



Trust Performance and Quality Report

September 2025



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Executive Summary



Chelsea and Westminster Hospital
NHS Foundation Trust

Patient Safety and Experience

There three severe harm and death incidents reported in month . This incident and harm level is being reviewed in line with PSIRF and internal governance systems.

The Trust is meeting the targets set for medication safety and management . There were 3 cases of C.Diff which have been reported in month, with a Trust total of 28 against a threshold of 33. There was 1 case of MRSA bacteraemia. All cases are being reviewed and monitored through Infection Control committee.

Friends and Family response rates and recommendation rates remain above target for inpatient areas and 96.6% adult inpatients report being treated with dignity and respect. ED experience score is below Trust target but is in line with the London position. Improvement work being discussed with the ED team, focussing on waiting times and communication. Children and Young People has been reported separately for the first time, with low response rates which are being reviewed with West London Children's Division. The Trust response rate for complaints continues to be non-compliant. An improvement program has commenced with the central teams and divisions to recover this, including standardisation of processes across services.

VTE assessments are above target at both sites, however further analysis is required on the Hospital Acquired VTE cases between the sites. Improvement work continues with completion rates of initial assessments for patients, focusing on digital tools to support this. Data validation is underway, and it is anticipated that the initial assessment position will improve in future reports. The time spent on the stroke unit deteriorated in month but remains above target of 80% at both sites. The time to theatre for fractured NOF patients for WM remains positive with; 12 patients medically cleared for theatre on admission and 11 of them operated on within 36 hours (91.7%). However, following 3 months of improved performance at CW there has been a dip of compliance in month with 7 out of 17 medically fit patients operated on within 36 hours (46.7%), this was due to patients arriving in clusters and no theatre space to increase capacity. An action plan is in place to support improvement on the CW site and reviewed to incorporate actions about surges in attends.

Patient Access and Operating Plan

The Trust reported performance of 77.77% for A&E 4-hour performance, marginally below the 78% standard.

The NHS England Cancer 28-Day Faster Diagnostics Standards and 31-Day standards were met, with the 62-Day reporting non-compliance for August 2025 (validated).

Elective Referral to Treatment (RTT) 18-week wait performance achieved the planned trajectory and 60% national target in September 2025 at 61.1%. There was an increase in the RTT Patient Tracking List and backlog performance remained challenged by the overall activity reduction. Backlogs for 52ww is at 1745(+408) and 65ww at 62 (+23), in addition there was one patient waiting over 78ww who has since been treated.

Performance against the DM01 diagnostic standard (which measures the percentage of patients waiting <6 weeks) was reported at 85.83% against the 95% standard, but above the 25/26 Operating Plan

Workforce

The Trust's Month 6 performance reflects a total staffing position (37.1 WTE / 0.49%) that is within the trust's establishment (excluding maternity). The trust has exceeded its PDR target rate (93.9%) upon closure of the appraisal window. Sickness levels increased marginally to 3.82%, with CSD and SCD exceeding 5%. Vacancy and turnover rates at Trust level are below thresholds, at 5.88% vacancy and 8.37% turnover.

Finance

The adjusted financial position at Month 6 is a £0.88m deficit which is £0.1m favourable against plan.

Performance Summary

Trust level



Chelsea and Westminster Hospital
NHS Foundation Trust

Section/KPI	Target	Actual	Prev. 3 Mth Trend
Patient Safety and Experience			
Incidents per 1000 FCE bed days	TBC	46.86	
Patient safety incident investigations	n/a	6	
Never Events	0	0	
Dementia screening %	90%	93.95%	
ED sepsis screening %	90%	87.77%	!
Inpatient sepsis screening %	90%	86.67%	!
C. Difficile cases	n/a	3	
E. coli cases	n/a	7	
Formal complaints received	n/a	92	
Inpatient FFT % good experience	90%	94.50%	
A&E FFT % good experience	90%	78.81%	!
Outpatient FFT % good experience	90%	92.04%	
Maternity FFT % good experience	90%	86.90%	!
Mortality			
Summary Hospital-level Mortality Index	<100	75.55	
Hospital Standardised Mortality Ratio	<100	80.58	

Section/KPI	Target	Actual	Prev. 3 Mth Trend
Patient Access			
A&E waiting times type 1&3 (4hrs)	78%	77.77%	
LAS handovers 30 mins	n/a	217	
18 week RTT incompletes	60%	61.10%	!
Diagnostic waiting times < 6 weeks	95%	85.83%	!
28 day Faster Diagnosis Standard	77%	78.63%	
31 day diagnosis to first or subsequent treatment	96%	98.81%	
62 day GP referral to first treatment combined	85%	75.54%	!
Operating Plan and Capacity			
Theatre utilisation (uncapped)	85%	84.77%	
PIFU rate	5%	9.29%	
Workforce			
Medical PDR compliance	90%	86.1%	
Non-medical PDR compliance	45%	93.9%	
Core skills compliance	90%	91.6%	

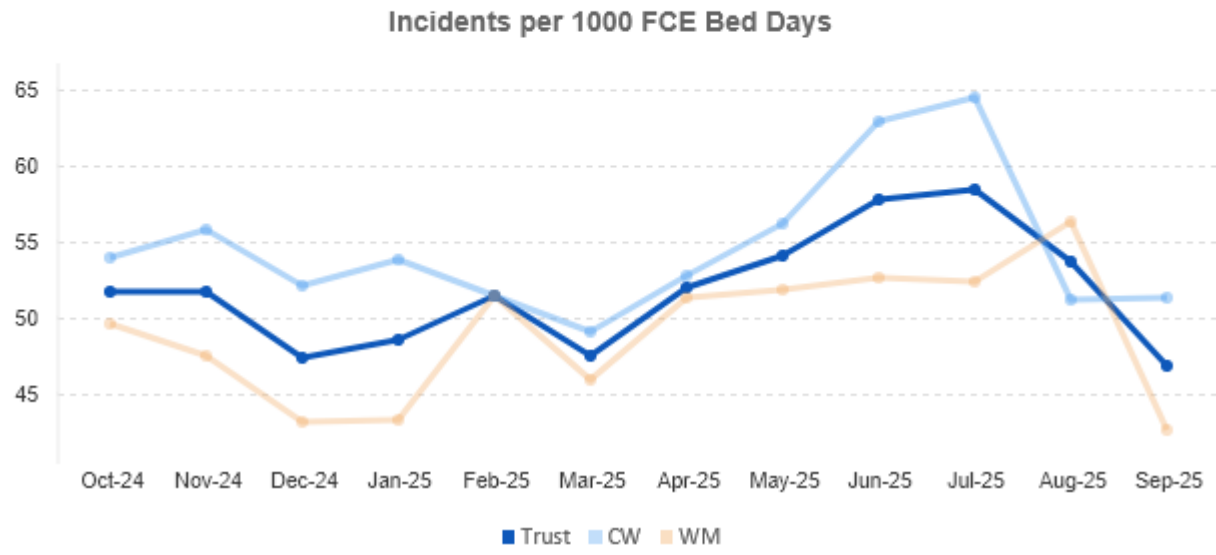


Either site or Trust overall performance red in each of the past three months



Patient Safety and Experience

Trend



Narrative

Performance: Incident reporting is a recognised indicator of an organisation’s safety culture. Higher reporting rates typically reflect a positive culture where staff feel empowered to speak up. While reporting rates have shown variability, there is a clear upward trend. However, we remain slightly below the national benchmark—both for the current month and on a 12-month rolling basis—where the national average is >54.9. In September, a total of 1,430 patient-related incidents were reported—144 fewer than in July, which marked the peak over the past 12 months. The 12-month rolling total stands at 17,316. The trust continues to proactively identify areas for improvement in response to recurring themes and trends.

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

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

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

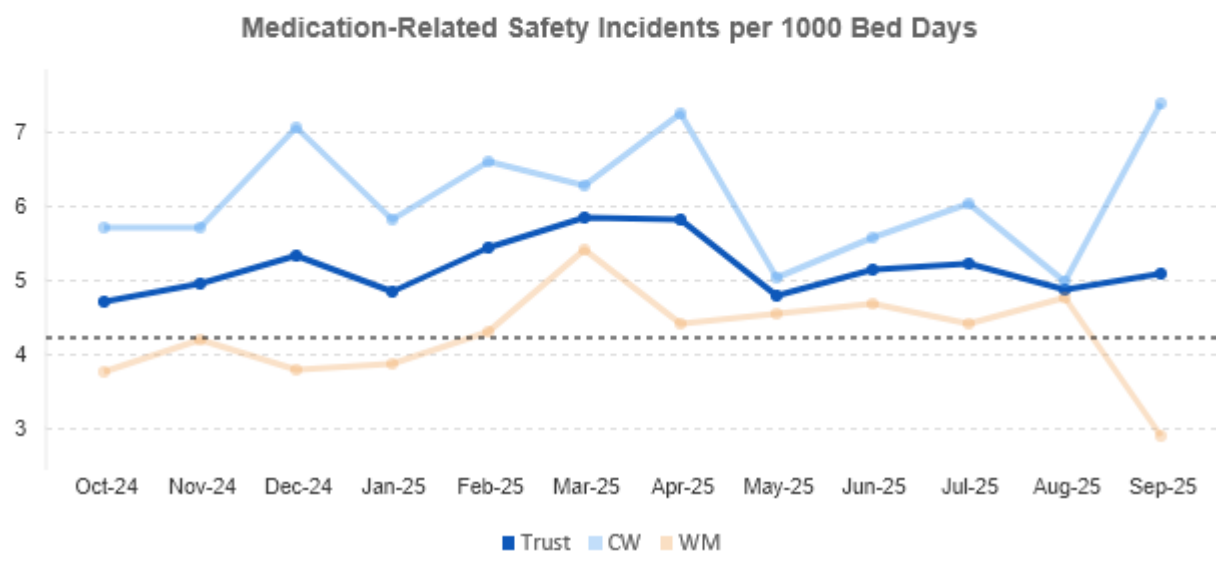
In-Month Performance

	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	51.33	2	1	0.07
WM	42.53	3	2	0.13
Trust	46.81	5	3	0.10

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Incidents per 1000 FCE Bed Days (Target:)	CW	56.2	62.9	64.5	51.2	51.3	56.3
	WM	51.8	52.6	52.4	56.3	42.5	51.0
	Trust	54.1	57.8	58.4	53.6	46.8	53.7
Incidents Resulting in Severe Harm or Death (Target:)	CW	0	1	1	1	2	8
	WM	0	1	2	3	3	9
	Trust	0	2	3	4	5	17
Incidents Resulting in Death (Target:)	CW	0	0	0	1	1	3
	WM	0	0	1	1	2	4
	Trust	0	0	1	2	3	7
Incidents Resulting in Death per 1,000 FCE Bed Days (Target:)	CW	0.00	0.00	0.00	0.07	0.07	0.03
	WM	0.00	0.00	0.07	0.07	0.13	0.05
	Trust	0.00	0.00	0.04	0.07	0.10	0.04

Trend



Narrative

Trust targets achieved, however there was a notable decline in the reporting rate at WM site. This will be monitored closely by the MSG.

One incident of moderate harm reported in September at CW site, relating to incorrect preparation of unfractionated heparin (UFH) for intravenous infusion. Incorrect reconstitution of UFH resulted in over-dilution (*no further dilution required as a ready to use preparation*) and sub-therapeutic anticoagulation, leading to a concern about possible heparin resistance. Patient’s surgical procedure was cancelled due to over-anticoagulation (APTT<6) with a revised perioperative anticoagulation management plan from the anticoagulation team. Patient’s surgery was re-scheduled during current admission resulting in prolonged hospital admission.

Nursing staff are now trained in the correct preparation and use of UFH, aware of Trust guideline and escalation using appropriate resources/specialists when unfamiliar with medication.

In-Month Performance

	Medication Related Safety Incidents per 1000 Bed Days	Medication Related Safety Incidents With Moderate or Above Harm
CW	7.38	0.9%
WM	2.88	0.0%
Trust	5.07	0.6%

Year-to-Date Performance

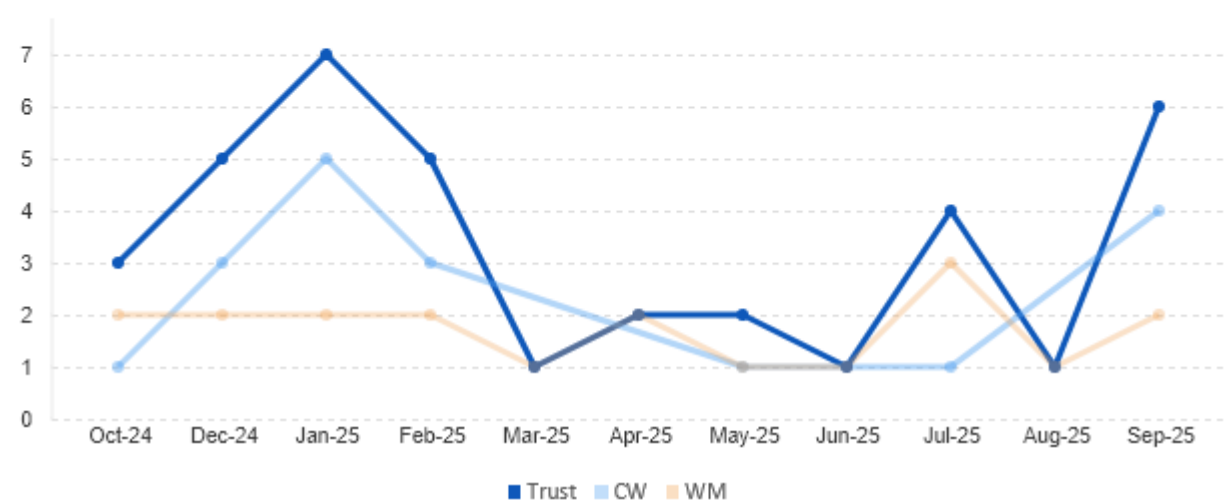
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Medication Related Safety Incidents per 1000 Bed Days (Target: >=4.2)	CW	5.01	5.57	6.01	4.97	7.38	6.03
	WM	4.53	4.68	4.41	4.75	2.88	4.25
	Trust	4.77	5.13	5.20	4.86	5.07	5.14
Medication Related Safety Incidents % Moderate or Above Harm (Target: <1%)	CW	0.0%	0.0%	0.0%	1.4%	0.9%	0.4%
	WM	0.0%	1.6%	0.0%	1.5%	0.0%	0.5%
	Trust	0.0%	0.7%	0.0%	1.4%	0.6%	0.5%

Incidents Reported on STEIS (Sis/PSIIs)

Safe

Trend

Patient Safety Incident Investigations



Narrative

Performance: The trend shows a reduction in the number incidents reported externally on StEIS. This is expected with PSIRF encouraging proportionate responses focused on learning opportunities. Within the 12-month rolling period, the PSII indication was as follows: 55% (21) locally defined incidents requiring local PSII, 40% (15) Nationally defined priority – MNSI and 5% (2) Nationally defined incident – Never events.

In September, six PSIIs were declared for incidents occurring between July-September. Incidents included the incorrect prescription of antibiotics to a neonate, an unexpected cardiac arrest, two MNSI cases (an unplanned admission to NICU, an intrauterine death), a delayed diagnosis of ovarian torsion, and an unintended uterine and bowel injury during a gynaecological procedure

Improvements: Themes are regularly reviewed and used to identify local quality and safety priorities and inform our Patient Safety Incident Response Plans (PSIRPs), which are currently being updated for 2025/26.

Work streams continue for priority areas including care of the deteriorating patient and implementation of the new national safety standards for invasive procedures (which supports never event improvement).

Forecast Risks: The Trust is seeing delays in the completion of learning responses which is partly being caused by the learning curve and culture change that PSIRF requires. Local actions are underway with a focus on training and support for staff.

In-Month Performance

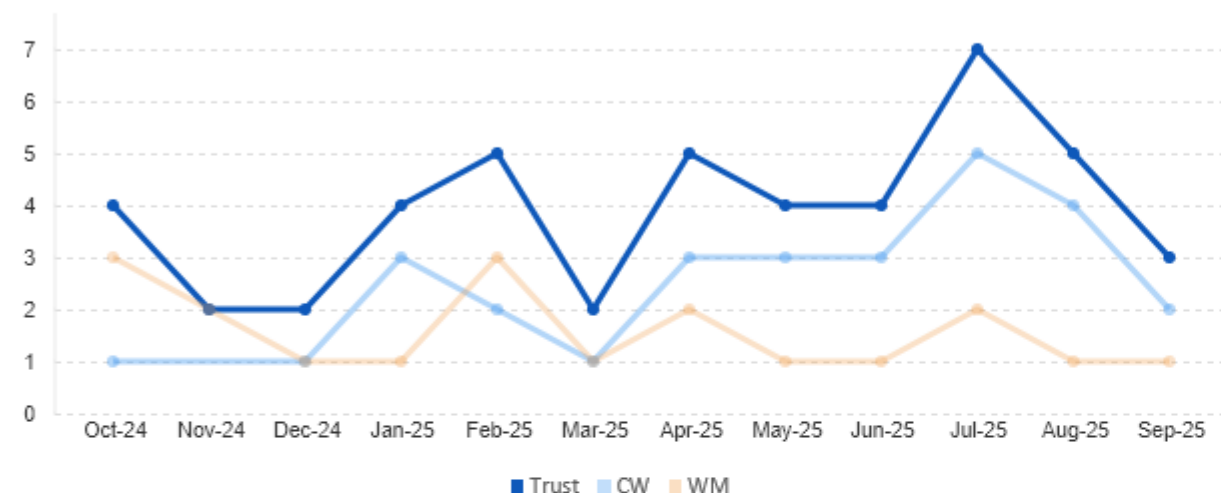
	Patient Safety Incident Investigations	Never Events	Learning Resp. Declared (AAR)	Learning Responses Declared (Thematic Review)	Learning Responses Declared (MDT)
CW	4	0	2	0	0
WM	2	0	2	0	0
Trust	6	0	4	0	0

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Patient Safety Incident Investigations	CW	1	0	1	0	4	6
	WM	1	1	3	1	2	10
	Trust	2	1	4	1	6	16
Never Events (Target: 0)	CW	0	0	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	0	0
Learning Responses Declared (AAR)	CW	2	2	1	3	2	14
	WM	2	1	2	2	2	9
	Trust	4	3	3	5	4	23
Learning Responses Declared (Thematic Review)	CW	0	0	0	0	0	0
	WM	0	0	1	0	0	1
	Trust	0	0	1	0	0	1
Learning Responses Declared (MDT)	CW	1	1	0	0	0	2
	WM	0	0	0	0	0	0
	Trust	1	1	0	0	0	2

Trend

C. Difficile Cases



Narrative

CDI

There were 3 healthcare associated CDI cases in September 2025 and a total of 28 cases this financial year, this is a 33% reduction in comparison to the same 2024/25 period. Two cases occurred at CWH on Nell Gwynne and Ron Johnson ward and one case at WMH on Lampton ward. PSIRF meetings are currently pending for all September cases.

MRSA

There was 1 healthcare associated MRSA bacteraemia in September 2025 which occurred at the CWH site on Nell Gwynne ward. A PSIRF meeting was held which identified learning around device usage and documentation, thrombophlebitis and challenges with aggression, that may have contributed to the development of bacteraemia, an action plan has been disseminated to the ward/ division and supported by IPC including a 4 week programme of focussed audit around line and device management.

In-Month Performance

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

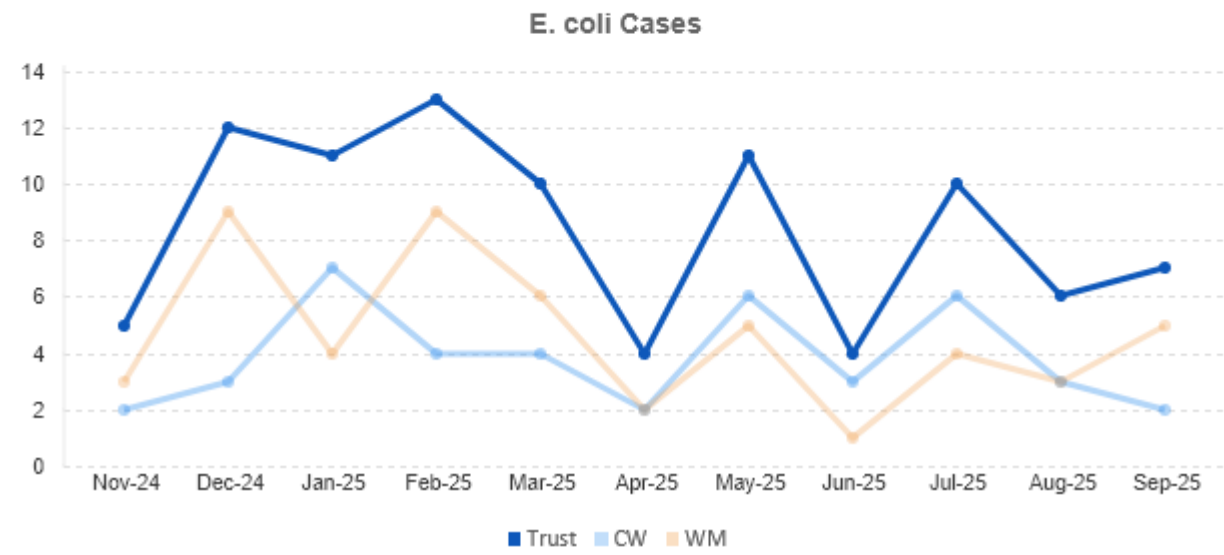
Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
C. Difficile Cases (Target: <33)	CW	3	3	5	4	2	20
	WM	1	1	2	1	1	8
	Trust	4	4	7	5	3	28
MRSA Bacteraemia (Target: 0)	CW	0	0	1	1	1	3
	WM	0	0	1	0	0	1
	Trust	0	0	2	1	1	4

Healthcare Associated E.Coli Infections

Safe

Trend



Narrative

E.coli

There were 7 healthcare associated *E.coli* cases that occurred in September 2025, 2 at CWH and 5 at WMH. From April – September 2025 there have been a total of 42 healthcare associated bacteraemias, a reduction of 26% in comparison to the 2024/25 time period. Cases continue to be reviewed on a monthly basis to identify learning and likely source and are reported on Datix if an improvement opportunity in treatment/management is identified.

Hand Hygiene

Hand hygiene compliance continues to track above the local 95% compliance target across both sites.

In-Month Performance

	E. Coli Cases	Hand Hygiene Compliance
CW	2	96.0%
WM	5	98.0%
Trust	7	96.9%

Year-to-Date Performance

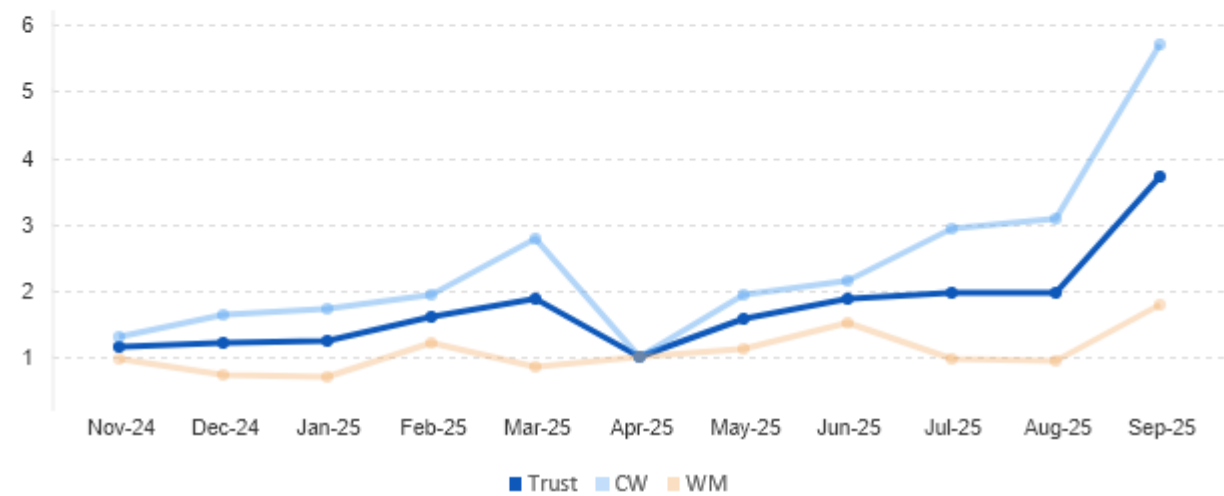
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
E. coli Cases	CW	6	3	6	3	2	22
	WM	5	1	4	3	5	20
	Trust	11	4	10	6	7	42
Hand Hygiene Compliance (Target: >95%)	CW	94.6%	95.8%	98.3%	98.9%	96.0%	96.6%
	WM	98.7%	97.5%	98.7%	99.0%	98.0%	98.0%
	Trust	96.6%	96.5%	98.5%	99.0%	96.9%	97.2%

Formal Complaints

Responsive

Trend

Complaints Received per 1000 Bed Days



Narrative

Formal complaints rose sharply in September, with 85 opened — a 130% increase from August (37) and 57% increase from July (54). Maternity and obstetrics received the highest number of complaints (22), followed by Emergency Department and Care of the Elderly/General Surgery. Divisional breakdown - SCD: 31 (36%), EIC: 29 (34%), PC: 16 (19%), WLCH: 4 (5%), CSD: 4 (5%), Corporate: 1 (1%)

Despite the rise in formal complaints, response compliance improved from 47% in August to 64% in September. Improvement attributed to staff return, prioritisation of complaints, daily huddles, and more effective escalation processes. Chelsea site recorded the highest number of complaints, consistent with survey feedback, particularly in inpatient and maternity services.

56 formal complaints were closed in September (up from 32 in August). Of these, 20 were fully upheld and 25 partially upheld. Key learning points:

- Maternity:** A midwife acknowledged poor communication and behaviour, resulting in mandatory refresher training, enhanced supervision, and team-wide learning.
- Paediatrics:** Documentation errors during a newborn examination (e.g. missing record of Mongolian Blue spots) led to staff reminders on accurate discharge summaries.
- Gastroenterology:** Delays in processing and communicating faecal elastase results prompted system corrections and an apology for distress caused.
- Orthopaedics:** Poor coordination between Great Ormond Street and Chelsea & Westminster led to missed follow-ups and splint delays, prompting action to improve cross-site communication.

143 informal complaints were closed in September. 67 were resolved within 5 working days (47%), showing a slight improvement from August's 46%.

In-Month Performance

	Complaints Received per 1000 Bed Days	Complaints Responded to <25 Working Days	Complaints Upheld by PHSO	Complaints Open > 90 Days
CW	5.7	59.5%	0	0
WM	1.8	100.0%	0	1
Trust	3.7	65.9%	0	1

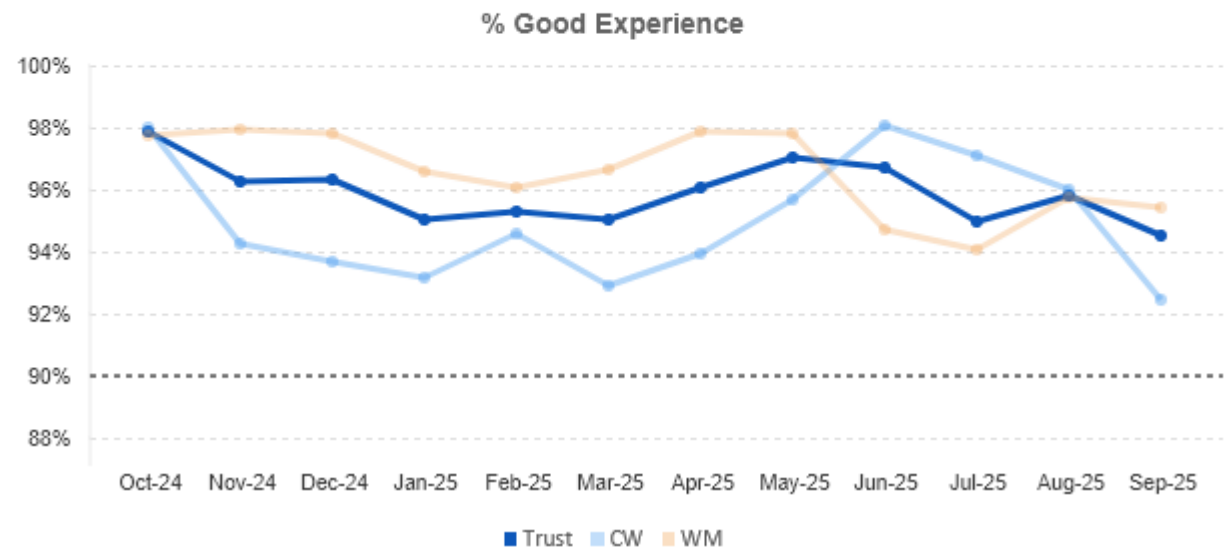
Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Complaints Received per 1000 Bed Days	CW	1.9	2.2	2.9	3.1	5.7	2.7
	WM	1.1	1.5	1.0	0.9	1.8	1.2
	Trust	1.6	1.9	2.0	2.0	3.7	2.0
Complaints Responded to <25 Working Days (Target: >90%)	CW	77.8%	68.2%	80.0%	48.0%	59.5%	70.9%
	WM	60.0%	85.7%	52.6%	46.7%	100.0%	67.1%
	Trust	73.0%	75.0%	71.2%	47.5%	65.9%	69.8%
Complaints Responded to <45 Working Days (Target: >90%)	CW	85.2%	100.0%	95.0%	100.0%	Reports a month in arrears	94.7%
	WM	90.0%	100.0%	89.5%	86.7%		91.4%
	Trust	86.5%	100.0%	93.2%	95.0%		93.6%
Complaints Upheld by PHSO	CW	0	0	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	0	0
Complaints Open > 90 Days	CW	0	0	0	0	0	0
	WM	0	1	1	0	1	3
	Trust	0	1	1	0	1	3

Inpatient Friends & Family Test

Caring

Trend



Narrative

Response Totals and Operational Support

- Slight improvement in response totals for September, primarily driven by progress at West Middlesex.
- Ongoing efforts to engage ward clerks in the survey inputting process at Chelsea continue to face challenges.
- An additional volunteer has been introduced at Chelsea to support data entry and help improve response rates.

Themes

- Inpatient experience scores saw a slight decline in September but remained above the 90% target.
- Positive feedback continues to centre on basic care provision, respectful treatment, and clear, consistent communication.
- Underperforming wards are being addressed individually; issues are seen across both medical and surgical areas, suggesting inconsistency rather than a trend in one specialty.
- Chelsea site continues to show lower patient experience scores compared to West Middlesex

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	277	29.8%	92.4%	96.0%
WM	632	51.4%	95.4%	97.0%
Trust	909	42.1%	94.5%	96.6%

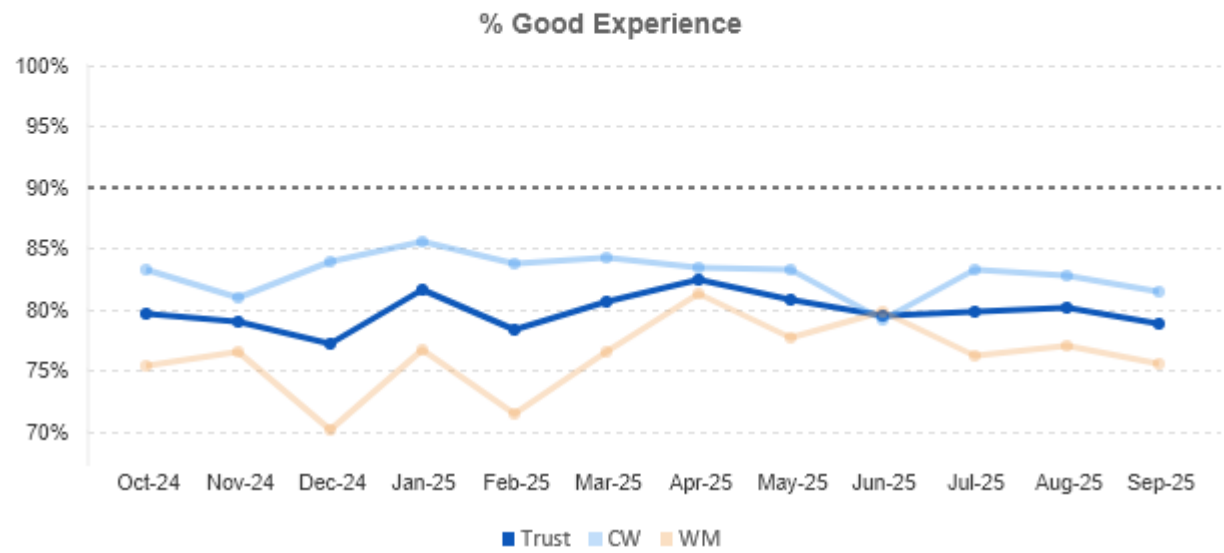
Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Responses	CW	346	203	311	273	277	1,840
	WM	594	132	703	513	632	3,090
	Trust	940	335	1,014	786	909	4,930
Response Rate (Target: >10%)	CW	20.4%	24.4%	42.7%	36.1%	29.8%	28.0%
	WM	36.8%	75.0%	49.4%	36.8%	51.4%	42.7%
	Trust	28.4%	33.2%	47.1%	36.6%	42.1%	35.7%
% Good Experience (Target: >90%)	CW	95.7%	98.0%	97.1%	96.0%	92.4%	95.3%
	WM	97.8%	94.7%	94.0%	95.7%	95.4%	96.0%
	Trust	97.0%	96.7%	95.0%	95.8%	94.5%	95.7%
Treated With % Dignity and Respect (Target: >90%)	CW	95.8%	92.0%	98.0%	96.0%	96.0%	95.3%
	WM	95.2%	96.0%	96.0%	98.0%	97.0%	96.3%
	Trust	95.4%	94.6%	96.7%	97.3%	96.6%	96.0%

Emergency Department Friends & Family Test

Caring

Trend



Narrative

Response Totals and Themes

- Both sites saw a slight increase in response totals during the period.
- Patient experience dipped slightly, with recurring themes around wait times, lack of support during waiting periods, and inconsistent information provision.
- West Middlesex data did not show any notable increase in concerns around waiting, despite ongoing refurbishments. Continued monitoring of October results may highlight emerging trends for this as may become more prominent.

Improvement Planning and Engagement

- The Patient Experience Team will be discussing feedback themes at upcoming A&E team away days, UTC management meetings, and A&E Clinical Governance meetings.
- These sessions aim to acknowledge positive feedback and explore improvement initiatives, particularly around the provision of clear and consistent information.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	1,009	9.9%	81.5%	86.0%
WM	808	8.1%	75.5%	81.0%
Trust	1,817	9.0%	78.8%	83.8%

Year-to-Date Performance

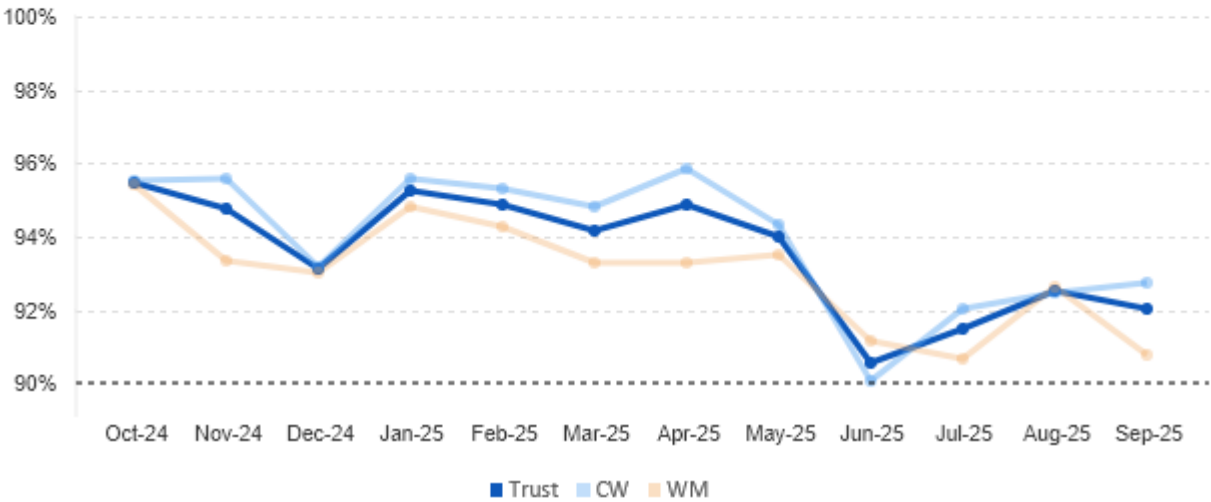
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Responses	CW	995	950	881	914	1,009	5,771
	WM	823	768	838	797	808	4,822
	Trust	1,818	1,718	1,719	1,711	1,817	10,593
Response Rate (Target: >10%)	CW	9.6%	15.8%	8.9%	9.7%	9.9%	10.3%
	WM	7.8%	13.2%	7.9%	8.5%	8.1%	8.6%
	Trust	8.7%	14.5%	8.4%	9.1%	9.0%	9.5%
% Good Experience (Target: >90%)	CW	83.3%	79.2%	83.2%	82.7%	81.5%	82.2%
	WM	77.8%	79.8%	76.1%	77.0%	75.5%	77.9%
	Trust	80.8%	79.5%	79.8%	80.1%	78.8%	80.2%
% Treated With Dignity and Respect (Target: >90%)	CW	82.9%	86.0%	88.0%	87.0%	86.0%	85.7%
	WM	76.7%	84.0%	82.0%	82.0%	81.0%	80.8%
	Trust	80.1%	85.1%	85.1%	84.7%	83.8%	83.5%

Outpatient Friends & Family Test

Caring

Trend

% Good Experience



Narrative

Survey Response and Performance

- Survey responses increased, though overall performance declined slightly.
- Common concerns were noted in Trauma & Orthopaedics at West Middlesex and Urology across both sites.

Site-Specific Feedback

- At Chelsea, patients gave consistently positive feedback in Burns, Gynaecology, and Orthopaedics.
- Lower satisfaction was reported in Paediatric Gastroenterology, General Paediatric Outpatients, Pain Management, and Urology.
- At West Middlesex, Paediatric Surgery, Cardiology, and Medical Oncology scored well, though some results were based on low response volumes.
- Areas with more negative feedback included Antenatal Care, Breast Surgery, Urology, Trauma & Orthopaedics, ENT, and Neurology (consistent across most months).

Comparative Insights

- Chelsea patients reported more positive experiences overall, particularly regarding waiting times and clarity of information.
- This trend mirrors A&E feedback and highlights the need to improve information provision at West Middlesex.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	1,280	15.1%	92.7%	98.0%
WM	692	81.9%	90.8%	96.0%
Trust	1,972	21.1%	92.0%	97.3%

Year-to-Date Performance

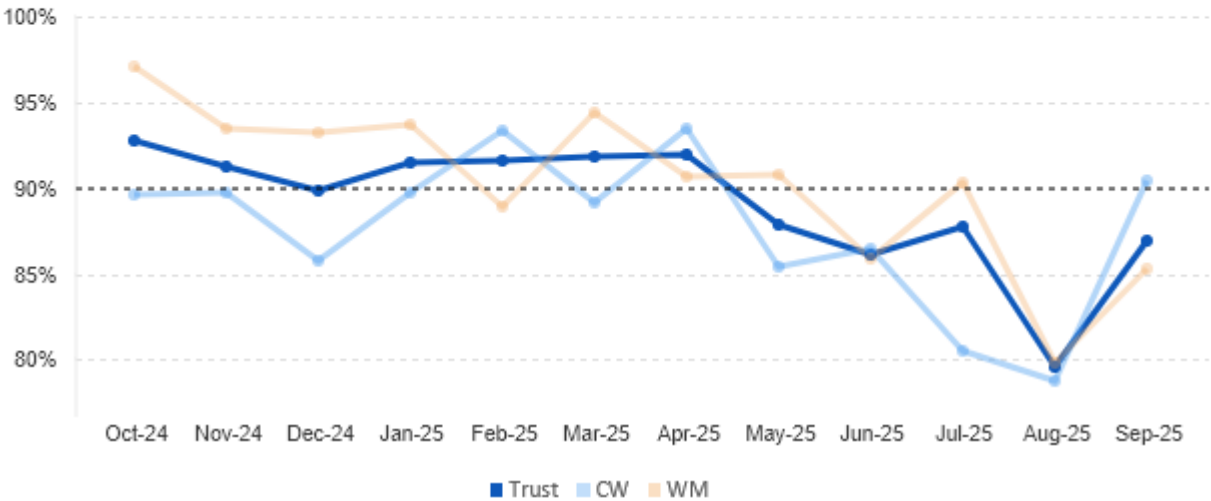
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Responses	CW	913	1,602	1,647	1,060	1,280	7,416
	WM	649	1,399	1,128	640	692	5,091
	Trust	1,562	3,001	2,775	1,700	1,972	12,507
Response Rate (Target: >10%)	CW	5.4%	19.8%	10.1%	7.6%	15.1%	9.4%
	WM	4.9%	25.8%	11.1%	7.1%	81.9%	10.1%
	Trust	5.2%	22.2%	10.5%	7.4%	21.1%	9.7%
% Good Experience (Target: >90%)	CW	94.3%	90.1%	92.0%	92.5%	92.7%	92.5%
	WM	93.5%	91.1%	90.7%	92.7%	90.8%	91.7%
	Trust	94.0%	90.6%	91.5%	92.5%	92.0%	92.2%
% Treated With Dignity and Respect (Target: >90%)	CW	94.4%	95.0%	97.0%	96.0%	98.0%	96.4%
	WM	97.1%	96.0%	95.0%	96.0%	96.0%	95.8%
	Trust	96.2%	95.5%	96.2%	96.0%	97.3%	96.1%

Maternity Friends & Family Test

Caring

Trend

% Good Experience



Narrative

Improvements in Feedback and Experience

- Both hospital sites saw improved patient feedback, supported by increased awareness, uptake, and volunteer assistance with data entry.
- Positive trends were noted in the experience of women accessing maternity care overall.

Rise in Maternity Complaints

- September saw a significant increase in maternity complaints, despite improvements in survey feedback.
- The overarching theme was a breakdown in care delivery, with concerns around poor communication, inconsistent clinical standards, and lack of compassion.
- Women reported coming to harm, emotional trauma, and long-term consequences due to inadequate pain relief, poor hygiene, insufficient feeding support, and experiences of discrimination.
- Women continue to report a worse experience at Chelsea, particularly in relation to communication and responsiveness.

Next Steps

- Feedback is being triangulated with national maternity survey data.
- Work needs to commence with maternity teams to ensure effective learning and targeted improvement

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	73	18.2%	90.4%	90.0%
WM	156	5.8%	85.3%	93.0%
Trust	229	7.4%	86.9%	92.0%

Year-to-Date Performance

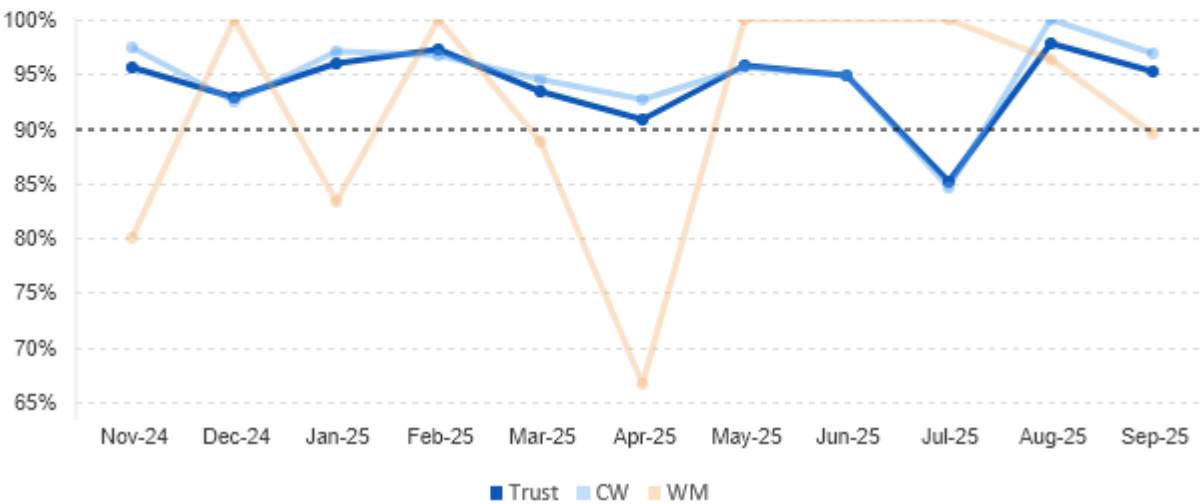
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Responses	CW	110	59	36	33	73	403
	WM	87	106	103	104	156	674
	Trust	197	165	139	137	229	1,077
Response Rate (Target: >10%)	CW	20.2%	18.2%	7.5%	7.2%	18.2%	14.6%
	WM	19.7%	10.0%	4.7%	5.4%	5.8%	7.7%
	Trust	20.0%	11.9%	5.2%	5.7%	7.4%	9.4%
% Good Experience (Target: >90%)	CW	85.5%	86.4%	80.6%	78.8%	90.4%	87.3%
	WM	90.8%	85.8%	90.3%	79.8%	85.3%	86.9%
	Trust	87.8%	86.1%	87.8%	79.6%	86.9%	87.1%
% Treated With Dignity and Respect (Target: >90%)	CW	99.0%	91.0%	86.0%	80.0%	90.0%	91.1%
	WM	84.2%	88.0%	94.0%	87.0%	93.0%	89.0%
	Trust	91.9%	89.1%	91.9%	85.2%	92.0%	89.9%

Children and Young People Friends & Family Test

Caring

Trend

% Good Experience



Narrative

CYP Experience and Survey Uptake

- Slight decline in satisfaction rates, currently based only on inpatient data. Outpatient experience is excluded due to how submissions are separated in the data warehouse. Work is underway to develop a more inclusive score across all CYP areas, in line with expected reporting standards.
- Continued engagement with location leads to improve understanding and uptake of the CIVICA reporting system.

Survey Refresh and Accessibility

- WLCH is finalising a refreshed, age-appropriate survey for children and young people, developed in collaboration with Imperial, Chelsea and Westminster, and WLCH leadership.
- Children and parents have directly contributed to the design, with launch expected in October.
- Accessibility remains a barrier across surveys, particularly for CYP. This is being addressed with CIVICA, as per contractual agreement.

In-Month Performance

	Responses	Response Rate	% Good Experience	% Treated With Dignity and Respect
CW	66	11.6%	97.0%	96.0%
WM	19	6.2%	89.5%	95.0%
Trust	85	9.7%	95.3%	95.8%

Year-to-Date Performance

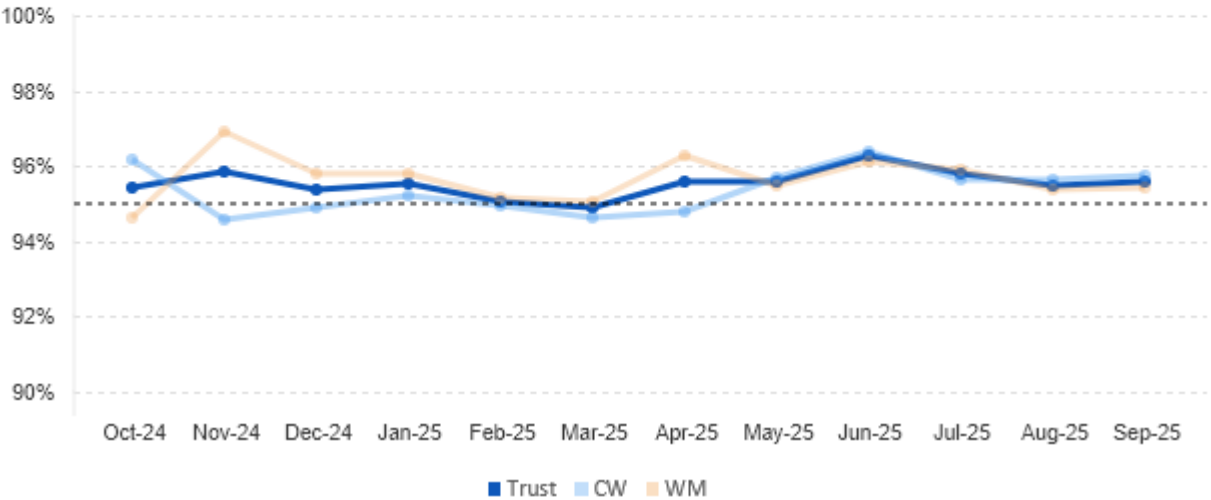
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Responses	CW	46	39	26	20	66	238
	WM	2	-	1	27	19	52
	Trust	48	39	27	47	85	290
Response Rate (Target: >10%)	CW	16.2%	30.5%	12.5%	9.9%	11.6%	14.5%
	WM	0.6%	-	100.0%	100.0%	6.2%	5.4%
	Trust	7.5%	24.5%	12.9%	20.4%	9.7%	11.2%
% Good Experience (Target: >90%)	CW	95.7%	94.9%	84.6%	100.0%	97.0%	94.5%
	WM	100.0%	-	100.0%	96.3%	89.5%	92.3%
	Trust	95.8%	94.9%	85.2%	97.9%	95.3%	94.1%
% Treated With Dignity and Respect (Target: >90%)	CW	87.5%	92.0%	90.0%	94.0%	96.0%	91.9%
	WM	85.9%	-	0.0%	94.0%	95.0%	70.0%
	Trust	87.0%	80.7%	81.7%	94.0%	95.8%	87.5%

VTE Risk Assessments Completed

Safe

Trend

VTE Assessments Completed



Narrative

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

Hospital Associated VTE (HAT) Events:

- Cross-Site:** 'VTE alert' included in positive VTE imaging reports for identification of VTE diagnosis.
- CW Site:** HATs under-reported due to identification. Awaiting Business Analyst team resource to develop and implement digital identification with auto-reporting of HATs from Cerner patient admission records (*highlighted at Patient Safety Group*).
- Cross-Site:** All reported HATs on Datix undergo investigation with VTE lead clinical review, shared learning and any actions to prevent recurrence.
- Quarterly review of HATs shared at Thrombosis and Thromboprophylaxis Group meeting, with appropriate action/wider dissemination and shared learning.

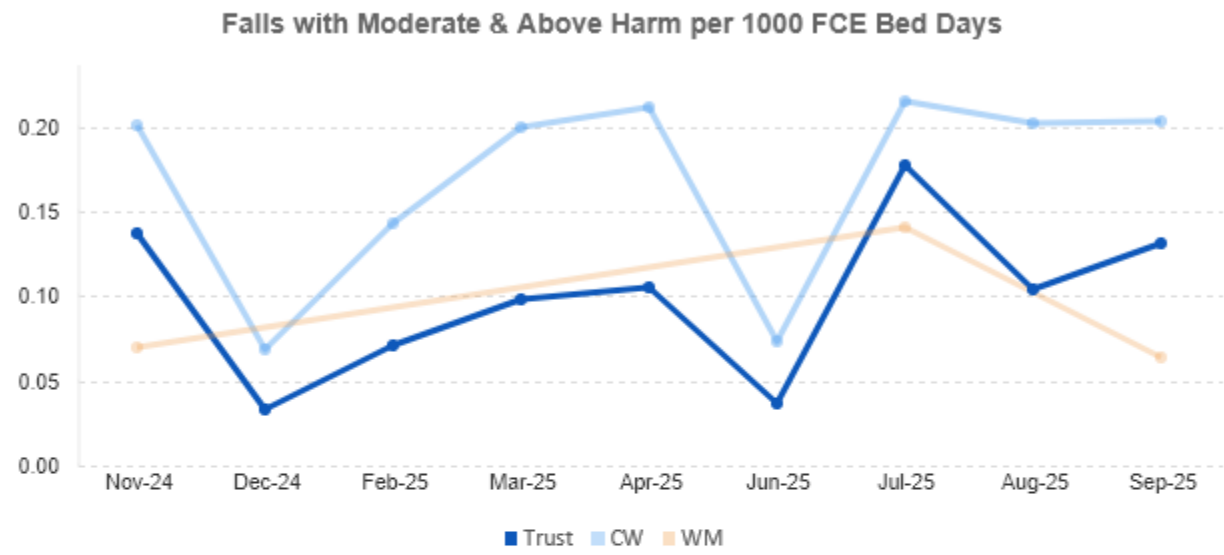
In-Month Performance

	VTE Assessments Completed	Hospital Aquired VTE Cases	Hospital Aquired VTE per 1000 FCE Bed Days
CW	95.8%	0	0.0
WM	95.4%	2	0.1
Trust	95.6%	2	0.1

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
VTE Assessments Completed (Target: >=95%)	CW	95.7%	96.4%	95.6%	95.6%	95.8%	95.7%
	WM	95.5%	96.1%	95.9%	95.4%	95.4%	95.8%
	Trust	95.6%	96.2%	95.8%	95.5%	95.6%	95.7%
Hospital Aquired VTE Cases	CW	1	0	1	1	0	3
	WM	6	5	4	2	2	25
	Trust	7	5	5	3	2	28
Hospital Aquired VTE per 1000 FCE Bed Days	CW	0.1	0.0	0.1	0.1	0.0	0.0
	WM	0.4	0.4	0.3	0.1	0.1	0.3
	Trust	0.2	0.2	0.2	0.1	0.1	0.2

Trend



Narrative

Activity: there has been a slight increase in falls with harm, three of which were falls from commodes. This has been discussed at the falls steering group and they are exploring a "stay with me" initiative in key areas.

Cerner Update: the new falls risk assessment is currently being built on Cerner which will support a more comprehensive holistic assessment of patients. The new risk assessments will be more intuitive and have been developed to pull information that is already contained within the EPR. The new enhanced therapeutic observations risk stratification tool has been built on Cerner and the Trust are planning to launch this in November.

Risk assessment compliance: A data quality issue has been identified with the risk assessment data capture. This has been rectified in the FDP and is waiting upload to the IQPR. Compliance for falls risk assessment is at >90% for September

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	3	2	0.20	3.18	67.8%
WM	1	0	0.06	4.99	74.1%
Trust	4	2	0.13	4.11	70.9%

Year-to-Date Performance

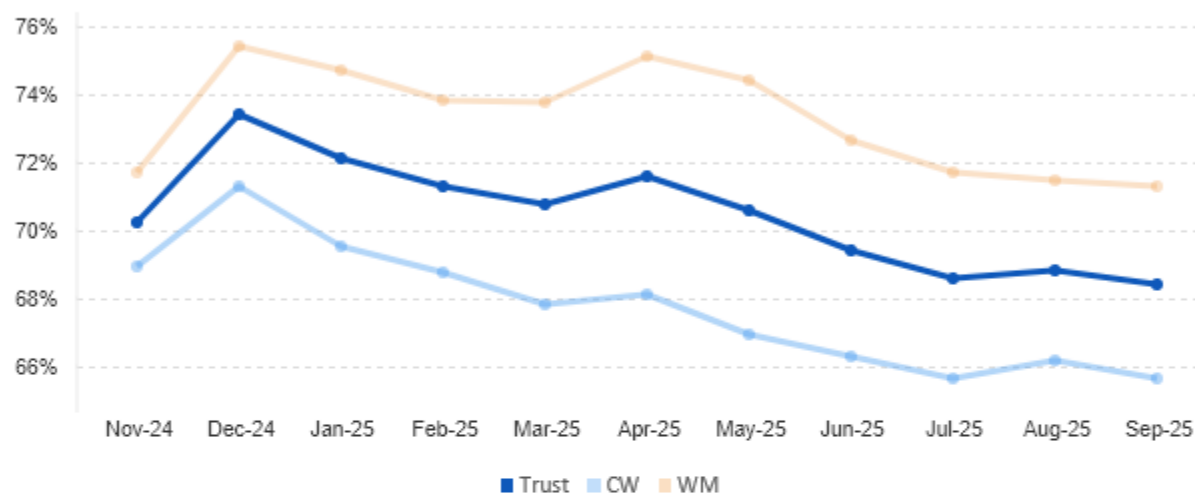
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Inpatient Falls with Moderate & Above Harm	CW	0	1	3	3	3	13
	WM	0	0	2	0	1	3
	Trust	0	1	5	3	4	16
Inpatient Falls Resulting in Severe Harm or Death (Target: 0)	CW	0	0	1	1	2	5
	WM	0	0	1	0	0	1
	Trust	0	0	2	1	2	6
Falls with Moderate & Above Harm per 1000 FCE Bed Days	CW	0.00	0.07	0.21	0.20	0.20	0.15
	WM	0.00	0.00	0.14	0.00	0.06	0.04
	Trust	0.00	0.04	0.18	0.10	0.13	0.09
Falls per 1000 FCE Bed Days	CW	3.71	4.33	2.65	4.10	3.18	3.77
	WM	4.31	3.12	4.48	3.60	4.99	4.22
	Trust	4.00	3.73	3.57	3.86	4.11	3.99
Compliance with Falls Risk Assessment (Target: >=90%)	CW	69.7%	68.9%	68.1%	68.4%	67.8%	68.9%
	WM	77.1%	75.7%	74.6%	74.6%	74.1%	75.6%
	Trust	73.3%	72.2%	71.3%	71.5%	70.9%	72.2%

Pressure Ulcers

Safe/Effective

Trend

% Compliance with Purpose T Risk Assessment



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	65.6%	2	0	0	-
WM	71.3%	2	0	0	-
Trust	68.4%	4	0	0	-

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Compliance with Purpose T Risk Assessment (Target: >=90%)	CW	67.0%	66.3%	65.7%	66.2%	65.6%	66.5%
	WM	74.4%	72.7%	71.7%	71.5%	71.3%	72.7%
	Trust	70.6%	69.4%	68.6%	68.9%	68.4%	69.5%
Category 2 Pressure Ulcers	CW	1	1	2	1	2	7
	WM	1	4	0	3	2	12
	Trust	2	5	2	4	4	19
Category 3 Pressure Ulcers (Target: 0)	CW	0	0	2	0	0	2
	WM	2	0	0	0	0	4
	Trust	2	0	2	0	0	6
Category 4 Pressure Ulcers (Target: 0)	CW	0	0	0	0	0	0
	WM	0	0	0	0	0	0
	Trust	0	0	0	0	0	0
Medical Device Related Pressure Ulcers	CW	0	1	0	0	2	3
	WM	1	2	1	0	0	4
	Trust	1	3	1	0	2	7

Narrative

Category 3&4 pressure damage: There have been no cases of category 3 or 4 pressure damage reported in month, with the last incidence of category 3 being in July. YTD the Trust has had 6 category 3 pressure ulcers, all have been reviewed as an IIR or an AAR and learning will be brought through the Pressure Ulcer Group for further dissemination and monitoring. A key theme across all reviews is the need for thorough and accurate assessment and documentation both on admission and during the patients hospital stay.

Category 2: There has been 4 category 2 pressure ulcers reported in month which is the same as the previous month.

MDR pressure damage: There have been 2 reported MDR pressure ulcers in month.

Themes

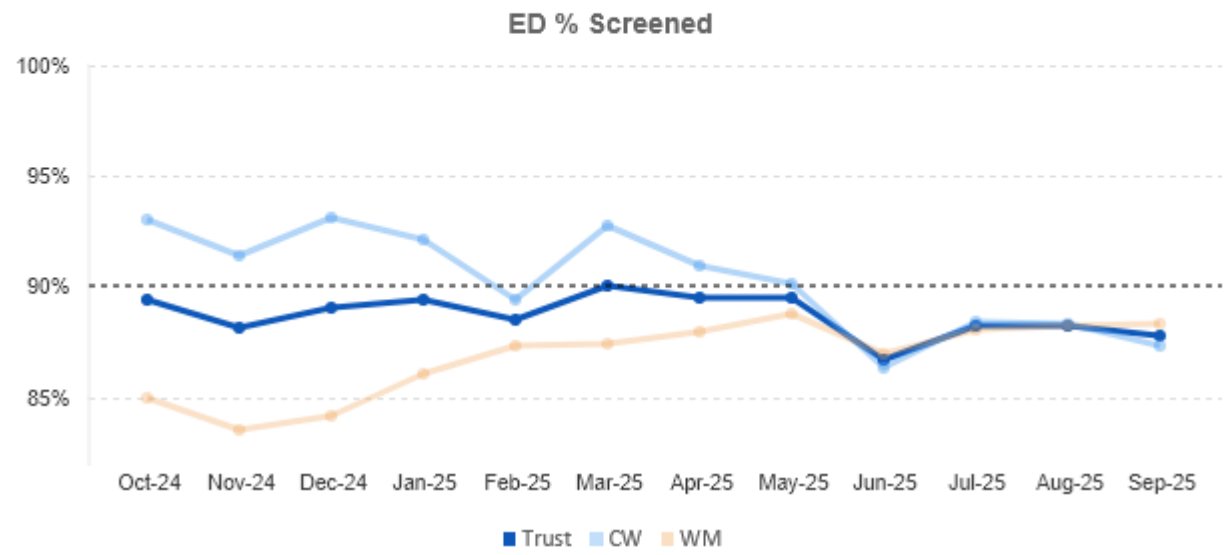
- Community acquired pressure damage sometimes still being coded as hospital acquired due to poor admission documentation .
- Incorrect grading meaning true validation of category is happening later than is ideal .
- Risk assessments not always taking place on admission or on ward transfer in a timely manner.
- Need for clear and accurate documentation of ongoing wound care prevention and management plans.

Actions

There is a trust wide action plan in place with regards to reducing hospital acquired pressure damage in addition to local action plans for areas of high prevalence.

Risk assessment compliance: A data quality issue has been identified with the risk assessment data capture. This has been rectified in the FDP and is waiting upload to the IQPR. Compliance for purpose T is at >80% for September

Trend



Narrative

Renewed focus required on screening required in all areas. Whilst performance is good, it is below previous compliance. New guidance currently being worked through APC Deteriorating Patient Group. A focussed education piece is being planned alongside this.

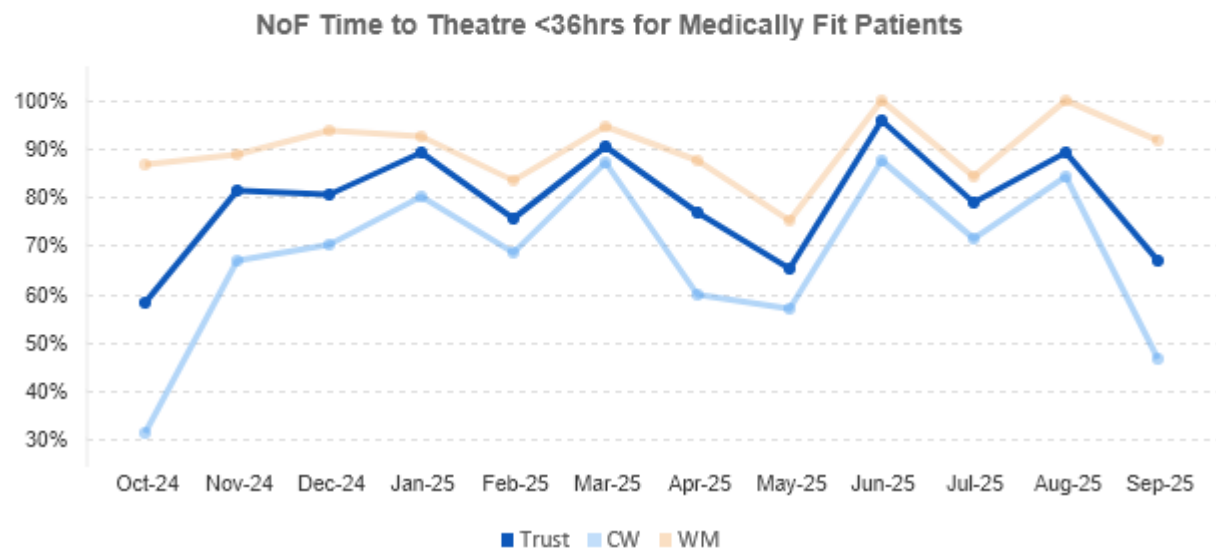
In-Month Performance

	ED % Screened	ED % Potential Red Flags Reviewed	Ward % Screened	Ward % Potential Red Flags Reviewed
CW	87.3%	77.3%	85.7%	96.0%
WM	88.3%	94.2%	87.9%	96.8%
Trust	87.8%	84.9%	86.7%	96.3%

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
ED % Screened (Target: >90%)	CW	90.1%	86.4%	88.4%	88.3%	87.3%	88.6%
	WM	88.8%	87.0%	88.0%	88.2%	88.3%	88.1%
	Trust	89.5%	86.7%	88.2%	88.2%	87.8%	88.3%
ED % Potential Red Flags Reviewed (Target: >90%)	CW	86.3%	82.7%	88.7%	90.3%	77.3%	84.7%
	WM	92.2%	92.4%	94.7%	90.6%	94.2%	92.5%
	Trust	88.7%	86.6%	91.5%	90.4%	84.9%	88.1%
Ward % Screened (Target: >90%)	CW	87.6%	86.9%	83.0%	83.0%	85.7%	85.1%
	WM	92.5%	88.5%	88.7%	88.7%	87.9%	89.8%
	Trust	90.0%	87.7%	85.7%	85.6%	86.7%	87.4%
Ward % Potential Red Flags Reviewed (Target: >90%)	CW	94.7%	93.9%	95.6%	97.8%	96.0%	95.5%
	WM	97.3%	95.6%	96.1%	96.6%	96.8%	96.0%
	Trust	96.0%	94.9%	95.8%	97.2%	96.3%	95.7%

Trend



Narrative

NoF Time to Theatre: WM compliance remains positive with; 12 patients medically cleared for theatre on admission and 11 of them operated on within 36 hours. However, following 3 months of improved performance at CW there has been a dip of compliance in month with 7 out of 17 medically fit patients operated on within 36 hours, this was due to patients arriving in clusters and no theatre space to increase capacity. An action plan is in place to support improvement on the CW site and reviewed to incorporate actions about surges in attends.

Breach of Same Sex Accommodation: there were 28 breaches in month at the West Middlesex site all due to delayed discharges from ICU. The team continue to work with the site team to facilitate timely step downs.

Stroke: compliance with time spent on a stroke unit dipped in month but remains above target

Dementia Screening: Dementia screening improved in month back to a compliant position. Action plans remain in place with positive effect

In-Month Performance

Table with 5 columns: Metric, CW, WM, Trust. Rows include NoF Time to Theatre <36hrs for Medically Fit Patients, Breach of Same Sex Accommodation, Time Spent on Dedicated Stroke Unit, and Dementia Screening Case Finding.

Year-to-Date Performance

Table with 8 columns: Metric, Site, May-25, Jun-25, Jul-25, Aug-25, Sep-25, 2025-2026. Rows include NoF Time to Theatre <36hrs for Medically Fit Patients, Breach of Same Sex Accommodation, Time Spent on Dedicated Stroke Unit, and Dementia Screening Case Finding.



Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Jun-25	Jul-25	Aug-25	2025-2026	Jun-25	Jul-25	Aug-25	2025-2026	Jun-25	Jul-25	Aug-25	2025-2026 Q2	2025-2026	Trend charts
Workforce	Midwife to birth ratio (Target: 1:30)	1:23	1:23	1:23	1:23	1:25	1:26	1:27	1:27	1:24	1:25	1:25	1:25	1:25	-
	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)	427	451	433	2157	366	370	390	1856	793	821	823	1644	4013	-
	Total number of bookings (Target:> CW 580 WM 478)	574	586	544	2880	462	441	412	2219	1036	1027	956	1983	5099	-
	Maternity 1:1 care in established labour (Target: >95%)	99.0%	98.0%	99.0%	98.8%	97.0%	97.0%	99.0%	97.6%	98.0%	97.5%	99.0%	98.3%	98.2%	-
Safety	Admissions >37/40 to NICU/SCBU	6	36	0	71	5	0	14	120	11	36	14	36	71	-
	Number of reported Serious Incidents	3	4	3	20	2	3	1	12	5	7	4	11	32	-
	Cases of hypoxic-ischemic encephalopathy (HIE)	0	0	0	0	0	0	0	1	0	0	0	0	1	-
	Pre-term (gestation <37 weeks) as % of mothers delivered	8.0%	8.0%	5.0%	6.1%	5.5%	5.0%	6.0%	5.6%	6.8%	6.5%	5.5%	6.0%	5.8%	-
	Number of stillbirths	2	0	2	6	2	1	0	5	4	1	2	3	11	-
	Number of Infant deaths	0	1	1	4	2	1	1	10	2	2	2	4	14	-
	Number of Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Outcomes	% of women on a continuity of care pathway	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-
	Spontaneous unassisted vaginal births	24.0%	21.0%	24.0%	24.4%	29.0%	26.0%	31.0%	28.4%	26.5%	23.5%	27.5%	25.5%	26.4%	-
	Vaginal Births - spontaneous & induced	38.0%	36.0%	39.0%	38.2%	43.0%	39.0%	43.0%	41.8%	40.5%	37.5%	41.0%	39.3%	40.0%	-
	Instrumental deliveries	53	59	53	292	35	60	47	228	88	119	100	219	520	-
	Pre-labour elective caesarean sections	96	99	78	425	59	51	55	278	155	150	133	283	703	-
	Emergency caesarean sections in labour	112	121	129	594	113	114	121	568	225	235	250	485	1162	-



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

Workforce: In September, the midwifery staffing ratios were reported as 1:28 at the Chelsea site and 1:23 at West Middlesex. The latest *Birthrate Plus* (2024) recommendations advise revised staffing ratios of 1:23 at Chelsea (previously 1:26) and 1:21 at West Middlesex (previously 1:22), reflecting current levels of acuity and activity. While the national birth rate continues to decline, local data indicates an increase in acuity particularly among women categorised as levels 4 and 5 (high risk) with a corresponding reduction in low-risk (category 1) cases. This evolving case mix has important implications for workforce planning and the delivery of safe maternity care. Despite significant investment a staffing shortfall of 32.77 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 anticipate implementing the demand management SOP from 29th September 2025, with an expected reduction in AN activity from mid-October 2025 and births in Spring 2026.

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

Red flags and Birthrate Plus Compliance

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

West Middlesex Site

- **Labour Ward:** Compliance declined to 83% in September from **88% in August**, with an increase in red flags (**5 in September vs 1 in August**), Delay between admission for induction and beginning of process (**n=4**) and Delay in providing pain relief (n=1).
- **Birth Centre:** Compliance remained stable at 67% in September with **2 red flags reported**, Delayed or cancelled time critical activity (n=1) and No Additional support MW available (No second MW for birth) (n=1)
- **Antenatal Ward:** Following the rollout of the **Birthrate Plus Acuity App**, compliance remained stable at 73% in September. Red flags decreased again to 6 **from 12 in August**, including:
 - Delay between admission for induction and start of process (n=1)
 - Delay/cancellation of time-critical activity (n=4)
 - One midwife unable to provide continuous one-to-one care in established labour (n=1)
- **Postnatal Ward:** Compliance continued to improve from 90% **in August** to 93% in September with only **1 red flag** reported (delay or cancellation of a time-critical activity).

Chelsea and Westminster Site

- **Labour Ward:** Compliance remained stable at **74%**, with an increase in red flags (**4 in September vs 1 in August**),
 - relating to a **delay or cancellation of a time-critical activity (n=2)**
 - Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) (n=1)
 - Coordinator not able to maintain supernumerary/supervisory status (n=1).
- **Birth Centre:** Compliance declined to 31% from **48% in August** September with **3 red flags reported**,
 - Delayed or cancelled time critical activity (n=1), Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) (n=1)
 - Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour (n=1).
- **Simpson Unit (Recovery & HDU):** Compliance declined to 58% from **65% in August**, with a reduction in red flags reported (n=2):
 - Delayed/cancelled time-critical activity (n=2)
- **Antenatal Ward:** Compliance remained low at **27% in September**, with 1 red flag reported for Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
- **Postnatal Ward:** Compliance saw a decline in September to 68% from **77% in August**, with **3 red flags reported**
 - Delayed or cancelled time critical activity (n=1)
 - Delay in providing pain relief (n=2)

Summary

Overall, **red flag incidents continued to decrease in September**, particularly at WMUH. The **senior leadership team** continues to review incidents to identify causes and ensure sustained compliance. While **WMUH reporting is improving in consistency**, the **Chelsea site continues to experience fluctuations in Birthrate Plus Acuity App reporting**, which impacts confidence.



Neonatal Staffing

The neonatal leadership team continue to strengthen the local QIS programme to optimise skill mix. At the Chelsea site, QIS compliance declined slightly this month to 38.1%, while at WMUH rates improved from 70% to 78.4%. Several nurses are currently undertaking QIS training, with completion expected by spring 2026. Based on current trajectories, WMUH is predicted to remain above 70% by November 2025, with Chelsea reaching this threshold by February 2026. Recruitment under Phase 1 and 2 of the neonatal business case has been completed, increasing establishment by 23 WTE above budgeted levels, reinforcing the Trust's commitment to achieving BAPM compliance.

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 Q 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 will be established to oversee project delivery, supported by guidance from a neighbouring Trust that has recently completed a successful SCBU-to-LNU transition.

Safety:

WM site: There was 1 patient safety incident in September:

1. IIR-

Datix reporting system: There were 108 incidents reported on Datix in September.

- 15 Transfusion, blood/blood products
- 14 Access to care/admissions
- 10 maternal readmissions

Incidents not yet closed over 3 months old x167.

Neonatal Service:

- Number of Datix: 32 CW + 10 WM

CWH site: There were 2 patient safety incidents:

1. IIR – post-natal neonatal readmission following collapse at home
2. IIR – Maternal ITU admission (pending decision)

Datix reporting system: In September 157 Datix incidents reported - compared to August (157).

- Transfusion policy – x10 BT was not informed when the MOH/PPH event was stood down; x3 Traceability
- 10 Delay in access to care/hospital
- 9 Communication within team
- 8 MOH/Unexpected NICU admission

Oldest incidents not yet closed x3 June 2025.

Currently CW site have the oldest incident from 06/06/25, and the team reviewed and closed 145 incidents in August 2025.



Neonatal Service:

- Number of Datix: 32 CW + 10 WM

Currently CW site have the oldest incident from 06/06/25, and the team reviewed and closed 145 incidents in August 2025.

1. **PMRT (Cross site):** CW site reported 2 cases, x2 stillbirths (39+2 and 29+4), 1 NND and 1 MTOP. WMUH reported 0 cases.
2. **ATAIN (Cross site):** WMUH, 16 term admissions with a term admission rate of 4.53% awaiting full review. CW data pending.
3. **Audit program:** All national and local audits have been registered and a cycle of audit and leads have been identified. A review of obstetric metrics has been undertaken and full dilatation CS will now be reviewed monthly given the increased associated risk to preterm birth in subsequent pregnancies.
4. There has been a slight decline in compliance with Saving Babies' Lives Care Bundle version 3 (SBLCBv3), LMNS validation increased SBLv3 compliance to 90%. Deterioration was noted in in Element 1, linked to staffing gaps within the Tobacco Dependency Services which has now been recruited to. SBLCBv3, launched in May 2023, requires agreement of a local trajectory with the LMNS and quarterly reviews to monitor and assure progress.

Element 1: Reducing smoking: Compliance with several SBLCBv3 Element 1 interventions has been affected by data gaps, staff turnover in the tobacco dependency team, and recent recruitment, leading to shortfalls in CO testing documentation, smoking status recording at 36 weeks, and staff training completion. Actions underway include reinforcing documentation requirements, making key fields mandatory in K2, scheduling training for all new staff, and reviewing the need for certain audits, with improvements expected by the end of Q2. **Compliant with 4/10 interventions**

Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction: Element 2 compliance has been affected by a slight drop in vitamin D supplementation provision and limited availability of serial scans beyond 36 weeks due to ultrasound capacity, with staffing increases expected by September to enable full compliance by Q3. **Compliant with 17/20 interventions.**

Element 3: Raising awareness of reduced fetal movements: Element 3 compliance is at 100%, but inaccurate recording of induction of labour indications is affecting audit accessibility and data accuracy, prompting staff reminders to improve documentation. **Compliant with 2/2 interventions.**

Element 4: Effective fetal monitoring during labour: A forthcoming K2 update will move the hourly risk assessment prior to the CTG review this adjustment is intended to enhance compliance with guidance. The fetal monitoring team is maintaining visibility through handovers, ward reminders, newsletters, and recognition initiatives, with training and on-site support planned ahead of the 29 July 2025 implementation of physiological changes. **Compliant with 5/5 interventions.**

Element 5: Reducing Pre-term Birth: Element 5 compliance is being strengthened through updates to the preterm birth risk assessment, integration into the K2 system, and actions in response to declines in Actim Partus testing, neonatal counselling documentation, and delayed cord clamping and temperature monitoring. These measures, supported by updated guidance, parent information resources, and staff communications, are expected to achieve full compliance across interventions by the end of Q2 2025. **Compliant with 26/27 interventions.**

Element 6: Management of Pre-existing Diabetes in pregnancy: Q1 saw a slight drop in third-trimester HbA1c measurement compliance, prompting staff reminders to prioritise this assessment, especially for enhanced monitoring of results over 48mmols. **Compliant with 6/6 interventions.**

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				
		Jun-25	Jul-25	Aug-25	2025-2026	Jun-25	Jul-25	Aug-25	2025-2026	Jun-25	Jul-25	Aug-25	2025-2026 Q2	2025-2026
Perinatal Quality	Training compliance for all staff groups in maternity related to the core competency framework (Target: >90%)	89.0%	90.0%	96.0%	89.8%	92.0%	91.0%	94.0%	90.4%	90.5%	90.5%	95.0%	92.8%	90.1%
	Training compliance for all staff groups in maternity related to fetal monitoring (Target: >90%)	95.0%	95.0%	94.0%	93.6%	94.0%	95.0%	96.0%	93.0%	94.5%	95.0%	95.0%	95.0%	93.3%
	Service User Feedback FFT	86.4%	80.6%	78.8%	86.7%	85.8%	90.3%	79.8%	87.5%	86.1%	87.8%	79.6%	83.7%	87.1%
	Staff Feedback from board safety champion	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	9	0	0	0	0	9
	Progress in achievements of NHSR MIS (10 safety actions) Green									0	7	7	14	28
	Progress in achievements of NHSR MIS (10 safety actions) Amber									0	3	3	6	7.5
	Progress in achievements of NHSR MIS (10 safety actions) Red									0	0	0	0	10
	Ockenden compliance against 7 IEA's (49 compliance questions) (Total of 49 being 100%)									100.0%	100.0%	100.0%	100.0%	100.0%

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

Perinatal Quality Surveillance Model



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 September, overall multi-disciplinary training compliance decreased slightly to 92% from 9 in August. Fetal monitoring training continues to exceed the 90% compliance target, at 96% across both sites. 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 improved from 76.5% in August to 91% in September. Respondents were predominantly White British (43%), White-Other (27%), and Black-Black British (7%), with most aged 25–34 years (60%) and 81% English-speaking. The lowest-scoring areas remained involvement in decision-making (60%) and whether concerns were taken seriously (70%), issues also reflected in complaints. In contrast, 90% felt able to ask questions.

At the West Middlesex site, positive feedback saw some improvement from 82% in August to 87% in September. Respondents included Asian/Asian British-Indian (37%), White British (21%), and White-Other (9%), with most aged 25–34 years (56%) and 35–44 years (37%). Lowest scores related to concerns being taken seriously (67%) and involvement in decision-making (74.6%), although 92.5% reported having the opportunity to ask questions.

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

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

Maternity (Perinatal) incentive Scheme year 7: MIS Year 7, Version 1.0, published on 2 April 2025, marks the start of a new reporting period with revisions to parts of the technical guidance. The service is currently reporting compliance with 9 of the 10 Safety Actions and partial compliance with 1, (Safety Action 1). Action plans remain in progress for Safety Action 3 (Transitional Care at WMUH) and Safety Action 4 (Neonatal Nursing at CW), and the service is on track to achieve full compliance within the reporting period.

Interim Ockenden report (7 IEAs): The interim Ockenden was published in December 2020, and the service has been working to achieve full compliance with the report. The service is fully compliant and will continue the audits to ensure the IEAs are embedded. Single Delivery Plan: The Single Delivery Plan (SDP) for maternity and neonates guides safer, more personalised, and equitable care. It aligns national priorities such as *Ockenden*, *Better Births*, and *Saving Babies' Lives* with local improvements in safety, digital innovation, workforce resilience, and health inequalities. The service is currently compliant with 28 actions and partially compliant with 15. The Trust's focus is on continuity of care, staff wellbeing, and patient experience to achieve consistently excellent outcomes for women, birthing people, babies, and families.

CQC Inspection (February 2023): The Care Quality Commission inspection in of the Maternity Service took place in February 2023 on both sites and received the final report in May. 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 with the 3 must do actions and progress on the 14 should do's continue and are being tracked via a cross-site assurance group. (7 for WM and 7 for CW). 4 of the should do actions are on track and 10 have been completed, 1 should do action awaits the outcome of the WM consultant consultation. 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.



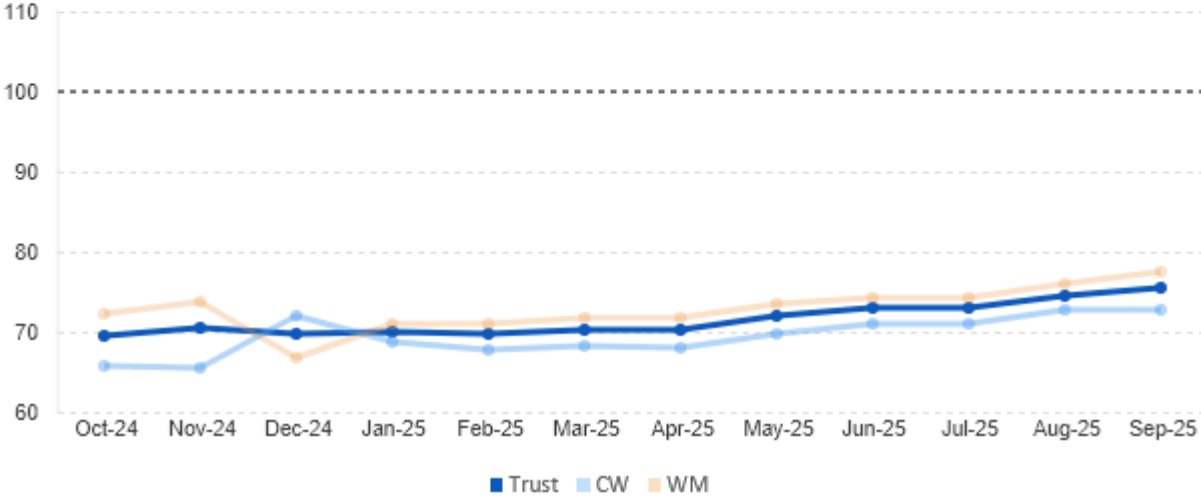
Mortality

Summary Hospital-level Mortality Index

Effective

Trend

Summary Hospital-level Mortality Index



Narrative

Mortality figures remain strong in comparison to national and regional comparators. The slight increase (non-statistically significant) since May / June 2025 represents the re-coding of SDEC patients to Type 5 activity – thereby reducing the denominator we are reporting

In-Month Performance

	Summary Hospital-level Mortality Index	Hospital Standardised Mortality Ratio
CW	72.8	78.4
WM	77.5	84.3
Trust	75.5	80.6

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
SHMI (Target: <100)	CW	69.7	71.0	71.0	72.6	72.8	70.8
	WM	73.5	74.3	74.3	76.0	77.5	74.5
	Trust	71.9	72.9	72.9	74.6	75.5	73.0
HSMR (Target: <100)	CW	70.1	69.7	78.3	78.6	78.4	75.7
	WM	87.4	82.0	84.2	81.0	84.3	84.3
	Trust	80.4	76.9	80.5	79.5	80.6	79.6



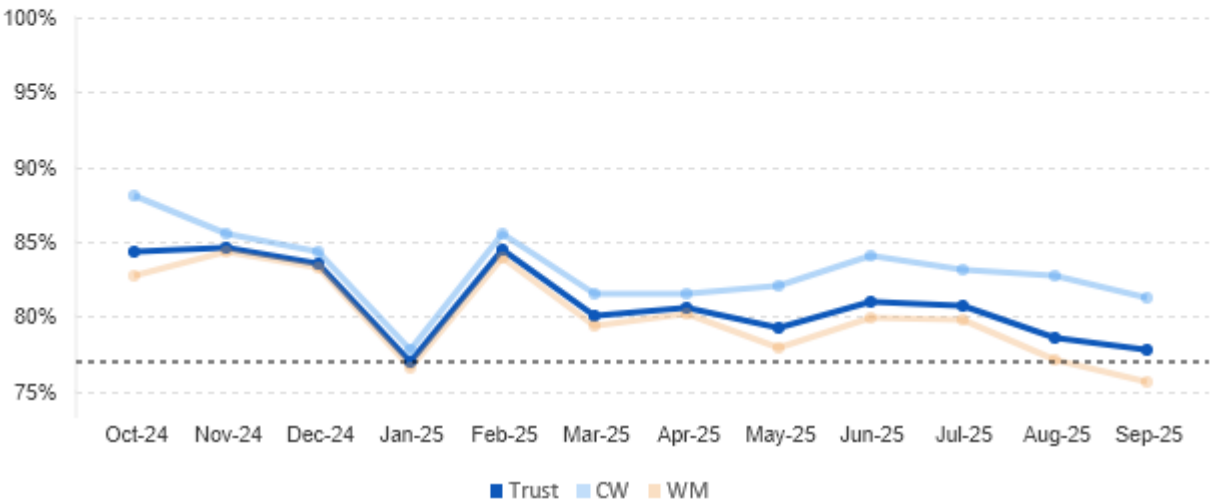
Patient Access

Access to Cancer Care (Diagnosis)

Responsive – Operating Plan

Trend

28 Day Faster Diagnosis Standard



Narrative

The Trust continues to meet the National KPIs for 28-Day FDS performance in August 2025 as well as September 2025, which is at present unvalidated.

Overall, the primary challenge is within the Sarcoma service which has seen significant demand for MDT discussions, impeding on the FDS performance. The service is enacting criteria for MDT discussion as well as a surgical MDT to support the demand, and NWL Pare engaged with some support from the histopathology side.

In-Month Performance

	28 Days Faster Diagnosis Standard	2 Weeks from Referral to First Seen (All Urgent Referrals)
CW	81.3%	97.3%
WM	75.7%	95.5%
Trust	77.8%	96.3%

Year-to-Date Performance

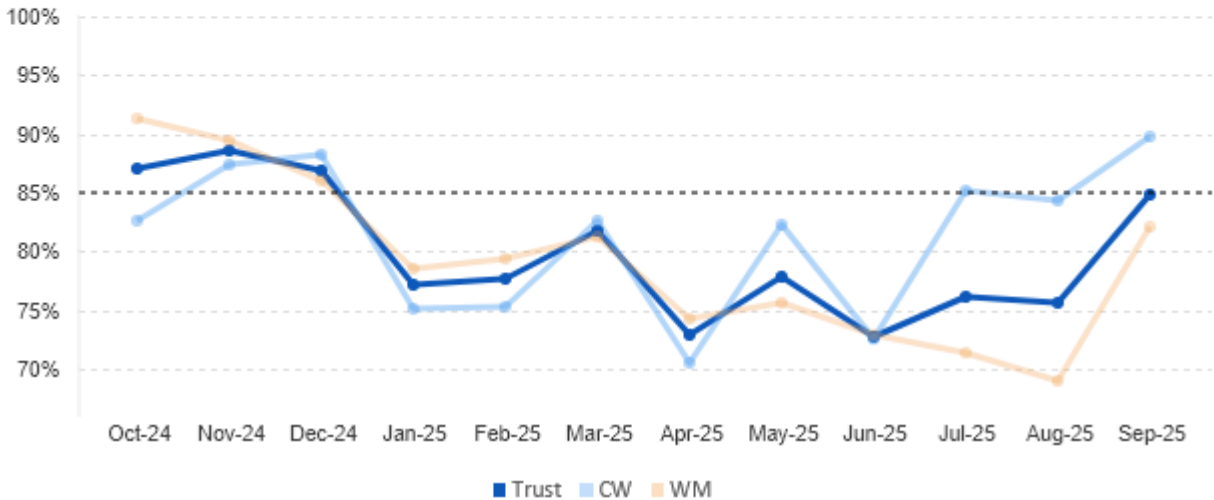
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
28 Day Faster Diagnosis Standard (Target: >=77%)	CW	82.1%	84.1%	83.1%	82.7%	81.3%	82.4%
	WM	77.9%	79.9%	79.8%	77.1%	75.7%	78.5%
	Trust	79.2%	81.0%	80.7%	78.6%	77.8%	79.7%
2 Weeks from Referral to First Seen (All Urgent Referrals) (Target: >=96%)	CW	96.1%	95.9%	88.0%	95.6%	97.3%	94.4%
	WM	98.2%	93.6%	95.8%	97.7%	95.5%	96.3%
	Trust	97.3%	94.5%	92.7%	96.8%	96.3%	95.6%

Access to Cancer Care (Treatment)

Responsive – Operating Plan

Trend

62 Day GP Referral to First Treatment Combined



Narrative

In August 2025, the 62-Day standard was non-compliant at 75.5%, with key drivers of patients deferring treatments and high level of breaches within the Urology pathway. However, we are seeing recovery within our 62D performance in September, which is at present un-validated, where the Chelsea site is sitting at 90.6% and our West Middlesex site at 79.3% giving the Trust overarching performance at present at 83.2%.

Six tumour sites are in assurance meetings with the cancer performance team and recovery plans are being worked through with support from RMP. Urology is seeing a recovery of performance within September which is reflected in the 62D and reduction of breaches as a key factor.

The Trusts 31-Day position remains strong and above the national KPI of 96% with the un-validated September position currently standing at 99.4%.

In-Month Performance

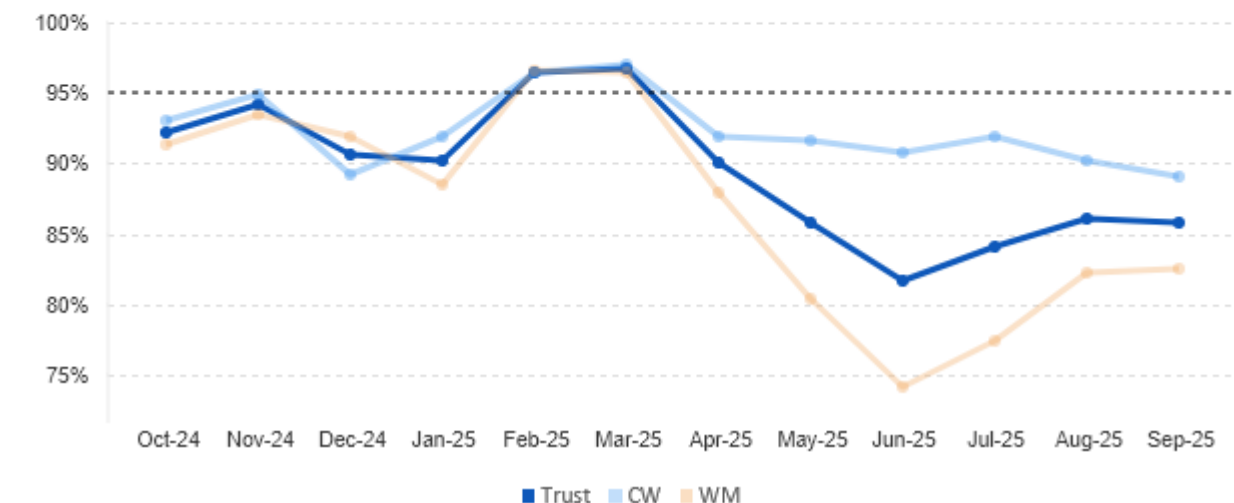
	62 Day GP Referral to First Treatment Combined	31 Day Diagnosis to First or Subsequent Treatment	62+ Day Backlog (Target: 100)
CW	89.8%	98.5%	
WM	82.1%	100.0%	
Trust	84.8%	99.4%	109

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
62 Day GP Referral to First Treatment Combined (Target: >=85%)	CW	82.3%	72.5%	85.2%	84.3%	89.8%	80.4%
	WM	75.5%	72.8%	71.4%	69.0%	82.1%	74.4%
	Trust	77.8%	72.7%	76.2%	75.5%	84.8%	76.7%
31 Day Diagnosis to First or Subsequent Treatment (Target: >=96%)	CW	95.6%	97.7%	98.6%	98.7%	98.5%	97.9%
	WM	97.6%	99.0%	100.0%	98.9%	100.0%	99.3%
	Trust	96.9%	98.4%	99.5%	98.8%	99.4%	98.7%
62+ Day Backlog (Target: 100)	CW						
	WM						
	Trust	99	95	94	108	109	109

Trend

Diagnostic Waiting Times < 6 Weeks



Narrative

September's performance showed a slight decline to 85.83%. This represents a drop of 0.26% when compared to August performance of 86.09%. While the pressure points remain the same as previous months the downwards trend was mainly driven by the reduction in performance of Endoscopy (Flexi-sigmoidoscopy and gastroscopy) and cystoscopy.

Diagnostic physiology remains the main pressure point with echocardiography accounting for 42% of the total breach number. This modality remains with 3 vacant posts reducing capacity. Interim plans for recovery are underway while recruitment process is not concluded. Endoscopy is challenged by the increased demand in 2ww pathway, reducing capacity for routine referrals. Another compounding factor is the existing vacancy within nursing and consultant workforce, further compromising the service provision.

WMUH continues to be the most challenged site across most modalities and performed at 82.55% against CW performance of 89.13%, however WMUH has improved performance compared to last month. CW was the site seeing a deterioration in position.

In-Month Performance

	Diagnostic Waiting Times < 6 Weeks	Diagnostic Waiting Times > 6 Weeks: Actuals	Diagnostic Waiters 13+ Weeks
CW	89.1%	633	0
WM	82.6%	1,022	0
Trust	85.8%	1,655	0

Year-to-Date Performance

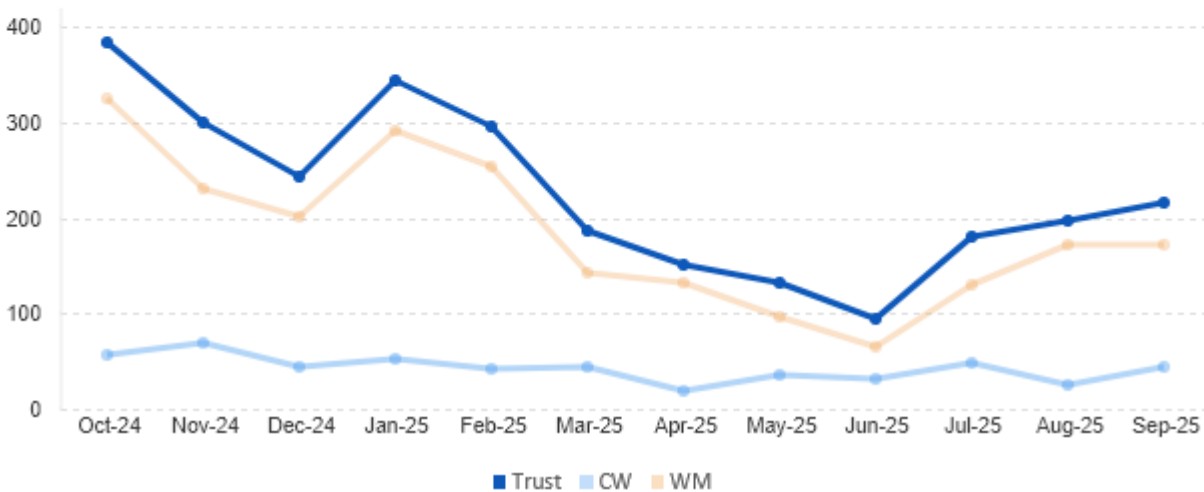
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Diagnostic Waiting Times < 6 Weeks (Target: >95%)	CW	91.6%	90.8%	91.8%	90.2%	89.1%	90.9%
	WM	80.4%	74.2%	77.4%	82.3%	82.6%	80.5%
	Trust	85.8%	81.6%	84.1%	86.1%	85.8%	85.5%
Diagnostic Waiting Times > 6 Weeks: Actuals	CW	473	489	459	532	633	633
	WM	1,193	1,680	1,471	1,059	1,022	1,022
	Trust	1,666	2,169	1,930	1,591	1,655	1,655
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 September 2025, the Trust reported 4 60-minute LAS handover delays, with a slight deterioration against the 30-minute handover delays on the Chelsea site and the West Middlesex site stayed the neutral. The 15-minute handover was non-compliant across both sites. 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	764	79.8	45	0
WM	993	154.1	172	4
Trust	1,757	233.9	217	4

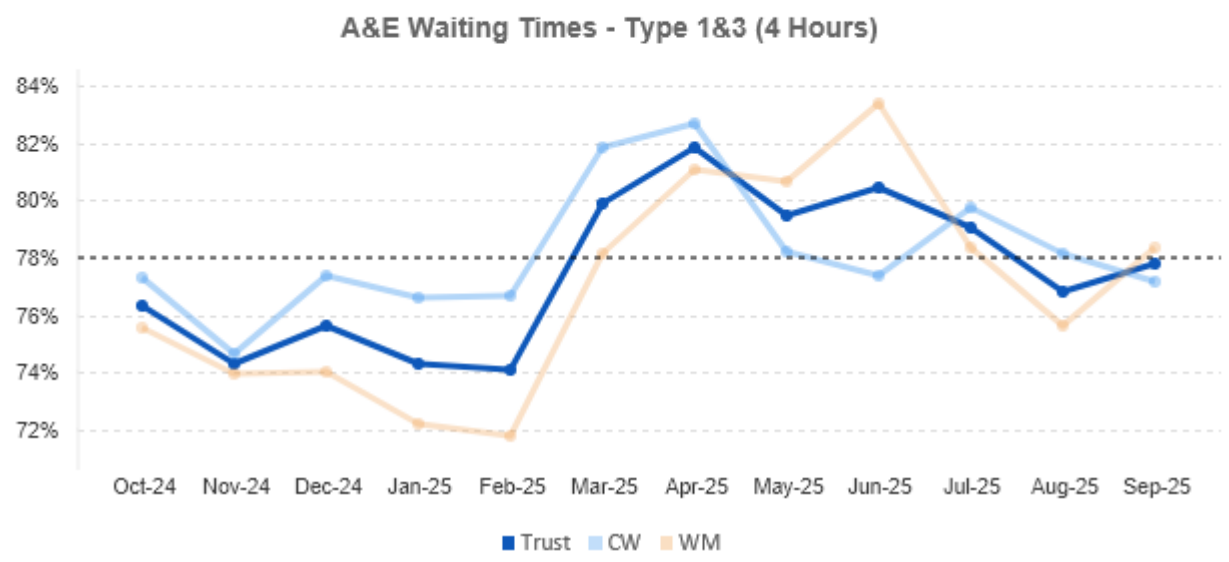
Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
LAS 15 Min Breach Performance	CW	799	707	805	734	764	4,465
	WM	844	772	924	924	993	5,427
	Trust	1,643	1,479	1,729	1,658	1,757	9,892
LAS Time Lost (Hrs)	CW	75.9	73.1	81.7	69.8	79.8	441.9
	WM	103.4	89.8	128.4	143.1	154.1	753.3
	Trust	179.3	162.9	210.1	212.9	233.9	1,195.2
LAS Handovers 30 Mins	CW	36	31	49	26	45	206
	WM	97	64	131	172	172	769
	Trust	133	95	180	198	217	975
LAS Handovers 60 Mins	CW	1	0	0	0	0	1
	WM	1	0	2	0	4	10
	Trust	2	0	2	0	4	11

Urgent & Emergency Department Waits

Safe/Responsive – Operating Plan

Trend



Narrative

Performance
Performance against the 4-hour standard in September 2025 was 77.77%. West Middlesex achieved 78.4% with 13,452 attendances and the Chelsea site 77.1% with 12,815 attendances.

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

Improvement
There has been an ongoing focus on A&E time to triage, in September West Middlesex achieved an average time to triage of 7 minutes, at the Chelsea site and 16 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	77.1%	2.8%	00:16	12,814	784	25
WM	78.4%	2.8%	00:07	13,453	898	21
Trust	77.8%	2.8%	00:11	26,267	1,682	46

Year-to-Date Performance

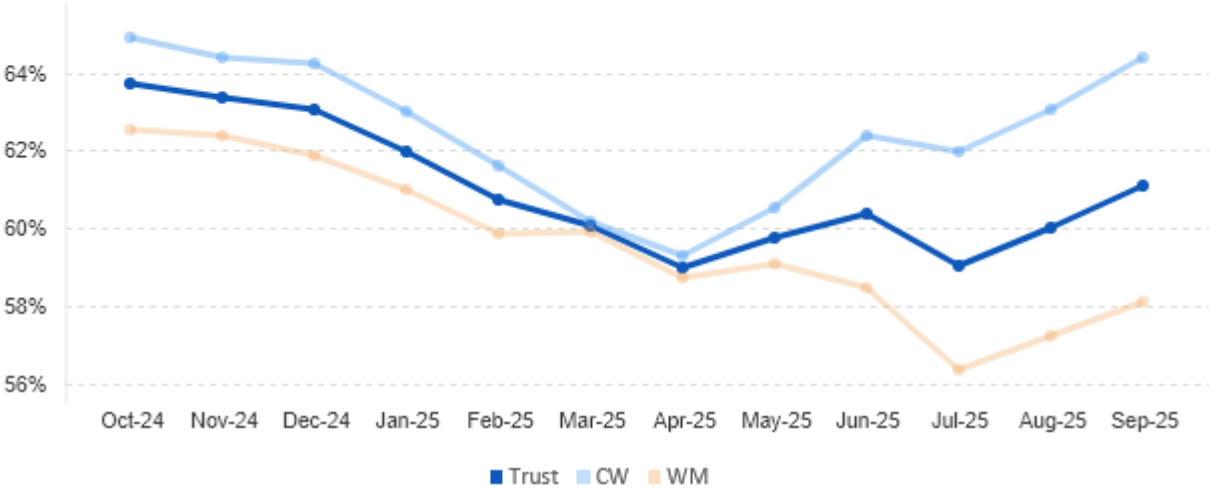
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
A&E Waiting Times Type 1&3 (4 Hrs) Target: >78%	CW	78.2%	77.3%	79.8%	78.1%	77.1%	78.8%
	WM	80.7%	83.4%	78.4%	75.6%	78.4%	79.6%
	Trust	79.5%	80.4%	79.0%	76.8%	77.8%	79.2%
A&E Waiting Times Type 1&3 (12 Hrs) (Target: <2.8%)	CW	2.0%	1.7%	1.8%	1.2%	2.8%	1.8%
	WM	1.9%	1.1%	2.3%	3.2%	2.8%	2.2%
	Trust	1.9%	1.4%	2.1%	2.2%	2.8%	2.0%
A&E Time to Triage (Target: 15mins)	CW	00:16	00:16	00:15	00:14	00:16	00:15
	WM	00:11	00:06	00:07	00:06	00:07	00:08
	Trust	00:14	00:11	00:10	00:10	00:11	00:12
Total Attendances Type 1&3	CW	13,353	13,151	12,694	11,874	12,814	76,139
	WM	13,960	13,537	13,902	12,803	13,453	80,991
	Trust	27,313	26,688	26,596	24,677	26,267	157,130
Referrals to SDEC (Target as Per Op Plan)	CW	687	702	757	691	784	4,304
	WM	988	923	959	842	898	5,533
	Trust	1,675	1,625	1,716	1,533	1,682	9,837

Referral to Treatment Waits

Responsive – Operating Plan

Trend

18 Week RTT Incompletes



Narrative

Performance: Elective Referral to Treatment (RTT) 18-Week Wait performance was reported at 61.1%, above the national 60% target and ahead of our external planning target for Month 6.

The number of patients waiting over 52ww increased to 1745 (+408), the 65ww is at 62(+23) and there was one patient reported as waiting over 78ww. The patient has since been treated and discharged.

Enhanced assurance is in place for at-risk areas with routine monitoring of RTT backlogs. ERF cap within the current year's operating plans, which is leading to reduced activity levels and consequently fewer clock-stop.

Improvement : Recovery plans have been tailored for each specialty, with those not meeting compliance subject to weekly assurance reviews. Clinic templates have been revised implemented with additional surgical and outpatient capacity drives commencing in Q3 to accommodate these patient cohorts.

Risk : Potential further Industrial action

In-Month Performance

	18 Week RTT Incompletes	18 Week RTT Incompletes Paeds	52 Week RTT Incompletes	52 Week Waiters	65 Week Waiters
CW	64.4%	70.6%	2.0%	700	29
WM	58.1%	45.0%	2.6%	1,045	33
Trust	61.1%	56.9%	2.3%	1,745	62

Year-to-Date Performance

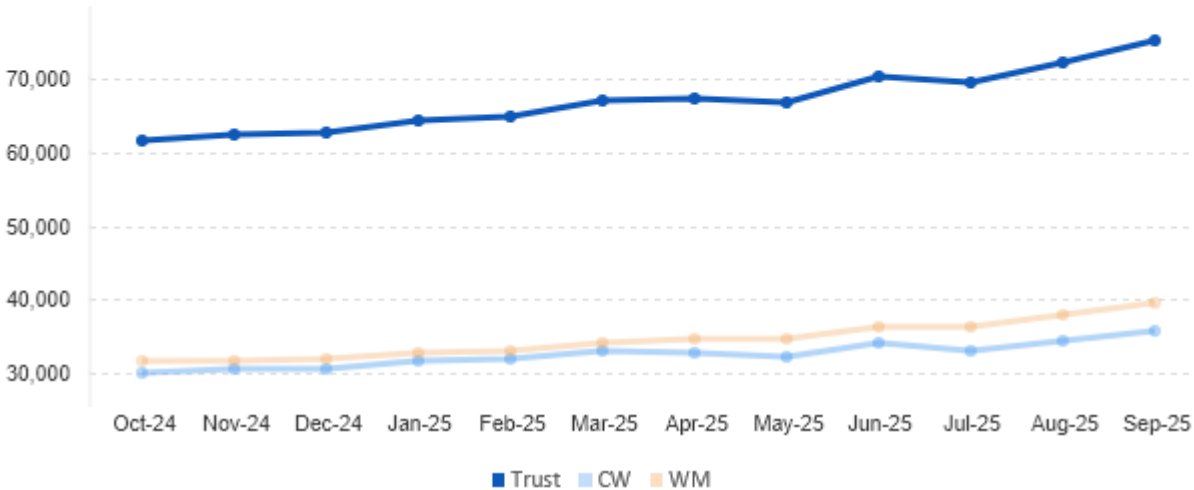
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
18 Week RTT Incompletes (Target: >60%)	CW	60.5%	62.4%	62.0%	63.1%	64.4%	64.4%
	WM	59.1%	58.5%	56.4%	57.2%	58.1%	58.1%
	Trust	59.8%	60.4%	59.0%	60.0%	61.1%	61.1%
18 Week RTT Incompletes Paeds	CW	69.9%	72.0%	70.0%	69.5%	70.6%	70.6%
	WM	54.6%	52.7%	48.6%	46.8%	45.0%	45.0%
	Trust	61.2%	61.3%	57.9%	57.0%	56.9%	56.9%
52 Week RTT Incompletes (Target: <1%)	CW	1.1%	1.3%	1.4%	1.6%	2.0%	2.0%
	WM	1.1%	1.7%	2.1%	2.1%	2.6%	2.6%
	Trust	1.1%	1.5%	1.8%	1.8%	2.3%	2.3%
52 Week Waiters	CW	353	432	466	540	700	700
	WM	385	606	771	797	1,045	1,045
	Trust	738	1,038	1,237	1,337	1,745	1,745
65 Week Waiters	CW	4	8	6	23	29	29
	WM	2	3	7	16	33	33
	Trust	6	11	13	39	62	62

Referral to Treatment Waits

Responsive – Operating Plan

Trend

Total Waiting List (PTL)



Narrative

Performance: In Month 6 the total RTT Patient Treatment List (PTL) was reported as 75,290. The focus remains on ensuring less 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 patient via routine administrative validation leveraging digital technologies to engage with patients and confirm the identification of those requiring treatment. Capacity drive across surgical and outpatient areas underway in Q3, focused on prioritising patients in the backlog cohorts.

Specialty level monitoring in place with set trajectories to address recovery. These are highlighted in weekly meetings focusing on at-risk specialties. These include Vascular Surgery, Urology, ENT, Paediatrics ENT, Trauma & Orthopaedics, Colorectal Surgery, Plastic Surgery and General Surgery.

Risk : Potential further Industrial action

In-Month Performance

	Total Waiting List (PTL)	Total Waiting List (PTL) Paeds	Patients Waiting < 18 Weeks for First Appointment	RTT Clearance Time: Size of Waiting List
CW	35,789	5,220	65.1%	6.1
WM	39,501	6,008	58.4%	7.2
Trust	75,290	11,228	61.4%	6.7

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Total Waiting List (PTL)	CW	32,147	33,960	33,115	34,454	35,789	35,789
	WM	34,653	36,363	36,372	37,873	39,501	39,501
	Trust	66,800	70,323	69,487	72,327	75,290	75,290
Total Waiting List (PTL) Paeds	CW	4,129	4,611	4,472	4,764	5,220	5,220
	WM	5,412	5,727	5,832	5,853	6,008	6,008
	Trust	9,541	10,338	10,304	10,617	11,228	11,228
Patients Waiting < 18 Weeks for First Appointment	CW	67.5%	67.6%	66.3%	65.3%	65.1%	65.1%
	WM	63.8%	61.9%	58.6%	58.5%	58.4%	58.4%
	Trust	65.5%	64.5%	62.1%	61.6%	61.4%	61.4%
RTT Clearance Time: Size of Waiting List	CW	6.1	6.4	5.3	6.9	6.1	6.1
	WM	6.9	7.3	6.3	8.0	7.2	7.2
	Trust	6.4	6.8	5.8	7.4	6.7	6.7

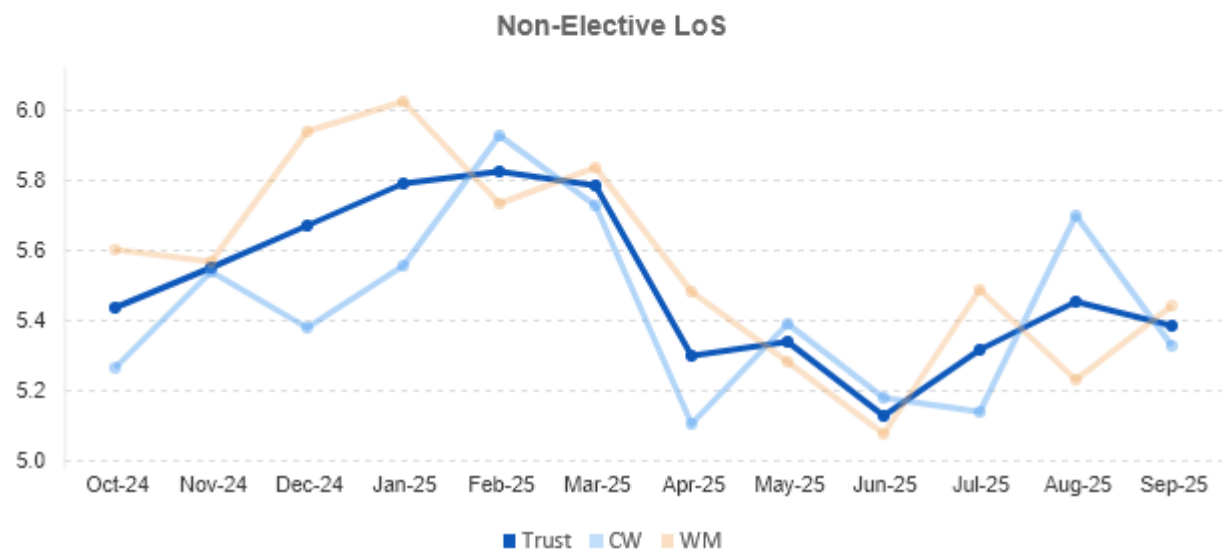


Operating Plan and Capacity

Flow & Discharge – Admitted Care

Responsive/Effective

Trend



Narrative

LOS
Elective LoS is complaint with the standard year to date.
Non-Elective LOS is non-compliant across both sites, with some improvement. Overall Non-Elective long stayers for >7 and >21 days have increased. Continued focus through long length of stay, the Trust Flow Board and Stage 3 escalation meetings with community partners.

Critical Care Occupancy
Critical care activity continues with high occupancy; both sites reflecting >85% occupancy in September . Flow challenges with admission and discharges from the critical care, with a rising number of delayed discharges reflects some of the activity. Critcon 0 consistently reported with flexible nursing staffing to reflect capacity demands.

In-Month Performance

	Elective LoS	Non-Elective LoS	Non-Elective Long Stays (>=7 days)	Non-Elective Long Stays (>=21 Days)	Critical Care Occupancy
CW	2.7	5.3	471	115	85.3%
WM	2.2	5.4	562	144	111.1%
Trust	2.5	5.4	1,033	259	97.5%

Year-to-Date Performance

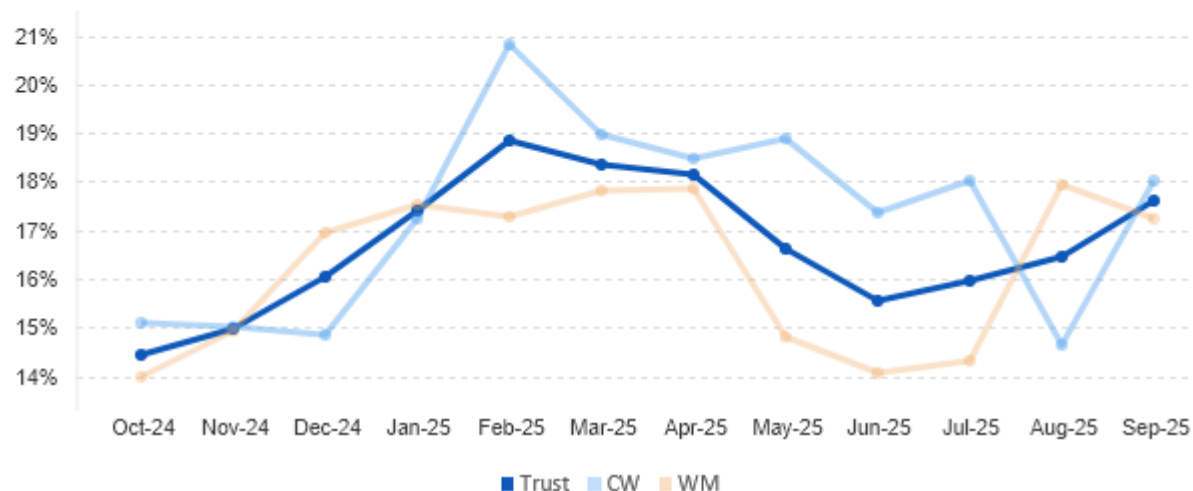
	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Elective LoS (Target: <2.9)	CW	2.6	2.7	2.5	3.0	2.7	2.9
	WM	2.8	2.9	2.8	2.0	2.2	2.5
	Trust	2.7	2.7	2.6	2.7	2.5	2.8
Non-Elective LoS (Target: <3.95)	CW	5.4	5.2	5.1	5.7	5.3	5.3
	WM	5.3	5.1	5.5	5.2	5.4	5.3
	Trust	5.3	5.1	5.3	5.5	5.4	5.3
Non-Elective Long Stays (>=7 days)	CW	465	416	427	432	471	2,621
	WM	522	484	511	526	562	3,151
	Trust	987	900	938	958	1,033	5,772
Non-Elective Long Stays (>=21 Days)	CW	127	121	101	121	115	686
	WM	141	110	132	136	144	798
	Trust	268	231	233	257	259	1,484
Critical Care Occupancy (Target: <85%)	CW	71.3%	68.3%	86.8%	96.8%	85.3%	80.2%
	WM	88.9%	98.1%	93.9%	107.2%	111.1%	99.6%
	Trust	79.6%	82.5%	90.2%	101.7%	97.5%	89.4%

Flow & Discharge – Discharges

Responsive

Trend

Patient Not Meeting CTR by Trust of Pathway



Narrative

Percentage of discharges on discharge ready date remains stable. The percentage of patients with nCTR is above the trust target of 14%. Readmission rates remain below the Trust target.

Work with boroughs continues to support a reduce in percentage of nCTR and timescales for pathway discharges to align with the NWL target for 25/26. Work internally to improve and sustain time scales of EDN / ADD completion, sustained improvement across both sites. Focus to continue on patients with nCTR and LOS. Monitoring to continue via the weekly discharge improvement meetings.

Identified risk remains equipment provision. New arrangements have commenced, these arrangements continue to be monitored via weekly meetings and the impact reported via an internal weekly sitrep and escalation.

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	18.0%	13.7%	89.1%	10.9%	4.4%
WM	17.2%	12.1%	86.2%	13.8%	5.8%
Trust	17.6%	12.9%	87.6%	12.4%	5.1%

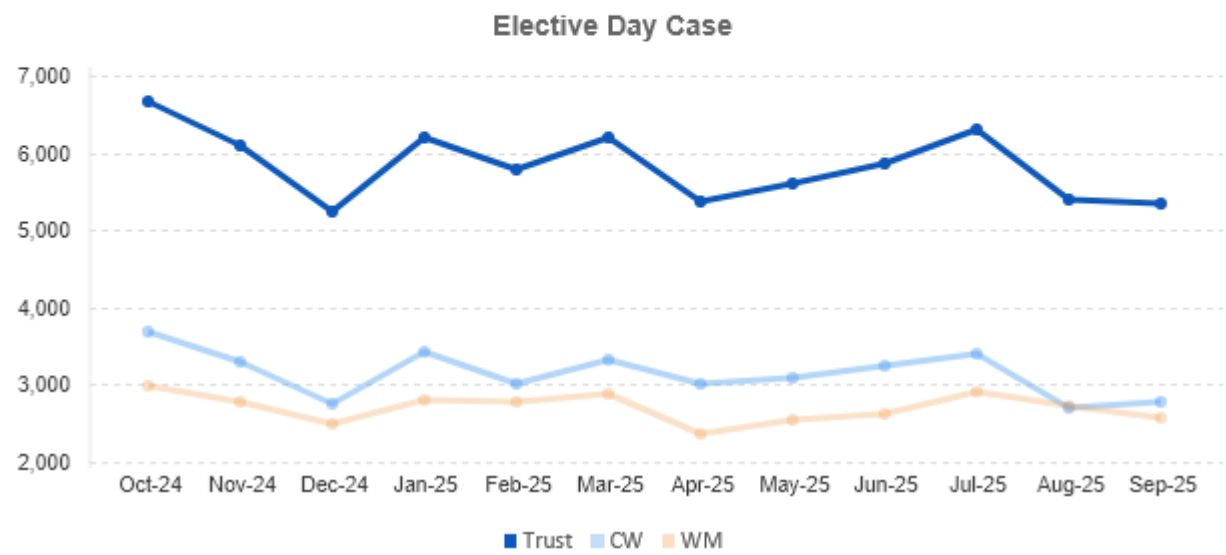
Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Patient Not Meeting CTR Daily Average	CW	18.9%	17.4%	18.0%	14.6%	18.0%	17.5%
	WM	14.8%	14.1%	14.3%	17.9%	17.2%	16.0%
	Trust	16.6%	15.5%	16.0%	16.4%	17.6%	16.7%
Discharges Before 12	CW	15%	13%	13%	14%	14%	14%
	WM	16%	13%	14%	13%	12%	13%
	Trust	16%	13%	13%	13%	13%	13%
Discharge Date Same as Discharge Ready Date	CW	88.6%	89.9%	89.8%	89.7%	89.1%	89.3%
	WM	85.4%	87.5%	87.3%	85.7%	86.2%	86.2%
	Trust	86.9%	88.7%	88.5%	87.6%	87.6%	87.7%
Discharge Date After Discharge Ready Date	CW	11.4%	10.1%	10.2%	10.3%	10.9%	n/a
	WM	14.6%	12.5%	12.7%	14.3%	13.8%	n/a
	Trust	13.1%	11.3%	11.5%	12.4%	12.4%	n/a
Emergency Re-Admissions < 30 Days of Discharge (Target: <7.6%)	CW	4.9%	4.9%	5.1%	5.1%	4.4%	4.9%
	WM	6.3%	6.5%	4.9%	6.4%	5.8%	6.0%
	Trust	5.5%	5.7%	5.0%	5.7%	5.1%	5.4%

Operating Plan Performance

Responsive – Operating Plan

Trend



Narrative

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

Whilst at an aggregate level outpatient activity is on plan, further work is being undertaken to reduce the level of follow up activity in order to increase capacity for new patients. This includes a review of clinic templates to address this balance.

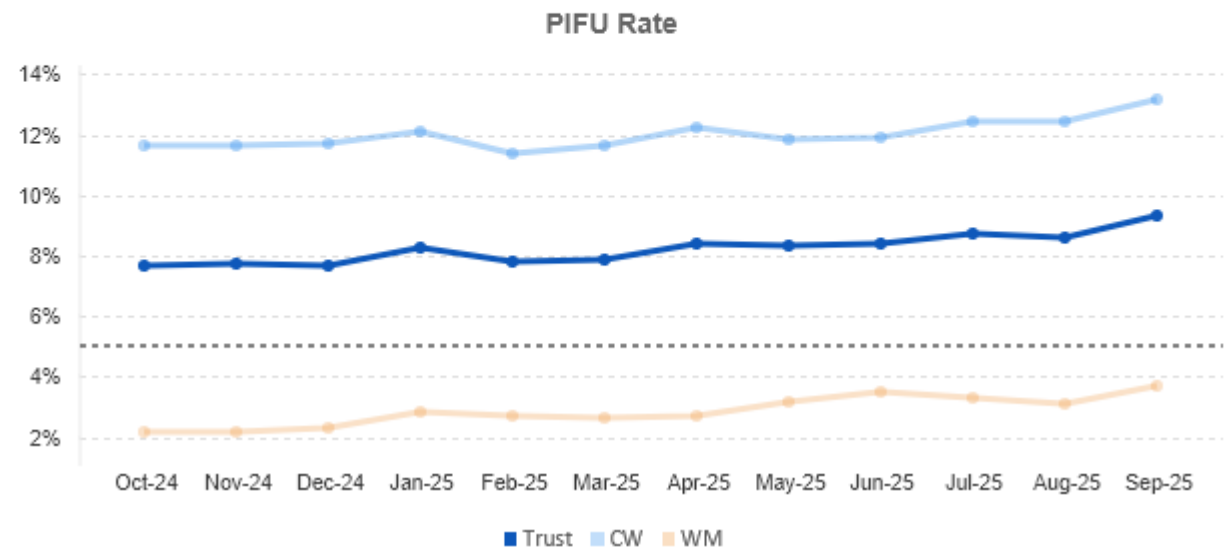
In-Month Performance

	Elective Day Cases	Elective Ordinary Admissions	OP Procedures	OP First Attendance Without Procedure	OP FUp Attendance Without Procedure
CW	2,767	426	5,029	10,733	18,964
WM	2,578	209	3,261	8,771	10,695
Trust	5,345	635	8,290	19,504	29,659

Year-to-Date Performance

	Site	Jun-25	Jul-25	Aug-25	Sep-25	Plan YTD	2025-2026
Elective Day Cases	CW	3,238	3,390	2,693	2,767	17,384	18,181
	WM	2,618	2,915	2,708	2,578	15,746	15,697
	Trust	5,856	6,305	5,401	5,345	33,130	33,878
Elective Ordinary Admissions	CW	392	418	409	426	2,227	2,433
	WM	176	208	230	209	875	1,168
	Trust	568	626	639	635	3,102	3,601
OP Procedures	CW	5,530	5,722	4,793	5,029	27,360	31,333
	WM	3,194	3,454	2,908	3,261	17,610	19,107
	Trust	8,724	9,176	7,701	8,290	44,970	50,440
OP First Attendance Without Procedure	CW	9,569	10,566	8,564	10,733	62,346	58,807
	WM	8,583	9,074	7,490	8,771	48,700	49,254
	Trust	18,152	19,640	16,054	19,504	111,046	108,061
OP FUp Attendance Without Procedure	CW	17,277	19,271	15,628	18,964	99,447	107,560
	WM	10,641	10,901	8,970	10,695	70,033	62,349
	Trust	27,918	30,172	24,598	29,659	169,479	169,909

Trend



Narrative

PIFU performance improved at both sites in September, with an impressive 9.3% of patients moved to PIFU pathways, the highest rate the Trust has achieved to date. This continues to be a key indicator to enable a shift in our new-to-follow up ratio.

DNA rates improved slightly for new appointments and by a fraction for follow ups, and overall the trend remains positive. We continue to focus on ways to improve our ‘new’ DNA rate, including Patient Led Validation, and our volunteers are kindly helping with phone calls in some areas.

In-Month Performance

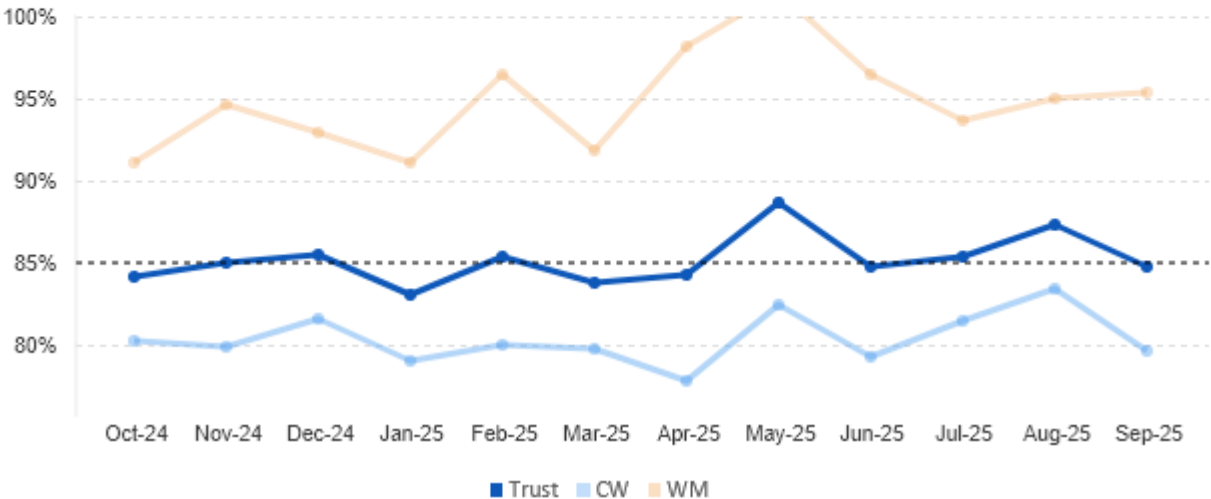
	PIFU Rate	DNA Rates - First Appointment	DNA Rates - Follow Up Appointment	Virtual Contacts
CW	13.2%	10.9%	8.6%	4,252
WM	3.7%	10.3%	6.7%	3,930
Trust	9.3%	10.6%	7.9%	8,182

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
PIFU Rate (Target: 5%)	CW	11.8%	11.9%	12.4%	12.5%	13.2%	12.4%
	WM	3.2%	3.5%	3.3%	3.1%	3.7%	3.3%
	Trust	8.4%	8.4%	8.7%	8.6%	9.3%	8.6%
DNA Rates - First Appointment	CW	10.6%	11.1%	10.7%	10.6%	10.9%	10.7%
	WM	10.3%	9.8%	10.0%	10.9%	10.3%	10.1%
	Trust	10.5%	10.5%	10.3%	10.7%	10.6%	10.4%
DNA Rates - Follow Up Appointment	CW	8.4%	8.9%	8.8%	8.6%	8.6%	8.6%
	WM	7.2%	7.1%	7.5%	6.8%	6.7%	7.1%
	Trust	7.9%	8.2%	8.3%	7.9%	7.9%	8.0%
Virtual Contacts	CW	4,169	4,142	4,462	3,615	4,252	24,873
	WM	3,660	3,862	4,162	3,457	3,930	22,518
	Trust	7,829	8,004	8,624	7,072	8,182	47,391

Trend

Theatre Utilisation (Uncapped)



Narrative

Trust-Wide utilisation saw a slight deterioration in September 2025, at 84.8%. This was driven by a decrease at the CW site, in both the Day Surgery Unit, and Paediatric theatres due to an increase in cancellations on the day (largely patient unwell and DNA). Theatre utilisation remains significantly above the 85% target at 95% on the West Middlesex site. Focused work is being down in the Paediatric and DSU theatres through the Theatres Improvement Programme., with a focus on consultant productivity data to drive improvement.

Day case rates increase slightly in month, going up to down to 88%. Both sites remain well above the 85% target.

OTD cancellations there were one patient cancelled on the day for non-clinical reasons and rebooked outside of 28 days, meaning the YTD total now stands at 14 in 25/26. 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	88.9%	0.8%	1	79.7%
WM	88.3%	0.4%	0	95.3%
Trust	88.6%	0.6%	1	84.8%

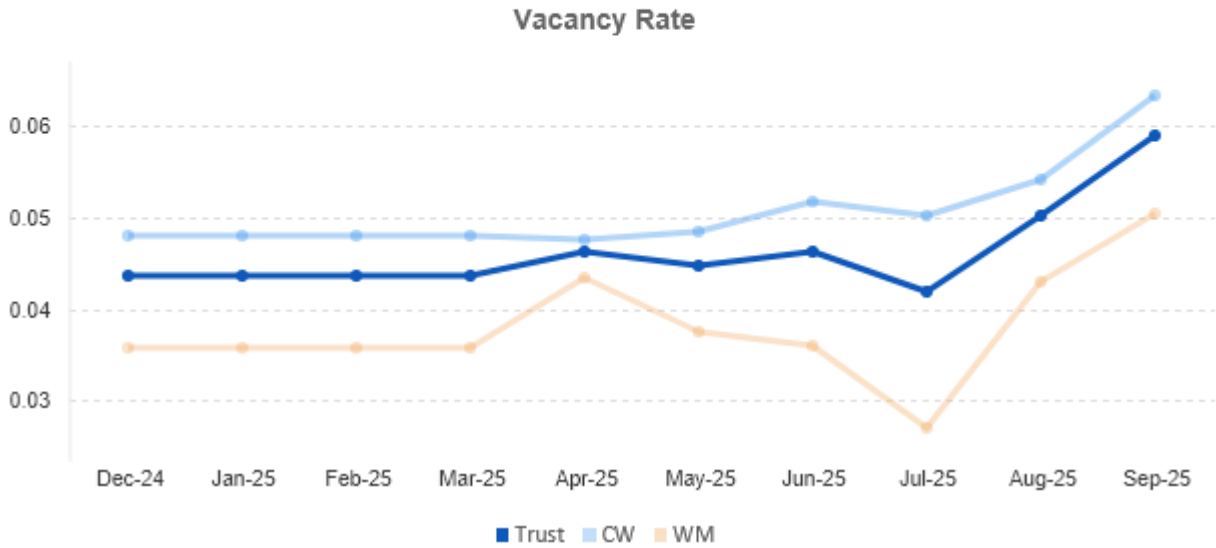
Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Basket Procedures Carried Out as Daycases (Target: >85%)	CW	83.1%	85.4%	89.6%	85.8%	88.9%	86.6%
	WM	90.7%	83.9%	86.3%	80.6%	88.3%	85.9%
	Trust	85.5%	84.9%	88.6%	83.9%	88.6%	86.4%
OTD Non-Clinical Cancellations as % Elective Admissions (Target: <0.8%)	CW	0.5%	0.6%	0.9%	0.5%	0.8%	0.7%
	WM	0.4%	0.5%	0.5%	0.4%	0.4%	0.5%
	Trust	0.5%	0.5%	0.7%	0.5%	0.6%	0.6%
OTD Cancellations Not Re-booked < 28 Days (Target: 0)	CW	0	3	2	0	1	9
	WM	0	0	1	0	0	5
	Trust	0	3	3	0	1	14
Theatre Utilisation (Uncapped) (Target: >85%)	CW	82.4%	79.3%	81.4%	83.4%	79.7%	80.6%
	WM	101.4%	96.5%	93.7%	95.0%	95.3%	96.5%
	Trust	88.6%	84.7%	85.4%	87.3%	84.8%	85.8%



Workforce

Trend



Narrative

The Trust’s Month 06 position was within the operating plan target level for total staffing (89.46 WTE / 1.1%). Substantive and agency staffing continue to be within the operating plan target however; bank staffing exceed the target for the third consecutive month (42 WTE / 7%). EIC, PCD and SCD exceeded their operating target levels for total staffing.

Agency Spend remains within the targeted reductions for 2025/26. In Month 06, bank spend the Trust has breached the trajectory in month spend. It is notable that Trust YTD remains within target spend.

Trust staffing (excluding maternity and career breaks) is within establishment by 37.05 WTE / 0.49%. However, EIC (-134.9 WTE / -7.5%), PCD (-1.25 WTE / -0.09%) and SCD (-75.7 WTE / -4.6 %) all exceeded their total establishment.

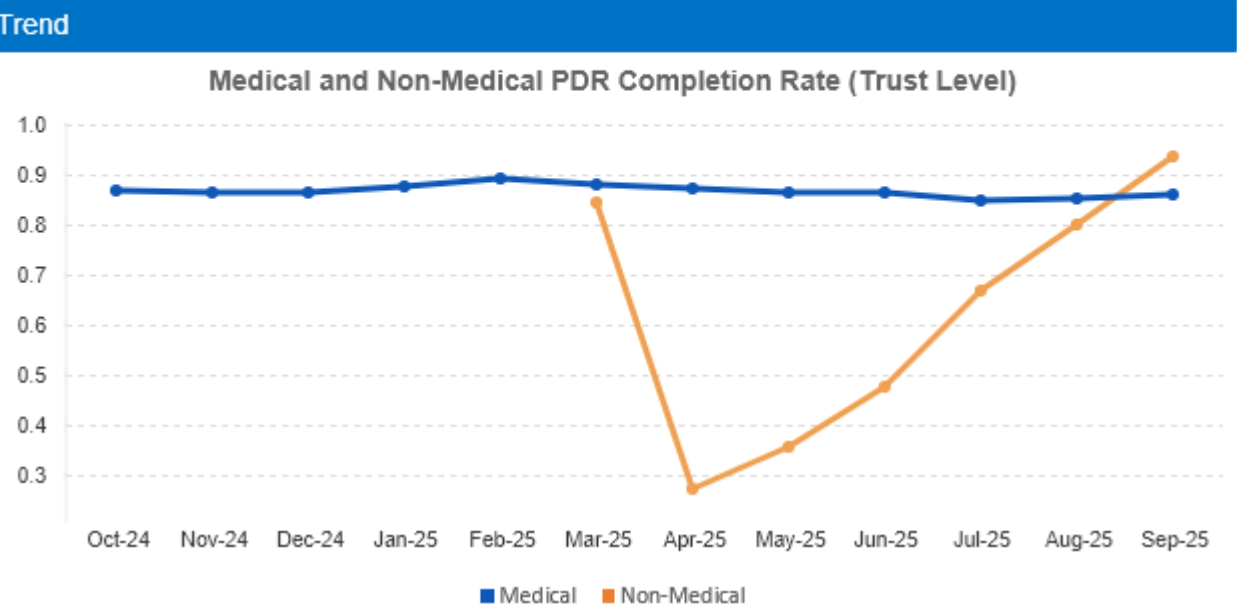
The vacancy (5.88%) and voluntary turnover rates (8.37%) are within the target level. The vacancy rate has no unexpected outliers (corporate rates are above 10% in line with the vacancy holds), however, Voluntary Turnover has two outliers in CSD and WLCH. CSD’s. The key marker for concern regarding pressure remains the sickness levels which increased marginally on last month (0.03%) with particular pressure in CSD and SCD which are above 5% for in-month sickness. CSD and SCD both exceeding the 4% threshold for rolling sickness rates. The Divisions supported by Business Partners and the ER Team are proactively intervening and providing managers support but we need to continue to acknowledged that the team is stretched with current holds on A&C posts.

In-Month Performance

	Vacancy Rate	Voluntary Turnover	Sickness Absence	Agency Usage	Bank Usage
CW	6.34%	8.9%	4.2%	0.3%	7.0%
WM	5.05%	7.4%	4.7%	0.2%	9.8%
Trust	5.88%	8.4%	4.3%	0.3%	8.0%

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Vacancy Rate	CW	4.9%	5.2%	5.0%	5.4%	6.3%	6.3%
	WM	3.8%	3.6%	2.7%	4.3%	5.1%	5.1%
	Trust	4.5%	4.6%	4.2%	5.0%	5.9%	5.9%
Voluntary Turnover	CW	9.0%	9.5%	9.4%	9.4%	8.9%	8.9%
	WM	7.6%	7.9%	7.8%	7.7%	7.4%	7.4%
	Trust	8.5%	8.9%	8.8%	8.8%	8.4%	8.4%
Sickness Absence	CW	3.4%	3.5%	3.6%	3.8%	4.2%	4.2%
	WM	3.3%	3.9%	4.4%	4.2%	4.7%	4.7%
	Trust	3.3%	3.6%	3.9%	3.9%	4.3%	4.3%
% Agency Usage	CW	0.4%	0.4%	0.5%	0.4%	0.3%	0.3%
	WM	0.2%	0.1%	0.1%	0.2%	0.2%	0.2%
	Trust	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
% Bank Usage	CW	9.4%	8.6%	7.5%	7.3%	7.0%	7.0%
	WM	12.6%	11.9%	9.5%	10.2%	9.8%	9.8%
	Trust	10.6%	9.8%	8.2%	8.3%	8.0%	8.0%



Narrative

The introduction of a PDR window has been a success with the PDR rate for Month 06 being 93.89%.

EIC (95.5%) and CSD (94.59%) have the highest rates across the divisions. In addition, all the staff groups excluding Admin and Clerical (89.46%) have exceed the target with Qualified Nursing (95.90%) and AHPs (94.65%) having the highest rate.

In-Month Performance

	Medical PDR Completion Rate (Trust Only)	Non-Medical PDR Completion Rate	Core Skills Completion Rate
CW	-	93.1%	90.9%
WM	-	95.3%	92.8%
Trust	86.1%	93.9%	91.6%

Year-to-Date Performance

	Site	May-25	Jun-25	Jul-25	Aug-25	Sep-25	2025-2026
Medical PDR Completion Rate (Trust Only)	CW						
	WM						
	Trust	86.4%	86.5%	84.9%	85.2%	86.1%	86.1%
Non-Medical PDR Completion Rate	CW	34.8%	46.0%	64.1%	77.9%	93.1%	93.1%
	WM	37.3%	50.9%	72.4%	84.1%	95.3%	95.3%
	Trust	35.7%	47.7%	67.0%	80.0%	93.9%	93.9%
Core Skills Completion Rate	CW	91.9%	92.0%	92.1%	92.2%	90.9%	90.9%
	WM	93.0%	93.4%	93.8%	93.6%	92.8%	92.8%
	Trust	92.3%	92.5%	92.8%	92.7%	91.6%	91.6%

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 & nonstage									
	RN	HCA	RN	HCA										M	12M	M	12M	M	12M	M	12M	M	12M	M	12M	M	12M	M	12M
Maternity	93%	94%	99%	92%	6.4	2.0	0.0	0.0	8.40	12.79	-9.21%	6.70%	10.97%	0	2	0	0	0	0	0	0	5	81	0	0	10	73	95.51%	
Annie Zunz	102%	100%	100%	100%	6.4	2.5	0.0	0.0	8.90	8.73	0.02%	8.00%	0.00%	1	11	0	0	0	0	0	0	0	9	0	0	1	4	95.71%	
Apollo	107%	\	103%	\	22.0	0.0	0.0	0.0	22.00	N/A	-1.77%	3.42%	0.00%	0	0	0	0	1	0	0	0	1	23	0	0	0	2		
Mercury	100%	\	98%	\	9.1	0.0	0.0	0.0	9.10	9.94	7.70%	13.25%	0.00%	0	3	0	0	0	0	0	0	7	84	0	0	0	4	100.00%	
Neptune	110%	\	116%	\	11.7	0.0	0.0	0.0	11.70	13.06	13.03%	11.16%	0.00%	0	1	0	0	0	0	0	0	1	33	0	0	0	2	96.55%	
NICU	94%	\	95%	\	12.9	0.0	0.0	0.2	13.10	26.91	-19.54%	6.59%	0.00%	0	0	0	0	0	0	0	0	5	78	0	0	0	5	100.00%	
AAU	104%	99%	98%	113%	6.3	1.8	0.0	0.0	8.10	8.4	5.89%	2.86%	24.42%	10	112	0	2	1	2	0	0	9	85	0	0	1	26	94.44%	
Nell Gwynne	96%	91%	100%	122%	3.7	4.3	0.0	0.1	8.10	7.82	1.26%	4.80%	11.16%	3	53	0	1	0	1	0	1	2	12	0	0	1	8	88.89%	
David Erskine	100%	90%	124%	121%	3.7	2.9	0.0	0.2	6.90	7.14	0.63%	8.47%	11.04%	4	52	0	1	1	0	0	0	6	32	0	0	0	3	100.00%	
Edgar Horne	129%	98%	133%	128%	4.3	3.4	0.0	0.0	7.60	6.78	2.31%	4.88%	5.88%	1	67	0	3	0	2	0	0	3	25	0	0	4	19	80.00%	
Lord Wigram	71%	62%	93%	91%	3.7	2.0	0.3	0.3	6.30	7.81	19.97%	4.56%	21.77%	1	32	0	1	0	3	0	1	1	30	0	0	1	5	100.00%	1
St Mary Abbots	102%	94%	97%	94%	4.0	2.5	0.0	0.0	6.50	7.55	32.71%	11.31%	38.70%	1	33	0	1	0	1	0	1	7	38	0	1	2	16	86.05%	7
David Evans	79%	63%	82%	94%	4.4	2.4	0.0	0.2	7.00	7.55	3.13%	0.00%	0.00%	1	22	0	1	0	0	0	0	4	21	1	0	0	17	93.24%	
Chelsea Wing	143%	106%	100%	85%	10.5	5.2	0.0	0.0	15.80	7.55	9.34%	6.02%	14.61%	0	8	1	0	0	0	0	0	1	19	0	0	1	6		
Burns Unit	119%	100%	199%	100%	31.0	4.0	1.0	0.0	36.00	N/A	7.97%	7.40%	0.00%	0	8	0	0	0	0	0	0	1	11	0	0	0	5	100.00%	
Ron Johnson	96%	100%	100%	100%	4.4	2.4	0.0	0.0	6.80	5.51	7.66%	5.96%	11.11%	3	47	0	0	1	2	0	0	4	34	0	0	1	4	100.00%	
ICU	101%	\	102%	\	24.2	0.0	1.0	0.0	25.20	26.91	3.53%	8.27%	22.22%	1	6	0	0	0	5	0	0	3	46	0	0	0	5		
Rainsford Mowlem	101%	80%	84%	93%	3.3	3.0	0.1	0.0	6.50	7.5	0.81%	6.41%	8.21%	2	67	0	1	0	3	0	0	1	48	0	1	1	18	100.00%	
Nightingale	99%	102%	99%	141%	3.4	3.9	0.0	0.0	7.30	7.5	19.06%	0.00%	6.49%	1	83	0	1	0	2	0	0	4	25	0	0	2	6	75.00%	
Emergency Department	100%	93%	108%	105%	-	-	-	-	-	N/A	4.64%	8.20%	7.97%	6	55	0	1	0	0	0	0	12	79	0	0	22	167	90.39%	
DSU	80%	56%	102%	60%	-	-	-	-	-	N/A	15.63%	4.82%	0.00%	1	2	0	0	0	0	0	0	1	15	0	0	3	11	93.48%	
Theatres	95%	90%	100%	100%	-	-	-	-	-	N/A	-28.43%	6.02%	24.40%	0	0	0	0	0	0	0	0	1	7	0	0	1	8		
OPD	78%	86%	-	-	-	-	-	-	-	N/A	4.00%	0.00%	0.00%	1	4	0	1	0	0	0	0	1	14	0	0	24	324	92.02%	
Averages /Totals	100%	89%	106%	102%	9.2	2.2	0.1	0.1	11.6		4.36%	6.05%	9.52%	37	668	1	14	4	21	0	3	80	849	1	2	75	738	93.75%	8

Safe Staffing & Patient Quality Indicators – West Middlesex



Chelsea and Westminster Hospital
NHS Foundation Trust



	Average fill rate				CHPPD					National Benchmark	Vacancy rate	Turnover		Inpatient fall with harm				Trust acquired pressure ulcer				Medication incidents				Complaints		FFT	Red Flags
	Day		Night		RN	HCA	RNA	ANA	Total			Qualified	Unqualified	No Harm & Mild		Moderate & Severe		Stage				No Harm & Mild		Moderate & Severe					
																		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	111%	76%	119%	93%	3.5	2.7	0.0	0.0	6.10	7.5	8.30%	0.00%	6.16%	3	59	0	1	6	12	0	3	3	32	0	0	1	11	96.43%	
Richmond	105%	37%	97%	63%	4.0	1.7	0.0	0.2	5.90	7.55	9.71%	0.00%	17.51%	1	19	0	1	0	1	0	0	0	17	0	0	1	15	94.12%	1
Syon 1 cardiology	100%	103%	104%	117%	4.3	2.1	0.0	0.1	6.50	7.93	5.42%	0.00%	36.66%	2	37	1	0	0	1	0	1	3	19	0	0	2	13	93.33%	
Syon 2	101%	91%	98%	99%	3.5	3.1	0.3	0.0	6.80	7.14	0.92%	4.28%	0.00%	9	44	0	0	0	4	0	2	6	49	0	1	4	17	89.66%	
Starlight	116%	\	102%	\	9.4	0.0	0.0	0.0	9.40	13.06	30.90%	16.01%	200.00%	0	3	0	0	0	1	0	0	1	30	0	0	0	7	100.00%	
Kew (Lampton)	107%	112%	113%	156%	3.5	3.6	0.0	0.1	7.20	7.5	8.92%	5.34%	0.00%	3	44	0	0	0	3	0	1	3	27	0	0	1	10	100.00%	
DRU (Crane)	93%	81%	100%	68%	3.0	3.1	0.0	0.2	6.20	7.5	2.91%	0.00%	15.93%	3	54	0	0	0	1	0	1	1	38	0	0	3	14	100.00%	
Osterley 1	102%	83%	105%	115%	3.9	2.3	0.0	0.0	6.30	7.81	6.51%	0.00%	15.95%	1	56	0	0	4	14	0	1	5	55	0	0	4	23	97.14%	
Osterley 2	100%	87%	98%	101%	3.6	2.7	0.2	0.0	6.50	7.55	5.20%	2.66%	0.00%	5	27	0	0	0	1	0	0	0	37	0	0	1	20	100.00%	
MAU	102%	79%	109%	107%	6.3	2.4	0.0	0.0	8.60	8.4	9.59%	1.55%	0.00%	14	96	0	0	2	8	0	0	5	85	0	0	1	26	93.58%	
Maternity	98%	85%	107%	93%	7.0	1.8	0.0	0.0	8.80	12.79	-4.53%	5.30%	0.00%	0	1	0	0	0	0	0	0	2	39	0	0	3	22	89.70%	
Special Care Baby Unit	102%	\	95%	\	8.3	0.0	0.0	0.0	8.30	13.06	-0.29%	7.45%	10.88%	0	0	0	0	0	0	0	0	0	24	0	0	1	2		
Marble Hill 1	118%	88%	130%	100%	4.4	2.4	0.1	0.0	6.80	6.8	-3.82%	7.33%	11.09%	7	68	0	0	0	4	0	0	2	130	0	0	2	16	92.31%	1
Marble Hill 2	111%	119%	116%	151%	3.3	3.5	0.2	0.0	7.00	6.78	5.87%	0.00%	10.45%	5	60	0	0	2	3	0	1	3	39	0	0	2	14	100.00%	
ITU	93%	\	92%	\	24.2	0.0	0.0	0.0	24.20	26.91	0.24%	10.32%	33.33%	1	2	0	0	2	10	0	0	4	58	0	0	1	6		
Redlees (Kew)	108%	100%	100%	83%	3.8	2.9	0.2	0.5	7.40	7.82	-0.15%	4.74%	0.00%	4	46	0	0	0	0	0	0	0	18	0	0	0	4	100.00%	
Emergency Department	99%	100%	111%	80%	-	-	-	-	-	N/A	12.06%	9.26%	0.00%	4	43	0	0	0	0	0	0	5	47	0	1	17	119	78.00%	
DSU	95%	109%	-	-	-	-	-	-	-	N/A	-13.64%	0.00%	0.00%	1	7	0	1	0	0	0	0	0	4	0	0	2	17	93.48%	
Theatres	94%	79%	100%	100%	-	-	-	-	-	N/A	6.21%	4.75%	5.38%	0	0	0	0	0	0	0	0	2	7	0	0	0	7		
OPD	95%	85%	-	-	-	-	-	-	-	N/A	3.38%	14.52%	12.91%	1	4	0	0	0	0	0	0	0	14	0	0	54	381	91.09%	
Averages /Totals	102%	89%	105%	102%	6.0	2.1	0.1	0.1	8.3		4.69%	4.67%	18.81%	64	670	1	3	16	63	0	10	45	769	0	2	100	744	94.64%	2



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 nurse staffing meetings continue to deploy staff as required in order to maintain patient safety.

West Middlesex site:

Kew, Marble Hill 1 & 2 all had increased HCA fill rates to support enhanced observation for patients requiring mental health supervision. AMU and Lampton Frailty Unit had low daytime HCA fill rates due to sickness and an inability to secure bank cover. DRU Ward had lower HCA fill rates day and night attributed to reduced patient acuity and changes to the staffing template. Richmond Ward reported low HCA fill rates due to staff sickness and a lack of bank cover. To maintain safe staffing levels, supernumerary staff and the ward manager supported the provision of clinical care. Theatres had low HCSW fill during the day due to sickness and inability to cover with bank staff.

Chelsea and Westminster site:

Chelsea Wing saw increased RN fill rates on days due to staff on long term sickness. Nell Gwynne and David Erskine had higher HCA fill rates at night to support enhanced observation for patients who were confused and at risk of falls. Additionally, David Erskine had increased RN fill rates at night to support patients requiring tracheostomy care. Edgar Horne and Nightingale had increased RMN and/or HCA fill rates to provide enhanced observations for patients requiring mental health supervision and those at risk of falls due to confusion. Rainsford Mowlem had reduced RN fill rates at night and reduced HCA fill rate during the day due to bed closures. Staff were redeployed to support other areas. Lord Wigram experienced low RN and HCA fill rates during the day due to staff sickness and inability to fill with bank cover. Staff were redeployed from other units to support area. Fill rates for both RN and HCA were reduced on David Evans Ward both day and night due to reduced elective activity, staff were redeployed to other planned care areas. The Burns Unit had increased RN fill rates at night due to the acuity in Burns ITU and sickness in the unit.

Outpatient Department (OPD) RN fill rates were low due to staff sickness and lack of available bank cover. The area Matron provided support. Day Surgery Unit (DSU) experienced low RN and HCA fill rates (day and night) due to changes in the staffing template. Patient care and safety was maintained throughout.

Incidents:

In September there were three incidents with harm reported.

The patient on Chelsea Wing sustained an unwitnessed fall and reported a headache during post fall examination. They were assessed in accordance with the falls protocol and later transferred to the Intensive Care Unit (ICU) for further management.

A patient sustained an unwitnessed fall on Syon 1 ward, resulting in a laceration to the right elbow. The patient was assessed in line with the falls protocol. An Initial Incident Review (IIR) was completed following the incident.

A medication error occurred involving the incorrect dilution of an infusion prescribed for an elective patient on David Evans. This resulted in the administration of an incorrect dosage and a delay to the patient's planned theatre session.

The Friends and Family Test showed six wards at WM and seven wards at CW scoring 100%.

FFT response rates on Nightingale were below average at 75%, due to limited staff engagement and many patients being unable to complete forms independently. No themes were identified in the feedback. The issue was raised during Feedback Fridays, and staff are now actively distributing FFTs to improve uptake. The Emergency department at WM scored 78% with feedback regarding the waiting times in the department.

Please note all incident figures are correct at time of extraction from DATIX. There were ten red flags raised in September, two at the WM site and eight at CW. All were related to staffing shortfalls and inability to assess patient's vitals. The vacancy rate and turnover are from September 2025.

Nursing, Midwifery and care staff average fill rate September 2025				
Day and Night average fill rate		Monthly trust workforce data: Care hours per patient day (CHPPD)		
Registered (%)	Care staff (%)	Registered	Care staff	Total CHPPD
101.99% ↑	94.94% ↑	6.0 ↓	2.4 ↔	8.3 ↓

RN/M Fill Rates (ward areas) increased from 99.80% in August 2025 to 101.99% in September 025. The RN vacancy rate (whole trust) August 2025 was 2.92%

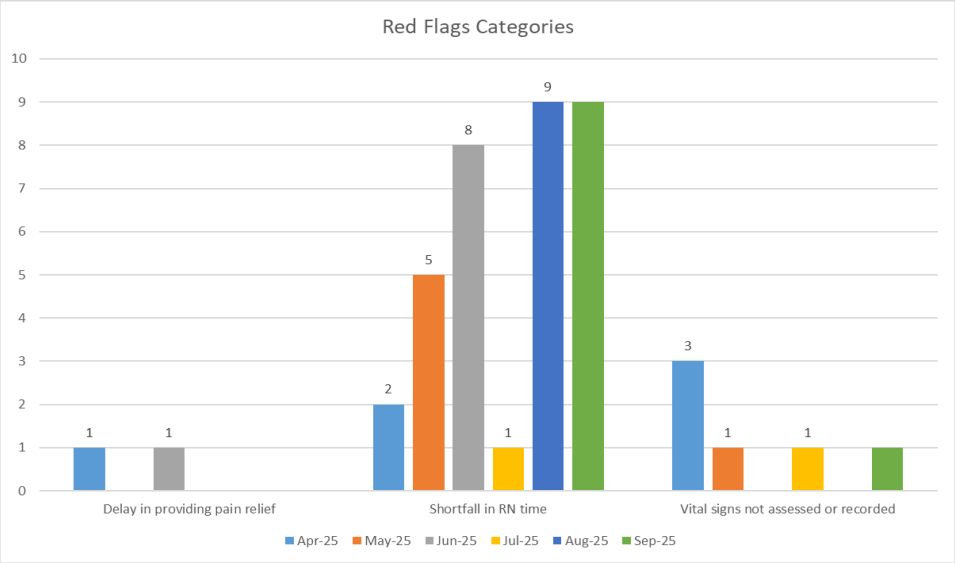
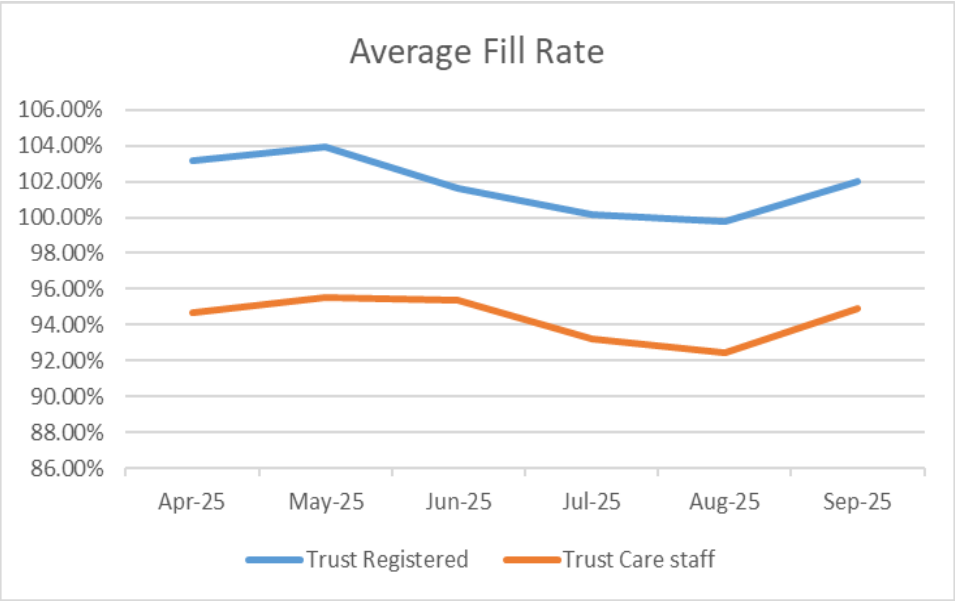
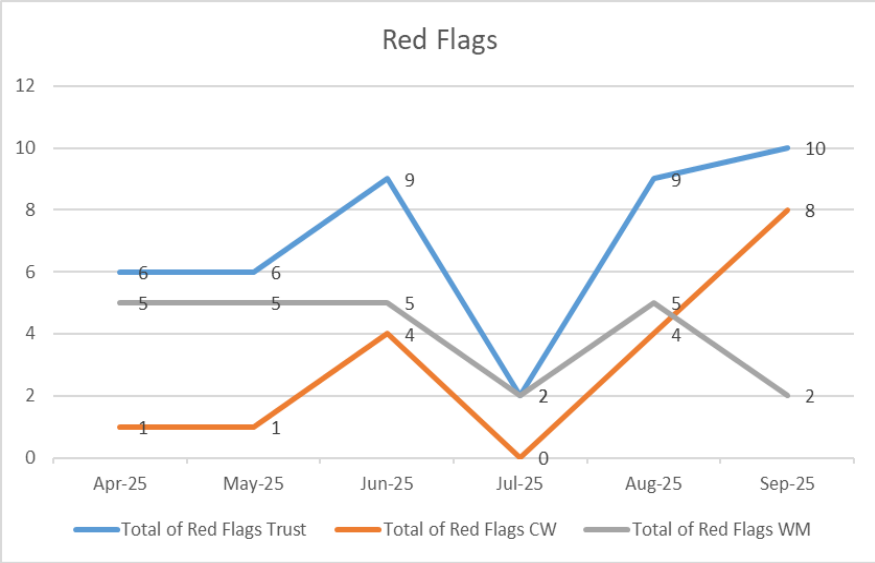
Care Staff Fill Rates (ward areas) increased from 92.44% in August 2025 to 94.94% in September 2025 There has been an extensive HCA recruitment campaign maintained. The HCA vacancy rate (whole trust) in August 2025 was 11.34% .

The Trust overall fill rate (ward areas) (RN and Care Staff combined) increased from 96.12% in August 2025 to 98.46% in September 2025.

Care Hours per Patient Day (CHPPD) continues to be collated on a monthly basis. The most current Trust measure from the Model Hospital* (July 2025) was 8.7. Trust workforce data confirms the CHPPD was 8.3 in September 2025, down from August 2025 – 8.6.

Safe Staffing Red Flags – 10 red flags from the 5 categories (tables below) were reported during September 2025 where majority were Shortfall in RN time.

CHPPD - Taken from the Model Hospital*	Care Hours per Patient Per Day (CHPPD) – July 2025
Trust	8.7
Hillingdon Hospital	9.8
London NW	9.4
Imperial	10.1
National Median	9.0





Finance

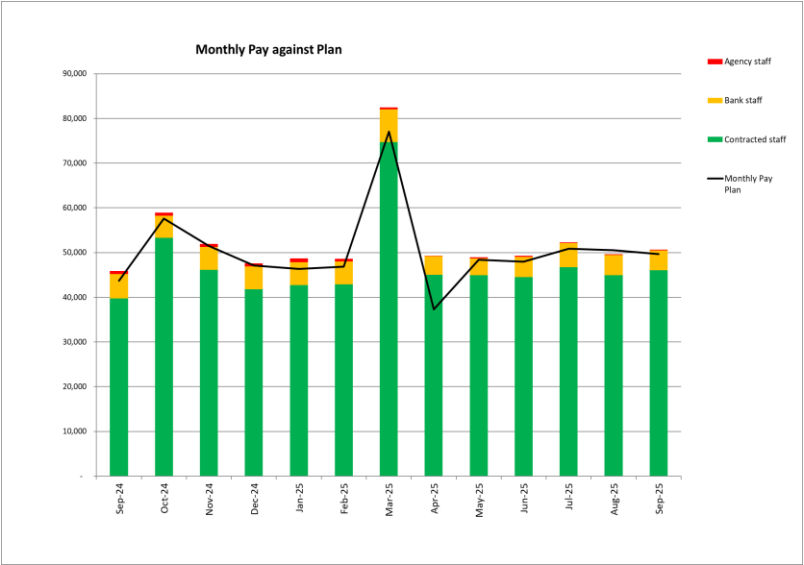
Type of Spend	Plan to Date £'000	Actual to Date £'000	Variance to Date £'000
Income	507,571	506,338	(1,233)
Expenditure			
Pay	(294,227)	(300,011)	(5,784)
Non-Pay	(182,206)	(181,076)	1,131
EBITDA	31,138	25,252	(5,886)
EBITDA %	6%	4.99%	-1.1%
Depreciation	(17,395)	(17,681)	(286)
Non-Operational Exp-Inc	(7,581)	(6,988)	593
Surplus/Deficit	6,162	582	(5,579)
Control total Adj - Donated asset, Impairment & Other	(7,140)	(1,779)	5,360
PFI Model recalculation		316	316
Adjusted financial performance surplus/(deficit)	(978)	(881)	97

The adjusted YTD financial position at month 6 is a £0.88 m deficit which is £0.01m favourable against plan.

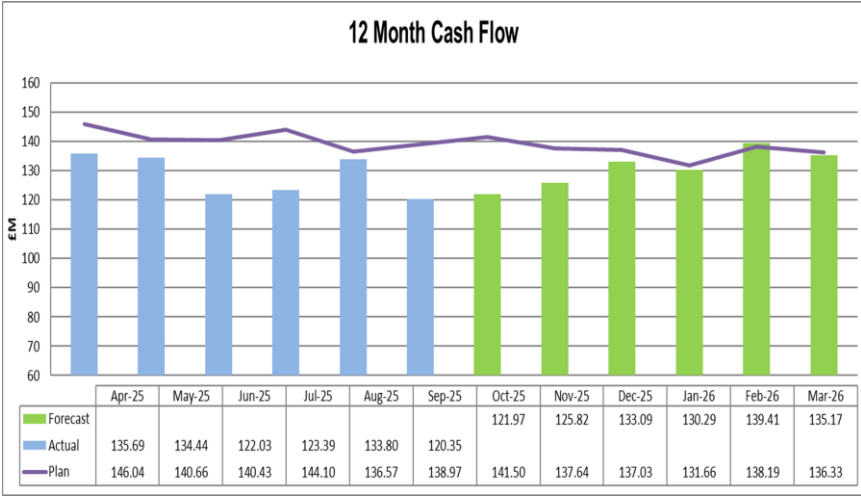
Pay: £5.78m adverse against plan. The adverse variance at Month 6 includes spend to cover Industrial action, additional clinics, WLI as well as cover or vacancies, sickness, gaps in rota and other forms of leave.

Non-Pay: There is a £1.13m favourable variance which includes adjustment to budget to match NHSi return.

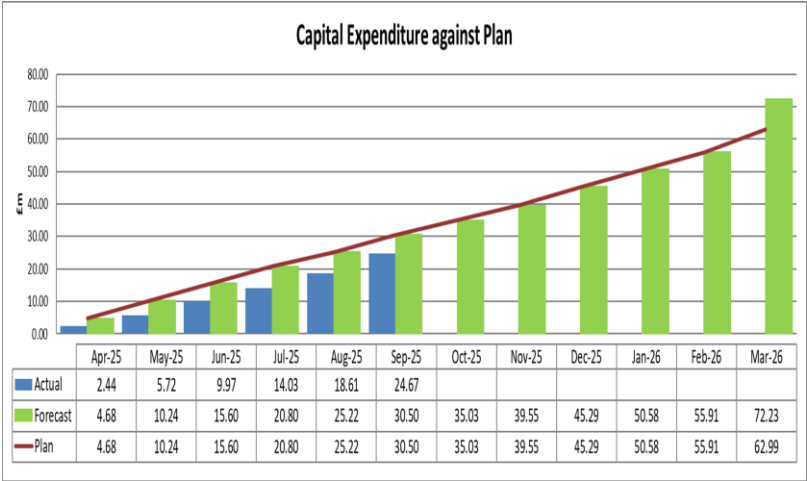
Income: M06 Income performance for the month is favourable relative to plan; however, year-to-date results remain adverse. The positive in-month variance is primarily attributable to the over performance of High Cost Drugs, which fall under the variable components of the contract. Activity within the variable elements of the contract remains minimal and is not financially material. Sexual Health services continue to underperform against planned levels, largely due to demand management measures.



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



Comment: The negative cash variance to plan in M6 of £18.62m is negative cash variance b/fwd from M5 of £2.77m, lower receipts to plan of £14.65m (ICB & NHS England & FT'S £1.59m lower, Local Authority & AR £0.62m Higher, Other Income £0.05m Higher, PP Income £0.30m Higher, Donations £4.0m Lower, Interest £0.02m Lower, PDC Drawdow £10m lower) plus higher cash outflows to plan £1.2m(Higher Creditor payments)



Comment: The original capital programme for 2025/26 was £62.99m, which has been adjusted to £72.23m following the carry forward of the additional grant for the IECCP project from 2024/25, the new grant donation of £250k for the CW Paeds ED waiting room project and the allocation of £6.19m from the ICS reserves/ contingency. The capital budget has been allocated to the various departments, with £39.87m for the ADC Project, £1.52m for the Treatment Centre, £2.11m For PFI schemes, £1.97m for Medical Equipment, £2.0m for IT equipment, £3.70m for Estates schemes, £6.3m for the Human Challenge Fund, £1.13m for IFRS16, £3.50m for IECCP, £0.13m for WM site development and £10m for PDC funded projects which will be allocated to support the ADC project and other estates works. Individual budgets have been allocated from the available capital budgets and business cases for these projects will be submitted to CPB for approval through the year. The P06 YTD underspend of £5.83m which mainly relates to the PDC funded schemes and will be spent in the upcoming months.



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

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