



Trust Performance and Quality Report

June 2026



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Executive Summary



Chelsea and Westminster Hospital
NHS Foundation Trust



Patient Safety and Experience

There were 6 cases of C.Difficile reported in-month, 4 occurring at WM and 2 at CW, bringing the YTD total cases to 10. Whilst no threshold has been set currently for 2026/27 the Trust previous years threshold of 33 remains. The Trust has an established Quality Priority for Infection Prevention and Control, which is mirrored across the APG given the year end position for 2025/26 (58 cases against a threshold of 33). There has been 1 MRSA bacteremia which was community onset, healthcare associated. This brings the Trust position to 2 YTD.

The complaint response time within 25 working days reduced to 74.1% and compliance with 45 working days performance reported a month in arrears but remains strong with compliance at 100% for the previous months. A reduction has been seen within open and overdue PALS, which is hoped will impact on complaint position. Inpatient FFT remains in a strong position exceeding response rates and experience of care.

VTE assessment rates remain above target YTD, but a slight dip in performance at CW in month 94.2%. There have been 6 moderate and above falls in month which are undergoing learning responses. Falls risk assessment rates are compliant across both sites, and a falls improvement plan being agreed alongside the ETOC policy, which will be implemented with education teams. There was 1 hospital acquired pressure ulcers at category 3 or above during June, which is an improved position. Ongoing improvement work as part of the Trust Quality priority is ongoing.

Sepsis improvement work has continued within the ED, with an improving position for the last 5 months at Chelsea. This work will be shared with West Middlesex, and the improvement plan will be monitored through Divisional Meetings and the Clinical Effectiveness Group.

The time to theatre for fractured NOF patients was not met at Chelsea (85.7% -18/21 patients) due to theatre constraints due to heatwave. Additional chillers have been installed at CW. 100% performance was achieved at WM. The Trust reported same sex breaches at West Middlesex due to delays in stepping down patients from ITU. This was a result of managing capacity across urgent and elective care.

Patient Access and Operating Plan

Attendances to the Emergency Departments and Urgent Treatment Centres were 6.7% higher in June 26 compared to same period last year. Demand pressures impact the Trust performance at 76.92% for A&E 4-hour which is under the 26/27 improvement trajectory. The Emergency Care improvement plan remains in place and progress has been seen in month in reducing time to initial assessment.

Performance against Cancer standards was strong in May 2026 with achievement of all targets: 31-Day standard at 99.3%, 62-day standard at 92.3%, 28-Day Faster Diagnostics at 82.2%.

Elective Referral to Treatment (RTT) 18-week wait performance increased to 67.93% for June 2026, meeting the Operating Plan trajectory and a continued improvement in performance. Overall PTL size remains stable. The number of long waiting patients continues to be above trajectory and an area of focus for improvement with additional capacity being put in place to support this. There were 917 patients waiting over 52 weeks (-85) There were no patients waiting over 65weeks or 78weeks.

Performance against the DM01 diagnostic standard (which measures the percentage of patients waiting <6 weeks) was reported at 80.71% against the 95% standard, below the Operating Plan trajectory. Recovery plans and trajectories are in place to improve this position over the coming months.

Workforce

The Trust's Month 3 position shows the vacancy (6.7%), voluntary turnover rates (7.4%) and % Bank and Agency Usage (0.2%) are well within the target level. The Trust has achieved its PDR target at the close of the window with 95% of PDRs completed.

Finance

The adjusted YTD financial position at month 3 is a £2.21m deficit which is £0.07m favourable to 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	51.02	
Patient safety incident investigations	n/a	2	
Never Events	0	0	
Dementia screening %	90%	96.23%	
ED sepsis screening %	90%	89.58%	!
Inpatient sepsis screening %	90%	86.69%	!
C. Difficile cases	n/a	6	
E. coli cases	n/a	11	
Formal complaints received	n/a	53	
Inpatient FFT % good experience	90%	95.16%	
A&E FFT % good experience	90%	79.32%	!
Outpatient FFT % good experience	90%	92.98%	
Maternity FFT % good experience	90%	91.18%	
Mortality			
Summary Hospital-level Mortality Index	<100	78.41	
Hospital Standardised Mortality Ratio	<100	77.34	

Section/KPI	Target	Actual	Prev. 3 Mth Trend
Patient Access			
A&E waiting times type 1&3 (4hrs)	80%	76.92%	!
LAS handovers 30 mins	n/a	183	
18 week RTT incompletes	66%	67.93%	
Diagnostic waiting times < 6 weeks	95%	80.71%	!
28 day Faster Diagnosis Standard	80%	81.96%	
31 day diagnosis to first or subsequent treatment	96%	99.29%	
62 day GP referral to first treatment combined	85%	91.90%	
Operating Plan and Capacity			
Theatre utilisation (uncapped)	85%	87.85%	
PIFU rate	5%	9.45%	
Workforce			
Medical PDR compliance	90%	85.0%	
Non-medical PDR compliance	45%		
Core skills compliance	90%	91.9%	



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



Patient Safety and Experience

Patient Safety Incidents

Safe



Chelsea and Westminster Hospital
NHS Foundation Trust

Trend

Incidents per 1000 FCE Bed Days



Narrative

Performance: Incident reporting is a recognised indicator of an organisation's safety culture, with higher reporting rates typically reflecting a positive environment in which staff feel empowered to speak up. Reporting rates have shown some variability over the rolling 12-month period. The Trust continues to proactively identify and address areas for improvement, informed by recurring themes and trends across patient safety events that impact patients both directly and indirectly, in line with the national Learning from Patient Safety Events (LFPSE) framework.

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 August 2026, will support the standardisation of processes across the APG 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	47.32	3	0	0.00
WM	50.98	2	0	0.00
Trust	49.10	5	0	0.00

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Incidents per 1000 FCE Bed Days (Target:)	CW	48.3	49.6	46.9	50.2	47.3	48.1
	WM	48.9	49.1	48.8	54.2	51.0	51.3
	Trust	48.6	49.4	47.9	52.1	49.1	49.7
Incidents Resulting in Severe Harm or Death (Target:)	CW	2	1	3	0	3	6
	WM	2	0	3	0	2	5
	Trust	4	1	6	0	5	11
Incidents Resulting in Death (Target:)	CW	0	0	0	0	0	0
	WM	0	0	1	0	0	1
	Trust	0	0	1	0	0	1
Incidents Resulting in Death per 1,000 FCE Bed Days (Target:)	CW	0.00	0.00	0.00	0.00	0.00	0.00
	WM	0.00	0.00	0.07	0.00	0.00	0.02
	Trust	0.00	0.00	0.03	0.00	0.00	0.01

Medication Safety Incidents

Safe

Trend

Medication-Related Safety Incidents per 1000 Bed Days



Narrative

- The Trust target to reduce medication incidents with moderate harm or above to < 1% was not achieved in June 2026, as 2 moderate harm incidents reported.
- 1 moderate harm medication incident reported in June 2026 at WMUH site. Patient established on Ozempic pen prior to hospital admission, and incorrectly supplied with NovoRapid insulin pen in TTO without pharmacy dispensing label and likely to be given from ward stock on discharge. Patient thought NovoRapid pen was their Ozempic pen and self-administered NovoRapid 60units at home (*incorrect insulin preparation*). Patient re-admitted to hospital with severe hypoglycaemia . PSIRF incident investigation in progress.
- 1 moderate harm medication incident reported in June 2026 at CW site. Patient prescribed latanoprost-timolol eye drops but medication not available. Patient referred to GP, but GP informed patient there is a national shortage of medication, and to return back to hospital for alternative medication. Alternate eye-drops/management not suggested.
- The Trust did not meet the medication incident reporting target in June 2026. Medication incident reporting has declined at Chelsea site compared to previous months, and WMUH site have improved reporting and met the target (4.2).
- Medication incident reporting to be discussed at WMUH senior nursing meeting on 24/07/26.
- Medication Safety Group has requested divisions for an improvement plan to encourage and promote staff with medication incident reporting, with regular discussion and feedback at meetings.
- Within paediatrics, medication incident reporting is embedded in inductions, study days, safety huddles, medication rounds, newsletters, and other educational opportunities.
- Incident reporting is tabled at Safety Huddle which is then cascaded to all departments to support improving incident reporting rates.
- The new incident reporting form for the new incident system (Ideagen) has required additional extensive reviews and updates with NWL APG/MSO APG, and information fields streamlined to support staff reporting. Concerns escalated to CWFT Clinical Governance team.

In-Month Performance

	Medication Related Safety Incidents per 1000 Bed Days	Medication Related Safety Incidents With Moderate or Above Harm
CW	3.43	3.6%
WM	4.20	3.1%
Trust	3.81	3.3%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Medication Related Safety Incidents per 1000 Bed Days (Target: >=4.2)	CW	4.93	5.18	4.84	4.27	3.43	4.16
	WM	4.72	3.98	3.81	3.98	4.20	4.00
	Trust	4.83	4.58	4.34	4.13	3.81	4.08
Medication Related Safety Incidents % Moderate or Above Harm (Target: <1%)	CW	0.0%	0.0%	0.0%	0.0%	3.6%	1.0%
	WM	0.0%	0.0%	0.0%	1.8%	3.1%	1.7%
	Trust	0.0%	0.0%	0.0%	0.8%	3.3%	1.3%

Incidents Reported on STEIS (Sis/PSIIs)

Safe

Trend

Patient Safety Incident Investigations



Narrative

Over the rolling 12-month period, PSII indications comprised 67% (25) locally defined incidents requiring local PSII, 30% (11) nationally defined priority incidents subject to MNSI and 3% (1) nationally defined priority (Never Event). 2 PSIIs were declared in June, comprising an unexpected admission to SCBU (MNSI) and a neonatal death (MNSI).

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

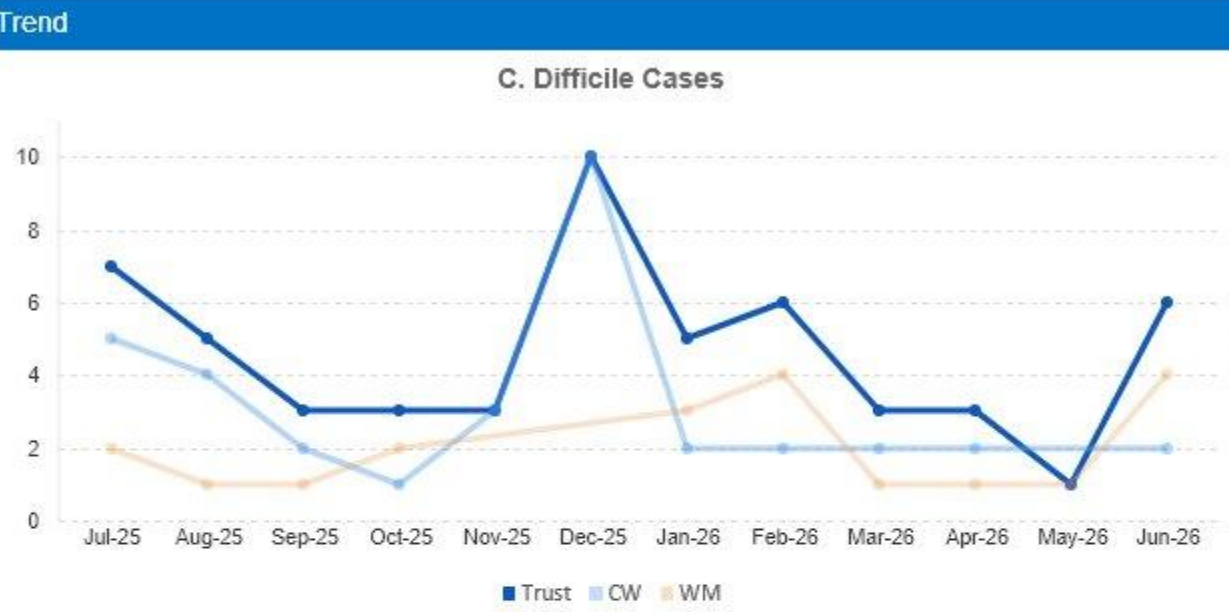
Forecast Risks: The Trust has seen a reduction in the number of cases exceeding their completion deadlines; however, some incidents continue to experience delays in completing learning responses beyond the timeframes set out in the PSIRF Policy. Delays in incident review risk slowing the identification and implementation of learning and corrective actions, which may impact the Trust's ability to improve patient safety in a timely manner.

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	3
WM	2	0	1	0	1
Trust	2	0	2	0	4

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Patient Safety Incident Investigations	CW	1	4	2	2	0	4
	WM	1	1	1	3	2	6
	Trust	2	5	3	5	2	10
Never Events (Target: 0)	CW	0	0	0	1	0	1
	WM	0	0	0	0	0	0
	Trust	0	0	0	1	0	1
Learning Responses Declared (AAR)	CW	2	1	2	1	1	4
	WM	0	0	4	1	1	6
	Trust	2	1	6	2	2	10
Learning Responses Declared (Thematic Review)	CW	0	0	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	0	0
Learning Responses Declared (MDT)	CW	1	3	1	0	3	4
	WM	2	1	0	1	1	2
	Trust	3	4	1	1	4	6



In-Month Performance

	C. Difficile Cases	MRSA Bacteraemia
CW	2	1
WM	4	0
Trust	6	1

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
C. Difficile Cases (Target: <33)	CW	2	2	2	-	2	4
	WM	4	1	1	1	4	6
	Trust	6	3	3	1	6	10
MRSA Bacteraemia (Target: 0)	CW	0	0	0	-	1	1
	WM	0	1	0	1	0	1
	Trust	0	1	0	1	1	2

Narrative

MRSA

There was one healthcare associated MRSA bacteraemia in June 2026, the case occurred at CWH in the maternity department and was classified as Community Onset, healthcare associated (COHA). The patient was bacteraemic on the day of admission but had a recent inpatient admission at CWH within the past 28 days. A PSIRF meeting was held on 24/06/26 where no clear lapse in care was identified. Discussions focused on strengthening surgical site infection surveillance, improving Datix reporting, reinforcing MRSA screening guidance for emergency Caesarean sections and ensuring accurate vancomycin prescribing and cannula documentation.

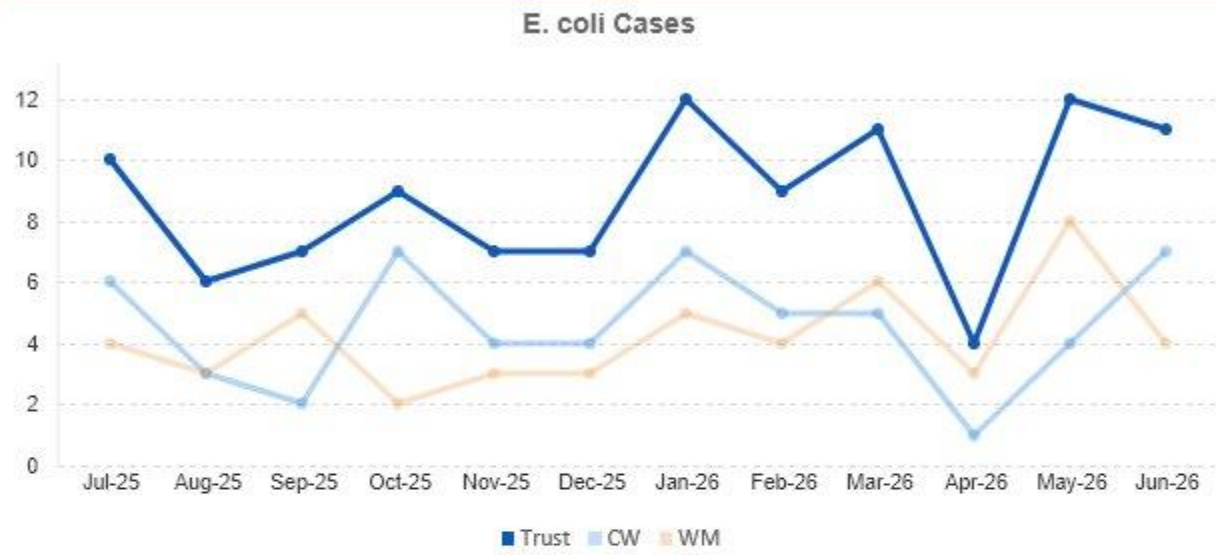
CDI

There were six healthcare associated CDI cases in June 2026, taking the organisation to a total of 10 cases in Q1 2026/27, this is a reduction of 23% in comparison to Q1 2025/26. Four cases occurred at WMH and 2 at CWH across different wards and division, with no evidence of cross-transmission. All CWH PSIRFs have been held with no lapses in care contributing to disease development noted, at WMH 3 PSIRF meetings are pending.

Healthcare Associated E.Coli Infections

Safe

Trend



Narrative

E.coli

There were 11 healthcare associated *E.coli* bacteraemia in June 2026, 4 occurred at WMH and 7 at CWH across 4 (inpatient) divisions.

This is a total of 27 healthcare associated cases in q1 2026/27 and a decrease of 15% in comparison with q4 2025/26.

The leading four sources of *E.coli* bacteraemias at CWFT in Q1 are:

- Gastrointestinal/ Intra-abdominal (26%)
- Lower Urinary Tract (26%)
- Hepatobiliary (11%)
- Genital System (Maternity) (8%)

All healthcare associated bacteraemias are reviewed at a monthly MDT meeting with learning and improvement opportunities shared quarterly at IPCG.

In-Month Performance

	E. Coli Cases	Hand Hygiene Compliance
CW	7	95.9%
WM	4	97.3%
Trust	11	96.5%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
E. coli Cases	CW	5	5	1	4	7	12
	WM	4	6	3	8	4	15
	Trust	9	11	4	12	11	27
Hand Hygiene Compliance (Target: >95%)	CW	94.3%	97.3%	96.1%	96.1%	95.9%	96.0%
	WM	94.6%	94.3%	94.2%	86.9%	97.3%	92.8%
	Trust	94.4%	95.9%	95.2%	92.0%	96.5%	94.5%

Formal Complaints

Responsive

Trend

Complaints Received per 1000 Bed Days



Narrative

- Formal complaint response compliance declined in June compared with May, with the most notable decline seen within West Middlesex. This reflects a combination of factors, including increased complaint complexity, higher volumes of PALS concerns, and competing operational priorities. While the majority of overdue responses were within EIC, there were also a small number within SCD. The Patient Experience team continues to work closely with divisions to provide support with complaint resolution, response drafting and improving responsiveness.
- During June, demand through PALS increased significantly, with 375 concerns opened compared with 277 in May, including 197 at West Middlesex. This increase may have contributed to pressures on divisional capacity and response times for formal complaints. Formal complaints opened reduced from 63 in May to 50 in June.
- Despite the increase in activity, PALS performance improved markedly. A total of 419 concerns were resolved and closed during June, compared with a typical monthly range of 250-320. At month end, there were 150 open PALS cases, of which 86 were overdue, representing a significant improvement on previous months where open caseloads were typically above 200, with 150-180 overdue cases.
- Of the 72 formal complaints closed during June, 4 were fully upheld and 39 were partially upheld.
- Complaints performance continues to receive close scrutiny, with ongoing support provided to divisions to improve response timeliness. Work is also underway to review policies and processes, including the potential use of standardised responses for common themes such as waiting times and communication concerns where appropriate, alongside consideration of approaches for managing and responding to AI-generated complaints.

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	76.6%	0	2
WM	1.0	70.6%	0	0
Trust	2.1	74.1%	0	2

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Complaints Received per 1000 Bed Days	CW	4.6	3.8	3.7	3.8	3.2	3.5
	WM	1.1	1.4	2.2	1.9	1.0	1.7
	Trust	2.8	2.5	2.9	2.9	2.1	2.6
Complaints Responded to <25 Working Days (Target: >90%)	CW	84.8%	96.8%	91.1%	87.5%	76.6%	85.0%
	WM	79.2%	87.5%	95.5%	94.7%	70.6%	84.0%
	Trust	82.9%	94.9%	92.5%	89.6%	74.1%	84.7%
Complaints Responded to <45 Working Days (Target: >90%)	CW	100.0%	100.0%	100.0%	100.0%	Reports a month in arrears	100.0%
	WM	100.0%	100.0%	100.0%	100.0%		100.0%
	Trust	100.0%	100.0%	100.0%	100.0%		100.0%
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	4	4	3	2	2	7
	WM	0	1	2	0	0	2
	Trust	4	5	5	2	2	9

Inpatient Friends & Family Test

Caring



Narrative

Continued efforts across both hospital sites have helped maintain strong levels of inpatient survey participation. Response rates remain particularly positive across EIC wards, although opportunities remain to increase participation within some Planned Care and SCD areas relative to patient activity – specifically Lord Wigram, SMA, Osterleys and Richmond. Patient feedback remains largely positive regarding the care received. Consistent themes continue to relate to involvement in decisions, understanding of care and treatment, and addressing worries and concerns. Wards continue to use Friends and Family Test and survey feedback to inform local quality improvement work.

Complaint learning across inpatient services has highlighted recurring themes around communication with patients and families, documentation, personal care, pressure area and wound management, medication records, and discharge arrangements. Whilst clinical care was generally found to be appropriate, investigations identified opportunities to improve documentation, timely escalation of concerns, follow-up arrangements, and keeping patients and carers informed throughout their admission.

Learning and actions

- Reinforce standards for clinical documentation, including observations, wound care, nutrition and medication records.
- Improve escalation processes where specialist review or intervention is required.
- Continue learning around dignity, personal care and compassionate communication with patients and families.
- Improve discharge planning and follow-up arrangements, ensuring patients and carers are clear on ongoing plans and responsibilities.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	822	76.6%	95.6%	97.0%
WM	1,009	69.2%	94.8%	97.0%
Trust	1,831	72.3%	95.2%	97.0%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Responses	CW	631	736	641	700	822	2,163
	WM	891	1,023	908	1,016	1,009	2,933
	Trust	1,522	1,759	1,549	1,716	1,831	5,096
Response Rate (Target: >10%)	CW	68.1%	61.1%	64.1%	68.7%	76.6%	70.0%
	WM	74.2%	41.4%	66.0%	51.1%	69.2%	60.8%
	Trust	71.6%	47.8%	65.2%	57.0%	72.3%	64.4%
% Good Experience (Target: >90%)	CW	95.6%	95.4%	94.9%	96.0%	95.6%	95.5%
	WM	95.7%	95.8%	96.7%	95.9%	94.8%	95.8%
	Trust	95.7%	95.6%	95.9%	95.9%	95.2%	95.7%
Treated With % Dignity and Respect (Target: >90%)	CW	97.0%	96.0%	98.0%	98.0%	97.0%	97.6%
	WM	97.0%	98.0%	98.0%	97.0%	97.0%	97.3%
	Trust	97.0%	97.1%	98.0%	97.4%	97.0%	97.5%

Caring

% Good Experience



FFT themes remain consistent with previous months. Survey feedback continues to show a more positive experience at Chelsea and Westminster compared with West Middlesex across all domains, including waiting times, communication about tests and results, quality of care, and understanding of next steps following discharge.

Complaint learning from Emergency Department services continues to centre on the patient experience rather than clinical decision-making. Common themes included communication with patients and relatives, clarity of care plans and follow-up arrangements, delayed updates, maintaining dignity and confidentiality, and coordination between teams involved in a patient's care. A small number of complaints also identified medication-related errors and delays in aspects of care delivery.

Learning and actions

- Improve communication with patients and families regarding diagnosis, treatment plans and follow-up arrangements.
- Improve expectations around confidentiality, professionalism and compassionate care.
- Improve coordination and clarity of responsibilities where patients move between teams or services.
- Continue learning from medication incidents, escalation processes and documentation standards.

In-Month Performance

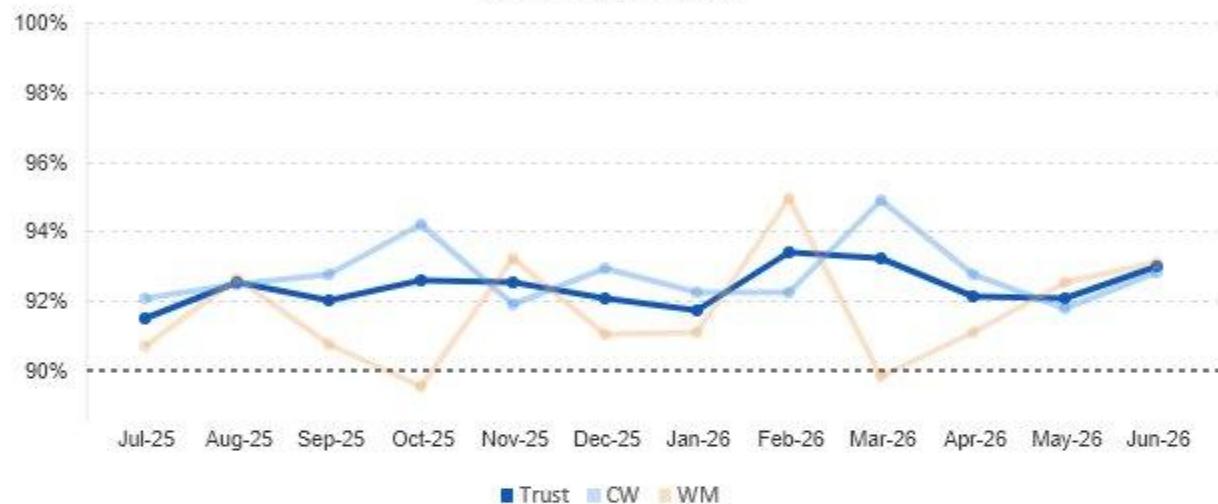
	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	897	8.3%	81.8%	86.0%
WM	926	7.6%	76.9%	82.0%
Trust	1,823	7.9%	79.3%	84.0%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Responses	CW	892	932	865	959	897	2,721
	WM	794	859	915	953	926	2,794
	Trust	1,686	1,791	1,780	1,912	1,823	5,515
Response Rate (Target: >10%)	CW	9.4%	8.7%	9.1%	8.8%	8.3%	8.7%
	WM	7.6%	7.2%	8.4%	7.9%	7.6%	8.0%
	Trust	8.5%	7.9%	8.7%	8.3%	7.9%	8.3%
% Good Experience (Target: >90%)	CW	83.4%	83.4%	83.0%	81.8%	81.8%	82.2%
	WM	74.3%	72.8%	78.4%	73.0%	76.9%	76.1%
	Trust	79.1%	78.3%	80.6%	77.4%	79.3%	79.1%
% Treated With Dignity and Respect (Target: >90%)	CW	88.0%	89.0%	87.0%	86.0%	86.0%	86.3%
	WM	80.0%	80.0%	83.0%	80.0%	82.0%	81.6%
	Trust	84.3%	84.7%	85.0%	83.0%	84.0%	84.0%

Caring

% Good Experience



Outpatient survey feedback continues to be more positive at Chelsea and Westminster than at West Middlesex. Response numbers vary across specialties, with AEC, Eye Clinic, Dermatology, Gynaecology and Trauma & Orthopaedics generating the most feedback, while Endoscopy, Elizabeth Suite, Burns, Antenatal and Phlebotomy received relatively few responses.

The main themes from both survey feedback and complaints relate to waiting times, appointment changes, communication and access to information. Patients highlighted difficulties with clinic navigation and wayfinding, understanding next steps, knowing who to contact, and managing their care at home. Complaints also identified issues with appointment delays, referral processes and inconsistent communication regarding treatment plans and waiting times.

Learning and actions

- Improve communication around waiting times, cancellations and appointment changes.
- Ensure clinical priority is considered when appointments are rescheduled.
- Improve tracking of follow-up appointments and investigations.
- Improve coordination between administrative and clinical teams.
- Review appointment information to support wayfinding and clearer communication of next steps.

Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
1,215	9.4%	92.8%	97.0%
1,106	10.3%	93.1%	96.0%
2,321	9.8%	93.0%	96.5%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Responses	CW	1,107	1,627	1,132	1,215	1,215	3,562
	WM	807	786	720	761	1,106	2,587
	Trust	1,914	2,413	1,852	1,976	2,321	6,149
Response Rate (Target: >10%)	CW	4.9%	6.8%	8.5%	7.8%	9.4%	8.5%
	WM	6.7%	4.0%	4.1%	3.5%	10.3%	5.1%
	Trust	5.5%	5.5%	6.0%	5.3%	9.8%	6.7%
% Good Experience (Target: >90%)	CW	92.2%	94.9%	92.8%	91.8%	92.8%	92.4%
	WM	94.9%	89.8%	91.1%	92.5%	93.1%	92.4%
	Trust	93.4%	93.2%	92.1%	92.1%	93.0%	92.4%
% Treated With Dignity and Respect (Target: >90%)	CW	96.0%	98.0%	96.0%	97.0%	97.0%	96.7%
	WM	97.0%	94.0%	96.0%	96.0%	96.0%	96.0%
	Trust	96.4%	96.7%	96.0%	96.6%	96.5%	96.4%

Maternity Friends & Family Test

Caring

Trend

% Good Experience



Narrative

FFT response rates remain low across maternity inpatient areas when compared with the volume of women cared for. Ann Stewart generated the highest number of responses during the month (80), all of which were positive. All other maternity inpatient areas received fewer than 40 responses, with some receiving fewer than 20, making it difficult to draw firm conclusions.

The themes reported remain consistent with previous months. Women were generally positive about the care they received, particularly the kindness and support from staff. Areas for improvement focused on information provision, involvement in decisions, and ensuring concerns are listened to and acted upon.

Complaint themes were similar and predominantly related to services at Chelsea. Whilst clinical decision-making was generally found to be appropriate, investigations identified opportunities to improve communication, documentation and the overall patient experience. Women reported feeling unprepared for aspects of their care, particularly where there were delays, changes to plans, ward transfers or medication decisions.

Learning and actions

- Improve communication throughout the maternity pathway, particularly when delays or changes to care occur.
- Ensure women receive clear explanations about treatments, procedures, medication and ward transfers.
- Reinforce timely completion of observations, feeding records and medication documentation.
- Continue learning from patient feedback to improve postnatal support and overall experience.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	129	28.1%	92.2%	97.0%
WM	109	26.8%	89.9%	89.0%
Trust	238	27.5%	91.2%	93.5%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Responses	CW	102	122	114	133	129	376
	WM	77	63	83	78	109	270
	Trust	179	185	197	211	238	646
Response Rate (Target: >10%)	CW	22.3%	22.9%	23.4%	23.8%	28.1%	25.0%
	WM	19.0%	15.3%	21.4%	18.4%	26.8%	22.2%
	Trust	20.7%	19.6%	22.5%	21.5%	27.5%	23.7%
% Good Experience (Target: >90%)	CW	84.3%	86.1%	91.2%	87.2%	92.2%	90.2%
	WM	84.4%	88.9%	91.6%	82.1%	89.9%	88.1%
	Trust	84.4%	87.0%	91.4%	85.3%	91.2%	89.3%
% Treated With Dignity and Respect (Target: >90%)	CW	88.0%	91.0%	93.0%	92.0%	97.0%	94.0%
	WM	83.0%	97.0%	95.0%	88.0%	89.0%	90.4%
	Trust	86.0%	92.9%	93.8%	90.6%	93.5%	92.6%

Caring

In-Month Performance



Narrative

A key development during June was the introduction of the new Children and Young People FFT survey across inpatient and outpatient services. The survey remains in its early implementation and testing phase, therefore more meaningful analysis and trends will be available from July onwards.

Complaint themes during the month centred on communication with children and families, delays in assessments and reports, coordination between services, and ensuring appropriate support for children and young people with additional needs. Learning also highlighted opportunities to strengthen documentation and incident reporting processes.

Learning and actions

- Strengthen communication with children and families, particularly during assessments and procedures.
- Improve timeliness of reports, follow-up arrangements and updates on progress.
- Ensure reasonable adjustments and support needs are discussed and clearly documented.
- Improve coordination between services to provide a more joined-up experience for children and families.
- Reinforce expectations around incident reporting and documentation where concerns arise.

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	52	8.7%	92.3%	99.0%
WM	46	14.1%	91.3%	100.0%
Trust	98	10.6%	91.8%	99.4%

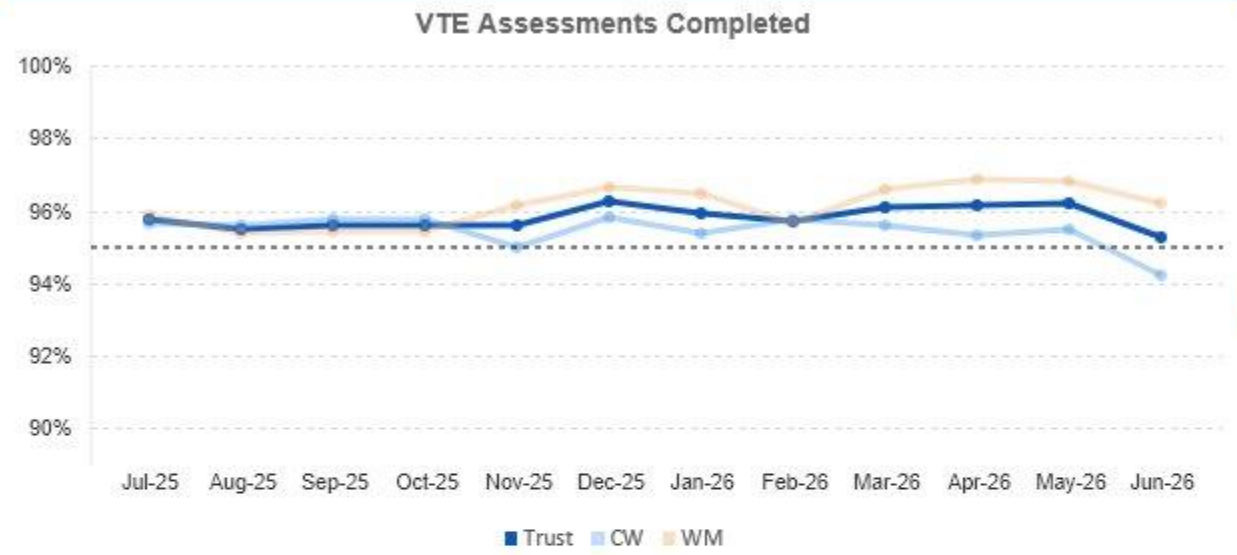
Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Responses	CW	45	35	48	57	52	157
	WM	11	49	93	53	46	192
	Trust	56	84	141	110	98	349
Response Rate (Target: >10%)	CW	7.8%	5.5%	8.5%	8.7%	8.7%	8.6%
	WM	4.2%	14.9%	30.5%	14.4%	14.1%	19.2%
	Trust	6.7%	8.7%	16.2%	10.8%	10.6%	12.4%
% Good Experience (Target: >90%)	CW	97.8%	94.3%	100.0%	94.7%	92.3%	95.5%
	WM	100.0%	98.0%	95.7%	96.2%	91.3%	94.8%
	Trust	98.1%	96.4%	97.2%	95.5%	91.8%	95.1%
% Treated With Dignity and Respect (Target: >90%)	CW	99.0%	97.0%	100.0%	99.0%	99.0%	99.4%
	WM	100.0%	100.0%	95.0%	98.0%	100.0%	97.1%
	Trust	99.1%	97.8%	97.9%	98.7%	99.4%	98.5%

VTE Risk Assessments Completed

Safe

Trend



In-Month Performance

	VTE Assessments Completed	Hospital Aquired VTE Cases	Hospital Aquired VTE per 1000 FCE Bed Days
CW	94.2%	1	0.1
WM	96.2%	4	0.3
Trust	95.3%	5	0.2

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
VTE Assessments Completed (Target: >=95%)	CW	95.7%	95.6%	95.3%	95.5%	94.2%	95.0%
	WM	95.6%	96.6%	96.8%	96.8%	96.2%	96.6%
	Trust	95.7%	96.1%	96.1%	96.2%	95.3%	95.9%
Hospital Aquired VTE Cases	CW	2	0	0	1	1	2
	WM	2	3	5	6	4	15
	Trust	4	3	5	7	5	17
Hospital Aquired VTE per 1000 FCE Bed Days	CW	0.1	0.0	0.0	0.1	0.1	0.0
	WM	0.1	0.2	0.3	0.4	0.3	0.3
	Trust	0.1	0.1	0.2	0.2	0.2	0.2

Narrative

VTE Risk Assessment: Trust target achieved (WMUH [96.22%] met target and CW [94.24%] did not meet target). 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 (91%) and West London Childrens Hospital (76%).

Specialities requiring improvement: Vascular surgery [0%], plastic surgery [87%], ophthalmology [88%], trauma & orthopaedics [93%], urology [93%], general surgery [94%], and general medicine [94%].

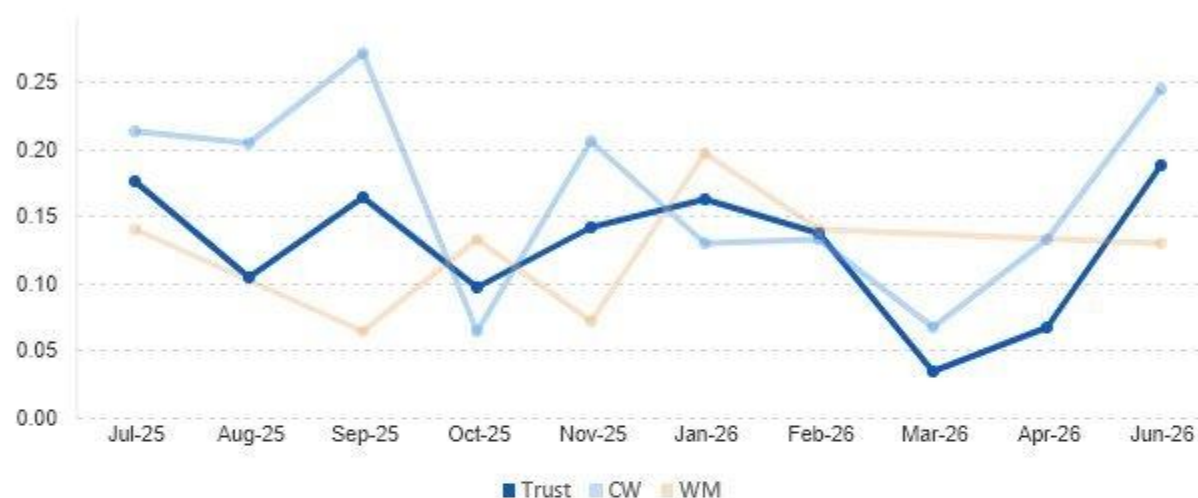
- Hospital Associated VTE (HAT) Events:**
- Cross-Site: 'VTE alert' included in positive VTE imaging reports for identification of VTE diagnosis.
 - CW Site: HATs under-reported due to identification. QlikSense HAT report under quality review for digital identification and auto-reporting of HATs from Cerner patient admission records. Paused due to clinical and operational commitments.
 - 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.**
 - HAT reporting and investigation fields optimisation on new incident reporting system with NWL APG.
 - 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 to address contributory factors.
 - New CW thrombosis pathway under review, with aim to standardise with WMUH site and NWL APG.

Patient Falls

Safe/Effective

Trend

Falls with Moderate & Above Harm per 1000 FCE Bed Days



Narrative

Falls with harm have increased in June, with 3 moderate and 3 severe for June. Considering we have seen an increase in our falls per 1000 days across both sites, a falls strategy has been written and will be shared at the falls steering group meeting on Tuesday 14th of July, this will focus on actions arising from the thematic review undertaken in April. In turn this will be shared at the patient safety group meeting for assurance. A new programme of education will be developed to support the strategy, along with a review of the current online falls module. Compliance with falls risk assessments is high and sustained (>90% for over six months) across adult inpatient areas. Bed rails compliance continues to sit between 85% and 90%.

Key risks remain around post-fall processes, including care plan completion, SBAR documentation, overnight medical response, and inconsistent bay tagging. These issues will be addressed in the strategy.

The ETOC policy was reviewed and ratified on the 24th of June and will be live on the Intranet week commencing 13th of July. Education programmes will be reviewed considering the ETOC policy, falls strategy and digital monitoring of care plans to provide a combined education programme rather than individual sessions. The Trust continues to align our local policies with national guidance and National audits (NAIF), providing assurance that governance and improvement arrangements are in place.

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	4	2	0.25	3.92	90.3%
WM	2	1	0.13	4.39	93.9%
Trust	6	3	0.19	4.15	92.3%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Inpatient Falls with Moderate & Above Harm	CW	2	1	2	0	4	6
	WM	2	0	0	0	2	2
	Trust	4	1	2	0	6	8
Inpatient Falls Resulting in Severe Harm or Death (Target: 0)	CW	0	1	2	0	2	4
	WM	1	0	0	0	1	1
	Trust	1	1	2	0	3	5
Falls with Moderate & Above Harm per 1000 FCE Bed Days	CW	0.13	0.07	0.13	0.00	0.25	0.13
	WM	0.14	0.00	0.00	0.00	0.13	0.05
	Trust	0.14	0.03	0.07	0.00	0.19	0.09
Falls per 1000 FCE Bed Days	CW	3.40	4.64	3.31	4.78	3.92	4.01
	WM	3.74	3.77	4.30	3.62	4.39	4.11
	Trust	3.56	4.21	3.79	4.23	4.15	4.06
Compliance with Falls Risk Assessment (Target: >=90%)	CW	90.6%	90.9%	90.6%	90.4%	90.3%	90.5%
	WM	93.3%	94.0%	94.4%	93.7%	93.9%	94.0%
	Trust	92.1%	92.6%	92.6%	92.1%	92.3%	92.3%

Pressure Ulcers

Safe/Effective

Trend

% Compliance with Purpose T Risk Assessment



Narrative

Risk assessment compliance: Trust compliance is improved in month with an overall compliance of 89.2%. Improvements are noted at the CW site however just below the Trust target. Local targeted training remains ongoing with oversight from the senior nursing team.

Pressure ulcer harm: Hospital acquired pressure damage has reduced in month with 2 category 2 and 1 category 3 HAPUs. This element of pressure ulcer care remains the key focus for addressing as part of the Trust's quality priority,

Overall position: The Trust continues to focus on reducing HAPUs with harm and while improvements have been noted in month this remains a continued focus. Risk assessment compliance at the WM site remains stable and above the Trust target. Focussed work continues at the CW to improve compliance to the Trust target.

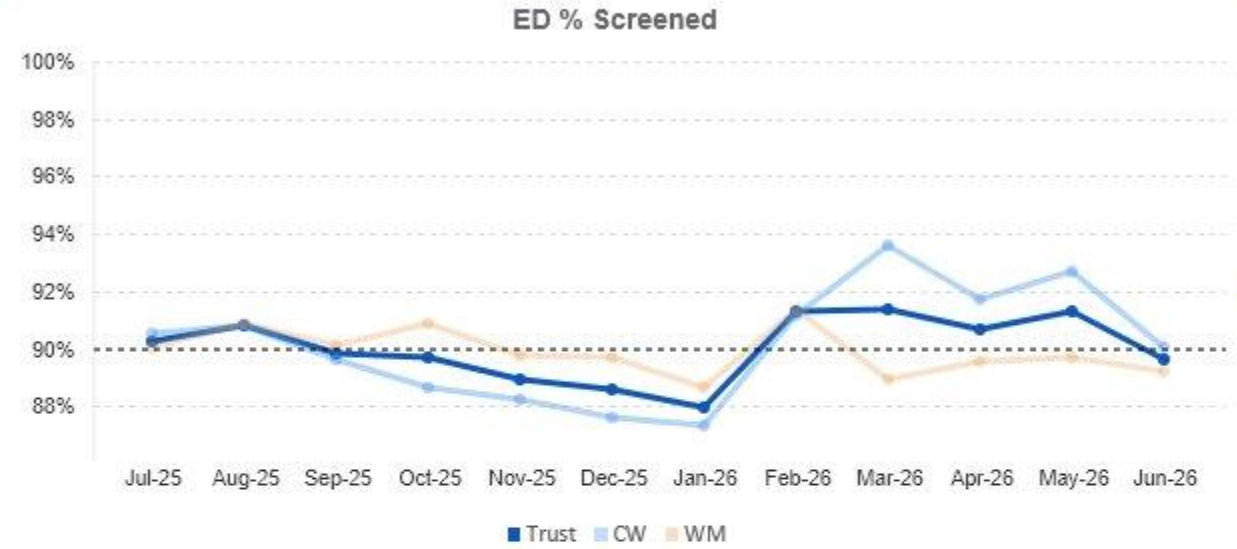
In-Month Performance

	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	86.1%	0	0	0	-
WM	91.7%	2	1	0	-
Trust	89.2%	2	1	0	-

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Compliance with Purpose T Risk Assessment (Target: >=90%)	CW	85.2%	85.7%	86.0%	85.1%	86.1%	85.7%
	WM	90.3%	91.0%	91.5%	91.3%	91.7%	91.5%
	Trust	87.9%	88.6%	88.9%	88.4%	89.2%	88.8%
Category 2 Pressure Ulcers	CW	0	1	1	2	0	3
	WM	0	0	1	1	2	4
	Trust	0	1	2	3	2	7
Category 3 Pressure Ulcers (Target: 0)	CW	0	0	1	3	0	4
	WM	1	0	2	1	1	4
	Trust	1	0	3	4	1	8
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	0	1	1	2	0	3
	WM	0	0	0	1	0	1
	Trust	0	1	1	3	0	4

Trend



Narrative

Improvement in performance across all areas. Specific focus on screening in WMUH ED with an improvement in ward areas noted.

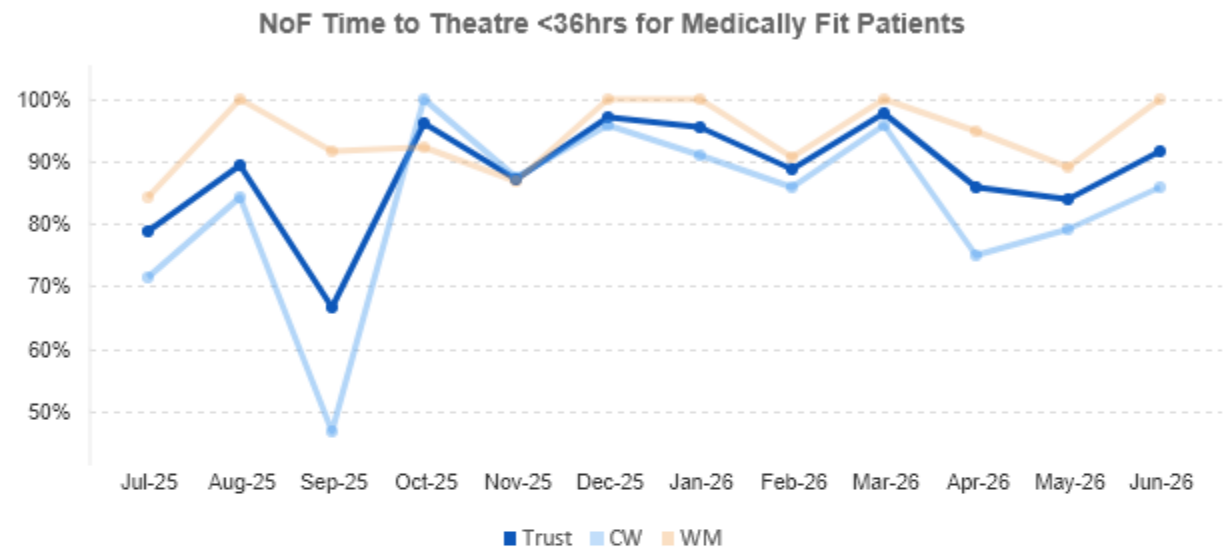
In-Month Performance

	ED % Screened	ED % Potential Red Flags Reviewed	Ward % Screened	Ward % Potential Red Flags Reviewed
CW	90.1%	85.6%	84.3%	94.3%
WM	89.2%	91.6%	89.7%	96.6%
Trust	89.6%	88.3%	86.7%	95.3%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
ED % Screened (Target: >90%)	CW	91.2%	93.6%	91.7%	92.7%	90.1%	91.5%
	WM	91.4%	88.9%	89.6%	89.7%	89.2%	89.5%
	Trust	91.3%	91.4%	90.7%	91.3%	89.6%	90.5%
ED % Potential Red Flags Reviewed (Target: >90%)	CW	72.4%	85.3%	85.6%	85.6%	85.6%	85.6%
	WM	95.1%	92.7%	95.5%	94.4%	91.6%	93.8%
	Trust	81.6%	88.3%	89.5%	89.2%	88.3%	89.0%
Ward % Screened (Target: >90%)	CW	83.2%	81.9%	84.9%	82.9%	84.3%	84.0%
	WM	86.9%	82.9%	86.6%	86.6%	89.7%	87.7%
	Trust	84.8%	82.3%	85.6%	84.4%	86.7%	85.6%
Ward % Potential Red Flags Reviewed (Target: >90%)	CW	95.8%	95.7%	96.1%	94.6%	94.3%	95.0%
	WM	95.3%	97.3%	95.1%	94.6%	96.6%	95.5%
	Trust	95.6%	96.5%	95.7%	94.6%	95.3%	95.2%

Trend



Narrative

NoF Time to Theatre - Performance against the 36-hour fractured neck of femur surgical target remained strong across both sites. WM achieved 100% compliance (15/15 patients), while CW improved to 86% (18/21 patients), compared with the previous month. Theatre capacity at CW was impacted during June due to elevated theatre temperatures associated with the heatwave. A third chiller unit has subsequently been installed to enhance temperature control and support theatre resilience during periods of extreme weather.

Breach of Same Sex Accommodation - breaches in month were at the West Middlesex Site all due to delayed discharges from ICU. The team continue to work with the site team for timely discharges

Time Spent on a Stroke Unit – compliance with time spent on a stroke unit has improved from May and is above the trust target

Dementia – In June 2026 we achieved 95% compliance at Chelsea and 97% compliance at WM. MDT completion of the 4AT continues to improve on both sites, further engagement will cross-site the downstream wards and has will formed part of the work we are doing focused on deconditioning and the prompt identification and treatment of delirium. This will also be further reinforced as part of the cross-site delirium policy review currently underway and due to be reviewed at CEG in August.

In-Month Performance

	NoF Time to Theatre <36hrs for Medically Fit Patients	Breach of Same Sex Accomodation	Time Spent on Dedicated Stroke Unit	Dementia Screening Case Finding
CW	85.7%	0	87.5%	94.8%
WM	100.0%	44	88.5%	97.2%
Trust	91.7%	44	88.1%	96.2%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
NoF Time to Theatre <36hrs for Medically Fit Patients (Target: 100%)	CW	85.7%	95.7%	75.0%	78.9%	85.7%	80.4%
	WM	90.5%	100.0%	94.7%	88.9%	100.0%	94.2%
	Trust	88.6%	97.6%	85.7%	83.8%	91.7%	87.0%
Breach of Same Sex Accomodation	CW	0	0	0	0	0	0
	WM	33	44	33	30	44	107
	Trust	33	44	33	30	44	107
Time Spent on Dedicated Stroke Unit (Target: >80%)	CW	100.0%	94.1%	100.0%	69.2%	87.5%	87.8%
	WM	96.3%	100.0%	86.7%	85.7%	88.5%	87.1%
	Trust	97.4%	96.6%	94.3%	79.4%	88.1%	87.4%
Dementia Screening Case Finding (Target: >90%)	CW	90.9%	86.3%	92.8%	90.9%	94.8%	92.7%
	WM	93.7%	96.0%	97.2%	91.1%	97.2%	95.0%
	Trust	92.6%	91.7%	95.3%	91.0%	96.2%	94.1%



Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Apr-26	May-26	Jun-26	2026-2027	Apr-26	May-26	Jun-26	2026-2027	Apr-26	May-26	Jun-26	2026-2027 Q1	2026-2027	Trend charts
Workforce	Midwife to birth ratio (Target: 1:30)	1:21	1:22	1:21	1:21	1:24	1:25	1:22	1:22	1:23	1:24	1:22	1:21.5	1:21.5	-
	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)	397	442	375	1214	337	363	331	1031	734	805	706	2245	2245	-
	Total number of bookings (Target:> CW 580 WM 478)	537	536	534	1607	407	458	411	1276	944	994	945	2883	2883	-
	Maternity 1:1 care in established labour (Target: >95%)	98.0%	99.0%	98.0%	98.3%	99.0%	99.0%	98.0%	98.7%	98.5%	99.0%	98.0%	98.5%	98.5%	-
Safety	Admissions >37/40 to NICU/SCBU	22	0	23	45	14	12	10	81	36	12	33	45	45	-
	Number of reported Serious Incidents	10	6	8	24	2	2	4	8	12	8	12	32	32	-
	Cases of hypoxic-ischemic encephalopathy (HIE)	0	0	0	0	1	2	0	3	1	2	0	3	3	-
	Pre-term (gestation <37 weeks) as % of mothers delivered	8.0%	8.0%	5.0%	7.0%	6.0%	6.0%	6.0%	6.0%	7.0%	7.0%	5.5%	6.5%	6.5%	-
	Number of stillbirths	0	0	1	1	0	2	0	2	0	2	1	3	3	-
	Number of Infant deaths	0	1	2	3	3	1	0	4	3	2	2	7	7	-
	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	3.0%	4.0%	2.0%	3.0%	10.0%	8.0%	6.0%	8.0%	6.5%	6.0%	4.0%	5.5%	5.5%	-
	Spontaneous unassisted vaginal births	26.0%	24.0%	23.0%	24.3%	27.0%	26.0%	27.0%	26.7%	26.5%	25.0%	25.0%	25.5%	25.5%	-
	Vaginal Births - spontaneous & induced	39.0%	37.0%	36.0%	37.3%	42.0%	43.0%	41.0%	42.0%	40.5%	40.0%	38.5%	39.7%	39.7%	-
	Instrumental deliveries	55	69	66	190	37	31	47	115	92	100	113	305	305	-
	Pre-labour elective caesarean sections	70	78	87	235	63	60	57	180	133	138	144	415	415	-
	Emergency caesarean sections in labour	115	127	83	325	92	113	98	303	207	240	181	628	628	-



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 June, the midwifery staffing ratios were reported as 1:22 at the Chelsea site and 1:21 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 from late Spring 2026. Bookings on both sites have seen a decrease as expected which will create capacity for upcoming work to bring all antenatal care back to maternity (as opposed to being shared with GP services).

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+ 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 decreased to 84% from 85% in May, with 1 red flag reported (stable – 1 in May)
 - Delay between admission for induction and beginning of process (n=1)
- Birth Centre:** Compliance increased to 69% from 61% in May with 1 **red flag reported** (stable – 1 in May)
 - No additional support MW available (No second MW for birth) (n=1)
- Antenatal Ward:** Compliance decreased to 89% from 90% in May with 64 red flags reported (a decrease – 88 in May)
 - 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)
 - Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication) (n=2)
 - Delay in providing pain relief (n=11)
 - Delay between presentation and triage (n=9)
 - Full clinical examination not carried out when presenting in labour (n=9)
 - Delay between admission for induction and beginning of process (n=13)
 - Delayed recognition of and action on abnormal vital signs (n=9)
 - Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a women during established labour (n=8)
- Postnatal Ward:** Compliance decreased to 93% from 94% in May with 2 red flags reported (an increase - 0 in May)
 - Delayed or cancelled time critical activity (n=2)
 - Delay between admission for induction and beginning of process (n=1)

Chelsea and Westminster Site

- Labour Ward:** Compliance decreased to 68% from 80% in May, with 0 red flags reported (a decrease – 4 in May)
- Birth Centre:** Compliance increased to 75% from 69% in May with 4 red flags reported (stable - 4 in May)
 - 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 women during established labour (n=1)
 - No additional support MW available (No second MW for birth) (n=1)
- Simpson Unit (Recovery & HDU):** Compliance increased to 78% from 77% in May, with 3 red flags reported (an increase - 1 in May)
 - Delayed or cancelled time critical activity (n=2)
 - Delay between admission for induction and beginning of process (n=1)
- Antenatal Ward:** Compliance increased to 65% from 63% in May, with 10 red flags reported (an increase - 9 in May)
 - Delayed or cancelled time critical activity (n=2)
 - Delay in providing pain relief (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 women during established labour (n=2)
- Postnatal Ward:** Compliance decreased to 87% from 84% in May, with 10 red flags reported (an increase – 1 in May)
 - 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=2)
 - Delay in providing pain relief (n=4)

Summary: Compliance remained relatively stable in all clinical areas on the WMUH site, meeting the minimum targets to provide data confidence in all areas except the Birth Centre, which remains at less than 80%. Red flag incidents varied across the clinical areas in June, with the highest numbers consistently being reported from the Antenatal Ward. Action has been taken by the area Matron to support staff in utilising the tool effectively to capture red flag events.

Compliance on the CW site remained relatively stable across the clinical areas, with a slight increase in overall compliance noted for the majority of clinical areas. Red flag incidents were noted to vary across all areas in June. Area leads continue to work with staff to ensure data completion, and a review/discussion of overall compliance is expected to take place at the next cross site Maternity Quality & Safety meeting.



Neonatal Staffing: The neonatal leadership team continue to strengthen the local QIS programme to optimise skill mix. At the Chelsea site, QIS compliance improved to 47% in June from 46% in May. Further improvements are expected in imminently, 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 increased slightly to 68% in June from 63% in May, additionally a large cohort of staff have been sent on the 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:

WMH site: There were 4 patient safety incidents:

- IIR – Birth injury – local learning
- IIR – DKA and ITU admission – MDT
- IIR – Maternal ITU admission – under review
- IIR – SCBU admission – local learning

Datix reporting system: There were 133 Datix incidents reported (a decrease – 147 in May)

- Access to care/admissions
- Assault, abuse, aggression
- Provision of care/treatment

Incidents not yet closed over 3 months old: 84 (a slight increase from May). An action plan to address is in place.

CWH site: There were 8 patient safety incidents:

- IIR – Return to theatre – local learning
- IIR – NICU admission – under review
- IIR – Retained products of conception – under review
- IIR – Neonatal skull fracture – under review
- IIR – NICU admission – under review
- IIR – MRSA positive day 6 PN – under review
- IIR – Uterine rupture & MOH – under review
- IIR – Uterine rupture – under review

Datix reporting system: There were 134 Datix incidents reported (an increase – 94 in May)

- Unexpected NICU admissions
- Medication error
- MOH

Incidents not yet closed over 3 months old x4 (a decrease from May)

Neonatal Service:

- Number of Datix: 51 (39 CW + 12 WM) – a decrease from May.



Perinatal Quality Surveillance Dashboard

- **PMRT (Cross site):** CW site reported 3 cases 1: 1 NND on day 43 post birth at 37/40, 1 NND at 24/40 on day 2 post-birth and 1 stillbirth at 32/40. WM site reported 0 cases.
- **ATAIN (Cross site):** WM site reported 10 term admissions, with a term admission rate of 3.18%. CW site reported 23 admissions, with a term admission rate of 6.4%.
- **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.
- **Saving Babies Lives Care Bundle v.3.2:** At the close of Q4, 100% of interventions across all six elements of the care bundle have been implemented, however not all have been re-audited in this quarter based upon the traffic light system implemented by the LMNS. It is noted that 2 metrics within element 1, related to smoking cessation, have not met minimum targets for compliance. Action plans are in place to address this. A full baseline re-audit of all metrics within the care bundle is being undertaken for Q1 26-27 at present.

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				
		Apr-26	May-26	Jun-26	2026-2027	Apr-26	May-26	Jun-26	2026-2027	Apr-26	May-26	Jun-26	2026-2027 Q1	2026-2027
Perinatal Quality	Training compliance for all staff groups in maternity related to the core competency framework (Target: >90%)	91.0%	87.0%	n/a	89.0%	90.0%	94.0%		92.0%	90.5%	90.5%		90.5%	90.5%
	Training compliance for all staff groups in maternity related to fetal monitoring (Target: >90%)	90.0%	89.0%	n/a	89.5%	91.0%	94.0%		92.5%	90.5%	91.5%		91.0%	91.0%
	Service User Feedback FFT	91.2%	87.2%	92.2%	90.2%	91.6%	82.1%	89.9%	88.1%	91.4%	85.3%	91.2%	89.3%	89.3%
	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	0	0	0	0	0	0
	Progress in achievements of NHSR MIS (10 safety actions) Green									10	10	0	20	20
	Progress in achievements of NHSR MIS (10 safety actions) Amber									0	0	0	0	0
	Progress in achievements of NHSR MIS (10 safety actions) Red									0	0	0	0	0
	Ockenden compliance against 7 IEA's (49 compliance questions) (Total of 49 being 100%)									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 June, overall multi-disciplinary training compliance decreased slightly to 91% (WM) and increased to 93% (CW). Fetal monitoring training continues on the WM site at 98%, and improved to 93% at 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 88% in May to 92% in June. Respondents were predominantly White British (35%), White Other (29%), Asian/Asian British (15%) and Black/Black British (7%), with most aged 25-34 years (53%) and 87% English-speaking. The lowest-scoring area remained whether concerns were taken seriously (70%) which is unchanged from May. In contrast 98% reported that they were treated with respect and dignity. Negative feedback themes included temperature control, cleanliness of ward areas, disparities between night and day staff and a lack of breastfeeding support.

At the West Middlesex site, positive feedback increased from 80% in May to 89% in June. Respondents were predominantly Asian/Asian British (47%), White British (20%), and Other (13%), with most aged 25–34 years (63%). Lowest scores remained consistently related to concerns being taken seriously (76%). In contrast 96% reported positively that they were treated with kindness and compassion. Negative feedback themes included poor/unkind communication, cleanliness and noise in wards, delays in assessment and temperature control.

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 reported 100% compliance with all 10 safety actions. Actions plans remain in place regarding neonatal staffing. The service is currently undertaking a gap analysis of MIS Yr 8, with senior team meetings in place to commence planning and action associated with the new requirements.

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 has submitted its final position to the ICB and has declared full compliance with the 43 associated actions and awaits verification on the matter.

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 bench marking 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

Stable performance in mortality indices , with strong performance regionally and nationally.

In-Month Performance

	Summary Hospital-level Mortality Index	Hospital Standardised Mortality Ratio
CW	76.1	70.2
WM	80.2	82.4
Trust	78.4	77.3

Year-to-Date Performance - Reporting Period Dec 24 to Nov 25

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
SHMI (Target: <100)	CW	72.4	72.5	74.0	75.0	76.1	75.0
	WM	78.3	77.4	80.2	79.4	80.2	79.9
	Trust	75.8	75.3	77.5	77.6	78.4	77.8
HSMR (Target: <100)	CW	66.9	66.9	67.8	69.3	70.2	69.1
	WM	83.2	80.5	82.7	83.3	82.4	82.8
	Trust	76.4	74.8	76.5	77.5	77.3	77.1



Patient Access

Access to Cancer Care (Diagnosis)

Responsive – Operating Plan

Trend

28 Day Faster Diagnosis Standard



Narrative

The Trust experienced a has seen a positive recovery in the 28D FDS performance with an uploaded performance in May of 82.2% and the current unvalidated performance for June is sitting at 81.9%, with both months above the national compliance metrics.

The 2ww pathways continue to perform above the national standard, with overall compliance for May being at 94.1% and currently the June performance is at 93.8%.

In-Month Performance

	28 Days Faster Diagnosis Standard	2 Weeks from Referral to First Seen (All Urgent Referrals)
CW	85.0%	90.8%
WM	79.8%	96.1%
Trust	81.9%	93.8%

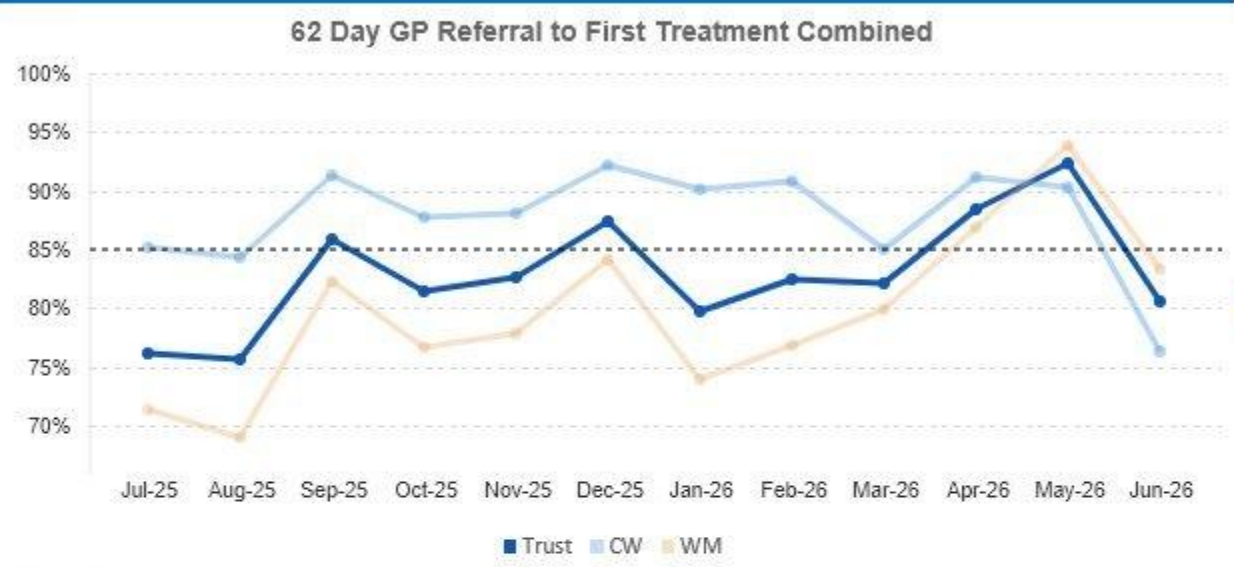
Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
28 Day Faster Diagnosis Standard (Target: >=80%)	CW	82.1%	80.4%	85.6%	85.4%	85.0%	85.3%
	WM	81.5%	77.2%	76.8%	80.2%	79.8%	78.8%
	Trust	81.7%	78.1%	79.2%	82.2%	81.9%	81.1%
2 Weeks from Referral to First Seen (All Urgent Referrals) (Target: >=96%)	CW	94.6%	93.9%	90.9%	90.2%	90.8%	90.6%
	WM	97.3%	96.4%	95.5%	96.6%	96.1%	96.1%
	Trust	96.2%	95.3%	93.7%	94.1%	93.8%	93.8%

Access to Cancer Care (Treatment)

Responsive – Operating Plan

Trend



Narrative

The Trust has continued with strong performance in May 2026, with an uploaded position of 92.3%, one of the highest in the country for 62D Performance, with several services achieving very high standards, Urology being one of these. The unvalidated performance has reduced slightly for June 2026, currently sitting at 83.0%, due to previous month impacts on unforeseen staffing gaps alongside imaging delays (due to impact of heat).

The Trusts 31D position remains above the National KPIs of 96% with May 2026 showing a 99.3% compliance and June is current sitting at 100.0%.

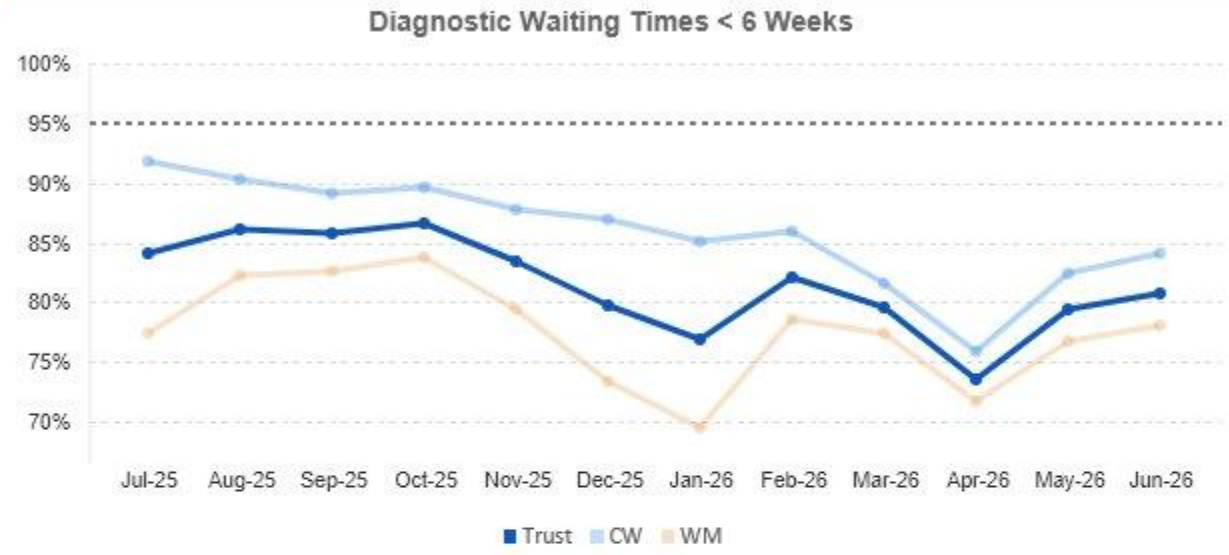
In-Month Performance

	62 Day GP Referral to First Treatment Combined	31 Day Diagnosis to First or Subsequent Treatment	62+ Day Backlog (Target: 100)
CW	76.3%	100.0%	
WM	83.3%	100.0%	
Trust	80.6%	100.0%	0

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
62 Day GP Referral to First Treatment Combined (Target: >=85%)	CW	90.8%	85.0%	91.1%	90.2%	76.3%	85.8%
	WM	76.8%	79.8%	86.8%	93.9%	83.3%	87.5%
	Trust	82.4%	82.2%	88.4%	92.3%	80.6%	86.8%
31 Day Diagnosis to First or Subsequent Treatment (Target: >=96%)	CW	100.0%	98.9%	97.4%	98.4%	100.0%	98.6%
	WM	98.8%	98.9%	100.0%	100.0%	100.0%	100.0%
	Trust	99.3%	98.9%	99.0%	99.3%	100.0%	99.4%
62+ Day Backlog (Target: 100)	CW						
	WM						
	Trust	96	99	120	130	0	0

Trend



Narrative

June represents a further improvement from May in the Trust’s DM01 performance, increasing to 80.71% from 78.86%, although performance remains below the NHS constitutional standard. The improvement has been driven by sseveral key modalities at Chelsea site, including colonoscopy (95.83%), gastroscopy (96.98%) and CT (97.60%), reflecting the continued benefit of targeted recovery actions and additional capacity deployment.

Chelsea and Westminster site performance increased to 84.04% (from 81.35% in May), with improvement across most modalities, although challenges remain within MRI and urodynamics. West Middlesex also improved to 77.99% (from 76.77%), supported by gains in echocardiography, endoscopy and neurophysiology; however, performance continues to be significantly constrained by CT (62.73%), echocardiography (60.25%) and sleep studies (9.35%), where workforce and capacity limitations persist.

While insourcing, CDC utilisation and service optimisation continue to mitigate further deterioration and support recovery, the underlying demand and capacity imbalance remains evident across several diagnostic pathways. Sustained improvement will continue through implementation of targeted actions to increase capacity and to protect routine patients’ slots.

In-Month Performance

	Diagnostic Waiting Times < 6 Weeks	Diagnostic Waiting Times > 6 Weeks: Actuals	Diagnostic Waiters 13+ Weeks
CW	84.0%	1,221	0
WM	78.0%	2,055	0
Trust	80.7%	3,276	0

Year-to-Date Performance

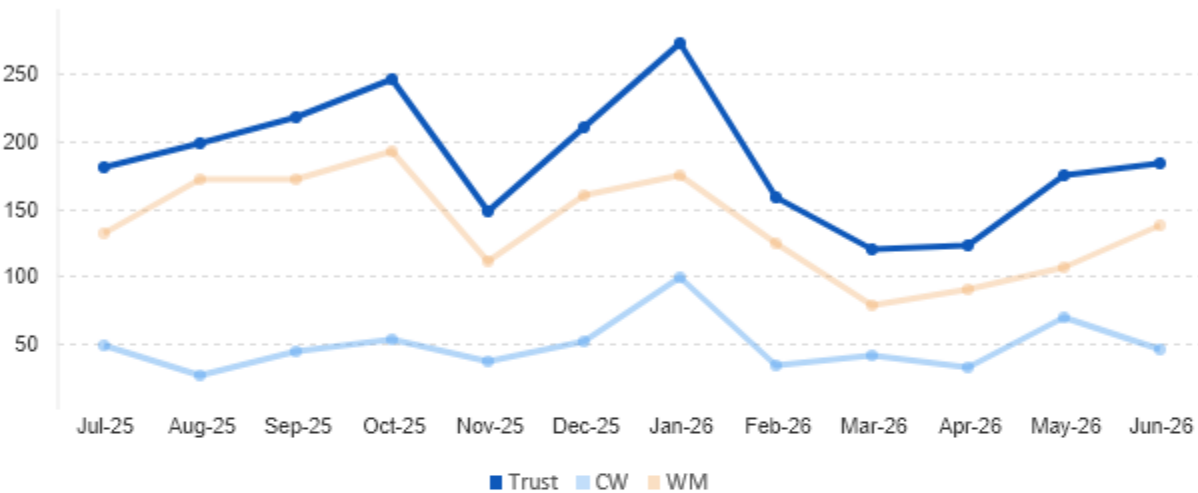
	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Diagnostic Waiting Times < 6 Weeks (Target: >95%)	CW	85.9%	81.6%	75.8%	82.4%	84.0%	80.7%
	WM	78.5%	77.3%	71.7%	76.8%	78.0%	75.4%
	Trust	82.1%	79.6%	73.6%	79.4%	80.7%	77.8%
Diagnostic Waiting Times > 6 Weeks: Actuals	CW	1,124	1,630	1,925	1,370	1,221	1,221
	WM	1,857	1,801	2,730	2,151	2,055	2,055
	Trust	2,981	3,431	4,655	3,521	3,276	3,276
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 comparatively strong. In the month of June 2026, the Trust reported one 60-minute LAS handover delays. The 15-minute handover target remains a particular focus with both sites not compliant with the Chelsea site 16:12 minutes and the West Middlesex site 17:29 minutes.

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	789	85.9	46	0
WM	1,087	146.9	137	1
Trust	1,876	232.8	183	1

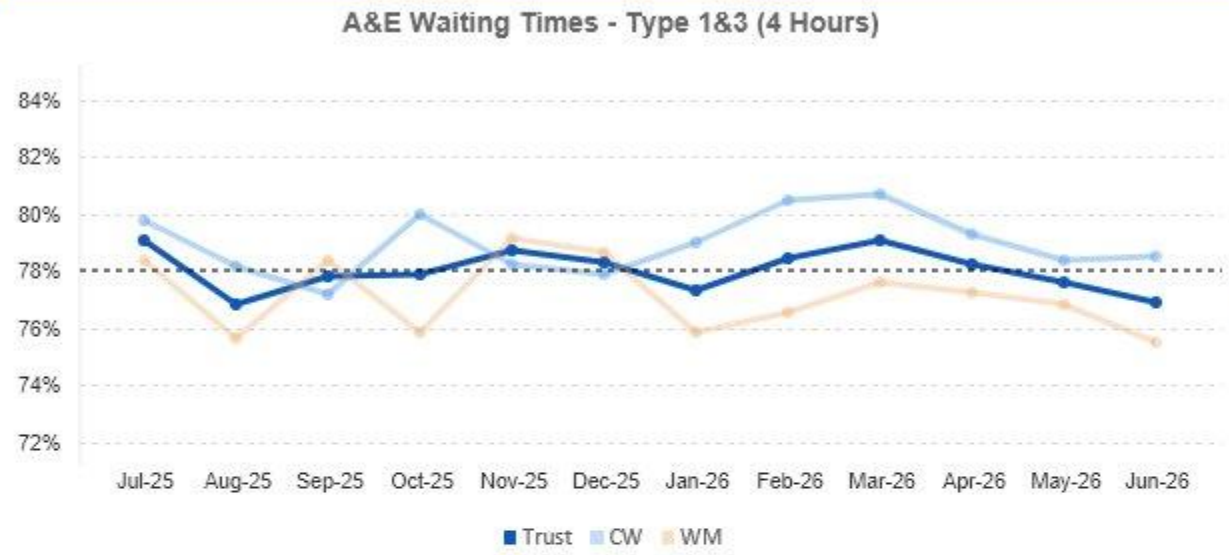
Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
LAS 15 Min Breach Performance	CW	780	835	764	897	789	2,450
	WM	970	975	953	1,036	1,087	3,076
	Trust	1,750	1,810	1,717	1,933	1,876	5,526
LAS Time Lost (Hrs)	CW	86.0	86.9	87.1	102.9	85.9	275.9
	WM	125.7	107.7	111.9	117.4	146.9	376.2
	Trust	211.7	194.6	199.0	220.3	232.8	652.1
LAS Handovers 30 Mins	CW	34	41	33	69	46	148
	WM	124	79	90	106	137	333
	Trust	158	120	123	175	183	481
LAS Handovers 60 Mins	CW	0	0	0	0	0	0
	WM	2	1	2	1	1	4
	Trust	2	1	2	1	1	4

Urgent & Emergency Department Waits

Safe/Responsive – Operating Plan

Trend



Narrative

Performance
Attendances to the Emergency Departments and Urgent Treatment Centers were 6.7% higher in June 26 compared to same period last year. Performance against the 4-hour standard was 76.9%. West Middlesex achieved 75.5% (14,894 attendances) and Chelsea 78.5% (13,573 attendances).

The 12-hour performance is 2.2% against our operating plan trajectory target of 2.8%.

Improvement
There has been an ongoing focus on A&E time to triage in June, West Middlesex achieved an average time to triage of 7 minutes and at the Chelsea site 18 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	78.5%	2.2%	00:14	13,574	847	0
WM	75.5%	3.4%	00:07	14,892	965	0
Trust	76.9%	2.8%	00:10	28,466	1,812	0

Year-to-Date Performance

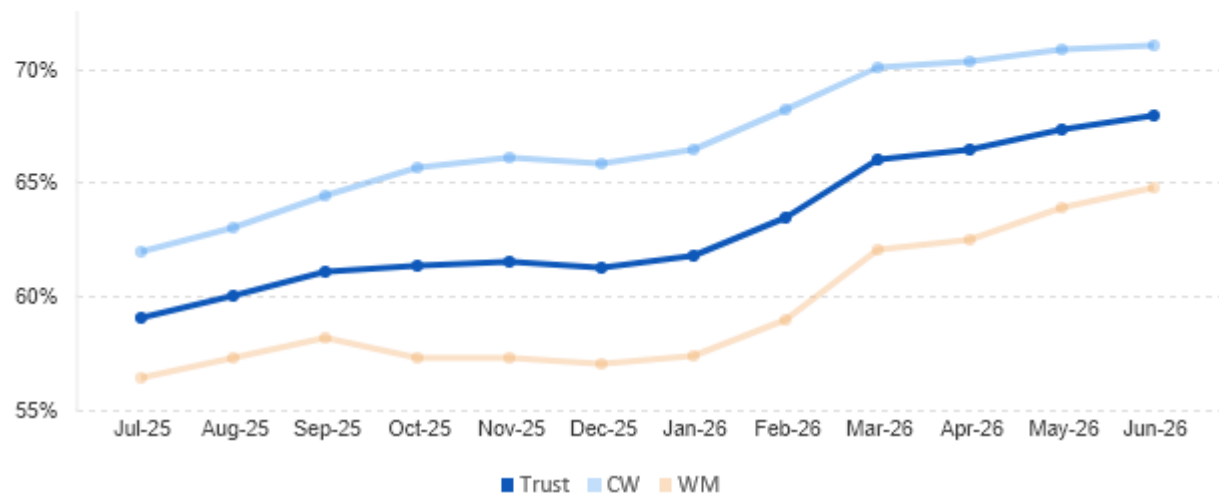
	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
A&E Waiting Times Type 1&3 (4 Hrs) Target: >80%	CW	80.5%	80.7%	79.2%	78.4%	78.5%	78.7%
	WM	76.6%	77.6%	77.3%	76.8%	75.5%	76.5%
	Trust	78.4%	79.1%	78.2%	77.6%	76.9%	77.5%
A&E Waiting Times Type 1&3 (12 Hrs) (Target: <2.8%)	CW	2.0%	1.8%	2.2%	2.5%	2.2%	2.3%
	WM	2.9%	2.1%	2.2%	2.5%	3.4%	2.7%
	Trust	2.5%	1.9%	2.2%	2.5%	2.8%	2.5%
A&E Time to Triage (Target: 15mins)	CW	00:14	00:15	00:15	00:15	00:14	00:15
	WM	00:06	00:07	00:07	00:07	00:07	00:07
	Trust	00:10	00:11	00:10	00:11	00:10	00:11
Total Attendances Type 1&3	CW	11,760	13,442	12,677	13,655	13,574	39,906
	WM	12,830	14,569	14,213	14,925	14,892	44,030
	Trust	24,590	28,011	26,890	28,580	28,466	83,936
Referrals to SDEC (Target as Per Op Plan)	CW	684	842	775	873	847	2,495
	WM	708	948	930	910	965	2,805
	Trust	1,392	1,790	1,705	1,783	1,812	5,300

Referral to Treatment Waits

Responsive – Operating Plan

Trend

18 Week RTT Incompletes



Narrative

Performance: Elective Referral to Treatment (RTT) 18-Week Wait position was reported at 67.93% showing a 0.56% improvement from the previous month. The Trust finishes Q1 ahead of 2026/27 trajectory.

The month ended with 0 65-week breaches and 917 52-week breaches, our lowest position of 2026/27. The 52ww performance at 1.25%, remains behind our target of 1% of the PTL.

Improvement : Funding arrangements were approved across the Trust and recruitment plans are being progressed to increase capacity. In/outsourcing along with WLIs will continue throughout the recruitment periods to ensure performance is maintained.

Risk : Potential further Industrial action (consultant ballot)

In-Month Performance

	18 Week RTT Incompletes	18 Week RTT Incompletes Paeds	52 Week RTT Incompletes	52 Week Waiters	65 Week Waiters
CW	71.1%	75.8%	1.0%	359	0
WM	64.8%	59.9%	1.5%	558	0
Trust	67.9%	68.8%	1.2%	917	0

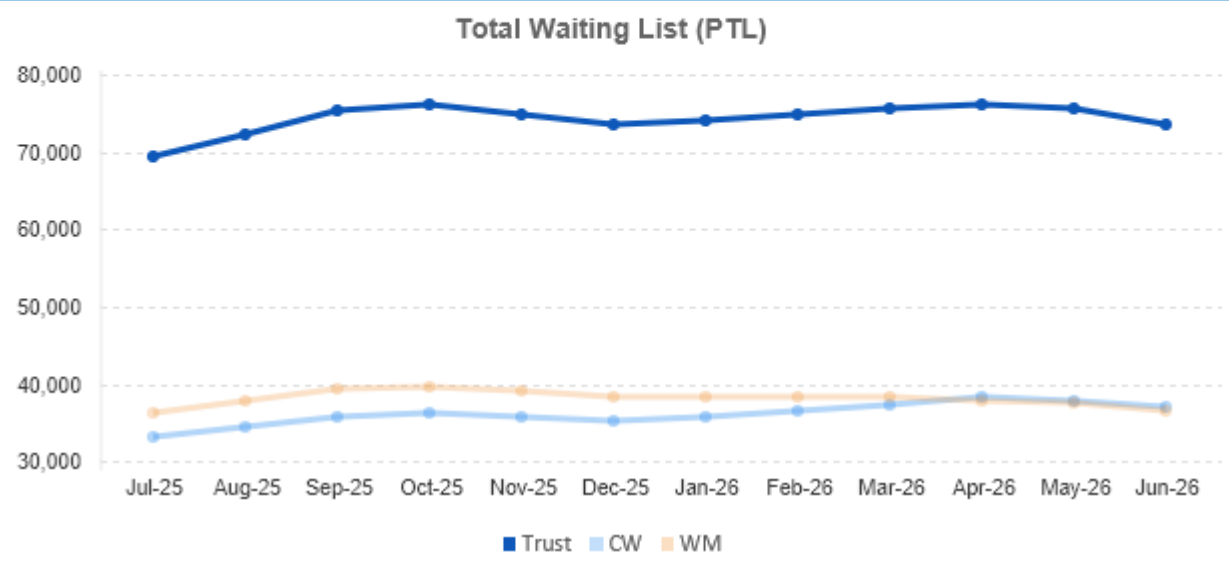
Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
18 Week RTT Incompletes (Target: >66.62%)	CW	68.2%	70.1%	70.4%	70.9%	71.1%	71.1%
	WM	59.0%	62.0%	62.5%	63.9%	64.8%	64.8%
	Trust	63.5%	66.0%	66.4%	67.4%	67.9%	67.9%
18 Week RTT Incompletes Paeds	CW	74.5%	76.0%	76.3%	75.6%	75.8%	75.8%
	WM	53.8%	56.1%	56.6%	61.2%	59.9%	59.9%
	Trust	64.4%	66.7%	67.4%	69.2%	68.8%	68.8%
52 Week RTT Incompletes (Target: <1%)	CW	1.2%	1.0%	1.0%	1.0%	1.0%	1.0%
	WM	1.9%	1.5%	1.5%	1.6%	1.5%	1.5%
	Trust	1.6%	1.3%	1.3%	1.3%	1.2%	1.2%
52 Week Waiters	CW	441	383	370	387	359	359
	WM	720	575	585	615	558	558
	Trust	1,161	958	955	1,002	917	917
65 Week Waiters	CW	3	0	1	1	0	0
	WM	1	0	2	1	0	0
	Trust	4	0	3	2	0	0

Referral to Treatment Waits

Responsive – Operating Plan

Trend



Narrative

Performance: In June the Trust total RTT Patient Treatment List (PTL) was reported as 73,615 a significant decrease on the previous month 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.

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. Specialty level monitoring in place with set trajectories to address recovery. These are highlighted in weekly meetings focusing on at-risk specialties.

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	37,043	6,376	-	6.1
WM	36,572	5,048	-	5.2
Trust	73,615	11,424	-	5.6

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Total Waiting List (PTL)	CW	36,495	37,259	38,270	37,905	37,043	37,043
	WM	38,254	38,386	37,906	37,628	36,572	36,572
	Trust	74,749	75,645	76,176	75,533	73,615	73,615
Total Waiting List (PTL) Paeds	CW	5,745	6,011	6,476	6,457	6,376	6,376
	WM	5,480	5,316	5,364	5,146	5,048	5,048
	Trust	11,225	11,327	11,840	11,603	11,424	11,424
Patients Waiting < 18 Weeks for First Appointment	CW	66.5%	67.8%	68.0%	68.0%	-	-
	WM	58.0%	60.4%	61.5%	63.0%	-	-
	Trust	61.8%	63.8%	64.5%	65.3%	-	-
RTT Clearance Time: Size of Waiting List	CW	6.5	6.3	7.0	6.9	6.1	6.1
	WM	6.5	5.9	6.3	6.2	5.2	5.2
	Trust	6.5	6.1	6.7	6.5	5.6	5.6



Operating Plan and Capacity

Flow & Discharge – Admitted Care

Responsive/Effective

Trend



Narrative

Elective LoS remains compliant with the Trust target YTD, with a Trust average of 2.7 days against the target of <2.9 days.

Non-elective LoS increased across both sites during June, rising from 5.6 to 6.6 days at CWH and from 5.3 to 5.4 days at WMH, resulting in a Trust increase from 5.4 to 6.0 days. This increase correlates with an increase in the number of patients experiencing prolonged non-elective stays greater than 21 days, which increased from 121 to 158 patients at CWH and from 125 to 142 patients at WMH between May and June. Consequently, the Trust total of patients with a non-elective stay exceeding 21 days increased from 246 to 300, reflecting ongoing challenges in discharging patients with complex health and social care needs. There is a weekly focus on long length of stay patients and patients with no criteria to reside. Escalation meetings with community partners continue, all with Trust flow board oversight.

During June, and the first quarter of 2026, ICU occupancy has continued to run above the GPICS recommended 85%, ranging from 92.3% at CWH to 124.8% WMH, indicating sustained operational pressure in the trust of 107.7% occupancy. This reflects increased pressure on the bed base with the requirement to discharge to admit. The primary driver is delayed discharge over four hours, which restricts patient flow and maintains high bed occupancy, and increases the risk of delayed admissions. The ICU team continue to work with the site team to enable flow through the system, with focus on keeping an available bed for emergency admissions.

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	2.7	6.6	478	158	92.3%	6.4
WM	3.0	5.4	585	142	124.8%	5.9
Trust	2.7	6.0	1,063	300	107.7%	6.2

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Elective LoS (Target: <2.9)	CW	2.9	2.9	2.4	3.1	2.7	2.8
	WM	2.3	2.2	2.7	2.3	3.0	2.7
	Trust	2.7	2.7	2.5	2.9	2.7	2.7
Non-Elective LoS (Target: <3.95)	CW	6.2	4.9	5.7	5.6	6.6	5.9
	WM	5.9	5.4	5.2	5.3	5.4	5.3
	Trust	6.0	5.1	5.4	5.4	6.0	5.6
Non-Elective Long Stays (>=7 days)	CW	465	469	484	504	478	1,466
	WM	549	554	520	543	585	1,648
	Trust	1,014	1,023	1,004	1,047	1,063	3,114
Non-Elective Long Stays (>=21 Days)	CW	145	114	127	121	158	406
	WM	162	141	135	125	142	402
	Trust	307	255	262	246	300	808
Critical Care Occupancy (Target: <85%)	CW	113.6%	98.1%	93.7%	87.1%	92.3%	91.0%
	WM	104.3%	105.8%	86.7%	107.2%	124.8%	105.5%
	Trust	108.9%	101.9%	90.2%	96.6%	107.7%	98.0%
Average days between the DRD and DD	CW	8.2	6.5	6.2	7.5	6.4	6.7
	WM	5.6	5.7	7.0	6.1	5.9	6.3
	Trust	6.7	6.0	6.6	6.8	6.2	6.5

Flow & Discharge – Discharges

Responsive

Trend

Patient Not Meeting CTR by Trust of Pathway



Narrative

Performance: The Trust continues to be an outlier in relation to the number of inpatients who do not meet the criteria to reside. This is largely attributable to patients requiring additional discharge support, including decluttering, deep cleaning of properties, housing arrangements, or nursing home placements (P3 discharges). Performance against discharge ready dates and readmission rates remains stable. Progress continues to be closely monitored through the weekly discharge performance meetings.

Additional escalation meetings remain in place to support a reduction in the number of patients awaiting P1 discharges across RBKC, Westminster, and LBHF. These arrangements are complemented by escalation processes with other system partners and participation in the NWL weekly GOLD system call to facilitate timely discharge planning and resolution of barriers.

Risk: That the number of patients who do not meet the criteria to reside increases due to the increase in temperature.

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	17.9%	16.1%	87.3%	12.7%	4.5%
WM	14.9%	13.3%	86.6%	13.4%	4.5%
Trust	16.2%	14.8%	87.0%	13.0%	4.5%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Patient Not Meeting CTR Daily Average	CW	17.7%	18.0%	19.3%	18.8%	17.9%	18.7%
	WM	16.4%	17.1%	14.6%	12.3%	14.9%	13.9%
	Trust	17.0%	17.5%	16.8%	15.3%	16.2%	16.1%
Discharges Before 12	CW	16%	14%	15%	16%	16%	15%
	WM	16%	14%	15%	13%	13%	14%
	Trust	16%	14%	15%	14%	15%	15%
Discharge Date Same as Discharge Ready Date	CW	88.0%	89.8%	87.2%	88.1%	87.3%	87.5%
	WM	85.5%	85.7%	88.2%	88.8%	86.6%	87.9%
	Trust	86.7%	87.8%	87.7%	88.5%	87.0%	87.7%
Discharge Date After Discharge Ready Date	CW	12.0%	10.2%	12.8%	11.9%	12.7%	n/a
	WM	14.5%	14.3%	11.8%	11.2%	13.4%	n/a
	Trust	13.3%	12.2%	12.3%	11.5%	13.0%	n/a
Emergency Re-Admissions < 30 Days of Discharge (Target: <7.6%)	CW	4.9%	4.8%	4.7%	4.5%	4.5%	4.6%
	WM	5.4%	5.5%	6.5%	6.5%	4.5%	5.8%
	Trust	5.1%	5.1%	5.6%	5.5%	4.5%	5.2%

Operating Plan Performance

Responsive – Operating Plan



Chelsea and Westminster Hospital
NHS Foundation Trust

Trend

Elective Day Case



Narrative

Operating plans for 2026/27 is being met for outpatients with Elective activity showing marginal levels below plan. A number of income recovery initiatives have taken place in M3 which will aim to recover elective activity going forward. Plans reflect the increase in activity across all elective PODs to support delivery of the RTT standards.

The Trust continues to review transformation programmes across key Outpatient, Theatres and Diagnostics areas to identify areas of opportunity to further improve pathway efficiency with these manages via appropriate governance routes. Planned recruitment process ongoing to support elective activity increase with an expectation this would be reflected in further months.

Risk to achieving future plans include Industrial action (consultant ballot).

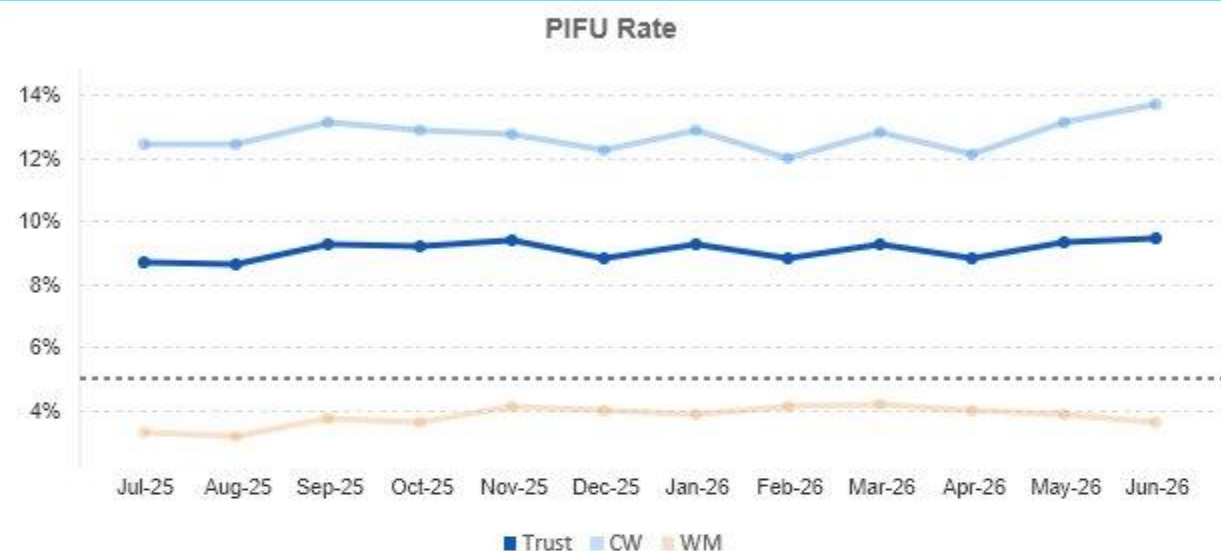
In-Month Performance

	Elective Day Cases	Elective Ordinary Admissions	OP Procedures	OP First Attendance Without Procedure	OP FUP Attendance Without Procedure
CW	2,873	462	5,936	10,945	18,501
WM	2,551	164	3,597	10,664	11,197
Trust	5,424	626	9,533	21,609	29,698

Year-to-Date Performance

	Site	Mar-26	Apr-26	May-26	Jun-26	Plan YTD	2026-2027
Elective Day Cases	CW	3,318	2,875	2,701	2,873	9,197	8,449
	WM	2,853	2,539	2,648	2,551	7,645	7,738
	Trust	6,171	5,414	5,349	5,424	16,842	16,187
Elective Ordinary Admissions	CW	533	465	465	462	1,317	1,392
	WM	217	165	180	164	534	509
	Trust	750	630	645	626	1,851	1,901
OP Procedures	CW	6,093	5,767	5,560	5,936	15,677	17,263
	WM	3,620	3,606	3,306	3,597	10,246	10,509
	Trust	9,713	9,373	8,866	9,533	25,923	27,772
OP First Attendance Without Procedure	CW	10,890	10,222	9,657	10,945	30,587	30,824
	WM	10,384	9,595	9,706	10,664	26,277	29,965
	Trust	21,274	19,817	19,363	21,609	56,864	60,789
OP FUP Attendance Without Procedure	CW	18,497	18,557	17,743	18,501	53,229	54,801
	WM	10,420	10,009	9,746	11,197	32,478	30,952
	Trust	28,917	28,566	27,489	29,698	85,707	85,753

Trend



Narrative

'Patients added to **PIFU**' improved again in June, rising up to 9.5% against the 5% Trust target, which is our highest ever performance. More than ever this is driven by the Chelsea site, and Specialist Care in particular, and in fact WMUH's performance is dipping. This is largely due to a drop in a small number of specialities which we are investigating.

DNA rate in June was mixed in comparison with the previous month. New DNA dipped slightly overall, with an improvement at Chelsea off-set by WMUH's performance dropping. But Follow up DNA improved on both sites. Overall our performance (for both new and f/up) benchmarks well against our historic performance, but we will be focussing in particular on New DNA and exploring how to equalise these metrics. An outline plan was well-received at June's OP Board, with further detail to follow in July.

In-Month Performance

	PIFU Rate	DNA Rates - First Appointment	DNA Rates - Follow Up Appointment	Virtual Contacts
CW	13.7%	10.3%	8.0%	4,907
WM	3.6%	9.9%	7.5%	4,521
Trust	9.5%	10.1%	7.8%	9,428

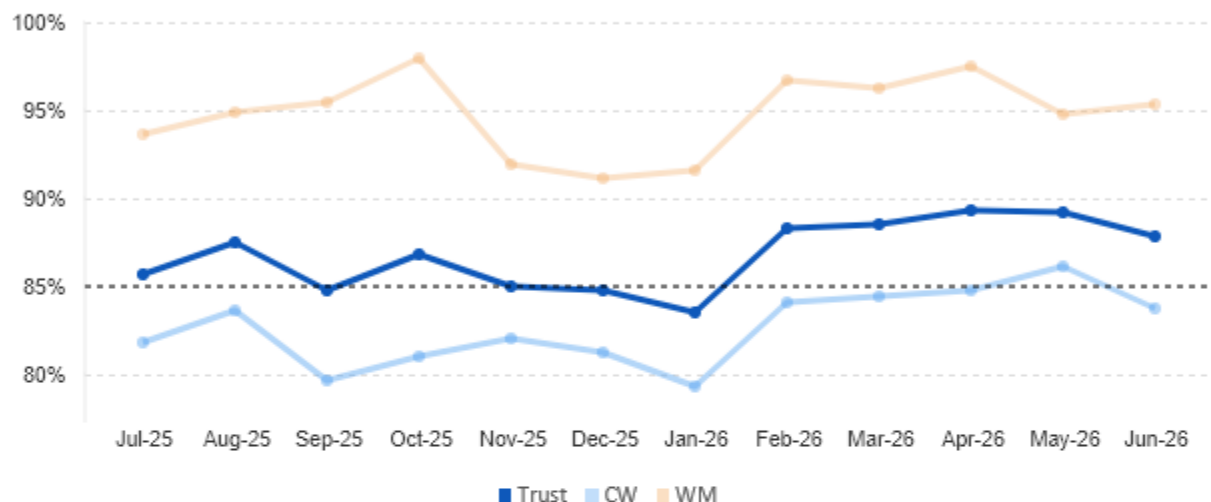
Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
PIFU Rate (Target: 5%)	CW	12.0%	12.8%	12.1%	13.1%	13.7%	13.0%
	WM	4.1%	4.2%	4.0%	3.9%	3.6%	3.8%
	Trust	8.8%	9.2%	8.8%	9.3%	9.5%	9.2%
DNA Rates - First Appointment	CW	10.6%	10.9%	11.4%	10.7%	10.3%	10.8%
	WM	9.9%	10.0%	9.7%	9.1%	9.9%	9.6%
	Trust	10.2%	10.5%	10.6%	9.9%	10.1%	10.2%
DNA Rates - Follow Up Appointment	CW	8.3%	7.8%	8.1%	8.0%	8.0%	8.0%
	WM	7.6%	7.1%	7.3%	7.9%	7.5%	7.6%
	Trust	8.0%	7.5%	7.8%	8.0%	7.8%	7.9%
Virtual Contacts	CW	4,815	4,531	4,758	4,315	4,907	13,980
	WM	3,948	4,295	4,134	4,098	4,521	12,753
	Trust	8,763	8,826	8,892	8,413	9,428	26,733

Responsive

Trend

Theatre Utilisation (Uncapped)



Narrative

Trust-Wide uncapped utilisation continued to be compliant with a performance of 87.9%. There was a decrease in utilisation at the CW site, driven by lower utilisation in Day Surgery Unit and Paediatric theatres. Cancellations on the day was the main driver for this and being focused on through improvement workstreams. Both Main Theatres maintained continued performance of >90% utilisation.

Day case rate was at 89.8% for June. This was driven by a vast improvement at CW, moving from 83.5% to 91.6%

OTD cancellations were fairly static for June, with no patients breaching. There was a continued high number of non-clinical cancellations on the CW site, with 1.5% cancelled on the day for a nonclinical reason. The on the day cancellation rate remains a focus on improvement work streams and working closely with operational teams to identify capacity to rebook.

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	87.5%	1.5%	1	83.8%
WM	88.4%	0.8%	0	95.4%
Trust	87.8%	1.2%	1	87.9%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Basket Procedures Carried Out as Daycases (Target: >85%)	CW	84.6%	83.7%	80.7%	83.4%	87.5%	83.4%
	WM	92.6%	89.0%	91.0%	88.8%	88.4%	89.5%
	Trust	87.0%	85.6%	83.7%	85.2%	87.8%	85.3%
OTD Non-Clinical Cancellations as % Elective Admissions (Target: <0.8%)	CW	0.9%	0.8%	1.4%	1.1%	1.5%	1.3%
	WM	0.6%	0.3%	0.6%	0.6%	0.8%	0.7%
	Trust	0.8%	0.6%	1.1%	0.9%	1.2%	1.0%
OTD Cancellations Not Re-booked < 28 Days (Target: 0)	CW	1	0	0	0	1	1
	WM	0	0	0	0	0	0
	Trust	1	0	0	0	1	1
Theatre Utilisation (Uncapped) (Target: >85%)	CW	84.2%	84.5%	84.8%	86.1%	83.8%	84.9%
	WM	96.7%	96.3%	97.5%	94.8%	95.4%	95.8%
	Trust	88.3%	88.5%	89.3%	89.2%	87.9%	88.8%

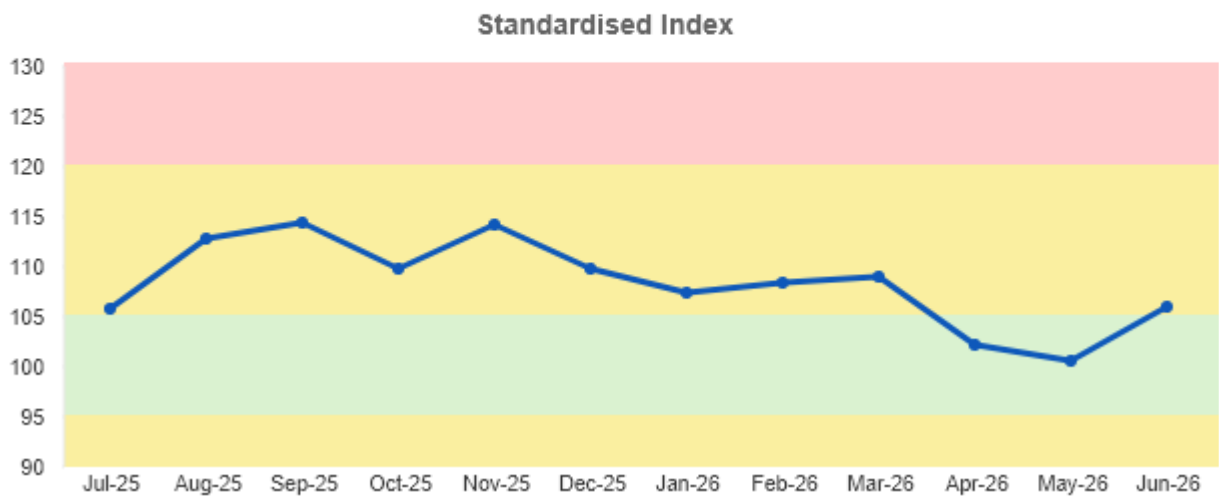


Equality, Diversity and Inclusion

Inequity-RTT Waiting Times

Equality, Diversity and Inclusion

Trend



Narrative

The number of patients waiting over 40 weeks for 1st OPA from IMDQ1 is at 6.4%, slightly above other quintiles. The total number of patients is our lowest since recording commenced however, we have seen PTL reduction so proportionally the number has remained the same.

For 2026/27, our elective care specialties have all completed a tailored trajectory to address inequity in their waiting list and improvement targets around 40 week waits amongst the IMDQ1 population forms pars of those trajectories. All Division aim to ensure all patients have a first OPA before 40 weeks regardless of the quintile they sit within.

Appropriate monitoring dashboards will be developed and the performance against trajectory of each specialty will be reviewed through Elective Access.

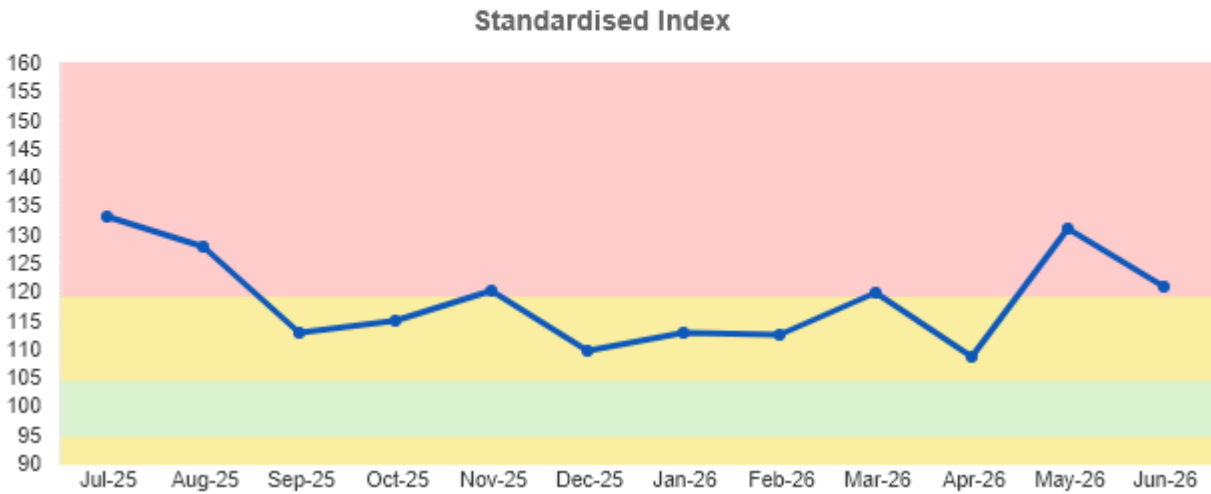
In-Month Performance

	Standardised Index	Proportion IMDQ1	Proportion IMDQ2-5	IMDQ1 >40wk	IMDQ2 - 5 >40wk
Trust	106	6.4%	6.0%	530	3,870

Year-to-Date Performance

Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Standardised Index	108	109	102	101	106	103
Proportion IMDQ1	8.2%	7.1%	6.7%	6.5%	6.4%	6.6%
Proportion IMDQ2-5	7.6%	6.5%	6.6%	6.5%	6.0%	6.4%
IMDQ1 >40wk	682	592	576	553	530	1,659
IMDQ2 - 5 > 40wk	4,924	4,278	4,367	4,272	3,870	12,509

Trend



Narrative

The Trust continues to utilise admin resource and proactively contacts patients ahead of their appointments to reduce DNA rates for IMDQ1 (new appointments). To date, 4,289 of 8,888 patients have been contacted, with 46% confirming attendance, 44% not responding, 3% rebooking, and 1% being discharged. An audit of patients who subsequently DNA'd despite confirming their appointment identified no consistent pattern, with reasons including illness on the day, work-related commitments, and simply forgetting the appointment.

Challenges:

- Patients not answering phone calls or respond to voice mail.
- Limited volunteer resources.

In-Month Performance

	Standardised Index	Proportion IMDQ1	Proportion IMDQ2-5	IMDQ1	IMDQ2 - 5
Trust	121	11.7%	9.7%	395	2,553

Year-to-Date Performance

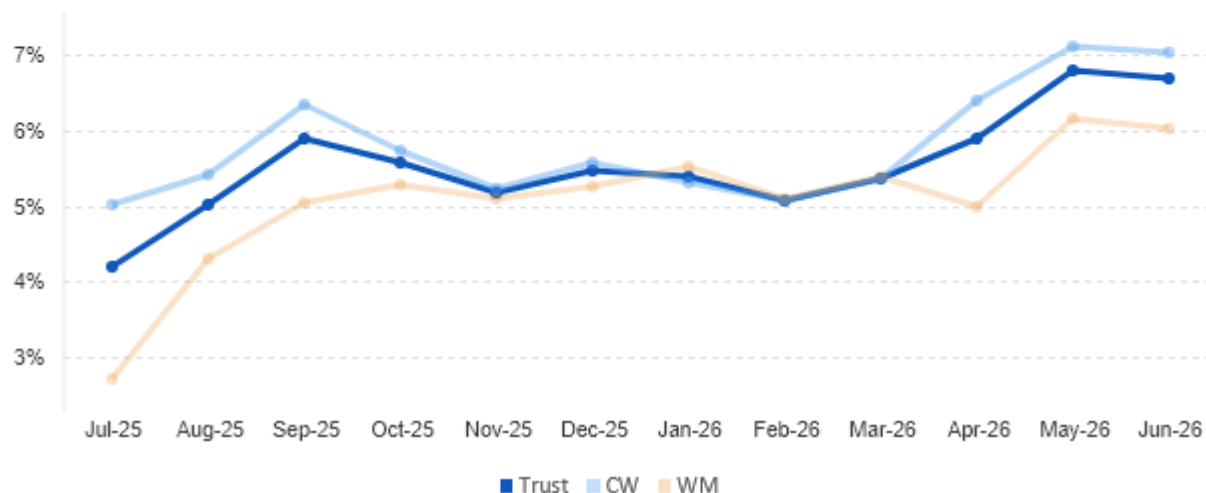
Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Standardised Index	112	120	109	131	121	120
Proportion IMDQ1	10.6%	11.6%	10.8%	12.0%	11.7%	11.5%
Proportion IMDQ2-5	9.4%	9.7%	10.0%	9.1%	9.7%	9.6%
IMDQ1	322	374	339	365	395	1,099
IMDQ2 - 5	2,278	2,509	2,458	2,168	2,553	7,179



Workforce

Trend

Vacancy Rate



Narrative

The Trust's Month 3 position shows the vacancy (6.7%), voluntary turnover rates (7.4%) and % Bank and Agency Usage are well within the target level.

The key marker for concern remains the sickness levels which increased marginally on last month with increases in PCD which is above 4% for in-month sickness. CSD, PCD and SCD are also exceeding the 4% threshold for rolling sickness rates. The Divisions supported by Business Partners and the ER Team are proactively intervening and providing manager with support to return the sickness percentage to below target.

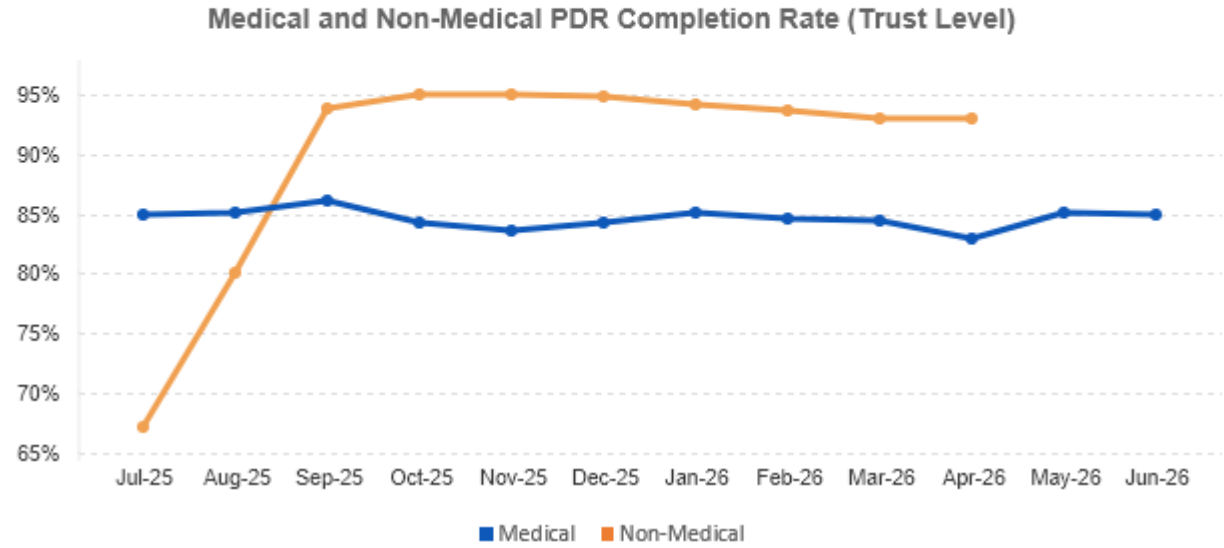
In-Month Performance

	Vacancy Rate	Voluntary Turnover	Sickness Absence	Agency Usage	Bank Usage
CW	7.04%	7.9%	4.0%	0.2%	7.8%
WM	6.02%	6.6%	4.9%	0.2%	10.1%
Trust	6.68%	7.4%	4.3%	0.2%	8.7%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Vacancy Rate	CW	5.1%	5.4%	6.4%	7.1%	7.0%	7.0%
	WM	5.1%	5.4%	5.0%	6.2%	6.0%	6.0%
	Trust	5.1%	5.4%	5.9%	6.8%	6.7%	6.7%
Voluntary Turnover	CW	8.7%	8.5%	8.3%	8.2%	7.9%	7.9%
	WM	7.2%	6.7%	6.4%	6.5%	6.6%	6.6%
	Trust	8.2%	7.8%	7.7%	7.6%	7.4%	7.4%
Sickness Absence	CW	4.2%	4.1%	4.4%	4.1%	4.0%	4.0%
	WM	4.8%	4.6%	4.5%	4.3%	4.9%	4.9%
	Trust	4.4%	4.3%	4.4%	4.2%	4.3%	4.3%
% Agency Usage	CW	0.3%	0.4%	0.2%	0.2%	0.2%	0.2%
	WM	0.3%	0.5%	0.2%	0.3%	0.2%	0.2%
	Trust	0.3%	0.4%	0.2%	0.3%	0.2%	0.2%
% Bank Usage	CW	8.9%	9.2%	7.8%	8.1%	7.8%	7.8%
	WM	11.2%	11.1%	9.7%	9.9%	10.1%	10.1%
	Trust	9.7%	9.9%	8.5%	8.7%	8.7%	8.7%

Trend



Narrative

The trust is recently completed the PDR window (1st April - 30th June).

The trust has achieved its target PDR rate is 95% with four of the six divisions achieving the 95% target.

The trust has completed 95% of PDRs. WLCH has the highest rate 97.8% with EIC 96.2%; CSD 96.2%; PDC 94.1%; SCD 92.6% and COR 97.2%.

In-Month Performance

	Medical PDR Completion Rate (Trust Only)	Non-Medical PDR Completion Rate	Core Skills Completion Rate
CW	-	-	91.3%
WM	-	-	92.8%
Trust	85.0%	-	91.9%

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Jun-26	2026-2027
Medical PDR Completion Rate (Trust Only)	CW						
	WM						
	Trust	84.6%	84.4%	82.9%	85.1%	85.0%	85.0%
Non-Medical PDR Completion Rate	CW	92.9%	92.4%	92.4%			
	WM	95.0%	94.1%	94.1%			
	Trust	93.7%	93.0%	93.0%			
Core Skills Completion Rate	CW	91.3%	91.3%	91.3%	91.3%	91.3%	91.3%
	WM	92.8%	92.8%	92.8%	92.8%	92.8%	92.8%
	Trust	91.9%	91.9%	91.9%	91.9%	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	94%	99%	95%	100%	7.8	2.7	0.0	0.0	10.43	12.79	-2.35%	6.15%	2.26%	1	4	0	0	0	0	0	0	9	66	0	0	3	74	88.48%	
Annie Zunz	93%	90%	100%	100%	6.1	2.2	0.0	0.0	8.30	8.73	6.09%	7.52%	0.00%	0	11	0	0	0	0	0	0	2	8	0	0	0	4	100.00%	
Apollo	92%	-	97%	-	20.0	0.0	0.0	0.0	19.98	N/A	-4.43%	5.61%	32.97%	0	1	0	0	0	1	0	1	3	21	0	0	0	0	100.00%	
Mercury	101%	-	101%	-	8.5	0.0	0.0	0.0	8.50	9.94	-0.79%	3.13%	0.00%	1	1	0	0	0	0	0	0	4	64	0	0	0	3	100.00%	
Neptune	134%	-	134%	-	8.0	0.0	0.0	0.3	8.31	13.06	10.68%	9.03%	0.00%	0	2	0	0	0	0	0	0	3	42	0	0	0	3	90.00%	
NICU	109%	-	108%	-	15.5	0.0	0.3	0.0	15.78	26.91	3.51%	1.95%	0.00%	0	0	0	0	0	0	0	0	4	98	0	0	0	6		
AAU	108%	92%	102%	130%	6.7	1.8	0.0	0.1	8.58	8.4	7.90%	4.11%	5.59%	14	132	1	4	0	5	0	1	5	92	1	0	1	18	96.88%	
Nell Gwynne	103%	95%	116%	121%	4.0	3.2	0.0	0.3	7.54	7.82	-2.74%	4.68%	16.93%	7	43	0	3	0	0	0	0	0	13	0	0	0	2	94.00%	
David Erskine	96%	90%	95%	126%	3.1	3.0	0.0	0.1	6.17	7.14	12.69%	4.42%	6.02%	2	70	0	1	0	0	0	0	4	32	0	0	0	6	90.91%	
Edgar Horne	105%	97%	100%	116%	3.0	3.0	0.2	0.0	6.22	6.78	5.88%	0.00%	0.00%	5	61	0	1	0	2	0	0	1	31	0	0	1	9	94.95%	
Lord Wigram	91%	93%	97%	95%	3.6	3.2	0.3	0.0	7.19	7.81	1.68%	2.79%	10.05%	2	32	1	0	0	4	0	1	0	27	0	0	0	3	100.00%	5
St Mary Abbots	91%	96%	94%	96%	3.6	3.4	0.0	0.0	6.94	7.55	11.16%	20.77%	24.79%	0	31	0	0	0	0	0	0	1	34	0	0	0	8	96.43%	
David Evans	87%	95%	95%	100%	4.6	3.1	0.0	0.3	8.02	7.55	4.42%	0.00%	5.48%	0	18	0	2	0	0	0	0	1	29	0	1	0	6	95.00%	
Chelsea Wing	149%	131%	102%	90%	11.3	6.2	0.0	0.0	17.53	7.55	17.82%	24.08%	18.18%	0	4	0	1	0	0	0	0	3	24	0	0	2	10		1
Burns Unit	103%	112%	176%	100%	16.5	2.3	0.0	0.2	18.94	N/A	8.89%	7.70%	0.00%	2	17	0	0	0	0	0	0	0	8	0	0	0	3		
Ron Johnson	101%	123%	100%	116%	4.5	2.9	0.0	0.0	7.42	5.51	7.66%	0.00%	0.00%	3	57	0	0	1	0	0	0	1	38	0	0	0	5	100.00%	
ICU	101%	-	102%	-	27.4	0.0	0.3	0.0	27.73	26.91	1.22%	8.94%	23.36%	1	9	0	0	0	2	0	1	1	44	0	0	0	1		
Rainsford Mowlem	108%	101%	99%	118%	3.0	3.1	0.3	0.0	6.44	7.5	6.93%	3.82%	4.32%	1	43	1	1	0	0	0	0	0	17	0	0	1	10	93.55%	
Nightingale	116%	99%	100%	140%	3.3	3.4	0.0	0.1	6.80	7.5	8.98%	0.00%	6.49%	11	90	0	1	0	1	0	0	4	41	0	0	0	4	98.84%	
Emergency Department	104%	91%	111%	98%	-	-	-	-	-	N/A	6.46%	6.82%	0.00%	3	51	0	2	0	0	0	0	11	102	0	0	7	96	85.43%	
DSU	86%	73%	102%	100%	-	-	-	-	-	N/A	11.42%	5.24%	3.18%	1	7	0	0	0	0	0	0	0	15	0	0	0	4	96.77%	
Theatres	94%	90%	102%	102%	-	-	-	-	-	N/A	-0.97%	2.94%	14.09%	0	0	0	0	0	0	0	0	1	8	0	0	0	5		
OPD	66%	91%	-	-	-	-	-	-	-	N/A	0.98%	9.17%	10.75%	1	3	0	1	0	0	0	0	1	9	0	0	9	101	89.35%	
Averages /Totals	101%	98%	106%	109%	8.5	2.3	0.1	0.1	10.9		5.35%	6.04%	8.02%	55	687	3	17	1	15	0	4	59	863	1	1	24	381	95.03%	6

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	111%	95%	128%	98%	3.4	2.8	0.0	0.1	6.27	7.5	1.10%	0.00%	4.82%	3	57	0	0	1	9	0	0	3	57	1	1	0	2	91.30%	
Richmond	95%	98%	103%	103%	3.9	2.9	0.2	0.0	6.99	7.55	5.10%	0.00%	7.74%	3	19	0	0	0	0	0	0	2	9	0	0	0	3	100.00%	
Syon 1 cardiology	102%	91%	97%	124%	4.2	1.9	0.1	0.2	6.35	7.93	4.89%	5.95%	40.26%	5	39	0	2	0	0	0	0	2	18	0	0	0	0	96.36%	
Syon 2	110%	93%	104%	101%	3.8	3.2	0.2	0.0	7.18	7.14	5.65%	0.00%	0.00%	1	46	0	1	1	3	0	0	3	44	0	0	0	6	98.41%	
Starlight	130%	-	122%	-	8.8	0.0	0.0	0.0	8.84	13.06	15.78%	7.57%	200.00%	0	3	0	0	0	1	0	0	3	41	0	0	0	9	94.12%	
Kew	123%	126%	140%	136%	4.1	3.7	0.1	0.0	7.90	7.5	9.44%	5.28%	9.31%	6	38	0	2	0	1	0	1	1	27	0	0	0	2	100.00%	
DRU	98%	85%	101%	100%	2.9	3.0	0.1	0.1	6.14	7.5	0.63%	0.00%	16.46%	4	54	0	1	1	2	0	0	6	20	0	0	0	5	100.00%	
Osterley 1	103%	96%	103%	94%	4.1	2.6	0.1	0.2	6.97	7.81	8.75%	3.55%	10.24%	3	52	0	0	2	12	0	2	6	39	0	0	0	4	100.00%	
Osterley 2	99%	97%	98%	102%	3.5	3.1	0.2	0.1	6.88	7.55	5.13%	0.00%	4.88%	0	36	0	0	0	4	0	3	2	29	0	0	0	4	90.91%	
MAU	102%	101%	110%	108%	6.4	2.7	0.0	0.1	9.18	8.4	11.29%	1.54%	0.00%	12	94	0	1	0	3	0	0	7	92	0	1	0	10	96.93%	
Maternity	103%	85%	106%	96%	8.7	2.4	0.0	0.0	11.02	12.79	-1.03%	3.74%	2.32%	0	1	0	0	0	0	0	0	5	41	0	0	1	12	90.05%	
Special Care Baby Unit	115%	-	127%	-	9.2	0.0	0.0	0.0	9.20	13.06	11.05%	6.25%	0.00%	0	0	0	0	0	0	0	0	0	20	0	0	0	1		
Marble Hill 1	103%	137%	109%	158%	3.9	3.8	0.0	0.0	7.69	6.8	0.69%	3.69%	5.80%	6	99	0	2	0	2	1	0	3	60	0	0	0	6	90.67%	
Marble Hill 2	122%	115%	141%	122%	3.9	3.1	0.0	0.1	7.07	6.78	7.47%	15.03%	11.21%	5	63	0	2	0	0	0	0	4	80	0	0	0	7	100.00%	
ITU	94%	-	98%	-	22.4	0.0	0.0	0.0	22.36	26.91	3.50%	7.99%	0.00%	0	5	0	0	1	3	0	0	4	38	1	1	0	0		
Redlees	99%	96%	104%	120%	3.7	3.6	0.0	0.4	7.73	7.82	1.45%	4.97%	0.00%	7	51	1	0	0	0	0	0	3	17	0	0	0	2	96.67%	1
Emergency Department	107%	89%	109%	60%	-	-	-	-	-	N/A	8.75%	7.75%	0.00%	5	43	0	0	1	2	0	0	8	56	0	1	3	37	79.73%	
DSU	97%	134%	-	-	-	-	-	-	-	N/A	-3.31%	0.00%	0.00%	2	4	0	0	0	0	0	0	0	2	0	0	0	4	86.47%	
Theatres	91%	82%	114%	100%	-	-	-	-	-	N/A	3.72%	1.61%	17.07%	1	2	0	0	0	0	0	0	0	7	0	0	1	7		
OPD	88%	86%	-	-	-	-	-	-	-	N/A	1.29%	4.57%	6.45%	0	3	0	0	0	0	0	0	0	11	0	0	4	45	92.01%	
Averages /Totals	105%	100%	112%	108%	6.1	2.4	0.1	0.1	8.6		5.07%	3.97%	16.83%	63	709	1	11	7	42	1	6	62	708	2	4	9	166	94.33%	1



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:

Starlight had increased RN fill rates at night to support enhanced observation for patients requiring mental health supervision. Marble Hill 1 & 2, Kew, and Redlees reported increased HCA fill rates (day and night), to support enhanced observation for patients with mental health needs and those at risk of falls. Marble Hill 2, Syon 1 and Lampton Frailty Unit had increased RN fill rate day and night to staff escalation areas.

ED reported low HCA fill rates (day and night) due to sickness and limited specialist bank availability; however, patient care was maintained. DSU reported increased day HCA fill rate due to escalation and additional lists.

Chelsea and Westminster site:

Chelsea Wing experienced increased RN fill rates during the day to meet additional clinic demand. A business case is currently being developed to reflect the increased acuity and staffing requirements. Ron Johnson had increased HCA fill rate in the night due to additional escalation beds. Nightingale and had increased HCA fill rates to support the opening of escalation beds. Night-time HCA fill rates were increased on AAU, Nell Gwynne, and David Erskine to support enhanced observations for patients with mental health needs and those at risk of falls.

Burns Unit reported increased RN fill rates to meet the higher acuity and care needs of patients. In OPD RN fill rates were low due to staff sickness and limited availability of bank cover. Matron and managers provided support with cross cover arrangements, patient safety was maintained throughout.

The DSU reported low daytime HCA fill rates due to vacancies and limited specialist bank cover. Patient care was maintained through management support. Neptune reported increased RN fill rates on both day and night shifts due to enhanced observations required for a patient with mental health needs.

Incidents:

In June, eight patient harm incidents were reported, comprising four falls, three medication incidents, and one Trust-acquired pressure ulcer. A review of all incidents identified no evidence that short staffing was a contributory factor.

On AAU and Rainforest Mowlem, witnessed patient falls resulted in fractured hips requiring surgical intervention. Incident Investigation Reviews (IIRs) were completed for both incidents. On Lord Wigram and Redlees wards, unwitnessed patient falls also resulted in fractured hips requiring surgical intervention. IIRs were undertaken, and Duty of Candour was initiated in line with Trust policy.

On Marble Hill 1, a Trust-acquired pressure ulcer to the sacral area was reported. An Incident Investigation Review (IIR) has been initiated, and the case remains under review to determine any contributory factors.

On AAU, a medication incident involved the omission of regular prescribed pain relief, resulting in opioid withdrawal symptoms. The incident was reviewed, an apology was provided to the patient, and actions have been taken to strengthen medication management processes.

On ITU WM a medication incident involved a delay to monitor Activated Partial Thromboplastin Time (APTT) levels and titrate a heparin infusion accordingly. This resulted in a delay to commencing continuous renal replacement therapy (CRRT).

On Lampton a failed discharge involving the dispensing of an incorrect medication is currently under investigation.

The Friends and Family Test showed 100% scores in five wards at WM and five wards at CW. One area received FFT feedback scores below 80%. Feedback from WM Emergency Department related to waiting times and overall experiences within the department. Please note all incident figures are correct at time of extraction from DATIX. There were 7 red flags raised in June. One at Wm and the remaining at CW.

The vacancy rate and turnover are from May 2026.



Nursing, Midwifery and care staff average fill rate June 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
104.94% ↓	103.95% ↓	6.1 ↓	2.6 ↓	8.8 ↓

RN Fill Rates (ward areas) decreased from 105.72% in May 2026 to 104.94% in June 2026. The RN vacancy rate (whole trust) in May 2026 was 4.76%.

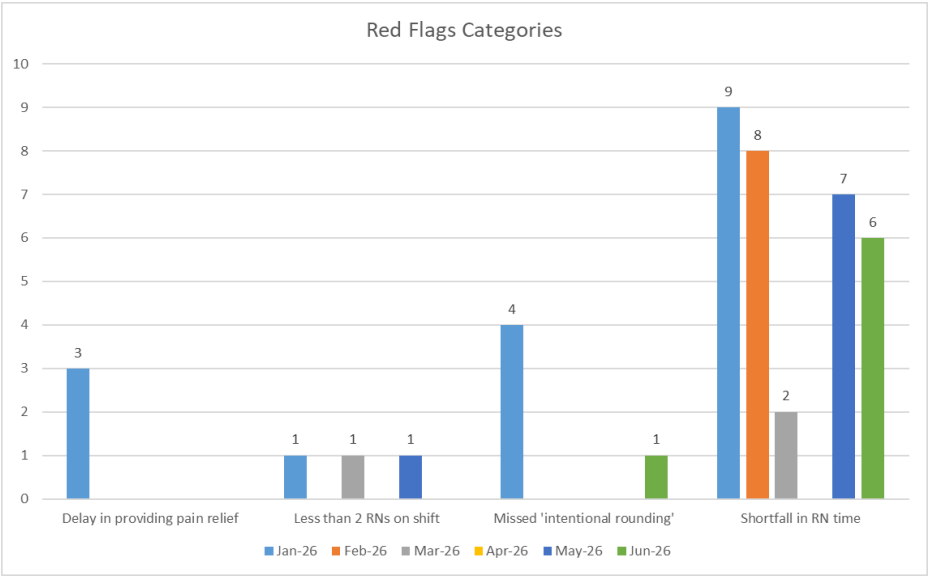
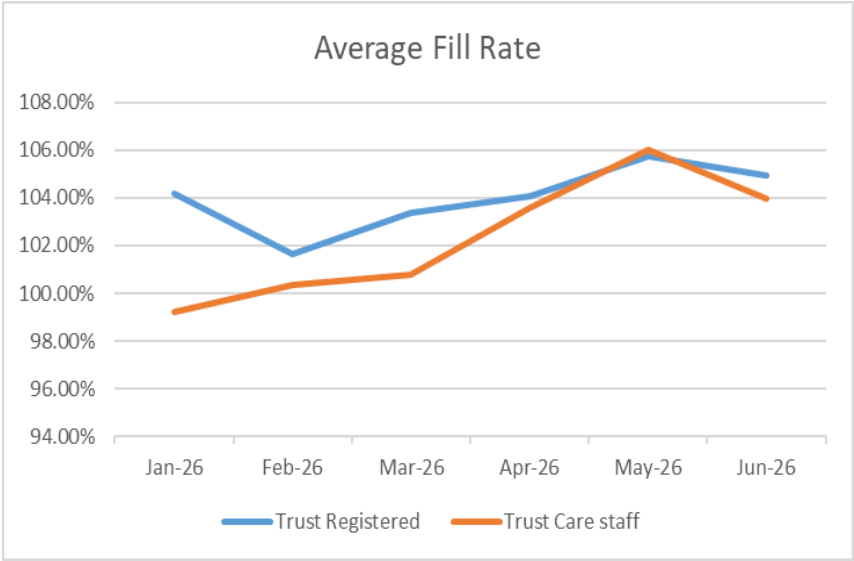
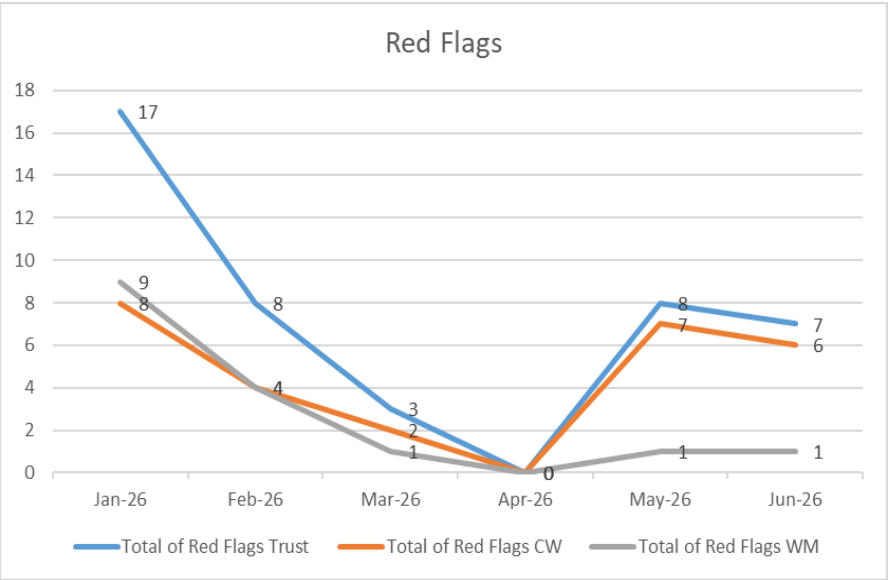
Care Staff Fill Rates (ward areas) decreased from 105.99% in May 2026 to 103.95% in June 2026. There has been an extensive HCA recruitment campaign maintained. The HCA vacancy rate (whole trust) in May 2026 was 8.47%

The Trust overall fill rate (ward areas) (RN and Care Staff combined) decreased from 105.86% in May 2026 to 104.45% in June 2026.

Care Hours per Patient Day (CHPPD) continues to be collated on a monthly basis. The most current Trust measure from the Model Hospital* (March 2026) was 9.0. Trust workforce data confirms the CHPPD was 8.8 in June 2026, slightly down from May 2026 – 8.9.

Safe Staffing Red Flags – 7 red flags from the 5 categories (tables below) were reported during June 2026 where majority were Shortfall in RN time.

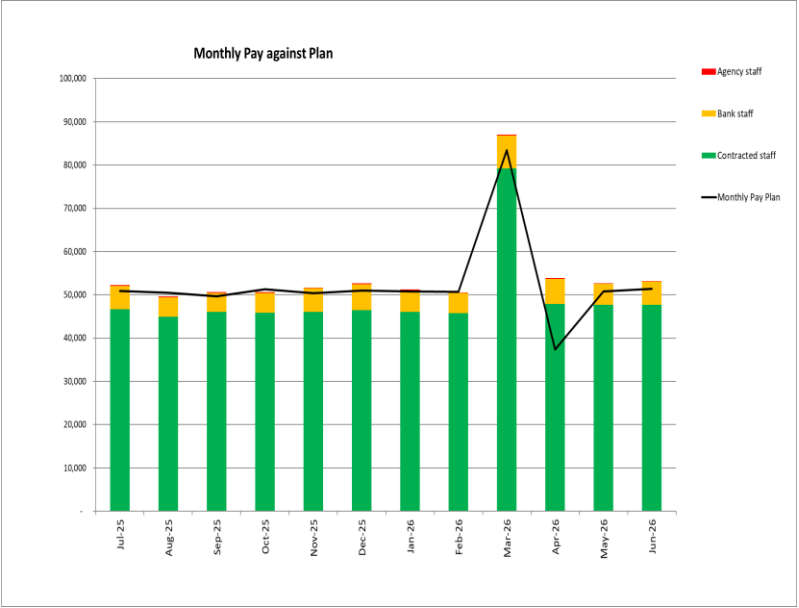
CHPPD - Taken from the Model Hospital*	Care Hours per Patient Per Day (CHPPD) – Mar 2026
Trust	8.7
Hillingdon Hospital	9.0
London NW	9.3
Imperial	10.3
National Median	9.0





Finance

Type of Spend	Plan to Date £'000	Actual to Date £'000	Variance to Date £'000
Income	273,673	268,020	(5,653)
Expenditure			
Pay	(152,857)	(159,584)	(6,727)
Non-Pay	(108,392)	(96,971)	11,421
EBITDA	12,425	11,466	(959)
EBITDA %	5%	4.28%	(0)
Depreciation	(9,027)	(8,416)	611
Non-Operational Exp-Inc	(3,630)	(3,180)	450
Surplus/Deficit	(232)	(130)	102
Control total Adj - Donated asset, Impairment & Other	(2,055)	(1,760)	295
PFI Model recalculation		(324)	(324)
Adjusted financial performance surplus/(deficit)	(2,287)	(2,214)	73



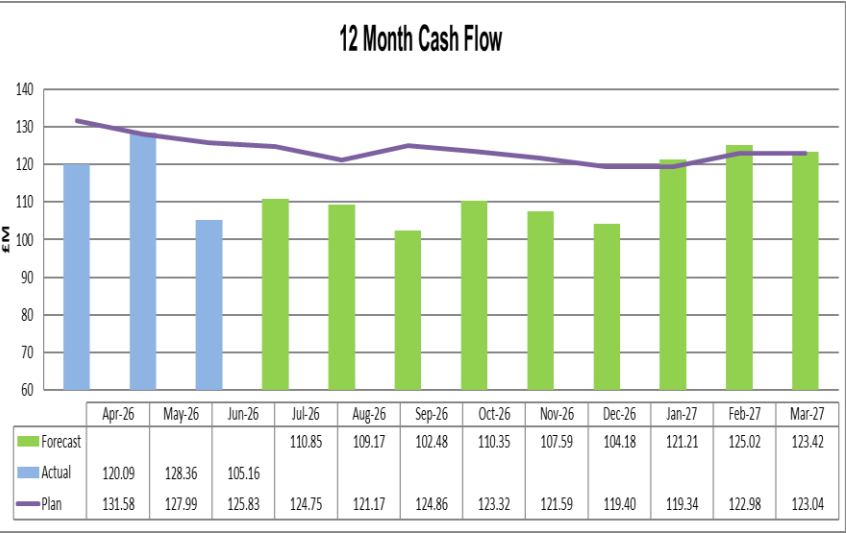
Comment: Mar 26 12 payroll figures include additional spend for 9.4% Pension contribution - £33.08 m a notional figure
July 25 includes £1m spend on industrial action and a YTD increase in the payaward accrual to reflect the latest guidance.

The adjusted YTD financial position at month 3 is a £2.21m deficit which is £0.07m favourable to plan.

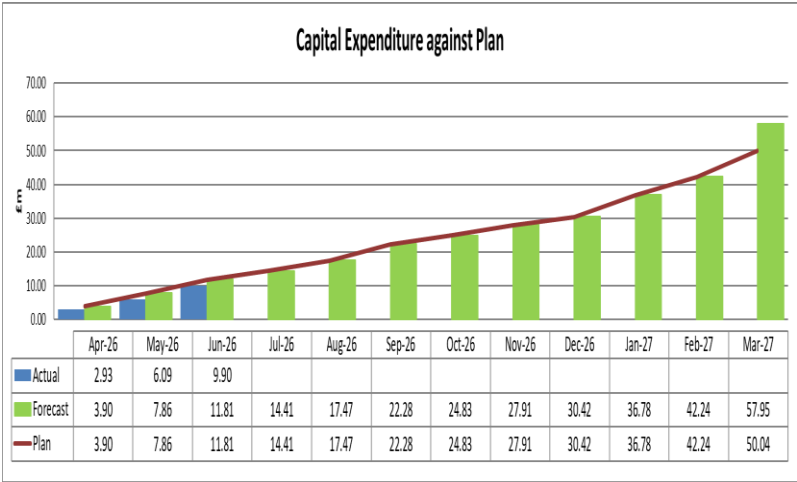
Pay: £6.73m adverse against plan. The adverse variance at Month 3 includes premium cover for Industrial Action in April, slippage against CIPs as well cover for WLI, vacancies, sickness, rota gaps, and other forms of leave

Non-Pay: There is a £11.42m favourable variance which includes adjustment to budget to match NHSi return.

Income: Income is below plan due to adjustments in Urgent and Emergency Care income and ERF performance being lower than expected. Day-case activity is currently being investigated to understand the underlying issues. Sexual Health activity was also lower than anticipated in April, which has impacted the year-to-date accruals. Unbundled imaging and drug income are performing in line with plan.



Comment: The negative cash variance to plan in M3 of £20.67m is positive cash variance b/fwd from M2 of £0.37m, lower receipts to plan of £2.93m (ICB & NHS England & FTs £3.06m lower, Local Authority & AR £0.81m lower, Other Income £0.14m higher, PP Income £0.77m higher, Interest Income £0.04m higher) plus higher cash outflows to plan of £18.12m (higher creditor payments).



Comment: The original gross capital programme for 2026/27 was £50.05m, which has been adjusted to £57.96m at P03. The increase is due to additional donation funding being carried forward from 2025/26, £5.6m CW+ donations and £0.14m from Imperial for the DTEC ADC programme, £1.87m for the IECCP FDP Programme, £0.09m for the CIL funding for the WM Development plan. The budgets have been allocated to the various areas, with £24.61m for the DTEC build and equipment, £9.50m for general estate projects, £3.50m for IT projects, £2.70m for medical equipment purchases, £6.51m for the Human Challenge projects, £1.87m for the IECCP (FDP) programme, £1.98m for the PFI unitary charge, and £7.25m for PDC funded Imaging schemes. The planned YTD spend for P03 was £11.81m and the actual spend incurred is £9.90m, resulting in an under spend of £1.91m. This under spend will be incurred in later 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