PROUD TO CARE

QUALITY REPORT

2023/24

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust


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PART 1

OVERVIEW AND WELCOME

Statement from the chief executive

I am pleased to introduce the 2023/24 Quality Report for Chelsea and Westminster Hospital NHS Foundation Trust (the Trust), reflecting on the work of our two main hospital sites, Chelsea and Westminster Hospital and West Middlesex University Hospital, and all our community-based services.

At the start of last year we set ambitious quality priorities to improve the clinical effectiveness, safety and experience of care received by all our patients. These included a focus on end of life care, safe and timely discharge of patients, improving the identification and care of frail patients and implementing the new patient safety incident response framework. This report sets out the progress we have made on these, with the Trust retaining our position as one of the safest places in the country to receive care.

It has been a very busy 12 months for our Trust, during which we have navigated the continued recovery from COVID-19 and improved our performance in all areas. This progress has been achieved despite industrial action and increasing pressures on the system. We celebrated 30 years of Chelsea and Westminster Hospital and started much-anticipated capital projects to transform the Treatment Centre at Chelsea and build a state-of-the-art Ambulatory Diagnostic Centre at West Middlesex—both designed to improve care for patients, increase access and provide new opportunities for staff for decades to come.

We have stayed completely focused on our patients and staff, and I hope this is evident throughout this report. We have concentrated on the recovery of our elective care programme, ensuring we treat our cancer and urgent patients first, and then treating our longest waiting patients. While we always strive to do our best, we acknowledge that there are times when we get things wrong. Please be assured that we are committed to learning from our mistakes and continually striving to improve.

Our commitment to ensuring patient flow and safe discharge has remained—with the addition of a new Discharge Ready Unit to support the safe discharge of patients who require care in the community. We remain in the top 10 for Accident and Emergency performance in the country, are among the safest and highest performing NHS trusts, and our maternity services retained CQC ratings of ‘outstanding’ and ‘good’. Performance against cancer standards has remained strong.

Our internationally-recognised sexual health services continue to develop in the communities they serve. Our pioneering TransPlus service has been commissioned nationally, and our gender surgery services will increase in scope over the coming months. Our clinicians continue to press ahead with research and development, with a newly established chair of medicine. Areas of innovation include maternal and women’s health, burns, infectious diseases, vaccine development, colorectal surgery and ‘human challenge’ studies. Our focus is to ensure that everyone living and working locally has the opportunity to take part in research, which ultimately improves the care and experience of our patients.

We have worked with colleagues within the acute provider collaborative to provide mutual aid for both the acute and elective programmes. We have seen the conclusion of works at Central Middlesex Hospital which has seen the opening of the North West London Elective Orthopaedic Centre ensuring that even more patients are treated in a timely way.

In partnership with Imperial College Healthcare NHS Trust we have seen our children's services structured in such a way that increasing numbers of patients are seen and the learning across the paediatric specialties becomes more resilient.

We have worked hard with colleagues in community and mental health services to ensure that our patients are treated in the most therapeutic setting and that we share skills and learning across professional backgrounds to ensure more joined-up care for our patients.

Our volunteers have been central to the care we provide to patients and the support we offer our staff, and I am always inspired by the selfless commitment they offer to our patients.

Enabling our clinical work is a strong digital strategy, including our shared digital platform allowing seamless access to patient records, and enabling clinical staff to have access to relevant patient information securely and quickly. This has not only improved the coordination of patient care but is contributing to better and more efficient care for all patients. There is still much to do in our digital infrastructure and development, but we are excited about the progress we have made.

But ultimately, nothing is possible without our committed workforce who live our PROUD values every day. Despite another difficult year for the NHS and its people—with operational pressures, continued focus on elective recovery and periods of industrial action—they have continued to care for patients and each other with kindness, compassion, skill and the utmost dedication. I am so grateful for all they do. That is why, following an extensive programme of staff wellbeing and recognition in this past year, I'm delighted that our recent NHS staff survey results show improvement in our staff engagement—with our people recommending our organisation as a top place to work.

It has been a positive year for our Trust, but there is always more to do to ensure that we go above and beyond for the patients and communities we serve. This includes a relentless focus on tackling inequities wherever we find them. I'm delighted that Dr Natasha Singh (consultant obstetrician), in her new role as equality, diversity and inclusion advisor to the board, will support us in this vitally important piece of work.

On that note I want to acknowledge the excellent support of our partners in the acute collaborative, other NHS partners, primary care, local government and the voluntary sector. On behalf of everyone at Chelsea and Westminster Hospital NHS Foundation Trust, I would like to extend my thanks to our members, governors, patients, community and staff for your commitment and support during these past 12 months.

This coming year we will continue to improve together. I hope you enjoy reading this Quality Report, and agree that we have had a challenging but successful year.

Our values

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

They are:

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

Our vision

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

Our priorities

Our Trust strategic priorities have remained the same as the previous year.

Strategic priority 1: Deliver high-quality, patient-centred care

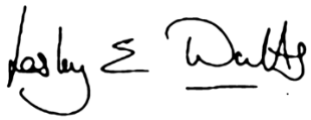
Patients, their friends, family and carers will be treated with unfailing kindness and respect by every member of staff in every department, and their experience and quality of care will be second to none.

Strategic priority 2: Be the employer of choice

We will provide every member of staff with the support, information, facilities and environment they need to develop in their roles and careers. We will recruit and retain the people we need to deliver high-quality services to our patients.

Strategic priority 3: Delivering better care at lower cost

We will look to continuously improve the quality of care and patient experience through the most efficient use of available resources (financial and human, including staff, partners, stakeholders, volunteers and friends).



Lesley Watts
Chief Executive Officer

Our Trust

Chelsea and Westminster Hospital NHS Foundation Trust is one of the top ranked and top performing hospital trusts in the UK. We employ more than 7,500 staff across our two main hospital sites, Chelsea and Westminster Hospital (CW) and West Middlesex University Hospital (WM), including several community-based clinics within North West London.

The Trust delivers specialist and general hospital care at Chelsea and Westminster Hospital and West Middlesex University Hospital. Both hospitals have major A&E departments and our Trust provides the one of the largest maternity services in England.

Our specialist hospital care includes the burns service for London and the South East, children's inpatient and outpatient services, cardiology intervention services and specialist HIV care. We also manage a range of community-based services, including our award-winning sexual health clinics, which extend to outer London areas.

We are active partners in the North West London Integrated Care System (ICS), which brings together all parts of the NHS and local authorities to focus on improving the health of the local population. We have exercised our functions in accordance with the plans of the Integrated Care Board (ICB) that governs the ICS and have worked in partnership in developing joint capital resource plans in accordance with NHS England's guidance on good governance and collaboration.

Within the ICS we are part of the North West London Acute Provider Collaborative along with Imperial College Healthcare NHS Trust, The Hillingdon Hospitals NHS Foundation Trust and London North West University Healthcare NHS Trust. Our collaborative is focused on reducing health inequalities to patients accessing acute care across North West London by developing joint clinical pathways and providing mutual aid.

The Trust serves a catchment area of more than one million people in the following areas:

- Brent
- Central London
- Ealing
- Hammersmith and Fulham
- Harrow
- Hillingdon
- Hounslow
- Kensington and Chelsea
- Richmond
- Wandsworth
- West London
- NHS England for specialised services commissioning

We also have a series of contractual, systems management and other partnership arrangements with respective local authorities. This includes membership and reporting arrangements to health and wellbeing boards and overview and scrutiny committees. We have established our partnership duties through a series of accountability and reporting mechanisms to local Healthwatch groups (the statutory patient representative organisation).

Key facts and figures

	2019/20	2020/21	2021/22	2022/23	2023/24
Outpatient attendances (excluding sexual health and private patients)	791,337	651,567	795,583	777,916	806, 884
Emergency department (A&E) attendances	331,525	215,438	335,374	348,754	269,256[1]
Inpatient admissions	142,233	100,221	138,448	153,670	164,721
Babies delivered (excluding private patients)	10,550	9,959	10,066	9,740	10,458
Patients operated on in our theatres	26,573	13,643	13,526	25,102	30,457
X-rays, scans and procedures carried out by clinical imaging (excluding private patients)	453,922	357,932	450,240	455,334	457,364
Total average number of employees (WTE basis)	6,835	6,821	7,174	7,365	7,510

Our vision

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

Our ambition is to strengthen our position as a major health provider in north west London and beyond to enhance our position as a major university teaching hospital, driving internationally recognised research and development, and to establish ourselves as one of the NHS's primary centres for innovation.

[1] In 2023/24, the management of the Urgent Treatment Centre (UTC) at West Middlesex University Hospital was transferred to the Trust and, as a result, patients attending the UTC who need to be seen in the main Emergency Department are now registered only once in the system—this change is reflected in the reduced attendance figures for 2023/24

The year in photos

April 2023

HIV and sexual health services shortlisted for 2 HSJ Digital Awards for their pioneering digital solutions

Our new Discharge Ready Unit opens at West Middlesex University Hospital

May 2023

Staff celebrated the 30th anniversary of the opening of Chelsea and Westminster Hospital

Maternity services at West Middlesex University Hospital rated ‘outstanding’ by the CQC

June 2023

Staff commemorated the first anniversary of our Paediatric Ambulatory Care Clinic (PACC)

We celebrated National Volunteers Week with a series of events across our sites including barbecues

July 2023

We made a splash at the Pride in London parade with our first ever Trustwide float

NHS chief executive Amanda Pritchard joined us to mark the 75th birthday of the NHS live on air

August 2023

Staff at West Mid celebrated South Asian culture as part of South Asian Heritage Month

Ron Johnson Ward at Chelsea awarded ‘silver’ as part of our ward accreditation programme

September 2023

Gynaecology staff held a session to raise awareness of gynaecological cancers

We commenced our campaign to vaccinate staff against flu and COVID-19

October 2023

Covered in the *Evening Standard*, a local family thanks doctors for saving their baby's life after a 7-week battle with Strep A by fundraising for CW+

We worked with LFB to promote their #ChargeSafe campaign on the dangers of incorrectly storing and charging e-bikes, featured on BBC online

November 2023

Celebrating the important role of our healthcare assistants during HCA Day

Chelsea FC, in collaboration with our charity CW+, ran a wellbeing session for trans staff

December 2023

The Great Big Thank You Week was packed with events across our sites in appreciation of our staff

We celebrated 35 years of HIV care at our Trust with a gala-style evening including a panel discussion

January 2024

NHS chief executive Amanda Pritchard met with staff in our Ambulatory Emergency Care unit

Staff were treated to a complimentary breakfast as part of our health and wellbeing programme

February 2024

Celebrating our staff who advanced their careers though our learning and development programme

Final approval is announced for the construction of a state-of-the-art Acute Diagnostic Centre at West Mid

March 2024

We recognised the achievements of women in our Trust with events at both hospitals to mark International Women's Day

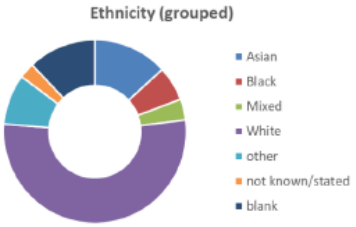
Our refurbished Nuclear Medicine department opened with new, high-definition scanners enabling advanced diagnostics across a range of specialties

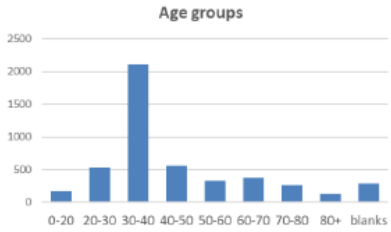
Achievements to highlight

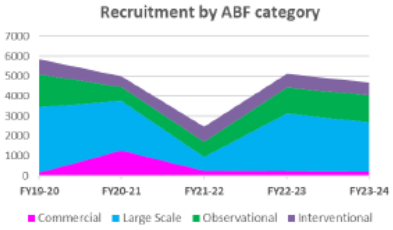
Research and development (R&D)

The number of patients receiving relevant health services provided or subcontracted by the Trust in 2023/24 who were recruited during the period to participate in research approved by a research ethics committee was 4,776—4,587 of these were recruited into National Institute of Healthcare Research (NIHR) non-commercial portfolio-adopted studies and 189 into commercial studies.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer, making our contribution to wider health improvement, tackling health inequalities and ensuring our clinical staff stay abreast of the latest treatment possibilities.







Through the participant research experience survey (PRES) the Trust also gathers feedback from research participants which is used to ensure delivery of high-quality participant safety and data integrity. There were 202 PRES completed during 2023/24 against a target of 200.

Positives about the research experience

'The team are so genuine helpful and dedicated to the research.'

'Having extra appointments and support from midwifes'

'Receiving a Covid vaccine early, being a part of research, helping humanity.'

'Kindness and professionalism shown by all the staff.'

'I had a full MOT!'

Suggestions for improvement

'Explain what the research goals and objectives are.'

'More communication about waiting times on baseline visit.'

'Long wait between preparation and getting the vaccine.'

'More postal questionnaires'

'To be updated about the results'

The Trust was involved in conducting 220 research studies in 2023/24 in the following specialities:

- Anaesthesia
- Cancer
- Cardiovascular disease
- Children
- Critical care
- Dermatology
- Diabetes
- Emergency care
- Gastroenterology
- Genetics
- Haematology
- Hepatology
- Infection
- Infectious diseases
- Metabolic and endocrine disorders
- Musculoskeletal disorders
- Neurological disorders
- Obstetrics and gynaecology
- Perioperative medicine and pain management
- Reproductive health and childbirth
- Respiratory disorders
- Stroke
- Surgery and trauma
- Women's health

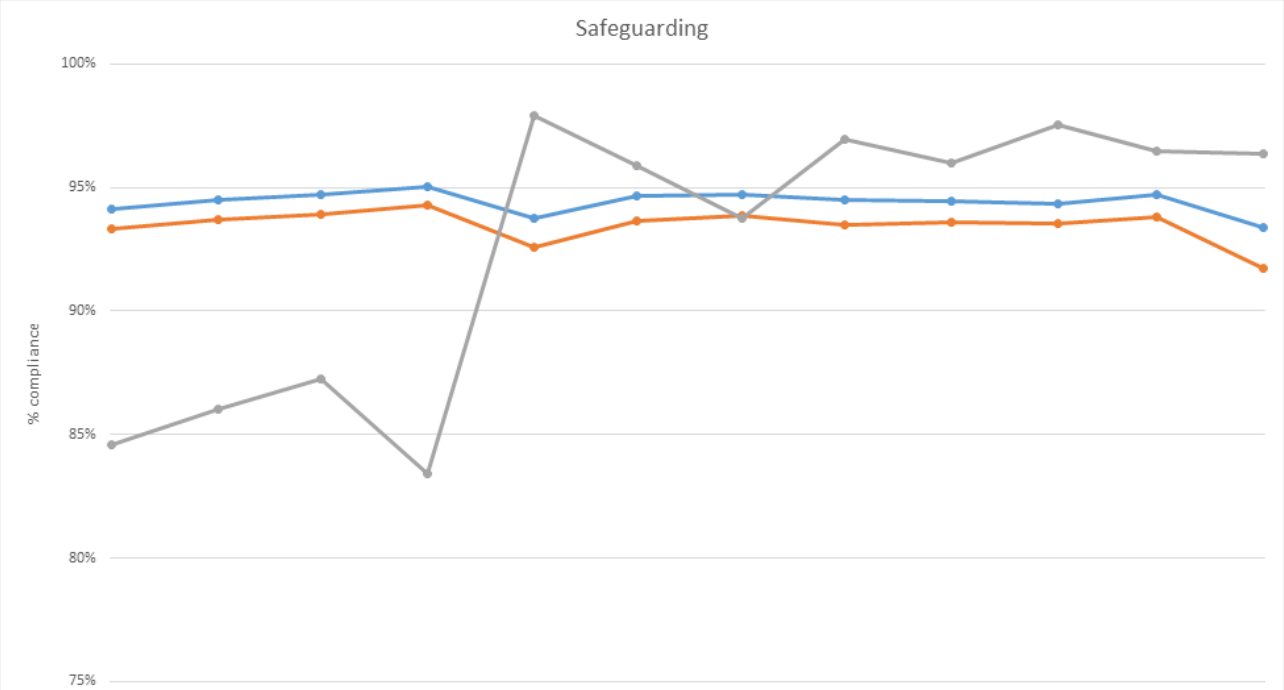
132 staff members participated as chief investigators (CIs) or principal investigators (PIs) for research studies approved by the research ethics committee at the Trust during 2023/24. Over the last year, 440 publications have resulted from our involvement in research and audits, which shows our commitment to transparency and our desire to improve patient outcomes and experience across the NHS.

The R&D sponsor team oversee a portfolio of studies sponsored by the Trust, which is made up of 12 studies, including 7 CTIMPs (drug trials) with a total contract value of more than £4m. Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques.

R&D community engagement events

Learning disability service and adult safeguarding

The Trust has increased support to patients with learning disabilities and autistic people. 2023/24, the Trust approved a business case to increase staffing to enhance service provision, subsequently recruiting an additional practitioner in May 2023. Since July 2023, the team has led an effective awareness campaign around staff engagement with the service, resulting in a marked increase in adult safeguarding mandatory training compliance:



	30-Apr-2023	31-May-2023	30-Jun-2023	31-Jul-2023	31-Aug-2023	30-Sep-2023	31-Oct-2023	30-Nov-23	31-Dec-23	31-Jan-24	29-Feb-24	31-Mar-24
Level 1	94%	94%	95%	95%	94%	95%	95%	95%	94%	94%	95%	93%
Level 2	93%	94%	94%	94%	93%	94%	94%	93%	94%	94%	94%	92%
Level 3	85%	86%	87%	83%	98%	96%	94%	97%	96%	98%	96%	96%

The team is actively involved in reviewing deaths of patients with learning disabilities. The lead nurse for learning disability attends specialist team mortality review meetings to support shared learning and facilitate multidisciplinary discussions around care provision. By identifying best practice and where patient care could have been better, both the nursing and medical teams can work together to enhance patient experience and learn from the deaths of adult patients with learning disabilities.

During 2023/24, the team also had the opportunity to speak at the NHS Pan-London End of Life Care for People with a Learning Disability event. This involved collaboration between the lead nurse for learning disability and the lead nurse for end of life and palliative care. The team hosted stalls in June and November 2023 to highlight Learning Disability Week and Safeguarding Awareness Week respectively.

Safeguarding Awareness Week 2023

In Sep 2023, the team welcomed students for the sixth year of the Project SEARCH internship programme in conjunction with the Queensmill Trust. In the last five years, the Trust's specialist, autism-friendly team has worked together with hospital staff to train more than 45 young people to transition from school and college into the workplace.

Across the Trust, 17 interns are now working in paid or voluntary roles in departments as diverse as pharmacy, sexual health, finance and support services. This is a great achievement, as the national employment rate for people with a learning disability is less than 7%. Our one-year programme demonstrates that our interns are loyal, reliable and hardworking with some of our graduates still working on site at the Trust.

In addition, during 2023/24 the team collaborated with the Trust apprenticeship team to create the first supported apprenticeship for neuro-diverse individuals, who are able to gain a business qualification following completion of their apprenticeship work placement.

Gender affirmation service

The Trust established the Chelsea Centre for Gender Surgery (CCGS) in 2022 to provide masculinising lower surgery for trans and non-binary patients who were assigned female at birth (AFAB).

The overarching vision for the CCGS is a patient-centred service, supported by a dynamic culture of innovation and a comprehensive research programme. The multidisciplinary team draws on expertise from nursing, gynaecology, urology, plastics, radiology, pharmacy, therapies and psychology.

Chelsea Centre for Gender Surgery multidisciplinary team

In 2023/24, there has been a focus on training consultants within the team under the supervision of Prof Miro Djordjevic, aiming to increase the number of specialist gender surgeons in the UK. In addition, there has been an emphasis on raising awareness of the healthcare needs of trans and non-binary patients, with more than 650 staff trained to date in-person and online.

As a national service commissioned by NHS England, the CCGS is compliant with the service specification for gender identity services for adults (surgical interventions) and submits quality metrics to NHS England quarterly. Since going live, the service has

received 128 referrals from the NHS Gender Dysphoria National Referral Support Service (GDNRSS) and has performed 38 metoidioplasty surgeries with lower than expected complication rates.

All surgical outcomes are monitored through digital patient reported outcome measures (PROMs) and patient reported experience measures (PREMs). These reported measures show improvements in gender (in)congruence-related mental wellbeing and life satisfaction.

Discharge ready unit

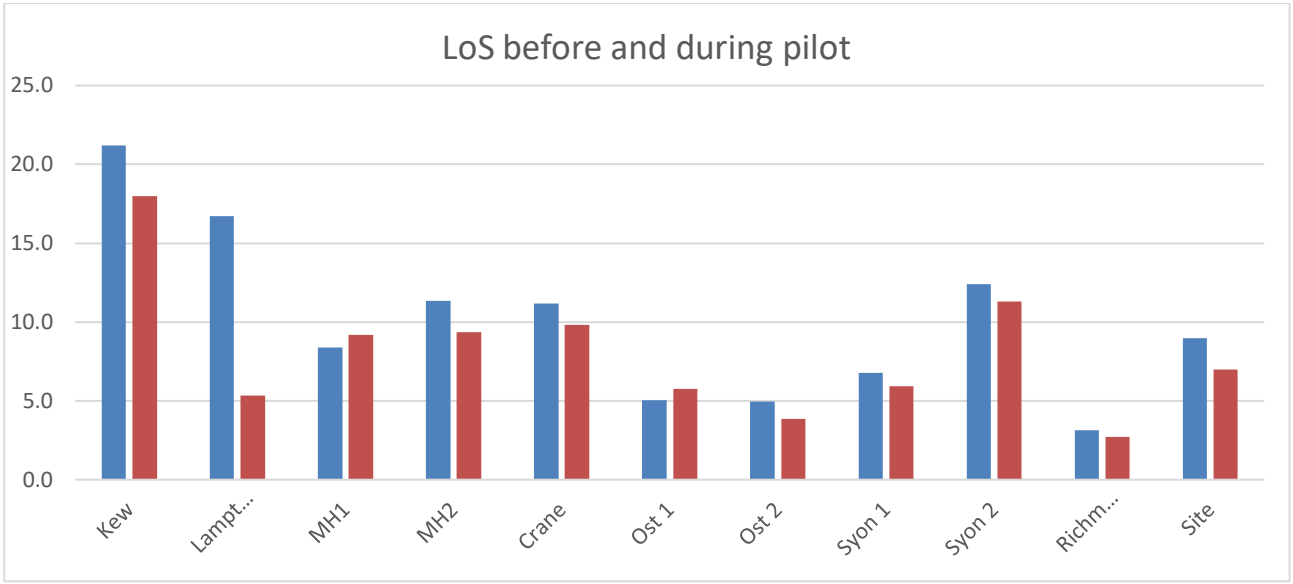
West Middlesex University Hospital regularly has a large number of medically-optimised patients awaiting external placement. This cohort experiences discharge delays while waiting for confirmation of an available discharge pathway. These delays have significant implications for both patients and hospital processes, including an increased risk of hospital-acquired infections, a decline in patient conditioning, an extended length of stay (LoS), and reduced bed capacity.

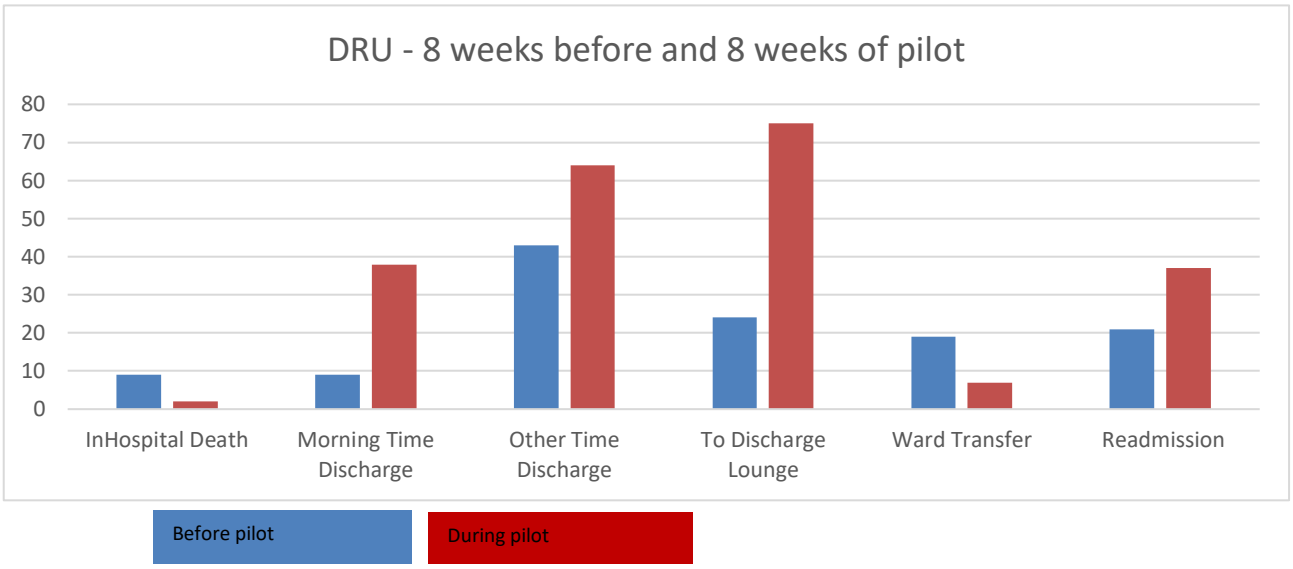
Discharge Ready Unit team at West Middlesex

A project team was established to improve the productivity of our bed base by cohorting patients who no longer require acute care into one area—the discharge ready unit (DRU). This aimed to reduce the length of stay by increasing focus on a person's mobility to prevent deconditioning, as well as ensuring staff resources were directed towards the right person at the right time. Specifically, we expected to see improvements in:

- patient flow through the hospital, contributing to a reduced LoS on acute wards
- reducing the number of patients staying more than 21 days
- reducing locum spend
- improving patient experience
- preventing deconditioning

What we found during the 8-week pilot was a 2-day average LoS reduction at site level (discharging ward), a 322% increase in morning discharges, a 213% increase in the use of the discharge lounge and that 14% of patients discharged were done so with reduced care needs:





Patient experience feedback was as follows:

- 94% rated their experience on the DRU as good or excellent
- 85% felt the DRU environment was conducive to wellbeing and recovery compared to previous ward

Further areas for improvement include providing better information to patients, as 36% felt they had been moved out of the ward without enough information.

Robotic surgery

The Trust's robotics journey began in 2013 with use of a surgical robot in paediatrics. Our programme expanded quickly in 2022 with the purchase of the first of two latest generation da Vinci surgical robots, with a second purchased in 2023. Our goals with this expansion:

- Improve surgical outcomes, including reducing length of stay
- Enhance our ability to recruit and retain the top surgical talent
- Futureproof our surgical services to remain an innovator in the field

Activity began with a focus on certain gynaecological, colorectal and general surgery procedures, including benign hysterectomies, myomectomies, endometriosis treatment, colorectal resections—both benign and malignant—and robotic ileoanal pouch formation. Work has also started on performing robotic abdominal wall reconstruction and day case robotic hernia repair. As a result, our Trust has become a support to the broader North West London system, taking on cases from other trusts as needed.

Our vision is to be recognised as UK leaders in robotics and the leading comprehensive centre for gynaecological and colorectal surgery. This includes being a recognised centre for training and education, aligning with the Trust's goal to be the provider of choice.

Robotic surgery is just one component of our larger digital transformation agenda, which also includes 'Artificial Intelligence' and data utilisation. This programme is crucial for continuing to advance our work within the broader environment.

The robotic hernia surgery team

PART 2.1

PRIORITIES FOR IMPROVEMENT

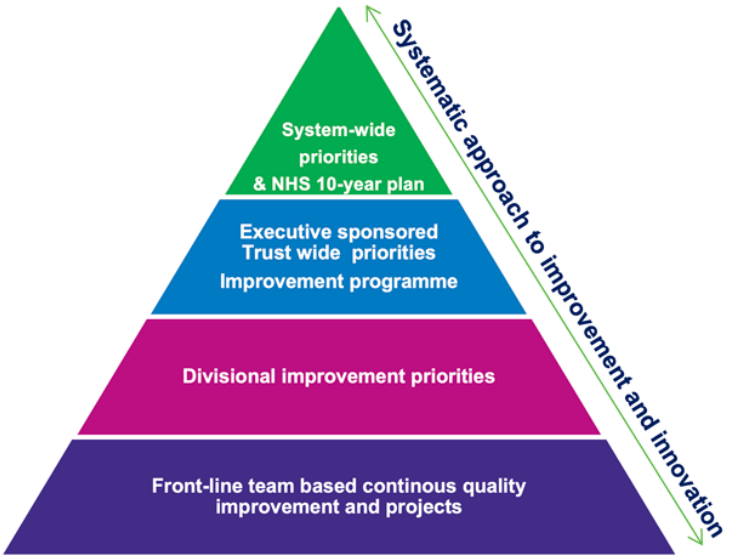
This section provides an overview of our approach to quality improvement, our improvement priorities for the upcoming year and a review of our performance over the last year. We are proud of our quality and safety culture and ongoing focus to improve and innovate to drive best practice.

Our culture of improvement and innovation

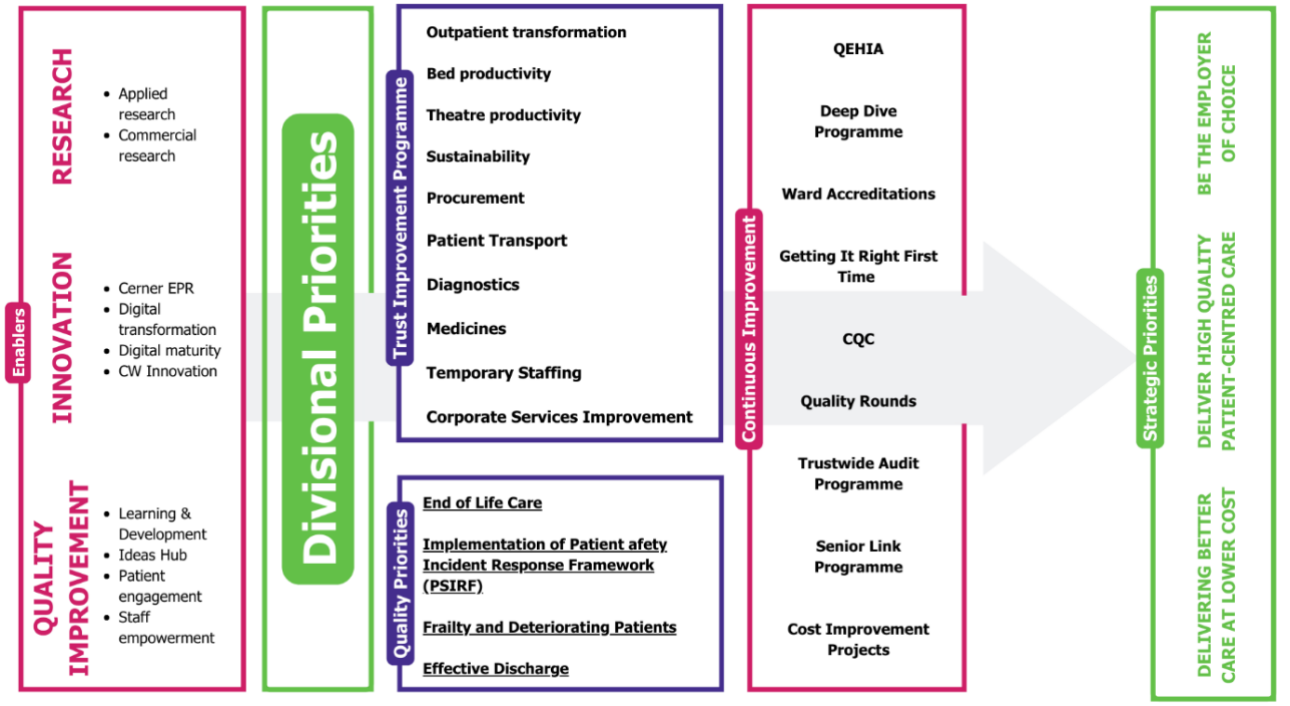
The Trust operates an ambitious quality improvement programme. Our well-embedded improvement process is based around the Trust PROUD values and an improvement framework.

We have a dedicated quality improvement team that works to support colleagues to develop ideas, grow their skills and deliver changes to improve patient care.

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



During the last financial year, we have focused on growing collaborations among research, innovation and quality improvement.



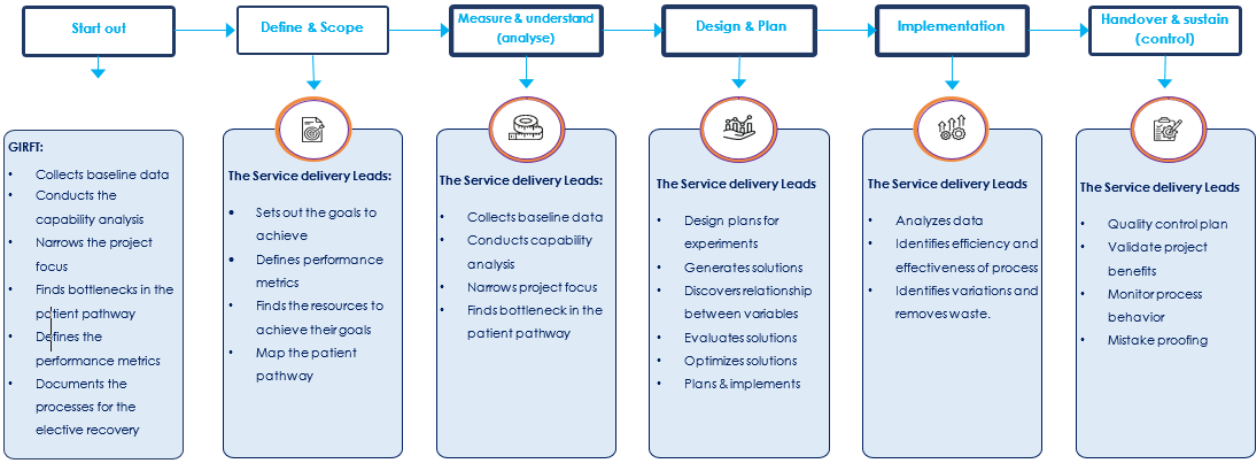
The annually-set quality priorities help deliver the Trust's quality strategy: "Quality priorities delivered and supported by a systematic improvement method." These priorities are agreed upon as part of the business planning process each year. They align with one or more of the Trust's three strategic objectives and focus on areas with the greatest opportunities for improvement. This focus is determined by reviewing improvement opportunities from sources such as Getting It Right First Time (GIRFT), the model hospital,

[2] QEHIA refers to the Quality, Equality and Health Inequalities Assessment process

and themes from claims, incidents and complaints, and data from the Friends and Family Test (FFT).

Getting it right first time (GIRFT) programme

GIRFT is a national programme designed to improve medical care by reducing unwarranted variations in the way services are delivered across the NHS and by sharing best practice guides between trusts. GIRFT identifies changes that will help improve care and patient outcomes, delivering efficiencies such as reducing unnecessary procedures and achieving cost savings. GIRFT engages integrated care systems and regions to work quickly to agree on standardised pathways, adopt best practices, and pool capacity and resources to achieve top-decile performance in clinical outcomes and equity of access to care for our populations.



The success of the GIRFT programme at the Trust has relied heavily on effective stakeholder engagement. The Trust recognised the importance of involving key stakeholders, including clinical staff and administrative personnel, in the planning and implementation stages. The following steps were taken to engage stakeholders:

- **Identification:** The Trust's GIRFT lead conducted a stakeholder analysis to identify individuals and groups affected by the GIRFT programme, including clinical departments and support services.

- **Communication:** A comprehensive communication plan was developed to ensure stakeholders were informed about the purpose and objectives of the GIRFT programme. Regular meetings, newsletters and online platforms were used to disseminate information and gather feedback.

- **Consultation:** Stakeholders were actively involved in the decision-making process through consultation exercises. Their insights and perspectives were sought to understand existing challenges and potential improvement opportunities.

- **Collaboration:** Collaborative working groups were established to facilitate the implementation of specific GIRFT recommendations. These groups consisted of representatives from different stakeholder groups, who worked together to develop and execute action plans.

To improve performance and patient experience, we developed a comprehensive implementation plan based on GIRFT recommendations. The plan focused on the following areas:

- **Clinical pathways redesign:** The Trust conducted a detailed analysis of clinical pathways to identify areas of improvement. Based on GIRFT recommendations, the Trust redesigned pathways to streamline patient journeys, reduce variation in care, and enhance outcomes.

- **Performance monitoring and reporting:** Robust systems for monitoring and reporting key performance indicators were implemented. This allowed the Trust to identify areas of underperformance and take timely corrective actions.

- **Patient engagement:** Patient feedback and involvement were prioritised throughout the implementation process. The Trust established patient engagement forums and utilised technology to collect real-time feedback, enabling them to address concerns and improve patient experience.

- **Collaborative partnerships:** The Trust actively collaborated with other healthcare organisations, research institutions, and industry partners to share best practices, benchmark performance, and drive innovation. This allowed for learning from peers and accelerated the implementation of improvements.

Key outcomes and impacts of the GIRFT implementation plan include:

- **Reduced waiting times:** Streamlined clinical pathways and improved resource allocation resulted in reduced waiting times for patients, ensuring timely access to care.

- **Enhanced clinical outcomes:** Standardisation of care and adoption of evidence-based practices led to improved clinical outcomes, such as reduced infection rates and better patient recovery rates.

- **Improved patient satisfaction:** Through active patient engagement and addressing feedback, patient satisfaction scores significantly improved, indicating a positive experience in accessing and receiving care.

- **Cost savings:** The implementation of GIRFT recommendations resulted in cost savings for the Trust through efficient resource utilisation and reduction of unwarranted variation in care.

GIRFT successes 2023/24

Pancreatic cancer peer review
GIRFT launched a London-wide peer review into services for pancreatic cancer patients to gain insight into the service and its delivery by multidisciplinary teams (MDTs) at surgical hubs and their referral sites (‘spokes’). As part of the review, they focused on histopathology services offered for patients with pancreatic cancer.

The peer review aimed to identify examples of innovative, high-quality and efficient service delivery and looked at areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based pancreatic cancer care. The findings of the peer review will

culminate in the publication of a national report, which will include a set of national recommendations aimed at improving the quality of care and reducing expenditure on complications, procurement and treatments which lack an appropriate evidence base.

On 5 Mar 2024, the peer review meeting took place, and all trusts presented their activity data, operational processes, challenges and improvement initiatives. This was discussed at great length and good practices were shared. Our Trust was found to be an exemplar in its MDT processes and patient pathways, having introduced a separate pathway for complex benign pancreatic conditions, boosting the efficiency of the MDT. As our Trust has the shortest waiting lists, it has been suggested that a network-wide, rather than Trust-specific, waiting list could speed up the pathway.

Further Faster handbooks and checklists

Nationally, the NHS has a large number of patients waiting over 52 weeks for an appointment. The Further Faster programme unites clinicians and operational teams to tackle the challenge of advancing our pathways swiftly and efficiently, with the goal of reducing and eliminating 52-week waiting times.

Key focus areas include:

- Pre-appointment processes
- Decreasing and managing Did Not Attend (DNA) numbers
- Enhancing outpatient activity and capacity
- Implementing remote appointments
- Providing care through Patient Initiated Follow-Up (PIFU)
- Optimising surgical pathways
- Increasing day cases
- Establishing elective surgical hubs
- Addressing barriers to change effectively

GIRFT tasked us with reviewing handbooks and completing checklists for 48 specialties across Trust divisions by 31 Mar 2024. Our Trust not only delivered ahead of the deadline but also became the first in the country to do so, showcasing our commitment to proactive improvement and efficient delivery. These checklists will form part of the 48 specialties' improvement plans to eliminate 52-week wait times for patients under their care.

Our quality priorities for 2024/25

In establishing the Trust quality priorities for the year, consideration was given to the definition of quality and the requirement to address health inequalities. Therefore, in addition to the Trust's strategic priorities and objectives, the quality priorities also align with one or more of the following:

- Patient safety
- Patient experience
- Clinical effectiveness
- Addressing health inequalities

The quality priorities have been selected through a review of improvement opportunities, triangulating data sources such as GIRFT, the model hospital, top themes from claims/complaints/incidents and national audit data. Additional consideration was given to collaborative improvement work, national priorities and locally identified improvements within the divisions.

Each priority has been aligned to a division to act as a lead for the implementation of the quality priority, in addition to local improvement initiatives for the divisions. Progress on the delivery of the Trust's quality priorities will be monitored quarterly through reporting to the executive management board and the quality committee. We are committed to focusing on these priorities to improve the quality of care, patient experience, and the environment and culture within which our staff work.

In addition to our quality priorities, we are also working with the other three acute trusts in the North West London Acute Provider Collaborative (Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust, and The Hillingdon Hospitals NHS Foundation Trust) on several priority areas where there is an opportunity to improve care through collaboration. These include infection prevention and control, the implementation of the new national safety standards for invasive procedures (NatSSIPs2) and improving mental health in the acute setting.

Progress is monitored through a fortnightly Acute Provider Collaborative quality meeting, attended by the chief medical officers and chief nurses from each trust, and reported quarterly to the Acute Provider Collaborative quality committee.

Divisional quality priorities 2024/25

We have set the following quality priorities for 2024/25:

- **Priority 1:** Deteriorating patient (PEWS and Call 4 Concern)
- **Priority 2:** Tobacco and smoking reduction
- **Priority 3:** Improving care for our frail patients
- **Priority 4:** Patient experience (nutrition and hydration)
- **Priority 5:** Implementation of PSIRF
- **Priority 6:** Transitional care

Priority 1: Deteriorating patient (PEWS & Call 4 Concern)

Why have we chosen this as a quality priority?

Improving the identification and management of deteriorating patients is a key improvement workstream across the Acute Provider Collaborative. Nationally, there is a requirement for trusts to implement the Paediatric Early Warning Score (PEWS), which will be complemented by a training programme for staff.

The Call 4 Concern initiative is linked to the national announcement in Feb 2024 for trusts to implement Martha's Rule. This follows the family of Martha Mills campaigning to help improve the care of patients experiencing acute deterioration. Martha Mills sadly died aged 13 in 2021 from sepsis at King's College Hospital after her family's concerns about her deteriorating condition were not responded to promptly. In 2023, a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

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

What do we aim to achieve during 2024/25?

The plan is to establish a 24/7 contact number and process for patients, families and carers to raise concerns about deterioration. Additionally, we aim to ensure that 95% of patients are reviewed within an hour of any Call 4 Concern referral.

How will we measure our success?

Metric	Baseline
All adult patients, their families, carers and advocates have 24/7 access for rapid review if they have concerns about the patient's condition	All staff have 24/7 access to rapid Critical Care Outreach Team (CCOT) review
Adult Call 4 Concern patient escalation is reviewed by CCOT within 1 hour of receiving the call	None

Priority 2: Tobacco and smoking reduction

Why have we chosen this as a quality priority?

The NHS long term plan links to key areas on improving the population's health, preventing illness and disease and reducing health inequalities. Approximately 64,000 people die from smoking-related illnesses in England every year. While smoking is most commonly associated with lung cancer, it can also cause 15 other cancers and more than 100 other diseases. This means that 2 out of every 3 smokers will die from a smoking-related disease.

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

What do we aim to achieve during 2024/25?

Within the tobacco/smoking reduction priority, there is also the expectation that this will be expanded to include staff, alongside the implementation of the NHS smoke-free policy. Our Trust policy will be updated and implemented accordingly. It is important to note that this priority is a new programme that the Trust is implementing, and therefore the baseline figures are low due to the collection of new data that did not exist before.

How will we measure our success?

Metric	Baseline	Ambition
Percentage of inpatients with smoking status recorded	12%	75%
Percentage of known inpatient smokers referred	96%	100%
Percentage of known inpatient smokers receiving very brief advice (VBA)	74%	100%
Percentage of known inpatient smokers offered nicotine replacement therapy (NRT)	96%	100%

Priority 3: Improving care for our frail patients

Why have we chosen this as a quality priority?

With an aging population, early recognition and timely intervention for frail patients can save lives, prevent harm, prevent decompensation and maximise patients' ability to live well. Improving the early identification and management of frail patients requires a systematic approach, including training, protocols and technology, resulting in better patient outcomes and reduced healthcare costs. There is a national focus on frailty and integration of care. As a Trust, we can improve the identification, management and prevention of frailty through evidence-based interventions, multidisciplinary teams, and data-driven approaches earlier within a patient's pathway and within the emergency pathway.

Our vision is for frailty to become everyone's business, with more integration of teams and services across hospital divisions and the wider community to provide excellent, proactive and seamless care pathways. By addressing frailty at the front door and initiating the comprehensive geriatric assessment (CGA), we will identify patients who are at risk of adverse outcomes in hospital and those who are at risk of prolonged hospital admission. We will utilise the comprehensive assessment to provide targeted interventions to these patients and support early discharge from the hospital.

By adopting this front door approach, we will reduce avoidable admissions and select suitable patients for further treatment and monitoring in the community or home setting upon discharge. All frail patients, including those requiring emergency admission, will benefit from specialist input through the initiation of the CGA, including early discharge planning as soon as they present to the hospital.

What do we aim to achieve during 2024/25?

Phase 1 of the frailty work programme focused on establishing a front door frailty service (started in Q4 2023/24). Successful recruitment during 2023/24 resulted in a cross-site multidisciplinary team with an additional focus on achieving the national frailty CQUIN (Commissioning for Quality and Innovation) scheme.

Phase 2 of the plan (Q4 2023/24 and 2024/25) aims to further embed and extend the service at the front door, establish and improve 'acute in-reach' services and establish formal alignment with surgical and end of life pathways.

How will we measure our success?

Indicator	Aim	Baseline	Target	Trust Model
Admission avoidance	To reduce avoidable admissions by 10%	5,532 (cross site)	553 avoided	• Front door assessment and redirection/ community pathways
Same day emergency care (SDEC)	To deliver new patient slots	None at Chelsea site, ad hoc provision at West Mid site	20 per week per site	• Provide same day emergency care

Indicator	Aim	Baseline	Target	Trust Model
Length of stay (LoS)	Reduction of LoS across medical wards	14.5 days (Trustwide)	2-day reduction	• Improved inpatient management • Reduction in avoidable admissions • Increased use of SDEC for admission avoidance • Facilitated discharge
Re-admissions	10% reduction in patients readmitted after 30-day discharge	383 (cross site)	38 re-admissions avoided	• Improved medical management • Discharge with appropriate support closer to home
Virtual Ward	To reduce avoidable admissions, LoS and readmission	0	To support 80% capacity utilisation (NHSE)	• Front door redirection • Early supported discharge • Care at home

Priority 4: Patient experience (nutrition and hydration)

Why have we chosen this as a quality priority?

The NHS patient survey programme (NPSP) collects feedback on patient care and is commissioned by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England. As part of the NPSP, the adult inpatient survey has been conducted annually since 2002. In 2022, the inpatient survey results showed various themes that were not as favourable as we would have hoped.

The adult inpatient survey benchmarks the Trust against 11 themes. The Trust scored 'about the same' for 8 of these themes and 'worse' for 3.

While the patient experience group is monitoring an improvement plan, the actions regarding nutrition and hydration need to be implemented Trustwide across all services. Proper nutrition and hydration are vital for promoting healing and recovery.

How will we measure our success during 2024/25?

Metric	Baseline	Ambition
Percentage of patients that have had a Malnutrition Universal Screening Tool (MUST) assessment completed	12%	80%
Percentage of patients who were referred to dietitian support if triggered/indicated as a result of the MUST	27.6%	80%
FFT response on the percentage of inpatients getting meal support: "Did you get enough help and support with your meals?"[3]	54%	75%

[3] This question is due to be added to the FFT questions—currently the patient experience team ask this question within ward accreditations, which has been used to obtain the baseline

Priority 5: Implementation of PSIRF

Why have we chosen this as a quality priority?

The Patient Safety Incident Response Framework (PSIRF) is a national contractual requirement aimed at developing and maintaining effective systems and processes for responding to patient safety incidents to foster learning and improve patient safety. It helps identify key areas of concern that can be monitored within a robust and strategically aligned system, ensuring that the patient voice is at the core of our agenda.

Our Trust began implementing PSIRF in Apr 2024. While early adoption has taken place, further work is needed in training, education and embedding the approaches used.

What do we aim to achieve during 2024/25?

We aim to empower and enable our staff to respond to patient safety events through the implementation of the patient safety incident response framework, in collaboration with the Acute Provider Collaborative.

This involves continuing to embed PSIRF methodology across the Trust and using learning responses to feed into existing safety improvement plans, as assured by the sub-groups of the patient safety and clinical effectiveness groups.

Engagement, training and support will be monitored and co-designed, following the Trust's successful recruitment of a patient safety partner (PSP)

How will we measure our success?

- 90% of all staff will complete level 1 (essentials for patient safety) training
- 90% of our staff at band 6 and above and our medical professionals will complete level 2 (access to practice patient safety) training
- The Trust will measure the effectiveness of learning response methodology and in meeting the local safety priorities as identified in the Trust's PSIRF plan
- The Trust will measure the effectiveness of engagement work across the divisions with the support of our PSP

Priority 6: Transitional care

Why have we chosen this as a quality priority?

Transition is defined as a purposeful and planned process of supporting young people to move from children's to adults' services. It is not a single act but a process starting from around age 12 that seeks to involve children and young people (CYP) in discussions and decisions on all elements of their care management. Although guidance and good practice principles for transitional care exist, evidence shows these principles are not universally reflected in practice.

Transition can be a difficult and anxious time for young people and their families and, without proper support, there is a risk that young people may not engage with services,

resulting in disruptions to care during the vulnerable adolescent period. Feedback from our CYP, their families, carers and staff indicates much work is needed to ensure developmentally appropriate transition pathways are in place for all CYP in every specialty and meet the needs of the diverse range of patients we care for.

What do we aim to achieve during 2024/25?

A coordinated transition plan across all services will make it clear when care and support provided to a young person will move from children's to adults' services and how it will be delivered. Children's and adults' services will work together with the young person and their family or carers to develop a transition plan that meets the young person's individual needs, is practical to implement and avoids gaps in services due to variation in the age for transition between different services.

This will help young people and their families and carers to know what to expect, reducing uncertainty and stress. For young people covered by health and social care or education legislation, this will be part of a broader plan.

To achieve coordinated transition plans for all CYP, foundational work is required to ensure:

- adequate systems and processes for the recording and reporting of activity
- the identification of training needs
- the delivery of training and education
- the development of clear policy and guidelines

How will we measure our success?

- Following a review of digital transition tools, select a preferred tool for common use
- Develop and agree a transition policy in consultation with adult services
- Establish a common approach for recording the identification and tracking of CYP through the transition and transfer process using CernerEPR (electronic patient record)
- Establish simple data metrics to enable common and consistent reporting
- Complete a skills gap audit in partnership with adult services—identify and deliver training and education priorities in at least two specialties
- Develop best practice transition pathways in at least two specialties

Our quality priority achievements in 2023/24

During 2023/24, the Trust set a range of quality priorities aimed at improving the clinical effectiveness, safety and experience of care received by our patients.

These priorities focused on the following areas:

- **End of life care:** Supporting people in their last months or years of life
- **Effective discharge:** Enabling safe and timely discharge
- **Frailty care:** Improving the identification and care of frail patients
- **Patient Safety Incident Response Framework (PSIRF):** Enhancing patient safety through learning and improvement

Priorities were identified through engagement with multiple stakeholder groups:

- Engagement and feedback from our council of governors and engagement forum which included external stakeholders
- Engagement and feedback from our board's quality committee
- Review of incident reporting and feedback from complaints and claims

We are proud of the progress we have made against our 2023/24 quality priorities. Although not all our ambitions were realised, the Trust has continued to deliver year-on-year improvements to our services, thereby promoting better quality of care. A brief progress update for each quality priority is provided below.

Priority 1: Improving end of life care

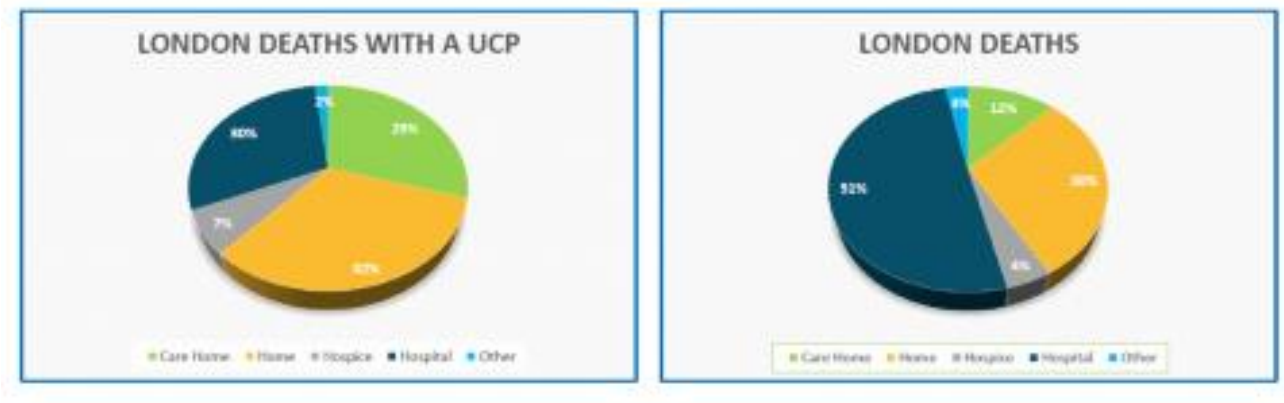
Why we chose this as a quality priority

Nationally, a third of NHS inpatients are within the last 12 months of life. The Trust is committed to ensuring that these patients receive personalised, appropriate care tailored to their needs and the needs of those important to them. The Trust implemented a 2-year quality priority in 2022/23, focusing on the provision of coordinated, individualised care at the end of life, delivered by staff who have received appropriate training and education and in line with the preferences of the patient.

Aim

The introduction of the London Universal Care Plan (UCP) digital system (previously called the London Urgent Care Plan) aims to provide a shared record of patients' care preferences, including decisions around goals and treatment escalation. This system is important because of the association between the presence of a UCP and the place of death, with more patients dying outside of the hospital setting if they had a UCP:

Doing the right thing report on universal care plans

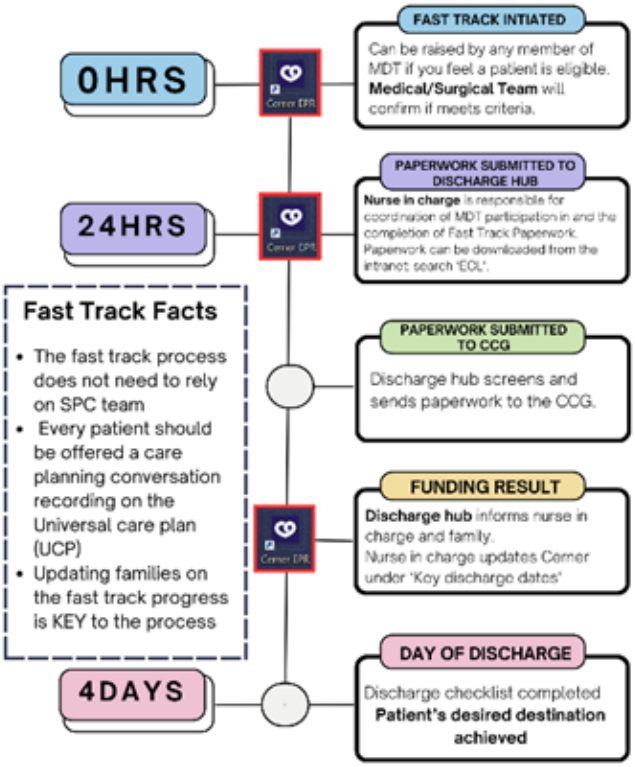


Supporting people's preferences for place of care and death can have significant impacts on our patients and those important to them. For this reason, the Trust has committed to improving the 'fast-track' discharge process. Fast-track is a process to rapidly access NHS funding for care outside of hospital, either at home or in a care home, for patients who are rapidly deteriorating in the context of a life-limiting illness. It is the Trust's ambition to reduce the timeframe of these transfers so that patient preferences can best be met at the end of life.

Progress update

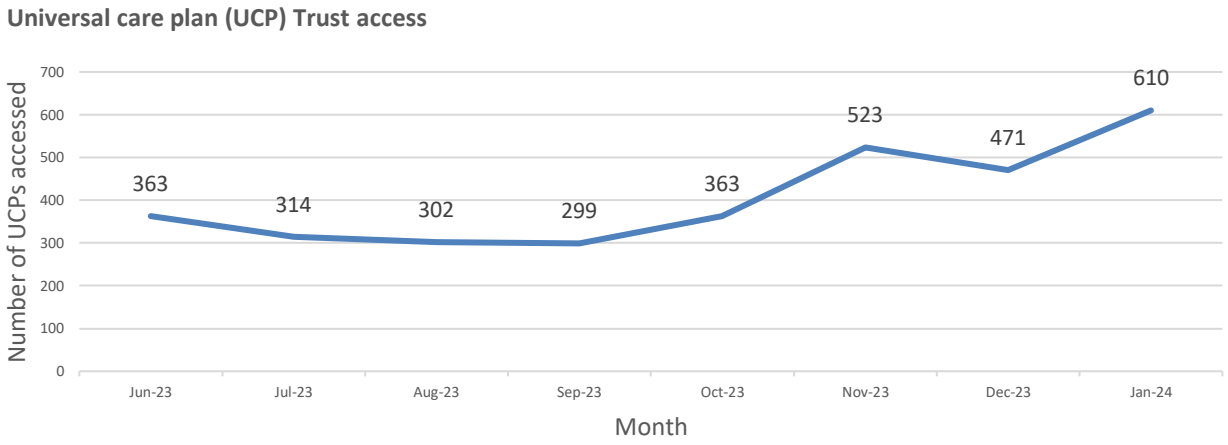
- Increased operational Trustwide visibility owing to CernerEPR reporting of three fast-track key moments under ‘key discharge dates’:
    - fast track—initiated
    - fast track—paperwork submitted
    - fast track—approved
- Further improvement will lead to this being visible on the Timely Care Hub (Trust clinical system which provides an overview of the patient's care and assessments). Meanwhile, an interim solution for reporting has been developed, though it is not visible to all staff.
- Ongoing communications are in place to develop the fast-track paperwork in digital form, increasing the safety and efficiency of completion.
- Significant improvement has been made to the ‘end of life matters’ intranet page, making it a useful signposting tool and supportive to staff, including the most up-to-date fast-track documentation.
- Ongoing training and support for members of the multidisciplinary team highlight the fast-track pathway:

Simplified fast track process map highlighting key moments to update CernerEPR ‘key discharge dates’



- There has been an increase in the use of the universal care plan (UCP) with targeted training and communications. However, we rely on the external company ‘Better’ to provide more granular detail of these metrics, which is currently being addressed by the Trust (see charts on the next page).

UCP access 2023/24 by the Trust provided by external company 'Better'



Metric	Target	Achieved
Fast-track transfers to be delivered in less than 4 days with centralised support for the management of fast-track discharges[4]	>75% (not met)	• Chelsea site at average of <13.5 days • West Mid site at average of 13 days
Patients with a UCP attending A&E are identified	100%	100% (see charts above)

Key challenges

The fast-track discharge process is intricate, involving dynamic challenges that have influenced the execution of the quality priority. Initially, there was no sustainable reporting tool at the onset of the quality priority, leading to reliance on manual data extraction. However, following the implementation of the CernerEPR change, a report now exists for identifying fast-track patients, offering insights into the duration between crucial fast-track milestones.

In-depth examinations of fast-track patients revealed paperwork as a major factor contributing to delays. Continuous education and assistance have been provided to ward teams—however, true improvements have been realised through the introduction of digital paperwork systems.

4 Figures based on Jan 2024 data

Forward plan

A working group comprising key members has been established to sustain the progress of improvement plans. As part of the Trust's quality priorities for 2024/25, end-of-life care will be highlighted whenever relevant connections are identified. End-of-life care will continue to be reported to the following meetings:

- End of life steering group (bi-monthly)
- Clinical effectiveness group (bi-annually)

Priority 2: Supporting effective discharge

Why we chose this as a quality priority

Hospital discharge arrangements impact patient outcomes, experience and the cost of healthcare provision. By integrating discharge processes within digital solutions, the Trust can ensure timely and safe discharges, reduce readmissions and provide patients with the support they need to manage their conditions at home. This approach also supports better information availability and communication between teams, improving the continuity and quality of care.

Aim

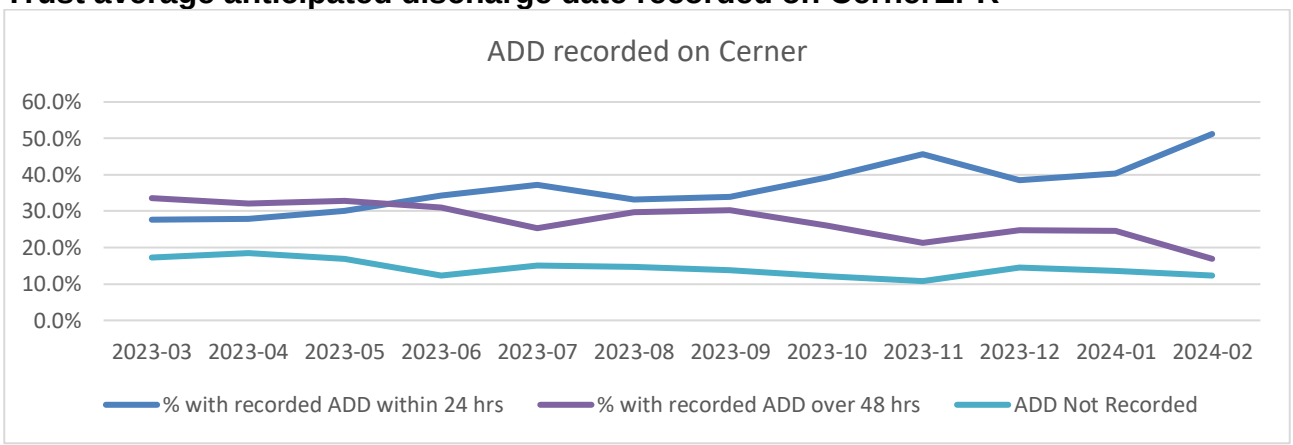
Development of a digital solution designed to support communication between system partners and patients, minimise internal delays and optimise the discharge process.

Progress update

There has been an overall improvement in the number of patients having an anticipated discharge date (ADD) recorded within 24 hours, although the target of 95% has not been achieved. Once the baseline was established (27.8%), the Acute Medical Unit (AMU) and the Acute Assessment Unit (AAU), as admitting areas, were identified as the wards contributing to more than 40% of the total ADDs set. Therefore, these were highlighted as areas of focus for improvement.

The following chart demonstrates a 23.4% increase in the number of ADDs being completed within 24 hours of admission. There has also been a reduction in the number of ADDs recorded over 48 hours (15.1%) and ADDs not recorded (6.1%).

Trust average anticipated discharge date recorded on CernerEPR



Metric	Target	Baseline (Apr 2023)	Achieved
Patients to have an identified anticipated discharge date within 24 hours of admission	95%	27.8%	51.2%
Community/social care referrals (where relevant) completed within 24 hours	75%	17% (started Mar 2024)	17.8%

Key challenges

There have been significant challenges extracting data to report on the early discharge notification (EDN) during the timeline of the quality priority. The chart below shows the breakdown by site.

Community social EDN referrals by site

EDN completed within 24 hours		
	WM	CW
Apr-23	11.1%	22.9%
May-23	17.0%	30.0%
Jun-23	14.6%	14.1%
Jul-23	16.0%	28.6%
Aug-23	11.6%	7.6%
Sep-23	9.9%	15.4%
Oct-23	10.1%	21.1%
Nov-23	8.9%	16.9%
Dec-23	11.4%	15.1%
Jan-24	10.8%	10.5%
Feb-24	10.5%	13.2%
Mar-34	11.2%	27.9%
Apr-24	14.0%	12.5%
May-24	16.2%	19.4%

A discharge dashboard is in the development stages and is expected to be completed during 2024/25, which will enable improved visibility of key discharge metrics.

During the quality priority, staff have become more familiar with the use of recording key discharge moments in CernerEPR due to ongoing training and support, including specific training delivered on each component of the EDN and what constitutes a good referral.

Forward plan

The metrics identified in the quality priority are part of a wider discharge transformation programme which will continue ongoing improvement plans and report to the clinical effectiveness group (quarterly).

Priority 3: Improving frailty care

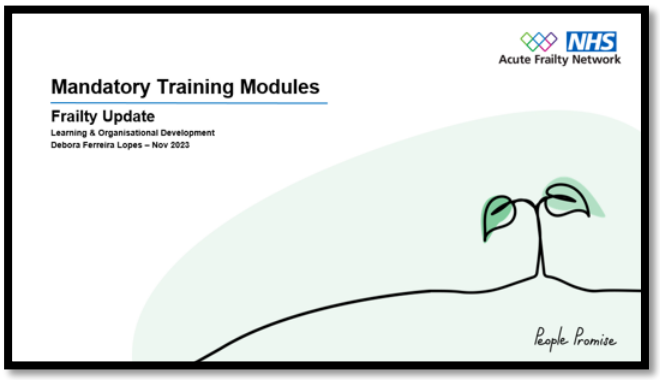
Why we chose this as a quality priority

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

people are at risk of developing frailty. Early recognition and timely intervention can save lives, prevent harm, improve patient experience and reduce unwarranted variation in care. It is, therefore, the Trust's ambition to improve how we recognise frailty, assess patient needs, and intervene to best support patients and reduce risk.

Aim

To improve the identification, management and prevention of frailty through evidence-based interventions, multidisciplinary team reviews and using data-driven approaches at an earlier point within a patient's pathway, and within the emergency care pathway. We aim to complement these goals with a robust assessment of patient experience through our integrated care coordinators working closely with the patient experience team to develop a continuous acute frailty service (AFS) evaluation.



Progress update

The frailty quality priority was able to meet and exceed the 35% national CQUIN (Commissioning for Quality and Innovation) targets for completing a clinical frailty assessment and ensuring appropriate follow-up care was received, reaching 98.7% and 50% on average, respectively.

We deployed a reporting solution through the Trust's digital and business intelligence teams, ensuring a sustainable method of CQUIN reporting for the future:

Monthly frailty metrics

Detailed initiatives	Target	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Patients ≥65 attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment	35%	98.3%	98.0%	97.0%	99.6%	99.2%	97.7%	98.4%	99.8%	99.7%	99.3%	99.7%	99.4%
Patients ≥ 65 attending A&E or same-day emergency care (SDEC) receiving appropriate follow-up	35%	48%	48%	41.1%	48.6%	53.9%	51.4%	49.8%	55.4%	50.4%	64.7%	56.6%	62.2%
Basic frailty training for patient facing staff	95%	Training rolled out Feb 2024—compliance register in development											

Metric	Target
Patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.	35%
Basic frailty training for all patient facing staff (for selected staff group)	95%

We also built and deployed a frailty training programme for the Trust in Feb 2024. While the training is open to all clinical staff, in the initial phase, we prioritised three tiers of the front door workforce (e.g. A&E/SDEC/Acute Assessment Unit) and aim to collect monthly compliance lists in the new financial year.

Key challenges

Despite the overall success of the quality priority, the team encountered some key challenges, including:

- Identifying the comprehensive geriatric assessment (CGA) exact criteria with North West London leads for appropriate follow-up involved numerous discussions with service directors and consultants to ensure the criteria were fair and applicable to all clinical scenarios.

- To accurately report the clinical frailty score (CFS) and CGA compliance rate without manually reviewing the data, the business intelligence team was asked to support the automation of the data request and analysis. Despite challenges in operationalising some of the CernerEPR data, this was used in subsequent months to provide clear data to all board meetings.

Forward plan

Identified as a priority for 2024/25.

Priority 4: Patient Safety Incident Response Framework (PSIRF)

Why we chose this as a quality priority

The Patient Safety Incident Response Framework (PSIRF) is an innovative national approach to developing and maintaining effective systems and processes for responding to patient safety incidents. It is a core element of the NHS patient safety strategy. The framework enhances the Trust's approach to safety learning and supports strategic, preventative, collaborative, fair, just, credible and people-focused investigations.

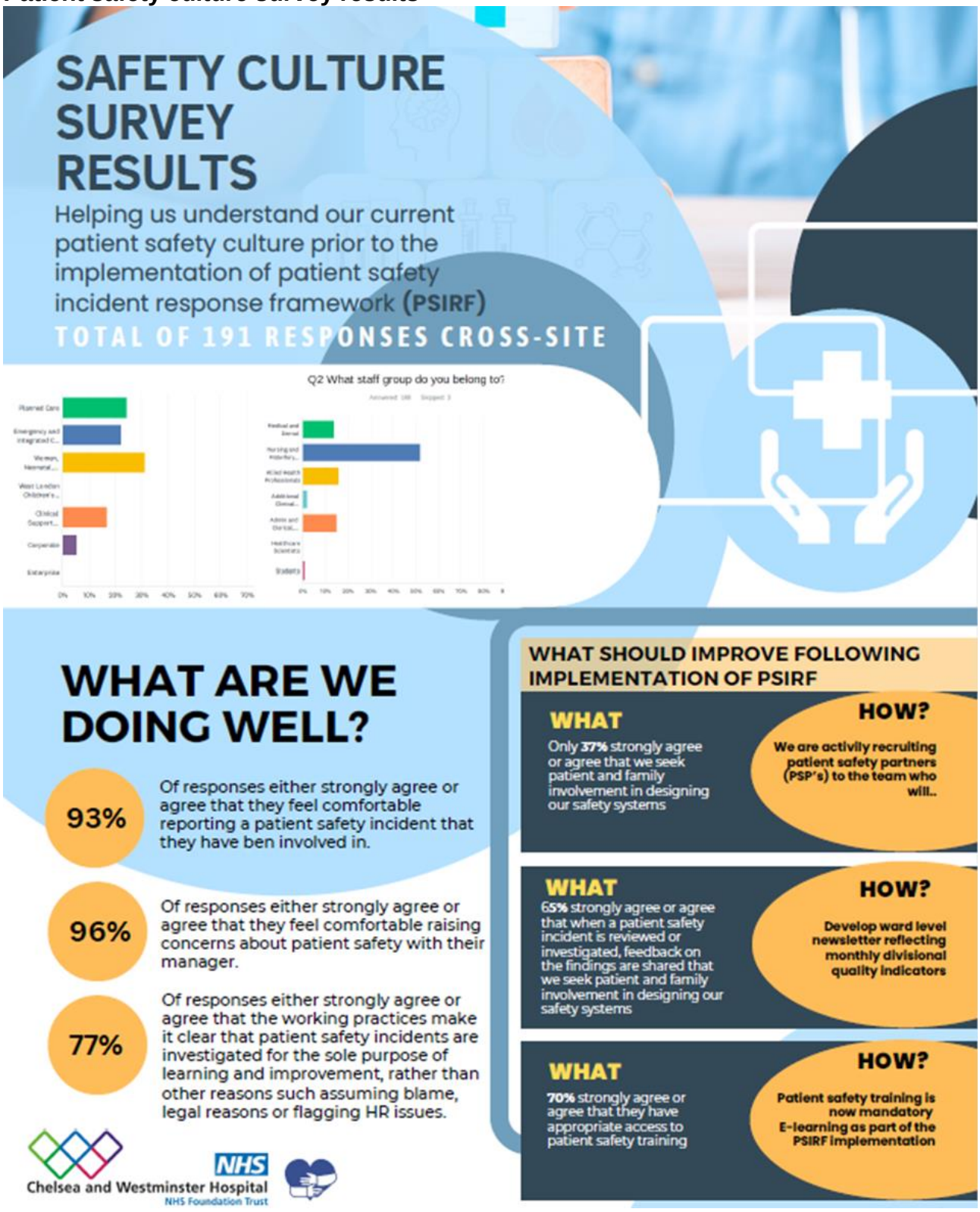
The changes required to implement PSIRF will be coordinated across the Acute Provider Collaborative to enhance sector consistency. To assess the organisation's appetite for PSIRF, a staff survey was conducted during Q2 of 2023/24 to better understand our safety culture.

Aim

To empower and enable our staff to respond to patient safety events through the implementation of the Patient Safety Incident Response Framework in collaboration with the North West London Acute Provider Collaborative.

The Trust launched its PSIRF implementation plan at the end of the 2023/24 financial year and has gained a better understanding of the safety culture of the organisation and areas for improvement.

Patient safety culture survey results



Update

Progress has been made with the rollout of PSIRF, including:

- ICB approved PSIRF policy and plan published on the Trust's external website
- 80 staff members attended the 2-day accredited training
- Patient safety levels 1 and 2 training launched mid-Jun 2023, however, Trust communications were not released until late Aug 2023—there has been a steady increase with targeted communications to divisions
- Recruitment of patient safety partners (PSPs)
- Adaptation of governance report templates to include PSIRF methodology

Metric	Target	Performance[5]
Staff to receive level 1 (essentials for patient safety) training	90%	40%
Staff at band 6 and above and our medical professionals to receive level 2 (access to practice patient safety) training	90%	30%

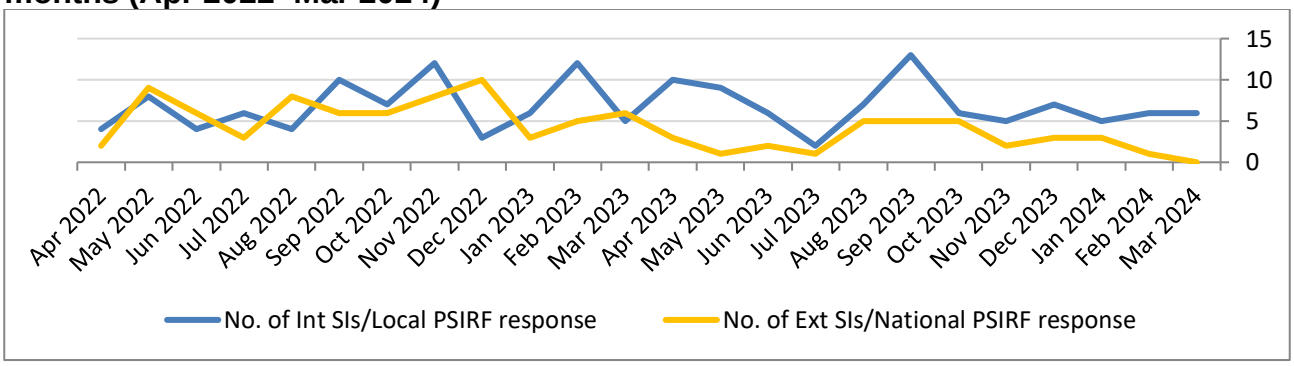
Key challenges

Patient safety level 1 and 2 e-learning was initially hosted on the eLearning for Health (eLfH) platform, which decreased visibility and ease of access. However, this has improved since the eLearning was moved to Chelwest Learning, the Trust's main eLearning platform, in Mar 2024. Prior to this change, our compliance rate was at 20% and has seen a marked improvement in the last month of the financial year.

Running a hybrid system of both the serious incident framework (as we phased it out) and PSIRF created an increased workload on all divisions who were tasked with testing new methodology while also completing existing open serious incidents.

There was a significant increase in the number of responses during the transition period, but this has resolved with the complete phasing out of the old framework and full rollout of PSIRF during the last quarter of 2023/24.

Comparison between external and internal serious incidents (SIs)/patient safety incident investigations (PSIIs)/safety responses declared/commenced in last 24 months (Apr 2022–Mar 2024)



Forward plan

Identified as a priority for 2024/25.

[5] Data taken from QlikView as at 3 Apr 2024

PART 2.2

STATEMENTS OF ASSURANCE FROM THE BOARD OF DIRECTORS

This section includes mandatory statements about the quality of services that we provide, relating to financial year 2023/24. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. The statements are designed to provide assurance that the board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

Review of services

During 2023/24, Chelsea and Westminster Hospital NHS Foundation Trust provided and/or subcontracted 80 relevant health services.

The Trust has reviewed all the data available on the quality of care in these NHS services through our performance management framework and assurance processes.

The income generated by the relevant health services reviewed in 2023/24 represents 100% of the total income generated from the provision of relevant health services by the Trust for the year.

Participation in clinical audits and national confidential enquiries

Clinical audits drive improvement through a cycle of service review against recognised standards. We use audits to benchmark our care against local and national guidelines, allowing us to allocate resources to areas requiring improvement and to ensure the best treatment and care for our patients. National confidential enquiries investigate an area of healthcare and recommend ways to improve.

During 2023/24, 53 national clinical audits and 6 national confidential enquiries covered health services provided by the Trust. During that period, we participated in 90.5% of the national clinical audits and 100% of the national confidential enquiries applicable to the Trust. The national clinical audits and national confidential enquiries the Trust was eligible to participate in during 2023/24 are listed within Annex 1 on page 80.

National clinical audit

Outcome reports from 34 national clinical audits were reviewed by the Trust during 2023/24. Annex 2 on page 84 provides a summary of some of the actions the Trust intends to take to improve quality, safety and clinical effectiveness arising from participation in national clinical audit—this is not intended to be a comprehensive reflection of the action plans. Actions are ongoing and are monitored via divisional quality boards and the clinical effectiveness group (CEG).

Local clinical audit

The reports of 218 local clinical audits were registered by the Trust via the clinical governance team during 2023/24 as per the table below:

Division	Cross-site	CW	WM	Total
Clinical Support	9	14	4	27
Emergency and Integrated Care	14	18	13	45
Planned Care	15	45	25	85
Specialist Care and West London Children's Healthcare	17	30	14	61
Enterprise	0	0	0	0
Total	**55**	**107**	**56**	**218**

150 local audits were reviewed (logged as complete with the clinical governance team) during 2023/24. They have been presented at various forums including divisional boards, directorate meetings, patient safety group, clinical effectiveness group and clinical governance half days to discuss key findings, recommendations, and action plans to support improvements. Below are examples of local clinical audit projects undertaken across the organisation, demonstrating actions to improve the safety and effectiveness of our services:

Local clinical audit (title/objectives)	Summary/agreed actions from local clinical audits
Pain management protocol—adherence to clinical guidelines **Standards** **Target:** Zero cases of delayed discharge due to bowel non-functioning post-surgery. **Action:** All patients must have at least one regular stimulant laxative prescribed to prevent constipation: • Recommended laxative: a stimulant laxative such as Senna, as per NICE guidelines in Jan 2023. • At the time of first prescription (not only after constipation is established)	**Current practice:** • 38% of inpatients receive regular stimulant laxatives in concurrence with opioid analgesia. • Improvement target: Achieve 100% prescription of regular stimulant laxatives for all patients on opiate analgesia. **Solution:** • Provide better education to healthcare providers on the importance of laxative prescribing and post-operative constipation management. • CernerEPR careset to remind and streamline adherence. • Risk: Failure to address iatrogenic constipation may lead to complications such as delirium/delayed discharge. **Actions identified:** • Teaching session at divisional forums. • Re-audit the cycle to assess intervention efficacy. • Consider CernerEPR prompt to include a stimulant laxative with opioid prescriptions.
Audit of regional chest wall blocks for patients with rib fractures at West Middlesex University Hospital **Standards** As per rib fracture pathway, eligible patients should be assessed for a block within 24 hours of referral and if a catheter is placed, this should be topped up with local anaesthetic every 12 hours while the block is still providing safe and effective analgesia.	**Audit results:** • 57% of patients are being assessed for a block within 24 hours of admission and referral. This likely represents the workload of emergency theatres, where these blocks are currently being performed. However, the majority (81%) were seen/block performed within 48 hours. • Block top-ups were generally timely, with 78% occurring 12–14 hours post last top-up. Documentation was, however, varied, making handover potentially difficult and could compromise safety (if not clearly documented and consistently, risk of early top-up or top-up being missed). **Areas for improvement:** • Variability in documentation of the procedure: Some in the anaesthetic chart. Not always recorded in block book (especially single shot). • Pain scores often documented before, but not after block—so difficult to assess how effective the top-ups were from the notes. **Actions identified:** • Collaboration with the anaesthetic team in theatre 5 so if capacity is limited but there is space to perform chest wall blocks in other theatres this occurs to reduce patients waiting >24 hours. • Consistent documentation of blocks (separate CernerEPR note entry), and top-ups (entry in notes and record in block book to facilitate safe handover).

Local clinical audit (title/objectives)	Summary/agreed actions from local clinical audits
End-of-life care on ITU (Intensive Treatment Unit): Evaluating end-of-life care and treatment escalation planning on the adult intensive care **Standards** • Faculty of Intensive Care Medicine 'Care at the End of Life' • Chelsea and Westminster treatment escalation planning (TEP) guidelines	**Conclusions—treatment escalation planning (TEP) discussions:** • TEP forms were completed promptly for all patients admitted to ITU. • Patients are more likely to have a TEP form prior to ITU admission if medical admission compared to surgical. • Not for cardiopulmonary resuscitation (CPR) decisions were always discussed with patients and/or family members appropriately. • TEP forms for full escalation are less often discussed, though guidance on correct procedure for this is unclear. **Conclusions—end of life (EOL) care:** • Communication with families was always conducted and clearly documented when patients were nearing the end of life. • Appropriate TEP and anticipatory medications in place at EOL. • A smaller proportion of patients were discussed with palliative care, referred for spiritual support, and had an end-of-life form completed. **Actions identified:** • Further education of medical/surgical teams • Trustwide data to be presented at the surgical governance meeting • Clarification of the correct process for CPR decisions • Review ITU use of the end-of-life form
The effect of anterior colporrhaphy on female urinary continence **Standards** • Urinary incontinence and pelvic organ prolapse in women: management, NICE guideline [NG123], 2019 • Glazener CMA, Cooper K, Mashayekhi A, Anterior vaginal repair for urinary incontinence in women, Cochrane Database of Systematic Reviews 2017, Issue 7, art n°: CD001755, DOI: 10.1002/14651858.CD001755.pub2	**Observations including any risks identified:** • Anterior colporrhaphy resulted in a 6-fold reduction in women with stress urinary incontinence. • Cure rate (85%) was within the range observed in the literature (43–91%) **Actions identified:** • Longer-term follow-up of patients to assess the recurrence of stress urinary incontinence symptoms. • Re-audit of data in 12 months. • Use of ICIQ-UI (International Consultation on Incontinence Questionnaire-Urinary Incontinence) pre and post-op and record results on the British Society of Urogynaecology (BSUG) database.
Prevalence of NAFLD and other liver diseases among patients living with HIV infection in Kobler Clinic of Chelsea and Westminster Hospital **Background** The prevalence of non-alcoholic fatty liver disease (NAFLD) is notably higher (>40%) in people living with HIV (PLWH). We aimed to evaluate the prevalence of NAFLD in our population through FibroScan screening and identify risk factors associated with high Controlled Attenuation Parameter (CAP).	**Observations including any risks identified:** • FibroScan screening in PLWH with risk factors for NAFLD may help to detect early diagnoses. In our study, BMI ≥25 emerged as a relevant criterion, leading to a non-negligible reduction of missed NAFLD diagnoses in people without known risk factors. **Action identified:** • Evaluate if capacity is present to continue FibroScan patients and review benefits

Local clinical audit (title/objectives)	Summary/agreed actions from local clinical audits
Compliance with West Mid dermatology unit LocSSIP (local safety standards in invasive procedures) checklist **Aim/objectives** • Assess compliance with the LocSSIP checklist in the minor operation theatre and identify any gaps or deficiencies in the implementation of the checklist. • Provide recommendations for improvement based on the findings, aimed at enhancing compliance with the checklist and ultimately improving patient safety during minor operations.	Data collected revealed good compliance overall; however, gaps in completion were noted, particularly in the sections concerning the referring dermatologist and the patient performance status. **Actions identified:** • Training and awareness: Provide training sessions for staff members on the importance of completing all sections of the LocSSIP, emphasising the significance of sections with noted gaps. • Re-audit: Monitor compliance and reinforce checklist completion standards, ensuring that team members complete and verify the checklist.
An audit of time allocation for dental treatment with special needs under general anaesthesia (GA) in theatre 5 **Background** The paediatric dental department is one of the few units in London specialising in delivering full mouth rehabilitation for children with special needs. The department follows a set of criteria to allot time slots for patients with special needs: single slot (45 minutes for straightforward treatments), double slot (90 minutes for children on the autism spectrum, challenging behaviour requiring pre-medications, or medically compromised patients), and triple slot (135 minutes for RCT and long procedures).	**Observations including any risks identified:** • 33% of the cases were running late, the majority of which were allotted single slots and were fit and well. • 61% (20 cases) were fit and well—24% (8 cases) of those cases running late were additional special needs cases. • The average delay for cases running late was 14 minutes for single slots and 12 minutes for double slots. • The average time taken for dental treatment was 31 minutes for single slots and 36 minutes for double slots. **Action identified:** • Discuss slot allocation with the dental team and anaesthetists • RCT (root canal treatment)
Refusal for multiple extractions under general anaesthetic at new patient consultation	**Actions identified:** • Contact referrers and ask them to inform parents/guardians that we follow the UK National Guidelines when treatment planning for GA before they refer them to us. • Ensure referrers only refer parents/guardians willing to accept multiple extractions and emphasize that any pulpally-involved carious teeth (whether symptomatic or asymptomatic) will need to be extracted. • Re-audit after this has been implemented to check if this has impacted the number of refusals for multiple extractions under GA at new patient consultations.
Traumatic ankle pain—adequacy of clinical information with reference to the Ottawa ankle rules **Aim** • Evaluate the adequacy of clinical information provided and compliance by clinicians with reference to the Ottawa Ankle rules in both documentation and imaging requests. • The audit was guided by relevant improvement cycle tools.	**Observations including any risks identified:** Adequate documentation of examination findings is essential to justify imaging requests and justify ionising radiation with consideration to IRMER (Ionising Radiation Medical Exposure Regulations) guidelines. **Actions identified:** • Visual poster creation and placement across West Mid Emergency Department. • Delivery of an educational presentation illustrating the importance of clinical documentation to specific guidelines. • Inclusion of the documentation guidelines in the Emergency Department junior doctor handover.

Local clinical audit (title/objectives)	Summary/agreed actions from local clinical audits
Traumatic knee pain—adequacy of clinical information with reference to the Ottawa knee rules **Aim** • Evaluate the adequacy of clinical information provided and compliance by clinicians with reference to the Ottawa Knee rules in both documentation and imaging requests. • The audit was guided by relevant improvement cycle tools.	**Observations including any risks identified:** Adequate documentation of examination findings is essential to justify imaging requests and justify ionising radiation with consideration to IRMER (Ionising Radiation Medical Exposure Regulations) guidelines. **Actions identified:** • Visual poster creation and placement across WM Emergency Department. • Delivery of an educational presentation illustrating the importance of clinical documentation to specific guidelines. • Inclusion of the documentation guidelines in the Emergency Department junior doctor handover.
Minimising time from presentation to antibiotic administration in suspected neutropaenic sepsis in ED (Emergency Department) **Aim** Evaluate compliance with national/Trust standards for timely and appropriate administration of antibiotics for patients with suspected neutropaenic sepsis.	**Observations including any risks identified:** Long waits (3 hours +) for antibiotics were due to: • Diagnosis of other conditions (chemo-induced nausea and vomiting/colitis) revised when blood results showed neutropaenia. • Long wait to see a doctor. • Times antibiotics were given were taken as the time they were signed off on the drug chart, not necessarily the time they were administered. • Small sample size, incomplete data set. **Actions identified:** • Triage nurses to alert the ED registrar in charge whenever they have a patient receiving SACT (Systematic Anti-Cancer Therapy) who has any infective symptoms. • Doctors attending to patients receiving SACT to take a thorough history and specifically rule out infective symptoms. • Doctors attending to patients receiving SACT who have a recent history of infective symptoms to prescribe Tazocin and Amikacin immediately (meropenem in case of penicillin allergy, or urgently discuss with microbiology if there is a history of anaphylaxis to penicillin). • Nurses attending to patients receiving SACT who have a recent history of infective symptoms to administer antibiotics as soon as possible after they are prescribed and sign for them immediately afterwards.
Bedside visual assessment in falls admissions in over 65s **Aim** Assess the levels of visual assessment carried out at the time of medical clerking. Our goal is to achieve a gross visual assessment in all over-65s coming in with a fall.	**Observations including any risks identified:** Non-compliance likely related to time pressures, limitations to assessment and availability of equipment (e.g. Snellen chart, fundoscope). **Actions identified:** • Poster to be put up in clinical areas • Making vision public • Teaching for trainees • Refresher teaching • Re-audit findings

Local clinical audit (title/objectives)	Summary/agreed actions from local clinical audits
Perioperative prescribing of SGLT2i (Sodium-glucose co-transporter-2 inhibitors) at both sites **Aim** • Evaluate pre-operative omission practices of SGLT2i in patients living with type 2 diabetes undergoing surgery—what percentage of patients are holding the SGLT2i/advised to omit? • Evaluate post-operative ketone monitoring practices—what percentage of patients have post-operative ketones checked? • Identify the incidence of eDKA (the adverse outcomes we aim to prevent).	**Observations including any risks identified:** • Elective: Preoperative assessment documentation. SGLT2i omission advice—30% compliance. • Emergency: Preoperative omission on prescription chart. 68% compliance pre-op D1, 76% compliance operative day. • Elective and emergency: Post-operative ketone measurement, prior to SGLT2i re-commencement—18% compliance. • Elective and emergency: Evidence of 'usual' oral intake in medical and nursing notes—90% compliance. **Actions identified:** • Revised perioperative guidelines to explicitly mention ketone monitoring. • Improve pre-assessment documentation. • Posters in clinical areas (ED and wards) to improve clinical team SGLT2i prescribing knowledge. • On-board pharmacy to guideline to help oversee ketone monitoring. • Re-audit.
X-Ray requests for naso-gastric (NG) tube fed patients with pH 5.5	**Actions identified:** • Further training for nurses regarding documentation of pH aspirate value. • Education around guideline recommendation for pH checking. • Doctors to consider changing the routine timing of imaging to 12 noon or 2pm.
Patients having food record charts (FRCs) and anthropometry if malnutrition universal screening tool (MUST) score ≥1	**Actions identified:** • Enhance the completion of MUST training from Chelwest Learning. • For all patients scoring MUST >1 and above, keep daily food record charts including the amount consumed.

Commissioning for quality and innovation (CQUIN) schemes

The Commissioning for Quality and Innovation (CQUIN) framework allows commissioners to agree annual payments to hospitals based on the number of schemes implemented. This scheme was re-introduced in 2022/23—however, the Trust's income was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework because the scheme was suspended nationally.

During 2023/24, there were 17 national CQUIN indicators, of which the following 8 were relevant to the Trust:

- Flu vaccinations for frontline healthcare workers
- Supporting patients to drink, eat, and mobilise (DrEaM) after surgery
- Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria
- Compliance with timed diagnostic pathways for cancer services

- Identification and response to frailty in emergency departments
- Timely communication of changes to medicines to community pharmacists via the discharge medicines service
- Recording of and response to NEWS2 (National Early Warning Score 2) for unplanned critical care admissions
- Assessment and documentation of pressure ulcer risk

Of these 8, the following 5 schemes have been identified as financially linked CQUINs for the Trust:

- Staff flu vaccination
- Supporting patients to drink, eat, and mobilise after surgery
- Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria
- Recording of and appropriate response to NEWS2 for unplanned critical care admissions
- Identification and response to frailty in emergency departments

Each scheme is structured around indicators and milestones designed to drive improvement—directly or indirectly—in aspects of patient safety, patient experience and clinical effectiveness. A proportion of clinical services income within each contract is linked to these schemes and actual payments are made based on how well the schemes are delivered according to an assessment by the commissioner of evidence submitted by the Trust.

Delivery of our improvement goals associated with CQUINs is monitored by the Trust board on a quarterly basis as per the table below.

CQUIN	Target	Q1	Q2	Q3	Q4
CQUIN 01: Staff flu vaccination Staff flu vaccinations are critical in reducing the spread of flu during winter months, protecting those in clinical risk groups, reducing the risk of contracting both flu and COVID-19 simultaneously, reducing staff absence, and ensuring the overall safe running of NHS services.	75%	n/a	20%	21%	34%
CQUIN 02: Supporting patients to drink, eat and mobilise after surgery Ensuring that patients drink, eat and mobilise ('DrEaM') as soon as possible after surgery is an element of the NHS's enhanced recovery programme that helps to prevent post-operative blood clots and respiratory complications and should result in an average 37.5% reduction in length of stay for patients who 'DrEaM' in the first 24 hours after surgery.	80%	99%	100%	99%	99.5%

CQUIN	Target	Q1	Q2	Q3	Q4
CQUIN 03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria There are significant benefits to IVOS (intravenous oral switch) interventions demonstrated in research literature, including increasing hospital bed capacity to support recovery from the COVID-19 pandemic, reducing exposure to broad-spectrum antibiotics, increasing nursing workforce capacity, reducing drug expenditure, reducing the carbon footprint of medicines, and reducing healthcare-associated bloodstream infections.	≤40%	13%	9%	13%	8%
CQUIN 04: Compliance with timed diagnostic pathways for cancer services Faster diagnosis is proven to improve clinical outcomes: patients are more likely to receive successful treatment when diagnosed earlier. This indicator sets out key elements of the timed pathways for colorectal, lung, oesophago-gastric, prostate, head and neck, and gynaecological cancers, which have been identified by a clinical expert group as crucial to achieving faster diagnosis targets.	55%	26%	15%	In all cases the required diagnostic tests and actions are being completed, but not within the required specific timeframes outlined within the CQUIN, which is why it is presenting as non-compliant.	
CQUIN 05: Identification and response to frailty in emergency departments There are well-evidenced links between frailty and adverse health outcomes, including deconditioning, malnutrition and irreversible cognitive decline, which may all lead to increased health and care requirements. Early identification of frailty can mitigate some of these risks. Under the NHS Long Term Plan, every acute hospital with a Type 1 Emergency Department (ED) has to provide acute frailty services for at least 70 hours a week. Patients with grades of frailty (British Geriatric Society clinical frailty scale (CFS) 6 or above should be assessed for frailty-associated syndromes via a comprehensive geriatric assessment and/or be referred to the acute frailty service.	30%	49%	47%	52%	62%

CQUIN	Target	Q1	Q2	Q3	Q4
CQUIN 06: Timely communication of changes to medicines to community pharmacists via the discharge medicines service (DMS) NICE NG5 recommends that medicines-related communication systems should be in place when patients move from one care setting to another and the act of reconciling medicines should happen within one week of the patient being discharged. This indicator directly incentivises acute trusts to make a referral into the NHS DMS, compliant with the minimum quality requirements described in the NHS DMS toolkit. Patients who are supported by this service are less likely to be readmitted (5.8% vs 16% at 30 days) and spend fewer days in hospital (7.2 days on average compared to 13.1 for patients who did not have access to the service) where they are readmitted.	1.5%	This CQUIN is reported at the end of the financial year NHS futures data to Jan 2024: 1.06% PharmOutcomes data to Jan 2024: 2.79%[6]			
CQUIN 07: Recording of and appropriate response to NEWS2 score for unplanned critical care admissions The NEWS2 protocol is the RCP and NHS-endorsed best practice for spotting the signs of deterioration and ensuring a timely response, the importance of which has been emphasised during the pandemic. This measure incentivises adherence to evidence-based steps in the identification, recording, and timely response to deterioration, which will reduce the rate of preventable deaths and ICU admissions in England.	30%	93%	89%	84%	93%
CQUIN 12: Assessment and documentation of pressure ulcer risk NICE clinical guideline CG179 sets out clear best practices for assessing the risk of pressure ulcer development and acting upon any risks identified. It is fully aligned with the recently republished NPIAP (national pressure injury advisory panel) international clinical practice guidelines. This indicator has been expanded to include inpatients in acute settings as well as community hospitals. This is expected to contribute to reducing the number of pressure ulcers nationally, improving standards of care for patients in both settings.	85%	26%	34%	38%	36%

For the new financial year 2024/25, it has been announced that traditionally established CQUINs will be paused. This will allow the Trust to focus more on established quality priorities.

[6] There are known quality issues with the data reported on NHS Futures, hence we compare with local data from PharmOutcomes—this has only been published up to Jan 2024

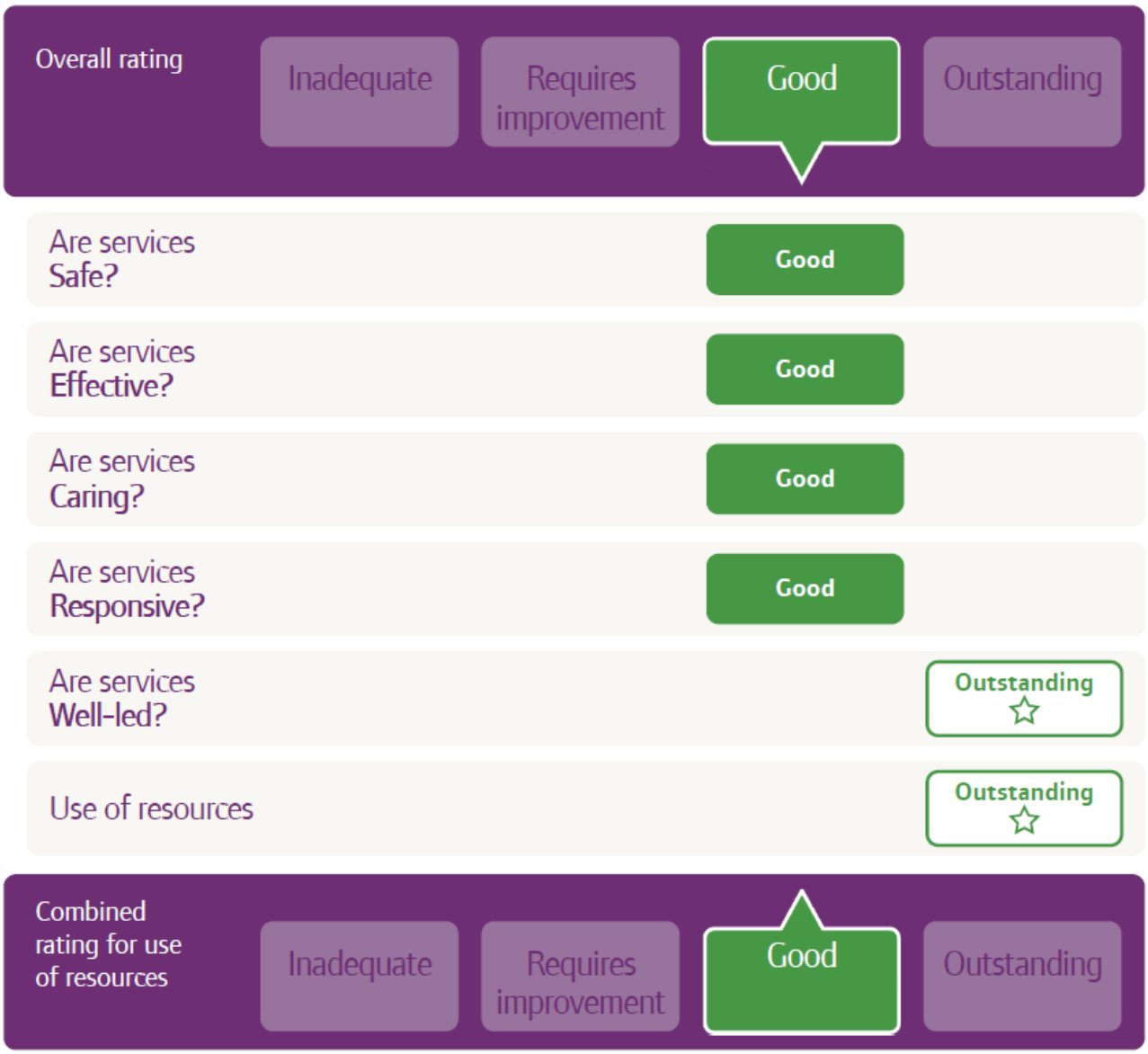
Registration with the Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care in England. They register and licence providers of care services if they meet essential standards of quality and safety. They monitor licenced organisations regularly to ensure continued compliance with these standards.

The Trust is required to register with the CQC, and its current registration status is 'fully registered' with 'no conditions' on registration. The CQC has not taken enforcement action against the Trust during 2023/24.

Trust overall CQC rating

The Trust's overall CQC rating is 'good'. The Trust's well-led rating and use of resources rating remain 'outstanding'.



CQC rating split by hospital, core service and CQC domain

Rating for Chelsea and Westminster Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Outstanding ☆	Good	Good	Good
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Maternity	Requires Improvement	Good	Good	Outstanding ☆	Good	Good
Services for children and young people	Good	Good	Outstanding ☆	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Requires Improvement	Good
HIV and Sexual Health Services	Good	Not rated	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Overall	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆

Chelsea and Westminster Hospital remains rated as 'outstanding' overall, with critical care and HIV and sexual health services both rated as 'outstanding'.

Maternity services were inspected in Feb 2023, and the report published in May 2023, for the 'safe' and 'well-led' key questions. Maternity services at Chelsea and Westminster Hospital remained 'requires improvement' for 'safe' and 'good' for 'well-led'.

Rating for West Middlesex University Hospital

West Middlesex University Hospital remains rated as 'good' overall.

Maternity services were inspected in Feb 2023, and the report published in May 2023, for the 'safe' and 'well-led' key questions. Maternity services at West Middlesex University Hospital remained 'good' for 'safe' and 'outstanding' for 'well-led', retaining its overall 'outstanding' rating.

Secondary uses service (SUS) information

The Trust submitted records during 2023/24 to the SUS for inclusion in the hospital episode statistics included in the latest published data. Best/worst figures were unavailable for NHS number completeness and General Medical Council (GMC) practice code completeness.

Data security and protection toolkit

Information governance covers the way organisations process or handle information related to patients, staff and corporate data, ensuring it is handled appropriately and securely, with an emphasis on managing personal data within data protection legislation.

The data security and protection toolkit (DSPT) is an online self-assessment tool that all organisations with access to NHS patient data and systems must use to provide assurance of good data security practices. The DSPT is audited pre-submission by our internal auditors.

For 2022/23, the Trust achieved 'standards met,' and the organisation believes it will again achieve this standard for 2023/24. See www.dsptoolkit.nhs.uk for more information.

ODS	Organisation name	Status	Published
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	22/23 Standards Met	29/06/2023

Clinical coding error rate

The Trust was not subject to the payment by results clinical coding audit during 2023/24 by the Audit Commission.

Data quality

The Trust is taking the following actions to improve data quality:

- **Validation of referral to treatment (RTT) data:** The Trust utilises a standard operating procedure for the validation of referral to treatment data. Findings are shared with service managers and divisional leads to ensure robust actions are taken in response to learning.

- **Information governance steering group (IGSG):** The information and data quality policy has been updated with the next review date of Mar 2025. This has been shared with the IGSG via the DGSG (data quality steering group) to ensure oversight and assurance.

- **Data quality (DQ) monitoring:** Several dashboards have been built on the Qlik Sense app to monitor data quality from CernerEPR systems concerning agreed DQ measures. The Foundry tool is also used to manage data quality on inpatient/outpatient waiting lists. Outputs are shared and monitored by the data quality steering group, at weekly elective access meetings and, where applicable, the clinical and operational innovation steering group.

Learning from deaths

During 2023/24, 1,400 adult and child deaths occurred within the Trust's hospital sites. This comprised the following number of deaths which occurred in each quarter of that reporting period—331 in Q1, 317 in Q2, 388 in Q3, and 364 in Q4.

By 2 May 2024, 1,279 cases had been screened for potential learning and 570 full case record reviews had been undertaken by consultants. This represents case screening/ review of 91% of total deaths.

The impact of problems in care provision is graded using the classification system initially developed within the confidential enquiry into stillbirth and deaths in infancy (CESDI). CESDI outcome grading system:

- **Grade 0:** Unavoidable death, no suboptimal care
- **Grade 1:** Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome
- **Grade 2:** Suboptimal care, but different care might have affected the outcome (possibly avoidable death)
- **Grade 3:** Suboptimal care, different care would reasonably be expected to have affected the outcome (probable avoidable death)

Where case record reviews or investigations identified potential areas for improvement, individual action plans are developed to support and monitor change delivery. Learning from case record reviews is scrutinised at the organisation's mortality surveillance group (MSG) and also cascaded to divisional and specialty mortality and morbidity groups.

During the reporting period, there were 6 cases identified where suboptimal care more likely than not affected the outcome for the patient. All 6 cases had a safety learning response in addition to the mortality review, and the CESDI 3 case was investigated as a serious incident with an associated safety improvement action plan being undertaken and completed by the relevant division.

Confirmed CESDI grade[7]	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2023	Feb 2023	Mar 2023	Total
Grade 0	42	40	33	33	39	27	44	50	41	34	18	23	424
Grade 1	8	3	7	5	9	15	6	9	7	2	5	-	76
Grade 2	2	1	-	-	1	-	-	-	-	1	-	-	5
Grade 3	1	-	-	-	-	-	-	-	-	-	-	-	1
Total	**53**	**44**	**40**	**38**	**49**	**42**	**50**	**59**	**48**	**37**	**23**	**23**	**506**

Excellent clinical care is provided to the majority of patients who die at the Trust. However, areas for improvement are identified via the case record review process. Key themes for improvement identified via this route include:

- The process for handover between clinical teams
- Communication and coordination between clinical teams
- Quality of clinical record-keeping
- Establishment of, and ongoing communication with, patients and their families regarding ceilings of care and escalation planning
- Demand and staffing resource

The Trust uses the summary hospital-level mortality indicator (SHMI) to monitor the relative risk of mortality. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on the characteristics of the patient. The metric is calculated by NHS England using information submitted by all acute providers.

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

[7] Closed cases: 506/570

Reporting against core indicators

The following data outlines the Trust's performance on a selected core set of indicators. Comparative data shown is sourced from the former Health and Social Care Information Centre (HSCIC), now NHS Digital, where available.

Where the data is not available from NHS Digital, other sources have been used as indicated. Data which has not been published is indicated as 'data not published' (dnp).

Core indicators

Summary hospital-level mortality indicator (SHMI)

	2019/20	2020/21	2021/22	2022/23	2023/24[8]
Summary hospital level mortality indicator (SHMI)	0.77	0.75	0.72	0.71	0.72
National Performance: Highest	1.19	1.20	1.22	1.22	1.25
National Performance: Lowest	0.68	0.69	0.72	0.71	0.72
National Performance: Mean	1	1	1	1	1

Data source: digital.nhs.uk/data-and-information/publications/statistical/shmi

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

- The Trust maintains excellent performance in terms of the relative risk of mortality and has seen sustained improvement in this national indicator since Mar 2017
- The Trust submits data as part of the Secondary Uses Statistics (SUS) return that is then used by NHS Digital to compile the national SHMI

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

- Maintaining the mortality surveillance and assurance provided by scrutinising and analysing information from mortality reviews, serious incidents, external datasets and triggers/indicators associated with the SHMI
- Promoting further clinical engagement and use of the organisation's safety learning systems, which provide a platform for recording and analysing consultant-led reviews
- Undertaking patient-level clinical and coding reviews of any specialties or conditions which show as mortality outliers when compared with national data

[8] The reporting period for 2023/24 is Jan–Dec 2023

Percent of patient deaths with palliative care coding

	2019/20	2020/21	2021/22	2022/23	2023/24[9]
Percentage of patient deaths with palliative care coded	54%	55%	47%	48%	54%
National performance: Lowest	9%	8%	11%	13%	16%
National performance: Highest	58%	63%	64%	66%	67%
National performance: Mean	36%	36%	40%	40%	42%

Data source: digital.nhs.uk/data-and-information/publications/statistical/shmi

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

- The National Audit of Care at the End of Life (2022/23) identified that 89% of case notes audited recorded an individualised care plan
- The specialist palliative care team supports 65% of the total deaths that occur annually in the Trust
- Progress with last year's quality priority is demonstrated by improved access to the universal care plan (UCP) via CernerEPR, the UCP education and training provided to staff, the redesign of the fast-track discharge process, and the breadth of training delivered around the new process

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

- Participating in the national audit of care at the end of life (NACEL) and using findings from the 2023 audit to triangulate and monitor this metric
- Our ambition to deliver more integrated, person-centred care to patients in their last months of life
- Continuing the butterfly volunteering programme to provide companionship to patients in the last days of life and those important to them, with evaluation demonstrating the positive impact of the service
- Improving communication with families to ensure their understanding of the UCP and to manage family expectations

Patient reported outcome measures (PROMs)

Patient reported outcome measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of two clinical procedures—hip replacement or knee replacement. They include different indicator measures such as the EQ-5D index, EQ-5D visual analogue scale (VAS) and Oxford score.

[9] The reporting period for 2023/24 is Jan–Dec 2023

Percentage of patients reporting an improvement in health following surgery[10]		2019/20		2020/21		2021/22		2022/23	
		Trust	National average	Trust	National average	Trust	National average	Trust	National average
Hip replacement	EQ-VAS	70.5%	69.4%	63.6%	69.7%	60.4%	70.1%	dnp	70.4
	EQ-5D	96.3%	89.4%	100%	89.8%	96.3%	89.9%	dnp	89.6
	Oxford Hip Score	99.2%	96.9%	100%	97.2%	100%	96.8%	dnp	95.8
Knee replacement	EQ-VAS	57.8%	59.5%	60.0%	58.6%	69.6%	60.7%	dnp	61.1%
	EQ-5D	81.7%	82.4%	72.7%	82.2%	72%	82.3%	dnp	81.9%
	Oxford Knee Score	93.9%	94.3%	92.3%	94.1%	100%	94.5%	dnp	93.3%

Data source: digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms

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

- Established processes were in place to collect, collate and calculate data associated with this indicator before submission to NHS Digital (monthly)—however, the Trust had not participated in PROMs since 2022

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

- Discussing monitoring PROMs performance within the Planned Care division's quality board and resourcing the data collection internally during the next financial year to support oversight of the process

- Reporting assurance to the clinical effectiveness group

Readmission within 28 days

Age 0–15 years	2019/20	2020/21	2021/22	2022/23	2023/24
Readmission (28 days)	6.3%	5.7%	9.0%	6.20%	6.8%
National performance: Worst	16.9%	17.7%	17.5%	19.6%	22.3%
National performance: Best	4.5%	3.0%	0.0%	0.0%	0.0%
National performance: Mean	8.7%	9.1%	8.1%	9.8%	10.1%

Age 16+ years	2019/20	2020/21	2021/22	2022/23	2023/24
Readmission (28 days)	13.2%	9.4%	9.7%	10.2%	10.6%
National performance: Worst	17.4%	15.8%	13.1%	21.2%	17.0%
National performance: Best	11.4%	5.2%	4.4%	0.0%	0.0%
National performance: Mean	13.9%	10.7%	8.7%	7.5%	8.5%

Readmission rates have increased compared to previous years and are now above the national mean. These indicators are routinely reviewed as part of the organisation's standard governance procedures and anomalies are investigated.

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

- Enhanced monitoring of readmissions through the bed productivity programme, ensuring an overarching and coordinated approach to monitoring quality indicators relating to flow through our hospitals, including safe discharge—oversight and assurance are provided by the improvement board and the quality committee (QC)

[10] National data publication for 2022/23 by NHSE—PROMs outcomes are provisional and pending hospital-level breakdown, data for 2023/24 is not yet available

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

- Ensuring timely and safe discharges, reducing readmissions and providing patients with the support they need to manage their conditions at home, as identified by the quality priority work completed in relation to fast-track discharge

Responsiveness to personal needs

The national inpatient survey asks five questions focusing on responsiveness and personal care. NHS England stopped publishing data in relation to this indicator three years ago—therefore, we have included the following data from the inpatient survey to demonstrate the Trust's performance against some of the respective domains of the inpatient survey.

Section	Themes	2020	2021	2022[11]
Admission to hospital	Did not mind waiting as long as did for admission	61%	60%	71%
	Did not have to wait a long time to get to a bed on the ward	85%	78%	66%
Overall	Treated with respect and dignity	99%	98%	89%
	Rated overall experience as 7/10 or more	84%	85%	79%
	Asked to give views on quality of care during stay	25%	26%	17%

The patient survey results are overseen and acted upon by the patient and public experience and engagement group, which reports to the quality committee. The patient experience team triangulates feedback alongside the Friends and Family Test (FFT), pulling themes from the national patient survey, Trust complaints and patient advice and liaison service (PALS) queries.

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

- **Protected mealtime policy:** In Aug 2023, the Trust refreshed its protected mealtime policy and in Dec 2023 we created a mealtime ward helper volunteer role to support patients with feeding on the ward.

- **Cross-site campaigns:** Delivered in Mar 2024 to ensure staff understood the importance of providing a supportive, protected and high-quality meal service. From Dec 2023 (creation of volunteer role) to Mar 2024, a total of 130 shifts were delivered by the mealtime ward helper volunteers to support patients with feeding across inpatient areas.

- **Staff education and empowerment:** Focused on survey themes of basic care provision, conversations and involvement in treatment and care with patients, and how patients are discharged from the hospital.

[11] The data period is up to 2022 as the sample month is November—i.e. for the 2023 iteration of the survey, patients admitted in November 2023 are currently being surveyed now

- **Ward-based issues:** Addressing issues such as noise at night through the Magnet shared decision-making councils, allowing for focused and innovative improvements in main inpatient areas. Solutions include white noise speakers, night-time staff champions, and pre-bed activities to promote calmness in wards.

Staff recommending our Trust

	2019/20	2020/21	2021/22	2022/23	2023/24
Staff are happy with the standard of care that would be provided to a friend or a relative	79%	79.0%	76.1%	72.1%	77.8%
National performance: Worst	39.8%	49.7%	43.6%	39.2%	44.3%
National performance: Best	90.5%	91.7%	89.5%	86.4%	88.8%
National performance: Mean	71.4%	74.2%	66.9%	61.9%	63.3%

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

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

- The indicator is part of the nationally reported and validated staff survey data set

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

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

Venous thromboembolism risk assessment

Venous thromboembolism (VTE) occurs when a deep vein thrombosis (blood clot in a deep vein, most commonly in the legs) or a pulmonary embolism (where a blood clot travels in the blood and lodges in the lungs) causes substantial long-term health complications or death. Risk assessments for VTE ensure the identification of patient and hospital-related risks to prompt appropriate preventative measures at the earliest opportunity, helping reduce the risk of VTE developing.

	2019/20	2020/21	2021/22	2022/23[12]	2023/24
Percentage of admitted patients risk assessed for VTE	83.0%	83.7%	93.2%	92.7%	95.0%
National performance: Worst	71.7%	dnp	dnp	dnp	dnp
National performance: Best	100%	dnp	dnp	dnp	dnp
National performance: Mean	95.5%	dnp	dnp	dnp	dnp

Data source: www.england.nhs.uk/patient-safety/venous-thromboembolism-vte-risk-assessment-19-20/

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

- The Trust achieved the national VTE risk assessment target of 95% for 2023/24

- The thrombosis and thromboprophylaxis group includes VTE risk assessment performance as a standing agenda item as part of ongoing work to monitor performance and support divisions with improvement

[12] NHS England's national VTE data collection and publication programme was suspended from 2020—national benchmarking will be included in the Trust quality report when publication recommences

- Performance is tabled in the monthly divisional quality board reports
- Performance is overseen by the executive management board via the monthly performance and quality report
- Performance is tabled in the quarterly thrombosis and thromboprophylaxis sub-group report to the patient safety group
- Monthly VTE risk assessment performance reports are disseminated to divisional and clinical leads for feedback, areas for improvement and wider awareness
- Optimisation of CernerEPR VTE risk assessment forms and online data reporting has supported processes, including real-time monitoring and feedback on performance
- CernerEPR includes a VTE risk assessment status on the handover list and care organiser to visually indicate if VTE risk assessment has been completed for inpatients
- VTE risk assessment performance and prescribing of appropriate pharmacological and mechanical thromboprophylaxis (if clinically indicated and no contraindications present), by clinical area and ward, is audited quarterly, with a summary of key messages, shared learning, and actions disseminated to divisions via a quarterly VTE performance report
- Cohorting arrangements (assessment, data capture, and reporting) for VTE risk assessments were reviewed and updated for groups of patients undergoing procedures considered low risk of VTE using the Department of Health/NICE risk assessment categories
- An annual Trustwide VTE bulletin supports shared learning and key messages
- The thrombosis and thromboprophylaxis group has developed and introduced specific patient information leaflets on blood clot conditions (e.g. deep vein thrombosis, pulmonary embolism, atrial fibrillation) to increase patient education, awareness and support counselling
- VTE education is delivered via multiple platforms, including induction programmes, Trustwide clinical governance meetings, grand rounds and departmental updates

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

- Continuing to disseminate monthly VTE risk assessment performance reports to divisional and clinical leads for feedback on performance, areas for improvement and wider awareness
- Performing quarterly audits on inpatients at risk of VTE prescribed appropriate pharmacological and/or mechanical thromboprophylaxis (if clinically indicated and no contraindications present), with feedback to divisional clinical leads and pharmacy staff—actions will be taken to address any contributory factors, such as the management of omitted medication, staff education and awareness, and the review and update of clinical guidelines.

- Hospital-associated VTE events will undergo a root cause analysis (RCA) investigation—shared learning and actions to reduce the risk of recurrence will be disseminated to clinical teams, divisional boards and the thrombosis and thromboprophylaxis group.

Clostridium difficile (*C.diff*) occurrence

Public Health England changed the surveillance definitions for *C.diff* in April 2019—before this date, cases of *C.diff* detected four or more days after admission to the hospital were classified as healthcare-associated.

Following the Apr 2019 change, the classification of hospital-onset healthcare-associated (HOHA) was given to all cases identified two or more days post-admission (where the day of admission is counted as day 1).

Patients diagnosed as positive for *C.diff* within two days but with a history of an inpatient stay at the Trust within 28 days of the positive result are classified as community-onset healthcare-associated (COHA) and are Trust-apportioned, even if the previous admission was unrelated to the current presentation.

	2019/20	2020/21	2021/22	2022/23	2023/24
Count: Hospital onset, healthcare associated	32	20	36	27	35
Rate: Hospital onset, healthcare associated per 100,000 bed days	11.9	9.5	11.5	9.3	12.1
National performance: Worst	64.6	80.6	dnp	dnp	92.5
National performance: Best	0	0	dnp	dnp	0
National performance: Mean	15.01	18.2	dnp	dnp	27.6

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

During 2023/24, there were 35 Trust healthcare-associated *C.diff* cases against an apportioned Trust target of 25.

A root cause analysis (RCA) of each Trust-apportioned case was initiated by the infection prevention and control team, engaging senior medical and nursing staff caring for each patient. Action plans were subsequently developed to address lessons learned and are monitored at Trust quality and risk meetings.

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

- The dataset is nationally reported and locally validated

- Performance is monitored through the Trust infection prevention and control group (IPCG) and reported at the North West London Integrated Care System and Acute Provider Collaborative (APC) groups

- Performance is overseen by the executive management board and Trust board via the monthly performance and quality report

- Root cause analysis (RCA) meetings were held for all cases

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

- **Clinical engagement:** Ongoing education for all staff on the early recognition of *C.diff* symptoms and appropriate sample testing, along with clinical RCA meeting attendance and discussion and feedback at RCA meetings to improve clinical management and divisional oversight

- **Antibiotic stewardship:** Facilitated by the introduction of the ICNET® clinical surveillance system (web-based software platform) at West Middlesex in Jul 2021—the use of this service across both hospital sites has improved antimicrobial prescribing, monitoring and auditing, and there is ongoing review to identify inappropriate prescribing and review of prescribing in known cases of *C.diff*

- **Environmental decontamination:** Ongoing high levels of environmental hygiene, monitored at IPCG and through ward accreditation

- **Isolation nursing:** Prompt recognition and isolation of patients with suspected infectious diarrhoea/suspected or confirmed *C.diff*

- **Documentation and communications:** *C.diff* checklist on CernerEPR and an additional poster devised to support staff on appropriate testing

- **Hand hygiene:** Supporting high levels of hand hygiene compliance through a monthly audit programme with Trustwide feedback/data availability

- **Hand hygiene compliance:** Areas with lower compliance produced divisional action plans—compliance is monitored at the infection prevention and control group and through monthly divisional dashboards

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

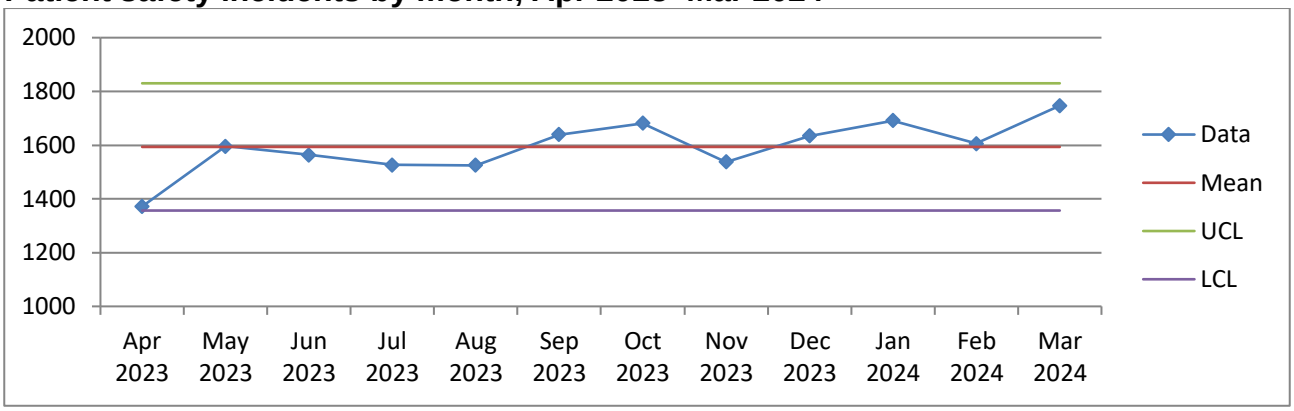
- **Collaboration:** Learning from *C.diff* cases is shared at North West London APC and Integrated Care System levels to improve local and sector management and support the reduction of hospital-associated infections

Number of patient safety incidents that resulted in severe harm or death

Patient safety incidents can have a devastating impact on our patients and staff. The Trust is committed to continuously improving the quality of the care and services provided to our patients—this improvement process is supported by a system for reporting, responding and learning from patient safety incidents.

A key indicator of an organisation's safety culture is its willingness to report safety events that could have or did affect patient safety and embed the changes required to reduce the risk of recurrence. A high incident reporting rate reflects a positive reporting culture.

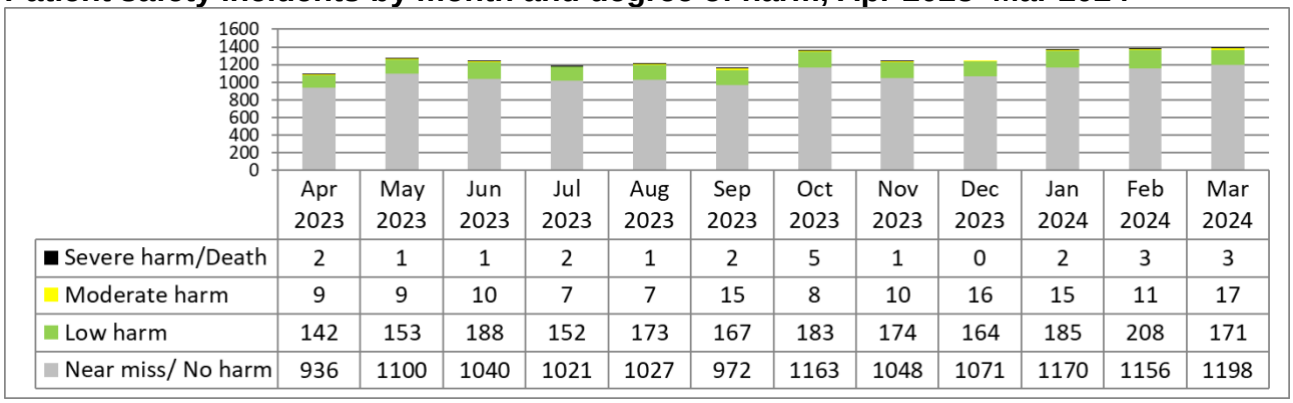
Patient safety incidents by month, Apr 2023–Mar 2024



During 2023/24, 15,119 patient safety incidents were reported by staff across all our departments and services. This represents a 7.7% increase in crude patient safety incident reports made during the previous financial year (n=14,043).

The vast majority of patient safety incidents reported during 2023/24 led to no harm to the patient involved (n=12,902, 85%). Reporting safety improvement opportunities in the absence of harm is a positive safety culture indicator. During this reporting period, 0.15% (n=23) of incidents were concluded to have led to severe harm or the death of a patient.

Patient safety incidents by month and degree of harm, Apr 2023–Mar 2024



	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Severe harm/Death	2	1	1	2	1	2	5	1	0	2	3	3
Moderate harm	9	9	10	7	7	15	8	10	16	15	11	17
Low harm	142	153	188	152	173	167	183	174	164	185	208	171
Near miss/ No harm	936	1100	1040	1021	1027	972	1163	1048	1071	1170	1156	1198

For incidents requiring immediate review, an Initial Incident Review will be undertaken to ensure immediate safety improvement actions are taken and the case is presented to the Trust's initial incident review group (IIRG). This group is made up of executive leads and divisional representatives who oversee a system of proportionate decision-making to ensure that incidents are responded to effectively and deliver learning and improvement to support safe, high-quality care.

Serious incidents (SIs)/ Patient safety incident investigations (PSIIs)

The serious incident framework (SIF) was replaced by the patient safety incident response framework (PSIRF)—this national change replaces the serious incident investigation processes with a range of alternative safety learning responses. The implementation of PSIRF is intended to support safety learning, compassionate support, engagement, improvement approaches and result in fewer in-depth investigations but improved quality.

The Trust began to phase out SIF tools in Q4 2023/24 with a plan to stop declaring incidents under SIF before the new financial year commences.

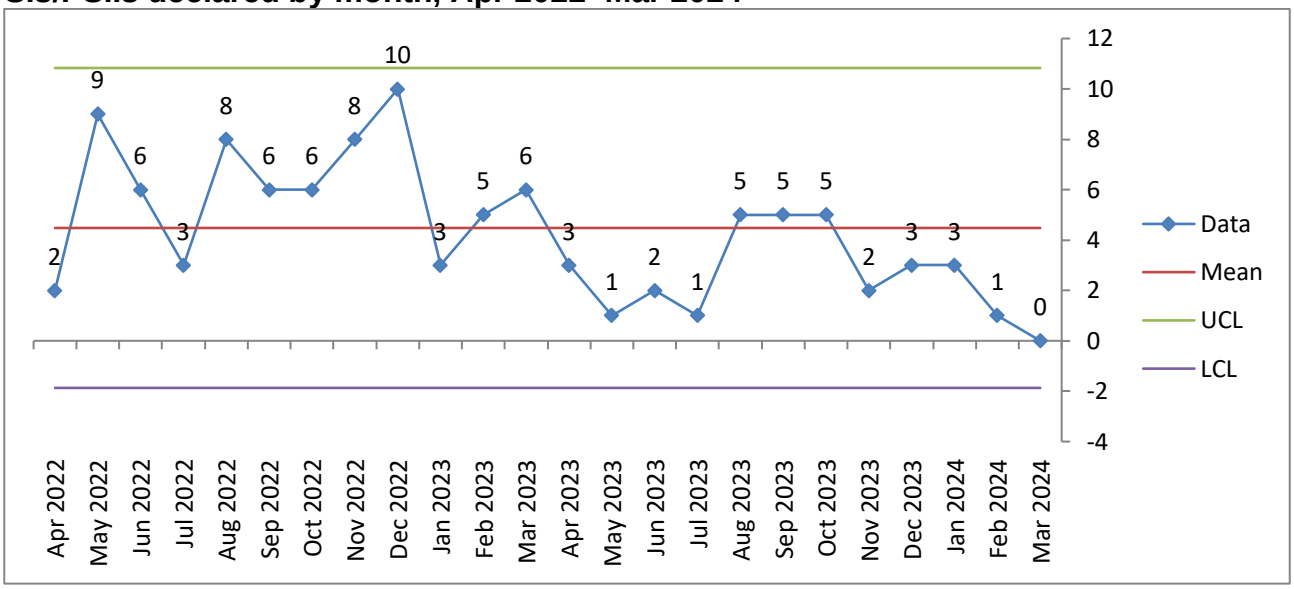
The chart below highlights the number of externally reportable SIs and PSIIs undertaken. Following the implementation of the Trust's PSIRF Plan, the number of external incidents reported is likely to reduce—this is due to changes in national definitions and indications for Patient Safety Incident Investigations (PSIIs). Indications for PSIIs are grouped as follows:

- **Nationally defined priority:** Review by another body e.g. maternity and newborn safety investigations (MNSI), child death review, learning disability mortality review (LeDeR), safeguarding

- **Nationally defined incidents requiring local PSII:** e.g. never events, learning from deaths, suicide/self-harm

- **Locally defined incidents requiring local PSII:** e.g. cases with significant learning or predefined incidents included in the Trust PSIRF plan

SIs/PSIIs declared by month, Apr 2022–Mar 2024



A never event is a particular type of serious incident that is deemed to be wholly preventable due to strong systemic barriers that should have been in place based on the national guidance and recommendations available. Five never events were declared by the Trust during 2023/24:

Never event category	Degree of harm
Medication: Overdose of insulin due to abbreviations or incorrect device	Low
General: Misplaced nasogastric or orogastric tubes	Moderate
Surgical: Wrong implant/prosthesis	Moderate
Surgical: Retained foreign object post-procedure	Low
Surgical: Wrong site surgery	Low

Specific learning identified in relation to the most frequent never event categories was as follows:

Wrong site surgery

- Improve learning through stories—speak more about never events and near misses openly with staff

- Complete visits to areas of concern by completing and checking the audit data
- Support engagement with human factors training programme and the use of simulation
- Change our culture—make the patient the most important member of the team
- Promote effective teamworking
- Reduce the number of handovers
- Ensure messaging is clear through better-structured handovers

Wrong implant/prosthesis

- Build and support the confidence of clinical teams to speak up when a checklist is not followed
- Improve the exchange of information to ensure a shared understanding of ‘what’ has to be done with ‘which’ specific equipment
- Role modelling and demonstrable procedural compliance by senior clinicians to ensure that the whole team has a shared awareness of the task
- Consistency with ensuring each member of the team introduces themselves and identifies their role
- Efficient management and ordering of stocks

Retained foreign object post-procedure

- Local induction and handover practice should reinforce the safe count procedure
- Procedures should only begin when the agreed minimum number and skill mix of staff for that procedure are present
- Establishments and day-to-day staffing for all professional groups must be adequate to meet the predicted procedural workload
- Methods and documentation for counting and reconciliation should be standardised and accessible in all areas to all staff

Duty of candour

Patient safety incidents can have emotional and physical consequences for patients, their families and carers, and can be distressing for the professionals involved. The Trust is committed to being open and transparent when there are issues or errors in care. When patient safety incidents are identified, we aim to discuss the event with those involved promptly, fully and compassionately so that patients and professionals are best supported to cope with the after-effects.

As a CQC regulated provider of healthcare services, the Trust has a legal requirement under Regulation 20: Duty of Candour to ensure that patients and their families are informed when a notifiable safety incident occurs (these are cases assessed to have led to moderate harm, severe harm or death).

The Trust’s duties include:

- Making an immediate verbal disclosure to the patient and apologising

- Providing a written post-investigation explanation of the causes of the incident and what improvement actions we are taking as a result

During 2023/24, 149 notifiable patient incidents were identified:

- Verbal notification and apology were given for 93% of cases (n=139):
    - For 7% of cases (n=10), it has been documented within Datix that a verbal notification and apology was not given at the time of the incident owing to circumstances that did not permit a verbal notification and apology to take place e.g. patient deceased with no next of kin

- Written outcome of investigation letters were provided for 57% of cases (n=85):
    - 20% of cases (n=30) are still pending the outcome of the incident investigation e.g. cases that are with the MNSI for completion, and have not yet had a written outcome of the investigation sent
    - 23% of cases (n=34) did not have a written outcome of the investigation sent, with a rationale recorded e.g. patient deceased with no next of kin

All efforts are undertaken to identify and engage with the relevant person (the person who was harmed or someone acting lawfully on their behalf). Unfortunately, this was either not possible or was declined for a number of cases (n=9).

This is identified as an exception for Regulation 20: Duty of Candour under section 5. The Trust includes these cases for transparency.

PART 3

OTHER INFORMATION AND ANNEXES

This section provides further information on the quality of care we offer based on our performance against NHS Oversight Framework Indicators, national targets, regulatory requirements and other metrics we have selected.

Performance indicators

During 2023/24, the NHS faced particular challenges in achieving key regulatory and contractual performance metrics, including quality and workforce key performance indicators (KPIs). The Trust has performed well compared to peers within this extremely challenging operating environment.

Below is a summary of some of our KPIs for 2023/24. These should be read in conjunction with the main narrative of the Annual Report and Accounts for a better understanding of the context of these performance measures. You can find details of our current performance, updated monthly, on our website www.chelwest.nhs.uk.

NHS Improvement (NHSI) risk assurance framework

The table below summarises the performance indicators for the Trust.

	Target	Performance
Incidents of *C.diff* (hospital-associated infections)	25	35
All cancers: 31-day wait from diagnosis to first treatment	96%	82.8%
All cancers: 31-day wait for second or subsequent treatment (surgery)	94%	82.8%
All cancers: 31-day wait for second or subsequent treatment (anti-cancer drug treatments)	98%	82.8%
Cancer: Two-week wait from referral to date first seen (breast symptomatic)	93%	98.1%
Cancer: Two-week wait from referral to date first seen (comprising all cancers)	93%	95.4%
Referral to treatment waiting times <18 weeks—incomplete	92%	60.1%
A&E: Total time waiting in A&E ≤4 hours	76% (Trust target: 95%)	79.53%
Emergency care pathway—length of stay	4.5	4.05
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	compliant	compliant

Local quality indicators

Local quality indicators provide us with an opportunity to review the KPIs that are important to us and the quality of patient care that our patients receive. The following indicators are tracked by the executive management board and the quality committee to ensure we focus on embedding and sustaining improvements and sharing learning.

Indicator		2019/20	2020/21	2021/22	2022/23	2023/24
Patient safety	Patients with hospital-acquired MRSA infections (target 0)	1	4	6	7	4
	Hand hygiene compliance (target >90%)	86.0%	92.6%	92.1%	95.3%	96.3%
	Number of serious incidents	72	76	75	69	31
	Number of never events (target 0)	1	2	2	1	5
	Incident reporting rate per 100 admissions (target >8.5%)	8.9%	11.6%	9.3%	9.2%	9.4%
	Percentage of patient safety incidents resulting in severe harm or death (NRLS reportable)	0.01%	0.03%	0.02%	0.02%	0.01%
	Medication-related (NRLS reportable) safety incidents per 1,000 FCE bed days (target >=4.2)	4.51	4.49	3.74	3.92	4.43
	Medication-related (NRLS reportable) safety incidents % with moderate harm and above (target <2%)	0.1%	0.6%	0.5%	0.2%	0.4%
	Summary hospital mortality indicator (SHMI) (target <100)	77	75	72	71	72

Indicator		2019/20	2020/21	2021/22	2022/23	2023/24
Clinical effectiveness	Dementia screening case findings (target >90%)	88.2%	74.3%	94.0%	94.7%	94.4%
	Fractured neck of femur time to theatre <36 hours for medically fit patients (target 100%)	92.1%	90.4%	78.4%	75.1%	81.3%
	Stroke care: Time spent on dedicated stroke unit (target >80%)	92.0%	87.2%	93.8%	89.6%	89.8%
	VTE: Hospital-acquired	18	16	26	58	44
	VTE risk assessment (target >95%)	82.1%	86.2%	93.1%	92.7%	95.0%
	Sepsis: Inpatient wards percentage of patients with high NEWS score screened for sepsis (target >90%)	N/A	86.1%	88.5%	93.2%	95.7%

Indicator		2019/20	2020/21	2021/22	2022/23	2023/24
Patient experience	FFT: Inpatient satisfaction (target >90%)	94.8%	95.5%	95.5%	95.6%	95.8%
	FFT: A&E satisfaction (target >90%)	89.8%	89.9%	82.2%	79.3%	82.0%
	FFT: Maternity satisfaction (target >90%)	92.3%	88.8%	88.0%	89.1%	89.7%
	Complaints: Number of formal complaints received	840	392	448	476	479
	Complaints: Number of formal complaints responded to within 25 working days	395 (47%)	238 (61%)	341 (76%)	401 (84%)	269 (56.2%)
	Complaints: Number of formal complaints referred and upheld by the Ombudsman	13	4	3	1	6

Other quality improvement indicators

Each division has an established structure for continuous quality improvement in the Trust to improve quality of care, reduce variation in a sustained manner and support an improvement culture across the organisation. During 2023/24, in addition to the Trust quality priorities, each division led a set of local priorities as follows:

Clinical Support division

- **Adapting the environment to patient needs:** Engaging patient ambassadors to walk around and advise regarding the division's estate
- **Right patient, right test, right treatment:** Continued work to embed patient ID audit and feedback results to senior leadership and pharmacy antimicrobial stewardship
- **Improving communications across care boundaries:** Improved the quality of communication between the patient access team and our patients as well as across specialties
- **Cancer services:** Successful 2-week wait cancer performance

Emergency and Integrated Care division

- **Embed digital tools:** To maximise adoption of existing and new digital enablers the division had oversight of all digital projects, shared good practice, and agreed on a common approach to implementation and measurement
- **Virtual wards:** Virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital—the benefits of this programme include admission avoidance, reduction in length of stay, supporting delivery of patient care at home, community pathway development and reducing follow-up appointments

- **Configuration of inpatient beds:** To increase 7-day working and reduce variability in discharge by the day of the week

- **Making every contact count:** Improved identification, management, and prevention of frailty through evidence-based interventions, multidisciplinary teams and data-driven approaches earlier within a patient's pathway

Planned Care division

- **Treating patients in the right location to optimise capacity:** To ensure that patients receive their procedures in the most appropriate environment based on their clinical need and improve the treatment centre utilisation

- **Documentation quality:** Improved risk assessments and evaluation of care for inpatients

- **Cholecystectomy improvement project (CHIP):** Reduced patient morbidity and improved patient safety through developing an in-house transcystic bile duct aspiration service which reduced the number of patients transferred and increased income

- **Robotic surgery:** Our robotic surgery programme has reduced the length of stay and recovery time for many patients

Specialist Care division

- **Escalation in maternity:** Reviewed themes from serious incidents and supported staff to escalate to reduce the risk of adverse outcomes from delayed communication of urgency

- **Babies born and cared for in the right place and time:** Improved outcomes and patient experience through better access to specialist care and a more holistic referral pathway

- **Cancer care (dermatology):** Enhanced patient experience through the introduction of individualised care plans and better transfer of care

- **Cancer care (gynaecology):** Improved patient experience through improved compliance with national standards and cancer targets

- **Early pregnancy care:** Introduced a 7-day service, provided bereavement training and ensured counselling provision was in place

- **Gender affirmation service:** Offers a unique range of services for trans and non-binary patients, including gender-affirming surgery and a specialist gender identity clinic

West London Children's Healthcare

- **Escalation:** Joint project with maternity, Neonatal Intensive Care Unit, and Paediatric Emergency Department (PED) to reduce unnecessary attendances to PED

- **From chaos to care:** Improved discharge planning for complex paediatric patients

- **Standardised reflection:** Introduced a standardised reflection tool for medics following medication errors to improve medication safety

- **Best for you:** Adolescent inpatient improvement project

Additional quality highlights

Magnet4Europe

The Magnet4Europe International Study (horizon funded research study) was launched in the Trust in 2021 to explore the applicability of Magnet standards across 66 European hospitals. Magnet accreditation is awarded to hospitals internationally that meet various standards relating to patient experience, clinical outcomes, staff experience, shared decision-making and educational attainment.

Magnet4Europe is a four-year study. In the past year, the hospital has benefited from being twinned with US partners at Robert Wood Johnson and learning from reciprocal site visits.

Some of the benefits of the study include:

- **Patient experience and FFT:** Improvement in patient experience and FFT scores, and staff turnover and experience on six wards where shared decision-making was piloted

- **Evidence-based practice:** Promoted the importance of evidence-based practice and engaged frontline staff in decision-making

- **Shared decision-making:** Rolled out shared decision-making from an initial 6 to 30 wards and departments, developing improvement projects relating to patient outcomes, patient experience and staff wellbeing

- **Education audit:** Launched an annual education audit to consult nursing staff on their educational needs

- **Educational funding:** Ring-fenced educational money for top-up degrees for nurses with diplomas

- **Peer feedback:** Implemented peer feedback as part of the PDR (personal development review) process

- **Nursing research:** Increased the number of nursing research projects

- **Nurse-sensitive indicators:** Provided locally benchmarked nurse-sensitive indicators for inpatient units

- **Transformational leadership:** Promoted transformational leadership across nursing, midwifery and Associated Healthcare Professionals (AHPs) through the launch of the ‘leading an empowered organisation’ course

Ward accreditation

Ward and department accreditation was introduced at the Trust during summer 2016. The tool was developed to link the CQC key lines of enquiry with internal assurance systems. The accreditation visits occur on published days, with representatives from across the Trust volunteering to participate as part of the inspection team. Following an accreditation, the area is awarded one of the four Trust quality grades. The Trust grading of 'gold to white' generally follows the CQC's method of ratings.

A review of the accreditation process was completed during 2022/23 against existing accreditation systems used across London, and in preparation for the new CQC inspection framework. The new framework, implemented from Jun 2023, utilises a core inspection team of subject matter experts to ensure consistency of approach across the inspections. The inspections occur weekly and are unannounced to reflect the approach of a short-notice CQC inspection. The individual tools used have also been adapted to reflect service-specific key lines of enquiry.

In creating the new tool/framework, digital solutions were explored. The new method is electronic using an 'in-house' digital solution. Themed audits are completed via Microsoft Forms and results are automatically pulled into an Excel report. Moving forward, results will be pulled through to Qlik (Trust application portal). The business intelligence (BI) team is working on this solution, which is expected to be in place during 2024/25. The new accreditation method consists of a snapshot inspection using an approved audit tool. The core themes of the audit include:

- Infection prevention and control
- Health and safety
- Environment
- Medicines management
- Harm-free care (nursing and midwifery care, falls prevention, pressure ulcer prevention, nutrition and hydration, documentation)
- End of life care
- Safeguarding and mental health
- Patient experience
- Governance

Accreditation visits take place on a weekly basis unless operational pressures prevent prioritisation. The decision to cancel accreditation must come from the chief nursing officer (CNO) or deputy chief nursing officer (DCNO) in the absence of the CNO.

CQC inspection of maternity services

Published in May 2023, the CQC inspections of maternity services at the Trust rated Chelsea and Westminster Hospital as 'good' and West Middlesex University Hospital as 'outstanding'. The CQC identified several outstanding areas of practice across both sites, including:

- Services were awarded the national positive practice in mental health winner for 2022 in perinatal and maternal mental health for its maternal trauma and loss care (M-TLC) service, which offers integrated psychological specialist support with maternity services to treat and prevent trauma associated with childbirth

- Services were shortlisted for their work in adapting and improving during the ‘excellence during a global pandemic’ award—innovations included using private ambulance services to secure the homebirth service, swiftly adapting services using technology and redeployment, and developing an antenatal vaccination centre

- Services improved their engagement with local communities, particularly through the maternity voices partnership, which co-produced a Muslim mum’s memo card with local Muslim women

- Services had a strong focus on reducing workforce inequalities and inequities experienced by women and birthing people using the service—part of this work included developing 12 staff as maternity cultural safety champions.

- The maternity cultural safety champions address inequalities and improve equity for staff and people using services with protected characteristics—the champions deliver cultural safety training as part of yearly mandatory training, and the service is working towards accreditation from the Capital Midwife anti-racism framework to eradicate racism in the workplace

- Services focused on staff wellbeing through initiatives like staff recognition schemes, award nominations, career clinics and emotional wellbeing support

- At the Chelsea site, the CQC recognised the provision of obstetric-led urgent ultrasound clinics within the maternity triage setting to enable women and birthing people timely access to scans, recommended as part of saving babies lives care bundle v2—the clinic provided a ‘one-stop shop’ with continuity of care where results of scans were discussed and care planning was completed straight away.

Our Maternity Cultural Safety team has been recognised for creating a culturally safe maternity unit at the Trust and was shortlisted for the Dame Elizabeth Anionwu award for inclusivity in nursing and midwifery

We also had 14 areas for improvement identified by the CQC (3 ‘must do’ and 11 ‘should do’)—we have completed and are now compliant with 9 of these as detailed below:

Site	Category	Action	Progress
Chelsea and Westminster Hospital	Must	The service must ensure that all daily safety checks are completed, and all equipment is in date, clean and ready for use.	**Compliant:** All maternity areas at the hospital have seen improvement in equipment safety checks and PPE (personal protective equipment) compliance, and have been re-audited through the Trust ward accreditation schemes, with the majority of areas achieving Silver.
Chelsea and Westminster Hospital	Must	The service must ensure that compliance with appropriate PPE in the maternity inpatients department improves.	
Chelsea and Westminster Hospital	Must	The service must ensure that all staff have the level of safeguarding training appropriate to their role, including doctors, and compliance with mandatory training targets improves.	**Compliant:** The service has seen improvement across all staff groups regarding both safeguarding and mandatory training.
Both sites	Should	The service should ensure compliance with MEOWS (modified early obstetric warning score) chart completion and audits improves.	**In progress:** All areas within the service use an electronic MEOWS audit template and results are routinely monitored by the service leadership. Work remains ongoing to improve assessment completion.
Both sites	Should	The service should take measures to provide all staff with an annual appraisal.	**In progress:** Work remains ongoing to improve appraisal rates for staff, although increases have been made across both sites.
Chelsea and Westminster Hospital	Should	The service should ensure all records within the maternity pathway are completed contemporaneously in line with professional standards, in particular: telephone consultations in the triage area. The service should ensure that antenatal documentation is completed including, but not limited to risk assessment and fetal wellbeing.	**In progress:** Telephone consultations are routinely recorded and documented on clinical systems, and progress has been made to ensure the service records antenatal documentation, such as risk assessments and fetal monitoring, in our electronic clinical systems.
Chelsea and Westminster Hospital	Should	The service should ensure recording and monitoring of maternity staffing ‘red flag’ events takes place.	**Compliant:** Staffing red flags are routinely recorded by the service and monitored at division, Trust and ICB levels.
Chelsea and Westminster Hospital	Should	The service should ensure that incidents are harm-rated appropriately.	**Compliant:** Incidents continue to be logged routinely and reviewed through the service and Trust governance groups.
Chelsea and Westminster Hospital	Should	The service should maintain safe storage of medicine in all areas including, but not limited to ensuring medicine is in date, medicine is stored at the recommended temperature and risk assessments are reviewed regularly.	**In progress:** Medicines storage and management have improved and are monitored through regular audits and the Trust ward accreditation scheme. Work remains ongoing to improve storage and practices, particularly with regard to temperature monitoring.
West Middlesex Hospital	Should	The service should ensure midwifery staff are up to date with mandatory training modules.	**Compliant:** Mandatory training rates have improved and are above Trust targets across all staff groups.

Site	Category	Action	Progress
West Middlesex Hospital	Should	The service should ensure midwifery staff are up to date with safeguarding adults and children level 3 training.	**Compliant:** Overall compliance with safeguarding training has improved across all staff groups, and compliance of midwifery staff with safeguarding level 3 training is meeting the internal target.
West Middlesex Hospital	Should	The service should ensure that babies in the bereavement suite are stored in a secure and dignified way.	**Compliant:** Work has been completed to create dedicated resting places for babies in the bereavement suite when their parents are not with them.
West Middlesex Hospital	Should	The service should ensure that there is an improved risk assessment of access to neonatal resuscitation equipment on the Birth Centre.	**Compliant:** An improved risk assessment was completed and all rooms now have access to suitable neonatal resuscitation equipment. Work has also been completed to have additional neonatal resuscitation equipment, moveable resuscitaires, and to remove cosy cabinets for easy access.
West Middlesex Hospital	Should	The Trust should ensure medical cover for triage is sufficient.	**In progress:** Work remains ongoing to review job plans for staff.

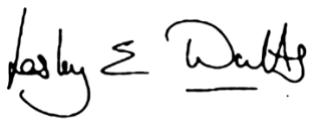
Declaration

As in previous years, there are inherent limitations in the preparation of quality reports that may impact the reliability or accuracy of the data reported. Data is derived from a large number of different systems and processes, only some of which are subject to external assurance or included in the internal audit programme of work each year.

National data definitions do not necessarily cover all circumstances, and local interpretations may differ. Where local interpretations of national data definitions are applied, the Trust ensures that variations are reviewed through appropriate governance processes to ensure the intent of the definition is achieved.

Data collection practices and data definitions are evolving, which may lead to differences both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

Notwithstanding these inherent limitations, to the best of my knowledge, the information in this report is accurate.



Lesley Watts
Chief Executive Officer

Annex 1: National clinical audit and confidential enquiries participation

National clinical audit participation

National programme work	Eligible	Participated	% submitted
Adult Respiratory Support Audit	yes	yes	not available at time of report preparation
BAUS Nephrostomy Audit	yes	no	n/a
Breast and Cosmetic Implant Registry	yes	yes	rolling data submission
British Hernia Society Registry	yes	registry not yet open	n/a
Case Mix Programme (CMP)	yes	yes	100%
Cleft Registry and Audit Network (CRANE) Database	no	no	n/a
Elective Surgery (National PROMs Programme)	yes	no	n/a
Emergency Medicine QIPs: Care of Older People	yes	yes	100%
Emergency Medicine QIPs: Mental Health (Self-Harm)	yes	yes	100%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	yes	yes	rolling data submission
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	yes	yes	rolling data submission
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	yes	yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	yes	yes	rolling data submission
Improving Quality in Crohn's and Colitis (IQICC)[13]	yes	no	n/a
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	yes	yes	100%
NATCAN: National Audit of Metastatic Breast Cancer	yes	yes	rolling data submission
NATCAN: National Audit of Primary Breast Cancer	yes	yes	rolling data submission
NATCAN: National Bowel Cancer Audit (NBOCA)	yes	yes	rolling data submission
NATCAN: National Lung Cancer Audit (NLCA)	yes	yes	rolling data submission
NATCAN: National Oesophago-Gastric Cancer Audit (NOGCA)	yes	yes	rolling data submission
NATCAN: National Prostate Cancer Audit	yes	yes	rolling data submission
National Adult Diabetes Audit (NDA): National Diabetes Core Audit	yes	yes	rolling data submission
National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	yes	partial	50%[14]
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	yes	yes	rolling data submission

[13] Previously named Inflammatory Bowel Disease (IBD) Audit
[14] WM did not submit data

National programme work	Eligible	Participated	% submitted
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	yes	yes	rolling data submission
National Asthma and COPD (chronic obstructive pulmonary disease) Audit Programme (NACAP): Adult Asthma Secondary Care	yes	yes	rolling data submission
National Asthma and COPD Audit Programme (NACAP): Children and Young People's Asthma Secondary Care	yes	yes	rolling data submission
National Asthma and COPD Audit Programme (NACAP): COPD Secondary Care	yes	yes	rolling data submission
National Asthma and COPD Audit Programme (NACAP): Pulmonary Rehabilitation	no	no	n/a
National Audit of Cardiac Rehabilitation	no	no	n/a
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	no	no	n/a
National Audit of Care at the End of Life (NACEL)	yes	yes	in progress
National Audit of Dementia (NAD)	yes	yes	in progress
National Audit of Pulmonary Hypertension	no	no	n/a
National Bariatric Surgery Registry	yes	yes	rolling data submission
National Cardiac Arrest Audit (NCAA)	yes	yes	rolling data submission
National Cardiac Audit Programme (NCAP): Left Atrial Appendage Occlusion (LAAO) Registry	no	no	n/a
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	yes	yes	rolling data submission
National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit (NACSA)	no	no	n/a
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	yes	yes	rolling data submission
National Cardiac Audit Programme (NCAP): National Audit of Mitral Valve Leaflet Repairs (MVLR)	no	no	n/a
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Intervention (NAPCI)	yes	yes	rolling data submission
National Cardiac Audit Programme (NCAP): National Congenital Heart Disease Audit (NCHDA)	no	no	n/a
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	yes	yes	rolling data submission
National Cardiac Audit Programme (NCAP): Patent Foramen Ovale Closure (PFOC) Registry	no	no	n/a
National Cardiac Audit Programme (NCAP): The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	no	no	n/a
National Child Mortality Database (NCMD)	yes	yes	100%
National Clinical Audit of Psychosis (NCAP)	no	no	n/a
National Early Inflammatory Arthritis Audit (NEIAA)	yes	yes	rolling data submission
National Emergency Laparotomy Audit (NELA)	yes	no	n/a
National Joint Registry	yes	yes	rolling data submission
National Maternity and Perinatal Audit (NMPA)	yes	yes	rolling data submission

National programme work	Eligible	Participated	% submitted
National Neonatal Audit Programme (NNAP)	yes	yes	100%
National Obesity Audit (NOA)	yes	yes	audit extracts data from existing datasets, CSDS and HES datasets
National Ophthalmology Database (NOD) Audit: National Cataract Audit	yes	no	n/a
National Paediatric Diabetes Audit (NPDA)	yes	yes	rolling data submission
National Vascular Registry (NVR)	no	no	n/a
NCABT: 2023 Audit of Blood Transfusion against NICE Quality Standard 138	yes	yes	100%
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	no	no	n/a
Paediatric Intensive Care Audit Network (PICANet)	no	no	n/a
Perinatal Mortality Review Tool (PMRT)	yes	yes	100%
Perioperative Quality Improvement Programme	yes	yes	100%[15]
Prescribing Observatory for Mental Health (POMH): Monitoring of patients prescribed lithium	no	no	n/a
Prescribing Observatory for Mental Health (POMH): Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	no	no	n/a
Sentinel Stroke National Audit Programme (SSNAP)	yes	yes	90%
Serious Hazards of Transfusion UK National Haemovigilance Scheme	yes	yes	n/a[16]
Society for Acute Medicine Benchmarking Audit	yes	partial	50%[17]
The Trauma Audit & Research Network (TARN)	yes	yes	n/a
UK Cystic Fibrosis Registry	no	no	n/a
UK Renal Registry Chronic Kidney Disease Audit	no	no	n/a
UK Renal Registry National Acute Kidney Injury Audit	yes	yes	100%

Confidential enquiry participation

Confidential enquiry project title	Eligible	Participated	% submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance and confidential enquiry	yes	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal confidential enquiries	yes	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality surveillance	yes	yes	100%
Medical and Surgical Clinical Outcome Review Programme: Endometriosis	yes	yes	50%
Medical and Surgical Clinical Outcome Review Programme: Juvenile Idiopathic Arthritis	yes	yes	50%

[15] This is a recruitment study
[16] This is a reporting system only—the Trust transfusion team reports adverse events and reactions related to transfusion based on a set of definitions
[17] WM did not submit data

Confidential enquiry project title	Eligible	Participated	% submitted
Medical and Surgical Clinical Outcome Review Programme: End of Life Care	yes	yes	82%
Mental Health Clinical Outcome Review Programme (NCISH)	not eligible but Trust reviews annual NCISH recommendations		

National confidential enquiry participation

Confidential enquiry project title	Eligible	Participated	% submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance and confidential enquiry	yes	yes	ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal confidential enquiries	yes	yes	ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality surveillance	yes	yes	ongoing
National Perinatal Mortality Review Tool	yes	yes	ongoing
Medical and Surgical Clinical Outcome Review Programme: Transition from child to adult health services	yes	yes	42%
Medical and Surgical Clinical Outcome Review Programme: Crohn's Disease	yes	yes	83%
Medical and Surgical Clinical Outcome Review Programme: Community Acquired Pneumonia	yes	yes	73%
Medical and Surgical Clinical Outcome Review Programme: Testicular Torsion	yes	yes	100%
Mental Health Clinical Outcome Review Programme (NCISH)	not eligible but Trust reviews annual NCISH recommendations		

Annex 2: National clinical audits reviewed by the Trust

Action plan completion is monitored by the divisional quality boards and reported to the clinical effectiveness group.

Audit	Department	Summary and agreed actions arising
National Heart Failure Audit	Cardiology	• Chelsea and Westminster Hospital has no cardiology bed base, but the cardiology team manages heart failure patients on AMU/AAU, where appropriate, with an in-reach model and a consultant with heart failure expertise. • West Middlesex University Hospital has a dedicated cardiology/heart failure ward with an in-reach service from both cardiology wards and heart failure clinical nurse specialists for other wards. • Both sites achieved above national average for disease-modifying medication. • A proforma for a heart failure discharge checklist on CernerEPR has been created for both sites to capture referrals to community services. • Exploring funding streams to improve referral to cardiac rehabilitation including heart failure and trialling a new data capture process to automate audit data download.
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Cardiology	• Applicable only to West Middlesex University Hospital. • Follows best practice as outlined in the NAPCI 2022 summary report. • Although not a primary PCI centre, the hospital reviews its STEMI protocols to see where improvements can be made in the use of newer antiplatelet agents, in particular Prasugrel, during primary PCI.
Royal College of Emergency Medicine (RCEM): Consultant Sign Off (Apr–Oct 2022)	Emergency Medicine	• A QI (quality improvement) working group has been set up to drive improvement against audit standards—the group will include junior and registrar teaching and re-auditing of practice. • West Middlesex is better than UK average for documenting own reviews for consultants and Tier 4 in paediatrics and consultants in adults—on the Chelsea and Westminster site, senior decision-makers are made aware of this recommendation in the department and practice of this will be audited. • A senior review tab has been implemented on CernerEPR and its use is being reinforced in the Chelsea and Westminster ED department. This will be re-audited with a view to further improvement.
National Audit of Dementia (Care in general hospitals) Round 5	Older Adults and Frailty	• A monthly audit is carried out to identify people with dementia admitted to the Trust—this is reportable as a key performance indicator. A process is in place to collect data showing the proportion of people with dementia affected by falls, delayed discharges, readmissions, pressure ulcers and incidents of violence/aggression. • Monitoring is in place to identify the proportion of ward-based staff who have received Tier 2 level training in dementia. Discussions are taking place with the learning and development team to ascertain available training in the use of appropriate tools for comprehensive pain assessment (e.g. eLfH pain management programme). • The dementia team is currently in conversation with ICB regarding dementia services and representation at dementia steering group meetings—reporting to be established.
National Audit of Care at the End of Life (NACEL)	Palliative Care	• The current UCP reporting capability is limited and is not able to provide sufficient detail around user activity. This has limited the ability to target training or to monitor progress with quality improvement. This has been escalated through NWLP EoLC (end-of-life care) APC group. • There is a business case in place to increase establishment by 1 WTE Clinical Nurse Specialist on each site and increase the Consultant establishment by 1.6 WTE (whole time equivalent) —this will increase the capacity to support EoLC education and training.

Audit	Department	Summary and agreed actions arising
FFFAP: National Hip Fracture Database (NHFD)	Trauma and Orthopaedics	• Orthogeriatrician service and development plan in progress. • The NHFD team prioritise all optimised hip fracture patients on trauma lists as identified during handover in between shifts—these are discussed in daily trauma meetings. There is also an ongoing monthly performance review. NHFD audit performance data is disseminated across the team. There is a local audit in place aiming to identify common factors contributing to delirium and implement a plan to mitigate these.
FFFAP: Inpatient Falls	Trauma and Orthopaedics	• Falls data is available to view on the analytics hub and is shared with the shared decision-making team. • A new falls education programme is under development at the Trust—QR codes have been provided to ward areas with a how-to guide on LSBP (lying standing blood pressures) and local QI projects on LSBP—these will be shared at the falls steering group. • Post-falls assessment, checks for injury and a post falls evaluation form are standardised on CernerEPR and are auditable—these also form part of the weekly fall training which includes a video on how to carry out post falls checks. • An observable indicators pain assessment tool will be relaunched as part of the dementia service development.
FFFAP: Fracture Liaison Service Database (FLS-DB)	Trauma and Orthopaedics	• At West Middlesex University Hospital, there is a plan to utilise a new pharmacist to help with follow-ups and medication compliance issues. The FLSDB CNS is working with the digital innovation team to provide an automated DXA (bone density scanning) request once a patient completes an electronic questionnaire—this will improve the time to DXA key performance indicator. Currently, a virtual electronic questionnaire is disseminated to patients to get them involved in decision-making around their care—this is currently only available in English and there are plans to incorporate other languages.
NATCAN: National Lung Cancer Audit (NLCA)	Medical Oncology	• The Chelsea team has the highest data completeness of any multidisciplinary team within the Trust, and one of the highest in the network. The Trust is already incorporating new metrics such as smoking status. The Chelsea multidisciplinary team meets lung cancer clinical expert group (LCCEG) standards, although West Middlesex has yet to achieve this—the site continues to make improvements.
National Ophthalmology Database Audit (NOD): National Cataract Audit	Ophthalmology	• This audit is applicable to Chelsea and Westminster Hospital only. West Middlesex University Hospital has no ophthalmology service in place. Chelsea and Westminster Hospital does not have access to Medisoft/Medisight EPR so is not submitting data to the audit—the non-participation is on the risk register. However, the site meets the audit's key performance indicators—there is a pathway for pre and post-operative VA (Visual Acuity) collection (outside of COVID restrictions on Face-2-Face appointments).
RCEM: Pain in Children (care in emergency departments)	Emergency Medicine	• There is no play specialist assigned to paediatric ED but there is active involvement of family with regard to re-evaluation. • At West Middlesex University Hospital there is ongoing work towards building a paediatric emergency medicine (PEM) clinical team. The paediatric consultant is to formulate a framework and timetable teaching for all PEM consultants and paediatric ED nurse lead responsible, to help deliver and clinically supervise staff. All staff who are trained will be revalidated—staff who are not will be encouraged to complete their training.
National Paediatric Diabetes Audit (NPDA)	Diabetes/ endocrine	• Chelsea and Westminster Hospital is not able to fully meet the key performance indicator around health checks—eye screening results from the community are not recorded on CernerEPR and the local team do not have sight of these. This is a national problem with NWL primary care to rectify/improve availability.

Annex 3: Statement of directors' responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations (amended in 2020) to prepare quality reports for each financial year.

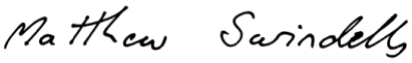
NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report is not inconsistent with internal and external sources of information, including:
    - Board minutes and papers for the period Apr 2023–Mar 2024
    - Papers relating to quality reported to the board over the period Apr 2023–Mar 2024
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The latest national patient survey
    - The latest national staff survey
    - CQC inspection reports
- The quality report presents a balanced picture of Chelsea and Westminster Hospital NHS Foundation Trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The quality report has been prepared in accordance with the NHS foundation trust annual reporting manual 2023/24 (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report

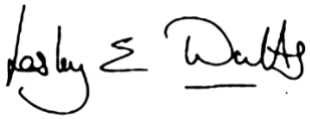
The directors confirm, to the best of their knowledge and belief, they have complied with the above requirements in preparing the quality report.

By order of the board:



Matthew Swindells
Chairman

27 June 2024



Lesley Watts
Chief Executive Officer

27 June 2024

Annex 4: Statement from the Council of Governors

Governors' comments on the Quality Report 2023/24

As a Council of Governors, we welcome this report, which outlines the progress made by the Trust in delivering safe, high-quality, patient-centred care. We thank all the staff who have worked tirelessly during what has been such a challenging year. The Trust continues to perform well in seeing patients as quickly as possible in our busy A&E departments, reducing our waiting lists, diagnosing and treating cancers, and supporting mothers and babies in our maternity units. We continue to innovate and improve, continually seeking the best for our patients and working closely with our local partners and communities.

As governors, we are elected by patients, the public, and staff. As such, we are accountable to our wider membership for the role we play in ensuring that Trust services are accessible, responsive, and safe. We do this in various ways—through sharing the experience of local communities, through 'meet the governor' sessions, and through our regular formal and informal meetings, which include working closely with and holding our non-executive board directors to account. We enjoy positive and constructive relationships with the Trust's leadership, challenging where we need to, but always working together in the interests of patients.

Over the past year, we have focused on a range of aspects of quality, including the following:

- **Maternity:** We discussed the Care Quality Commission's (CQC) inspection of our services. We were pleased with the outcome of the inspection, whereby we maintained our 'good' and 'outstanding' ratings, but also explored where we need to do more to improve. We particularly welcomed the engagement of women and families, the continued cultural safety champion work to address inequalities, and the progress in recruiting more staff, specifically midwives.

- **Winter planning and vaccinations:** Winter is always a busy time for the NHS. We scrutinised the plans in place in the Trust and with system partners to ensure we were well-prepared. As part of this, we considered vaccine uptake for flu and COVID-19 vaccinations, focusing on staff but also looking at how we could encourage our wider communities to protect themselves.

- **Patient experience:** Patients should have a positive experience of care at our Trust. We considered the progress made through the 'PLACE' inspections, some of the findings of the national CQC surveys, our friends and family test surveys, and more general feedback (PALS, complaints, engagement), all of which serve to inform questions and debate. We also wanted to see action where experience was not good enough—mealtimes was one of these areas, and the focus on improvements to feed patients, through our volunteers, is just one of the examples where targeted action can have an impact.

- **Accessible care:** A number of governors have been instrumental in driving forward the programme to ensure that our Trust buildings and services are more accessible. A range of improvements were made, particularly to improve the access and experience of people with dementia; there is ongoing work on signage to support this.

- **Trust staff:** We spent a dedicated session on the results and actions in place in relation to the staff survey. In further meetings, we heard about the increased range of health and wellbeing initiatives, the improved retention and vacancy rates, and progress with equality, diversity, and inclusion (EDI). We know there is more to do, particularly in relation to EDI, and we welcome the Trust's continued focus on this.

- **Research and development:** This is an important factor to ensure we continue to progress in improving the quality of care. Widening access for local people to participate in research opportunities and trials is a priority for the Trust. We were pleased to see this and a number of other positive examples highlighted in the report, including:

    - The learning disability and adult safeguarding team's successful internship programme
    - The discharge-ready unit at West Middlesex, which has significantly reduced the length of stay, helping patients recover and return home when they are ready
    - Our innovative robotic surgery team and the incredible impact this use of technology is having on the quality and timing of surgery

We believe that by listening to and engaging with patients, we will further improve services, making them more responsive to and tailored to our local communities. This is critical if we are to reduce the inequalities that we know exist for sections of our wider population. We have seen some positive steps in this regard, and it is where we as governors can make a significant contribution.

Looking forward, we welcome the quality priorities identified for 2024/25, which we discussed and endorsed earlier this year. These include a focus on deteriorating patients, improving care for our frail patients, patient experience (specifically nutrition and hydration), implementation of our new patient safety and incident reporting framework (which is more focused on learning), and transitional care for younger people.

We have been engaged in and are excited about the direction set out in our refreshed Trust Clinical Strategy, particularly our developments in terms of the Chelsea and Westminster Treatment Centre and the West Middlesex Ambulatory Diagnostic Centre.

While the information within the report shows that the Trust is a high-quality and safe provider of services, we know there is always more that can be done to improve and, as governors, this will be our focus in partnership with the Trust's leadership and our local communities over the coming year. As ever, the Trust's staff, volunteers and partners are central to all of this, and we thank them for their continued commitment and dedication.

Nigel Clarke
Lead Governor

24 June 2024

Epilogue

About the Trust website

The maintenance and integrity of the Trust's website is the responsibility of the directors. The work carried out by the assurance providers does not involve consideration of these matters, and accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Your comments are welcome

We hope that you have found our quality report interesting and easy to read. We would like to hear your thoughts about it, so please let us have your comments using the contact details below.

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You can receive our newsletter to stay up-to-date and get involved in improving quality at our hospitals by becoming a member of our foundation trust. Please see www.chelwest.nhs.uk/membership for details.

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