treatment)

Responsive – Operating Plan

Trend

62 Day GP Referral to First Treatment Combined



Narrative

The Trust continues to see an overall strong 62-Day Combined performance, with the validated performance for December 2025 meeting the National KPI compliance of 87.4% uploaded position. This position is within January 2026 is slightly lower but still maintaining over 80% with a current unvalidated performance of 80.2%.

The West Middlesex site continues to be more challenged within several services coming into January 2026 with Head and Neck and Colorectal have a more challenged month. This is a mix of complexity and ITR transfers. Breast Performance is improving for February and there are clear plans from the service in place, and Urology, whilst not within compliance, is retaining a higher level of performance, sitting at a collective 72% cross site.

The Trusts 31D position remains strong and above the National KPIs of 96% with a validated December 2025 position of 99.4% and an unvalidated position for January 2026 being 100%.

In-Month Performance

	62 Day GP Referral to First Treatment Combined	31 Day Diagnosis to First or Subsequent Treatment	62+ Day Backlog (Target: 100)
CW	86.9%	100.0%	
WM	76.2%	100.0%	
Trust	80.2%	100.0%	98

Year-to-Date Performance

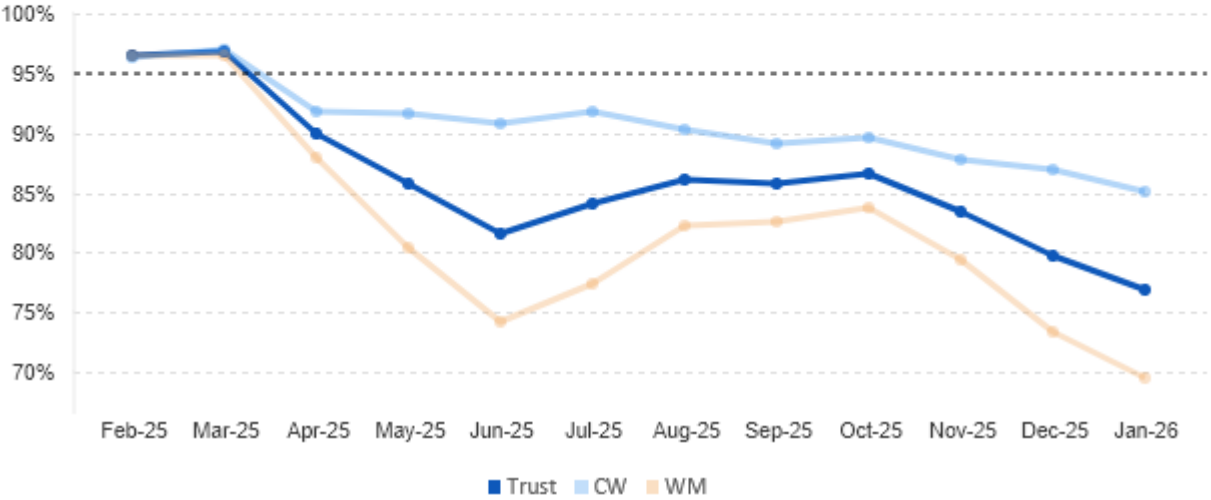
	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
62 Day GP Referral to First Treatment Combined (Target: >=85%)	CW	91.2%	87.8%	88.1%	92.2%	86.9%	84.4%
	WM	82.3%	76.7%	77.8%	84.2%	76.2%	76.1%
	Trust	85.8%	81.4%	82.5%	87.4%	80.2%	79.5%
31 Day Diagnosis to First or Subsequent Treatment (Target: >=96%)	CW	97.4%	97.4%	98.7%	100.0%	100.0%	98.2%
	WM	97.3%	97.2%	98.9%	99.0%	100.0%	98.8%
	Trust	97.4%	97.3%	98.8%	99.4%	100.0%	98.6%
62+ Day Backlog (Target: 100)	CW						
	WM						
	Trust	109	110	75	107	98	98

Access to Diagnostics

Responsive – Operating Plan

Trend

Diagnostic Waiting Times < 6 Weeks



Narrative

DM01 performance declined in January. While some improvement actions have started, the impact has not yet materialised. WM site remains the most challenged site, driven by challenges in Echocardiography, Endoscopy and CT which has seen increased demand from the Emergency Department. Improvement actions including increasing capacity remain in place.

In-Month Performance

	Diagnostic Waiting Times < 6 Weeks	Diagnostic Waiting Times > 6 Weeks: Actuals	Diagnostic Waiters 13+ Weeks
CW	85.1%	1,091	0
WM	69.5%	2,545	0
Trust	76.8%	3,636	0

Year-to-Date Performance

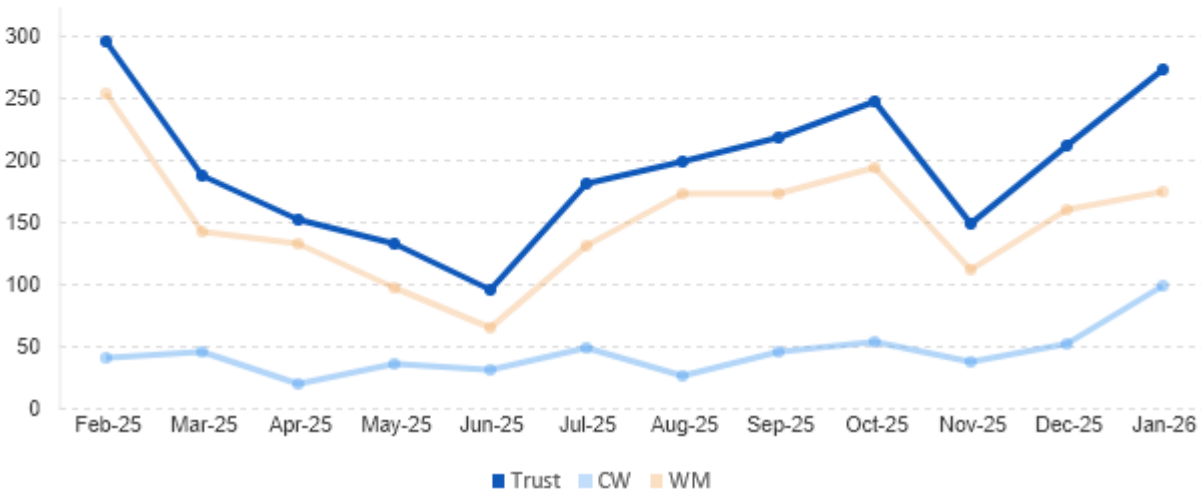
	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Diagnostic Waiting Times < 6 Weeks (Target: >95%)	CW	89.1%	89.7%	87.7%	86.9%	85.1%	89.3%
	WM	82.6%	83.7%	79.4%	73.3%	69.5%	78.5%
	Trust	85.8%	86.6%	83.4%	79.8%	76.8%	83.7%
Diagnostic Waiting Times > 6 Weeks: Actuals	CW	633	658	757	811	1,091	1,091
	WM	1,022	1,072	1,329	1,807	2,545	2,545
	Trust	1,655	1,730	2,086	2,618	3,636	3,636
Diagnostic Waiters 13+ Weeks	CW	0	0	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	0	0

Ambulance Handover Waits

Safe

Trend

LAS Handover 30 Mins



Narrative

Performance

The Trust's overall performance for ambulance handovers remains strong. In the month of January 2026, the Trust reported three 60-minute LAS handover delays. This is a decrease from the previous month of six 60-minute breaches. The 15-minute handover was non-compliant across both sites but there has been an improvement from last month. The Trust is working towards reducing the number of breaches against this target.

Improvement

The focus is on reducing the length of stay through the departments for all patients on arrival. There are a number of schemes being managed through the ED Improvement program.

Risk

Cubicle capacity in the department.

In-Month Performance

	LAS 15 Min Breach Performance	LAS Time Lost (Hours)	LAS Handovers 30 Mins	LAS Handovers 60 Mins
CW	886	116.6	99	1
WM	1,141	166.1	174	2
Trust	2,027	282.7	273	3

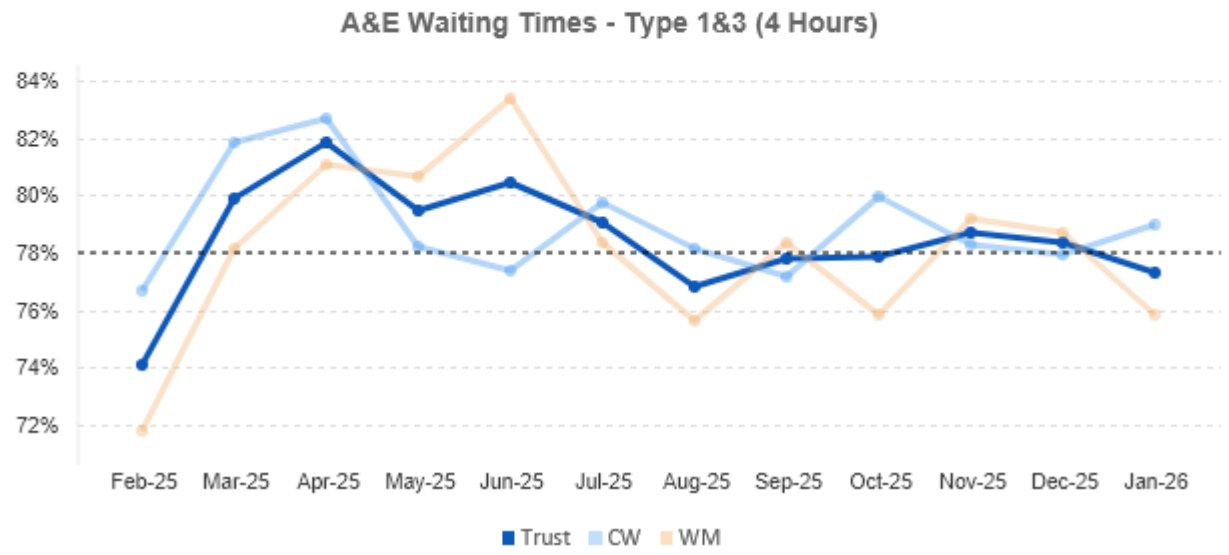
Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
LAS 15 Min Breach Performance	CW	764	758	704	793	886	7,606
	WM	993	1,078	969	1,055	1,141	9,670
	Trust	1,757	1,836	1,673	1,848	2,027	17,276
LAS Time Lost (Hrs)	CW	79.8	80.4	73.2	96.9	116.6	809.0
	WM	154.1	165.3	124.2	152.9	166.1	1,361.8
	Trust	233.9	245.7	197.4	249.8	282.7	2,170.8
LAS Handovers 30 Mins	CW	45	53	37	51	99	446
	WM	172	193	111	160	174	1,407
	Trust	217	246	148	211	273	1,853
LAS Handovers 60 Mins	CW	0	0	0	6	1	8
	WM	4	3	2	1	2	18
	Trust	4	3	2	7	3	26

Urgent & Emergency Department Waits

Safe/Responsive – Operating Plan

Trend



Narrative

Performance
Performance against the 4-hour standard in January 2025 was 77.3%. West Middlesex achieved 75.8% with 14,527 attendances and the Chelsea site 79% with 13,094 attendances.

The 12-hour performance is 3.5% against our operating plan trajectory target of 2.8%.

Improvement
There has been an ongoing focus on A&E time to triage. in January West Middlesex achieved an average time to triage of 6 minutes and at the Chelsea site 15 minutes.

Risk
Increased mental health presentation (MH) and long length of stay patients who have a decision to admit(DTA).

In-Month Performance

	A&E Waiting Times Type 1&3 (4 Hrs)	A&E Waiting Times Type 1&3 (12 Hrs)	A&E Time to Triage	Total Attendances Type 1&3	Referrals to SDEC	12hr Trolley Waits
CW	79.0%	3.2%	00:15	13,092	816	37
WM	75.8%	3.8%	00:06	14,525	896	17
Trust	77.3%	3.5%	00:10	27,617	1,712	54

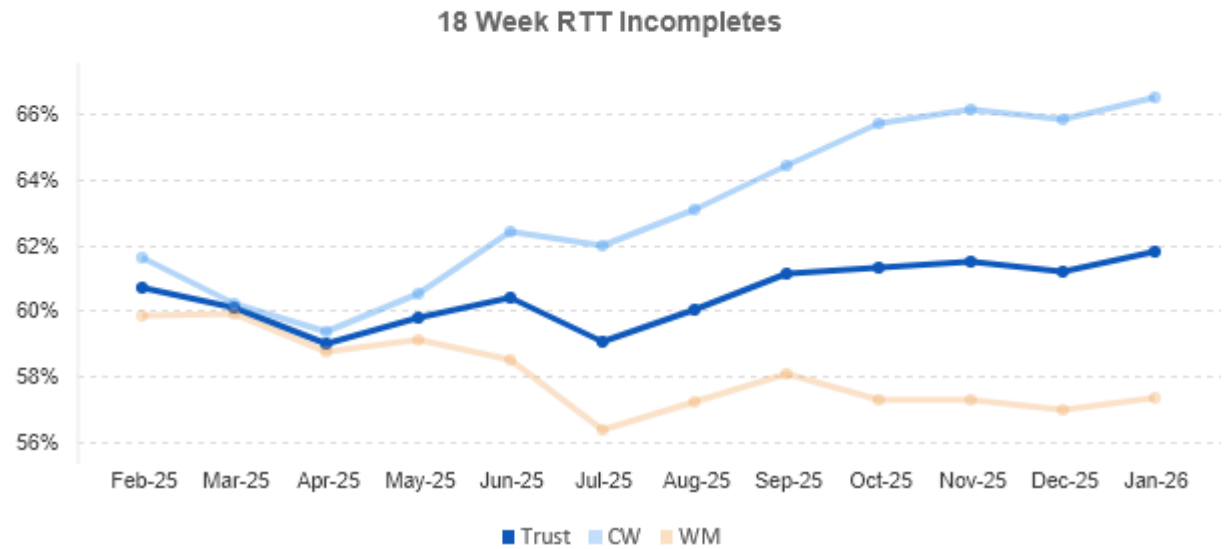
Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
A&E Waiting Times Type 1&3 (4 Hrs) Target: >78%)	CW	77.1%	80.0%	78.3%	77.9%	79.0%	78.8%
	WM	78.4%	75.8%	79.2%	78.7%	75.8%	78.7%
	Trust	77.8%	77.8%	78.7%	78.3%	77.3%	78.8%
A&E Waiting Times Type 1&3 (12 Hrs) (Target: <2.8%)	CW	2.8%	2.3%	1.9%	2.0%	3.2%	2.0%
	WM	2.8%	3.2%	1.7%	2.7%	3.8%	2.5%
	Trust	2.8%	2.8%	1.8%	2.4%	3.5%	2.2%
A&E Time to Triage (Target: 15mins)	CW	00:16	00:16	00:16	00:15	00:15	00:15
	WM	00:07	00:07	00:06	00:06	00:06	00:07
	Trust	00:11	00:11	00:11	00:10	00:10	00:11
Total Attendances Type 1&3	CW	12,814	13,347	13,440	12,674	13,092	128,692
	WM	13,453	14,077	14,064	14,645	14,525	138,302
	Trust	26,267	27,424	27,504	27,319	27,617	266,994
Referrals to SDEC (Target as Per Op Plan)	CW	784	827	703	770	816	7,420
	WM	898	892	767	839	896	8,923
	Trust	1,682	1,719	1,470	1,609	1,712	16,343

Referral to Treatment Waits

Responsive – Operating Plan

Trend



Narrative

Performance: Elective Referral to Treatment (RTT) 18-Week Wait performance was reported at 61.78% which whilst a 0.5% improvement on M9 is still behind our trajectory. The month ended with 6 65-week breaches and 1,274 52-week waits. Our January target was 1,300 so this represents an attainment of trajectory.

Enhanced assurance is in place for at-risk areas with routine monitoring of RTT backlogs. A note that ERF cap within the current year's operating plans has led to reduction in activity in H1 and consequently fewer clock-stops.

Improvement : In and outsourcing has increased since December and is now in place for 5 of the most pressured specialties. Over 200 additional clinic/theatre lists ae being undertaken each month and plans for a full month of activity drives are being scaled up for March.

Risk : Potential further Industrial action, reduced capacity and time taken to agree in/outsourcing opportunities.

In-Month Performance

	18 Week RTT Incompletes	18 Week RTT Incompletes Paeds	52 Week RTT Incompletes	52 Week Waiters	65 Week Waiters
CW	66.5%	74.4%	1.4%	495	3
WM	57.4%	51.3%	2.0%	769	3
Trust	61.8%	62.8%	1.7%	1,264	6

Year-to-Date Performance

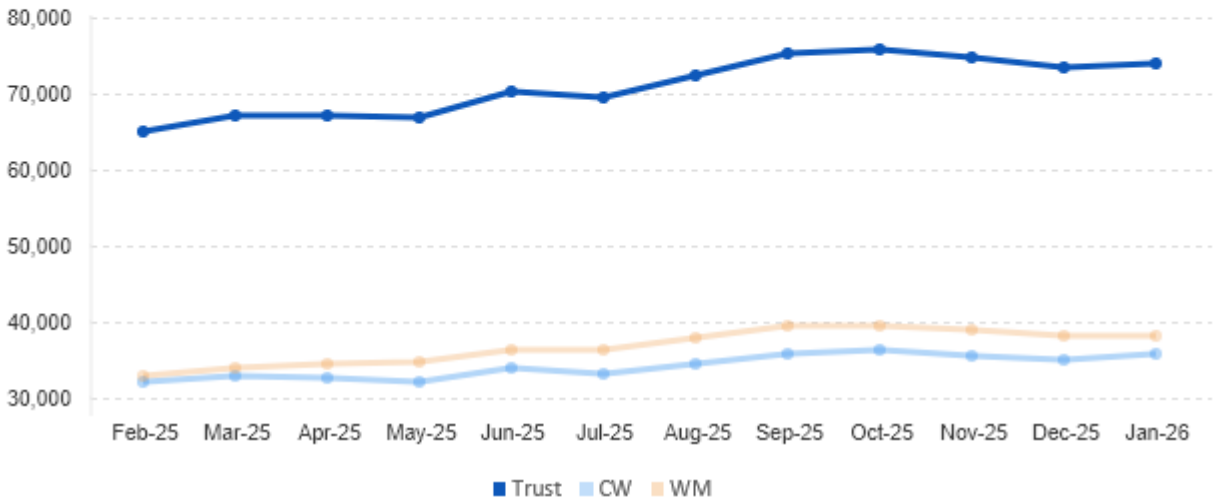
	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
18 Week RTT Incompletes (Target: >60%)	CW	64.4%	65.7%	66.1%	65.8%	66.5%	66.5%
	WM	58.1%	57.3%	57.3%	57.0%	57.4%	57.4%
	Trust	61.1%	61.3%	61.5%	61.2%	61.8%	61.8%
18 Week RTT Incompletes Paeds	CW	70.6%	69.4%	71.0%	71.6%	74.4%	74.4%
	WM	45.0%	43.7%	45.6%	48.4%	51.3%	51.3%
	Trust	56.9%	56.0%	57.8%	59.5%	62.8%	62.8%
52 Week RTT Incompletes (Target: <1%)	CW	2.0%	1.8%	1.8%	1.5%	1.4%	1.4%
	WM	2.6%	2.5%	2.4%	2.1%	2.0%	2.0%
	Trust	2.3%	2.2%	2.1%	1.8%	1.7%	1.7%
52 Week Waiters	CW	700	666	637	524	495	495
	WM	1,045	1,003	928	797	769	769
	Trust	1,745	1,669	1,565	1,321	1,264	1,264
65 Week Waiters	CW	29	34	29	9	3	3
	WM	33	47	31	11	3	3
	Trust	62	81	60	20	6	6

Referral to Treatment Waits

Responsive – Operating Plan

Trend

Total Waiting List (PTL)



Narrative

Performance: In Month 10 the total RTT Patient Treatment List (PTL) was reported as 74,145. The focus remains on ensuring fewer patients are awaiting first appointments and continually addressing chronological booking for the backlog cohorts as enhanced oversight and targeted interventions continue for at-risk specialities. Operating lists are booked on clinical urgency and in chronological order.

Improvement : The Trust continues to contact patients via routine administrative validation leveraging digital technologies to engage with patients and confirm the identification of those requiring treatment. Capacity drive across surgical and outpatient areas is underway in Q4, focused on prioritising patients in the backlog cohorts. Specialty level monitoring in place with set trajectories to address recovery. These are highlighted in weekly meetings focusing on at-risk specialties. These include Vascular Surgery, Urology, ENT, Paediatrics ENT, Trauma & Orthopaedics, Colorectal Surgery, Plastic Surgery, General Surgery and Paediatric Dermatology.

Risk : Potential further Industrial action, reduced WLI activity and time taken to agree in/outsourcing opportunities

In-Month Performance

	Total Waiting List (PTL)	Total Waiting List (PTL) Paeds	Patients Waiting < 18 Weeks for First Appointment	RTT Clearance Time: Size of Waiting List
CW	35,845	5,465	65.2%	5.9
WM	38,300	5,494	57.4%	6.6
Trust	74,145	10,959	60.9%	6.2

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Total Waiting List (PTL)	CW	35,789	36,369	35,663	35,156	35,845	35,845
	WM	39,501	39,597	39,058	38,243	38,300	38,300
	Trust	75,290	75,966	74,721	73,399	74,145	74,145
Total Waiting List (PTL) Paeds	CW	5,220	5,479	5,430	5,191	5,465	5,465
	WM	6,008	5,966	5,868	5,688	5,494	5,494
	Trust	11,228	11,445	11,298	10,879	10,959	10,959
Patients Waiting < 18 Weeks for First Appointment	CW	65.1%	66.2%	65.1%	63.6%	65.2%	65.2%
	WM	58.4%	57.2%	57.7%	56.0%	57.4%	57.4%
	Trust	61.4%	61.3%	61.0%	59.4%	60.9%	60.9%
RTT Clearance Time: Size of Waiting List	CW	6.1	5.6	5.8	6.2	5.9	5.9
	WM	7.2	6.5	6.9	6.6	6.6	6.6
	Trust	6.7	6.1	6.3	6.4	6.2	6.2



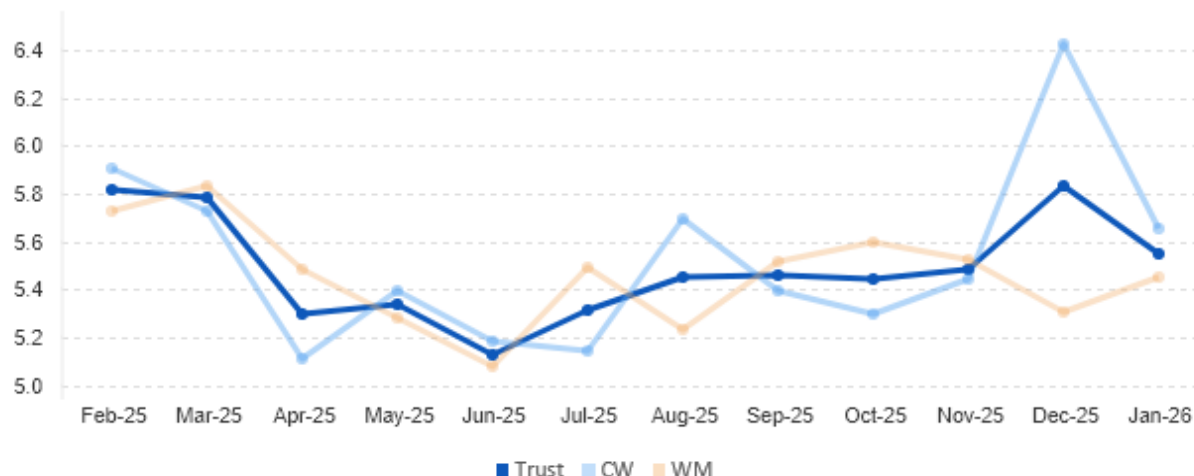
Operating Plan and Capacity

Flow & Discharge – Admitted Care

Responsive/Effective

Trend

Non-Elective LoS



Narrative

Elective LoS is compliant with the standard year to date.

Non-Elective LOS is non-compliant across both sites. In January there was an improvement in the position compared to December. Overall the Non-Elective long stayers for >7days and >21 days have remained static. There is continued focus through No Criteria to Reside, focus on long length of stay patients weekly, Stage 3 escalation meetings with community partners and Trust Flow Board oversight.

Critical Care occupancy continues to track above the recommended 85%,but has decreased from Nov with CWH site at 84.2% and WM at 89.7%. The higher occupancy continues to be linked to delays in stepping patients down to appropriate inpatient beds, with the potential impact of delaying admissions. These two measures continue to be monitored via ICNARC submission and patient safety incidents reports as required. An escalation process for delayed stepdown is now in place.

In-Month Performance

	Elective LoS	Non-Elective LoS	Non-Elective Long Stays (>=7 days)	Non-Elective Long Stays (>=21 Days)	Critical Care Occupancy	Average days between the DRD and DD
CW	2.6	5.7	475	159	99.0%	5.9
WM	1.8	5.4	568	149	101.9%	7.0
Trust	2.4	5.5	1,043	308	100.5%	6.5

Year-to-Date Performance

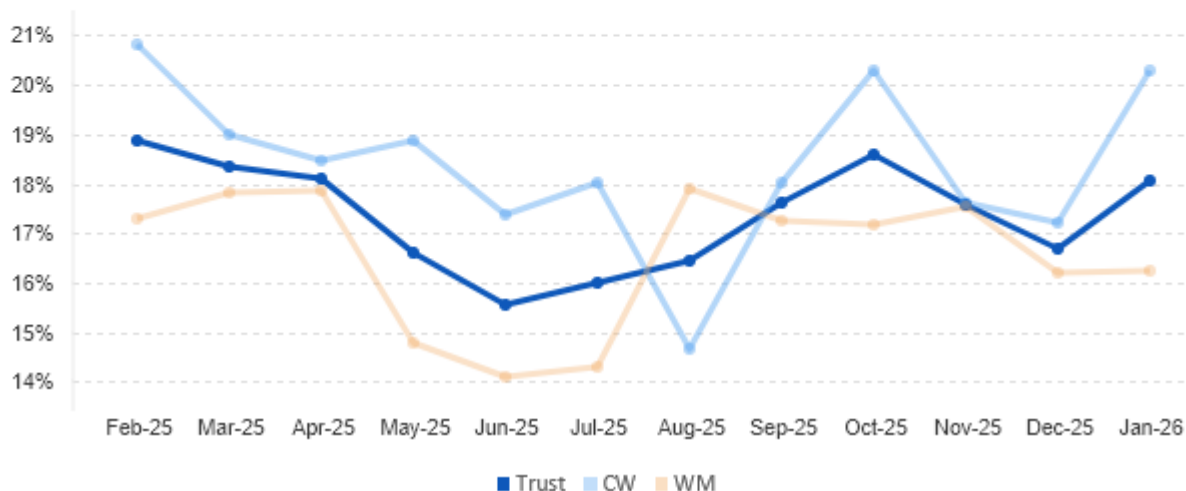
	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Elective LoS (Target: <2.9)	CW	2.7	2.8	2.1	2.8	2.6	2.8
	WM	2.1	2.7	3.0	2.1	1.8	2.4
	Trust	2.5	2.8	2.4	2.6	2.4	2.7
Non-Elective LoS (Target: <3.95)	CW	5.4	5.3	5.4	6.4	5.7	5.5
	WM	5.5	5.6	5.5	5.3	5.4	5.4
	Trust	5.5	5.4	5.5	5.8	5.5	5.4
Non-Elective Long Stays (>=7 days)	CW	471	511	417	515	475	4,539
	WM	560	594	501	572	568	5,383
	Trust	1,031	1,105	918	1,087	1,043	9,922
Non-Elective Long Stays (>=21 Days)	CW	115	131	126	148	159	1,250
	WM	144	144	150	150	149	1,391
	Trust	259	275	276	298	308	2,641
Critical Care Occupancy (Target: <85%)	CW	85.0%	88.7%	96.0%	84.2%	99.0%	84.9%
	WM	111.1%	118.3%	102.3%	89.7%	101.9%	100.9%
	Trust	97.4%	102.7%	99.2%	86.9%	100.5%	92.6%
Average days between the DRD and DD	CW	5.2	8.0	6.5	6.3	5.9	6.5
	WM	6.9	6.8	6.9	7.5	7.0	6.5
	Trust	6.2	7.3	6.7	7.0	6.5	6.5

Flow & Discharge – Discharges

Responsive

Trend

Patient Not Meeting CTR by Trust of Pathway



Narrative

The Trust remains an outlier for the number of patients in hospital who do not meet the criteria to reside in an acute hospital bed. This is predominately driven by patients requiring discharge with a package of care (P1 discharge) or to a nursing home (P3 discharge)

Three times a week escalation meetings are in place with system partners as well as a NWL weekly system GOLD call.

In-Month Performance

	Patients Not Meeting CTR Daily Average	Discharges Before 12	Discharge Date Same as Discharge Ready Date	Discharge Date After Discharge Ready Date	Emergency Re-admissions < 30 Days of Discharge
CW	20.3%	15.8%	87.2%	12.8%	4.6%
WM	16.2%	13.3%	86.4%	13.6%	4.6%
Trust	18.1%	14.6%	86.8%	13.2%	4.6%

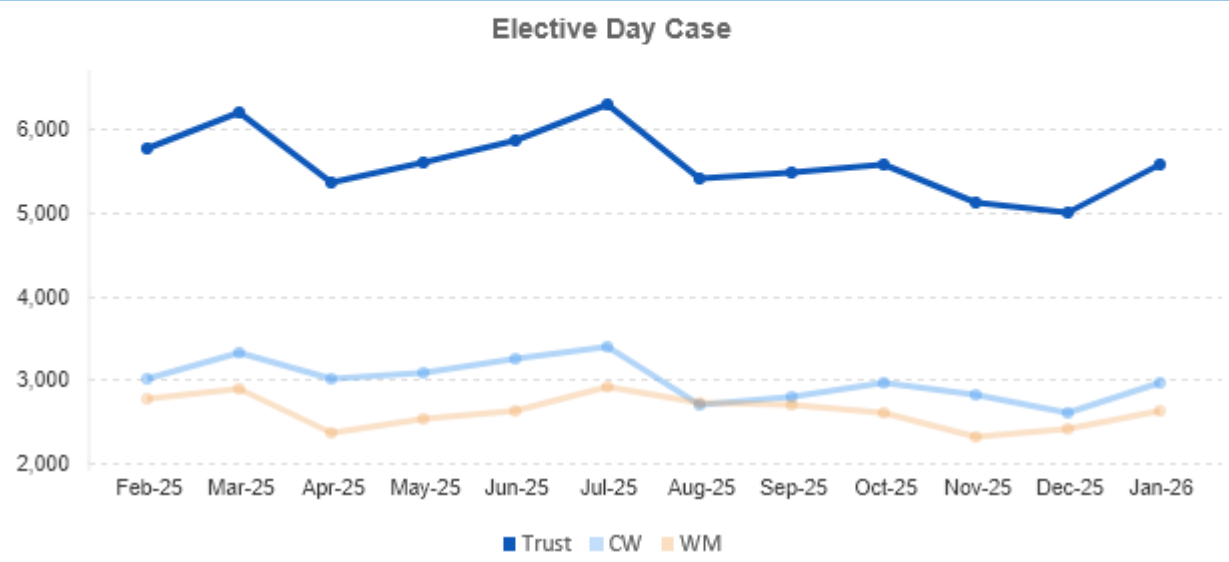
Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Patient Not Meeting CTR Daily Average	CW	18.0%	20.3%	17.6%	17.2%	20.3%	18.1%
	WM	17.2%	17.2%	17.5%	16.2%	16.2%	16.3%
	Trust	17.6%	18.6%	17.6%	16.7%	18.1%	17.1%
Discharges Before 12	CW	14%	16%	15%	14%	16%	14%
	WM	12%	15%	15%	14%	13%	14%
	Trust	13%	15%	15%	14%	15%	14%
Discharge Date Same as Discharge Ready Date	CW	89.0%	88.4%	89.8%	88.0%	87.2%	89.0%
	WM	86.2%	85.9%	85.0%	86.7%	86.4%	86.1%
	Trust	87.6%	87.1%	87.5%	87.3%	86.8%	87.5%
Discharge Date After Discharge Ready Date	CW	11.0%	11.6%	10.2%	12.0%	12.8%	n/a
	WM	13.8%	14.1%	15.0%	13.3%	13.6%	n/a
	Trust	12.4%	12.9%	12.5%	12.7%	13.2%	n/a
Emergency Re-Admissions < 30 Days of Discharge (Target: <7.6%)	CW	4.6%	4.1%	5.3%	5.4%	4.6%	4.9%
	WM	5.8%	6.5%	6.6%	5.9%	4.6%	6.0%
	Trust	5.2%	5.3%	5.9%	5.7%	4.6%	5.4%

Operating Plan Performance

Responsive – Operating Plan

Trend



Narrative

The Trust continues to meet its Operating plans for elective activity despite the planned reduction inactivity in 2025/26 due to the ERF cap.

For outpatients, further work has been undertaken to reduce the level of follow up activity in order to increase capacity for new patients. This includes a review of clinic templates to address this balance.

Risk to achieving plans include Industrial action and ERF cap.

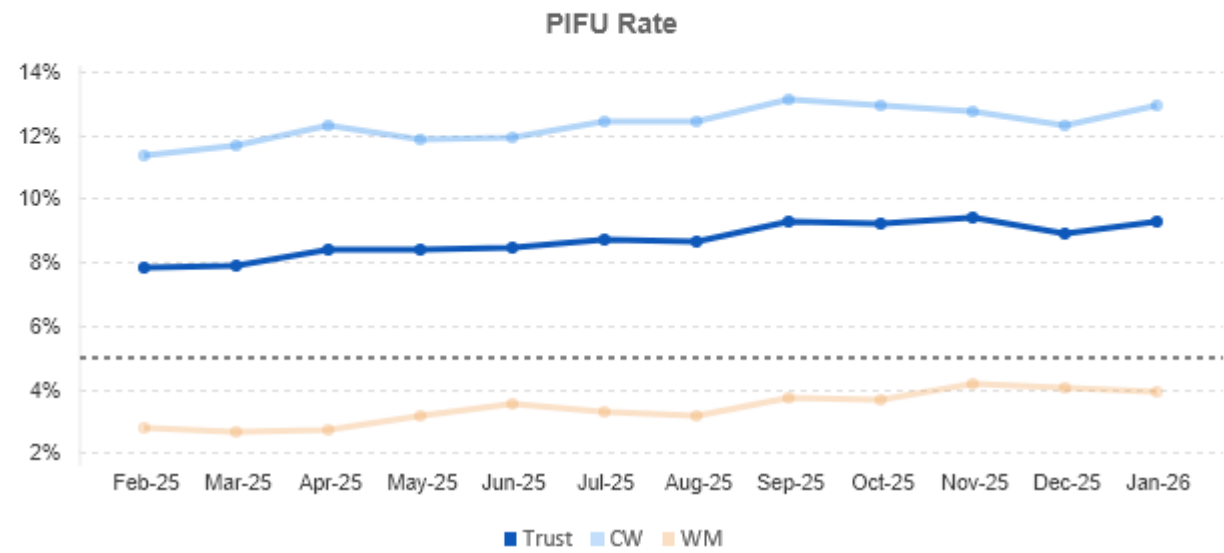
In-Month Performance

	Elective Day Cases	Elective Ordinary Admissions	OP Procedures	OP First Attendance Without Procedure	OP FUp Attendance Without Procedure
CW	2,964	429	5,281	10,990	18,734
WM	2,625	197	3,343	9,205	9,739
Trust	5,589	626	8,624	20,195	28,473

Year-to-Date Performance

	Site	Oct-25	Nov-25	Dec-25	Jan-26	Plan YTD	2025-2026
Elective Day Cases	CW	2,967	2,827	2,611	2,964	28,685	29,599
	WM	2,601	2,304	2,397	2,625	25,982	25,743
	Trust	5,568	5,131	5,008	5,589	54,667	55,342
Elective Ordinary Admissions	CW	464	510	438	429	3,694	4,273
	WM	206	189	193	197	1,452	1,960
	Trust	670	699	631	626	5,146	6,233
OP Procedures	CW	5,608	5,429	4,807	5,281	45,943	52,738
	WM	3,415	3,312	3,246	3,343	29,570	32,533
	Trust	9,023	8,741	8,053	8,624	75,514	85,271
OP First Attendance Without Procedure	CW	11,541	10,244	9,564	10,990	104,952	101,157
	WM	9,380	7,643	8,326	9,205	81,980	83,838
	Trust	20,921	17,887	17,890	20,195	186,932	184,995
OP FUp Attendance Without Procedure	CW	20,347	18,980	17,041	18,734	169,437	182,645
	WM	10,784	9,676	9,526	9,739	119,321	102,054
	Trust	31,131	28,656	26,567	28,473	288,758	284,699

Trend



Narrative

DNA rate improved across both sites for both new and follow up patients in January. We continue to focus on ways to improve DNA rates, including Patient Led Validation, and our volunteers are kindly helping with phone calls in some areas.

Percentage of **PIFU** remained consistent with the previous month. Overall 8.9% remains a competitive performance when compared with our peer Trusts and against the central NHS target. Focus continues on booking unbooked new appointments for long waiters.

The overall **first-to-follow-up ratio** has remained consistent with the previous month.

In-Month Performance

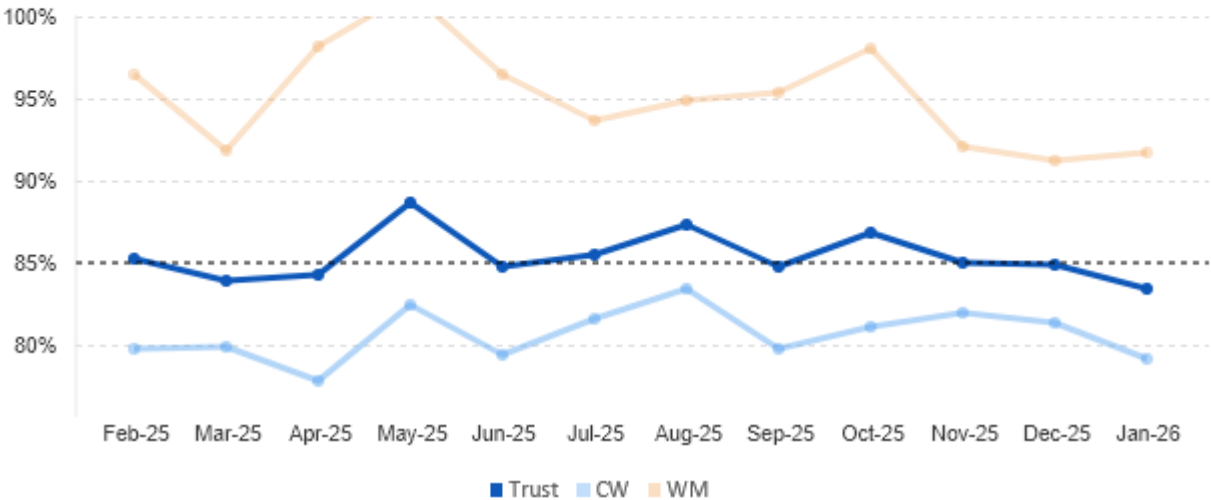
	PIFU Rate	DNA Rates - First Appointment	DNA Rates - Follow Up Appointment	Virtual Contacts
CW	12.9%	11.2%	8.0%	4,184
WM	3.9%	10.1%	7.4%	3,696
Trust	9.3%	10.7%	7.8%	7,880

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
PIFU Rate (Target: 5%)	CW	13.1%	12.9%	12.8%	12.3%	12.9%	12.5%
	WM	3.7%	3.6%	4.1%	4.0%	3.9%	3.5%
	Trust	9.3%	9.2%	9.4%	8.9%	9.3%	8.9%
DNA Rates - First Appointment	CW	11.0%	10.8%	10.8%	11.7%	11.2%	10.9%
	WM	10.5%	11.5%	12.4%	11.0%	10.1%	10.6%
	Trust	10.8%	11.1%	11.5%	11.4%	10.7%	10.8%
DNA Rates - Follow Up Appointment	CW	8.7%	8.2%	8.1%	8.4%	8.0%	8.4%
	WM	6.8%	7.4%	7.3%	7.6%	7.4%	7.2%
	Trust	8.0%	7.9%	7.8%	8.1%	7.8%	8.0%
Virtual Contacts	CW	4,270	4,723	4,208	4,312	4,184	42,330
	WM	3,974	4,227	3,621	3,634	3,696	37,752
	Trust	8,244	8,950	7,829	7,946	7,880	80,082

Trend

Theatre Utilisation (Uncapped)



Narrative

Trust-Wide utilisation decreased slightly in January at 83.4%. There was a small decrease in utilisation on both sites. The WM site remains above the 85% target. Lower utilisation at the CW site continues to be driven by the Day Surgery Unit, and Paediatric theatres. Focused work is being done through the Theatres Improvement Programme, with a focus on consultant productivity data to drive improvement.

Day case rates significantly improved in January at 93.7%. The increase was seen at the CW site which was at 96.9% (up from 84.5%). The WM site remained well above the 85% target.

OTD cancellations were static for January. The on the day cancellation rate remains a focus on improvement work streams and working closely with operational teams to identify capacity to rebook. There were 0x 28 rebook breaches on either site in January.

In-Month Performance

	Basket Procedures Carried Out as Daycases	OTD Non-Clinical Cancellations as % Elective Admissions	OTD Cancellations Not Re-booked < 28 Days	Theatre Utilisation (Uncapped)
CW	91.4%	1.3%	5	79.1%
WM	86.4%	0.9%	0	91.6%
Trust	89.3%	1.1%	5	83.4%

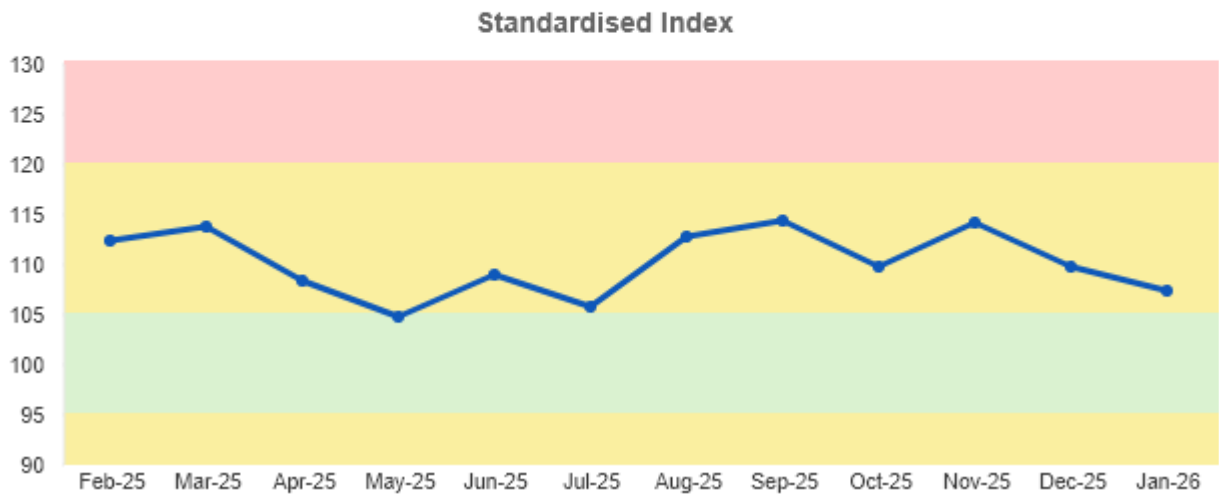
Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Basket Procedures Carried Out as Daycases (Target: >85%)	CW	87.9%	84.3%	85.5%	79.9%	91.4%	85.8%
	WM	88.8%	88.1%	90.1%	91.0%	86.4%	87.2%
	Trust	88.2%	85.6%	86.7%	83.5%	89.3%	86.3%
OTD Non-Clinical Cancellations as % Elective Admissions (Target: <0.8%)	CW	0.8%	0.4%	1.0%	0.7%	1.3%	0.7%
	WM	0.4%	0.6%	0.2%	0.4%	0.9%	0.5%
	Trust	0.6%	0.5%	0.6%	0.6%	1.1%	0.6%
OTD Cancellations Not Re-booked < 28 Days (Target: 0)	CW	1	0	0	5	5	19
	WM	0	1	0	0	0	6
	Trust	1	1	0	5	5	25
Theatre Utilisation (Uncapped) (Target: >85%)	CW	79.7%	81.1%	81.9%	81.2%	79.1%	80.7%
	WM	95.3%	98.0%	92.0%	91.2%	91.6%	95.1%
	Trust	84.8%	86.8%	84.9%	84.8%	83.4%	85.4%

Inequity-RTT Waiting Times

Equality, Diversity and Inclusion

Trend



Narrative

A monthly data pack has been developed by the Trust BI Team which has been ratified through ECB and now then distributed and reviewed monthly at the Elective Access Meeting.

This project is within the development stage.

- Whilst the data that will be used to inform Divisions of their performance has been agreed, no formal trajectories or improvement work streams have yet been set up.
- These trajectories will be set at specialty and Divisional level by the middle of March 2026 and will form part of the outpatient transformation work streams for 2026/27.
- These plans will be reviewed on a monthly basis through Access and also be subject to quarterly performance reviews.

There has been a consistent improvement in the % of patients in quintile 1 across the previous 5 months waiting longer than 40 weeks for their first OPA, which is in line with the overall reduction in longer waiting patients across the Trust.

In-Month Performance

	Standardised Index	Proportion IMDQ1	Proportion IMDQ2-5	IMDQ1 >40wk	IMDQ2 - 5 >40wk
Trust	107	8.1%	7.5%	675	4,872

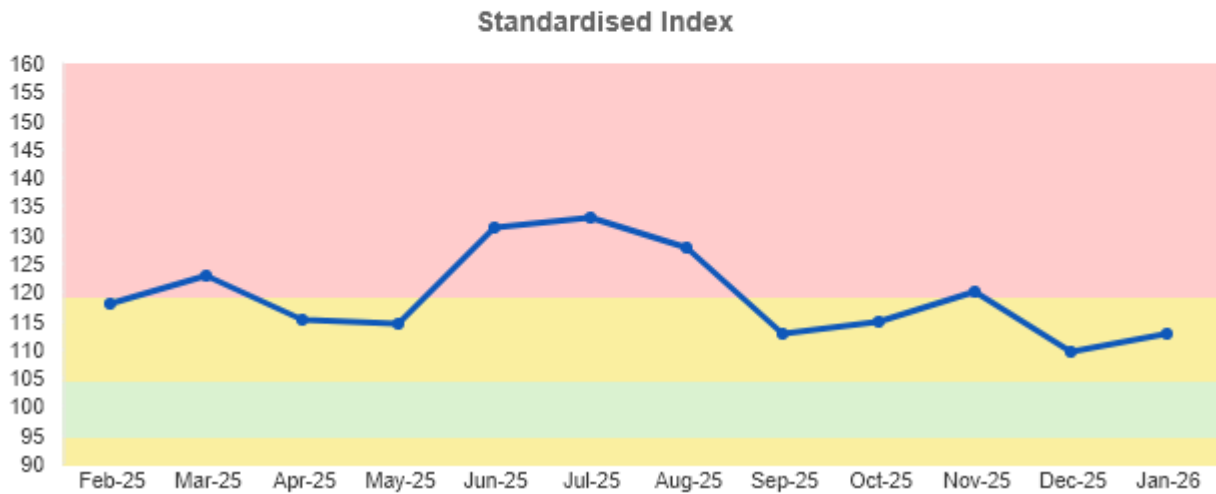
Year-to-Date Performance

Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Standardised Index	114	110	114	110	107	110
Proportion IMDQ1	11.0%	9.4%	9.7%	9.0%	8.1%	9.5%
Proportion IMDQ2-5	9.6%	8.6%	8.5%	8.2%	7.5%	8.6%
IMDQ1 >40wk	922	799	814	747	675	7,666
IMDQ2 - 5 > 40wk	6,258	5,672	5,527	5,259	4,872	53,800

Inequity-DNA Rates

Equality, Diversity and Inclusion

Trend



Narrative

In-Month Performance

	Standardised Index	Proportion IMDQ1	Proportion IMDQ2-5	IMDQ1 >40wk	IMDQ2 - 5 >40wk
Trust	113	11.5%	10.2%	381	2,543

Year-to-Date Performance

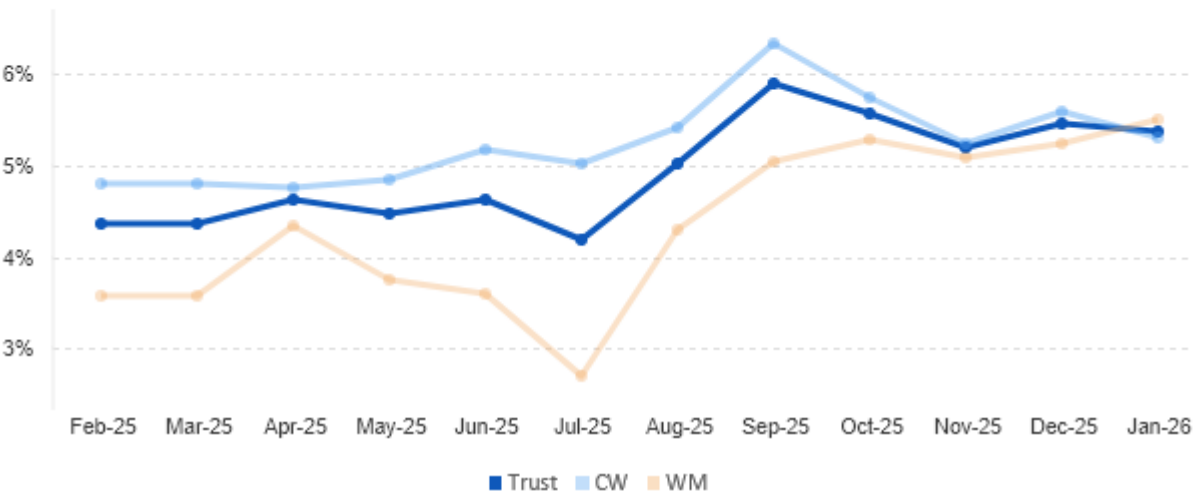
Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Standardised Index	113	115	120	109	113	118
Proportion IMDQ1	14.8%	15.1%	12.6%	12.0%	11.5%	13.0%
Proportion IMDQ2-5	13.1%	13.2%	10.5%	11.0%	10.2%	11.1%
IMDQ1 >40wk	363	389	377	329	381	3,606
IMDQ2 - 5 >40wk	3,099	3,299	2,363	2,413	2,543	25,100



Workforce

Trend

Vacancy Rate



Narrative

The Trust's Month 10 position exceeded the operating plan target level for total staffing (63WTE). Bank and agency staffing were within the operating plan target however; substantive staffing exceed the target for this month (134 WTE / 1.8%).

Agency Spend remains within the targeted reductions for 2025/26 and bank spend is within its trajectory in month and year to date.

The vacancy (5.4%) and voluntary turnover rates (8.24%) are within the target level. The key marker for concern regarding pressure remains the sickness levels which increased marginally on last month with pressure in CSD, PCD and SCD which are above 4% for in-month sickness. CSD, PCD and SCD both exceeding the 4% threshold for rolling sickness rates. The Divisions supported by Business Partners and the ER Team are proactively intervening and providing managers support but we need to continue to acknowledged that the team is stretched with current holds on A&C posts.

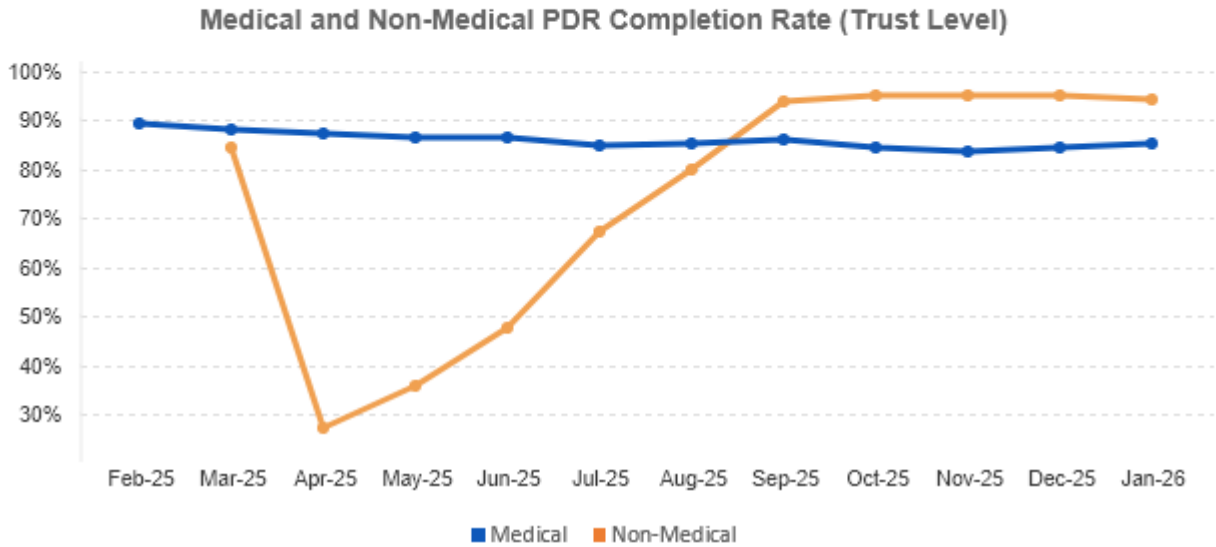
In-Month Performance

	Vacancy Rate	Voluntary Turnover	Sickness Absence	Agency Usage	Bank Usage
CW	5.31%	8.8%	4.3%	0.3%	8.2%
WM	5.51%	7.3%	5.0%	0.1%	10.6%
Trust	5.38%	8.2%	4.6%	0.2%	9.1%

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Vacancy Rate	CW	6.3%	5.7%	5.2%	5.6%	5.3%	5.3%
	WM	5.1%	5.3%	5.1%	5.2%	5.5%	5.5%
	Trust	5.9%	5.6%	5.2%	5.5%	5.4%	5.4%
Voluntary Turnover	CW	8.9%	8.9%	8.6%	8.5%	8.8%	8.8%
	WM	7.4%	7.1%	6.8%	7.0%	7.3%	7.3%
	Trust	8.4%	8.3%	8.0%	8.0%	8.2%	8.2%
Sickness Absence	CW	4.2%	4.4%	4.3%	4.7%	4.3%	4.3%
	WM	4.7%	4.5%	4.1%	4.6%	5.0%	5.0%
	Trust	4.3%	4.5%	4.2%	4.6%	4.6%	4.6%
% Agency Usage	CW	0.3%	0.3%	0.2%	0.3%	0.3%	0.3%
	WM	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%
	Trust	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%
% Bank Usage	CW	7.0%	7.5%	7.8%	7.9%	8.2%	8.2%
	WM	9.8%	10.6%	10.8%	9.6%	10.6%	10.6%
	Trust	8.0%	8.6%	8.9%	8.5%	9.1%	9.1%

Trend



Narrative

The introduction of a PDR window has been a success with the PDR rate for Month 10 being 94.22%.

EIC (94.93%) and CSD (95.02%) have the highest rates across the divisions. In addition, the staff groups excluding Medical have exceed the target with Qualified Nursing (95.39%) and AHPs(94.65%) having the highest rates.

In-Month Performance

	Medical PDR Completion Rate (Trust Only)	Non-Medical PDR Completion Rate	Core Skills Completion Rate
CW	-	93.7%	91.3%
WM	-	95.2%	92.8%
Trust	85.1%	94.2%	91.9%

Year-to-Date Performance

	Site	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	2025-2026
Medical PDR Completion Rate (Trust Only)	CW						
	WM						
	Trust	86.1%	84.3%	83.5%	84.3%	85.1%	85.1%
Non-Medical PDR Completion Rate	CW	93.1%	94.6%	94.6%	94.3%	93.7%	93.7%
	WM	95.3%	95.9%	95.8%	95.7%	95.2%	95.2%
	Trust	93.9%	95.1%	95.0%	94.8%	94.2%	94.2%
Core Skills Completion Rate	CW	90.9%	90.8%	91.1%	91.1%	91.3%	91.3%
	WM	92.8%	92.4%	93.0%	93.0%	92.8%	92.8%
	Trust	91.6%	91.4%	91.8%	91.8%	91.9%	91.9%

Safe Staffing & Patient Quality Indicators – Chelsea & Westminster Site



Chelsea and Westminster Hospital
NHS Foundation Trust

	Average fill rate				CHPPD					National Benchmark	Vacancy rate	Turnover		Inpatient fall with harm				Trust acquired pressure ulcer				Medication incidents				Complaints		FFT	Red Flags
	Day		Night		RN	HCA	RNA	ANA	Total			Qualified	Unqualified	No Harm & Mild		Moderate & Severe		Stage				No Harm & Mild		Moderate & Severe					
	RN	HCA	RN	HCA										M	12M	M	12M	M	12M	M	12M	M	12M	M	12M	M	12M		
Maternity	89%	96%	95%	99%	6.5	2.2	0.0	0.0	8.68	12.79	9.32%	6.43%	7.41%	1	3	0	0	0	0	0	0	7	86	0	0	7	71	85.18%	
Annie Zunz	93%	90%	100%	100%	5.5	2.1	0.0	0.0	7.53	8.73	2.18%	15.62%	0.00%	1	16	0	0	0	0	0	0	2	6	0	0	0	3	97.62%	
Apollo	90%	-	94%	-	19.9	0.0	0.0	0.0	19.92	N/A	-3.53%	5.46%	32.97%	0	1	0	0	0	1	0	0	3	22	0	0	0	1		
Mercury	99%	-	103%	-	8.0	0.0	0.0	0.0	7.95	9.94	-4.48%	6.37%	0.00%	0	3	0	0	0	0	0	0	5	87	0	0	0	2	91.67%	
Neptune	120%	-	116%	-	9.0	0.0	0.0	0.0	9.05	13.06	11.77%	5.84%	0.00%	0	3	0	0	0	0	0	0	7	41	0	0	1	3	77.78%	
NICU	107%	-	108%	-	15.6	0.0	0.3	0.0	15.88	26.91	3.44%	5.09%	0.00%	0	0	0	0	0	0	0	0	4	83	0	0	1	7	100.00%	
AAU	107%	91%	106%	144%	6.7	1.8	0.0	0.1	8.56	8.4	1.49%	5.48%	5.92%	14	105	0	1	1	5	0	0	7	90	0	0	1	14	99.13%	1
Nell Gwynne	97%	64%	116%	79%	3.8	2.9	0.0	0.0	6.80	7.82	-2.15%	4.75%	16.29%	3	54	1	2	0	0	0	1	1	14	0	0	0	3	97.67%	
David Erskine	98%	86%	92%	111%	3.6	2.8	0.0	0.1	6.48	7.14	5.46%	8.65%	11.69%	10	71	0	2	0	0	0	0	2	31	0	0	1	7	87.18%	
Edgar Horne	108%	113%	106%	136%	3.4	3.7	0.2	0.0	7.26	6.78	4.88%	0.00%	5.56%	2	57	1	2	0	2	0	0	3	27	0	0	0	9	94.67%	
Lord Wigram	96%	80%	99%	91%	3.4	2.7	0.1	0.1	6.35	7.81	2.10%	4.48%	14.86%	1	32	0	0	0	3	0	1	0	25	0	0	0	4	100.00%	4
St Mary Abbots	89%	98%	89%	97%	3.3	3.3	0.0	0.1	6.59	7.55	7.49%	15.19%	27.14%	3	28	0	0	0	1	0	0	0	39	0	0	0	10	90.00%	2
David Evans	91%	74%	87%	90%	4.7	2.8	0.0	0.2	7.70	7.55	-0.97%	0.00%	0.00%	2	21	0	2	0	0	0	0	5	22	0	1	1	9	98.48%	1
Chelsea Wing	133%	108%	100%	100%	10.2	5.8	0.0	0.0	15.97	7.55	33.91%	19.85%	22.50%	0	1	0	1	0	0	0	0	4	17	0	0	0	8		
Burns Unit	127%	164%	211%	197%	21.7	4.2	0.0	0.4	26.32	N/A	6.95%	4.71%	0.00%	3	8	0	0	0	0	0	0	1	8	0	0	0	4		
Ron Johnson	98%	102%	100%	105%	4.5	2.5	0.0	0.0	6.98	5.51	4.33%	0.00%	11.11%	11	34	0	0	0	1	0	0	2	30	0	0	1	3	100.00%	
ICU	104%	-	106%	-	22.3	0.0	0.7	0.0	23.00	26.91	1.89%	9.15%	20.92%	1	10	0	0	0	3	0	1	2	44	0	0	0	2		
Rainsford Mowlem	109%	93%	99%	117%	3.1	2.9	0.1	0.1	6.32	7.5	4.08%	6.59%	8.19%	4	65	0	2	0	2	0	0	3	33	0	0	1	7	94.17%	
Nightingale	102%	90%	101%	128%	3.1	2.9	0.0	0.1	6.19	7.5	13.78%	0.00%	0.00%	6	88	0	1	0	2	0	0	0	37	0	0	0	4	100.00%	
Emergency Department	104%	78%	112%	115%	-	-	-	-	-	N/A	6.47%	8.63%	0.00%	5	59	0	1	0	0	0	0	9	85	0	0	8	70	86.66%	
DSU	80%	61%	113%	100%	-	-	-	-	-	N/A	11.76%	4.60%	0.00%	1	3	0	0	0	0	0	0	2	10	0	0	0	5	100.00%	
Theatres	96%	89%	102%	97%	-	-	-	-	-	N/A	2.63%	9.02%	15.63%	0	0	0	0	0	0	0	0	0	6	0	0	0	6		
OPD	68%	87%	-	-	-	-	-	-	-	N/A	-5.26%	9.26%	10.64%	0	4	0	1	0	0	0	0	0	15	0	0	6	82	91.95%	
Averages /Totals	100%	92%	107%	112%	8.3	2.2	0.1	0.1	10.7		5.11%	6.75%	9.17%	68	666	2	15	1	20	0	3	69	858	0	1	28	334	94.01%	8

Safe Staffing & Patient Quality Indicators – West Middlesex



Chelsea and Westminster Hospital
NHS Foundation Trust



	Average fill rate				CHPPD					National Benchmark	Vacancy rate	Turnover		Inpatient fall with harm				Trust acquired presure ulcer				Medication incidents				Complaints		FFT	Red Flags
	Day		Night		RN	HCA	RNA	ANA	Total			Qualified	Unqualified	No Harm & Mild		Moderate & Severe		Stage				No Harm & Mild		Moderate & Severe					
																		1 & 2		3, 4 & nonstage									
	RN	HCA	RN	HCA										M	12M	M	12M	M	12M	M	12M	M	12M	M	12M	M	12M		
Lampton FU	109%	93%	130%	93%	3.3	2.7	0.0	0.1	6.08	7.5	8.30%	0.00%	5.64%	5	60	0	0	0	7	0	2	4	47	0	0	0	1	97.40%	
Richmond	110%	87%	111%	96%	4.0	2.6	0.1	0.0	6.74	7.55	-2.41%	0.00%	16.78%	1	20	0	0	0	0	0	0	2	12	0	0	0	5	100.00%	
Syon 1 cardiology	97%	94%	99%	111%	4.2	2.0	0.0	0.0	6.17	7.93	9.29%	5.83%	47.67%	4	40	0	1	0	1	0	1	0	16	0	0	0	0	96.83%	
Syon 2	99%	100%	100%	97%	3.5	3.2	0.2	0.0	6.81	7.14	4.07%	0.00%	0.00%	1	54	1	0	0	3	0	1	1	42	0	0	1	7	99.14%	
Starlight	148%	-	133%	-	8.0	0.0	0.0	0.0	8.02	13.06	7.09%	10.21%	100.00%	0	2	0	0	0	1	0	0	6	31	0	0	2	8		
Kew (Lampton)	102%	134%	98%	184%	3.2	4.1	0.2	0.2	7.74	7.5	8.43%	5.23%	3.54%	5	37	1	0	0	3	1	2	1	26	0	0	0	2	96.00%	
DRU (Crane)	99%	86%	100%	72%	2.9	3.2	0.2	0.0	6.24	7.5	3.11%	0.00%	11.70%	1	56	0	1	0	1	0	0	2	32	0	0	0	1	98.68%	
Osterley 1	91%	93%	100%	88%	3.7	2.6	0.2	0.0	6.52	7.81	10.94%	3.82%	11.09%	6	53	0	0	1	12	0	1	3	50	0	0	0	8	100.00%	4
Osterley 2	98%	90%	98%	98%	3.6	3.2	0.3	0.0	7.04	7.55	4.06%	0.00%	4.84%	4	26	0	0	0	1	0	0	2	24	0	0	1	5	100.00%	5
MAU	100%	92%	106%	101%	6.1	2.5	0.0	0.0	8.53	8.4	8.68%	1.52%	0.00%	5	109	1	1	0	6	0	0	6	87	0	1	2	13	96.36%	
Maternity	104%	90%	107%	92%	7.2	1.9	0.0	0.0	9.13	12.79	-3.99%	5.13%	3.27%	0	1	0	0	0	0	0	0	6	46	0	0	0	11	88.57%	
Special Care Baby Unit	101%	-	114%	-	8.7	0.0	0.0	0.0	8.65	13.06	16.77%	6.90%	9.28%	0	0	0	0	0	0	0	0	1	14	0	0	0	2		
Marble Hill 1	117%	103%	125%	124%	4.4	2.9	0.1	0.0	7.45	6.8	2.95%	3.76%	11.95%	5	91	0	2	0	4	0	0	8	92	0	0	0	5	93.44%	
Marble Hill 2	119%	117%	144%	130%	3.8	3.1	0.2	0.1	7.30	6.78	8.47%	4.77%	0.00%	10	68	0	1	0	0	0	1	8	54	0	0	2	7	97.83%	
ITU	94%	-	95%	-	24.2	0.0	0.0	0.0	24.25	26.91	6.03%	11.86%	40.00%	2	4	0	0	0	5	0	0	3	59	0	0	0	0		
Redlees (Kew)	100%	97%	100%	95%	3.6	3.28	0.2	0.36	7.47	7.82	-0.15%	0.00%	0.00%	4	44	0	0	0	0	0	0	1	19	0	0	0	2	96.30%	
Emergency Department	101%	96%	109%	73%	-	-	-	-	N/A	28.78%	13.99%	0.00%	0.00%	1	44	0	1	0	1	0	0	1	54	0	1	2	33	75.90%	
DSU	94%	149%	-	-	-	-	-	-	N/A	-3.31%	0.00%	0.00%	0.00%	0	7	0	0	0	0	0	0	1	5	0	0	1	5	93.16%	
Theatres	95%	53%	103%	84%	-	-	-	-	N/A	2.95%	3.20%	11.38%	11.38%	0	0	0	0	0	0	0	0	1	9	0	0	0	6		
OPD	76%	78%	-	-	-	-	-	-	N/A	-8.38%	14.59%	6.16%	6.16%	0	4	0	0	0	0	0	0	1	11	0	0	3	30	86.32%	
Averages /Totals	103%	97%	110%	103%	5.9	2.3	0.1	0.1	8.4		5.58%	4.54%	14.16%	54	720	3	7	1	45	1	8	58	730	0	2	14	151	94.75%	9



The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & Midwifery staffing fill rates and Care Hours per Patient Day (CHPPD) and NICE red flag categories with a review of trends in the previous six months. Emergency Departments, Day Surgery Units, Theatres and Out-patient Departments have been added to the report this month in accordance with Developing Workforce Safeguards Guidance. In relation to CHPPD, information has been compared against the national benchmarks and data has been triangulated with associated quality indicators and patient experience for the same month. Overall, key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Twice daily nursing safety huddles continue to oversee the deployment of staff, as required, in order to maintain patient safety.

West Middlesex site:

Kew, Marble Hill 1, and Marble Hill 2 reported increased HCA fill rates to support enhanced observation for patients requiring mental health supervision and for those who were confused and at risk of falls. Additionally, Marble Hill 1 and 2 maintained a high RMN fill rate during both day and night shifts, driven by the opening of escalation beds and the need for enhanced observation of patients requiring mental health supervision. DRU ward had lower HCA fill rates at night attributed to changes to the staffing template. CHPPD was not compromised. Lampton Frailty Unit and DSU had increased RN fill rate at night due to the opening of escalation beds. Starlight had increased day RN fill rates due to increased bed utilisation. ED and Theatres reported low HCA fill rates due to vacancies and lack of bank cover. Vacant posts are now fully recruited to. The Out-patient Department (OPD) experienced low RN and HCA fill rates during the day due to reduced acuity and changes attributed to staffing template.

Chelsea and Westminster site:

Chelsea Wing saw increased RN fill rates on days due to additional private clinic demands. AAU had increased fill rates at night rates to support enhanced observation for patients requiring mental health supervision and for those who were confused and at risk of falls. Nightingale had high night fill rate due to staffing escalation areas. Nell Gwynne had low HCA fill rate day and night due to sickness and inability to fill with bank cover. Edgar Horne had increased HCA night-time fill rates to provide enhanced observations for patients requiring mental health supervision. David Evans had a reduced HCA fill rate due to lower activity and acuity. Lord Wigram had a reduced HCA fill rate due to staff sickness and the inability to fill shifts with bank cover. The Burns Unit had increased RN and HCA fill rates to support enhanced observation for patients requiring mental health supervision. In OPD and ED HCA fill rates were low due to staff sickness and limited bank cover, while RN fill rates in OPD were impacted by vacancies. The Orthopaedic practitioners and matron provided support, patient safety was maintained throughout. The Day Surgery Unit (DSU) experienced low RN and HCA fill rates during the day due to reduced acuity and activity. Patient care and safety was maintained throughout.

Incidents:

In January, six incidents involving patient harm were reported: five related to falls and one to pressure damage. Following an unwitnessed fall, the patient on Edgar Horne sustained a forehead laceration, which was reviewed through post-fall assessments; the patient had declined slip socks on admission and was advised to wear them post-fall to prevent further harm. The patient on Nell Gwynne sustained a facial fracture after an unwitnessed fall, an Immediate Incident Review was completed, and the hospital falls protocol was followed with ongoing monitoring. The patient on Kew sustained a fractured neck of femur following an unwitnessed fall, and a full post-fall assessment was completed. The patient on AMU also sustained an unwitnessed fall, was assessed in line with the falls protocol, and was subsequently transferred to St Mary's Hospital for further management. On Syon 2 ward, the patient sustained a cut to the right eye following an unwitnessed fall. An IIR was completed, and the hospital post-fall protocol was followed. The patient on Kew ward was admitted with pre-existing pressure damage, and the left heel injury deteriorated during the admission. Tissue Viability were involved, appropriate care plans were in place, treatment remained ongoing, and the IIR was completed.

The Friends and Family Test showed 100% scores in five wards at CW and three wards at WM. WM Emergency Department scored below 80%, with feedback highlighting concerns about waiting times and overall experience in the Department

Neptune ward scored below 80% (77.7%) and the ward is reviewing areas highlighted where they can improve patient experience.

Please note all incident figures are correct at time of extraction from DATIX. There were 17 red flags raised in January: 15 for planned care and 2 for the EIC. All were related to staffing shortfalls and delays in medication and care. The vacancy rate and turnover are from January 2026.



Nursing, Midwifery and care staff average fill rate January 2026				
Day and Night average fill rate		Monthly trust workforce data: Care hours per patient day (CHPPD)		
Registered (%)	Care staff (%)	Registered	Care staff	Total CHPPD
104.17% ↑	99.20% ↑	5.9 ↓	2.4 ↓	8.4 ↓

RN Fill Rates (ward areas) increased from 101.28% in December 2025 to 104.17% in January 2026. The RN vacancy rate (whole trust) in January 2026 was 4.34%, same as from December 2025– 4.36%

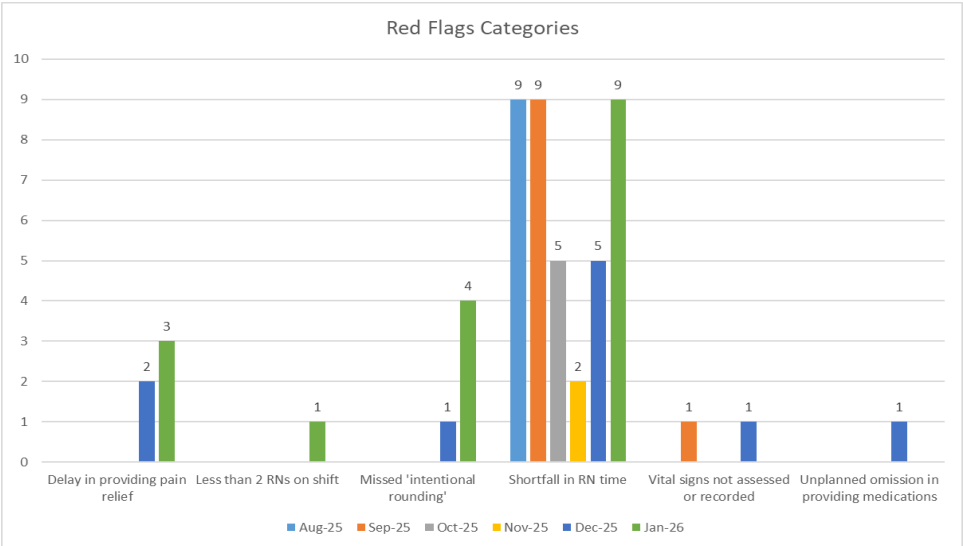
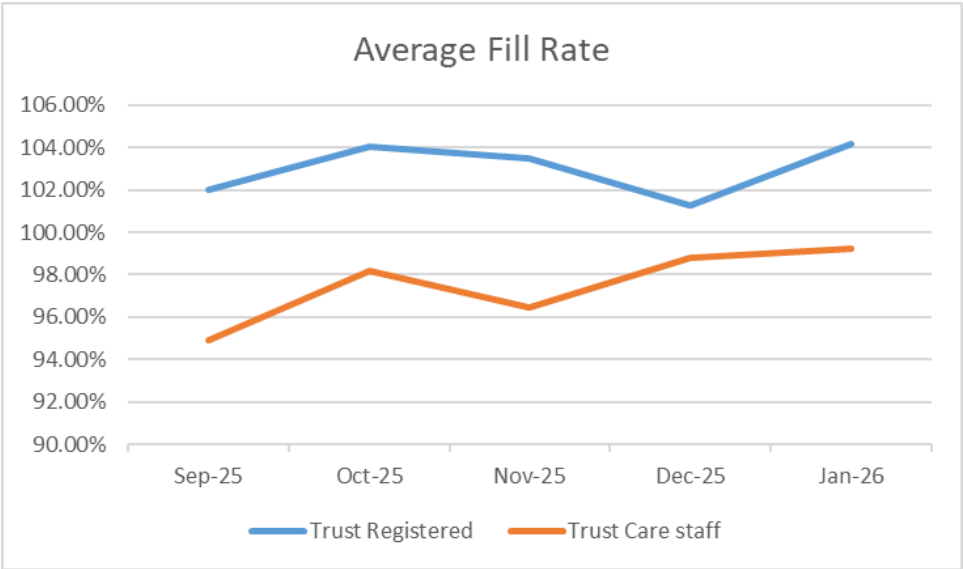
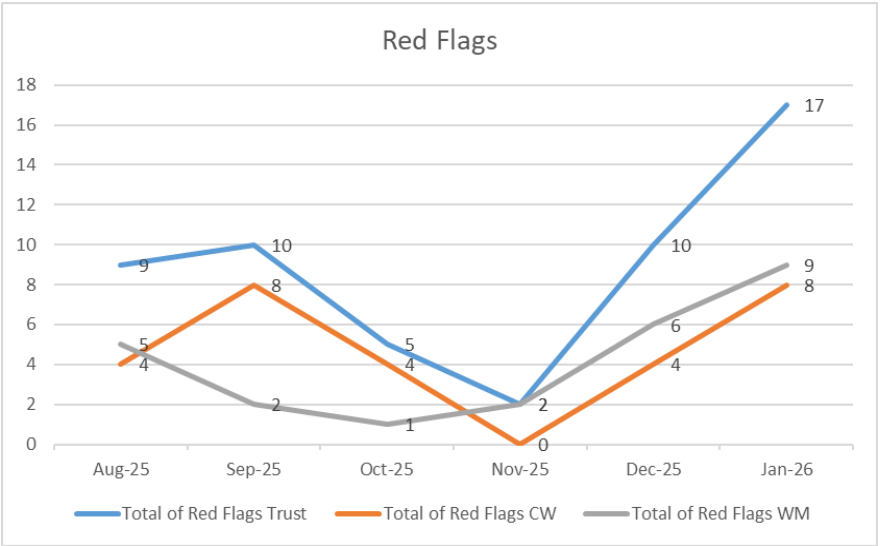
Care Staff Fill Rates (ward areas) increased from 98.79% in December 2025 to 99.20% in January 2026 . There has been an extensive HCA recruitment campaign maintained. The HCA vacancy rate (whole trust) in January 2026 was 9.12%, slightly down from 9.90% in December 2025.

The Trust overall fill rate (ward areas) (RN and Care Staff combined) increased from 100.04% in December 2025 to 101.69% in January 2026.

Care Hours per Patient Day (CHPPD) continues to be collated on a monthly basis. The most current Trust measure from the Model Hospital* (September 2025) was 8.3. Trust workforce data confirms the CHPPD was 8.4 in January 2026, down from December 2025 – 8.7.

Safe Staffing Red Flags – 17 red flags from the 5 categories (tables below) were reported during January 2026 where majority were Shortfall in RN time.

CHPPD - Taken from the Model Hospital*	Care Hours per Patient Per Day (CHPPD) – Sep 2025
Trust	8.3
Hillingdon Hospital	9.1
London NW	9.0
Imperial	10.4
National Median	8.8





Finance



Type of Spend	Plan to Date £'000	Actual to Date £'000	Variance to Date £'000
Income	861,974	863,661	1,687
Expenditure			
Pay	(497,752)	(506,197)	(8,445)
Non-Pay	(307,782)	(307,689)	93
EBITDA	56,440	49,775	(6,665)
EBITDA %	7%	5.76%	-0.8%
Depreciation	(29,187)	(29,479)	(292)
Non-Operational Exp-Inc	(12,857)	(28,203)	(15,346)
Surplus/Deficit	14,396	(7,907)	(22,303)
Control total Adj - Donated asset, Impairment & Other	(14,806)	7,306	22,112
PFI Model recalculation		485	485
Adjusted financial performance surplus/(deficit)	(410)	(116)	294



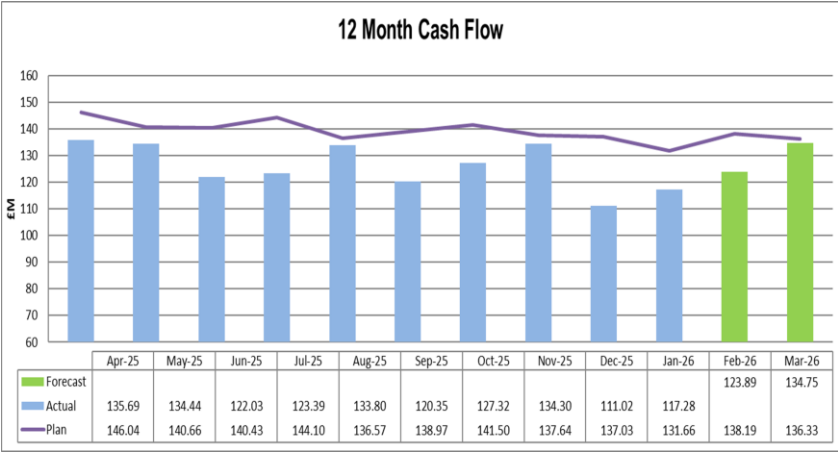
Comment: Mar 25 12 payroll figures include additional spend for 9.4% Pension contribution - £30.79 m a notional figure). In October 24 AFC staff, consultants and SAS doctor received YTD pay awards resulting in the in month spike. July 25 includes £1m spend on industrial action and a YTD increase in the pay award accrual to reflect the latest guidance.

The adjusted YTD financial position at month 10 is a £0.12m deficit which is £0.29 m favourable against plan.

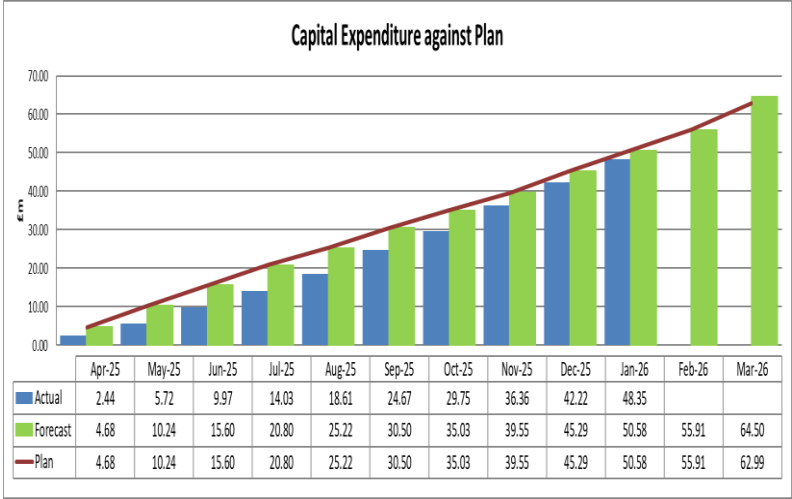
Pay: £8.45m adverse against plan. The adverse variance at Month 10 includes spend on additional clinics, WLI, and cover for vacancies, sickness, rota gaps, and other forms of leave also included is spend on Industrial Action and a gap CIPs

Non-Pay: There is a £0.09m favourable variance which includes adjustment to budget to match NHSi return.

Income: Income performance for the month and YTD is favourable against plan. The positive variance is driven by both, income released for WLI (offset by cost) and over performance on the variable elements of the contract (Drugs, Devices, Unbundled imaging). Sexual Health services continue to underperform against planned levels, largely due to demand management measures.



Comment: The negative cash variance to plan in M10 of £14.38m is the negative cash variance brought forward from M9 of £26.01m, higher receipts to plan of £0.53m (ICB & NHS England & FTs £0.63m lower, Local Authority & AR £1.48m higher, Other Income £0.05m higher, PP Income £0.33m lower, Interest £0.03m lower) plus lower cash outflows to plan of £11.11m (lower creditor payments)



Comment: The original capital programme for 2025/26 was £62.99m, which has been adjusted to £64.50m following the carry forward of the additional grant for the IECCP project from 2024/25, a new grant donation of £250k for the CW Paeds ED waiting room project, the allocation of £7.19m from the ICS reserves/contingency and the deferral of the Human Challenge Scheme £6.3m and CW+ donation of £2.76m to 2026/27. The capital budget has been allocated to the various departments, with £45.91m for the ADC Project, £0.68m for the Treatment Centre, £2.11m for the PFI, £1.39m for Medical Equipment, £1.26m for IT equipment, £3.87m for Estates schemes, £0.53m Central Contingency, £1.10m for IFRS16, £3.50m for IECCP, £0.13m for WM site development and £8.05m for PDC funded projects which are allocated to support some of the above listed items and other estates works. Individual budgets have been allocated from the available capital budgets and business cases for these projects are being submitted to CPB for approval throughout the year. The P10 YTD underspend of £2.23m which mainly relates to the PDC funded schemes and will be spent in the upcoming months



AAR = After Action Review
CW = Chelsea and Westminster Hospital
CTR = Criteria to Reside
DNA = Did not Attend
CQC = Care Quality Commission
ED = Emergency Department
FFT = Friends and Family Test
FCE = Finished Consultant Episode
HSMR = Hospital Standardised Mortality Ratio
LOS = Length of Stay
KPI = Key Performance Indicator
MDT = Multiple Discipline Team
MRSA = Methicillin-Resistant Staphylococcus Aureus
OPFU = Outpatient Follow-up

OPFA = Outpatient First Attendance
OP = Outpatient
PHSO = Parliamentary and Health Service Ombudsman
PDR = Performance Development Review
PIFU = Patient Initiated Follow-up
PSII = Patient Safety Incident Investigations
PTL = Patient Tracking List
PU = Pressure Ulcer
RTT = Referral to Treatment Time
SDEC = Same Day Emergency Care
SHMI = Summary Hospital-level Mortality Index
STEIS = Strategic Executive Information System
VTE = Venous Thromboembolism
WM = West Middlesex Hospital