



Trust Performance and Quality Report

May 2026



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Executive Summary



Chelsea and Westminster Hospital
NHS Foundation Trust



Patient Safety and Experience

There was 1 cases of C.Difficile reported in-month, occurring at WM bringing the YTD total cases to 4. 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). Cases are undergoing learning response review with no concerns on cross-contamination highlighted. The Quality Priority will focus on fundamentals of care, embedding best practice and antimicrobial stewardship.

The complaint response time within 25 working days dipped to 89.6% and compliance with 45 working days performance reported a month in arrears but remains strong with compliance at 100% for the previous months. Inpatient FFT remains in a strong position exceeding response rates and experience of care. Additional engagement work is required to improve response rates for outpatients, ED and Children and Young People.

VTE assessment rates remain above target. Falls risk assessment rates are compliant across both sites with the West Middlesex site also being compliant for Purpose T assessment. Further targeted work at the Chelsea site with respect to purpose T is ongoing through the use of Timely Care Hub. There was 4 hospital acquired pressure ulcers at category 3 or above during May and 0 fall with severe harm. Improvement plans remain in place for both pressure ulcers and falls which have been produced based on learning responses and are monitored through the patient safety group. Pressure Ulcer prevention is also a Trust Quality Priority for 2026/27.

Sepsis improvement work has continued within the ED, with an improving position for the last 4 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 both sites (78% Chelsea and 88.9% West Middlesex). This was a result of capacity and staffing constraints, in addition to clinical issues in theatre. The divisions will continue to monitor its improvement plan through Divisional Performance meetings. Dementia screening remains complaint at both sites. 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 Centers were 4.6% higher in May 26 compared to same period last year. Demand pressures impact the Trust performance at 77.6% 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.

Cancer standards were met in April 2026 for the 31-Day standard at 98.96% and the 62-day standard at 88.38%. The 28-Day Faster Diagnostics at 78.08% was just below the new 2026/27 target of 80%.

Elective Referral to Treatment (RTT) 18-week wait performance increase by 1% to was 67.37% for May 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 1002 patients waiting over 52 weeks (+47) and 2 patients waiting over 65 weeks (-1). There were no patients waiting over 78 weeks.

Performance against the DM01 diagnostic standard (which measures the percentage of patients waiting <6 weeks) was reported at 79.37% against the 95% standard and the Operating Plan trajectory of 89.2%. Recovery plans and trajectories are in place to improve this position over the coming months.

Workforce

The Trust's Month 2 position shows the vacancy (6.8%), voluntary turnover rates (7.6%) and % Bank and Agency Usage (0.2%) are well within the target level.

Finance

The adjusted YTD financial position in Month 2 is a £2.62m deficit. £0.04m above 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	51.62	
Patient safety incident investigations	n/a	5	
Never Events	0	1	
Dementia screening %	90%	91.04%	
ED sepsis screening %	90%	91.18%	!
Inpatient sepsis screening %	90%	84.31%	!
C. Difficile cases	n/a	1	
E. coli cases	n/a	12	
Formal complaints received	n/a	76	
Inpatient FFT % good experience	90%	95.94%	
A&E FFT % good experience	90%	77.41%	!
Outpatient FFT % good experience	90%	92.05%	
Maternity FFT % good experience	90%	85.31%	
Mortality			
Summary Hospital-level Mortality Index	<100	77.55	
Hospital Standardised Mortality Ratio	<100	77.46	

Section/KPI	Target	Actual	Prev. 3 Mth Trend
Patient Access			
A&E waiting times type 1&3 (4hrs)	80%	77.56%	!
LAS handovers 30 mins	n/a	175	
18 week RTT incompletes	66%	67.37%	
Diagnostic waiting times < 6 weeks	95%	79.37%	!
28 day Faster Diagnosis Standard	80%	79.15%	
31 day diagnosis to first or subsequent treatment	96%	98.96%	
62 day GP referral to first treatment combined	85%	88.38%	
Operating Plan and Capacity			
Theatre utilisation (uncapped)	85%	89.23%	
PIFU rate	5%	9.30%	
Workforce			
Medical PDR compliance	90%	85.1%	
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

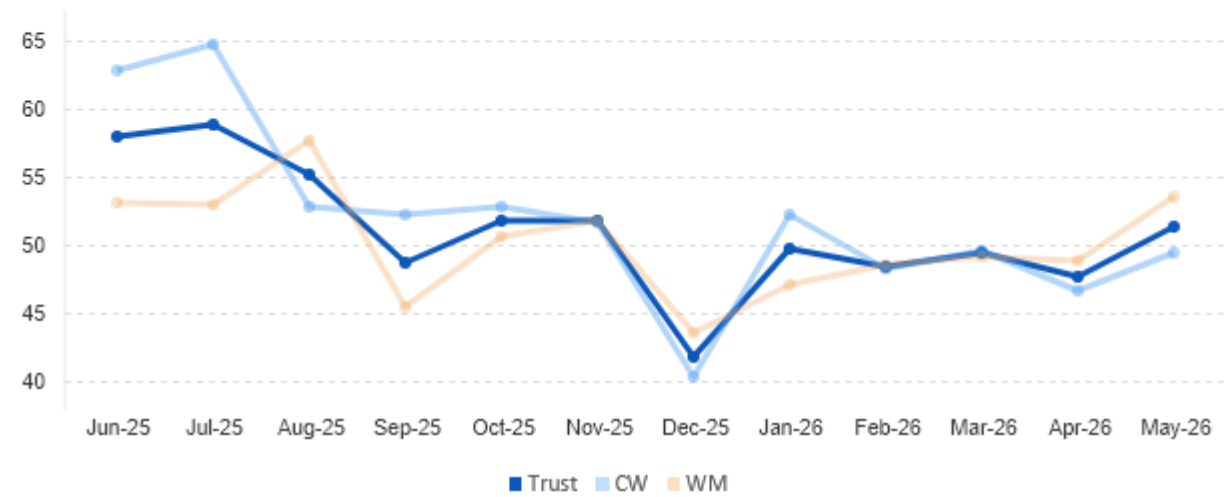
Safe



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 July 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	49.41	0	0	0.00
WM	53.60	0	0	0.00
Trust	51.40	0	0	0.00

Year-to-Date Performance

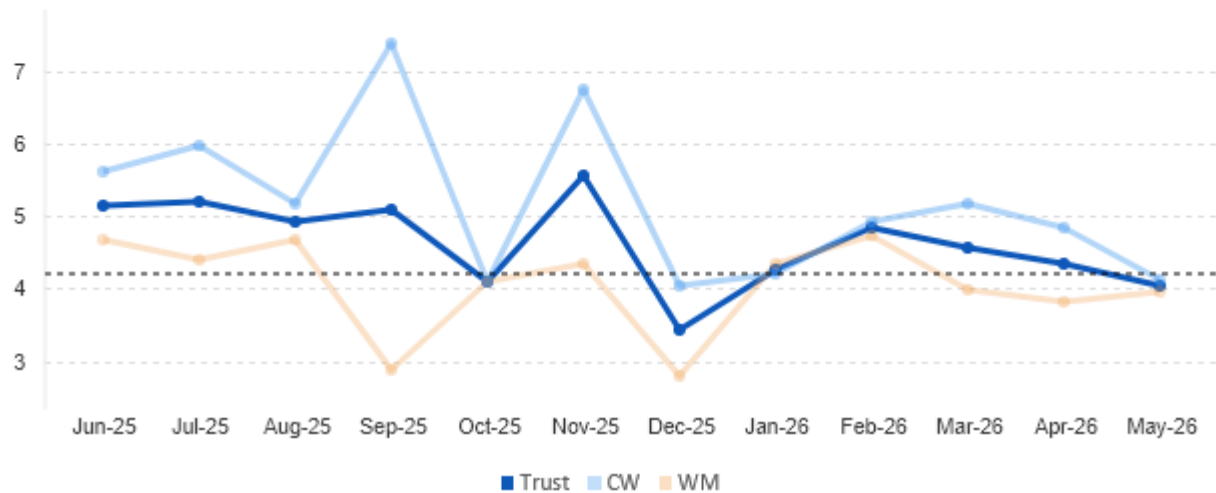
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Incidents per 1000 FCE Bed Days (Target:)	CW	52.3	48.3	49.6	46.7	49.4	48.1
	WM	47.1	48.6	49.1	48.8	53.6	51.2
	Trust	49.7	48.4	49.4	47.7	51.4	49.6
Incidents Resulting in Severe Harm or Death (Target:)	CW	2	2	1	3	0	3
	WM	3	2	0	3	0	3
	Trust	5	4	1	6	0	6
Incidents Resulting in Death (Target:)	CW	1	0	0	0	0	0
	WM	1	0	0	1	0	1
	Trust	2	0	0	1	0	1
Incidents Resulting in Death per 1,000 FCE Bed Days (Target:)	CW	0.06	0.00	0.00	0.00	0.00	0.00
	WM	0.07	0.00	0.00	0.07	0.00	0.03
	Trust	0.07	0.00	0.00	0.03	0.00	0.02

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 achieved in May 2026.
- Unfortunately, the Trust did not meet the medication incident reporting target in May 2026. The 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 has undergone extensive review, update, and streamlined information fields to support staff reporting.

In-Month Performance

	Medication Related Safety Incidents per 1000 Bed Days	Medication Related Safety Incidents With Moderate or Above Harm
CW	4.13	0.0%
WM	3.95	1.8%
Trust	4.05	0.8%

Year-to-Date Performance

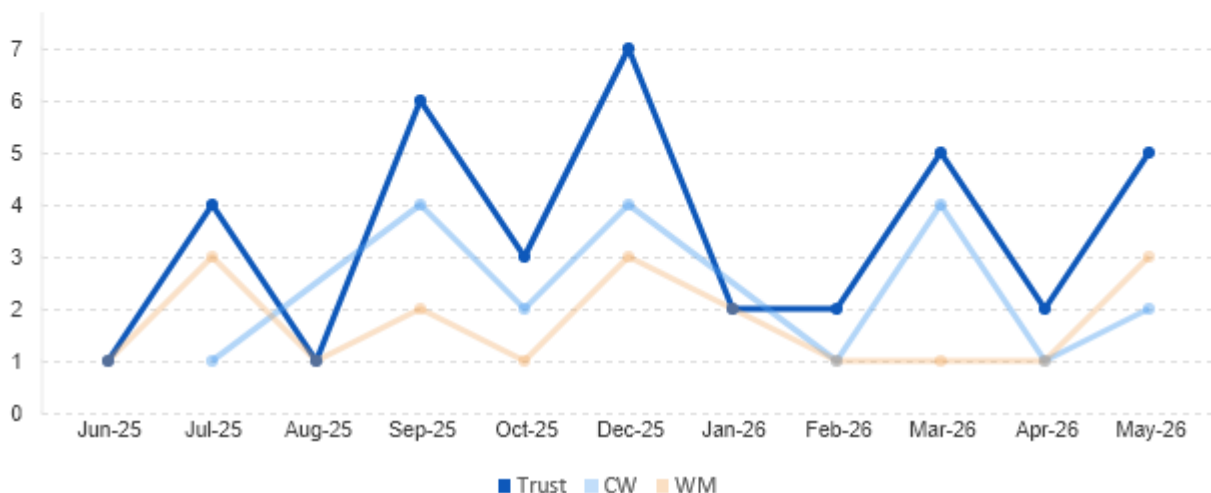
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Medication Related Safety Incidents per 1000 Bed Days (Target: >=4.2)	CW	4.20	4.93	5.18	4.84	4.13	4.48
	WM	4.34	4.72	3.98	3.81	3.95	3.88
	Trust	4.27	4.83	4.58	4.34	4.05	4.19
Medication Related Safety Incidents % Moderate or Above Harm (Target: <1%)	CW	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	WM	0.0%	0.0%	0.0%	0.0%	1.8%	0.9%
	Trust	0.0%	0.0%	0.0%	0.0%	0.8%	0.4%

Incidents Reported on STEIS (Sis/PSIIs)

Safe

Trend

Patient Safety Incident Investigations



Narrative

Performance: Since the implementation of PSIRF, the number of incidents reported externally via StEIS has decreased. This is an expected outcome, reflecting PSIRF's emphasis on proportionate responses and a greater focus on identifying and addressing local learning opportunities.

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). 5 PSIIs were declared in May, comprising a Never Event - wrong intraocular lens, two delayed cancer diagnosis, one maternity case and one unexpected death in ED.

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.

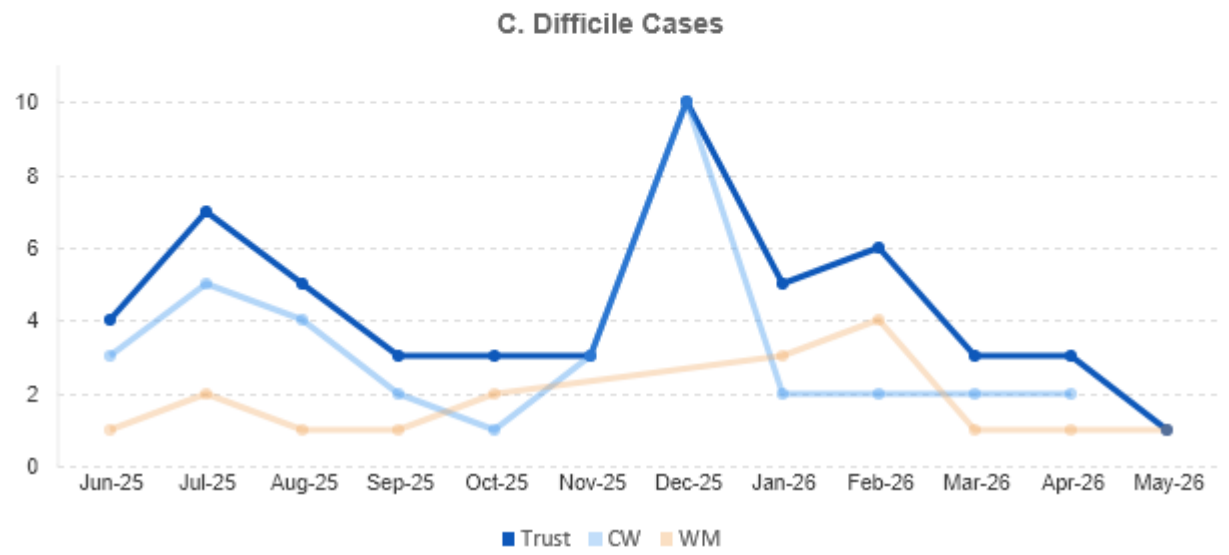
In-Month Performance

	Patient Safety Incident Investigations	Never Events	Learning Resp. Declared (AAR)	Learning Responses Declared (Thematic Review)	Learning Responses Declared (MDT)
CW	2	1	1	0	0
WM	3	0	1	0	1
Trust	5	1	2	0	1

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Patient Safety Incident Investigations	CW	0	1	4	1	2	3
	WM	2	1	1	1	3	4
	Trust	2	2	5	2	5	7
Never Events (Target: 0)	CW	0	0	0	0	1	1
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	1	1
Learning Responses Declared (AAR)	CW	1	2	1	2	1	3
	WM	0	0	0	4	1	5
	Trust	1	2	1	6	2	8
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	0	1	3	1	0	1
	WM	0	2	1	0	1	1
	Trust	0	3	4	1	1	2

Trend



Narrative

MRSA

There was one healthcare associated MRSA bacteraemia in May 2026, the first case this financial year and occurred at WMH, attributed to Marble Hill 2 ward. The patient was admitted to WMH with a community source MRSA positive blood culture in early May and then readmitted in late May with an MRSA positive blood culture. However due to the previous recent admission and UKHSA reporting criteria is categorised as a community onset –healthcare associated (COHA) case. A PSIRF meeting is pending.

C.Diff (CDI)

There was one community onset –healthcare associated (COHA) CDI case that occurred at WMH. The patient was known CDI positive and the result was previously reported to UKHSA (April 2025). Due to retesting and meeting the UKHSA reporting criteria, this result is counted as another episode of healthcare associated case against the organisation. A PSIRF is pending and a APG wide priority is in place regarding infection control

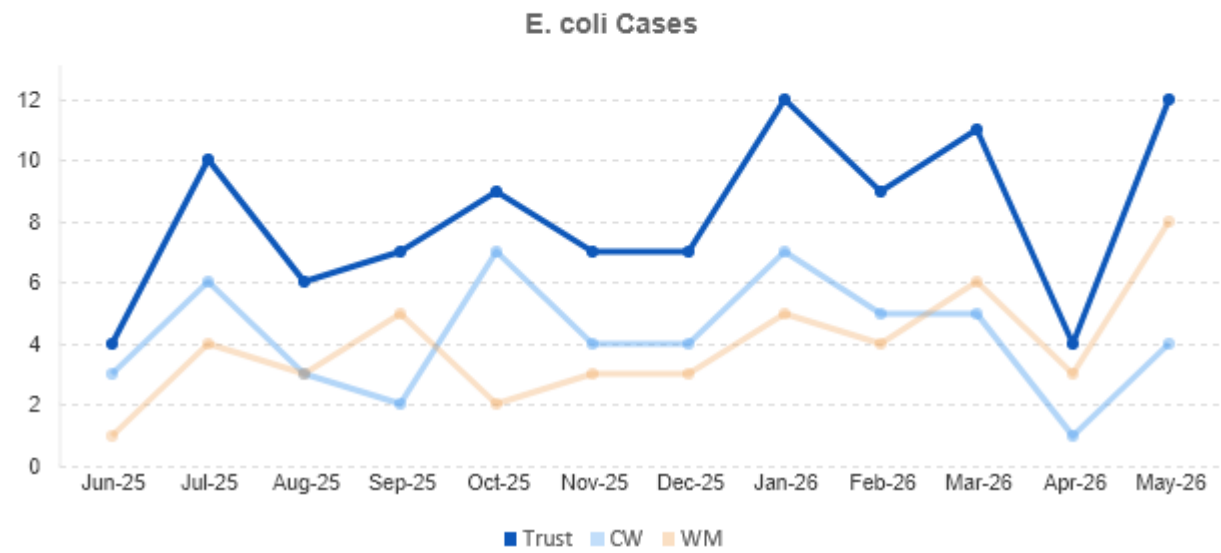
In-Month Performance

	C. Difficile Cases	MRSA Bacteraemia
WM	1	1
Trust	1	1

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
C. Difficile Cases (Target: <33)	CW	2	2	2	2	-	2
	WM	3	4	1	1	1	2
	Trust	5	6	3	3	1	4
MRSA Bacteraemia (Target: 0)	CW	0	0	0	0	-	0
	WM	1	0	1	0	1	1
	Trust	1	0	1	0	1	1

Trend



In-Month Performance

	E. Coli Cases	Hand Hygiene Compliance
CW	4	96.1%
WM	8	86.9%
Trust	12	92.0%

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
E. coli Cases	CW	7	5	5	1	4	5
	WM	5	4	6	3	8	11
	Trust	12	9	11	4	12	16
Hand Hygiene Compliance (Target: >95%)	CW	94.2%	94.3%	97.3%	96.1%	96.1%	96.1%
	WM	98.8%	94.6%	94.3%	94.2%	86.9%	90.5%
	Trust	96.4%	94.4%	95.9%	95.2%	92.0%	93.6%

Narrative

E.Coli

There were 12 healthcare associated E.coli bacteraemia in May 2026. Four occurred at the CWH site and eight at the WMH site, an increase on the previous month. Nine cases occurred in the Emergency and Integrated Care division, across 6 wards. 2 occurred in Planned Care division across two wards and 1 case occurred in the Specialist Care division. All cases will be reviewed at the healthcare associated bacteraemia review MDT meeting and PSIRF meetings arranged if required for modifiable risk factors.

Hand Hygiene Compliance

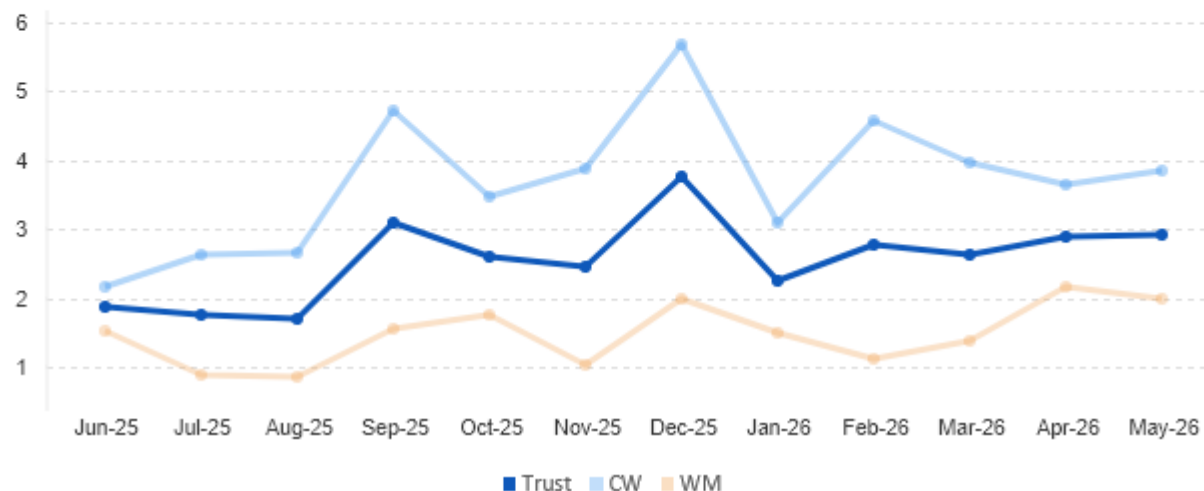
Hand hygiene compliance tracked above the 95% target at CWH in May 2026 however WMH compliance was very low due to high levels of non-submission of audit. Low compliance and completion will be discussed at Infection Control Meeting to understand and action accordingly.

Formal Complaints

Responsive

Trend

Complaints Received per 1000 Bed Days



Narrative

Formal complaints – May:

- 58 received in May – decrease from 64 in April.
- EIC highest volume received: 18 out of 58 (31%), mainly for ED/acute and 3 for haematology.
- SC Division received 15, 6 for gynaecology
- WLCH received 10 new complaints, sustained increase – mainly for CW, complex in nature

PALS (informal concerns) – May:

- 274 PALS logged, decrease from 346 in April.
- PC - 97, EIC - 88, SCD - 47; CSD - 26; WLCH - 7, Corporate - 9.
- Themes: appointments – delays and cancellations, communication with patients, access to treatment or drugs and discharges

Compliance and backlog:

- Formal complaint compliance just missed meet the KPI of 90% continued daily huddles and dedicated response writing in place, however volume of incoming correspondence continues both in PALS and Complaints.
- PALS performance: 120 of 274 resolved in time (44%)
- Despite volume pressures, new cases are still being managed promptly

Sustained increase in complaints and PALS concerns drives operational pressure. While formal complaint timeliness remains strong, the PALS backlog needs greater prioritisation within divisions.

In-Month Performance

	Complaints Received per 1000 Bed Days	Complaints Responded to <25 Working Days	Complaints Upheld by PHSO	Complaints Open > 90 Days
CW	3.8	87.5%	0	2
WM	2.0	94.7%	0	0
Trust	2.9	89.6%	0	2

Year-to-Date Performance

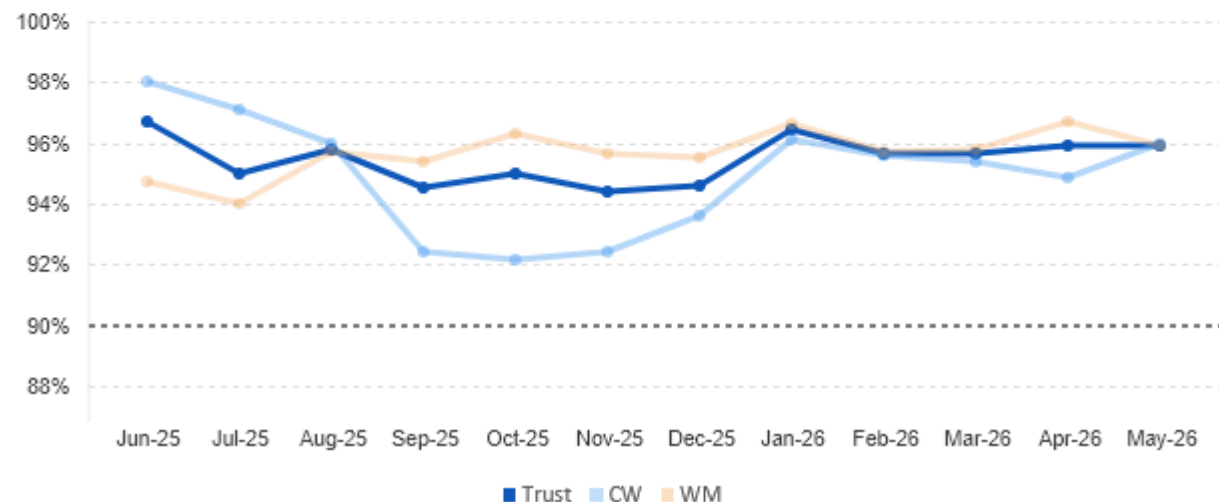
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Complaints Received per 1000 Bed Days	CW	3.1	4.6	4.0	3.7	3.8	3.7
	WM	1.5	1.1	1.4	2.2	2.0	2.1
	Trust	2.3	2.8	2.6	2.9	2.9	2.9
Complaints Responded to <25 Working Days (Target: >90%)	CW	92.6%	84.8%	96.8%	91.1%	87.5%	89.2%
	WM	92.6%	79.2%	87.5%	95.5%	94.7%	95.1%
	Trust	92.6%	82.9%	94.9%	92.5%	89.6%	91.0%
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	3	4	4	3	2	5
	WM	1	0	1	2	0	2
	Trust	4	4	5	5	2	7

Inpatient Friends & Family Test

Caring

Trend

% Good Experience



Narrative

For May, we saw a higher rate of responses for the wards at West Mid. Surgical wards response rate continues to be low for May. All wards achieving overall satisfaction rate of between 93 to 100% in May. Themes in May are consistent with previous months – positives for the most part around respect, dignity, communication and involvement.

Learning from complaints :

EIC/Planned Care: Improving rest and sleep at night has been made a Trust-wide quality priority. Actions include reducing unnecessary noise overnight, improving the ward environment, clearer expectations for night-time noise, increasing staff awareness, proactive use of earplugs and eye masks, and environmental changes where possible. Learning from recent complaints is being used to shape improvements on the acute wards.

Specialist Care (Maternity): A range of measures have been implemented to improve oversight of capacity, workforce deployment and patient flow across the service. These include enhanced escalation processes, regular review of activity and staffing levels, strengthened operational coordination, and demand-management arrangements. The aim of these measures is to ensure that women requiring admission, induction of labour, or urgent assessment can access care as promptly and safely as possible, while maintaining safe staffing levels and prioritising those with the greatest clinical need.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	700	68.7%	96.0%	98.0%
WM	1,016	51.1%	95.9%	97.0%
Trust	1,716	57.0%	95.9%	97.4%

Year-to-Date Performance

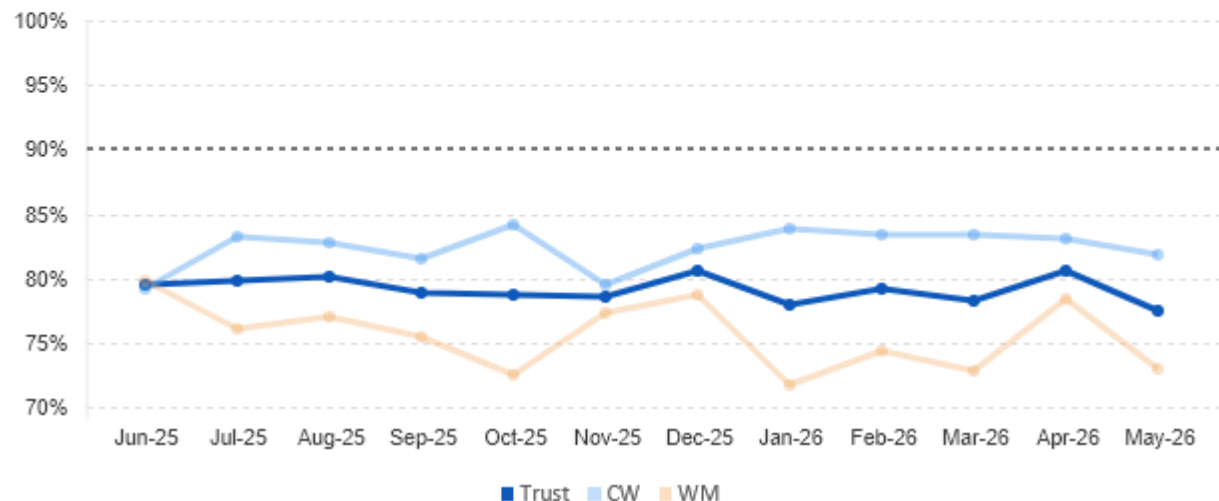
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Responses	CW	592	631	736	641	700	1,341
	WM	949	891	1,023	908	1,016	1,924
	Trust	1,541	1,522	1,759	1,549	1,716	3,265
Response Rate (Target: >10%)	CW	64.1%	68.1%	61.1%	64.1%	68.7%	66.4%
	WM	83.5%	74.2%	41.4%	66.0%	51.1%	57.2%
	Trust	74.8%	71.6%	47.8%	65.2%	57.0%	60.6%
% Good Experience (Target: >90%)	CW	96.1%	95.6%	95.4%	94.9%	96.0%	95.4%
	WM	96.6%	95.7%	95.8%	96.7%	95.9%	96.3%
	Trust	96.4%	95.7%	95.6%	95.9%	95.9%	95.9%
Treated With % Dignity and Respect (Target: >90%)	CW	97.0%	97.0%	96.0%	98.0%	98.0%	98.0%
	WM	97.0%	97.0%	98.0%	98.0%	97.0%	97.5%
	Trust	97.0%	97.0%	97.1%	98.0%	97.4%	97.7%

Emergency Department Friends & Family Test

Caring

Trend

% Good Experience



Narrative

A&E FFT

- For May, satisfaction scores for both CW and WM have declined, WM scores more markedly than CW.
- Reviewing the comments this appears to be linked to waiting times, treatment expectations not being met, waits for scans and the quality of information provided.
- Themes remain largely consistent with previous months, both positive and negative, recognising the pressure but being treated with friendliness and efficiency, and receiving a good service continuing to feature strongly in patient feedback.

Learning from A&E Complaints – May

- Additional emphasis will be placed on triage staff reviewing recent attendance records for re-attending patients, and on improving the explanation given, both verbally and in writing, when patients are transferred to SDEC.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	959	8.8%	81.8%	86.0%
WM	953	7.9%	73.0%	80.0%
Trust	1,912	8.3%	77.4%	83.0%

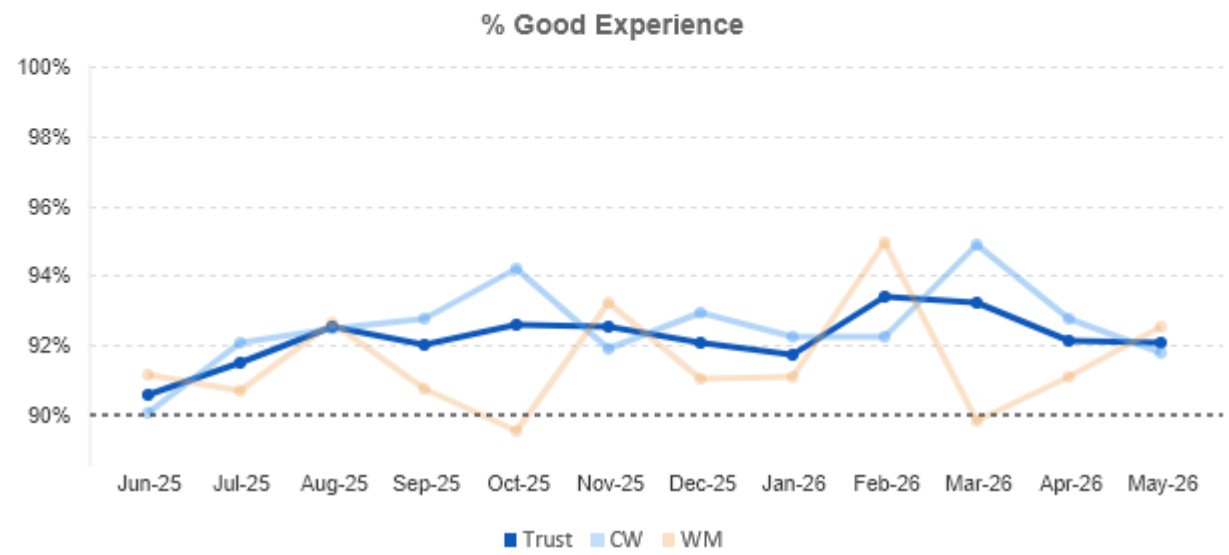
Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Responses	CW	1,041	892	932	865	959	1,824
	WM	991	794	859	915	953	1,868
	Trust	2,032	1,686	1,791	1,780	1,912	3,692
Response Rate (Target: >10%)	CW	9.9%	9.4%	8.7%	9.1%	8.8%	8.9%
	WM	8.5%	7.6%	7.2%	8.4%	7.9%	8.1%
	Trust	9.2%	8.5%	7.9%	8.7%	8.3%	8.5%
% Good Experience (Target: >90%)	CW	83.8%	83.4%	83.4%	83.0%	81.8%	82.3%
	WM	71.7%	74.3%	72.8%	78.4%	73.0%	75.6%
	Trust	77.9%	79.1%	78.3%	80.6%	77.4%	79.0%
% Treated With Dignity and Respect (Target: >90%)	CW	88.0%	88.0%	89.0%	87.0%	86.0%	86.5%
	WM	82.0%	80.0%	80.0%	83.0%	80.0%	81.5%
	Trust	85.1%	84.3%	84.7%	85.0%	83.0%	83.9%

Outpatient Friends & Family Test

Caring

Trend



Narrative

Outpatient FFT – Performance Summary

- The majority of outpatient areas continue to perform above the 90% satisfaction KPI.
- Lower response numbers remain a factor, driven largely by the organisation-wide budgeted approach to feedback collection.
- When triangulated with other feedback, the main negative themes last month relate to waiting times and appointment processes.

Chelsea – Key Points

- Strong overall experience reported in May with scores between 90-100%
- Comments outline good communication and great professionalism in the clinics.
- Burns outpatient department scored highly in May, despite low response rate.

West Mid – Key Points

- Performance broadly mirrors Chelsea, with most specialties scoring mid-80% to low-90%.
- Continued strong feedback in Cath Lab and Gynaecology.
- Same improvement themes: Involvement and Information are the most reported issues.

Cross-Site Overview

- Both hospitals show consistent performance, especially in communication and professionalism.
- Waiting and information provision remain the key improvement opportunities across both sites.
- Scoring is aligned across both sites.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	1,215	7.8%	91.8%	97.0%
WM	761	3.5%	92.5%	96.0%
Trust	1,976	5.3%	92.1%	96.6%

Year-to-Date Performance

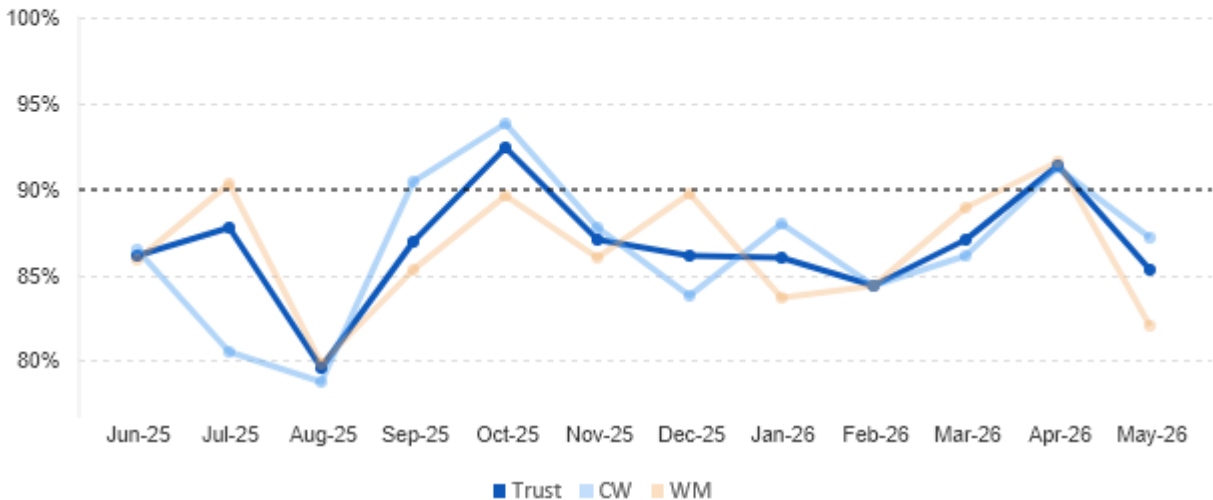
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Responses	CW	980	1,107	1,627	1,132	1,215	2,347
	WM	853	807	786	720	761	1,481
	Trust	1,833	1,914	2,413	1,852	1,976	3,828
Response Rate (Target: >10%)	CW	4.1%	4.9%	6.8%	8.5%	7.8%	8.1%
	WM	3.9%	6.7%	4.0%	4.1%	3.5%	3.7%
	Trust	4.0%	5.5%	5.5%	6.0%	5.3%	5.6%
% Good Experience (Target: >90%)	CW	92.2%	92.2%	94.9%	92.8%	91.8%	92.2%
	WM	91.1%	94.9%	89.8%	91.1%	92.5%	91.8%
	Trust	91.7%	93.4%	93.2%	92.1%	92.1%	92.1%
% Treated With Dignity and Respect (Target: >90%)	CW	96.0%	96.0%	98.0%	96.0%	97.0%	96.5%
	WM	96.0%	97.0%	94.0%	96.0%	96.0%	96.0%
	Trust	96.0%	96.4%	96.7%	96.0%	96.6%	96.3%

Maternity Friends & Family Test

Caring

Trend

% Good Experience



Narrative

Maternity – Performance Summary:

Both sites saw a decline in experience in May, though response numbers remain similar to April for each site. Themes seen in comments: positive reviews about kind and helpful staff, comments seen about the variability of service at night on both sites and mixed reviews regarding sharing information and responsiveness. Individual staff also praised in the comment report on both sites.

Learning from May Maternity Complaints:

Maternity Service are introducing a new Postnatal Ward booklet, which explains the discharge process and outlines that delays may occasionally arise due to emergencies or high ward activity. The aim is to ensure clearer expectations for women awaiting discharge.

In-Month Performance

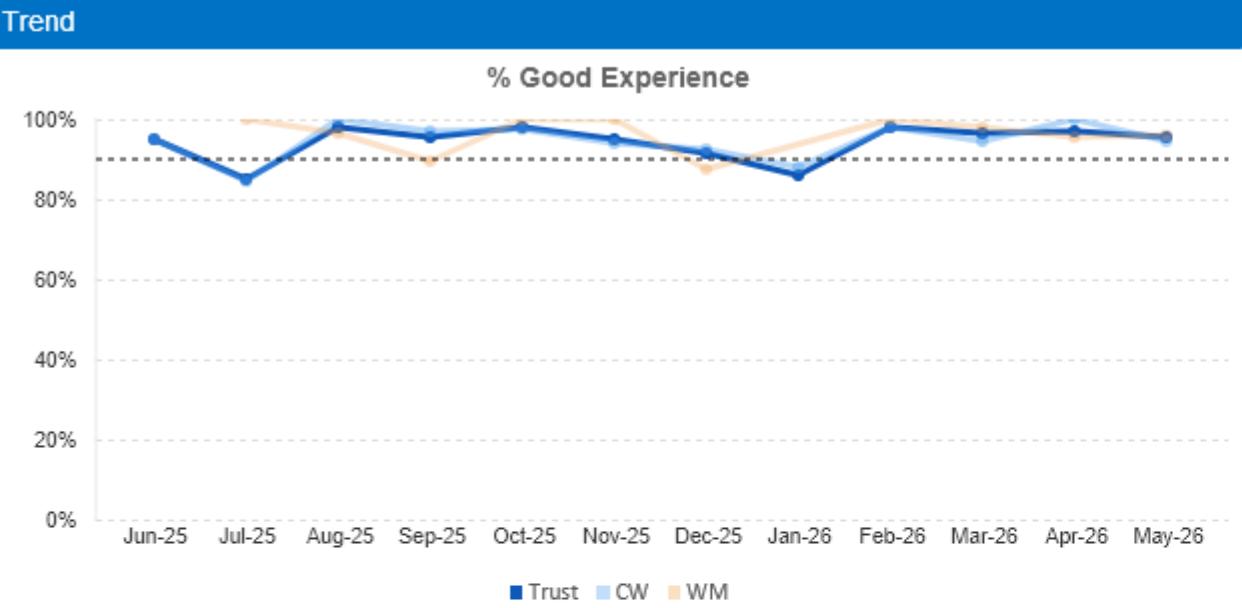
	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	133	23.8%	87.2%	92.0%
WM	78	18.4%	82.1%	88.0%
Trust	211	21.5%	85.3%	90.6%

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Responses	CW	100	102	122	114	133	247
	WM	86	77	63	83	78	161
	Trust	186	179	185	197	211	408
Response Rate (Target: >10%)	CW	18.0%	22.3%	22.9%	23.4%	23.8%	23.6%
	WM	18.9%	19.0%	15.3%	21.4%	18.4%	19.9%
	Trust	18.4%	20.7%	19.6%	22.5%	21.5%	22.0%
% Good Experience (Target: >90%)	CW	88.0%	84.3%	86.1%	91.2%	87.2%	89.1%
	WM	83.7%	84.4%	88.9%	91.6%	82.1%	87.0%
	Trust	86.0%	84.4%	87.0%	91.4%	85.3%	88.2%
% Treated With Dignity and Respect (Target: >90%)	CW	93.0%	88.0%	91.0%	93.0%	92.0%	92.5%
	WM	88.0%	83.0%	97.0%	95.0%	88.0%	91.5%
	Trust	90.9%	86.0%	92.9%	93.8%	90.6%	92.1%

Children and Young People Friends & Family Test

Caring



Narrative

Response rates are low across both sites, thereby limiting how representative the results are. However, teams continue to say they are actively promoting, and every response is still reviewed and used to inform local improvements.

Despite the small numbers, satisfaction consistently scores are 100%, indicating very positive experiences among those who do respond. Families of the Children’s Dental and the PSSU patients completed the most surveys.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	57	8.7%	94.7%	99.0%
WM	53	14.4%	96.2%	98.0%
Trust	110	10.8%	95.5%	98.7%

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Responses	CW	42	45	35	48	57	105
	WM	1	11	49	93	53	146
	Trust	43	56	84	141	110	251
Response Rate (Target: >10%)	CW	6.9%	7.8%	5.5%	8.5%	8.7%	8.6%
	WM	1.0%	4.2%	14.9%	30.5%	14.4%	21.7%
	Trust	6.1%	6.7%	8.7%	16.2%	10.8%	13.3%
% Good Experience (Target: >90%)	CW	88.1%	97.8%	94.3%	100.0%	94.7%	97.1%
	WM	0.0%	100.0%	98.0%	95.7%	96.2%	95.9%
	Trust	86.0%	98.1%	96.4%	97.2%	95.5%	96.4%
% Treated With Dignity and Respect (Target: >90%)	CW	95.0%	99.0%	97.0%	100.0%	99.0%	99.5%
	WM	89.0%	100.0%	100.0%	95.0%	98.0%	96.1%
	Trust	94.5%	99.1%	97.8%	97.9%	98.7%	98.2%

Safe

In-Month Performance

The chart displays the percentage of respondents who trust the U.S. president (Trump) from June 2025 to May 2026. The Y-axis represents the percentage, ranging from 90% to 100% in 2% increments. The X-axis shows the dates from Jun-25 to May-26. Three data series are plotted: Trust (dark blue line with circular markers), CW (light blue line with circular markers), and WM (orange line with circular markers). A horizontal dotted line is drawn at the 95% mark. The Trust series starts at approximately 96.3% in Jun-25, dips to 95.6% in Jul-25, and then fluctuates between 95.5% and 96.3% through May-26. The CW series starts at approximately 96.4% in Jun-25, dips to 95.6% in Jul-25, and then fluctuates between 95.2% and 95.8% through May-26. The WM series starts at approximately 96.2% in Jun-25, dips to 95.4% in Aug-25, and then generally trends upwards, ending at approximately 96.8% in May-26.

Date	Trust (%)	CW (%)	WM (%)
Jun-25	96.3	96.4	96.2
Jul-25	95.6	95.6	95.9
Aug-25	95.5	95.5	95.4
Sep-25	95.6	95.7	95.6
Oct-25	95.6	95.7	95.6
Nov-25	95.5	95.0	96.1
Dec-25	96.3	95.8	96.6
Jan-26	95.9	95.3	96.5
Feb-26	95.6	95.7	95.6
Mar-26	96.0	95.6	96.6
Apr-26	96.1	95.3	96.8
May-26	96.2	95.4	96.8

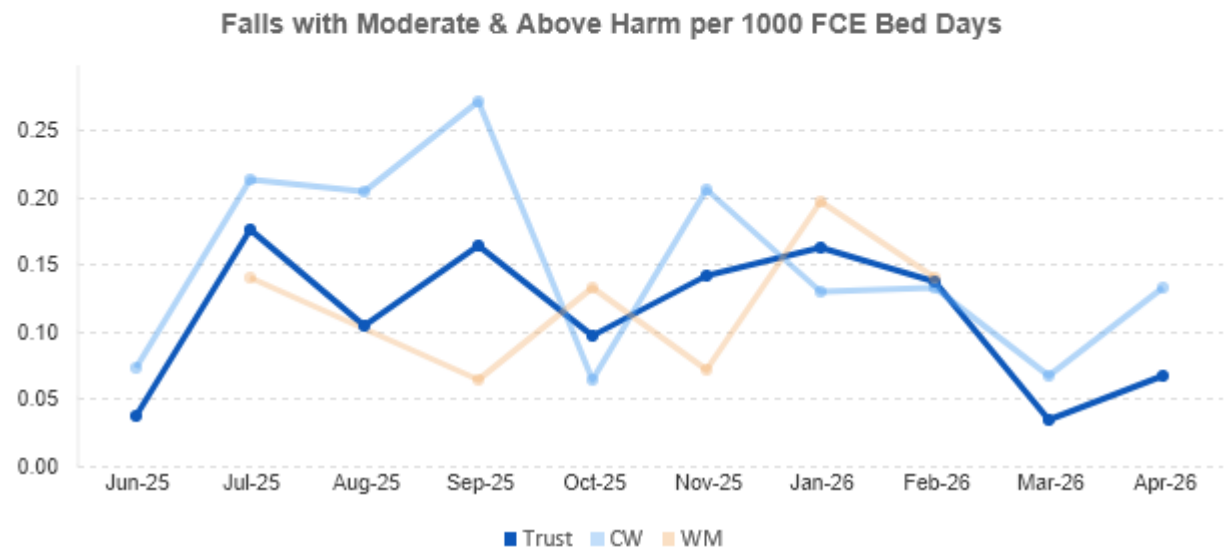
VTE Risk Assessment: Target achieved. Monthly VTE risk assessment performance by site, division, speciality and ward disseminated for leads to review and action as appropriate. Divisions requiring improvement: Planned Care (92%) and West London Children's Hospital (92%). Specialities requiring improvement: Vascular surgery [16%], plastic surgery [91%], ophthalmology [92%], trauma & orthopaedics [92%], urology [94%], and elderly medicine [93%].

- *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.
- *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.

	VTE Assessments Completed	Hospital Acquired VTE Cases	Hospital Acquired VTE per 1000 FCE Bed Days
CW	95.5%	1	0.1
WM	96.8%	6	0.4
Trust	96.2%	7	0.2

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
VTE Assessments Completed (Target: >=95%)	CW	95.4%	95.7%	95.6%	95.3%	95.5%	95.4%
	WM	96.5%	95.6%	96.6%	96.8%	96.8%	96.8%
	Trust	95.9%	95.7%	96.1%	96.1%	96.2%	96.2%
Hospital Aquired VTE Cases	CW	1	2	0	0	1	1
	WM	3	2	3	5	6	11
	Trust	4	4	3	5	7	12
Hospital Aquired VTE per 1000 FCE Bed Days	CW	0.1	0.1	0.0	0.0	0.1	0.0
	WM	0.2	0.1	0.2	0.3	0.4	0.4
	Trust	0.1	0.1	0.1	0.2	0.2	0.2

Trend



Narrative

Falls with harm reduced in May, with no incidents of moderate harm or above. While falls per 1,000 bed days increased at Chelsea and Westminster, these were low or no-harm incidents; West Middlesex saw an overall reduction. Compliance with falls risk assessments remains consistently high (>90%). Bed rail compliance continues to improve (85–89.9%).

Key risks relate to post-fall processes, including care planning, SBAR documentation, overnight medical review and consistent bay tagging. A Trust-wide falls review has been completed, informing development of a new Falls Strategy. Policy, education and digital monitoring are being aligned, alongside continued adherence to national guidance (NAIF).

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	0	0	0.00	4.83	90.4%
WM	0	0	0.00	3.60	93.7%
Trust	0	0	0.00	4.25	92.1%

Year-to-Date Performance

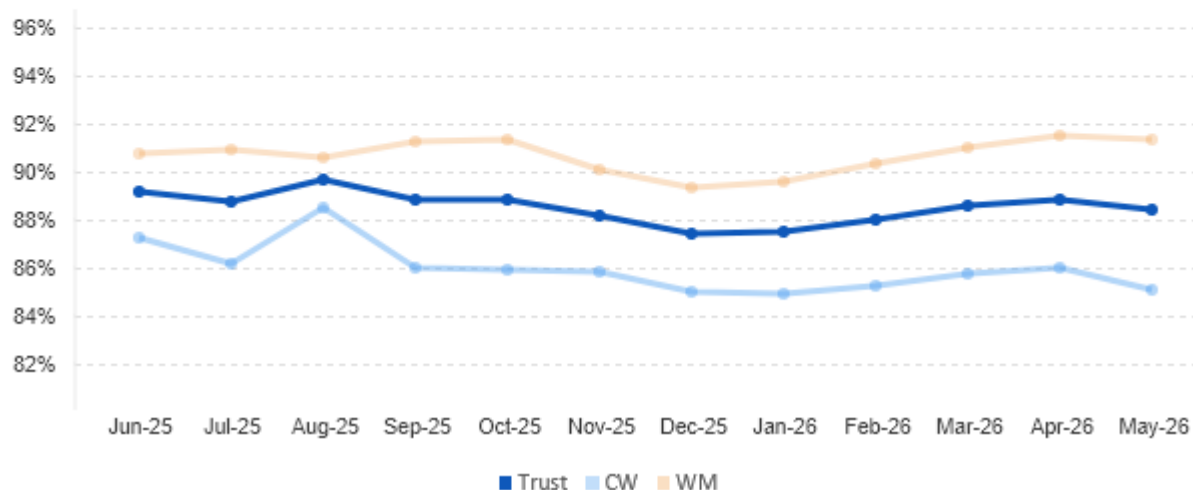
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Inpatient Falls with Moderate & Above Harm	CW	2	2	1	2	0	2
	WM	3	2	0	0	0	0
	Trust	5	4	1	2	0	2
Inpatient Falls Resulting in Severe Harm or Death (Target: 0)	CW	0	0	1	2	0	2
	WM	2	1	0	0	0	0
	Trust	2	1	1	2	0	2
Falls with Moderate & Above Harm per 1000 FCE Bed Days	CW	0.13	0.13	0.07	0.13	0.00	0.06
	WM	0.20	0.14	0.00	0.00	0.00	0.00
	Trust	0.16	0.14	0.03	0.07	0.00	0.03
Falls per 1000 FCE Bed Days	CW	4.78	3.47	4.64	3.31	4.83	4.09
	WM	3.95	3.74	3.77	4.30	3.60	3.95
	Trust	4.37	3.60	4.21	3.79	4.25	4.02
Compliance with Falls Risk Assessment (Target: >=90%)	CW	90.8%	90.6%	90.9%	90.6%	90.4%	90.5%
	WM	92.9%	93.3%	94.0%	94.4%	93.7%	94.0%
	Trust	91.9%	92.1%	92.6%	92.6%	92.1%	92.4%

Pressure Ulcers

Safe/Effective

Trend

% Compliance with Purpose T Risk Assessment



Narrative

Risk assessment compliance: Trust compliance is 88.4%, remaining below the $\geq 90\%$ target. WM is meeting the target (91.3%), while CW continues to underperform (85.1%). Trend data showed relatively stable performance over the year with a modest recent improvement, but insufficient to close the Trust gap and a decline in month. Training and education on the importance of risk assessments is ongoing.

Pressure ulcer harm: In-month data shows 3 Category 2 and 4 Category 3 pressure ulcers Trust-wide, with no Category 4 ulcers. This is an increase in both category 2 and 3 HAPU's, each incident is being reviewed in line with Trust policy to understand contributory factors and identify learning. Immediate actions were implemented at ward and Trust level, including enhanced tissue viability oversight, strengthened risk assessment and care planning and targeted clinical support. This increase will be monitored through the pressure ulcer group.

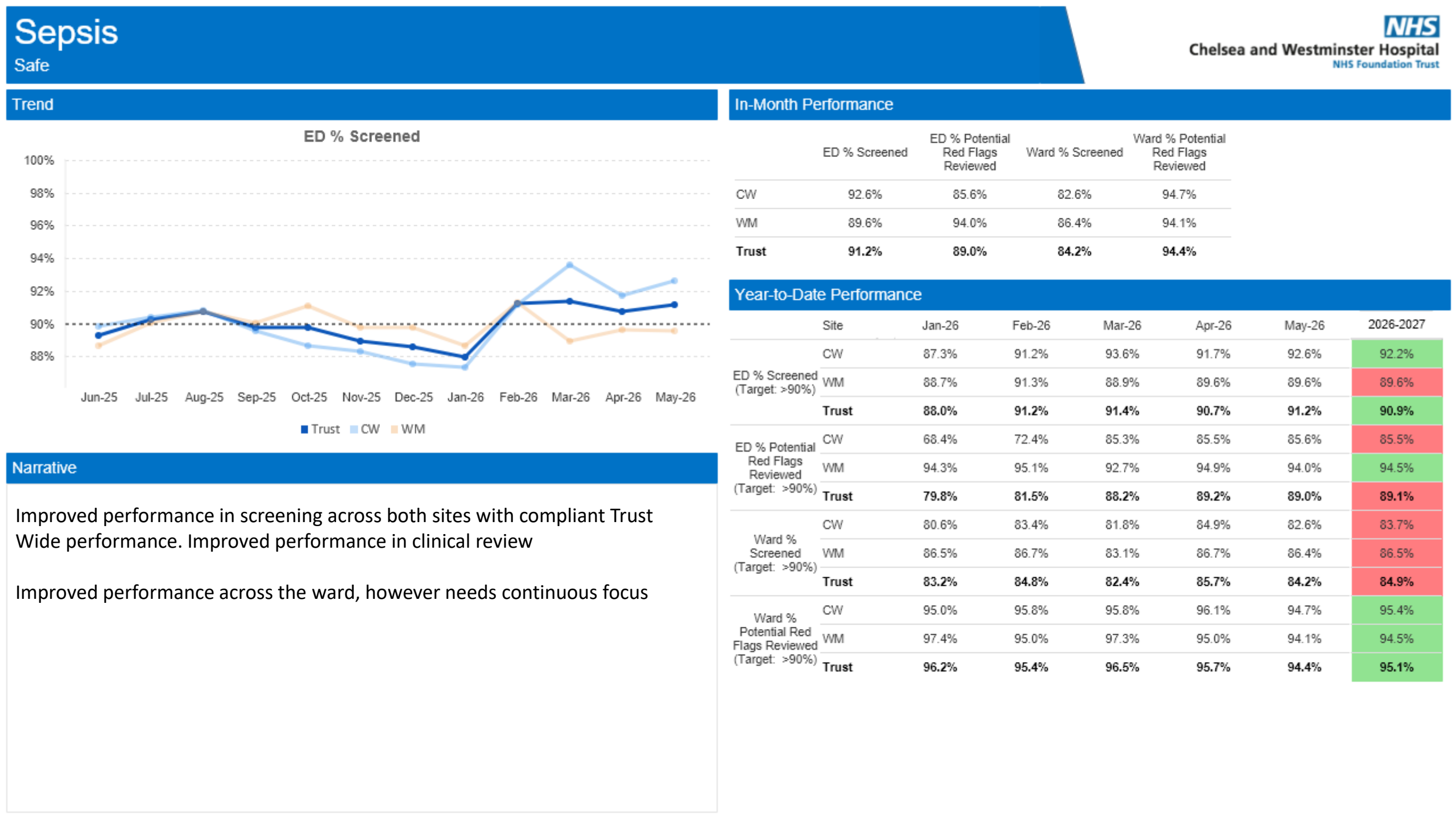
Overall position: The Trust has maintained control of the most severe harm (Category 4), but moderate avoidable harm (Category 2 and 3) persists and has increased. Targeted support and training has been implemented including an increased visibility of the tissue viability team on the wards and delivering of regular bite sized training on the wards.

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	85.1%	2	3	0	-
WM	91.3%	1	1	0	-
Trust	88.4%	3	4	0	-

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Compliance with Purpose T Risk Assessment (Target: $\geq 90\%$)	CW	84.9%	85.2%	85.7%	86.0%	85.1%	85.5%
	WM	89.6%	90.3%	91.0%	91.5%	91.3%	91.4%
	Trust	87.5%	87.9%	88.6%	88.9%	88.4%	88.6%
Category 2 Pressure Ulcers	CW	1	0	1	1	2	3
	WM	1	0	0	1	1	2
	Trust	2	0	1	2	3	5
Category 3 Pressure Ulcers (Target: 0)	CW	0	0	0	1	3	4
	WM	1	1	0	2	1	3
	Trust	1	1	0	3	4	7
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	0	1	1	2	3
	WM	0	0	0	0	1	1
	Trust	0	0	1	1	3	4

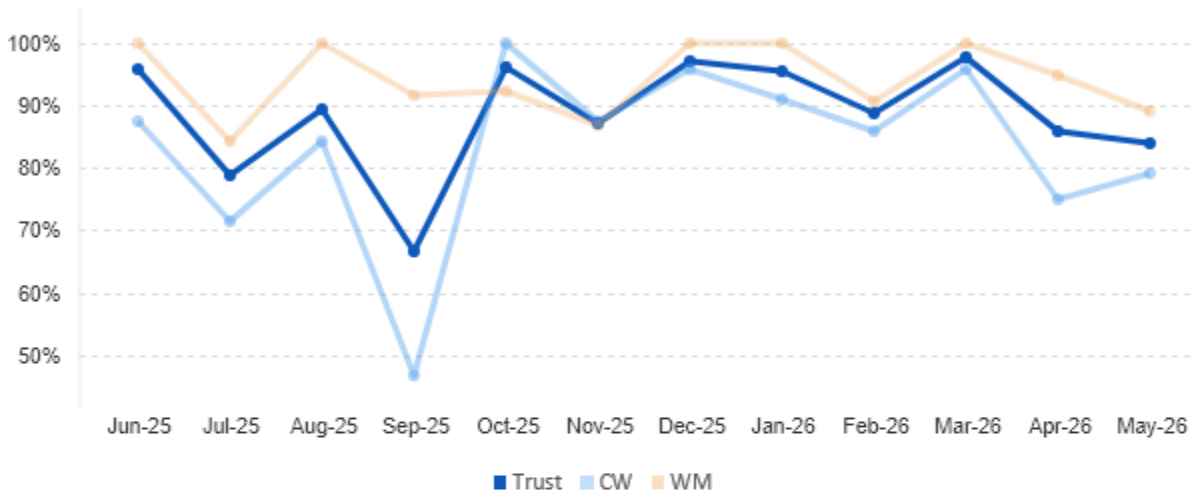


Best Practice

Safe

Trend

NoF Time to Theatre <36hrs for Medically Fit Patients



Narrative

NOF Time to Theatre: Compliance at the WM site decreased this month to 88.9%. Of the 18 medically fit patients, 2 did not meet the 36-hour target. One delay was due to the lack of an appropriate nail for fixation over the bank holiday weekend, which was sourced from another acute provider, and another was due to a delay in ICD deactivation to enable safe transfer to theatre.

CW showed a slight improvement from last month, with performance at 78.9%, and 15 of 19 patients operated on within 36 hours. The division is reviewing the current improvement plan, including what has worked well and where further focus is required.

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

Stroke: compliance with time spent on a stroke unit remains stable

Dementia: In May 2026, compliance across both sites was 91%, with improved MDT completion of the 4AT. Further engagement with downstream wards is planned through ongoing work on deconditioning and delirium identification. Compliance monitoring will be expanded to include all patients aged 65 and over in line with national guidance, with current coverage provided by the dementia (75+) and frailty (65+) teams.

In-Month Performance

	NoF Time to Theatre <36hrs for Medically Fit Patients	Breach of Same Sex Accommodation	Time Spent on Dedicated Stroke Unit	Dementia Screening Case Finding
CW	78.9%	0	69.2%	90.9%
WM	88.9%	30	85.7%	91.1%
Trust	83.8%	30	79.4%	91.0%

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
NoF Time to Theatre <36hrs for Medically Fit Patients (Target: 100%)	CW	90.9%	85.7%	95.7%	75.0%	78.9%	77.1%
	WM	100.0%	90.5%	100.0%	94.7%	88.9%	91.9%
	Trust	95.5%	88.6%	97.6%	85.7%	83.8%	84.7%
Breach of Same Sex Accommodation	CW	0	0	0	0	0	0
	WM	38	33	44	33	30	63
	Trust	38	33	44	33	30	63
Time Spent on Dedicated Stroke Unit (Target: >80%)	CW	88.9%	100.0%	94.1%	100.0%	69.2%	87.9%
	WM	88.0%	96.3%	100.0%	86.7%	85.7%	86.1%
	Trust	88.4%	97.4%	96.6%	94.3%	79.4%	87.0%
Dementia Screening Case Finding (Target: >90%)	CW	92.4%	90.9%	86.3%	92.8%	90.9%	91.8%
	WM	94.7%	93.7%	96.0%	97.2%	91.1%	93.9%
	Trust	93.7%	92.6%	91.7%	95.3%	91.0%	93.0%



Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Mar-26	Apr-26	May-26	2026-2027	Mar-26	Apr-26	May-26	2026-2027	Mar-26	Apr-26	May-26	2026-2027 Q1	2026-2027	Trend charts
Workforce	Midwife to birth ratio (Target: 1:30)	1:24	1:21	1:22	1:22	1:25	1:24	1:25	1:25	1:25	1:23	1:24	1:23.5	1:23.5	-
	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)	442	397	442	839	366	337	363	700	808	734	805	1539	1539	-
	Total number of bookings (Target:> CW 580 WM 478)	524	537	536	1073	407	407	458	865	931	944	994	1938	1938	-
	Maternity 1:1 care in established labour (Target: >95%)	99.0%	98.0%	99.0%	98.5%	98.0%	99.0%	99.0%	99.0%	98.5%	98.5%	99.0%	98.8%	98.8%	-
Safety	Admissions >37/40 to NICU/SCBU	0	22	0	22	0	14	12	48	0	36	12	22	22	-
	Number of reported Serious Incidents	9	10	6	16	1	2	2	4	10	12	8	20	20	-
	Cases of hypoxic-ischemic encephalopathy (HIE)	0	0	0	0	0	1	2	3	0	1	2	3	3	-
	Pre-term (gestation <37 weeks) as % of mothers delivered	7.0%	8.0%	8.0%	8.0%	9.0%	6.0%	6.0%	6.0%	8.0%	7.0%	7.0%	7.0%	7.0%	-
	Number of stillbirths	1	0	0	0	0	0	2	2	1	0	2	2	2	-
	Number of Infant deaths	1	0	1	1	0	3	1	4	1	3	2	5	5	-
	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	4.0%	3.0%	4.0%	3.5%	8.0%	10.0%	8.0%	9.0%	6.0%	6.5%	6.0%	6.3%	6.3%	-
	Spontaneous unassisted vaginal births	26.0%	26.0%	24.0%	25.0%	33.0%	27.0%	26.0%	26.5%	29.5%	26.5%	25.0%	25.8%	25.8%	-
	Vaginal Births - spontaneous & induced	36.0%	39.0%	37.0%	38.0%	48.0%	42.0%	43.0%	42.5%	42.0%	40.5%	40.0%	40.3%	40.3%	-
	Instrumental deliveries	59	55	69	124	38	37	31	68	97	92	100	192	192	-
	Pre-labour elective caesarean sections	90	70	78	148	59	63	60	123	149	133	138	271	271	-
	Emergency caesarean sections in labour	130	115	127	242	93	92	113	205	223	207	240	447	447	-



Please note that some of the metrics require full validation and will be updated in the following months report.

Workforce: In May, the midwifery staffing ratios were reported as 1:25 at the Chelsea site and 1:22 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 Antenatal activity starting from December 2025 and births in 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 Northwest 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 85% from 89% in April, with 1 red flag reported (a decrease – 2 in April)
 - Delay in providing pain relief (n=1)
- **Birth Centre:** Compliance decreased to 61% from 91% in April with 1 red flag reported (an increase – 0 in April)
 - No additional support MW available (No second MW for birth) (n=1)
- **Antenatal Ward:** Compliance increased to 90% from 89% in April with 88 red flags reported (an increase – 39 in April)
 - Delayed or cancelled time critical activity (n=6)
 - Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication) (n=3)
 - Delay in providing pain relief (n=15)
 - Delay between presentation and triage (n=14)
 - Full clinical examination not carried out when presenting in labour (n=13)
 - Delay between admission for induction and beginning of process (n=18)
 - Delayed recognition of and action on abnormal vital signs (n=11)
 - 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 94% from 97% in April with 0 red flags reported (a decrease - 1 in April)

Chelsea and Westminster Site

- **Labour Ward:** Compliance increased to 80% from 77% in April, with 4 red flags reported (a decrease – 9 in April)
 - Delayed or cancelled time critical activity (n=1)
 - Delay between admission for induction and beginning of process (n=3)
- **Birth Centre:** Compliance decreased to 69% from 72% in April with 4 red flags reported (a decrease - 7 in April)
 - Delayed or cancelled time critical activity (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=2)
- **Simpson Unit (Recovery & HDU):** Compliance increased to 77% from 73% in April, with 1 red flag reported (a decrease - 2 in April)
 - Delayed or cancelled time critical activity (n=1)
- **Antenatal Ward:** Compliance decreased to 63% from 72% in March, with 9 red flags reported (a decrease - 11 in April)
 - Delayed or cancelled time critical activity (n=3)
 - Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) (n=1)
 - 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=1)
- **Postnatal Ward:** Compliance decreased to 84% from 87% in April, with 1 red flag reported (a decrease – 17 in April)
 - Delay in providing pain relief (n=1)

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 saw a significant drop. Red flag incidents varied across the clinical areas in May, with the highest numbers consistently being reported from the Antenatal Ward. A meeting is to be held imminently to address the high numbers of red flags being reported in this area and an action plan will be generated to address any safety concerns identified.

Compliance on the CW site remained relatively stable across the clinical areas, with a slight reduction in overall compliance noted for the majority of clinical areas. Red flag incidents were noted to unanimously decrease across all areas in May. 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 46% in May from 37% in April. Further improvements are expected 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 decreased slightly to 63% in May from 66% in April, additionally a large cohort of staff have been sent on the QIS program in February 2026, which will boost QIS rate in time for the expansion/re-designation.

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 2 patient safety incidents:

1. IIR – NND, uterine rupture - MNSI investigation
2. IIR – Neonatal ?HIE/cooling – MNSI investigation

Datix reporting system: There were 147 Datix incidents reported (an increase – 106 in April)

- Access to care/admissions
- Communication
- MOH

Incidents not yet closed over 3 months old: 80 (a slight increase from April). An action plan to address is in place.

CWH site: There were 6 patient safety incidents:

1. IIR – NICU admission – under review
2. IIR – Birth injury – under review
3. IIR – Birth trauma – under review
4. IIR – Neonatal readmission (jaundice) – under review
5. IIR – Uterine rupture at MTOP – under review
6. IIR – Miscarriage at 20/40 – under review

Datix reporting system: There were 94 Datix incidents reported (a decrease – 114 in April)

- Communication
- Delay/failure in access to hospital/care
- NICU admissions

Incidents not yet closed over 3 months old x8 (a decrease from April)



Neonatal Service:

- Number of Datix: 164 (49 CW + 15 WM) – a decrease from April.

Perinatal Quality Surveillance Dashboard

- **PMRT (Cross site):** CW site reported 1 case: NND on day 18 post birth at 24/40 and x2 MTOP's not supported by the tool. WM site reported 3 cases; 1 NND on day 0 following birth at 39+6, 1 IUD at 33/40 and 1 IUD at 27/40.
- **ATAIN (Cross site):** WM site reported 12 term admissions, with a term admission rate of 3.54%. CW site data was not available at the time of writing.
- **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 will be undertaken at the close of Q1 26-27.

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				
		Mar-26	Apr-26	May-26	2026-2027	Mar-26	Apr-26	May-26	2026-2027	Mar-26	Apr-26	May-26	2026-2027 Q1	2026-2027
Perinatal Quality	Training compliance for all staff groups in maternity related to the core competency framework (Target: >90%)	93.0%	91.0%	87.0%	89.0%	90.0%	90.0%	94.0%	92.0%	91.5%	90.5%	90.5%	90.5%	90.5%
	Training compliance for all staff groups in maternity related to fetal monitoring (Target: >90%)	93.0%	90.0%	89.0%	89.5%	93.0%	91.0%	94.0%	92.5%	93.0%	90.5%	91.5%	91.0%	91.0%
	Service User Feedback FFT	86.1%	91.2%	87.2%	89.1%	88.9%	91.6%	82.1%	87.0%	87.0%	91.4%	85.3%	88.2%	88.2%
	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	10	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%)									0.0%	100.0%	100.0%	100.0%	100.0%

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

Perinatal Quality Surveillance Model



NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

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 May, overall multi-disciplinary training compliance increased slightly to 94% (WM) and decreased to 87% (CW). Fetal monitoring training continues on the WM site at 94%, however a drop to and 89% was noted 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 decreased from 91% in April to 88% in May. Respondents were predominantly White Other (34%), White British (30%), Asian/Asian British (8%) and Black/Black British (8%), with most aged 25-34 years (52%) and 81% English-speaking. The lowest-scoring area remained whether concerns were taken seriously (74%) which is unchanged from April. In contrast 98% reported positively that they were spoken to in a way they could understand. Negative feedback themes included delays in discharge from the postnatal ward, perceived understaffing, disparities in care quality between areas and day/night staff and temperature control.

At the West Middlesex site, positive feedback decreased from 91% in April to 80% in May. Respondents were predominantly Asian/Asian British (45%), White British (20%), and White Other (14%), with most aged 25–34 years (55%). Lowest scores remained consistently related to concerns being taken seriously (61%). In contrast 95% reported positively that they were treated with respect and dignity. Negative feedback themes included poor/unkind communication, perceived understaffing, poor facilities 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. Action 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.



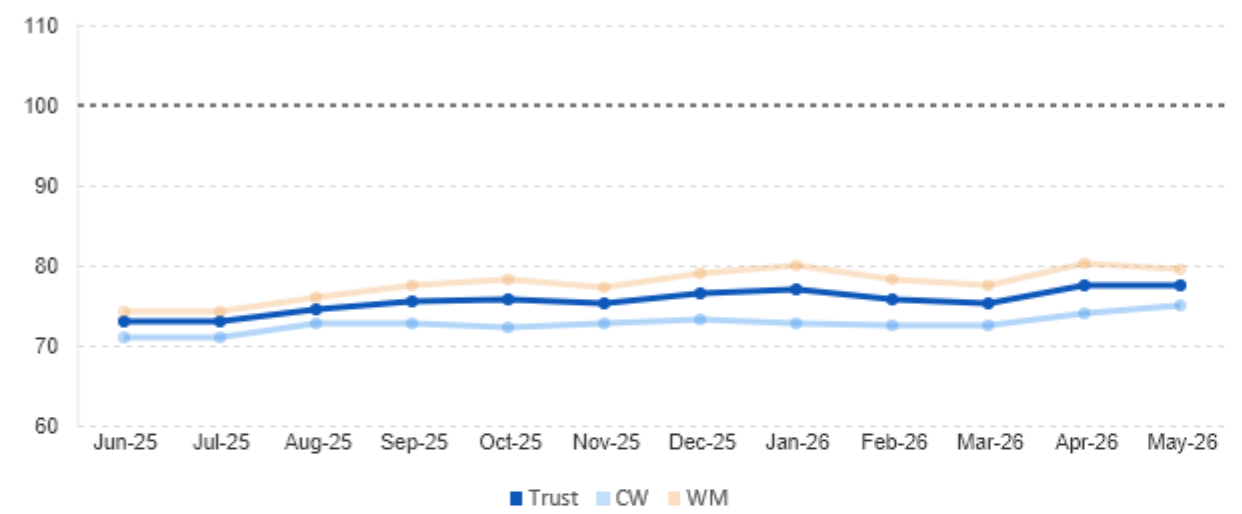
Mortality

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	75.0	69.3
WM	79.4	83.3
Trust	77.6	77.5

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

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
SHMI (Target: <100)	CW	72.8	72.4	72.5	74.0	75.0	74.5
	WM	80.1	78.3	77.4	80.2	79.4	79.8
	Trust	77.0	75.8	75.3	77.5	77.6	77.5
HSMR (Target: <100)	CW	67.0	66.9	66.9	67.8	69.3	68.6
	WM	85.0	83.2	80.5	82.7	83.3	83.0
	Trust	77.4	76.4	74.8	76.5	77.5	77.0



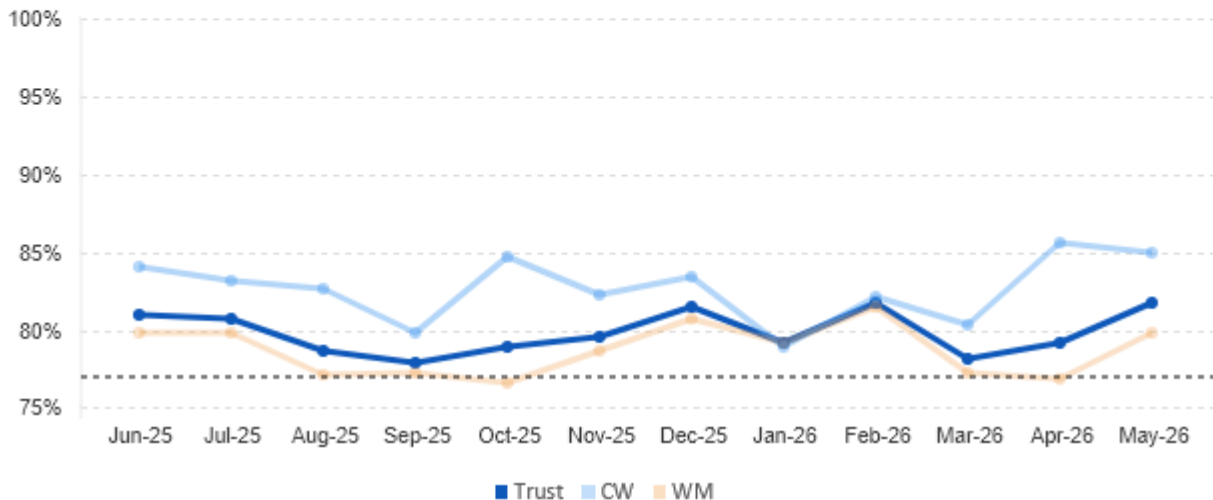
Patient Access

Access to Cancer Care (Diagnosis)

Responsive – Operating Plan

Trend

28 Day Faster Diagnosis Standard



Narrative

The Trust experienced a challenging position in April 2026, falling marginally below the new national 28-Day FDS compliance standard of 80%, with reported performance of 79.2%. However, performance has improved in May, with the Trust currently reporting an unvalidated compliance rate of 82.2%, indicating a strong recovery against the national target.

The 2ww pathways continue to perform above the national standard, with overall compliance consistently exceeding 93.0%.

In-Month Performance

	28 Days Faster Diagnosis Standard	2 Weeks from Referral to First Seen (All Urgent Referrals)
CW	85.0%	90.2%
WM	79.9%	96.6%
Trust	81.8%	94.1%

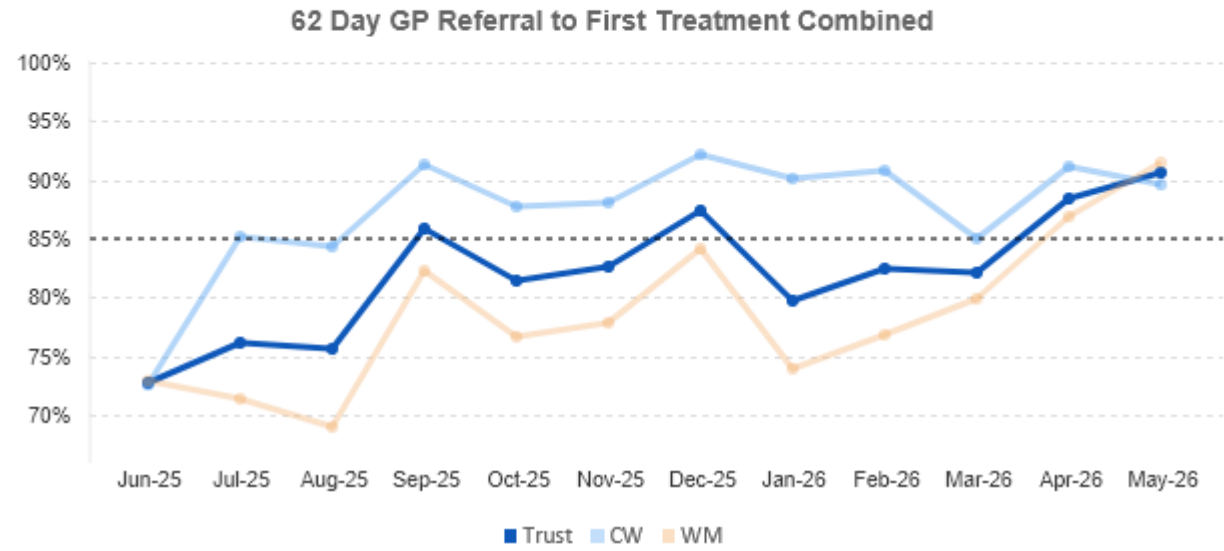
Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
28 Day Faster Diagnosis Standard (Target: >=80%)	CW	78.9%	82.1%	80.4%	85.6%	85.0%	85.2%
	WM	79.2%	81.5%	77.2%	76.8%	79.9%	78.2%
	Trust	79.1%	81.7%	78.1%	79.2%	81.8%	80.4%
2 Weeks from Referral to First Seen (All Urgent Referrals) (Target: >=96%)	CW	96.3%	94.6%	93.9%	90.9%	90.2%	90.5%
	WM	95.1%	97.3%	96.4%	95.5%	96.6%	96.1%
	Trust	95.6%	96.2%	95.3%	93.7%	94.1%	93.8%

Access to Cancer Care (Treatment)

Responsive – Operating Plan

Trend



Narrative

The Trust has commenced the financial year with strong performance against the Cancer 62-day (62D) standard, achieving over 85% in April 2026 and currently reporting an unvalidated performance of 89.9% for May 2026. Performance is consistently strong across tumour sites, with notable recovery in Urology making a significant contribution to the Trust meeting the national standard.

The Trusts 31D position remains above the National KPIs of 96% with both April and May 2026 showing strong compliance.

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	89.6%	98.3%	
WM	91.4%	100.0%	
Trust	90.6%	99.3%	130

Year-to-Date Performance

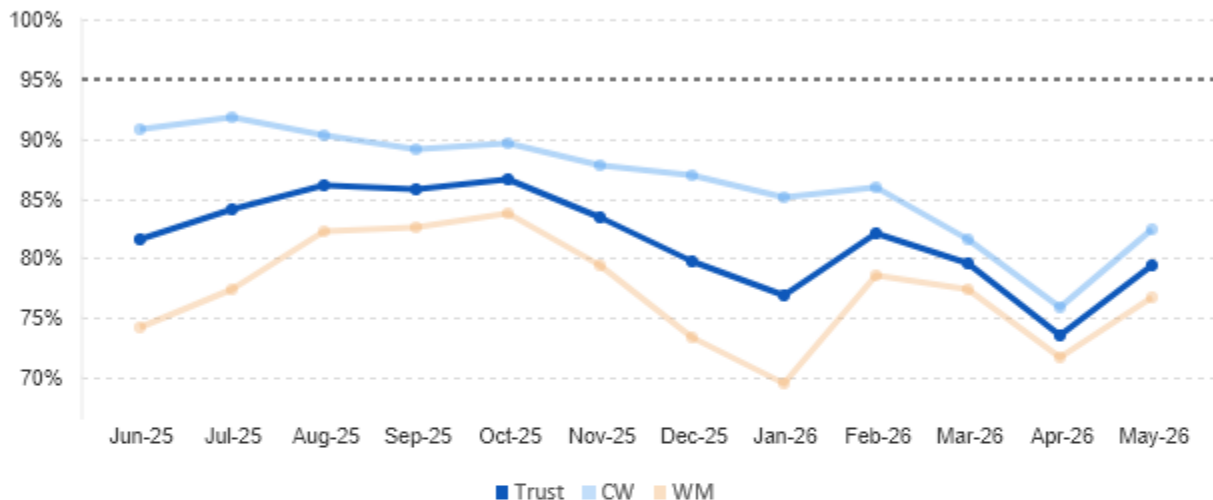
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
62 Day GP Referral to First Treatment Combined (Target: >=85%)	CW	90.1%	90.8%	85.0%	91.1%	89.6%	90.4%
	WM	74.0%	76.8%	79.8%	86.8%	91.4%	88.7%
	Trust	79.8%	82.4%	82.2%	88.4%	90.6%	89.4%
31 Day Diagnosis to First or Subsequent Treatment (Target: >=96%)	CW	100.0%	100.0%	98.9%	97.4%	98.3%	97.8%
	WM	100.0%	98.8%	98.9%	100.0%	100.0%	100.0%
	Trust	100.0%	99.3%	98.9%	99.0%	99.3%	99.1%
62+ Day Backlog (Target: 100)	CW						
	Trust	98	96	99	120	130	130

Access to Diagnostics

Responsive – Operating Plan

Trend

Diagnostic Waiting Times < 6 Weeks



Narrative

May represents a 5% improvement from April in the Trust's DM01 performance, increasing to 78.86%, although performance remains below the NHS constitutional standard. This improvement has been supported by stabilisation across several modalities. However, performance continues to be constrained by persistent pressures, particularly within echocardiography at West Middlesex (50.98%), non obstetric ultrasound at Chelsea and Westminster (69.69%), and CT capacity at West Middlesex (63.82%).

Chelsea and Westminster site outperformed West Middlesex in-month (81.35% vs 76.77%), with strong delivery across most radiology and diagnostic modalities partially offset by ongoing pressures in ultrasound and urodynamics. In contrast, West Middlesex performance continues to be significantly impacted by diagnostic physiology and CT, despite relatively strong delivery in MRI, DEXA and non-obstetric ultrasound. Both sites have improved performance from last month by 5%.

The Trust PTL remains elevated (17,066 total waiters), with 3,607 patients waiting over six weeks, reflecting the ongoing prioritisation of long waiters, which continues to displace routine activity. While insourcing and additional capacity deployment are contributing to incremental improvements, the underlying demand and capacity mismatch persists, and further recovery will be dependent on sustained workforce stabilisation and continued expansion of elective and CDC capacity.

In-Month Performance

	Diagnostic Waiting Times < 6 Weeks	Diagnostic Waiting Times > 6 Weeks: Actuals	Diagnostic Waiters 13+ Weeks
CW	82.4%	1,370	0
WM	76.8%	2,151	0
Trust	79.4%	3,521	0

Year-to-Date Performance

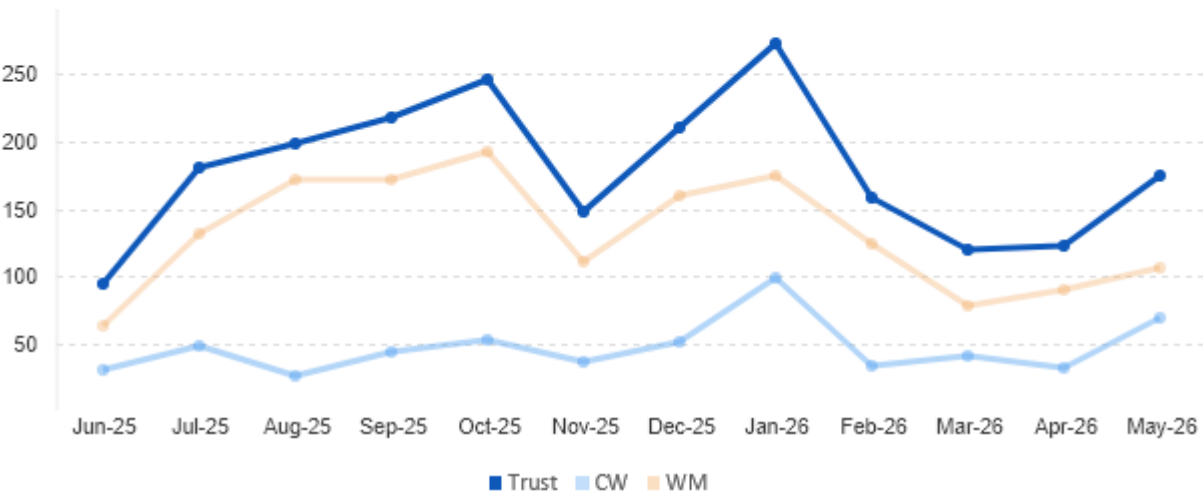
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Diagnostic Waiting Times < 6 Weeks (Target: >95%)	CW	85.1%	85.9%	81.6%	75.8%	82.4%	79.1%
	WM	69.5%	78.5%	77.3%	71.7%	76.8%	74.2%
	Trust	76.8%	82.1%	79.6%	73.6%	79.4%	76.4%
Diagnostic Waiting Times > 6 Weeks: Actuals	CW	1,091	1,124	1,630	1,925	1,370	1,370
	WM	2,545	1,857	1,801	2,730	2,151	2,151
	Trust	3,636	2,981	3,431	4,655	3,521	3,521
Diagnostic Waiters 13+ Weeks	CW	0	0	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	0	0

Ambulance Handover Waits

Safe

Trend

LAS Handover 30 Mins



Narrative

Performance

The Trust's overall performance for ambulance handovers remains strong. In the month of May 2026, the Trust reported one 60-minute LAS handover delays. The 15-minute handover was non-compliant across both sites have seen an increase from last month, the Chelsea site 17:06 and the West Middlesex site16:19. The Trust is working towards reducing the number of breaches against this target.

Improvement

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

Risk

Cubicle capacity in the department.

In-Month Performance

	LAS 15 Min Breach Performance	LAS Time Lost (Hours)	LAS Handovers 30 Mins	LAS Handovers 60 Mins
CW	897	102.9	69	0
WM	1,036	117.4	106	1
Trust	1,933	220.3	175	1

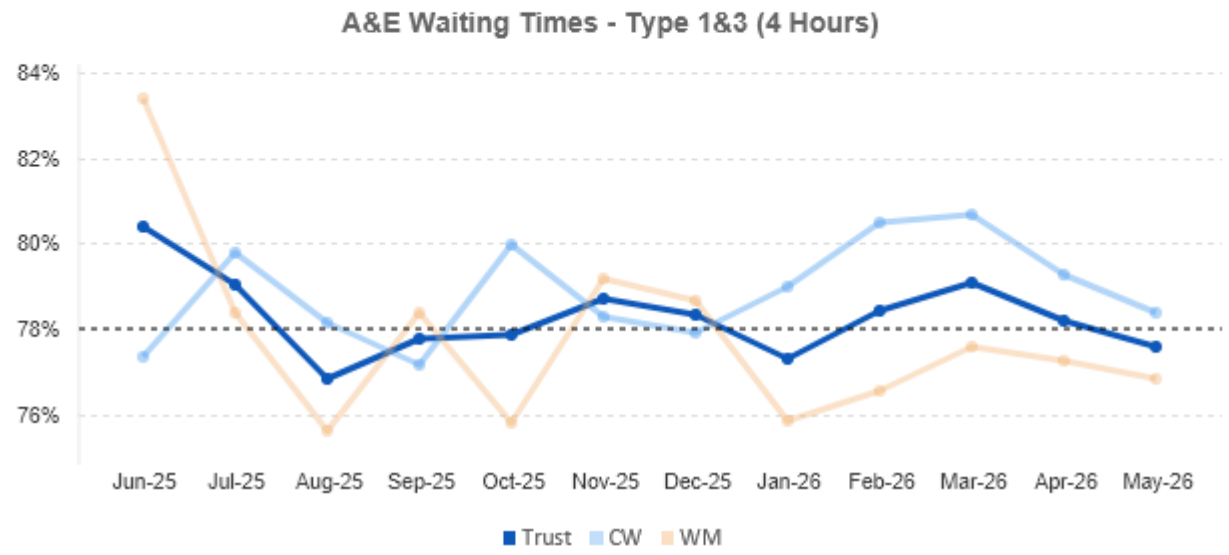
Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
LAS 15 Min Breach Performance	CW	886	780	835	764	897	1,661
	WM	1,141	970	975	953	1,036	1,989
	Trust	2,027	1,750	1,810	1,717	1,933	3,650
LAS Time Lost (Hrs)	CW	116.6	86.0	86.9	87.1	102.9	190.0
	WM	166.1	125.7	107.7	111.9	117.4	229.3
	Trust	282.7	211.7	194.6	199.0	220.3	419.3
LAS Handovers 30 Mins	CW	99	34	41	33	69	102
	WM	174	124	79	90	106	196
	Trust	273	158	120	123	175	298
LAS Handovers 60 Mins	CW	1	0	0	0	0	0
	WM	2	2	1	2	1	3
	Trust	3	2	1	2	1	3

Urgent & Emergency Department Waits

Safe/Responsive – Operating Plan

Trend



Narrative

Performance
Performance against the 4-hour standard in May 2026 was 77.6%. West Middlesex achieved 76.8% (14,925 attendances) and Chelsea 78.4% (13,655 attendances) with both sites seeing year-on-year growth of 6.9% and 2.3% respectively.

The 12-hour performance is 2.5% against our operating plan trajectory target of 2.8%.

Improvement
There has been an ongoing focus on A&E time to triage in April, West Middlesex achieved an average time to triage of 7 minutes and at the Chelsea site 19 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	78.4%	2.5%	00:15	13,655	873	29
WM	76.8%	2.5%	00:07	14,925	911	24
Trust	77.6%	2.5%	00:11	28,580	1,784	53

Year-to-Date Performance

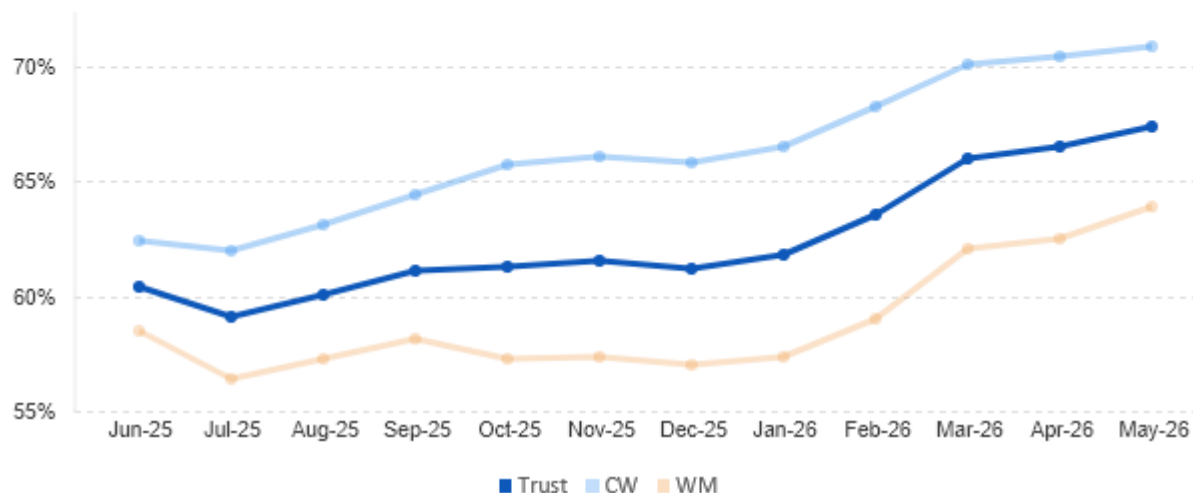
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
A&E Waiting Times Type 1&3 (4 Hrs) Target: >80%)	CW	79.0%	80.5%	80.7%	79.2%	78.4%	78.8%
	WM	75.8%	76.6%	77.6%	77.3%	76.8%	77.0%
	Trust	77.3%	78.4%	79.1%	78.2%	77.6%	77.9%
A&E Waiting Times Type 1&3 (12 Hrs) (Target: <2.8%)	CW	3.2%	2.0%	1.8%	2.2%	2.5%	2.4%
	WM	3.8%	2.9%	2.1%	2.2%	2.5%	2.3%
	Trust	3.5%	2.5%	1.9%	2.2%	2.5%	2.3%
A&E Time to Triage (Target: 15mins)	CW	00:15	00:14	00:15	00:15	00:15	00:15
	WM	00:06	00:06	00:07	00:07	00:07	00:07
	Trust	00:10	00:10	00:11	00:10	00:11	00:11
Total Attendances Type 1&3	CW	13,092	11,760	13,442	12,677	13,655	26,332
	WM	14,525	12,830	14,569	14,213	14,925	29,138
	Trust	27,617	24,590	28,011	26,890	28,580	55,470
Referrals to SDEC (Target as Per Op Plan)	CW	818	684	842	775	873	1,648
	WM	895	710	948	928	911	1,839
	Trust	1,713	1,394	1,790	1,703	1,784	3,487

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 67.37% showing a 1% improvement from the previous month. The Trust finishes M2 ahead of 2026/27 trajectory.

The month ended with 2 65-week breaches and 1002 52-week breaches due to challenged specialty areas.

Improvement : Funding arrangement have been approved across the Trust and recruitment plans are being finalised for 2026/27. In and outsourcing along with WLIs will continue throughout the recruitment periods to ensure performance is maintained.

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

In-Month Performance

	18 Week RTT Incompletes	18 Week RTT Incompletes Paeds	52 Week RTT Incompletes	52 Week Waiters	65 Week Waiters
CW	70.9%	75.6%	1.0%	387	1
WM	63.9%	61.2%	1.6%	615	1
Trust	67.4%	69.2%	1.3%	1,002	2

Year-to-Date Performance

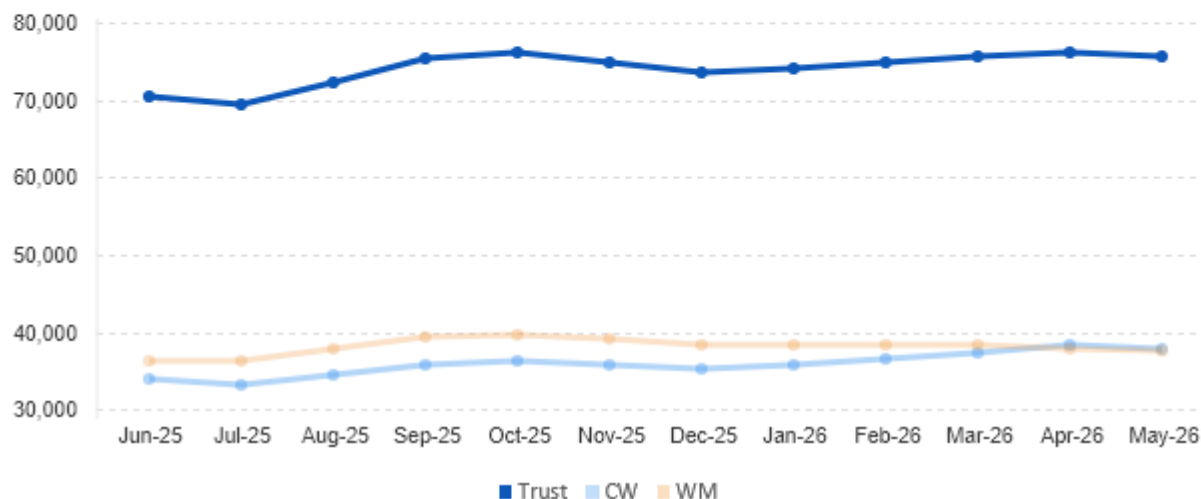
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
18 Week RTT Incompletes (Target: >66.07 %)	CW	66.5%	68.2%	70.1%	70.4%	70.9%	70.9%
	WM	57.4%	59.0%	62.0%	62.5%	63.9%	63.9%
	Trust	61.8%	63.5%	66.0%	66.4%	67.4%	67.4%
18 Week RTT Incompletes Paeds	CW	74.4%	74.5%	76.0%	76.3%	75.6%	75.6%
	WM	51.3%	53.8%	56.1%	56.6%	61.2%	61.2%
	Trust	62.8%	64.4%	66.7%	67.4%	69.2%	69.2%
52 Week RTT Incompletes (Target: <1%)	CW	1.4%	1.2%	1.0%	1.0%	1.0%	1.0%
	WM	2.0%	1.9%	1.5%	1.5%	1.6%	1.6%
	Trust	1.7%	1.6%	1.3%	1.3%	1.3%	1.3%
52 Week Waiters	CW	495	441	383	370	387	387
	WM	769	720	575	585	615	615
	Trust	1,264	1,161	958	955	1,002	1,002
65 Week Waiters	CW	3	3	0	1	1	1
	WM	3	1	0	2	1	1
	Trust	6	4	0	3	2	2

Referral to Treatment Waits

Responsive – Operating Plan

Trend

Total Waiting List (PTL)



Narrative

Performance: In M2 the Trust total RTT Patient Treatment List (PTL) was reported as 75,533 a 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.

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

In-Month Performance

	Total Waiting List (PTL)	Total Waiting List (PTL) Paeds	Patients Waiting < 18 Weeks for First Appointment	RTT Clearance Time: Size of Waiting List
CW	37,905	6,457	68.0%	6.9
WM	37,628	5,146	63.0%	6.2
Trust	75,533	11,603	65.3%	6.5

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Total Waiting List (PTL)	CW	35,845	36,495	37,259	38,270	37,905	37,905
	WM	38,300	38,254	38,386	37,906	37,628	37,628
	Trust	74,145	74,749	75,645	76,176	75,533	75,533
Total Waiting List (PTL) Paeds	CW	5,465	5,745	6,011	6,476	6,457	6,457
	WM	5,494	5,480	5,316	5,364	5,146	5,146
	Trust	10,959	11,225	11,327	11,840	11,603	11,603
Patients Waiting < 18 Weeks for First Appointment	CW	65.2%	66.5%	67.8%	68.0%	68.0%	68.0%
	WM	57.4%	58.0%	60.4%	61.5%	63.0%	63.0%
	Trust	60.9%	61.8%	63.8%	64.5%	65.3%	65.3%
RTT Clearance Time: Size of Waiting List	CW	5.9	6.5	6.3	7.0	6.9	6.9
	WM	6.6	6.5	5.9	6.3	6.2	6.2
	Trust	6.2	6.5	6.1	6.7	6.5	6.5

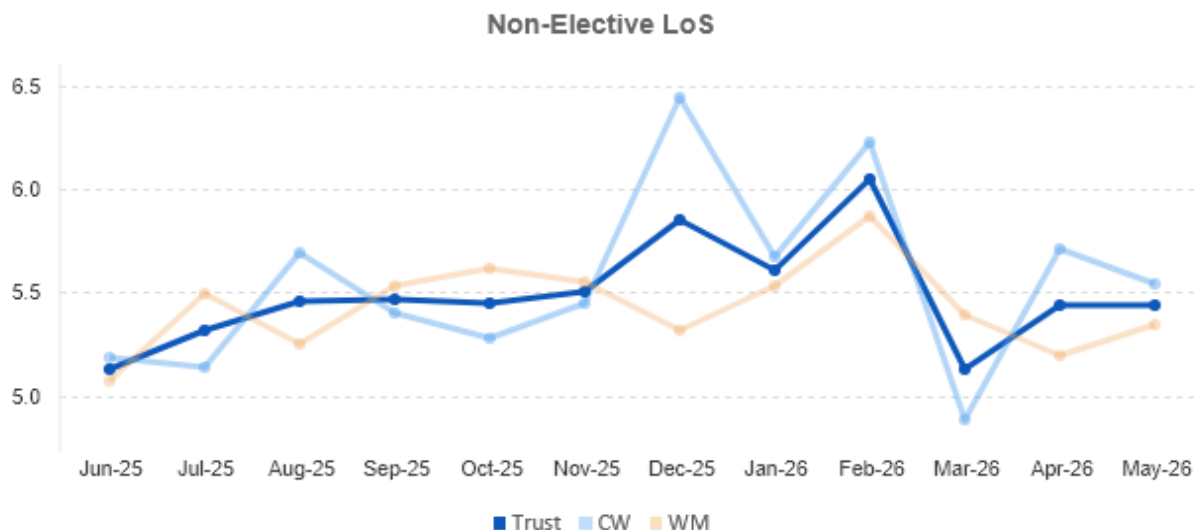


Operating Plan and Capacity

Flow & Discharge – Admitted Care

Responsive/Effective

Trend



Narrative

Elective LoS is compliant with the standard year to date. Non-Elective LOS is non-compliant across both sites. In May there was a decrease in LoS at the CW site compared to April. There is a continued decrease in patients equal and over 21 days LoS, and an increase in the number of patients equal and over 7 days LoS. 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 May 2026, ICU occupancy has consistently exceeded the GPICS recommended 85%, ranging from 86.7% at CWH to 106.8% WMH, indicating sustained operational pressure in the trust of 96.3% occupancy. The primary driver is delayed discharge over four hours, which restricts patient flow and maintains high bed occupancy. 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	3.2	5.5	505	121	89.7%	7.5
WM	2.4	5.3	545	127	106.1%	6.1
Trust	3.0	5.4	1,050	248	97.5%	6.8

Year-to-Date Performance

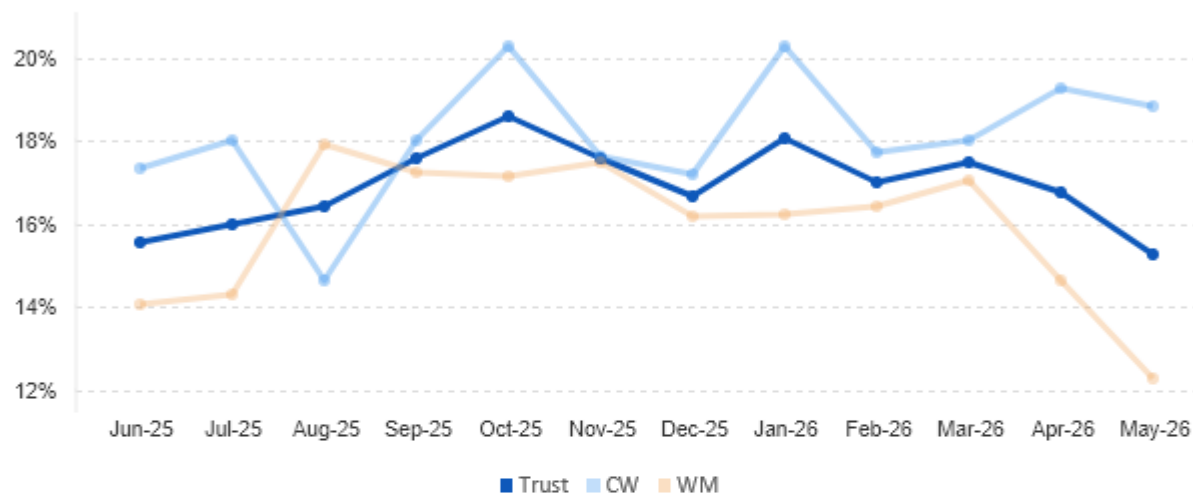
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Elective LoS (Target: <2.9)	CW	2.8	2.9	2.9	2.4	3.2	2.8
	WM	1.8	2.3	2.2	2.7	2.4	2.6
	Trust	2.5	2.7	2.7	2.5	3.0	2.7
Non-Elective LoS (Target: <3.95)	CW	5.7	6.2	4.9	5.7	5.5	5.6
	WM	5.5	5.9	5.4	5.2	5.3	5.3
	Trust	5.6	6.0	5.1	5.4	5.4	5.4
Non-Elective Long Stays (>=7 days)	CW	471	465	469	484	505	989
	WM	571	549	554	520	545	1,065
	Trust	1,042	1,014	1,023	1,004	1,050	2,054
Non-Elective Long Stays (>=21 Days)	CW	157	145	114	127	121	248
	WM	150	162	141	135	127	262
	Trust	307	307	255	262	248	510
Critical Care Occupancy (Target: <85%)	CW	99.0%	113.6%	98.1%	94.0%	89.7%	91.8%
	WM	107.7%	104.3%	105.5%	86.7%	106.1%	96.0%
	Trust	103.4%	108.9%	101.8%	90.3%	97.5%	93.9%
Average days between the DRD and DD	CW	5.9	8.2	6.5	6.2	7.5	6.8
	WM	7.0	5.6	5.7	7.0	6.1	6.5
	Trust	6.5	6.7	6.0	6.6	6.8	6.7

Flow & Discharge – Discharges

Responsive

Trend

Patient Not Meeting CTR by Trust of Pathway



Narrative

The Trust remains an outlier for the number of patients in hospital who do not meet the criteria to reside. This is predominantly driven by patients requiring support for discharge e.g., declutter, blitz clean; housing or nursing home (P3 discharge). Metrics for discharge ready date and readmissions remain consistent. This continues to be monitored as part of the weekly discharge performance meetings.

Additional escalation meetings have continued with the aim of reducing the number of patients waiting for P1 discharges within RBKC; Westminster and LBHF. Escalation meetings are in place with other system partners as well as a NWL weekly system GOLD call.

In-Month Performance

	Patients Not Meeting CTR Daily Average	Discharges Before 12	Discharge Date Same as Discharge Ready Date	Discharge Date After Discharge Ready Date	Emergency Re-admissions < 30 Days of Discharge
CW	18.8%	15.6%	88.1%	11.9%	4.3%
WM	12.3%	13.0%	88.8%	11.2%	6.1%
Trust	15.3%	14.4%	88.5%	11.5%	5.2%

Year-to-Date Performance

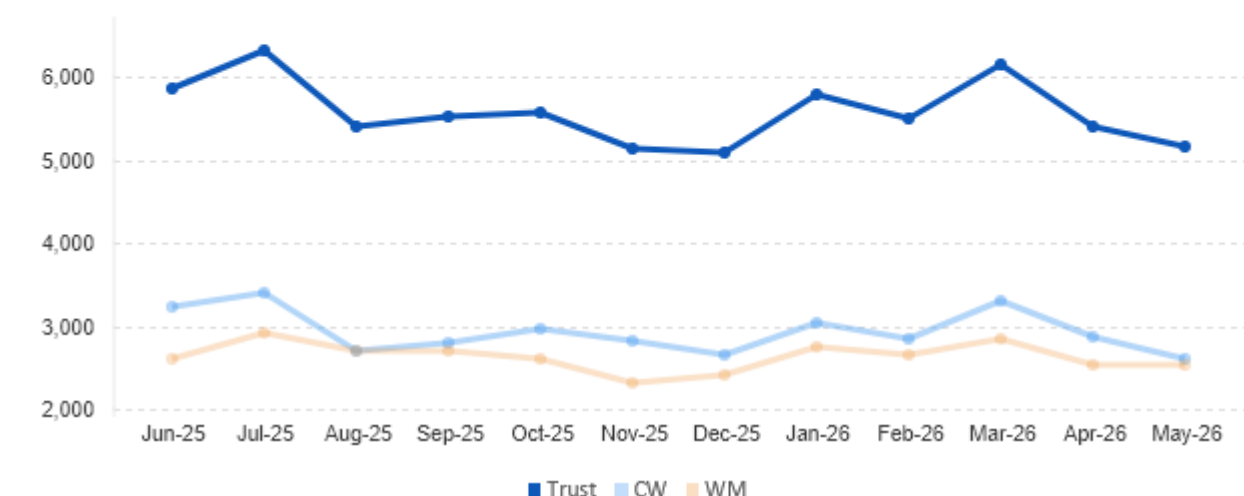
	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Patient Not Meeting CTR Daily Average	CW	20.3%	17.7%	18.0%	19.3%	18.8%	19.0%
	WM	16.2%	16.4%	17.1%	14.6%	12.3%	13.4%
	Trust	18.1%	17.0%	17.5%	16.8%	15.3%	16.0%
Discharges Before 12	CW	16%	16%	14%	15%	16%	15%
	WM	13%	16%	14%	15%	13%	14%
	Trust	14%	16%	14%	15%	14%	15%
Discharge Date Same as Discharge Ready Date	CW	87.2%	88.0%	89.8%	87.2%	88.1%	87.7%
	WM	86.5%	85.5%	85.7%	88.2%	88.8%	88.5%
	Trust	86.8%	86.7%	87.8%	87.7%	88.5%	88.1%
Discharge Date After Discharge Ready Date	CW	12.8%	12.0%	10.2%	12.8%	11.9%	n/a
	WM	13.5%	14.5%	14.3%	11.8%	11.2%	n/a
	Trust	13.2%	13.3%	12.2%	12.3%	11.5%	n/a
Emergency Re-Admissions < 30 Days of Discharge (Target: <7.6%)	CW	4.6%	4.9%	4.8%	4.7%	4.3%	4.5%
	WM	4.9%	5.4%	5.5%	6.4%	6.1%	6.3%
	Trust	4.8%	5.1%	5.1%	5.5%	5.2%	5.4%

Operating Plan Performance

Responsive – Operating Plan

Trend

Elective Day Case



Narrative

Operating plans for 2026/27 is being met for outpatients with Elective activity showing marginal levels below plan. Plans reflect the increase in activity across all elective PODs to support delivery of the RTT standards.

Transformation programmes are being worked up across key Outpatient, Theatres and Diagnostics areas to identify areas of opportunity to further improve pathway efficiency, and these are driven through appropriate governance routes.. Recruitment process has also begun to resource the forecasted activity increase with an expectation this would be reflected in further months.

Risk to achieving future plans include Industrial action.

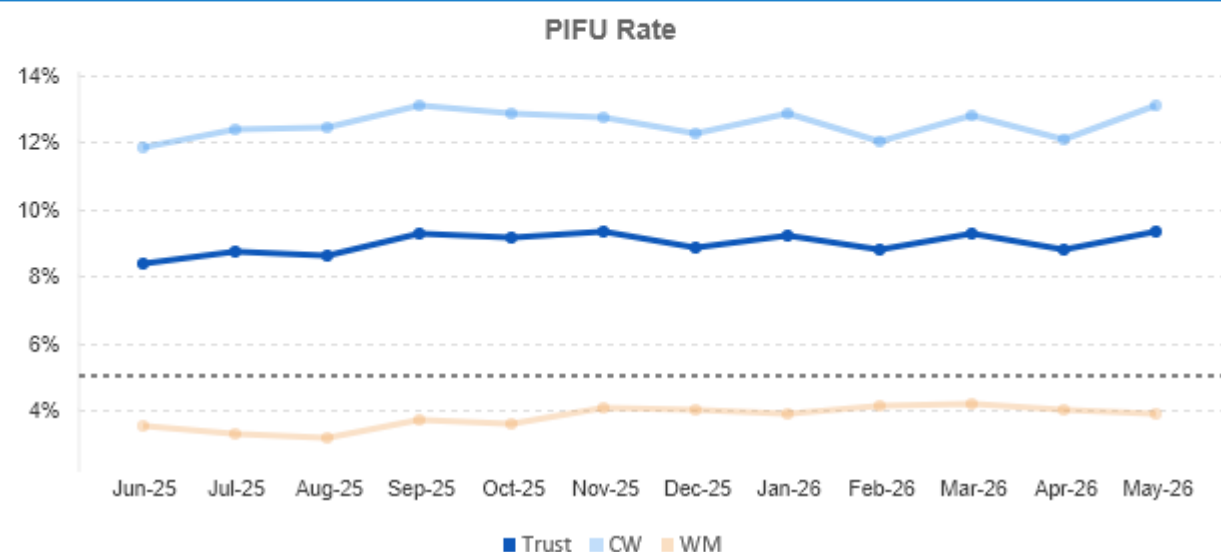
In-Month Performance

	Elective Day Cases	Elective Ordinary Admissions	OP Procedures	OP First Attendance Without Procedure	OP FUp Attendance Without Procedure
CW	2,615	465	5,501	9,686	17,729
WM	2,540	181	3,237	9,693	9,776
Trust	5,155	646	8,738	19,379	27,505

Year-to-Date Performance

	Site	Feb-26	Mar-26	Apr-26	May-26	Plan YTD	2026-2027
Elective Day Cases	CW	2,843	3,314	2,874	2,615	5,971	5,489
	WM	2,656	2,851	2,539	2,540	4,845	5,079
	Trust	5,499	6,165	5,413	5,155	10,816	10,568
Elective Ordinary Admissions	CW	462	533	465	465	868	930
	WM	190	217	165	181	351	346
	Trust	652	750	630	646	1,219	1,276
OP Procedures	CW	5,304	6,098	5,765	5,501	9,878	11,266
	WM	3,124	3,620	3,589	3,237	6,535	6,826
	Trust	8,428	9,718	9,354	8,738	16,413	18,092
OP First Attendance Without Procedure	CW	10,414	10,888	10,224	9,686	19,934	19,910
	WM	9,429	10,381	9,602	9,693	16,234	19,295
	Trust	19,843	21,269	19,826	19,379	36,168	39,205
OP FUp Attendance Without Procedure	CW	17,746	18,485	18,545	17,729	35,240	36,274
	WM	9,650	10,401	10,014	9,776	20,981	19,790
	Trust	27,396	28,886	28,559	27,505	56,221	56,064

Trend



Narrative

Our **DNA rate** in May improved overall, and particularly for new appointments where there were big gains on both sites. Follow ups were more mixed with an improvement at the Chelsea site counterbalanced by slippage at WMUH. Focus on DNA rates continues. We will be reviewing reminders in all services, as well as continuing to use Patient Led Validation, volunteer team phone calls, and we plan to roll out pilots in Choice Booking (8-6-4-2) in July.

Patients added to **PIFU** improved significantly in May up to 9.3% against the 5% target. As ever this strong performance is largely driven by the Chelsea site and Specialist Care in particular so there remains work to do especially at WMUH to get to the 5%.

In-Month Performance

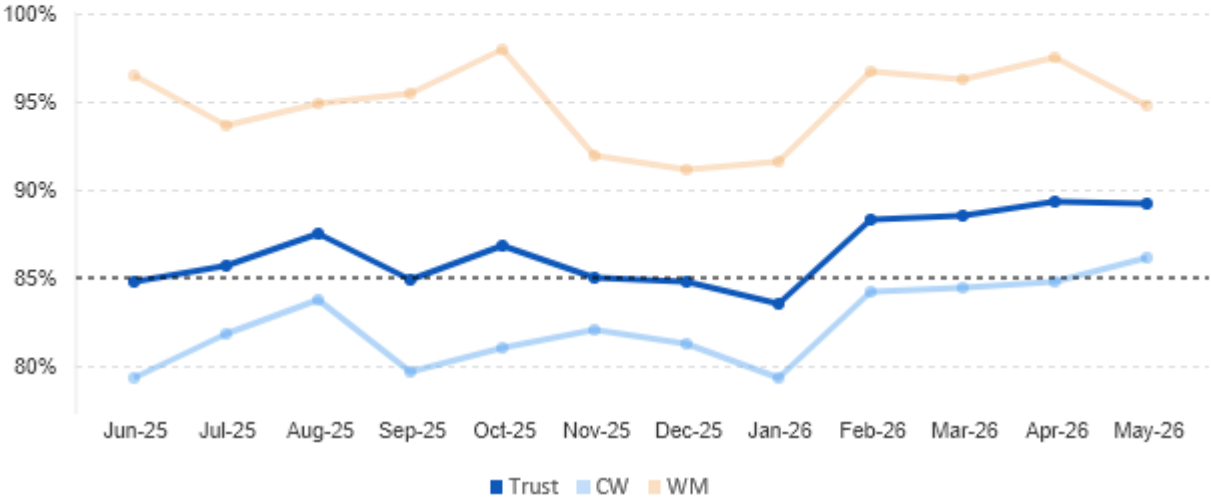
	PIFU Rate	DNA Rates - First Appointment	DNA Rates - Follow Up Appointment	Virtual Contacts
CW	13.1%	10.5%	7.8%	4,295
WM	3.9%	9.0%	7.8%	4,082
Trust	9.3%	9.8%	7.8%	8,377

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
PIFU Rate (Target: 5%)	CW	12.9%	12.0%	12.8%	12.1%	13.1%	12.6%
	WM	3.9%	4.1%	4.2%	4.0%	3.9%	3.9%
	Trust	9.2%	8.8%	9.2%	8.8%	9.3%	9.0%
DNA Rates - First Appointment	CW	11.6%	10.6%	10.9%	11.4%	10.5%	11.0%
	WM	10.4%	9.8%	10.0%	9.7%	9.0%	9.3%
	Trust	11.1%	10.2%	10.5%	10.6%	9.8%	10.2%
DNA Rates - Follow Up Appointment	CW	8.3%	8.3%	7.8%	8.1%	7.8%	8.0%
	WM	7.5%	7.6%	7.1%	7.3%	7.8%	7.6%
	Trust	8.0%	8.0%	7.5%	7.8%	7.8%	7.8%
Virtual Contacts	CW	4,201	4,809	4,531	4,753	4,295	9,048
	WM	3,718	3,948	4,293	4,133	4,082	8,215
	Trust	7,919	8,757	8,824	8,886	8,377	17,263

Trend

Theatre Utilisation (Uncapped)



Narrative

Trust-Wide uncapped utilisation continued to be compliant with a performance of 89.2%. There was an increase in utilisation at the CW site, driven by a continued improvement in utilisation of the new Day Surgery Unit and an improvement in Paediatric theatres. Both Main Theatres maintained continued performance of >90% utilisation.

Day case rates significantly increased to 92.9%. This was driven by a vast improvement at CW, moving from 80.8% to 92.4%

OTD cancellations were fairly static for April, with no patients breaching. There was a continued high number of non-clinical cancellations on the CW site, with 1.3% cancelled on the day for a non-clinical 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	85.6%	1.2%	0	86.1%
WM	86.8%	0.6%	0	94.8%
Trust	85.9%	1.0%	0	89.2%

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Basket Procedures Carried Out as Daycases (Target: >85%)	CW	87.6%	84.6%	83.6%	80.6%	85.6%	82.7%
	WM	86.0%	92.6%	89.0%	91.0%	86.8%	89.5%
	Trust	87.0%	87.0%	85.5%	83.7%	85.9%	84.6%
OTD Non-Clinical Cancellations as % Elective Admissions (Target: <0.8%)	CW	1.3%	0.9%	0.8%	1.4%	1.2%	1.3%
	WM	0.9%	0.6%	0.3%	0.6%	0.6%	0.6%
	Trust	1.1%	0.8%	0.6%	1.1%	1.0%	1.0%
OTD Cancellations Not Re-booked < 28 Days (Target: 0)	CW	6	1	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	6	1	0	0	0	0
Theatre Utilisation (Uncapped) (Target: >85%)	CW	79.4%	84.2%	84.5%	84.8%	86.1%	85.5%
	WM	91.6%	96.7%	96.3%	97.5%	94.8%	96.1%
	Trust	83.6%	88.3%	88.5%	89.3%	89.2%	89.3%

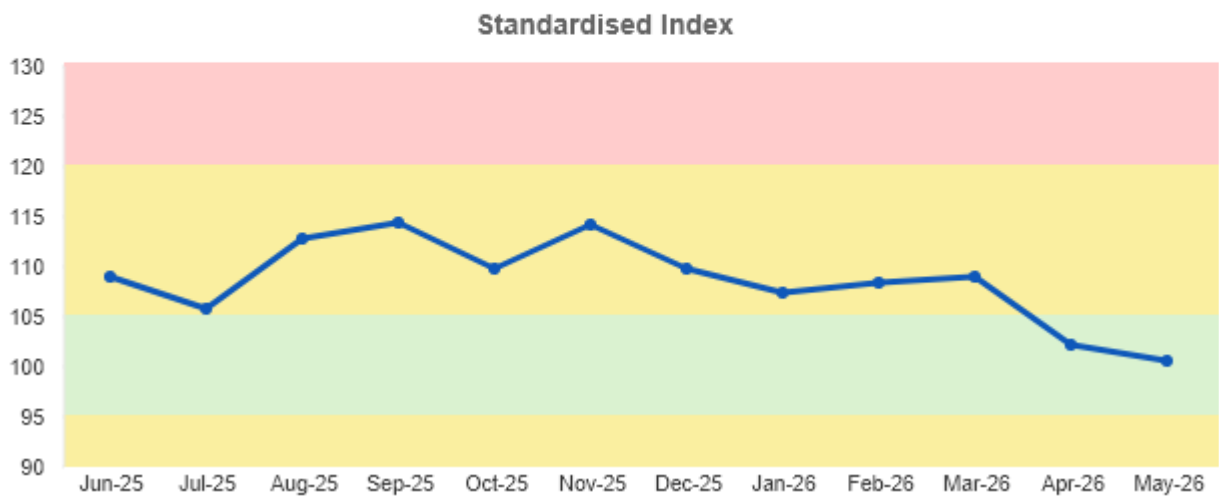


Equality, Diversity and Inclusion

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 6.5% of the quintile waiting longer than 40 weeks in line with all other quintiles.

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	101	6.5%	6.5%	553	4,272

Year-to-Date Performance

Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Standardised Index	107	108	109	102	101	101
Proportion IMDQ1	8.1%	8.2%	7.1%	6.7%	6.5%	6.6%
Proportion IMDQ2-5	7.5%	7.6%	6.5%	6.6%	6.5%	6.5%
IMDQ1 >40wk	675	682	592	576	553	1,129
IMDQ2 - 5 > 40wk	4,872	4,924	4,278	4,367	4,272	8,639

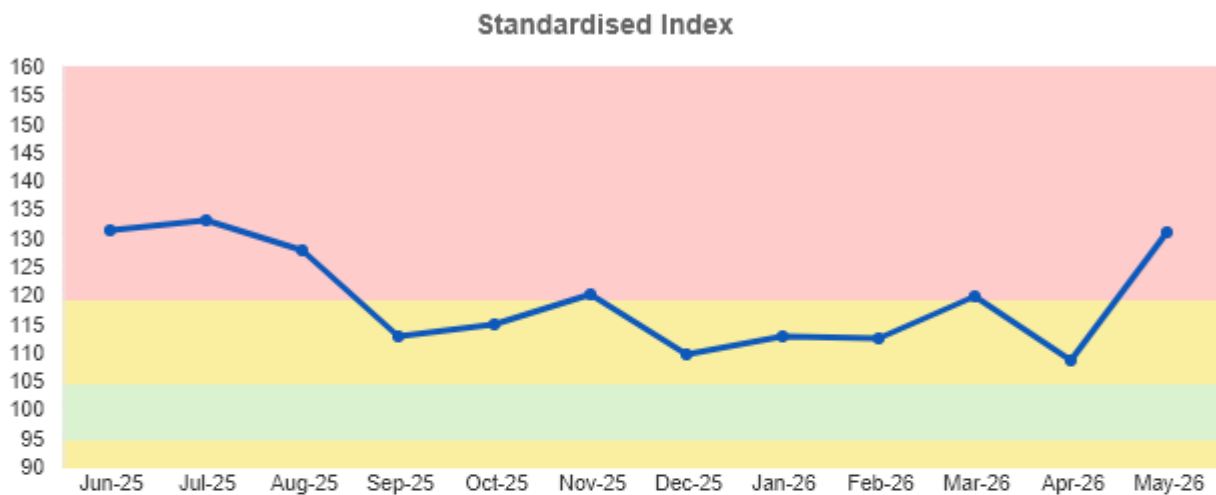
Inequity-DNA Rates

Equality, Diversity and Inclusion



Chelsea and Westminster Hospital
NHS Foundation Trust

Trend



Narrative

Increase of DNA rate this month relates to reduce volunteer resource due to tube strike and hot weather.

To date 3,387 patients called (out of 7511) ,of these 46% confirmed attendance, 49% did not respond, 3% rebooked and 2% discharged.

Audit undertaken to call patients who have DNA'd after confirming their appointment over the phone. The result does not show a theme. Reasons for DNA have been – Pt unwell on the day, work related reasons, did not remember.

In-Month Performance

	Standardised Index	Proportion IMDQ1	Proportion IMDQ2-5	IMDQ1 >40wk	IMDQ2 - 5 >40wk
Trust	131	12.0%	9.1%	365	2,168

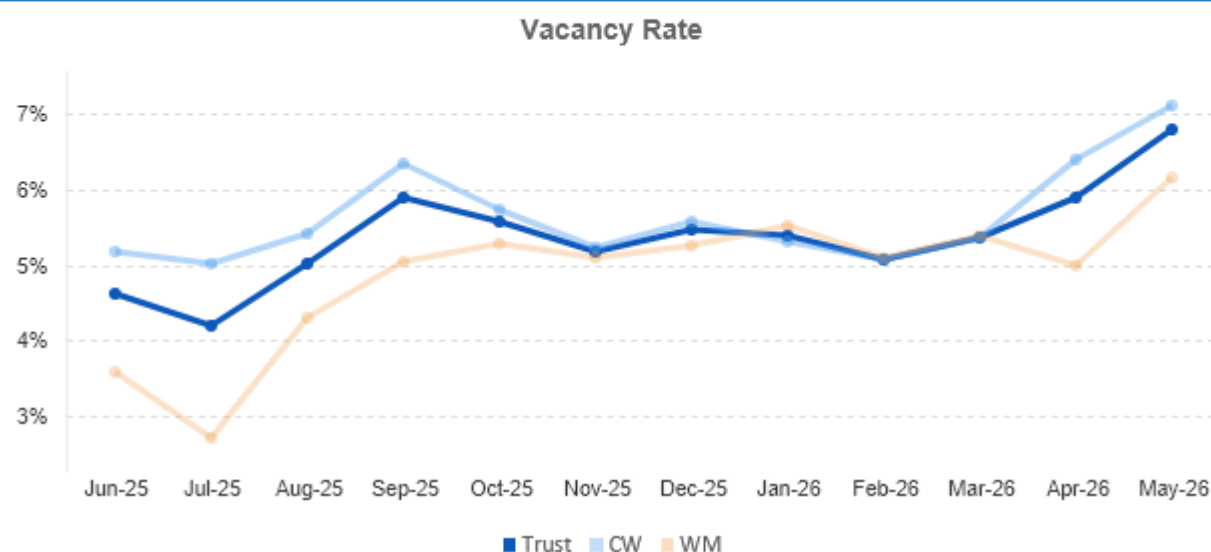
Year-to-Date Performance

Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Standardised Index	113	112	120	109	131	119
Proportion IMDQ1	11.5%	10.6%	11.6%	10.8%	12.0%	11.4%
Proportion IMDQ2-5	10.2%	9.4%	9.7%	10.0%	9.1%	9.6%
IMDQ1 >40wk	381	322	374	339	365	704
IMDQ2 - 5 >40wk	2,543	2,278	2,509	2,458	2,168	4,626



Workforce

Trend



Narrative

The Trust's Month 2 position shows the vacancy (6.8%), voluntary turnover rates (7.6%) 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.

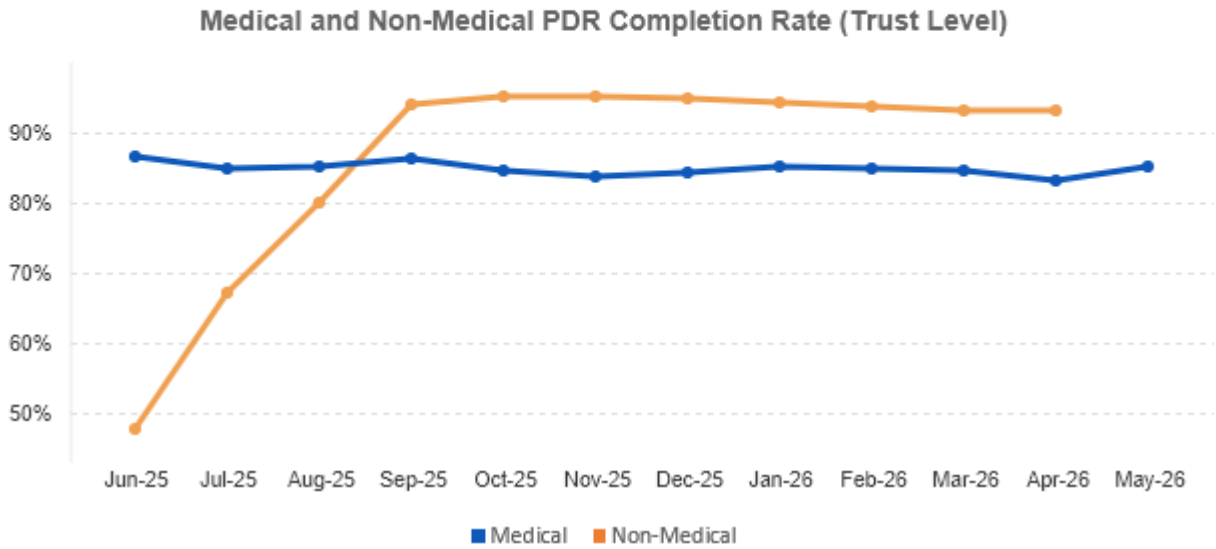
In-Month Performance

	Vacancy Rate	Voluntary Turnover	Sickness Absence	Agency Usage	Bank Usage
CW	7.13%	8.2%	4.1%	0.2%	8.1%
WM	6.16%	6.5%	4.3%	0.3%	9.9%
Trust	6.78%	7.6%	4.2%	0.3%	8.7%

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Vacancy Rate	CW	5.3%	5.1%	5.4%	6.4%	7.1%	7.1%
	WM	5.5%	5.1%	5.4%	5.0%	6.2%	6.2%
	Trust	5.4%	5.1%	5.4%	5.9%	6.8%	6.8%
Voluntary Turnover	CW	8.8%	8.7%	8.5%	8.3%	8.2%	8.2%
	WM	7.3%	7.2%	6.7%	6.4%	6.5%	6.5%
	Trust	8.2%	8.2%	7.8%	7.7%	7.6%	7.6%
Sickness Absence	CW	4.3%	4.2%	4.1%	4.4%	4.1%	4.1%
	WM	5.0%	4.8%	4.6%	4.5%	4.3%	4.3%
	Trust	4.6%	4.4%	4.3%	4.4%	4.2%	4.2%
% Agency Usage	CW	0.3%	0.3%	0.4%	0.2%	0.2%	0.2%
	WM	0.1%	0.3%	0.5%	0.2%	0.3%	0.3%
	Trust	0.2%	0.3%	0.4%	0.2%	0.3%	0.3%
% Bank Usage	CW	8.2%	8.9%	9.2%	7.8%	8.1%	8.1%
	WM	10.6%	11.2%	11.1%	9.7%	9.9%	9.9%
	Trust	9.1%	9.7%	9.9%	8.5%	8.7%	8.7%

Trend



Narrative

The Trust is currently in the PDR window (April - June) which closes on the 30th June.

At the end of week 10, the trust is currently at 63% of PDRs completed. EIC is currently has the highest rate 78.6%; CSD 63.6%; PDC 59.9%; COR 58.0% SCD 57.1% and WLCH 41.9%.

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	85.1%	-	91.9%

Year-to-Date Performance

	Site	Jan-26	Feb-26	Mar-26	Apr-26	May-26	2026-2027
Medical PDR Completion Rate (Trust Only)	CW						
	WM						
	Trust	85.1%	84.6%	84.4%	82.9%	85.1%	85.1%
Non-Medical PDR Completion Rate	CW	93.7%	92.9%	92.4%	92.4%		
	WM	95.2%	95.0%	94.1%	94.1%		
	Trust	94.2%	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 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 & no nstage											
	RN	HCA	RN	HCA										M	12M	M	12M	M	12M	M	12M	M	12M	M	12M	M	12M	M	12M		
Maternity	93%	101%	96%	101%	7.2	2.6	0.0	0.0	9.82	12.79	-3.70%	5.32%	5.77%	1	4	0	0	0	0	0	0	8	65	0	0	1	76	85.79%			
Annie Zunz	89%	100%	100%	100%	5.8	2.4	0.0	0.0	8.20	8.73	6.09%	7.52%	0.00%	0	12	0	0	0	0	0	0	0	7	0	0	0	4	100.00%			
Apollo	89%	-	94%	-	19.2	0.0	0.0	0.0	19.19	N/A	-4.43%	5.52%	32.97%	0	1	0	0	0	1	0	1	3	22	0	0	0	0	100.00%			
Mercury	99%	-	98%	-	8.1	0.0	0.0	0.0	8.13	9.94	-0.79%	3.13%	0.00%	0	2	0	0	0	0	0	0	4	69	0	0	1	3	100.00%			
Neptune	127%	-	141%	-	7.9	0.0	0.0	0.3	8.25	13.06	8.17%	5.85%	0.00%	0	2	0	0	0	0	0	0	3	40	0	0	0	3	100.00%			
NCU	114%	-	111%	-	16.0	0.0	0.3	0.0	16.32	26.91	3.02%	1.96%	0.00%	0	0	0	0	0	0	0	0	9	98	0	0	0	6				
AAU	104%	92%	98%	135%	6.3	1.8	0.0	0.1	8.18	8.4	8.94%	5.60%	5.75%	14	114	0	3	1	6	1	0	8	94	0	0	0	17	97.06%			
Nell Gw ynn e	126%	90%	132%	136%	4.5	3.3	0.0	0.3	8.10	7.82	-2.74%	4.79%	16.47%	4	46	0	3	0	0	0	0	2	13	0	0	0	2	93.02%			
David Erskine	110%	90%	94%	133%	3.9	3.4	0.0	0.1	7.40	7.14	7.87%	4.23%	6.02%	6	70	0	1	1	1	0	0	3	33	0	0	1	7	95.35%			
Edgar Horne	131%	106%	114%	135%	3.7	3.6	0.2	0.0	7.51	6.78	5.88%	0.00%	5.88%	5	60	0	1	1	2	1	0	0	33	0	0	0	9	97.47%			
Lord Wlgram	93%	111%	95%	123%	3.4	3.8	0.3	0.1	7.65	7.81	-0.57%	0.00%	9.95%	7	28	0	0	0	4	0	1	3	24	0	0	0	3	95.45%	6		
St Mary Abbots	95%	106%	94%	106%	3.5	3.6	0.0	0.1	7.10	7.55	6.61%	15.19%	30.16%	4	34	0	0	0	0	0	0	1	36	0	0	0	10	96.00%	1		
David Evans	90%	93%	91%	95%	4.4	2.9	0.0	0.3	7.56	7.55	0.14%	0.00%	0.00%	0	18	0	2	0	0	0	0	2	28	0	1	0	7	93.44%			
Chelsea Wing	136%	119%	99%	89%	8.5	4.8	0.0	0.0	13.31	7.55	14.60%	18.06%	18.18%	0	3	0	1	0	0	1	0	1	24	0	0	0	8				
Burns Unit	127%	136%	216%	100%	19.8	2.5	0.0	0.2	22.51	N/A	3.49%	3.89%	0.00%	5	11	0	0	0	0	0	0	2	8	0	0	1	3				
Ron Johnson	95%	123%	100%	126%	4.0	2.8	0.0	0.0	6.83	5.51	7.66%	0.00%	0.00%	7	63	0	0	0	0	0	0	3	35	0	0	1	6	100.00%			
ICU	102%	-	102%	-	24.2	0.0	0.5	0.0	24.78	26.91	2.32%	8.93%	20.92%	0	8	0	0	0	2	0	1	3	48	0	0	0	1				
Rainsford Mow lem	107%	98%	98%	116%	3.1	3.2	0.3	0.0	6.56	7.5	9.04%	3.90%	4.29%	4	45	0	1	0	0	0	0	0	20	0	0	0	9	95.27%			
Nightingale	123%	98%	100%	151%	3.0	3.1	0.0	0.1	6.20	7.5	8.98%	0.00%	6.49%	7	77	0	1	1	2	0	0	1	40	0	0	0	4	95.18%			
Emergency Department	104%	94%	111%	100%	-	-	-	-	-	N/A	8.52%	7.66%	0.00%	3	51	0	2	0	0	0	0	9	92	0	0	7	93	87.56%			
DSU	82%	63%	98%	97%	-	-	-	-	-	N/A	12.23%	6.73%	3.18%	3	5	0	0	0	0	0	0	1	16	0	0	0	4	100.00%			
Theatres	95%	82%	102%	100%	-	-	-	-	-	N/A	1.00%	2.94%	14.61%	0	0	0	0	0	0	0	0	2	8	0	0	0	5				
OPD	59%	98%	-	-	-	-	-	-	-	N/A	-6.32%	9.17%	10.64%	0	3	0	1	0	0	0	0	0	11	0	0	16	98	91.41%			
Averages /Totals	104%	100%	108%	114%	8.3	2.3	0.1	0.1	10.7		4.17%	5.23%	8.32%	70	657	0	16	4	18	3	3	68	864	0	1	28	378	95.72%	7		

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	M	12M		
Lampton FU	98%	94%	108%	101%	3.2	3.1	0.0	0.1	6.39	7.5	1.10%	0.00%	4.82%	3	53	0	0	0	8	0	0	11	52	0	0	0	2	94.59%		
Richmond	103%	90%	100%	100%	4.1	2.8	0.3	0.0	7.19	7.55	2.05%	0.00%	8.05%	4	19	0	0	2	2	0	0	0	11	0	0	0	3	100.00%		
Syon 1 cardiology	101%	91%	104%	98%	4.3	1.7	0.0	0.2	6.17	7.93	4.89%	5.84%	48.31%	6	36	0	2	0	0	0	0	0	15	0	0	0	0	100.00%		
Syon 2	112%	106%	110%	96%	4.0	3.3	0.1	0.0	7.39	7.14	5.65%	0.00%	0.00%	0	52	0	1	0	3	0	1	1	43	0	0	0	6	96.84%		
Starlight	124%	-	112%	-	9.7	0.0	0.0	0.0	9.71	13.06	10.07%	7.18%	100.00%	0	3	0	0	0	1	0	0	3	39	0	0	1	9	90.48%		
Kew	101%	115%	113%	118%	3.6	3.6	0.1	0.0	7.36	7.5	6.83%	5.15%	3.44%	5	40	0	2	1	1	0	1	2	28	0	0	0	2	100.00%		
DRU	101%	88%	100%	91%	3.2	3.4	0.1	0.0	6.64	7.5	4.06%	0.00%	11.91%	2	56	0	1	3	2	0	0	2	21	0	0	0	5	95.18%		
Osterley 1	111%	98%	112%	100%	4.5	2.9	0.3	0.1	7.82	7.81	8.78%	3.55%	10.51%	5	57	0	0	0	10	0	2	3	37	0	0	0	5	93.88%		
Osterley 2	103%	101%	102%	102%	4.0	3.6	0.2	0.0	7.84	7.55	5.13%	0.00%	4.88%	3	36	0	0	0	4	0	3	4	26	0	0	1	5	100.00%	1	
MAU	98%	103%	107%	105%	6.8	2.9	0.0	0.1	9.78	8.4	10.35%	1.51%	0.00%	3	93	0	1	1	3	0	0	8	90	0	1	1	14	95.53%		
Maternity	106%	91%	108%	97%	8.0	2.2	0.0	0.0	10.29	12.79	-0.88%	3.77%	2.32%	0	1	0	0	0	0	0	0	5	45	0	0	1	11	82.42%		
Special Care Baby Unit	112%	-	118%	-	8.7	0.0	0.0	0.0	8.70	13.06	12.85%	9.67%	0.00%	0	0	0	0	0	0	0	0	2	21	0	0	0	1			
Marble Hill 1	127%	127%	142%	128%	5.2	3.6	0.1	0.0	8.94	6.8	0.69%	3.69%	5.80%	6	104	0	2	0	4	0	0	8	63	0	0	1	6	96.00%		
Marble Hill 2	108%	125%	120%	138%	3.5	3.5	0.2	0.1	7.23	6.78	5.87%	9.78%	11.33%	5	62	0	2	0	0	0	1	9	74	0	0	0	8	97.30%		
ITU	89%	-	91%	-	24.2	0.0	0.0	0.0	24.23	26.91	3.00%	8.12%	0.00%	0	5	0	0	0	3	0	0	2	42	0	0	0	0			
Redlees	98%	101%	100%	123%	3.7	3.8	0.1	0.5	8.15	7.82	1.45%	4.97%	0.00%	4	47	0	0	0	0	0	0	1	17	0	0	0	2	100.00%		
Emergency Department	102%	85%	105%	60%	-	-	-	-	-	N/A	10.54%	7.39%	0.00%	2	36	0	0	1	2	0	0	6	50	0	1	6	37	75.18%		
DSU	93%	118%	-	-	-	-	-	-	-	N/A	-3.31%	0.00%	0.00%	0	3	0	0	0	0	0	0	0	2	0	0	0	5	91.84%		
Theatres	94%	72%	114%	100%	-	-	-	-	-	N/A	2.71%	1.60%	11.07%	1	0	0	0	0	0	0	0	0	7	0	0	0	7			
OPD	75%	86%	-	-	-	-	-	-	-	N/A	-2.76%	4.57%	6.45%	0	3	0	0	0	0	0	0	1	12	0	0	7	42	90.82%		
Averages /Totals	103%	99%	109%	104%	6.3	2.5	0.1	0.1	9.0		4.45%	3.84%	11.44%	49	706	0	11	8	43	0	8	68	695	0	2	18	170	94.12%	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 and Redlees reported increased HCA fill rates (day and night), alongside increased RN fill on Marble Hill wards, to support enhanced observation for patients with mental health needs and those at risk of falls.

ED reported low HCA fill rates (day and night) due to sickness and limited specialist bank availability; however, patient care was maintained. OPD also experienced low RN fill rates, mitigated through matron and managerial oversight with staff flexed based on acuity.

Theatres reported low daytime HCA fill rates due to vacancies and limited specialist bank cover; recruitment is ongoing, with CHPPD unaffected.

Chelsea and Westminster site:

Chelsea Wing saw increased RN fill rates on days due to additional private clinic demands. Ron Johnson, Nightingale and Lord Wigram had increased HCA and RN 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. Nell Gwynne had increased RN fill rates both day and night shifts, supporting enhanced supervision of patients requiring tracheostomy care. Edgar Horne reported increased daytime RN fill rates and night-time HCA fill rates to support enhanced observations for patients with mental health needs.

Lord Wigram had increased HCA fill rate at night due to the opening of escalation beds. Neptune ward had increased RN fill rate due to changes in summer template.

The Burns Unit had increased RN and HCA fill rates to support enhanced observation for patients requiring mental health supervision. 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 experienced low RN and HCA fill rates during the day due to changes in the staffing template. Patient care and safety was maintained throughout.

Incidents:

In May, three patient harm incidents were reported, all relating to Trust-acquired pressure damage; none were attributed to short staffing.

In Acute Assessment Unit (AAU), an acquired nasal pressure injury was recorded related to non-invasive ventilation (NIV) facial mask use. An Immediate Internal Review (IIR) was completed, an alternative mask provided, and tissue viability input was sought.

In Edgar Horne, an IIR was undertaken following identification of a sacral pressure injury associated with immobility; Tissue Viability Nurse (TVN) input was obtained and appropriate interventions were implemented.

A patient on the Chelsea Wing sustained bilateral heel pressure injuries; TVN reviewed with appropriate interventions implemented and Duty of Candour initiated.

The Friends and Family Test showed 100% scores in five wards at WM and six 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 8 red flags raised in May. All within planned care. The vacancy rate and turnover are from April 2026.



Nursing, Midwifery and care staff average fill rate May 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
105.72% ↑	105.99% ↑	6.2 ↔	2.7 ↑	8.9 ↔

RN Fill Rates (ward areas) increased from 104.08% in April 2026 to 105.72% in May 2026. The RN vacancy rate (whole trust) in May 2026 was 4.76%, slightly up April 2026 – 4.23

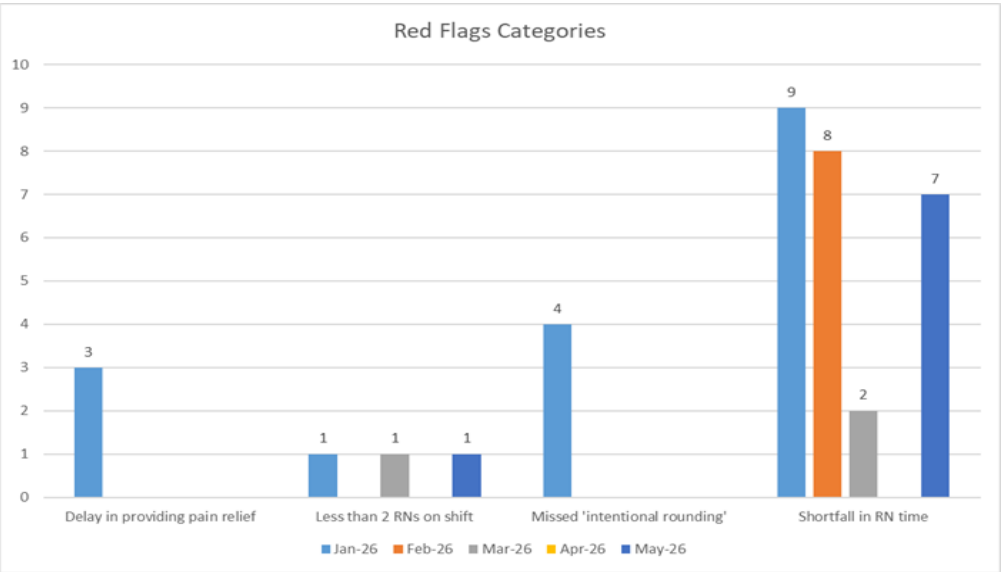
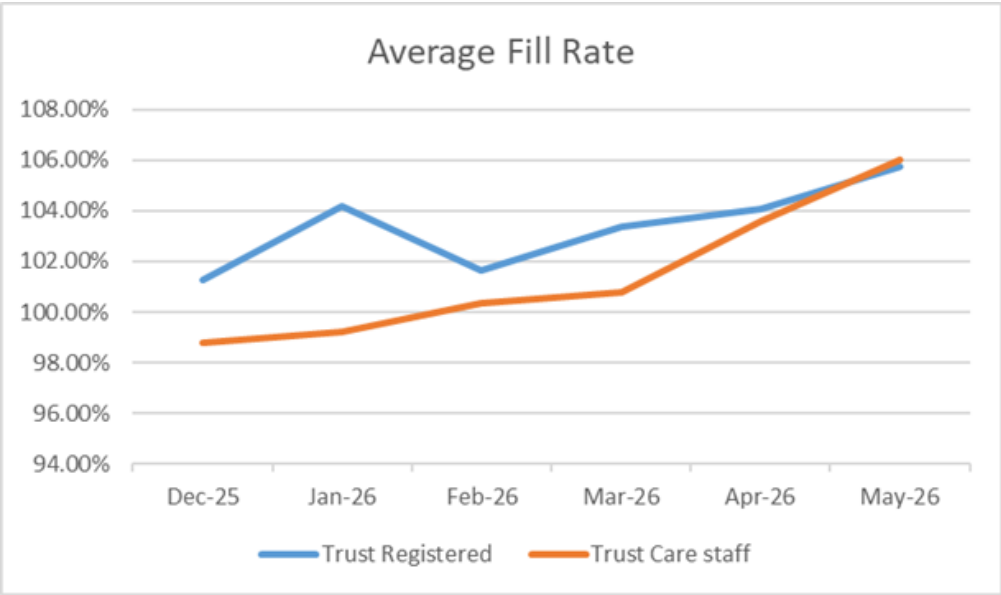
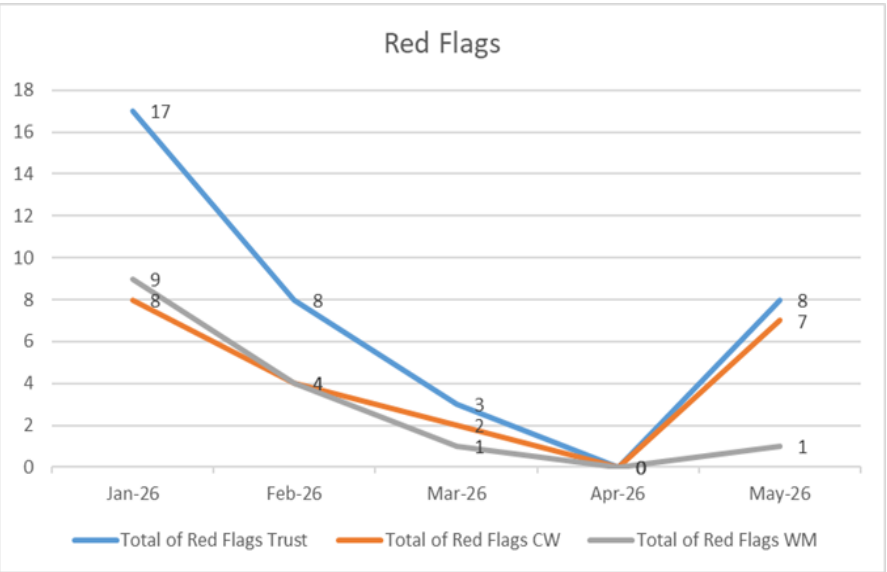
Care Staff Fill Rates (ward areas) increased from 103.61% in April 2026 to 105.99% in May 2026. There has been an extensive HCA recruitment campaign maintained. The HCA vacancy rate (whole trust) in May 2026 was 8.47%, slightly up from 8.16% in April 2026.

The Trust overall fill rate (ward areas) (RN and Care Staff combined) increased from 103.84% in April 2026 to 105.86% in May 2026.

Care Hours per Patient Day (CHPPD) continues to be collated on a monthly basis. The most current Trust measure from the Model Hospital* (December 2025) was 9.0. Trust workforce data confirms the CHPPD was 8.9 in May 2026, same as from April 2026. – 8.9.

Safe Staffing Red Flags – 8 red flags from the 5 categories (tables below) were reported during May 2026 where majority were Shortfall in RN time.

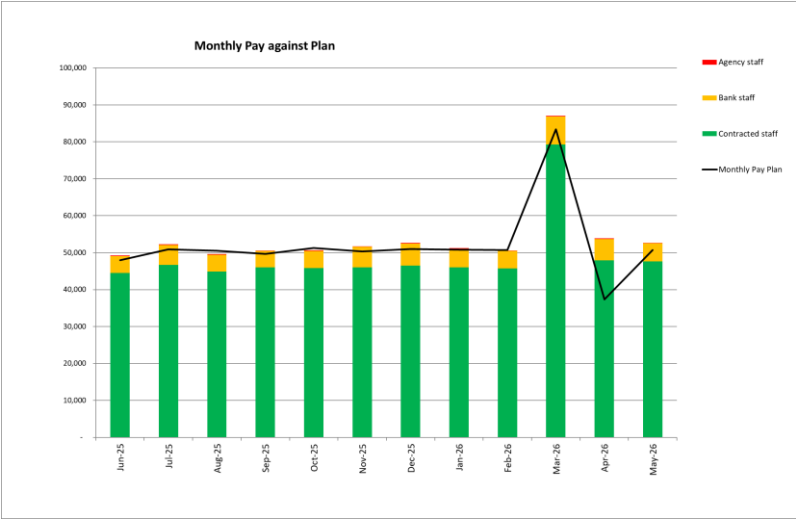
CHPPD - Taken from the Model Hospital*	Care Hours per Patient Per Day (CHPPD) – Dec 2025
Trust	8.7
Hillingdon Hospital	9.3
London NW	8.2
Imperial	10.7
National Median	9.0





Finance

Type of Spend	Plan to Date £'000	Actual to Date £'000	Variance to Date £'000
Income	180,224	175,893	(4,331)
Expenditure			
Pay	(101,418)	(106,471)	(5,054)
Non-Pay	(71,588)	(64,120)	7,468
EBITDA	7,219	5,302	(1,917)
EBITDA %	4%	3.01%	(0)
Depreciation	(6,018)	(5,610)	408
Non-Operational Exp-Inc	(2,415)	(2,100)	315
Surplus/Deficit	(1,214)	(2,408)	(1,195)
Control total Adj - Donated asset, Impairment & Other	(1,370)	3	1,373
PFI Model recalculation		(217)	(217)
Adjusted financial performance surplus/(deficit)	(2,584)	(2,622)	(39)



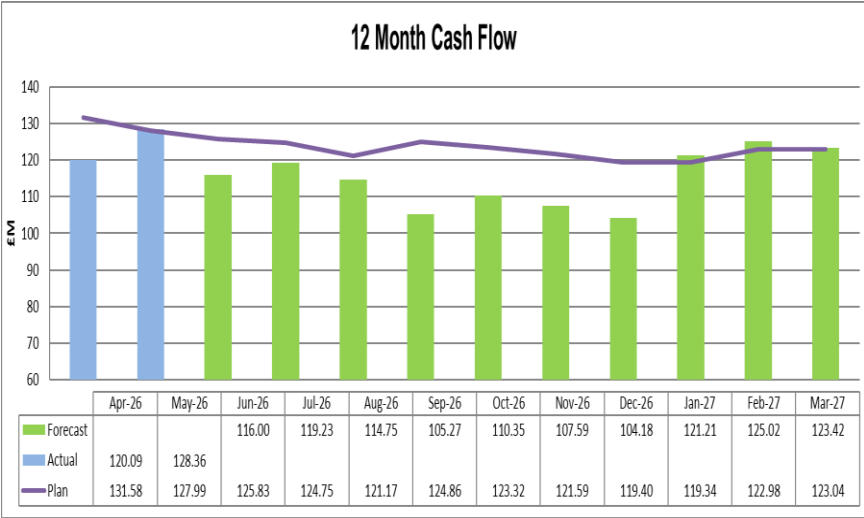
Comment: Mar 26 12 payroll figures include additional spend for 9.4% Pension contribution - £33.08 m a notional figure
July 25 includes £1m spend on industrial action and a YTD increase in the pay award accrual to reflect the latest guidance.

The adjusted YTD financial position at month 2 is a £2.62m deficit which is £0.04m over plan.

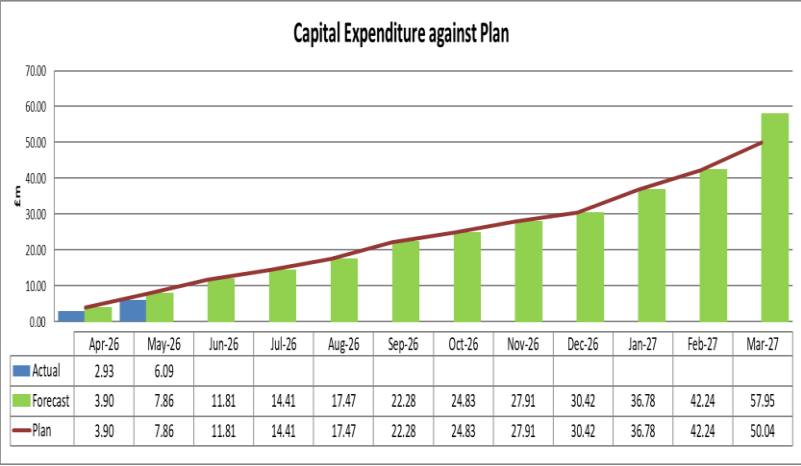
Pay: £5.05m adverse against plan. The adverse variance at Month 2 is driven by WLI, locum premium and cover for vacancies, sickness, rota gaps, and other forms of leave. As well as unidentified and red & Amber CIPs.

Non-Pay: There is a £7.47m favourable variance which includes adjustment to budget to match NHSi return.

Income: Month 02 clinical income performance was reported in line with plan, with an additional accrual recognised for the pay award uplift (offset by corresponding expenditure), which has yet to be reflected in contracts. Most ICB and NHS England contracts have been agreed, and the remaining ICBs are being actively pursued.



Comment: The positive cash variance to plan in M2 of £0.37m is cash variance brought forward from M1 of £11.49m, higher receipts to plan of £7.53m (ICB & NHS England & FTs £4.08m higher, Local Authority & AR £1.75m lower, Other Income £5.46m higher, PP Income £0.27m lower, Interest Income £0.02m higher) offset by lower cash outflows to plan of £4.33m (lower creditor payments and lower payroll).



Comment: The original gross capital programme for 2026/27 was £50.05m, which has been adjusted to £57.95m at P02. 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 £22.69m 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, £7.25m for PDC funded Imaging schemes and £1.87m central contingency. The planned YTD spend for P02 was £7.86m and the actual spend incurred is £6.09m, resulting in an under spend of £1.76m. This under spend will be incurred in later months.

CWFT OVERSIGHT FRAMEWORK SCORECARD — QUARTER 4 — 25/26

	Segment (following Financial Override)	Q4 SCORE	 Improvemen  Deterioration	% Current end of quarter target met
	OVERALL AVERAGE	1.6		% Current end of quarter target not met
			Unvalidated data	

Domain	Metric	Frequency	Q4 Score	Q4 Results /Score	Reporting Period										
					Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	TREND	
Access To Service	Domain Average														
	% of people waiting less than 18-weeks	Monthly	📈	2.30	66.00%	59.0%	60.0%	61.1%	61.3%	61.5%	61.2%	61.8%	63.5%	66.0%	
	% Difference between planned and actual 18-week performance	Monthly	📈	1.00	5.90%	0.2%	1.5%	2.5%	2.5%	2.4%	1.9%	2.2%	3.8%	5.9%	
	% of patients waiting over 52-weeks	Monthly	📉	2.37	1.30%	1.8%	1.8%	2.3%	2.2%	2.1%	1.8%	1.7%	1.6%	1.3%	
	% of people waiting over 52-weeks for community services	Monthly			0.00%										
	% of urgent referrals to receive definitive diagnosis within 4-weeks(Faster Diagnosis)	Monthly	📉	2.15	79.56%	80.8%	78.7%	77.9%	78.9%	79.6%	81.4%	79.1%	81.7%	78.1%	
	% of patients treated for cancer within 62 days of referral	Monthly	📉	1.00	81.60%	76.5%	76.6%	85.1%	80.6%	82.5%	87.4%	79.8%	83.0%	82.2%	
	% of ED attendances admitted, transferred or discharged within 4-hours	Monthly	📉	1.00	78.27%	79.0%	76.8%	77.9%	77.8%	78.7%	78.3%	77.3%	78.4%	79.1%	
% of ED attendances spending over 12-hours in the department -	Monthly	📉	1.37	2.88%	2.8%	2.9%	3.8%	3.8%	2.4%	3.1%	4.68%	3.36%	2.52%		

Effectiveness and Experience of Care	Domain Average														
	CQC inpatient survey satisfaction rate	Annual		2.00											
	SHMI			1.00		72.9	74.6	75.5	75.7	75.3	76.5	77.0	75.8	75.3	
	Average number of days from discharge ready date to actual discharge			2.49	0.94	0.7	1.0	0.8	1.0	0.9	0.9	0.9	1.0	0.8	

Patient Safety	Domain Average														
	NHS staff survey - raising concerns sub-score	Annual													
	CQC safe inspection score (if awarded within the preceding two-years)														
	12 month rolling count of MRSA bacteraemia cases	Monthly	↓	3.32	6.00	5	5	6	6	6	6	5	5	6	
	12 month rolling count of C. difficile cases as a proportion of Trust threshold	Monthly	↓	3.87	1.76	53	49	46	46	47	55	56	57	58	
	12 month rolling count of E. coli bacteraemia cases as a proportion of Trust threshold	Monthly	↑	1.00	0.98	104	101	93	97	92	99	100	96	97	

[illegible]

Finance and Productivity	Domain Average															
	Planned surplus/deficit score	Quarterly														
	Implied productivity level score	Quarterly														
	Variance year-to-date to financial plan score															
	Relative difference in costs (national cost collection adjusted for MFF)															



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