North West London
Acute Provider Collaborative

# NWL APC BOARD IN COMMON - PUBLIC - READING ROOM

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21 October 2025

11:00 GMT+1 Europe/London

The Oak Suite, W12 Conference Centre, Hammersmith Hospital

# AGENDA

# 3.1 PROVIDER CAPABILITY ASSESSMENTS - INDIVIDUAL TRUST REPORTS

## REFERENCES

Only PDFs are attached

- CWFT Provider Capability - Self Assessment Template Standing Committee.pdf
- ICHT Provider Capability - Self Assessment Template - for BiC - final.pdf
- HHFT Provider Capability - Self Assessment Template 1.2.pdf
- LNWH Provider Capability Assessment final.pdf

# Provider Capability Self-Assessment Template

## I. Strategy, leadership and planning

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Explanation where not confirmed and actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners | • Are the trust's financial plans linked to and consistent with those of its commissioning ICB or ICBs, in particular regarding capital expenditure?<br>• Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?<br>• Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy?<br>• Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level? | The trust has been a key partner in the North West London (NWL) Acute Provider Collaborative (APC) since 2022 and the Trust priorities are aligned with the APC strategy, which was approved in 2024. They are also aligned to the NWL Integrated Care System (ICS) Health and Care strategy.<br><br>The Trust develops an annual business plan each year, alongside other partner acute trusts in the APC and in partnership with the ICB. This includes developing activity, workforce and financial plans. The Board in Common approves the plans for each of the four trusts.<br><br>The trust's clinical strategy was refreshed and launched in September 2024, following extensive engagement with local and system stakeholders.<br><br>The trust's financial plan was developed through a collaborative process across the APC and with the Integrated Care Board (ICB), to ensure alignment across partners. The final plan was approved through local and APC governance.<br><br>Through the APC governance, the Trust has agreed a shared digital and data strategy with the other APC partners, which has enabled the four trusts to implement a single electronic patient record system allowing shared patient record access linked to the Federated Data Platform and NHS App. | • Trust Clinical Strategy<br>• NWL APC Strategy<br>• NWL ICS Health and Care Strategy<br>• Trust Quality Plan (approved through Executive Management Board (EMB) and coming to next Quality Committee)<br>• Trust Green Plan<br><br>Reports through the following:<br>• Board in Common (BiC)<br>• APC Digital and Data Committee (with sub-governance structure all overseen by the Chief Information Officer (CIO)<br><br>The Trust and APC are leaders in national data developments – e.g. Federated Data Platform (FDP) (trust referenced).<br><br>Trust is an innovator in developments in Artificial Intelligence (AI).<br><br>Trust and collaborative business plans for 2025/26 – report to BiC. | | Director of Transformation<br><br>Chief Financial Officer<br><br>Chief Information Officer | |

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|---|---|---|---|---|---|---|
| 2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE | • Is the trust currently complying with the conditions of its licence?<br>• Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)? | The trust is compliant with the provider licence conditions and is not subject to enforcement action by NHS England. | • Annual self-assessment against licence requirements, reported to Audit and Risk Committee annually (June 2025)<br>• Statement in the Annual Report 2024/25 | | Director of Corporate Governance | |
| 3. The board has the skills, capacity and experience to lead the organisation | • Are all board positions filled and, if not, are there plans in place to address vacancies?<br>• What proportion of board members are in interim/acting roles?<br>• Is an appropriate board succession plan in place?<br>• Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance? | The trust's board has a full complement of members, with the necessary range of skills and experience, and assigned leads accountable for all areas of operations.<br><br>Executive directors have clear accountabilities and responsibilities, with job descriptions and annual appraisals to enable reflection on any areas for further development. Succession planning for executive directors, including short-term business continuity plans and longer-term areas for development.<br><br>Non-executive directors have terms of office in line with Code of Governance guidance, and succession planning for non-executive directors is overseen by the APC Vice-Chairs group, taking into account the current board composition and existing / required skills. | • Trust and Board in Common (BiC) Members including biographies summarising skillset<br>• Board member skills matrix | | Director of Corporate Governance | |
| 4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and | • Is the trust contributing to and benefiting from its NHS trust collaborative?<br>• Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system?<br>• Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and | The trust is part of the NWL APC, with developed collaborative governance and leadership arrangements. These will be further strengthened in April 2026 with the move to a Single Accountable Officer/Group CEO.<br><br>The APC governance model, including a Board in Common and collaborative committees, ensures that the Trust | • APC website setting out strategic objectives, system projects and updates through BiC meetings for example:<br>○ Community diagnostic centres<br>○ Elective orthopaedic centre<br>○ Pathway redesign<br><br>APC strategy and trust strategy (referred to in no 1 above) contain further details. | | Director of Corporate Governance<br><br>Director of Transformation | |

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| population served | supporting wider service reconfiguration and shifts to community care where appropriate and agreed? | strategy and plans are aligned with other partners in the APC.<br><br>These arrangements have evolved to ensure collaborative development of strategy, including digital and data and estates and sustainability as well as in quality, finance and workforce. Task and finish groups have been established across the APC to develop specific strategies, such as the EDI task force, and trusts within the APC have worked together on a number of initiatives aimed at improving the population's health, for example the development of the elective orthopaedic centre following extensive consultation.<br><br>The Trust has developed a strategic alliance with The Hillingdon Hospitals NHS Foundation Trust, under the leadership of a single CEO and with several joint executive posts. This has enabled both trusts to share resource and learn / improve across both trusts.<br><br>Trust executives engage with system partners through various formal and informal mechanisms, including regular System Oversight Meetings. CEOs also attend the ICB strategic commissioning committee and there is a regular meeting of CEOs in NW London to ensure alignment across all partners in the ICS.<br><br>The trust plays a key role within integrated local partnerships and neighbourhood teams, with many examples of local community impact, for example the local Hounslow frailty model providing more holistic care for frail elders. | Trust CEO is NHS providers' partner member on ICB Board and chairs system flow board<br><br>Regular system oversight meetings (SOM) with executives from the trust and ICB scrutinise the performance and impact of the trust and discuss system wide working.<br><br>In addition to formal system and APC governance structures there are a range of APC and system wide groups meet to ensure collaborative working and constructive challenge – e.g. chief operating officer (COO)/MD and chief financial officer (CFO) groups<br><br>The hospital managing directors attend all borough/place based partnership meetings with local health and care partners e.g. Hounslow Health and Care and Bi-Borough Place-Based Partnership<br><br>Local projects demonstrating benefits of partnership working –e.g. Hounslow Frailty model and integrated neighbourhood teams. | | | |

## II. Quality of care

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients | • The trust can demonstrate and assure itself that internal procedures:<br>  ○ ensure required standards are achieved (internal and external)<br>  ○ investigate and develop strategies to address substandard performance<br>  ○ plan and manage continuous improvement<br>  ○ identify, share and ensure delivery of best practice<br>  ○ identify and manage risks to quality of care<br>• There is board-level engagement on improving quality of care across the organisation<br>• Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients<br>• Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community<br>• Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust<br>• Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement | The trust is committed to continuous improvement in quality of care, with robust monitoring processes in place.<br><br>The Board is assured of this through detailed reporting via the Trust's Quality Committee and supporting governance, which is triangulated through visits to Trust services by board members.<br><br>The trust benchmarks quality standards and performance through the APC Quality Committee, which supports sharing of good practice. | • Trust Quality Report 2024/25<br>• Agenda, minutes and papers for the Trust's Quality Committee<br>• Comprehensive governance structure feeding into the Quality Committee, including patient safety group, health, safety and environmental risk group, clinical effectiveness group, with further groups sitting beneath.<br>• Agenda, minutes and papers for the APC's Quality Committee<br>• Trust Quality Plan (approved by EMB)<br>• Reports to the Board in Common<br>• IQPR reports to EMB, board committees and standing committee<br>• NED maternity champion<br>• Executive and NED visits to points of care<br>• Council of Governors meetings and briefings, with quarterly quality updates and annual review<br>• Staff Survey 2024 - 84% of staff agreed that "Care of patients is my organisation's top priority."<br>• Risk management strategy and process, including quarterly reports to quality committee – separate corporate risk register and BAF reports.<br>• National oversight framework (NOF) rating of 1 for effectiveness and experience of care<br>• NOF rating for quality of care 2<br>• Patient Safety Incident Response Framework (PSIRF) Policy and Plan<br>• Patient safety specialists in post, embedded within portfolios of current staff to support full integration of approach<br>• Patient stories at trust quality committee and BiC – committee examples here and here<br>• Maternity and Neonatal Voices Partnership providing strong user voice and rep on maternal incident investigations<br>• Internal audit programme annually focused on quality risk areas – e.g. over | | Chief Nursing Officer<br><br>Chief Medical Officer | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | | past year: PSIRF, Mental Health Act, Safeguarding | | | |
| 6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board | • Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience?<br>• Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities?<br>• Is the board satisfied that it receives timely information on quality that is focused on the right matters?<br>• Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this?<br>• How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?<br>• Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? | The trust puts patient experience at the centre of all that we do. There are a range of ways in which this is done, through regular reporting and discussion through the board and APC's committees and at quarterly board meetings. The reports bring together findings from complaints, surveys, patient engagement meetings, healthwatch and visits, to provide a rounded picture of patient experience.<br>The trust's council of governors also provides feedback and insight via their constituencies through the quarterly CoG meetings and briefing sessions, some of which is gathered through 'meet the governor' sessions held on each hospital site. | • Trust patient and public experience and engagement report reported on quarterly basis to quality committee, with annual report summarising learning over whole year.<br>• Patient and public experience and engagement group, reporting in to the Quality Committee.<br>• Patient experience data on the friends and family trust (FFT), same sex accommodation and complaints reported monthly in performance and quality report to BiC<br>• Additional questions added to FFT focused on priority areas for improvement in line with national survey results<br>• National survey (maternity, ED, inpatient and outpatient) results reported through executive board and quality committee, along with action plans where improvement is needed.<br>• Patient led assessment of care environment (PLACE) surveys and action plans<br>• Patient stories at trust quality committee and BiC – committee examples here and here<br>• Council of Governors meetings and feedback<br>• National oversight framework (NOF) rating of 1 for effectiveness and experience of care<br>• NOF rating for quality of care 2<br>• Strong development framework for Nursing workforce<br>• Advanced Clinical Practice (ACP) opportunities and maturity matrix<br>• Apprenticeship provider<br>• Leader in volunteering provision<br>• Annual review of nursing and midwifery establishment, to ensure safe staffing | | Chief Nursing Officer | |

## III. People and culture

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 7. Staff feedback is used to improve the quality of care provided by the trust | • Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement?<br>• Does the board engage with staff forums to continually consider how care can be improved?<br>• Can the board evidence action taken in response to staff feedback? | The board and committees review feedback from staff through reports on the annual staff survey and related action plans, hear direct stories from staff at committee and board meetings and reports on other mechanisms of feedback, such as speaking up reports and updates regarding staff forums. Actions are tracked through the committee, including a tracker for impact in relation to staff stories.<br><br>The trust facilitates collaboration across research, innovation and quality improvement (RIQI). All staff are encouraged to participate in RIQI, with a focus on improving health outcomes, increasing clinical effectiveness and enhancing patient experience, culminating in an annual showcase. | • Staff survey results and action plan through thematic groups, reported to people and workforce committee (PWC)<br>• Staff stories to People and Workforce Committee, with tracker to monitor actions in response<br>• Staff stories at Board in Common<br>• Staff forums, with executive director leads<br>• Workforce Race Equality System and Disability Equality System<br>• NOF rating of 1 for people and workforce.<br>• Research innovation and Quality Improvement approach, including annual showcase event. | | Chief People Officer (CPO)<br><br>Chief Nursing Officer | |
| 8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels | • Does the trust regularly review skills at all levels across the organisation?<br>• Does the board see and, if necessary, act on levels of compliance with mandatory training? | The trust attracts high calibre staff with a wide range of skills. To support retention and development, the trust provides a comprehensive learning and development offer to staff at all levels, with high satisfaction rates evidenced through the last staff survey results where the trust was ranked number one in London for learning culture.<br><br>Mandatory training compliance levels are above target and monitored weekly by executives, with reports provided to board committees and through the board's quality and performance report for further scrutiny and action. The BiC receives a quarterly update on performance across the collaborative on core skills compliance supporting wider conversations and ability to share best practice across all four trusts. | • Positive learning and development offer for staff – evidenced through staff survey results on 'learning culture' – number one in London.<br>• Reports on mandatory training compliance to People and Workforce Committee (PWC) (and weekly to all managers and executives).<br>• Escalation reports from PWC to Board Standing Committee.<br>• APC PWC reports<br>• GMC survey outcomes – trust ranks positively compared to peers and improvement from previous year reported to PWC in 2024<br>• Core skills compliance in BiC IQPR above target<br>• NOF rating of 1 for people and workforce. | | Chief People Officer | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 9. Staff can express concerns in an open and constructive environment | • Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?<br>• Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?<br>• Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?<br>• Is there a safe reporting culture throughout the organisation? How does the board know?<br>• Is the trust an outlier on staff surveys across peers? | The Board receives quarterly reports on FTSU through the local people and workforce committee. A detailed trust level annual report is received at the board's standing committee with an aggregated report at BiC level to support comparison and learning across the APC.<br><br>The Board has a clearly communicated FTSU process, which is utilised by staff, who report above average levels of confidence in the process. | • FTSU policy and process, including NED lead, Guardian and champions across organisation – well publicised on intranet, through posters and awareness events<br>• Staff survey results on 'speaking up' above national averages.<br>• Regular updates and annual report on FTSU to People and Workforce Committee and BiC.<br>• Monthly partnership committee with trade union representatives - provides regular forum for raising or escalating concerns and reports through to People and Workforce Committee<br>• NOF rating of 1 for people and workforce. | | Chief People Officer | |

## IV. Access and delivery of services

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 10. Plans are in place to improve performance against the relevant access and waiting times standards | • Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary?<br>• Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this?<br>• Is there a plan to deliver improvement? | The trust has a strong track record in achievement of performance standards set in the annual operating plan.<br><br>For 2025/26 the trust is working towards achievement of all standards and where these are off trajectory, improvement plans are in place, with weekly monitoring. | • IQPR and elective recovery reports to committees and BiC<br>• NOF rating of 1 for access to services<br>• Weekly cancer and elective access meetings to drive improvement in performance.<br>• ED improvement plan<br>• Improvement Board – plus range of boards monitoring performance, trajectory against plan and actions required – e.g. outpatients, board, flow board and cancer board | | Managing Directors | |
| 11. The trust can identify and address inequalities in access/waiting times to NHS services | • The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place | The trust, with APC partners, established a health equity programme and agreed a set of metrics aimed at tackling key patient and population health related inequalities. These will be tracked through the performance and quality reports at trust and collaborative committees, and through the BiC. | • Trust QEHIA process<br>• Trust health inequalities and improvement committee, reporting through to trust quality committee<br>• APC Equity Improvement Plan | Further work to embed collection and tracking of new APC wide agreed equity metrics at trust and collaborative | Managing Directors | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| across its patients | | The trust's health inequalities committee oversees the trust's programme on reducing health inequalities and addressing unwarranted variation, with quarterly reports to the trust's quality committee.<br><br>The Trust collects demographic information such as age, sex, ethnicity, disability, deprivation, and geography, then analyse service usage and waiting times across these groups. By breaking down referral rates, treatment times, and outcomes, variations in access are identified. Comparative analysis will highlight variation and the health inequalities committee will agree appropriate action. Alongside this, patient feedback from surveys, patient feedback, and focus groups helps Trusts understand obstacles such as language, digital exclusion, or transport. | • Segmented data metrics agreed and to be included in Trust and APC IQPR<br>• NOF rating of 1 for access to services<br>• Patient communications charter ensuring a more targeted approach to patients most of risk of not attending appointments – with more inclusive communications and improved wayfinding.<br>• Focused work on inequalities in relation to cancer through the cancer alliance – RM Partners e.g. community and voluntary sector grants and partnership.<br>• Maternity - focus on addressing late bookings, in line with agreed APC equity target to support better outcomes for those with protected characteristics.<br>• Wider maternity equity work, also recognised nationally by CQC | level – priority for 2025/26 | | |
| 12. Appropriate population health targets have been agreed with the ICB | • Is there a clear link between specific population health measures and the internal operations of the trust?<br>• Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system? | The Trust has agreed a series of population health measures with the ICB which are aimed at preventing ill health and reducing inequalities. These include a focus on smoking cessation and support with substance misuse, which includes embedded teams through the maternity and emergency care pathway. | • Trust health inequalities and improvement committee, reporting through to trust quality committee<br>• APC Equity Improvement Plan<br>• Health Inequalities statement in Annual Report<br>• Wider maternity work referenced above. | | Director of Transformation | |

## V. Productivity and value for money

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board | • Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:<br>○ review its performance against peers<br>○ identify and understand any unwarranted variations | As part of an established acute provider collaborative, the trust has effective operational and governance arrangements to benchmark performance and share best practice across the collaborative.<br><br>The model health system data is considered annually at the trust's finance and performance committee, demonstrating overall high productivity levels when benchmarked | • Reports to trust and collaborative FPC<br>• APC FPC reports on productivity and proposed additional metrics/focus in 25/26<br>• Cancer productivity report to Sept APC FPC<br>• Programme of deep dives which include benchmarking data | | Director of Transformation<br><br>Managing Directors<br><br>Chief Financial Officer | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| and other guidance as relevant | ○ put programmes in place to reduce unwarranted negative variation<br>• The trust's track record of delivery of planned productivity rates | nationally. In addition the APC CFOs have worked collaboratively to develop locally agreed metrics to complement the nationally defined metrics, all of which are tracked through an APC productivity and efficiency dashboard and which were approved at the APC's finance and performance committee.<br><br>For those areas where productivity could be improved, for example cancer, there is joined up work across the wider cancer collaborative, which is reported to the APC FPC. | • Improvement Board – monitor cost improvement and productivity programmes – quarterly reports to FPC<br>• NOF rating of 1 for finance and productivity | | | |

### VI. Financial performance and oversight

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 14. The trust has a robust financial governance framework and appropriate contract management arrangements | • Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data<br>• Have there been any contract disputes over the past 12 months and, if so, have these been addressed?<br>• [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned? | The trust has a strong track record of delivery against financial plans, with comprehensive governance arrangements in place. The annual operating plan is developed in a collaborative way to ensure activity, workforce and finance data is aligned at trust and collaborative level. Performance against the plan is reviewed on a monthly basis through trust and APC governance.<br><br>A review of the trust's financial governance arrangements was included as part of the system's review under the investigation and intervention regime in late 2024. The review identified overall strong governance arrangements, with some recommendations for improvement which have since been enacted.<br><br>There have been minimal contractual disputes over the past 12 months and all have been resolved positively through appropriate governance routes. | • Financial governance structure<br>• Comprehensive internal audit plan agreed annually and progress tracked at each audit and risk committee meeting<br>• Reduction in bank and agency usage in relation to 2024/25 – reports to PWC and FPC<br>• Investigation and Invention Report for NWL ICS and report re CW<br>• NOF rating of 1 for finance and productivity<br>• Approval of business/operating plan through a collaborative approach across the APC and ICS. | | Chief Financial Officer (CFO) | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes | • Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care?<br>• Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing?<br>• Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers? | The trust has a strong track record in delivering cost improvement programmes, but does so by ensuring no reduction in the quality and safety of care provided. Each CIP must be accompanied by a quality and health inequalities impact assessment which is reviewed by executive leads, including medical and nursing leadership to ensure there is no adverse impact.<br><br>Overall financial performance for the trust and APC is monitored regularly through trust and APC level finance and performance committees, and reported quarterly through the board's standing committee and the board in common. | • Cost improvement programmes reviewed through equalities and quality health impact assessments to ensure no adverse impacts on quality or inequalities.<br>• Monitoring through trust and APC FPC, plus through the board standing committee and BiC.<br>• Through IQPR – finance workforce, performance – balanced scorecard<br>• NOF rating of 1 for finance and productivity | | CFO | |
| 16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn | • Is the board contributing to system-wide discussions on allocation of resources?<br>• Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system?<br>• Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS? | The trust works closely with system partners on financial planning to ensure full alignment across the APC and the wider ICS footprint. This is developed and considered through the local, collaborative and system finance and performance governance structure, supporting a joined up approach that focuses on the benefit to the overall population of north west London. | • Development of Medium Term Financial Strategy across APC<br>• APC Finance and Performance Committee<br>• APC pathway development programme<br>• NOF rating of 1 for finance and productivity<br>• APC CFOS with wider ICS CFOs developed financial plan, with ICB board signing off final allocations<br>• System oversight on finance, quality and performance through the quarterly System Oversight Meetings (SOM). | | CFO | |

# Provider Capability Assessment – Update for Board in Common

## 1. Introduction

NHS England's (NHSE) have published a new requirement for all providers to complete and submit a 'provider capability assessment' by the end of October 2025.
(NHSE guidance can be found here and the NHS Providers briefing here)

## 2. Process

It was agreed that the self-assessment would be reviewed through the Executive Strategic Deep Dive, EMB, Trust Standing Committee, with all APC Trust submissions approved at the Board in Common meeting on 21 October.

initial template (see from page 2) has been developed which is intended to be populated to sit alongside the self-assessment template (see below) to provide further detail on the Trust's assessment against each of the six elements below.  The template has been populated by the executive team and reviewed by the Trust Board.

## 3. Next steps

The Trust Board are asked to review and confirm the proposed ratings, assurance statements and actions that have been identified by the executive to be added to the Trust/Executive single improvement plan.

**Provider Capability - Self-Assessment Template**

| | *The Board is satisfied that…* | | *(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)* |
|---|---|---|---|
| **Strategy, leadership and planning** | • The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners<br>• The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE<br>• The board has the skills, capacity and experience to lead the organisation<br>• The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served | Confirmed | *If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:* |
| **Quality of care** | • Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients<br>• Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board | Confirmed | *If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:* |
| **People and Culture** | • Staff feedback is used to improve the quality of care provided by the trust<br>• Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels<br>• Staff can express concerns in an open and constructive environment | Confirmed | *If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:* |
| **Access and delivery of services** | • Plans are in place to improve performance against the relevant access and waiting times standards<br>• The trust can identify and address inequalities in access/waiting times to NHS services across its patients<br>• Appropriate population health targets have been agreed with the ICB | Confirmed | *If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:* |
| **Productivity and value for money** | • Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant | Confirmed | *If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:* |
| **Financial performance and oversight** | • The trust has a robust financial governance framework and appropriate contract management arrangements<br>• Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes<br>• The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn | Confirmed | *If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:* |
| | **In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.** | Confirmed | *If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:* |

Signed on behalf of the board of directors

Signature

Name

Date

# Provider Capability – Self Assessment Template

## I. Strategy, leadership and planning

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners | • Are the trust's financial plans linked to and consistent with those of its commissioning ICB or ICBs, in particular regarding capital expenditure?<br>• Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?<br>• Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy?<br>• Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level? | The Trust has clear strategic goals focused around creating high quality integrated care system with the population of NW London, developing a sustainable portfolio of outstanding services, and building learning, improvement and innovation into everything we do. To support delivery of those goals we have a set of strategic programmes, including outpatient transformation, theatre utilisation, cancer care improvement, patient flow, advancing equity and inclusion and estates optimisation.<br><br>These strategic priorities are refreshed every two years, and the priority programmes for 2025-2027 were agreed in January 2025 following staff and wider stakeholder engagement sessions.<br><br>The Trust has been a key partner in the North West London (NWL) Acute Provider Collaborative (APC) since 2022 and the Trust priorities are aligned with the APC strategy, which was approved in 2024. They are also aligned to the NWL Integrated Care System (ICS) Health and Care strategy.<br><br>The APC governance model, including a Board in Common and collaborative committees, ensures that the Trust strategy and plans are aligned with other partners in the APC. This has led to some key transformation programmes, such as the Elective Orthopaedic Centre, the Clinical Pathways Programme and the Corporate Transformation Programme. There is good co-ordination across the wider ICB in NW London with a regular monthly CEO meeting to ensure strategic alignment.<br><br>The APC provides effective mechanisms for the coordination of planning across the four trusts in North West London including capital planning. There is an APC wide board level committee that reviews all major estates and developments and capital projects to ensure coordination across the sector. These feed into ICB level plans through a series of informal meetings via the CFO's and the through the Strategic Commissioning Committee of the ICB (which is attended by the ICHT CEO) and the Planned Care Board of the ICB which is co-chaired by the ICHT CEO.<br>The Board in Common reviews and approves the plans for the four trusts. The Trust has also developed a 5- | • Trust Strategic key programmes 2025-27<br>• NWL APC Strategy<br>• NWL ICS Health and Care Strategy<br><br>Reports through the following:<br>• Board in Common (BiC)<br>• APC Digital and Data Committee (with sub-governance structure all overseen by the Chief Information Officer (CIO)<br><br>• Trust and collaborative business plans for 25/26 – report to Board in Common<br><br>• FIOC 5 -year capital plan | We are in active discussion with the ICB regarding unfunded activity – we will pick up contractual issues in the planning round 26/27 – as part of the medium term planning discussions. | Director of Strategy, Research and Innovation/CIO CFO | |

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| | | year capital plan, approved by the Finance, Investment and Operations Committee. The trust has a record of digital innovation, as part of the national digital exemplar and now has a shared Digital Strategy, under the leadership of a joint CIO across the APC, which has delivered benefits in standardisation, alignment and consistency in a range of digital tools and systems. The four trusts in the APC now have a single electronic patient record system allowing shared patient record access linked to the Federated Data Platform and NHS App. The ICT team at ICHT are actively involved in the development of the sub national secure data environment in London and work with partners across the city and with NHSE nationally to advance the digital agenda.<br><br>As a key institution in our local area, we run initiatives to positively influence the underlying social, economic and environmental conditions which support an equitable, healthy and prosperous local community. There has been a particular focus on access to employment in recent years, with continued efforts in our apprenticeships, work experience and volunteering initiatives. The volunteer employment programme, supported by Imperial Health Charity, has seen 80 out of 115 volunteers gain employment at the Trust in 2024-25. Since launching in 2023, our community recruitment work has supported 537 employees from the north west London population into work, significantly contributing to the total percentage increase of the Band 2 and Band 3 workforce residing in north west London.<br><br>We have fed into 'Upstream London' which is Hammersmith & Fulham Council's pioneering industrial strategy. Alongside Hammersmith & Fulham Council and Imperial College's Environmental Research Group we are aiming to co-create initiatives to reduce public exposure to air pollution and improved air quality in north west London. As part of Westminster #2035 – a joint partnership with Westminster City Council - we work with local communities to achieve the collective ambition of a healthier and fairer Westminster together by 2035. The collaboration aims to change futures and reduce inequalities through listening to our residents more effectively and proactively connecting with other organisations.<br><br>The Trust has strong academic and research partnerships with Imperial College London and other academic partners and is the largest BRC in the country. We continue to build on our strong relationships with | | | | |

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| | | industry / pharma through our life sciences work and are the preferred partner for several pharma companies.<br>We led the work that has resulted in setting up an ICB wide Research and Innovation Board chaired by Sir Mark Walport. We are active members of the Academic Health Science Centre (AHSC) with Imperial College London and Imperial College Health Partners Health Innovation Network (HIN). We have a strong bilateral relationship with a world leading research university at Imperial College London, with which we are developing joint strategies across a number of areas. We are working in increasing collaboration with acute Trust partners, GPs & emerging neighbourhood teams, local authorities & industry. We convened the Paddington Life Sciences partnership which is a leading example of an NHS led life sciences ecosystem.<br><br>Research & innovation are at the heart of our organisation with multidisciplinary leadership evidenced by >£2million grant income for Nurses, Midwives, AHPs, Healthcare Scientists, Pharmacy Staff and Psychologists (NMAHPPs) research in 2024 and 168 NMAHP publications.<br><br>Leveraging the value of two excellent specialist paediatric services West London Children's Healthcare (WLCH) have worked jointly between ICHT and CWFT to develop a single, joined up specialist paediatric service. Key achievements include:<br>• Supporting children and young people (CYP) with mental health needs in an acute setting<br>• Complications of excess weight clinic<br>• Transitioning well to adult services<br>• Implementation of Martha's Rule and digital<br>• Paediatric Early Warning Score (PEWS)<br>• POSCU (paediatric oncology shared care unit)<br>• accreditation<br>• Emergency surgical pathways transformation<br><br>WLCH Research activities related to Children and Young People have come together to form the Centre for Paediatrics and Child Health and we work collaboratively with a focus on the common diseases of childhood. | | | | |
| 2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement | • Is the trust currently complying with the conditions of its licence?<br>• Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of | The trust is compliant with the provider licence conditions and is not subject to enforcement action by NHS England. | • Annual self-assessment against provider licence requirements, reported to Audit and Risk Committee annually (June 2025)<br>• Annual report 2024/25<br>• Trust placed in Segment 1 in latest NOF ratings (September 2025) | | Director of Corporate Governance | |

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| action from NHSE | the national Performance Improvement Programme (PIP)? | | | | | |
| 3. The board has the skills, capacity and experience to lead the organisation | • Are all board positions filled and, if not, are there plans in place to address vacancies?<br>• What proportion of board members are in interim/acting roles?<br>• Is an appropriate board succession plan in place?<br>• Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance? | The trust's board has a full complement of members, with the necessary range of skills and experience, and assigned leads accountable for all areas of operations. All voting executive directors are on substantive employment contracts apart from the newly appointed interim chief operating officer, (a process is underway to recruit substantively by the end of November) with agreed job descriptions and delegated authorities.<br>NED terms of office are compliant with Code of Governance.<br><br>Our Remuneration & Appointments Committee (RemCo) considers any business continuity and succession planning risks in relation to executive directors, and succession / recruitment planning for non-executive directors is overseen by the APC Vice-Chairs group. All Trust level posts have emergency cover and are risk assessed in terms of losing the person currently in post, difficulty recruiting, and impact on the Trust in the event of a gap.<br><br>There are clear accountabilities and responsibilities across core domains such as quality, finance, operations etc, with named executive leads in place. We also have named non-executive champions where required including a Freedom to Speak Up champion and Maternity champion. There are sub-committees of the Board for quality, people, finance and operations. | • Trust and Board in Common (BiC) Members<br>• ICHT Organisation Chart<br>• Board member skills matrix<br>• CEO and executive director appraisals reported to Remuneration Committee<br>• NED annual appraisals completed<br>• Board compliance with STAM training reported in FPP returns | Exploit the potential of the group model to improve succession planning | Director of Corporate Governance<br>Chief People Officer | |
| 4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served | • Is the trust contributing to and benefiting from its NHS trust collaborative?<br>• Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system?<br>• Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed? | The trust has been a key partner in the NWL APC since 2022 and will be further strengthened in April 2026 with the move to a more formal group structure and the appointment of a Single Accountable Officer/Group CEO.<br>Together the collaborative has done some important work in setting up community facilities including community diagnostic centres and an elective surgical hub for orthopaedic surgery and improving clinical standards by a programme of clinical pathway redesign across all 28 specialties that are provided at all four trusts. We have worked on corporate consolidation of corporate functions held over multiple trusts, as well as clinical consolidation to support the delivery of high-quality services such as haematology between London North West and ICHT, and important work on equality diversity and inclusion through the APC EDI taskforce.<br>The governance model for the APC has evolved to ensure collaborative development of strategy, including | • APC website setting out strategic objectives, system projects and updates through BiC meetings for example:<br>○ Community diagnostic centres<br>○ Elective orthopaedic centre<br>○ Pathway redesign<br>○ Clinical pathways programme – case studies from event on 15 July<br><br>• APC strategy and trust strategy (referred to in no 1 above) contain further details.<br><br>• Trust CEO is lead CEO for the APC | | Director of Corporate Governance<br>Director of Strategy, Research and Innovation | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | digital and data and estates and sustainability as well as in quality, finance and workforce in order to ensure that it is able to leverage maximum value from collaboration in the future.<br><br>The trust shares a number of executive lead roles across the APC, including the Trust CEO chairing the APC EMB, and leads on a number of joint initiatives across the APC, including corporate transformation projects and the clinical pathways programme.<br><br>The executive team members also regularly engage with wider partners including the ICB, via System Oversight Meetings and membership / engagement in ICB governance, including the ICB strategic commissioning committee, the NW London CEOs group and the Planned Care Board which the ICHT CEO co-chairs.<br><br>Trust executives hold multiple roles in the NHS outside of the Trust, including regional and national roles. E.g. our Medical Director is the national director for urgent and emergency care and CEO sits on multiple national boards.<br><br>The trust is currently planning for the much needed redevelopment of its hospitals, including St. Mary's, Charing Cross and Hammersmith Hospitals.. We have had strong support from local councils and MPs for the St Mary's redevelopment and have established a joint task force with Westminster City Council with an independent chair, consisting of the trust, charity, Imperial College London, the city council and local MPs, in order to identify mechanisms for accelerating progress and we are now working with the NHSE national team in order to advance the redevelopment.<br><br>The CEO has a regular programme of engagement with all local MPs and all local councils, meeting regularly with MPs and with cabinet members for Health and Social Care and Oversight and Scrutiny Committee chairs.<br><br>The Trust Director of Engagement & Experience and Director of Strategy are regular attendees at Health & Wellbeing Boards and meetings with Councils e.g. North Paddington.<br><br>The trust is also working in partnership with Imperial College to develop the Fleming Institute and Centre – an | • APC and Trust level governance structures. | | | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | international initiative to raise awareness of antimicrobial resistance.<br><br>The Mohn Centre (part of the Imperial College School of Public Health) launched with a focus on the health and wellbeing of children and young people in an urban environment and we partner on patient experience and child health priorities through West London Children's Healthcare. | | | | |

**II. Quality of care**

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| 5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients | • The trust can demonstrate and assure itself that internal procedures:<br>○ ensure required standards are achieved (internal and external)<br>○ investigate and develop strategies to address substandard performance<br>○ plan and manage continuous improvement<br>○ identify, share and ensure delivery of best practice<br>○ identify and manage risks to quality of care<br>• There is board-level engagement on improving quality of care across the organisation<br>• Board considers both quantitative and qualitative information<br>• Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community<br>• Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust<br>• Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement | The Trust is committed to continuous improvement in quality of care, with robust monitoring processes in place. We provide some of the best outcomes in acute hospitals, consistently in the top 5 providers by mortality rates. The forward planners for all relevant committees align with national requirements for reporting with relevant national reports added when published with a process of local gap analysis and improvement planning.<br><br>Quality insights inform our quality and safety improvement priorities to ensure they represent our most significant areas of clinical risk, as well as opportunities to improve how we better engage with and involve patients and their families in our plans. Collectively, they aim to support delivery of the trust strategic objective to improve outcomes for patients and local communities. Progress with these is reported through our governance framework and summarised in our annual quality account.<br><br>Our five patient safety partners continue to ensure the patient's perspective is central to our improvement plans and have been integral to our work, including on the pilot programme to embed Martha's Rule, proving a patient focus for our hand hygiene improvement programme, and supporting our work to improve cancer pathways and outpatient services.<br><br>We have a robust quality governance framework in place at the Trust which provides a clear route for escalation of clinical risks and issues. These are discussed at our Executive management Board Quality meeting (EMBQ) and escalated to the Executive Management Board (EMB)B and Quality Committee. | • Trust Quality Account 2025/25<br>• Agenda, minutes and papers for the Trust's Quality Committee<br>• Agenda, minutes and papers for the APC's Quality Committee<br>• Reports to the Trust Standing Committee and Board in Common<br>• Executive and NED ward visits<br>• EQIA process and assessments, reporting to Quality Committee and TSC<br>• Trust quality scorecard reporting to EMBQ, EMB, Quality Committee and Standing Committee – demonstrates mortality rates among the lowest in the NHS, below average harm levels and an incident reporting rate that has been increasing year-on-year since 2021-22<br>• Improvement capability framework (intranet link)<br>• Improvement capability training data Improvement Dashboard - ICHT \| App overview - Qlik Sense<br>• Intranet link to tools & templates - Improvement tools and templates - The intranet | | Chief Nursing Officer<br>Chief Medical Officer<br>Director of Strategy, Research & Innovation | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | Quality review meetings (QRMs) provide a mechanism for key stakeholders to come together collectively to share and review information when a serious concern about the quality of care has been identified or raised, identify actions and provide support for staff. This process is supported by a SOP and is monitored via EMBQ.<br><br>We fully implemented the Patient Safety Incident Response Framework (PSIRF) in April 2024 moving to a more considered and proportionate response, focused on understanding how incidents happen and on engaging more deeply with and involving those affected.<br><br>We continue to adapt how we are embedding the new framework in practice to best suit our staff and patients including providing new training and support for staff, implementing new processes to better support the initial stages of the investigation so that we can more quickly identify learning and actions needed to improve patient care, and working with patients, families and staff involved in incidents to ensure we reflect their experience and views in our learning responses.<br><br>We are currently working with our partners across the North West London Acute Provider Collaborative to implement a joint new incident reporting and risk management system, which will help us to standardise reporting and metrics, and ensure we are more accurately capturing and identifying areas of risk and learning across our hospitals.<br><br>There is an established, significant and sustained culture of continuous and creative learning, innovation and improvement based on evidence and local need. This delivers improved outcomes, equality of access, experience and quality of life for people.<br><br>The trust has a high-quality improvement capability building programme to support staff to develop improvement skills and 20% of current Trust staff have completed QI training. Our improvement methodology and approach is applied across our key programmes including green, health equity, patient safety and performance (including outpatients) and outcomes are outlined in the relevant sections of this document.<br><br>The Board is assured of this through detailed reporting via the Trust's Quality Committee and supporting governance, which is triangulated through visits to Trust services by board members and NED Champions such as the Maternity NED Champion Board members hear | | | | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | directly from patients and staff via stories at Board Committees and the Board in Common<br><br>The trust benchmarks quality standards and performance through the APC Quality Committee, which supports sharing of good practice.<br><br>The trust utilises model hospital data and other benchmarking data to drive productivity and efficiency.<br><br>Improvement for All is our priority programme to systematically embed our improvement approach into the way we run our organisation. This is overseen by a programme board reporting to EMB.<br>This includes being clear and consistent about the application of improvement principles through areas of work – not only discrete QI projects - proper diagnosis of issues, clear aims, defined measures, demonstrable logic of how actions will achieve improvements and an approach for iterative testing.<br><br>Through Improvement for All we are developing single improvement plans at all levels of the organisation which supports teams to identify and prioritise all of their improvement requirements and see how they ultimately contribute to the trust's priorities which include how we are improving health inequity and population health. This has been developed at directorate level and is now being extended to individual wards and departments. | | | | |
| 6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board | • Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience?<br>• Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities?<br>• Is the board satisfied that it receives timely information on quality that is focused on the right matters?<br>• Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, | The trust has had a patient and public involvement strategy in place since 2016 and, in January 2023 we decided to strengthen engagement with patients and public by creating a user insight and experience function.<br><br>Under the executive director for engagement and experience, we ensure triangulation of multiple sources of feedback such as PALs and complaints data, FTSU concerns, questions from the public at the Board in Common meetings and feedback from our strategic lay forum. Our CEO and director of engagement and experience meet on a quarterly basis with the Save the NHS groups both locally to us but also across North West London and pick up feedback via this group.<br><br>The strategic lay forum is the centre of patient and public involvement at the Trust, setting and championing a clear vision for effective involvement. It works to ensure the Trust understands and responds to the needs and | • User insights and experience reported quarterly to Trust Quality Committee and Trust Standing Committee<br>• Patient and public engagement plan presented to the Trust Quality Committee and Trust Standing Committee<br>• Patient engagement strategy presented to the Trust Quality Committee<br>• PALs and Complaints reports presented annually to the Trust Quality Committee and Trust Standing Committee<br>• Patient experience data on FFT, same sex accommodation and complaints reported in Integrated Performance Scorecard<br>• Quality Assurance Report to Quality Committee and Trust Standing Committee.<br>• Patient stories at the Board in Common<br>• The FTSU service is in place for staff to raise safety concerns – this service reports to the CEO and a NED champion is in | To ensure appropriate updates from the strategic lay forum are reported on a regular basis to Quality Committee.<br><br>To ensure board consistently consider variation in experience for those with protected characteristics and patterns of actual and expected access from the Trust's communities | Director of Engagement & Experience<br><br>Medical Director<br><br>Chief Nurse<br><br>Director of Corporate Governance | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | and explore whether staff effectively respond to this?<br>• How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?<br>• Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? | preferences of patients and local communities and directly influences the development and delivery of the Trusts strategic priorities. It was established in November 2015 and consists of up to 20 lay partners plus up to 10 senior Trust staff and representatives from Imperial College London and Imperial Health Charity.<br><br>The Trust's strategic lay forum also provides feedback and insight via their regular meetings and briefing sessions with the Co-Chairs of the forum attending the Trust Standing Committee in April 2025 to present achievements from the previous year and priorities for the year ahead.<br><br>The Trust Quality Committee and Trust Standing Committee receive regular reports on user insights (patient experience) including reports on PALS and Complaints data including themes and actions taken to address concerns raised through these processes and receive and review the patient engagement strategy.<br><br>Friends and Family Test (FFT) data is included in the Integrated Performance Report.<br><br>Patient stories are presented to the Board in Common each quarter.<br><br>We have clinical representation on our board from both an executive and non-executive perspective.<br><br>Safety concerns are raised to the board via the quality assurance report that goes to the Quality Committee and Trust Standing Committee. | place and very engaged. FTSU updates are provided to the People Committee and Trust Standing Committee.<br>• An annual Raising concerns report is presented to the Audit, Risk and Governance Committee. | | | |

### III. People and culture

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| 7. Staff feedback is used to improve the quality of care provided by the trust | • Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement?<br>• Does the board engage with staff forums to continually consider how care can be improved?<br>• Can the board evidence action taken in response to staff feedback? | The trust leads the co-creation of evidence and data driven people priorities using a range of information sources, including the NHS staff survey, our FTSU Guardians, our staff networks, staff forums, our Guardian of Safe Working, Trade Union partners, WRES and WDES, Gender Pay Gap and our people performance metrics.<br><br>These Trust people priorities are based on the national people priorities of Looking after our People, Belonging in the NHS, Growing for Future and New Ways of Working and Delivering Care. They are co-created with | • Staff survey results and action plan through thematic groups, reported to the Trust's People Committee.<br>• Peoples priorities are monitored through People Committee and reported to the Trust Standing Committee<br>• Staff stories at the Trust People Committee and Board in Common<br>• Staff forums, including bi-monthly all-staff briefing chaired by the CEO and executive directors | Increase the level of board engagement with staff forums | Chief People Officer (CPO)<br><br>Director of Corporate Governance | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | stakeholders listed above to ensure they are targeted and designed to have impact.<br><br>The Trust has in place an Equality, Diversity and Inclusion (EDI) Strategy, overseen by a Trust EDI committee chaired by the CEO and reporting into the Board People Committee.<br><br>The APC has also established an EDI improvement steering group, comprising non-executive directors, executive directors and EDI expert membership from across the Collaborative, to develop recommendations to accelerate progress and surpass the NHS EDI High Impact Actions, including agreeing EDI objectives at board level.<br><br>Workforce composition relating to gender, age, ethnicity and disability are reported to the Trust People Committee through the annual WRES and Workforce Disability Equality Standards (WDES) reports, which are then published on the Trust website.<br><br>The Trust EDI work programme, overseen by the People Committee, includes a commitment to deliver on the WRES Model Employer goals. We have delivered a comprehensive approach to inclusive recruitment, which has demonstrated input and resulted in publication.<br><br>Our growing staff networks, including networks for Black, Asian and Minority Ethnic (BAME) , iCAN,(network for disabilities), LGBQ+, women etc, help support equity and diversity. These groups, supported by the trust, provide opportunities for staff to connect with each other and generate ideas to improve the organisation. There are executive sponsors in place for all of these networks and all of these groups report into the EDI Committee.<br><br>We have put considerable effort into increasing staff survey responses, achieving 65% response rate in 2024/25 (approx. 10,000 responses). We have acted on feedback related to fairness from BAME staff and initiated a programme for all managers called 'Improvement through People Management' to address concerns around relationships with immediate managers. We have seen improvement in this domain of the staff survey.<br><br>In response to feedback from staff on what would make their working lives better, we have created new flagship staff rest areas funded by charitable donations and provide breakroom supplies during busy times in the winter months. | • NHS Workforce Race Equality Standard (WRES)WRES and DES<br>• Freedom to Speak Up service reports into the Trust People Committee and Trust Standing Committee<br>Raising concerns annual report presented annually to the Audit, Risk & Governance Committee.<br>• EDI Action Plan linked to the programme<br><br>• Actions tracked arising from the Staff Stories presented at the People Committee<br><br>• Annual Reports to track improvements in Employee Relations<br><br>• Inclusive recruitment publication | | | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | We have Pathway to Excellence accreditation at Charing Cross Hospital and are working towards accreditation at Hammersmith Hospital and St Mary's Hospital. This programme, supported by the trust, empowers nurses to speak out and make changes to their individual areas and is supported by a network of local and site based councils.<br><br>The CEO leads weekly meetings with clinical directors, heads of specialty, general managers, matrons and lead nurses and holds bi-weekly all staff briefings (with up to approx. 500 staff attending) where staff are able to raise concerns and questions anonymously.<br><br>The Trust is committed to ensuring that staff feel able to raise concerns through the various routes available. Two key services that are included in this are the Employee Relations service which oversees casework including resolution, mediation, misconduct, sickness, grievances, performance, legal advice and settlements; as well as the Freedom to Speak Up service which provides a confidential service for staff where they can raise concerns to one of our five Guardians or to the executive lead or non-executive freedom to speak up champion. Other routes include the patient safety team (medical directors office), the local counter fraud team, a colleague from the wider People & Organisational Development (P&OD) team.<br><br>The Trust People Priority Programme is reviewed monthly at EMB and quarterly at the People Committee.<br><br>By developing single improvement plans staff are able to contribute their ideas for improvement and innovation, see how they contribute to improvement priorities at other levels of the organisation and know to what extent their improvement ideas is a priority and the rationale for why. | | | | |
| 8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels | • Does the Trust regularly review skills at all levels across the organisation?<br>• Does the board see and, if necessary, act on levels of compliance with mandatory training? | The trust attracts high calibre staff with a wider range of skills. To support retention and development, the trust provides a comprehensive learning and development offer to staff at all levels, with high satisfaction rates evidenced through the last staff survey results.<br><br>We have a broad range of staff leadership development programmes. We also offer apprenticeships and other training for staff at all grades. All new consultants attend a development course that teaches them how to work in the NHS, how to manage themselves and how to manage their colleagues. We have gone through a comprehensive programme of assessing the needs of | • Statutory and mandatory training compliance reported Improving Care Programme Board and to Trust People Committee.<br>• Board member compliance with stat/man training is checked annually as part of the Fit and Proper Persons Test submission to NHSE<br>• Escalation reports from Trust Education Committee to People Committee and onwards to Trust Standing Committee. | Improve the link between learning arising from incident reporting and how that feeds learning needs for others | CPO | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | our general managers and business managers and have put in place a programme of education to help them manage more effectively.<br><br>Our statutory and mandatory training levels have been over 90% for the past 5 years. Compliance rates are reviewed monthly at the Improving Care Programme Board chaired by the CEO as well as reports provided to the People Committee and through the trust's performance report for further scrutiny and action. The Board in Common receives a quarterly update on performance across the collaborative on core skills compliance supporting wider conversations and ability to share best practice across all four trusts. | • APC People Committee reports<br>• Core skills compliance included in the Integrated Performance Report to the Board in Common. | | | |
| 9. Staff can express concerns in an open and constructive environment | • Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?<br>• Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?<br>• Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?<br>• Is there a safe reporting culture throughout the organisation? How does the board know?<br>• Is the trust an outlier on staff surveys across peers? | The Trust has in place various routes for staff to raise concerns (including whistleblowing) and these include the employee relations service and Freedom to Speak Up service.<br><br>The Freedom to Speak Up service is led by the Director of Corporate Governance and sponsored by the CEO, consisting of four part-time guardians, supported by a network of wellbeing ambassadors. We also have non-executive 'Speaking Up' champion.<br><br>Complaints are managed by our director of engagement and experience. Complex complaints are signed off by the CEO and complaints relating to issues with patient care are managed jointly with the medical director's office so that the trust can provide a single joined up response to individual complainants.<br><br>There is a fortnightly triangulation meeting consisting of the director of corporate governance, medical director, chief nurse and chief people officer which enables us to triage concerns received to ensure appropriately senior level intervention when required, and to triangulate with other intelligence regarding services, so that appropriate action is co-ordinated.<br><br>Over the last four years our staff survey (with a return rate of 65%) has improved so that we are above the acute average in 8 out of 9 areas of the survey and the percentage of people recommending the trust as a place to have treatment is 70.71%, which is nearly 10% above the acute trust average (60.90%). Feedback in the annual staff survey has shown increasing levels of awareness and confidence of staff in feeling able to raise concerns should they need to. | • These are also set out for staff in the raising concerns and whistleblowing policy (appendix 1). FTSU policy and process, including NED champion, and guardians across organisation – well publicised on intranet, through posters and awareness events<br>• Staff survey results on 'speaking up' demonstrate increasing awareness of ways in which staff can raise concerns<br>• Regular updates on FTSU to the Trust People Committee<br>• Annual report on FTSU to Trust People Committee and Trust Standing Committee<br>• Raising Concerns annual report to Audit, Risk and Governance Committee | | Director of Corporate Governance<br>CPO<br>MDO | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | At the fortnightly all-staff briefing, the CEO regularly encourages staff to raise concerns and invites questions from staff that are addresses in the meeting.<br><br>We provide an annual report on FTSU trends and concerns raised, reviewed through the People Committee.<br><br>We provide a Raising Concerns annual report to the Audit, Risk and Governance Committee which provides assurance that the trust has robust processes in place to allow staff to raise concerns (including whistleblowing) in line with the raising concerns and whistleblowing policy and through various routes we have in place. This aligns to the to the Audit, Risk and Governance Committee's duty to review the adequacy and security of the trust's arrangements for its employees, contractors and external parties to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters or any other matters of concern. | | | | |

**IV. Access and delivery of services**

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 10. Plans are in place to improve performance against the relevant access and waiting times standards | • Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary?<br>• Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? Is there a plan to deliver improvement? | The Trust is in Segment One of the National Oversight Framework. Trust wide performance remains on track to meet NHSE agreed plans by March 2026.<br><br>All clinical and corporate divisions have regular meetings to review operational performance. The executive reviews operational performance across urgent and emergency care, elective performance, cancer performance and diagnostics weekly at the CEO chaired executive operational meeting.<br>. Our monthly EMB brings together performance across all domains which allows the executive to triangulate performance across functions, clinical and corporate divisions, and sites.<br><br>Areas identified for action are reviewed at divisional performance and accountability review meetings and directorates where performance may be suboptimal are placed into tiered measures of support to help bring them back on track.<br><br>At Board level we have the Finance, Investment and Operations Committee (FIOC) which oversees operational and financial performance, with monthly | • Operational performance report presented quarterly to the Trusts Finance, Investment and Operations Committee and Trust Standing Committee.<br>• Integrated Performance Report goes to the Collaborative Finance & Performance Committee and Board in Common. | Continue PARMs and targeted meetings to drive improvement and troubleshoot emergent issues.<br><br>Review of Performance Accountability Framework, Performance and BI functions to align with compliance of constitutional standards.<br><br>Robust capacity/demand work to aid proactive waiting times management | Chief Operating Officer | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | touchpoint meetings held between the chair of FIOC, the CFO and the COO.<br><br>The trust works with systems partners to deliver on access standards, and to provide mutual aid and support to the wider health economy in meeting these standards. | | Three-year business planning that aligns with recovery to constitutional standards. | | |
| 11. The Trust can identify and address inequalities in access/waiting times to NHS services across its patients | • The Board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place | The trust collects demographic information such as age, sex, ethnicity, disability, deprivation, and geography, then analyse service usage and waiting times across these groups. By breaking down referral rates, treatment times, and outcomes, variations in access are identified. Comparative analysis often highlights disparities. Alongside this, patient feedback from surveys, patient feedback, and focus groups helps Trusts understand obstacles such as language, digital exclusion, or transport. This is reported through Quality Committee.<br>This analysis is supporting the reduction of heath inequalities in two major transformation programmes focused on improving access and reducing waiting times.<br><br>For maternity services, the Trust is taking a data led approach including insights from communities through which we have identified the groups where improvements can be made in line with Core20Plus5 and the NHS 10 Year plan.<br><br>The trust undertook research into patients who did not attend (DNA) outpatient appointments and demonstrated a greater than 50% likelihood of DNA in patients from the top quartile of deprivation. This has led to a service in partnership with the Charity which has piloted, and is now refining, a volunteer led service to proactively call and support patients from our most deprived communities to increase likelihood of attending appointments and reduce DNAs. The DNA rates of the trust have reduced.<br><br>The Trust is developing a capability building programme to ensure that all staff understand what health inequality and how everyone can contribute to reducing these – supported by our Trust improvement methodology.<br><br>We are learning from these existing transformation programmes to ensure they are built into all future transformation work aligned with our shared APC / ICB priorities. | • Segmented data in Trust and APC IPR<br>• Trust Equality Impact Assessment (EQIA) process<br>• Reducing health inequalities and improving population health section (pages 41 to 44) of the Trust's annual report 2024-25<br>• Our 2024-25 response to NHS England's statement on information on health inequalities<br>• NWL ICB Joint Forward Plan (see page 17) | | Director of Strategy, Research and Innovation<br>CPO | |
| 12. Appropriate population | • Is there a clear link between specific population health | With APC partners, we lead collaborative and coordinated efforts to improve health across the four | • Reducing health inequalities and improving population health section | | Director of Strategy, | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| health targets have been agreed with the ICB | measures and the internal operations of the trust?<br>• Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system? | partner trusts. Together, we share learnings, and scale and spread successful work aligned to local priorities.<br><br>The Trust, with APC partners within the NWL ICB, established a population health equity programme and agreed a set of metrics aimed at tackling key patient and population health related inequalities. These are now tracked through the performance and reports at Trust and collaborative committees, and through the BiC.<br><br>Two of the four APC KPIs for advancing health equity are linked to major transformation programmes at the Trust, Maternity and Outpatients (see answer in question 11).<br><br>Teams across the Trust are increasingly aware of how their work is improving the wider health and wellbeing of people outside the system, examples below<br>- Trust Green programme has long term goals supported by staff across the Trust with awareness raising programmes and service level green plans<br>- Trust staff receive as a part of their induction an introduction to health equalities and equity. Trust staff are also invited to participate in our Community Walks programme in our local neighbourhoods highlighting the deep disparity in life expectancy and how we can improve the wider health of our communities.<br>Our health improvement team deliver an inpatient stop smoking service. This includes working with clinical teams to raise awareness of the "Making Every Contact Count" approach to improving patient's wider health and well-being by referring them to the programme. In June to August, 88% current smokers agreed to be supported, with 35% smokefree at 28 days.<br><br>Improving health inequity and population health is included in the single improvement plans as part of the improvement requirements to contribute to the trust's priorities. | (pages 41 to 44) of the Trust's annual report 2024-25<br>• APC Equity Improvement Plan<br>• NWL ICB Joint Forward Plan (see page 17)<br>• Supporting our patient to become smoke free | | Research and Innovation | |

**V. Productivity and value for money**

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 13. Plans are in place to deliver productivity improvements | • Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to: | As part of an established acute provider collaborative, the trust has effective operational and governance arrangements to benchmark performance and share best practice across the collaborative. | • Reports to Trust and collaborative APC EMB and Collaborative Finance and Performance Committee Productivity dashboard at | Further work is being done to drive productivity improvements | CFO<br>COO | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant | ○ review its performance against peers<br>○ identify and understand any unwarranted variations<br>○ put programmes in place to reduce unwarranted negative variation<br>• The Trust's track record of delivery of planned productivity rates (the collab are tackling productivity through Collab F&P | The model health system data is considered at the Trust's Finance, Investment and Operations Committee, demonstrating overall high productivity levels when benchmarked nationally.<br>In addition, the APC CFOs have worked collaboratively to develop locally agreed metrics to complement the nationally defined metrics, all of which are tracked through an APC productivity and efficiency dashboard and which were approved at the APC's Finance and Performance Committee.<br><br>For those areas where productivity could be improved, for example cancer, there is joined up work across the collaborative, which is reported to the APC.<br><br>Track record of delivery of planned productivity remains strong compared to the previous year, although further work to be done to close the gap to the 19/20 levels.<br><br>We are one of the only trusts that has created an internal productivity tool that allows us to track productivity at specialty level – this goes through EMB and FIOC and allows teams to interrogate the data in a way that is user friendly and meaningful. | collaborative level which is monitored at APC F&P<br><br>• Productivity monitored through EMB and FIOC. | | | |

**VI. Financial performance and oversight**

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 14. The trust has a robust financial governance framework and appropriate contract management arrangements | • Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data<br>• Have there been any contract disputes over the past 12 months and, if so, have these been addressed?<br>• Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned? | The Trust has a strong track record of delivery against financial plans, with comprehensive governance arrangements in place and has achieved its financial plan for the past 7 years.<br><br>The Trust's annual internal audit programme has a standing requirement to include a review of the financial systems control environment areas of focus are agreed through a cyclical or risk lens. To date theses have had positive ratings.<br><br>A review of the trust's financial governance arrangements was included as part of the system's review under the investigation and intervention regime in late 2024. The review identified overall strong governance arrangements, with some recommendations for improvement which have since been enacted. | • Financial governance structure<br>• Comprehensive internal audit plan agreed annually and progress tracked at each audit and risk committee meeting<br>• Reduction in bank and agency usage in relation to 2024/25<br>• I&I report | Contract negotiations with the ICB are ongoing and further disputes will be discussed as part of business planning. | Chief Financial Officer (CFO) | |
| 15. Financial risk is managed | • Does the board stress-test the impact of financial efficiency plans | The Trust has a cost improvement programme in place and ensures no reduction in the quality of safety of the care provided. Each CIP must be accompanied by an | • Cost improvement programmes reviewed through equalities and quality health impact assessments to | | CFO<br>CNO<br>Medical Director | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes | on resources available to underpin quality of care?<br>• Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing?<br>• Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers? | equality, quality and health inequalities impact assessment which is reviewed by the Chief Nurse and Medical Director (supported by PMO). All schemes with risk rating over 7 are discussed at a formal QEIA panel. The Trust continues to progress against its delivery plan with plans to convert most of the non-recurrent CIPs into recurrent.<br><br>Overall financial performance for the Trust and APC is monitored regularly through the Trust's Finance, Investment and Operations Committee and Collaborative Finance and Performance Committee, Trust Standing Committee and Board in Common. | ensure no adverse impacts on quality or inequalities.<br>• Monitoring through Trust Quality Committee and APC FPC. | | | |
| 16. The Trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn | • Is the board contributing to system-wide discussions on allocation of resources?<br>• Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system?<br>• Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS? | Colleagues have built up good working relationships that allow for open discussions regarding resource allocations including taking into account the views of all NHS partners across the sector – e.g. allocation of constrained capital, ICB reserves, contractual agreements etc. The Board is briefed with the opportunity to feedback, influence, challenge discussions etc.<br><br>The financial planning process is well progressed on joint working (always room for improvement) and seeks to ensure the APC Trust plans are developed on as consistent a basis as is possible with and alongside the wider ICS footprint. The alignment of activity, workforce, resources and achievement of performance is the working model with planning, in substance, owned by COO, CPO and CFO.<br><br>Plans are developed and considered through the local, collaborative and system finance and performance governance structure, supporting a joined-up approach that focuses on the benefit to the overall population of North West London.<br><br>The system oversight meetings allow system leaders check and challenge performance and test the Trust's ability to ensure it can meet the obligations agreed and signed off by the Board, what is working well, where support may be needed e.g. repatriation of NHS ophthalmology work back to the NHS, how fragmented sight and sounds services for children's are improved etc. | • Development of Medium-Term Financial Strategy across APC<br>• APC Finance and Performance Committee<br>• APC pathway development programme | | CFO | |

# Provider Capability Self-Assessment Template – v1.2

**Legend:**

| Rating | Meaning for NHSE Provider Capability |
|---|---|
| Green | High confidence – Light touch oversight. Trust is performing strongly. |
| Amber Green | Minor concerns – Targeted support. Trust is generally sound, minor issues. |
| Amber Red | Material concerns – Enhanced oversight. Trust has notable issues to address. |
| Red | Significant failure – Intensive intervention. Trust requires urgent action. |

## I. Strategy, leadership and planning

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Explanation where not confirmed and actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners | • Are the trust's financial plans linked to and consistent with those of its commissioning ICB or ICBs, in particular regarding capital expenditure?<br>• Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?<br>• Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy?<br>• Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level? | • The Trust's strategy (2022–26) and enabling strategies are aligned with the NWL Integrated Care System (ICS) Health and Care strategy<br>• Priorities are developed through engagement with staff, patients, and partners.<br>• Digital and capital plans are integrated with system partners.<br>• The trust's financial plan was developed through a collaborative process across the APC and with the ICB, to ensure alignment across partners. The final plan was | • Trust Strategy<br>• Trust Clinical Services Strategy 2024 - 2034<br>• NWL APC Strategy<br>• NWL ICS Health and Care Strategy<br>• Trust Green Plan<br><br>Reports through the following:<br>• Board in Common (BiC)<br>• APC Digital and Data Committee (with sub-governance structure all overseen by the Chief Information Officer (CIO)<br>• Hillingdon Health Care Partners (HHCP) reports through Trust Standing Committee<br>• System Oversight Meetings | | • Chief Infrastructure & Redevelopment Officer (Strategy)<br>• Chief Finance Officer<br>• Chief Information Officer | Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Explanation where not confirmed and actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | approved through local and APC governance.<br>• A strong governance framework exists for managing digital, data and technology (DDaT) within the Trust and across the APC. Each of the Trusts have local groups that provide oversight of compliance (including information governance and cyber security), strategy and project delivery. These groups feed into an APC DDaT Steering Group (chaired by the CIO), which reports to the APC DDaT Strategy Board (chaired by the CEO lead for digital), which reports to the APC Digital and Data Committee (a sub-committee of the Board in Common). | The Trust and APC are leaders in national data developments – e.g. Federated Data Platform (FDP) (trust referenced).<br><br>Trust and collaborative business plans for 2025/26 – report to BiC. | | | |
| 2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE | • Is the trust currently complying with the conditions of its licence?<br>• Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)? | The trust is compliant with the provider licence conditions and is not subject to enforcement action by NHS England. | • Annual self-assessment against licence requirements, reported to Audit and Risk Committee annually (June 2025)<br>• Annual Report 2024/25 | | Director of Corporate Governance | Green |
| 3. The board has the skills, capacity and experience to lead the organisation | • Are all board positions filled and, if not, are there plans in place to address vacancies?<br>• What proportion of board members are in interim/acting roles? | The trust's board has a full complement of members, with the necessary range of skills and experience, and assigned leads accountable for all areas of operations. | • Trust and Board in Common (BiC) Members<br>• Board member skills matrix | | Director of Corporate Governance | Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Explanation where not confirmed and actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | • Is an appropriate board succession plan in place?<br>• Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance? | There is an established process for developing deputies to provide short term emergency cover, through regular deputizing.<br>Talent is shared across the APC.<br>There is evidence of development plans in place for senior leaders and deputies. | | | | |
| 4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served | • Is the trust contributing to and benefiting from its NHS trust collaborative?<br>• Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system?<br>• Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed? | The trust is part of the NWL APC, with developed collaborative governance and leadership arrangements. These will be further strengthened in April 2026 with the move to a Single Accountable Officer/Group CEO.<br><br>The arrangements have matured since the inception of the APC in 2022, responding to an independent audit and review in 2023, with actions implemented in 2024 and further developments in 2025/26.<br><br>Trusts within the APC have worked together on a number of initiatives aimed at improving the population's health, for example the development of the elective orthopaedic centre following extensive consultation.<br><br>The trust is an integral partner of the local place based system – Hillingdon Health and Care Partnership (HHCP) and plays a key role as part of the development of local partnerships and the development of Integrated Neighbourhood Teams.<br><br>The Trust continues to work collaboratively across the system and with partners on developing its plans | • APC website setting out strategic objectives, system projects and updates through BiC meetings for example:<br>○ Community diagnostic centres<br>○ Elective orthopaedic centre<br>○ Pathway redesign<br><br>APC strategy and trust strategy (referred to in no 1 above) contain further details.<br><br>Trust CEO is NHS providers' partner member on ICB Board and chairs system flow board<br><br>Regular system oversight meetings (SOM) with executives from the trust and ICB scrutinise the performance and impact of the trust and discuss system wide working.<br><br>HHCP reports to Trust Standing Committee.<br><br>Trust representation on key HHCP governance meetings to include HHCP Executive Oversight Board.<br><br>In addition to formal system and APC governance structures there are a range of APC and system wide groups meet to ensure collaborative working and constructive challenge – e.g. COO and CFO groups | | • Director of Corporate Governance<br>• Managing Director/CMO | Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Explanation where not confirmed and actions underway/required | Exec lead | RAG rating |
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| | | for the New Hospital development aligned to the NHS 10-year plan. | | | | |

## II. Quality of care

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients | • The trust can demonstrate and assure itself that internal procedures:<br>○ ensure required standards are achieved (internal and external)<br>○ investigate and develop strategies to address substandard performance<br>○ plan and manage continuous improvement<br>○ identify, share and ensure delivery of best practice<br>○ identify and manage risks to quality of care<br>• There is board-level engagement on improving quality of care across the organisation<br>• Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients<br>• Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community<br>• Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust<br>• Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement | The trust is committed to continuous improvement in quality of care, with monitoring processes in place and has made good progress on its improvement journey, recognising further work to be done.<br><br>The Board is assured of this through detailed reporting via the Trust's Quality Committee and supporting governance, which is triangulated through visits to Trust services by board members.<br><br>The trust benchmarks quality standards and performance through the APC Quality Committee, which supports sharing of good practice. | • Trust Quality Report 2024/25<br>• Comprehensive governance structure feeding into the Quality and Safety Executive Committee (QSEC) which then reports to Quality and Safety Committee (QSC), including patient safety group, health, safety, patient experience, IPC , HCQP, clinical outcome and effectiveness group, with further groups sitting beneath.<br>• Agenda, minutes and papers for the APC's Quality and Safety Committee<br>• IQPR reports to EMB, board committees and Quality and Safety Committee<br>• Reports to the Board in Common<br>• NED maternity champion<br>• Executive and NED visits to points of care<br>• Council of Governors meetings and briefings, with quarterly quality updates and annual review<br>• Risk management strategy and process, including quarterly reports to quality committee – separate corporate risk register and BAF reports.<br>• National oversight framework (NOF) rating of 2 for effectiveness and experience of care<br>• NOF rating of 4 for Patient Safety<br>• Patient Safety Incident Response Framework (PSIRF) Policy and Plan<br>• Patient safety specialists in post, embedded within portfolios of current staff to support full integration of approach<br>• Partnership with Maternity and Neonatal Voices Partnership (MNVP) provides | Further strengthen learning dissemination and assurance. Continue to embed PSIRF and deliver CQC action plan. | Chief Nursing Officer<br><br>Chief Medical Officer | Amber-Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | | direct service-user input to maternity quality and safety improvements.<br>• MNVP members contribute to incident reviews, quality priorities and the Maternity and Neonatal Improvement Programme Board, aligning with NWL APC maternity equity objectives.<br>• Patient stories at Trust Quality and Safety committee and BiC<br>• Internal accreditation programme aligned with CQC new single assessment framework- new methodology including robust scoring system- reporting to Quality and Safety Committee<br>• Quarterly reporting of Trust Quality Priorities to QSEC and QSC.<br>• GIRFT or National Audits monitored and reviewed at Deep Dives, COEG and then to QSC<br>• Robust monitoring and reporting of CQC action plan to HCQP and MNIP Board which then reports to QSEC and QSC. | | | |
| 6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board | • Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience?<br>• Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities?<br>• Is the board satisfied that it receives timely information on quality that is focused on the right matters?<br>• Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this?<br>• How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?<br>• Is the board satisfied it is equipped with the right skills and experience to oversee | The trust puts patient experience at the centre of all that we do. There are a range of ways in which this is done, through regular reporting and discussion through the board and APC's committees and at quarterly board meetings. The reports bring together findings from complaints, surveys, patient engagement meetings, healthwatch and visits, to provide a rounded picture of patient experience.<br><br>National inpatient, outpatient, maternity and emergency department surveys are reviewed annually, with results presented to the Executive Management Board and Quality Committee.<br><br>Where improvement themes are identified, detailed action plans are developed, monitored and reported through the Trust's Quality Committee and, where relevant, through the APC | • Trust patient and public experience and engagement report reported on quarterly basis to quality committee, with annual report summarising learning over whole year.<br>• Patient experience data on the friends and family trust (FFT), same sex accommodation and complaints reported monthly in performance and quality report to BiC<br>• Patient stories at trust quality committee and BiC<br>• Council of Governors meetings and feedback | | Chief Nursing Officer | Amber-Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | all elements of quality and address any concerns? | Quality Committee to the Board in Common.<br><br>The Trust also undertakes Patient-Led Assessments of the Care Environment (PLACE), which provide a further independent view of patient experience and environment quality. Results and improvement plans are reported to the Quality Committee, with progress updates tracked through executive-level reviews.<br><br>Together with real-time feedback and the Friends and Family Test (FFT), these processes give the Board assurance that the Trust maintains a responsive approach to understanding and improving patient experience and has made good progress on its improvement journey, recognising further work to be done.<br><br>The trust's council of governors also provides feedback and insight via their constituencies through the quarterly CoG meetings and briefing sessions, some of which is gathered through 'meet the governor' sessions held on each hospital site. | | | | |

### III. People and culture

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 7. Staff feedback is used to improve the quality of care provided by the trust | • Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement?<br>• Does the board engage with staff forums to continually consider how care can be improved?<br>• Can the board evidence action taken in response to staff feedback? | The board and committees review feedback from staff through reports on the annual staff survey and related action plans, hear direct stories from staff at committee and board meetings and reports on other mechanisms of feedback, such as speaking up reports and updates regarding staff forums. Actions are tracked through the | • Staff survey results and action plan through thematic groups, reported to people committee (PC)<br>• Staff stories to PC, with tracker to monitor actions in response<br>• Staff stories at Board in Common<br>• Staff forums, with executive director leads<br>• Workforce Race Equality System and Disability Equality System<br>• NOF rating of 3 for people and workforce. | | Chief People Officer (CPO)<br><br>Chief Nursing Officer | Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| | | committee, including a tracker for impact in relation to staff stories. | | | | |
| 8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels | • Does the trust regularly review skills at all levels across the organisation?<br>• Does the board see and, if necessary, act on levels of compliance with mandatory training? | To support retention and development, the trust provides a comprehensive learning and development offer to staff at all levels.<br><br>Mandatory training compliance levels are within target (90.5% (August 2025), against the 90% target) and monitored, with reports provided to the Executive Management Board (EMB), Workforce Executive Committee (WEC), board committees and through the board's integrated quality and performance report (IQPR) for further scrutiny and action. The BiC receives a quarterly update on performance across the collaborative on core skills compliance supporting wider conversations and ability to share best practice across all four trusts. | • Reports on mandatory training compliance to People and Workforce Committee (PC), EMB, WEC<br>• Escalation reports from PC to Board Standing Committee.<br>• APC PWC reports<br>• Core skills compliance in BiC IQPR<br>• NOF rating of 3 for people and workforce. | | Chief People Officer | Green |
| 9. Staff can express concerns in an open and constructive environment | • Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?<br>• Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?<br>• Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?<br>• Is there a safe reporting culture throughout the organisation? How does the board know?<br>• Is the trust an outlier on staff surveys across peers? | The Board receives bi-annual reports on FTSU through the local PC committee. A detailed trust level annual report is received at the board's standing committee with an aggregated report at BiC level to support comparison and learning across the APC.<br><br>The Board has a clearly communicated FTSU process, which is utilised by staff. | • FTSU policy and process, including NED lead, Guardian and champions across organisation – well publicised on intranet, through posters and awareness events<br>• Staff survey results on 'speaking up' above national averages.<br>• Regular updates and annual report on FTSU to People and Workforce Committee and BiC. | Inphase/Ideagen implementation of FTSU module | Chief People Officer | Green |

## IV. Access and delivery of services

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 10. Plans are in place to improve performance against the relevant access and waiting times standards | • Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary?<br>• Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this?<br>• Is there a plan to deliver improvement? | The Trust maintains robust oversight of Urgent Care Access, Referral to Treatment (RTT), cancer, and diagnostics performance through the Integrated Quality and Performance Report (IQPR) and regular Board-level scrutiny.<br><br>UEC performance has been gradually improving since April 2025 and has been above 78% in June, July and August. September's performance is also expected to be compliant.<br><br>As of August 2025, RTT incomplete performance stands at 54.9%, significantly below the national standard of 92% However, the trust remains on track to deliver 60% compliance by the end of March 2025 as per the agreed operating plan.<br><br>The most challenged specialty is ENT services, which has a large waiting list with a significant volume of patients waiting over 40 weeks.<br><br>Cancer pathway performance across the 2-week wait, 31-day, and 62-day standards has also been below target in recent months although showing gradual improvement. Similarly, diagnostics performance (DM01) is currently at 67.5%, falling short of the 95% national threshold.<br><br>To address these challenges, the Trust has reviewed existing weekly Patient Tracking List (PTL) and Operations meetings alongside support from the NHSE Intensive Support Team (IST) monitor progress, validate data, and track improvement actions. While improvement plans are in place and under active review, performance remains below national standards in several areas.<br><br>The Trust continues to prioritise recovery and performance improvement, with governance | • IQPR<br>• Annual Report 2024/25<br>• Quality Account 2024/25<br>• RTT, cancer, and diagnostics performance data<br>• Weekly PTL and Ops meetings<br>• ED improvement plan | There is a comprehensive UEC Improvement Programme in place to oversee five workstreams from ED attendance to admission and discharge. This reports weekly to the trust Executive.<br><br>RTT and DM01 improvement plans have been presented to the executive and are being monitored on a bi-weekly basis. Mechanisms to improve performance include a focus on RTT training, increased capacity to reduce backlogs and improvements in productivity. | MD/CMO | Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | structures in place to ensure accountability and escalation where required. | | | | |
| 11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients | • The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place | The trust, with APC partners, established a health equity programme and agreed a set of metrics aimed at tackling key patient and population health related inequalities. These will be tracked through the performance and quality reports at trust and collaborative committees, and through the BiC.<br><br>The data has been reviewed at APC level and will form part of our IQPR and Board reporting on an ongoing basis. | • Trust QEIA process<br>• APC Equity Improvement Plan<br>• Segmented data metrics agreed and to be included in Trust and APC IQPR<br>• NOF rating of 3 for access to services<br>• Patient communications charter ensuring a more targeted approach to patients most of risk of not attending appointments – with more inclusive communications and improved wayfinding.<br>• Focused work on inequalities in relation to cancer through the cancer alliance – RM Partners e.g. community and voluntary sector grants and partnership. | Further embed equity metrics and reporting. Continue to deliver health inequalities improvement actions. | MD/CMO | Green |
| 12. Appropriate population health targets have been agreed with the ICB | • Is there a clear link between specific population health measures and the internal operations of the trust?<br>• Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system? | The Trust has agreed a series of population health measures with the ICB which are aimed at preventing ill health and reducing inequalities. These include a focus on smoking cessation and support with substance misuse, which includes embedded teams through the maternity and emergency care pathway. | • APC Equity Improvement Plan<br>• Health Inequalities statement in Annual Report | Ongoing development of population health metrics and reporting. | MD/CMO | Green |

### V. Productivity and value for money

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other | • Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:<br>○ review its performance against peers<br>○ identify and understand any unwarranted variations<br>○ put programmes in place to reduce unwarranted negative variation | As part of an established acute provider collaborative, the trust has effective operational and governance arrangements to benchmark performance and share best practice across the collaborative.<br><br>The model health system data is considered annually at the trust's finance and performance committee, demonstrating overall high productivity levels when benchmarked nationally. In addition, the APC CFOs have | • Reports to trust and collaborative FPC<br>• APC FPC reports on productivity and proposed additional metrics/focus in 25/26<br>• Cancer productivity report to Sept APC FPC<br>• Programme of deep dives which include benchmarking data<br>• Improvement Board – monitor cost improvement and productivity programmes – quarterly reports to FPC | • Ongoing focus on productivity and efficiency programmes.<br><br>• Further embed benchmarking and | MD/CMO | Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| guidance as relevant | • The trust's track record of delivery of planned productivity rates | worked collaboratively to develop locally agreed metrics to complement the nationally defined metrics, all of which are tracked through an APC productivity and efficiency dashboard and which were approved at the APC's finance and performance committee.<br><br>For those areas where productivity could be improved, for example cancer, there is joined up work across the wider cancer collaborative, which is reported to the APC FPC.<br><br>The trust has worked hard to improve medical productivity in 25/26, with a focus on reducing job plans over 12PAs and ensuring that outpatient clinic templates are maximised. Variation in theatre cases has been reviewed and addressed in certain specialties, such as ophthalmology. Where there have been hard to recruit posts, other options have been explored, and consultant posts have been replaced by clinical nurse specialists and clinical fellows at lower cost. There has been a significant and sustain reduction in agency usage, WLI and insourcing.<br><br>There is an ongoing focus on management of inpatient resources and reducing length of stay across elective and non-elective patients. Improvements can be seen in model hospital data. | • NOF rating of 2 for finance and productivity | improvement actions. | | |

### VI. Financial performance and oversight

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 14. The trust has a robust financial governance framework and appropriate contract management arrangements | • Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data<br>• Have there been any contract disputes over the past 12 months and, if so, have these been addressed?<br>• [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a | The Trust has a comprehensive internal audit plan, regular Audit and Risk Committee oversight.<br><br>The Trust acknowledges that while foundational elements of financial governance and contract management are in place, there is ongoing work to strengthen these frameworks. | • Financial governance structure<br>• Comprehensive internal audit plan agreed annually and progress tracked at each audit and risk committee meeting<br>• Investigation and Invention Report for NWL ICS and report re HHFT<br>• NOF rating of 2 for finance and productivity<br>• Approval of business/operating plan through a collaborative approach across the APC and ICS. | • Ongoing work to address financial sustainability risks.<br>• Continue to strengthen contract management and financial controls. | Chief Financial Officer (CFO) | Amber-Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned? | Financial oversight is supported by established policies and regular reporting, though further enhancements are being pursued to improve consistency, accountability, and strategic alignment.<br><br>Contract management arrangements are operational and cover key areas of procurement and compliance.<br><br>However, the Trust recognises the need to develop more systematic monitoring and review processes to ensure contracts deliver optimal value and meet evolving service requirements.<br>. | | • Full implementation of I&I actions | | |
| 15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes | • Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care?<br>• Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing?<br>• Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers? | The trust has a process in place to identify and monitor cost improvement programmes but does so by ensuring no reduction in the quality and safety of care provided. Each CIP must be accompanied by a Quality Equality Impact Assessment (QEIA) which is reviewed by executive leads, including medical and nursing leadership to ensure there is no adverse impact.<br><br>Overall financial performance for the trust and APC is monitored regularly through trust and APC level finance and performance committees and reported quarterly through the board's standing committee and the board in common. | • Monitoring through trust and APC FPC, plus through the board standing committee and BiC.<br>• Annual Report 2024/25<br>• IQPR<br>• Cost improvement programme documentation<br>• FPC, Board and APC FPC minutes<br>• BAF<br>• QEIA process<br>• NOF rating of 2 for finance and productivity | • Ongoing monitoring of financial and quality impact.<br>• Continue to strengthen risk management and assurance. | CFO | Green |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn | • Is the board contributing to system-wide discussions on allocation of resources?<br>• Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system?<br>• Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS? | The Trust works closely with system partners on financial planning to ensure alignment across the APC and ICS. Medium Term Financial Strategy and mutual aid arrangements are referenced in the Annual Report. Evidence of system collaboration is present, but explicit examples of resource reallocation or support to more challenged partners could be expanded. | • Development of Medium Term Financial Strategy across APC<br>• APC Finance and Performance Committee<br>• APC pathway development programme<br>• NOF rating of 2 for finance and productivity<br>• APC CFOS with wider ICS CFOs developed financial plan, with ICB board signing off final allocations<br>• System oversight on finance, quality and performance through the quarterly System Oversight Meetings (SOM). | • Ongoing collaboration on system financial sustainability.<br>• Continue to evidence system impact and alignment. | CFO | Green |

# Provider Capability Self-Assessment Template

## I. Strategy, leadership and planning

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Explanation where not confirmed and actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners | • Are the trust's financial plans linked to and consistent with those of its commissioning ICB or ICBs, in particular regarding capital expenditure?<br>• Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?<br>• Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy?<br>• Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level? | The trust's strategy 'Our Way Forward' was launched in 2023, following extensive engagement with local and system stakeholders including 2,314 staff, 887 patients and members of our community, and 42 stakeholders from partner organisations.<br><br>The trust strategy is aligned to the North West London (NWL) Acute Provider Collaborative (APC) strategy, which was approved in 2024, and is aligned to the NWL Integrated Care System (ICS) Health and Care strategy.<br><br>The trust played an active role in the refresh of the Joint Forward Plan with the ICB and held a leadership role in the development of the NWL Planned Care Strategy for the sector which supports the NHS 10-year plan.<br><br>The trust's financial plan was developed through a collaborative process across the APC and with the ICB, to ensure alignment across partners. The final plan was approved through local and APC governance.<br><br>The Digital Strategy across the APC enables benefits of standardisation, alignment and consistency in a range of digital tools and systems including a single electronic patient record system allowing shared patient record access linked to the Federated Data Platform and NHS App. | • LNWUH Our Way Forward Strategy<br>• NWL APC Strategy<br>• NWL ICS Health and Care Strategy<br>• NWL ICS Joint Forward Plan<br><br>Reports through the following:<br>• Board in Common (BiC)<br>• APC Finance and Performance Committee<br>• APC Data and Digital Strategy Board<br>• APC Digital and Data Committee (with sub-governance structure all overseen by the APC Chief Information Officer (CIO)<br><br>The Trust and APC are leaders in national data developments – e.g. Federated Data Platform (FDP)<br><br>Trust is an innovator in developments in Artificial Intelligence (AI).<br><br>Trust and collaborative business plans for 2025/26 – report to BiC. | | Director of Strategy and Transformation<br><br>Chief Financial Officer<br><br>Chief Information Officer | |
| 2. The trust is meeting and will continue to | • Is the trust currently complying with the conditions of its licence? | The trust is compliant with the provider licence conditions and is not subject to enforcement action by NHS England. | • Annual self-assessment against licence requirements, reported to Audit and Risk Committee annually (June 2025) | | Director of Corporate Affairs | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Explanation where not confirmed and actions underway/required | Exec lead | RAG rating |
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| meet any requirements placed on it by ongoing enforcement action from NHSE | • Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)? | | | | | |
| 3. The board has the skills, capacity and experience to lead the organisation | • Are all board positions filled and, if not, are there plans in place to address vacancies?<br>• What proportion of board members are in interim/acting roles?<br>• Is an appropriate board succession plan in place?<br>• Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance? | The trust's board has a full complement of members, with the necessary range of skills and experience, and assigned leads accountable for all areas of operations. The Board appointment and remuneration committee annually review the skills and diversity matrix of the Board and succession planning arrangements for Executive Directors. | • Trust and Board in Common (BiC) Members<br>• Board member skills and diversity matrix<br>• Succession Planning report to Board Appointment and Remuneration Committee<br>• Role Descriptions for Executive Directors detail the clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance. These are set out in the Board member biographies on the LNWH website | | Director of Corporate Affairs | |
| 4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served | • Is the trust contributing to and benefiting from its NHS trust collaborative?<br>• Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system?<br>• Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed? | The trust is part of the NWL APC, with developed collaborative governance and leadership arrangements, which will be further strengthened in April 2025 with the move to a Single Accountable Officer/Group CEO. The arrangements have matured since the inception of the APC in 2022, responding to an independent audit and review in 2023, with actions implemented in 2024 and further developments in 2025/26.<br><br>Regular system oversight meetings (SOM) with executives from the trust and ICB scrutinise the performance and impact of the trust, and discuss system wide working.<br><br>In addition to formal system and APC governance structures there are a range of APC and system wide groups that meet to ensure collaborative | • APC website setting out strategic objectives, system projects and updates through BiC meetings for example:<br>○ Community diagnostic centres<br>○ Elective orthopaedic centre<br>○ Pathway redesign<br><br>APC strategy and trust strategy (referred to in no 1 above) contain further details.<br><br>FDP collaboration including the development of new modules and tools across the APC<br><br>Clinical Pathways collaboration across the APC to reduce inequalities and aid efficiency<br><br>The trust has been a core system partner in enabling the shift of care from acute to community in areas such as the following:<br>• Paediatric Health Hubs | | Director of Strategy and Transformation | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Explanation where not confirmed and actions underway/required | Exec lead | RAG rating |
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| | | working and constructive challenge – e.g. COO and CFO groups<br>The Trust supports and pioneers collaborative initiatives, for example, it is the founder and host of the London-wide MBA Summer Interns scheme enabling career development and supporting internal and system transformation, productivity and efficiency<br><br>The Deputy CEO of the Trust attends all borough/place based partnership meetings with local health and care partners e.g. Brent and Harrow<br><br>The Director of Strategy and Transformation is the APC representative on the NWL PLACE Delivery Group | • Willesden Community Diagnostic Hubs<br>• Partnerships with third sector organisations like Brent Carers Centre to support reductions in DNAs from more deprived neighbourhoods<br>• NEON (Northwick and Ealing Outreach Network) working with local youth charities with youth workers meeting with patients admitted aged 16 to 25 to signpost to other community support | | | |

**II. Quality of care**

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| 5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of | • The trust can demonstrate and assure itself that internal procedures:<br>○ ensure required standards are achieved (internal and external)<br>○ investigate and develop strategies to address substandard performance<br>○ plan and manage continuous improvement<br>○ identify, share and ensure delivery of best practice<br>○ identify and manage risks to quality of care | The trust is committed to continuous improvement in quality of care, with robust monitoring processes in place.<br><br>The Board is assured of this through detailed reporting via the Trust's Quality and Safety Committee and supporting governance, which is triangulated through visits to Trust services by board members and NED Champions such as the Maternity NED Champion | • Trust Quality Account 24-25<br>• Agenda, minutes and papers for the Trust's Quality & Safety Committee<br>• Agenda, minutes and papers for the APC's Quality Committee<br>• Reports to the Board in Common<br>• NED maternity champion<br>• Executive and NED visits to points of care<br>• Staff Survey Score 2024 for 'care of patients is my organisations top priority 78.39% (above national average)<br>• Staff raising concerns aspect of staff survey is above national average at 6.42 | *Ongoing delivery of the local sustainability plan for Maternity Services reporting into NHS London* | Chief Nursing Officer<br><br>Chief Medical Officer | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
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| complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients | • There is board-level engagement on improving quality of care across the organisation<br>• Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients<br>• Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community<br>• Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust<br>• Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement | Board members hear directly from patients and staff via stories at Board Committees and the Board in Common<br><br>The trust benchmarks quality standards and performance through the APC Quality Committee, which supports sharing of good practice.<br><br>The trust utilises model hospital data and other benchmarking data to drive productivity and efficiency<br>The Trust takes learning from national inquiries to ensure its internal governance arrangements are as robust as possible<br><br>The Trust's Internal Audit Programme over the past 12 months has included areas such as Infection Prevention and Control which achieved substantial assurance<br><br>The Trust Audit and Risk Committee receives horizon scanning reports and national reports on varying aspects of governance and quality routinely at its committee meetings and cross fertilises these to appropriate governing committees of the Board for learning<br><br>The Trust has been nominated for (and indeed awarded) a number of national patient safety awards for its work in 2025 with some innovations shared nationally to aid learning<br><br>The Trust has a large scale transformation programme underpinned by IHI Quality Improvement Training and Methodology including the importance of co-production | • Staff Survey Score for 'we each have a voice that counts' is 6.70% (above national average)<br>• Quality Improvement Policy, Programme and Training<br>• Risk management strategy and process, including quarterly reports on risk to all Board Committees alongside Board Assurance Framework reports.<br>• Patient Stories and Staff Stories at Board Committees<br>• Integrated Quality and Performance Report<br>• External visits and accreditations<br>• National oversight framework (NOF) domain score of 2.45 for effectiveness and experience of care<br>• PSIRF training levels<br>• Appraisal training levels<br>• Staff survey appraisal score 2024 is 5.41 (above national average)<br>• Incident reporting levels and associated harm<br>• Exit from National Maternity Safety Programme 2024 | | | |
| 6. Systems are in place to monitor patient experience and | • Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself | The trust puts patient experience at the centre of all that we do. There are a range of ways in which this is done, through regular reporting and | • Trust patient and public experience and engagement report reported on quarterly basis to quality and safety committee | | Chief Nursing Officer | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| there are clear paths to relay safety concerns to the board | that it has a comprehensive picture of patient experience?<br>• Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities?<br>• Is the board satisfied that it receives timely information on quality that is focused on the right matters?<br>• Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this?<br>• How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?<br>• Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? | discussion through the board and APC's committees and at quarterly board meetings. The reports bring together findings from complaints, PALS, patient surveys, patient engagement meetings, family and friends test results, healthwatch and social website postings such as NHS Choices and Care Opinion to provide a rounded picture of patient experience.<br><br>The Trust uses co-production as a core improvement enabler in its approach to quality improvement including the voice of patients and carers<br><br>The Trust has a patient and carer participation group as part of its governance arrangements<br><br>The Trust has two Patient Safety Partners on its Quality and Safety Committee<br><br>The Trust has a number of specialist patient representative groups including stoma care, sickle cell, IBS and multiple cancer support groups<br><br>The Trust has led the development of the Equity Index which is now being adopted more widely across the NHS to understand inequities in healthcare and measures of improvement | • Trust Annual Report for statutory requirements such as Complaints includes equity lens<br>• Patient experience data on the friends and family test (FFT), same sex accommodation and complaints reported monthly in performance and quality report to BiC<br>• Patient stories at trust quality and safety committee and BiC<br>• National oversight framework (NOF) domain score of 2.45 for effectiveness and experience of care<br>• National Patient Survey Results:-<br>○ Inpatient Care<br>○ Maternity<br>○ Emergency Care<br>○ Paediatrics<br>○ Cancer Services | | | |

### III. People and culture

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 7. Staff feedback is used to improve the quality of care provided by the trust | • Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement?<br>• Does the board engage with staff forums to continually consider how care can be improved?<br>• Can the board evidence action taken in response to staff feedback? | The board and committees review feedback from staff through reports on the annual staff survey and related action plans, hear direct stories from staff at committee and board meetings and reports on other mechanisms of feedback, such as the GMC survey, freedom to speak up reports, guardian of safe working reports and updates regarding staff forums/networks.<br><br>Each staff network has an Executive Director sponsor<br><br>Executive Directors provide mentorship to staff network chairs<br><br>Model Employer findings are reported as a standard routine item in Committee and Board level workforce reports<br><br>WRES and WDES data is considered and reported at Committee and Board level<br><br>EDI strategy and improvement plan in place<br><br>Staff engagement newsletter includes a 'You said we did section' in response to staff feedback<br><br>Monthly all staff listening events hosted by the CEO and Executive Team enable open and anonymised questions to be put to Board members by all staff<br><br>In addition the trust has a strong quality improvement programme where all staff are supported and encouraged to lead improvement, including through an annual Quality Improvement event | • Staff survey results and action plan through thematic groups, reported to people equity and inclusion committee (PEIC)<br>• Staff stories at Board Committees<br>• NED attendance at Resident Doctor meetings<br>• NED Maternity Champion<br>• NED Wellbeing Champion<br>• Staff stories at Board in Common<br>• Staff forums, with executive director sponsors<br>• WRES and WDES<br>• NOF domain score of 1.87 for people and workforce.<br>• Healthy Workplace Initiative addresses hygiene factors for staff raised through staff ideas for improvement eg new rest rooms, staff breast feeding facilities etc<br>• Staff and patient survey feedback about wayfinding has resulted in a wayfinding scheme which is now being deployed across all of our Trust sites | | Chief People Officer (CPO) | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | showcasing quality improvements proposed by staff. | | | | |
| 8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels | • Does the trust regularly review skills at all levels across the organisation?<br>• Does the board see and, if necessary, act on levels of compliance with mandatory training? | The trust attracts high calibre and diverse staff with a wide range of skills. To support retention and development, the trust has recently refreshed it learning and development offer to staff at all levels, including additional learning and development opportunities for staff from a Global Majority Background to enhance developmental opportunities for such staff in senior positions.<br><br>Leadership training has recently been enhanced including a focus on management training and associated competencies including line management and budgetary management skills<br><br>Mandatory training compliance levels are monitored weekly by executives, with reports provided to board committees and through the board's quality and performance report for further scrutiny and action. The BiC receives a quarterly update on performance across the collaborative on core skills compliance supporting wider conversations and ability to share best practice across all four trusts. | • Learning and development offer for staff<br>• Staff Survey score 2024 for Learning Culture is 5.93 (above national average)<br>• Reports on mandatory training compliance to People Equity and Inclusion Committee PEIC (and weekly to all managers and executives).<br>• Escalation reports from PEIC to Board Standing Committee.<br>• APC reports<br>• Core skills compliance in BiC<br>• NOF domain score of 1.87 for people and workforce. | Our cultural review audit has identified that digital skills development is an area for future development and this is being incorporated into our Learning and Development Plan across the workforce. Developing this skill set will aid workforce transformation alongside digital and technological innovation and AI in healthcare to aid efficiency and productivity. | Chief People Officer | |
| 9. Staff can express concerns in an open and constructive environment | • Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?<br>• Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required? | The Board receives quarterly reports on FTSU through the local people equity and inclusion committee. A detailed trust level annual report is received at the board's standing committee with an aggregated report at BiC level to support comparison and learning across the APC. | • FTSU policy and process, including Executive Lead, NED lead, Guardian and champions across organisation – well publicised on intranet, through posters and awareness events<br>• Staff survey results on 'raising concerns' is above national averages at 6.42<br>• Staff survey results on being confident that the Trust would address concerns raised through speaking up is above national average at 50.80% | | Director of Corporate Affairs | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | • Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?<br>• Is there a safe reporting culture throughout the organisation? How does the board know?<br>• Is the trust an outlier on staff surveys across peers? | The Board has a clearly communicated FTSU process, which is utilised by staff, who report above average levels of confidence in the process. The latest staff survey saw the Trust improve its score for raising concerns to 58.31% and for being assured that the Trust will address their concerns to 50.80% (above national average levels) | • Quarterly reports on FTSU to people committee<br>• Annual report on FTSU to BiC. | | | |

## IV. Access and delivery of services

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 10. Plans are in place to improve performance against the relevant access and waiting times standards | • Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary?<br>• Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this?<br>• Is there a plan to deliver improvement? | The trust has a strong track record in achievement of performance standards set in the annual operating plan. For 2025/26 the trust is working towards achievement of all standards and where these are off trajectory, improvement plans are in place | • IQPR reports to committees and BiC<br>• NOF domain score of 2.17 for access to services<br>• Weekly access meetings to drive improvements in performance<br>• LNWH Finance and Performance Committee<br>• NWL APC Finance and Performance Committee<br>• ED improvement plan<br>• Winter Plan | Conversations are taking place with the ICB around the funding of activity to meet higher than contracted levels of demand. Without resolution to this is issue during M6 the RTT 18 week performance is at risk. | Chief Operating Officer | |
| 11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients | • The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place | The trust, with APC partners, established a health equity programme and agreed a set of metrics aimed at tackling key patient and population health related inequalities. These are now evolving into a routine part of our governance so that we can track these through the performance and quality reports at trust and collaborative committees, and through the BiC.<br>Locally, the newly established LNWH Equity Group has made reducing inequities in access a priority, with several key projects already underway. Particular focus has been placed on addressing deprivation-related disparities in missed appointments and the low uptake of bowel cancer screening. One flagship initiative | • Equity Index<br>• Some Segmented data in Trust and APC level reports<br>• Trust EQIA process<br>• APC Equity Improvement Plan | Segmented data to be routinely captured in wider range of metrics and reports · Mechanisms for APC KPI tracking are being established, with clear ownership assigned to local and APC level working groups. | Chief Operating Officer | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | involves community volunteer–led pre-appointment calls, delivered in partnership with Brent Carers Centre, to support patients in the most deprived areas of Brent.<br>The Trust has also launched the acclaimed Equity Index, an innovation to embed it into local governance structures to strengthen tracking and accountability on equity. This has been shared in national webinars and HSJ articles.<br>The Board monitors and works to minimise unwarranted variations in access to and delivery of services, with plans in place to address identified gaps. · The NWL APC has agreed four Board-level inequity KPIs to track access:<br>o Missed Appointments in IMD Quintile 1<br>o RTT <40 Weeks in IMD Quintile 1<br>o Maternity Late Bookings for Global Majority<br>o Delays to Analgesia for Sickle Cell | | | | |
| 12. Appropriate population health targets have been agreed with the ICB | • Is there a clear link between specific population health measures and the internal operations of the trust?<br>• Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system? | The Trust has agreed a series of population health measures with the ICB which are aimed at preventing ill health and reducing inequalities. These include a focus on smoking cessation and support with substance misuse, which includes embedded teams through the maternity and emergency care pathway. An FGM specialist is also in place in maternity.<br><br>Engagement with local system leaders and use of population health data has enabled us to respond to higher than average diabetes rates, higher than average child tooth decay and a high level of alcohol related conditions<br><br>Drivers of emergency admissions and associated patient conditions are reviewed with system partners in each borough including age profiles, ethnicity etc to determine the needs and shape of emergency and elective pathways and wider system initiatives | • APC Equity Improvement Plan<br>• Health Inequalities statement in Annual Report<br>• Sponsorship of Darzi fellow in diabetes to increase self awareness and care in the community thus reducing admission and re-admission levels | | Director of Strategy and Transformation | |

## V. Productivity and value for money

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant | • Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:<br>○ review its performance against peers<br>○ identify and understand any unwarranted variations<br>○ put programmes in place to reduce unwarranted negative variation<br>• The trust's track record of delivery of planned productivity rates | As part of an established acute provider collaborative, the trust has effective operational and governance arrangements to benchmark performance and share best practice across the collaborative. The model hospital system data is considered annually at the trust's finance and performance committee. In addition the APC CFOs have worked collaboratively to develop locally agreed metrics to complement the nationally defined metrics, all of which are tracked through an APC productivity and efficiency dashboard and which were approved at the APC's finance and performance committee.<br><br>For those areas where productivity could be improved, there is joined up work across the collaborative, which is reported to the APC. Finance Delivery Group as part of the Grip and Control checklist review and take needed action on the agreed NWL APC metrics (from Model Health System) – this communicates our performance against NWL APC peers. Use of Productivity and efficiency packs at APC Finance and Performance Committee on a regular basis.<br><br>Metrics are produced in real time (with SPC chart analysis) where possible so that remedial action can be put in place where needed (Model Health System often has data lags)<br><br>The Trust has produced its own productivity tool that uses timely information from the finance ledger and SLAM information to address productivity unwarranted variation at a specialty level, information that is | • Reports to trust and collaborative FPC<br>• APC FPC reports on productivity and proposed additional metrics/focus in 25/26<br>• Cancer productivity report to Sept APC FPC<br>• Use of productivity calculator<br>• Programme of deep dives which include benchmarking data<br>• NOF domain score of 1.63 for finance and productivity<br>• Model Hospital Data and other benchmarking data<br>• BDO Audit of CIP Programme (substantive assurance) | • Alignment/consolidation of corporate services across the APC to drive corporate efficiencies | Director of Strategy and Transformation<br><br>Chief Financial Officer | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | being used to support identification of our multi-year CIP programme. Divisional testing will conclude on 24/09 with full roll-out at the end of September 25.<br><br>Wider use of Model Hospital Benchmarking analysis is shared at specialty level as part of the annual efficiency planning and development of the multi-year CIP plan cycles. Areas of unwarranted variation is examined and addressed through development of the efficiency plans these are targeted. | | | | |

## VI. Financial performance and oversight

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| 14. The trust has a robust financial governance framework and appropriate contract management arrangements | • Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data<br>• Have there been any contract disputes over the past 12 months and, if so, have these been addressed?<br>• [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned? | The trust has a strong track record of delivery against financial plans, except 2024/25 which was a challenging year. Comprehensive governance arrangements are in place. The annual operating plan is developed in a collaborative way to ensure activity, workforce and finance data is aligned at trust and collaborative level. Performance against the plan is reviewed on a monthly basis through trust and APC governance.<br><br>A review of the trust's financial governance arrangements was included as part of the system's review under the investigation and intervention regime in late 2024. The review identified overall strong governance arrangements, with some recommendations for improvement which have since been enacted.<br><br>Over the past 12 months, there have been 2 Supplier disputes (1 resolved | • Financial governance structure<br>• Comprehensive internal audit plan agreed annually and progress tracked at each audit and risk committee meeting<br>• Reduction in bank and agency usage in relation to 2024/25 – reports to PEIC and FPC<br>• I&I report<br>• NOF domain score of 1.63 for finance and productivity<br>• BDO Audit Report - CIP Assurance (Including HFMA Sustainability Assessment Audit)– Outcome of Substantial Assurance given for both design and effectiveness of governance - March 2025<br>• BDO Audit Report - Cash Management – Substantial assurance given to design and Moderate assurance on effectiveness – September 2025 | Alignment of the Trusts Staffing and Financial Systems to show a consistent story regarding operational costs and activity carried out – this improvement work is continuing.<br><br>Work is underway to agree with the ICB a realignment of funding to reflect additional demand not planned into the contract agreed at the start of the year. A failure to agree this places either money or performance at risk | Chief Financial Officer (CFO) | Green / Amber |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | through collaboration and 1 active on the grounds of supplier's failure to provide sufficient supporting information to qualify full payment). There has been also one customer dispute that has arisen and now closed due to customer liquidation.<br><br>Work has taken place to align the Trusts Staffing and Financial Systems to show a consistent story regarding operational costs and activity carried out – this improvement work is continuing.<br><br>The Trust has significantly reduced its use of agency staffing and is now focussing on reducing the use of bank staff. KPIs to this effect are included in the Integrated Quality and Performance Report and are monitored on a monthly basis at Executive level and a quarterly basis at Board and Committee level<br><br>The Trust has robust contractual management in place for our Internal, External and Counter Fraud contracts with external parties.<br><br>The Audit Committee (subcommittee of the Board) are involved in co-developing the internal audit plan each year that is tailored to support the Trust in allocating internal audit support to high-risk areas. In 25/26, the Audit Committee specified a plan of work to support the audit committee in testing the robustness of out high-risk areas. The two main financial risks were linked to cask management and CIP assurance. Both assessments have been concluded.<br><br>Pertaining to internal contract management, the Finance Team has a dedicated commercial function that supports with complex contract resolution (if it arises) and this team | | | | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | also works alongside North West London Procurement Services (NWLPS) to support major tenders. | | | | |
| 15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes | • Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care?<br>• Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing?<br>• Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers? | The trust has a strong track record in delivering cost improvement programmes, but does so by ensuring no reduction in the quality and safety of care provided. Each CIP must be accompanied by an Equality and Quality Impact Assessment which is reviewed by executive leads, including medical and nursing leadership to ensure there is no adverse impact.<br><br>Overall financial performance for the trust and APC is monitored regularly through trust and APC level finance and performance committees, and reported quarterly through the board's standing committee and the board in common.<br><br>• Through the finance committee of the Trust, I&E (including efficiency) cash and capital are stress tested for deliverability. | • Cost improvement programmes reviewed through EQIA to ensure no adverse impacts on quality or inequalities.<br>• Live TRAKIT Reporting, our online cost improvement project and business case tool, includes reports on financial delivery, Patient and Staff impacts, and the EQIA status<br>• EQIA Panel<br>• Monitoring through trust and APC FPC, plus through the board standing committee and BiC.<br>• NOF domain score of 1.63 for finance and productivity<br>• Finance and Performance Committee papers / minutes<br>• APC Level transformation programme established to drive efficiencies | | CFO | |
| 16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn | • Is the board contributing to system-wide discussions on allocation of resources?<br>• Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system?<br>• Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS? | The trust works closely with system partners on financial planning to ensure full alignment across the APC and the wider ICS footprint. This is developed and considered through the local, collaborative and system finance and performance governance structure, supporting a joined up approach that focuses on the benefit to the overall population of north west London.<br><br>Through the NWL CFOs and APC CFOs there is a shared view of financial plans across the system. Together we address financial challenges linked to underlying deficits and in-year deterioration. This has | • Development of Medium Term Financial Strategy across APC<br>• APC Finance and Performance Committee<br>• APC pathway development programme<br>• NOF domain score of 1.63 for finance and productivity<br>• APC CFOS with wider ICS CFOs developed financial plan, with ICB board signing off final allocations<br>• System oversight on finance, quality and performance through the quarterly System Oversight Meetings (SOM).<br>• Procurement of shared NWL Procurement service/systems | | CFO | |

| Self-assessment criteria | Indicative evidence or lines of enquiry | Assurance statement | Trust evidence (summary list and links where available) | Actions underway/required | Exec lead | RAG rating |
|---|---|---|---|---|---|---|
| | | provided the needed platform to agree local distributions (or re-distributions) of revenue and capital where relevant.<br><br>The Trust has developed the MTFP model for the APC that is now looking to be adopted by the NWL ICS. This has been done in readiness for our autumn submission to NHSE. | | | | |

# 5.1.2 LEARNING FROM DEATHS QUARTER 1 REPORT - INDIVIDUAL TRUST REPORTS

## REFERENCES

Only PDFs are attached

- READING ROOM - CWFT Learning from deaths Q1 2025_26_Final.pdf
- READING ROOM - ICHT Learning from Death Quarter One 2025-26 final v1.pdf
- READING ROOM - LNWH Learning from Deaths Q1 2025-26 Updated Version V5  29-Jul-25.pdf
- READING ROOM - THH Learning from deaths Report Q1 25.26.pdf

NWL Acute Provider Collaborative Mortality Surveillance Group (Public)
27/08/2025
Item number: #
This report is: Public

# Chelsea and Westminster Hospital NHS Foundation Trust Learning from Deaths report Quarter 1 2025/26

Author: Stacey Humphries
Job title: Head of Clinical Governance

Accountable director: Sanjay Krishnamoorthy
Job title: Site Medical Director, WM

## Purpose of report (for decision, discussion or noting)

Purpose: Assurance

The board is asked to note this paper.

## Report history

Outline committees or meetings where this item has been considered before being presented to this meeting.

| | | |
|---|---|---|
| CWNHST Trust Mortality Surveillance Group | CWNHSFT Executive Management Board | CWNHSFT Trust Quality Committee |

## Executive summary and key messages

The Trust is one of the best performing acute (non-specialist) providers in England in terms of relative risk of mortality with a Trust wide SHMI of 0.71 (where a number below 1 is better than expected mortality) for period January - December 2024 (Source HES). This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality.

During the 12-month period to the end of July 2025; 1,288 in-hospital adult or child deaths were recorded on the Trust mortality review system (Datix), of these 94% were screened and 43% had a full mortality case review closed following speciality discussion.

There were no cases of sub-optimal care that would reasonably be expected to have made a difference to the patient's outcome. There were 7 cases of sub-optimal care grade CESDI 2 (suboptimal care identified and different care MIGHT have made a difference to the outcome) identified and escalated for a decision on appropriate learning response.

Where the potential for improvement is identified learning is shared at Divisional review groups and presented to the Trust-wide Mortality Surveillance Group; this ensures outcomes are shared and learning is cascaded.

## Impact assessment

Tick all that apply

- ☐ Equity
- ☒ Quality
- ☐ People (workforce, patients, families or careers)
- ☐ Operational performance
- ☐ Finance
- ☐ Communications and engagement
- ☐ Council of governors

Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes and experience for patients and their families.

## Strategic priorities

Tick all that apply

- ☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity (APC)
- ☐ Support the ICS's mission to address health inequalities (APC)
- ☐ Attract, retain, and develop the best staff in the NHS (APC)
- ☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APC)

# Main report

## 1. Learning and Improvements

The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed. This report provides a Trust-level quarterly review of mortality learning for Q1 2025/26 with performance scorecard (see Appendix 1 and 2) reflecting all quarters of the financial year.

### 1.1. Relative Risk of mortality

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. Both tools are used to determine the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths; this provides a relative risk of mortality ratio (where a number below 100 represents a lower than expected risk of mortality).

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI and HSMR are designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality the Trust is able to make comparisons between peer organisations and seek to identify improvement areas where there is variance.

### 1.2. Summary Hospital-level Mortality (SHMI) Indicator: Trust wide

The SHMI is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die based on the England average, given the characteristics of the patients treated. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge. Deaths related to COVID-19 are excluded from the SHMI.

The SHMI gives an indication of whether the observed number of deaths on our Trust sites within 30 days of discharge from hospital is 'higher than expected', 'as expected' or 'lower than expected' when compared to the national baseline. The following information is largely using the latest release of Hospital Episode Statistics (HES) dataset to the period ending December 2024.

There were significant changes made to the SHMI methodology in May 2024. Figures published after this date cannot be precisely compared with previous publications.

Figure one shows that both of the Chelsea and Westminster Hospital NHS Foundation Trust (CWHFT) sites have overall outcomes that are significantly below the national expected rate.

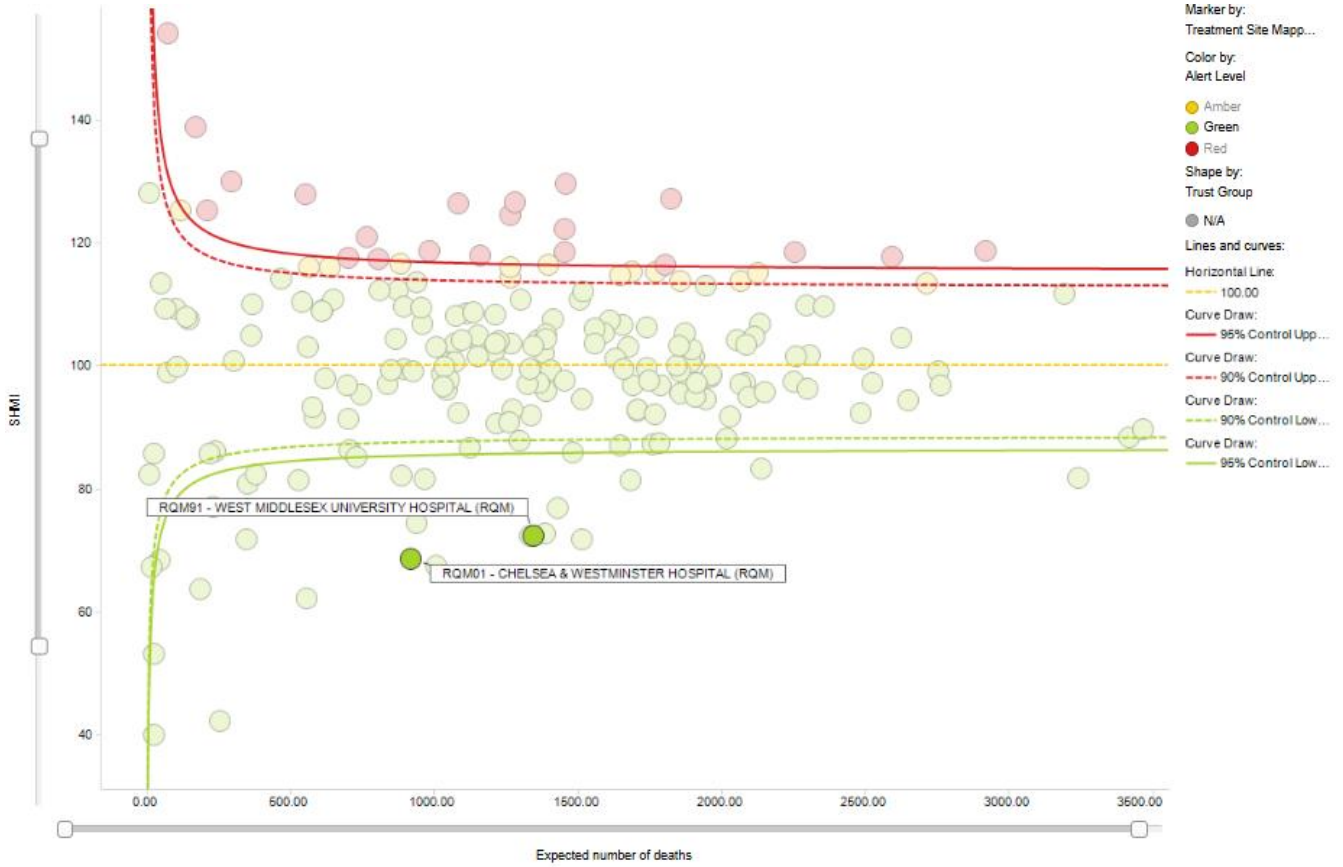



Figure 1: Funnel Plot (Rebasing period up to September 2024). SHMI comparison of England acute hospital sites based on outcomes between January and December 2024 - Updated 27/05/2025.

Using the SHMI dataset, within the period between January and December 2024, there have been 94305 discharges, of which 1628 patients died either in hospital or within 30 days of discharge. The number of expected deaths was 2322. 73% of deaths occurred in hospital.

The 'in hospital' and 'out of hospital' SHMI values are also below the expected range. Overall 75% of patients died in hospital (n=1218). Table 1 below shows that both Trust sites have similar SHMI outcomes.

| Site | SHMI | LCL 95%CI | UCL 95%CI | Expected number of deaths | Observed number of deaths | Total discharges | % adms. with palliative care coding | Mean comorbidity score per spell |
|---|---|---|---|---|---|---|---|---|
| CWH | 68.64 | 63.38 | 74.22 | 916.33 | 629 | 42534 | 1.44% | 3.2 |
| WMUH | 72.36 | 67.89 | 77.06 | 1343.22 | 972 | 50236 | 1.42% | 4.11 |
| CWHFT | 70.85 | 67.42 | 74.4 | 2259.84 | 1601 | 92770 | 1.43% | 3.69 |

Table 1. SHMI breakdown by site – Updated 27/05/2025

The positive assurance provided by the SHMI is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality.

**Diagnostic Groups:** The SHMI is made up of 142 different diagnostic groups which are then aggregated to calculate the Trust's overall relative risk of mortality. The Mortality Surveillance Group monitors expected and observed deaths across diagnostic groups; where statistically significant variation is identified the group undertakes coding and care review to identify any themes or potential improvement areas.

## 1.3. Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for all diagnostic (CCS) groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

The traditional HSMR is based on the 56 diagnostic groups which contribute to 80% of in-hospital deaths in England. We can access outcomes against the above or all diagnosis group.
HSMR (56 diagnosis groups) outcomes during the period January to December 2024 were below the expected range. The Trusts HSMR is 77.4 (upper CI 82 lower CI 72), with 968 observed deaths over the period with 1250 expected.

| Organisation - Provider | HSMR | HSMR 95% Upper CI | HSMR 95% Lower CI | Number of super-spells | Expected number of deaths | Number of observed deaths |
|---|---|---|---|---|---|---|
| R1K - LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST | 91.08 | 95.82 | 86.52 | 61692 | 1639.27 | 1493 |
| RAS - THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST | 92.69 | 100.64 | 85.22 | 23343 | 612.79 | 568 |
| RQM - CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST | 77.4 | 82.44 | 72.6 | 43755 | 1250.58 | 968 |
| RYJ - IMPERIAL COLLEGE HEALTHCARE NHS TRUST | 73.43 | 77.51 | 69.52 | 72143 | 1796.16 | 1319 |
| | | | | | | |
| RQM01 - CHELSEA & WESTMINSTER HOSPITAL | 66.38 | 73.72 | 59.61 | 17294 | 527.23 | 350 |
| RQM91 - WEST MIDDLESEX UNIVERSITY HOSPITAL | 85.66 | 92.69 | 79.04 | 24765 | 721.45 | 618 |

Table 10 – HSMR outcomes over period January – December 2024– updated 27/05/2025

## 1.4. Crude mortality

The crude rate is calculated by dividing the observed number of in hospital deaths by the total number of patients within the hospital. The outcome is multiplied by 1000 to give the number of mortalities per thousand patients. Crude rates provide a useful means of monitoring outcomes over time.

The disadvantage of crude rates is that they cannot be used to compare the mortality experience between different sites because of possible differences in the population demographic, hospital services and surrounding health economies. However, an advantage of such statistical bias is that it can illuminate the differences between the two hospital sites.
The following crude rates only include adult emergency admitted spells by age band.

This approach appears to reduce some of the variation when comparing the two sites. Although clearly there are other differences in terms of services provided and local demographic profiles, that shouldn't be forgotten when reviewing.

Note: changes to the method used to record "ambulatory/ Same Day Emergency Care" care contacts will have an impact on these crude rates as the denominator will be reduced.
Weekly adult emergency admitted spells and crude mortality rate per 1000 admissions:

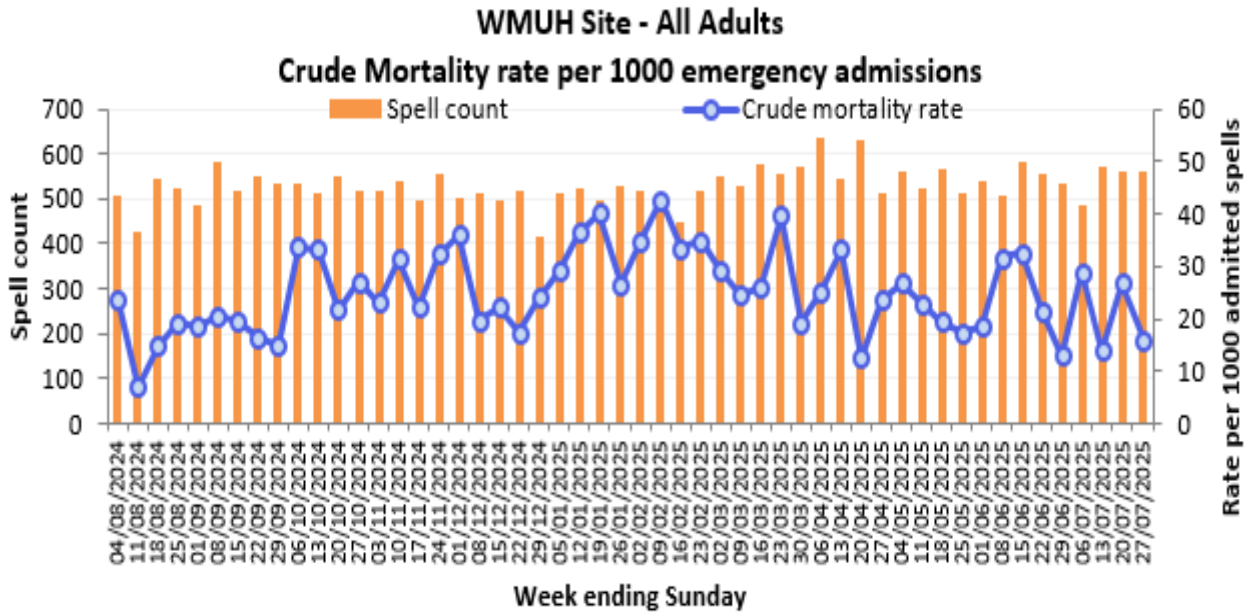



Figure 2 – Weekly adult emergency spell counts and crude mortality rate per 1000 patients, West Middlesex University Hospital

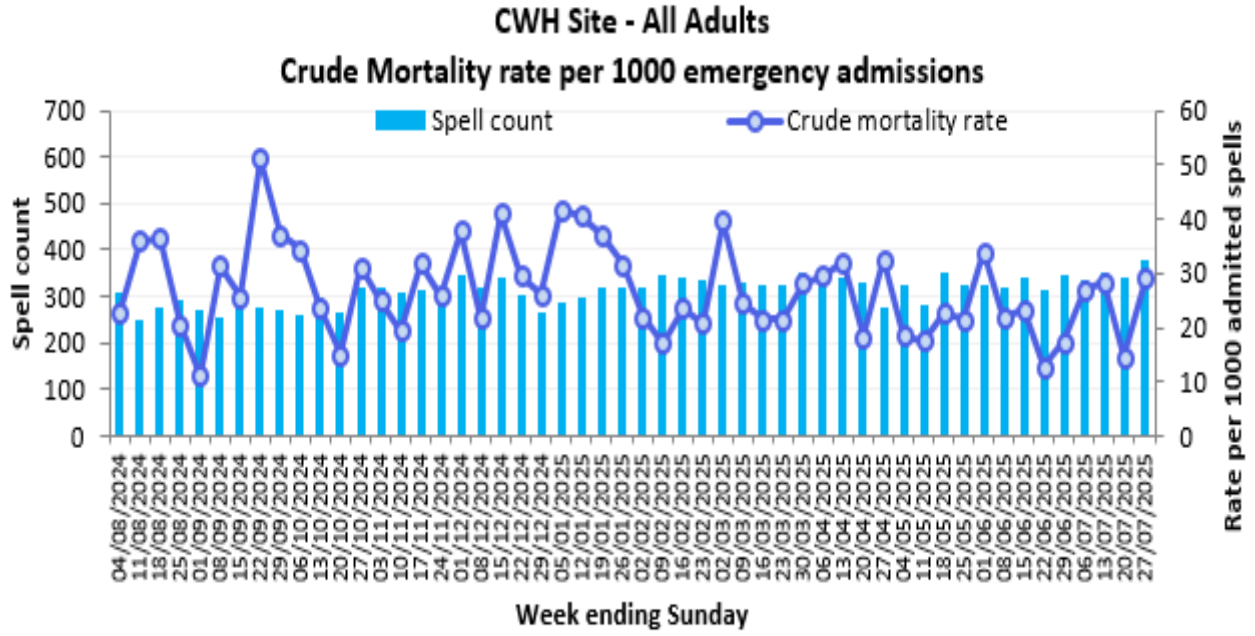



Figure 3 – Weekly adult emergency spell counts and crude mortality rate per 1000 patients, Chelsea and Westminster Hospital

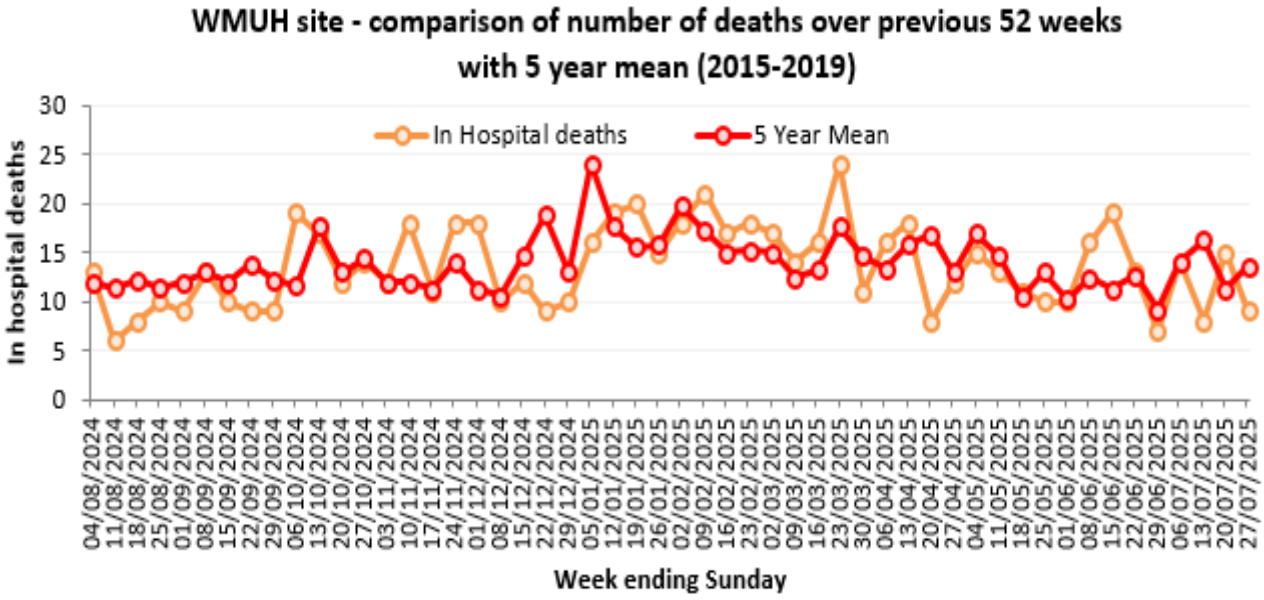



Figure 4 – Crude mortality in last 52 weeks compared with 5 year mean, West Middlesex University Hospital

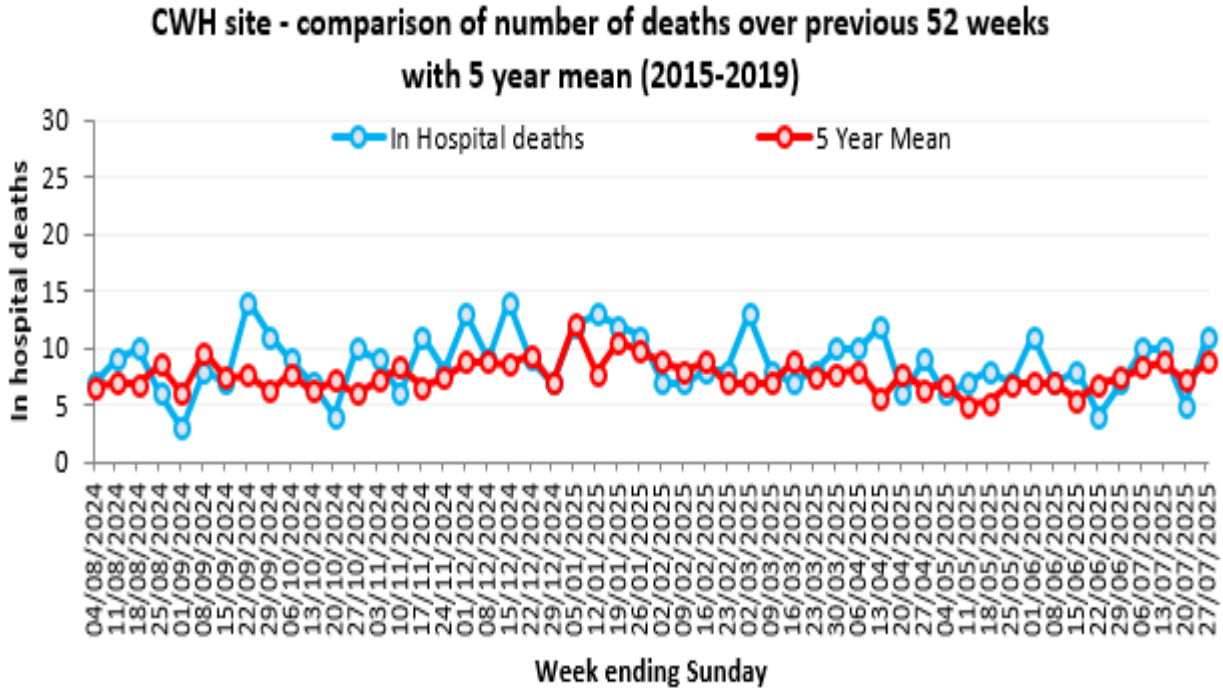
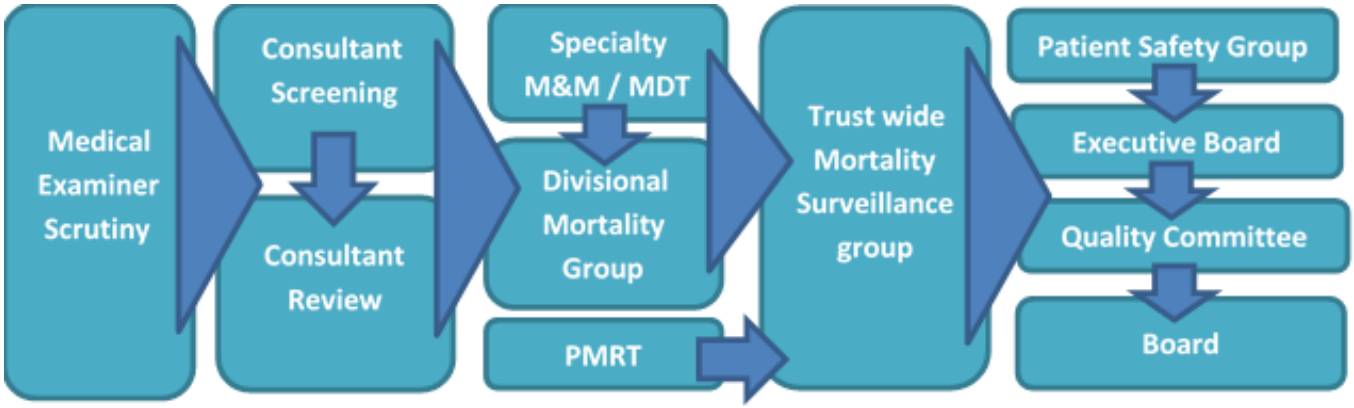



Figure 5 – Crude mortality in last 52 weeks compared with 5 year mean, Chelsea and Westminster Hospital

Crude mortality is monitored by the Mortality Surveillance Group on a monthly basis; no further review has been triggered as a result of this monitoring during this reporting period.

## 2. Thematic Review

The Mortality Surveillance Group (MSG) challenges assurance regarding the opportunity and outcomes from the Trust's learning from deaths approach.




MSG provides leadership to this programme of work; it is supported by monthly updates on relative risk of mortality, potential learning from medical examiners, learning from inquests, and divisional learning from mortality screening / review. MSG is a sub-group of the Patient Safety Group and is aligned to the remit of the Quality Committee.

## 3. Medical Examiner's office

An independent Medical Examiner's service was introduced to the Trust in April 2020 to provide enhanced scrutiny to deaths and to offer a point of contact for bereaved families wishing to raise concerns.

The purpose of this service is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data

During Q1 2025/26 the medical examiners service scrutinised 100% of in-hospital adult and child deaths and identified 53 cases of potential learning for the Trust and 13 cases of potential learning for other organisations. Potential learning identified during medical examiner scrutiny is shared with the patient's named consultant, divisional mortality review group and the Trust-wide Mortality Surveillance Group. Full consultant led mortality review is required whenever the MEs identify the potential for learning.

Thematic learning from medical examiner scrutiny is reported to the Mortality Surveillance Group, Executive Management Board, and Quality Committee (via annual ME report).

## 4. Adult and child mortality review

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

In-hospital adult and child deaths are screened by consultant teams using the screening tool within Datix, this supports the identification of cases that would benefit from full mortality review.

Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through Divisional Mortality Review Groups and the trust-wide Mortality Surveillance Group (MSG).

Trust mortality review targets:

- 100% of in-hospital adult and child deaths to be screened
- At least 30% of all adult deaths aligned to the Emergency and Integrated Care (EIC) Division to undergo full mortality review
- At least 80% of all adult and child deaths aligned to Planned Care Division (PCD), Women's Neonates, HIV/GUM, Dermatology (WCHGD), and West London Children's Health (WLCH) to undergo mortality review
- 100% of cases aligned to a Coroner inquest to undergo full mortality review
- 100% of cases where potential learning identified by Medical Examiner to undergo full mortality review

During July 2024 to June 2025; 1,200 in-hospital adult or child deaths were recorded within the Trust's mortality review system (Datix), of these 94% have been screened and 43% have had full mortality case review.

| | No. of deaths | No. of cases screened only and closed | No. of cases with full mortality review | No. of cases pending screening | % Screened | % with Full Review | % Pending |
|---|---|---|---|---|---|---|---|
| Q2 24/25 | 272 | 130 | 136 | 6 | **98%** | **50%** | **2%** |
| Q3 24/25 | 340 | 173 | 156 | 11 | **97%** | **46%** | **3%** |
| Q4 24/25 | 379 | 201 | 158 | 20 | **95%** | **42%** | **5%** |
| Q1 25/26 | 297 | 156 | 98 | 43 | **86%** | **33%** | **14%** |
| Totals | **1288** | **660** | **548** | **80** | **94%** | **43%** | **6%** |

Table 3: Adult and child mortality review status by financial quarter, July 2024 – June 2025

Process compliance is monitored by the Divisional Mortality Review Groups, Mortality Surveillance Group, and overseen by the Patient Safety Group, Executive Management Board, and Quality Committee.

| Division | No. of deaths | No. of cases screened and closed | No. of cases with full mortality review | No. of cases pending screening | % Screened | % with Full Review | % Pending |
|---|---|---|---|---|---|---|---|
| Emergency and Integrated Care | 1042 | 651 | 350 | 41 | 96% | 34% | 4% |
| Planned Care | 233 | 3 | 192 | 38 | 84% | 82% | 16% |
| West London Children's Healthcare | 7 | 0 | 6 | 1 | 86% | 86% | 14% |
| Specialist Care | 6 | 6 | 0 | 0 | 100% | 0% | 0% |
| Totals | 1288 | 660 | 548 | 80 | 94% | 43% | 6% |

*Table 4: Adult and child mortality review status by Division,* July 2024 – June 2025

Gaps in process compliance at Specialty and Divisional level are monitored by the Mortality Surveillance Group. Divisional plans to achieve the required compliance are reported to the Mortality Surveillance Group and Executive Management Board.

| | No. of deaths | No. of cases screened and closed | No. of cases with full mortality review | No. of cases pending screening | % Screened | % with full review | % Pending |
|---|---|---|---|---|---|---|---|
| Acute Frailty Service | 1 | 0 | 0 | 1 | **0%** | **0%** | **100%** |
| Acute Medicine | 335 | 246 | 87 | 2 | **99%** | **26%** | **1%** |
| Bariatric | 1 | 0 | 0 | 1 | **0%** | **0%** | **100%** |
| Burns | 5 | 0 | 4 | 1 | **80%** | **80%** | **20%** |
| Cardiology | 35 | 12 | 23 | 0 | **100%** | **66%** | **0%** |
| Care Of Elderly | 287 | 206 | 72 | 9 | **97%** | **25%** | **3%** |
| Colorectal | 7 | 0 | 2 | 5 | **29%** | **29%** | **71%** |
| Diabetes/Endocrine | 65 | 40 | 14 | 11 | **83%** | **22%** | **17%** |
| Emergency Department | 91 | 3 | 86 | 2 | **98%** | **95%** | **2%** |
| Gastroenterology | 56 | 21 | 34 | 1 | **98%** | **61%** | **2%** |
| General Surgery | 29 | 1 | 13 | 15 | **48%** | **45%** | **52%** |
| Gynaecology | 1 | 1 | 0 | 0 | **100%** | **0%** | **0%** |
| Haematology | 3 | 1 | 1 | 1 | **67%** | **33%** | **33%** |
| HDU | 8 | 0 | 6 | 2 | **75%** | **75%** | **25%** |
| Hepatology | 8 | 4 | 1 | 3 | **63%** | **13%** | **38%** |
| HIV | 5 | 5 | 0 | 0 | **100%** | **0%** | **0%** |
| ICU | 138 | 0 | 133 | 5 | **96%** | **96%** | **4%** |
| Medical Oncology | 23 | 17 | 2 | 4 | **83%** | **9%** | **17%** |
| Neurology | 1 | 1 | 0 | 0 | **100%** | **0%** | **0%** |
| Paediatric Medical | 7 | 0 | 6 | 1 | **86%** | **86%** | **14%** |
| Palliative Care | 1 | 1 | 0 | 0 | **100%** | **0%** | **0%** |
| Plastics/Hands | 1 | 0 | 1 | 0 | **100%** | **100%** | **0%** |
| Respiratory | 93 | 67 | 22 | 4 | **96%** | **24%** | **4%** |
| Stroke | 43 | 32 | 8 | 3 | **93%** | **19%** | **7%** |
| Trauma / Orthopaedics | 26 | 2 | 23 | 1 | **96%** | **88%** | **4%** |
| Urology | 18 | 0 | 10 | 8 | **56%** | **56%** | **44%** |
| Total | **1288** | **660** | **548** | **80** | **94%** | **43%** | **6%** |

*Table 5: Adult and child mortality review status by Specialty,* July 2024 – June 2025

The Trust operates a learning from deaths process that places significant value on case discussion and learning undertaken within specialty and divisional multi-disciplinary teams. These meetings are scheduled throughout the year (monthly) and supported by a wide range of clinical staff and the clinical governance department. This approach to quality ensures learning is agreed and widely cascaded.

Process compliance metrics should be reported to the Quality Committee and Board in arrears as some cases are still progressing and should therefore not be used to draw conclusions regarding process compliance.

## 5. Perinatal mortality review

The Perinatal Mortality Review Tool (PMRT) is a national mandatory monitoring and assurance dataset developed by MBRRACE-UK. It is used to collect very detailed information about the care mothers and babies have received throughout pregnancy, birth and afterwards. The purpose of the PMRT is to support hospital learn from deaths by providing a standardised and structured review process.

The PMRT is designed to support review of:

- All late fetal losses (22 weeks + 0 days to 23 weeks + 6 days);
- All antepartum and intrapartum stillbirths;
- All neonatal deaths from birth at 22 weeks + 0 days to 28 days after birth;

Learning from these cases is captured only within the PMRT and not duplicated within the Trust's mortality review system (Datix). The national target is to complete PMRT review within 6 months. The reporting time scales for PMRT do not align within the timescales of this report therefore the below data is 2 quarters behind. During the 6 month period ending December 2024; 37 cases were identified as requiring PMRT review (including post-neonatal deaths not reported via MBRRACE-UK).

| | No. reported | Not supported for review | Review in progress | Review completed | Grading of care: no. with issues in care likely to have made a difference to outcome |
|---|---|---|---|---|---|
| Stillbirths and late fetal losses | 28 | 8 | 0 | 20 | **1** |
| Neonatal and post-natal deaths | 20 | 3 | 0 | 17 | **1** |

*Table 6: PMRT review status by case category, 1 July 24 – 31 December 24*

Learning from PMRT review is reported to the Mortality Surveillance Group; where sub-optimal care that could have impacted outcome is identified cases are escalated as potential serious incidents. The organisation publishes a Learning from Serious Incidents report on a quarterly basis and outcomes / learning is received by the Patient Safety Group and Executive Management Board on a monthly basis.

## 6. Learning from Life and Death Reviews

A national Learning Disabilities Mortality Review (LeDeR) programme was established in May 2015 in response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities. From January 2022, LeDeR reports have included deaths of autistic people without a learning disability. In response to this change and following stakeholder

engagement, the new name for the LeDeR programme is 'Learning from Life and Death Reviews – people with a learning disability and autistic people'.

The Trust reported 6 deaths in Q1:

| Ref | Month of Death | Approval status | Specialty | CESDI grade |
|---|---|---|---|---|
| MM15106 | Jun | Awaiting Specialty Review | Acute Medicine | Pending |
| MM15067 | Jun | Closed | Respiratory | CESDI 0 |
| MM15037 | Jun | Awaiting Divisional Review | Acute Medicine | CESDI 1 |
| MM14945 | May | Closed | ICU | CESDI 0 |
| MM14793 | Apr | Closed | ICU | CESDI 0 |
| MM14645 | Apr | Closed | Diabetes/Endocrine | CESDI 0 |

*Table 7: Learning from Life and Death Review cases during April – June 2025*

The Learning from Life and Death Review programme seeks to coordinate, collate and share information about the deaths of people with learning disabilities and autistic people so that common themes, learning points and recommendations can be identified and taken forward at both local and national levels. The Trust is committed to ensuring deaths of patients with known / pre-diagnosed learning disabilities and /or autism are reported to the Learning from Life and Death Review programme and reviewed accordingly.

Since July 2023 Learning from Life and Death Review notifications are only for those aged 18 years and over. The NWL ICB have representatives attend Child Death Review Meetings. This ensures that the death is looked at from a health inequalities perspective. The Child Death Review Team monitor the themes from reviews and continue to share them with the NWL ICB Learning from Life and Death Review team.

## 7. Areas of focus

The Trust's mortality review programme provides a standardised approach to case review designed to improve understanding and learning about problems and processes in healthcare associated with mortality, and also to share best practice.

Where problems in care are identified these are graded using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories:

- Grade 0: No suboptimal care or failings identified and the death was unavoidable
- Grade 1: A level of suboptimal care identified during hospital admission, but different care would NOT have made a difference to the outcome and the death was unavoidable
- Grade 2: Suboptimal care identified and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable
- Grade 3: Suboptimal care identified and different care WOULD REASONABLY BE EXPECTED to have made a difference to the outcome i.e. the death was probably avoidable

During the past 12 months, 487 full mortality reviews have been closed following discussion at specialty, divisional or Trust wide mortality review groups.

| Period | CESDI 0 | CESDI 1 | CESDI 2 | CESDI 3 |
|---|---|---|---|---|
| Q2 24/25 | 104 | 23 | 3 | 0 |
| Q3 24/25 | 125 | 22 | 1 | 0 |
| Q4 24/25 | 120 | 22 | 3 | 0 |
| Q1 25/26 | 60 | 4 | 0 | 0 |
| Total | 409 | 71 | 7 | 0 |

*Table 8: Closed mortality cases by CESDI grade July 2024 – June 2025*

Seven cases were identified via the mortality review process as a CESDI 2 (different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable). Each of these cases were escalated to the executive for a decision on appropriate learning response.

All cases of suboptimal care are presented to the Mortality Surveillance Group to ensure shared learning across the Trust. There were four cases identified at West Middlesex hospital and one case identified at Chelsea and Westminster hospital. This is within expectations in a patient cohort with increased frailty and comorbidities.

| Mortality Ref | CESDI grade | Incident Ref | Site | Area | Datix sub-category | Incident investigation status |
|---|---|---|---|---|---|---|
| MM13118 | CESDI 2 | INC139391 | WMH | ICU | Airway Management Issues | AAR completed |
| MM13172 | CESDI 2 | INC139379 | WMH | Emergency Department | Delayed or Missed Diagnosis | IIR only completed |
| MM13196 | CESDI 2 | INC141119 | CWH | ICU | Death: Unexpected / unexplained | Mortality Review process (learning from deaths) completed |
| MM13640 | CESDI 2 | INC146405 | CWH | General Surgery | Inadequate or inappropriate care/treatment | PSII completed |
| MM14029 | CESDI 2 | INC148457 | CWH | Emergency Department | Failure / Delay to act on results | AAR completed |
| MM14374 | CESDI 2 | INC150601 | CWH | ICU | Airway Management Issues | AAR completed |
| MM14373 | CESDI 2 | INC152557 | WMH | Acute Medicine | Delay or failure to monitor | PSII underway |

*Table 9: CESDI grade 2 cases linked to an incident learning response,* July 2024 – June 2025

Population demographics, hospital service provision, intermediate/community service provision all have an effect on the numbers of incidents occurring on each site. Mortality reviews graded CESDI 2 and 3 will have an associated patient safety incident reported.

The Trust is committed to delivering a just, open and transparent approach to investigations that reduces the risk and consequence of recurrence. Key themes from incident investigations linked to mortality review are submitted to the Patient Safety Group and the Executive Management Group for shared learning and consideration of whether further Quality Improvement Projects, deep-dives, or targeted action is required.

The organisation publishes a learning from Safety learning responses on a monthly basis and outcomes/learning is received by the Patient Safety Group, local Quality Committee and Executive Management Board on a monthly basis (with case outlines and associated actions).

There were 71 cases graded as a CESDI 1 (e.g. level of suboptimal care identified during hospital admission, but different care or management would NOT have made a difference to the outcome and the death was unavoidable). Learning from CESDI 1 cases provides the Trust and our teams with excellent learning from which to develop our improvement approaches.

The following specialist teams have successfully identified CESDI 1 learning opportunities from across the patient journey (not necessary occurring whilst the patient was under the care of that speciality). The identification of CESDI grade 1 cases should not be used to draw conclusions regarding quality and safety within the identifying specialty.

| Specialty | CW | WM | Total |
|---|---|---|---|
| Acute Medicine | 12 | 10 | 22 |
| Care Of Elderly | 8 | 7 | 15 |
| ICU | 9 | 5 | 14 |
| Gastroenterology | 1 | 6 | 7 |
| Cardiology | | 3 | 3 |
| Diabetes/Endocrine | 2 | 1 | 3 |
| Trauma / Orthopaedics | | 2 | 2 |
| Respiratory | | 2 | 2 |
| General Surgery | 1 | | 1 |
| Plastics/Hands | 1 | | 1 |
| Emergency Department | | 1 | 1 |
| Total | **34** | **37** | **71** |

*Table 10: CESDI grade 1 cases by Specialty,* July 2024 – June 2025

The Divisional Mortality Review Groups (DMRGs) provide scrutiny to mortality cases so as to identify themes and escalate any issues of concerns. Following case discussions at the DMRGs, the following themes and issues were flagged to the Mortality Surveillance Group between July 2024 and June 2025:

- **Treatment Escalation Plans (TEPs)**: Numerous cases highlighted delays or incomplete documentation of TEPs, with emphasis on the need for senior review and regular updates during ward rounds.
- **Medical Outliers**: Several cases raised concerns about inappropriate placement of complex patients on outlier wards, leading to delays in care and poor outcomes.
- **Documentation Quality**: Inadequate or outdated notes, especially copy-pasted social histories, were flagged repeatedly. Accurate and timely documentation was stressed as essential.
- **Fast Track Discharge Issues:** Recurrent problems with fast track discharge requests, particularly for end-of-life patients, were noted as a pan-London issue needing escalation.
- **Radiology & Imaging Delays:** Delays in CT reporting, missed findings (e.g. fractures), and poor communication from radiology teams were common. Calls for improved imaging governance and consultant review of images were made.
- **Telemetry & Monitoring Failures:** Cases revealed failures in telemetry systems and lack of nursing oversight, prompting calls for SOPs and training.
- **Family Communication:** Many cases involved family complaints due to unclear or inconsistent communication. The importance of early, honest, and compassionate conversations was repeatedly emphasised.
- **Multidisciplinary Team (MDT) Engagement:** Lack of early MDT involvement, especially in complex or deteriorating patients, was a recurring issue. Better coordination across specialties was recommended.
- **Safeguarding & Consent:** Several cases involved patients with learning disabilities or complex needs, highlighting the need for robust safeguarding checks and inclusive communication.

Good practice or commendation were identified during the Medical Examiner process which includes discussions with the patients' relatives. The following themes were highlighted for deaths occurring between July 2024 and June 2025:

- **Compassionate and Respectful Care:** A dominant theme is the consistently high level of compassion shown by staff across wards. Families and next of kin (NOK) frequently praised nurses, doctors, and palliative care teams for their kindness, empathy, and respectful treatment—especially during end-of-life care.

- **Exemplary Communication:** Many comments highlight excellent communication, particularly from the Medical Examiner's Office (MEO). Families appreciated clear explanations of processes, sensitive discussions about prognosis, and timely updates. Named individuals were repeatedly commended for their bedside manner and clarity.

- **Rapid and Faith-Sensitive Documentation:** There was strong appreciation for the swift issuance of Medical Certificates of Cause of Death (MCCD), especially in cases requiring urgent faith-based burials. The ME office was frequently praised for its responsiveness and understanding of cultural and religious needs.

- **Outstanding End-of-Life Care:** Palliative care teams were described as "angels," "champions," and "wonderful," with specific mentions of their ability to provide peace, dignity, and comfort. The use of butterfly rooms and spiritual support from chaplains were also noted as meaningful.

- **Holistic and Coordinated Team Efforts:** Feedback often referenced multidisciplinary collaboration, with teams working seamlessly across departments (e.g., ICU, AAU, ED, surgical, and palliative care). This coordination was seen as critical to delivering high-quality care and maintaining dignity.

- **Personalised and Thoughtful Gestures:** Small acts—such as bringing cake for a patient's birthday or allowing family presence during resuscitation—were deeply appreciated and often cited as making a significant emotional impact.

## 8. Prevention of future deaths (PFD) 25/26

The Trust has not been issued with a Prevention of Future Deaths (PFD) notice during Q1 2025/26.

## 9. Conclusion

The outcome of the Trust's mortality surveillance programme continues to provide a rich source of learning that is supporting the organisation's safety improvement objectives.

The Trust continues to be recognised as having one of the lowest relative risk of mortality (SHMI) across the NHS in England. The Trust is committed to better understanding the distribution of mortality according to the breakdown of our patient demographics (Appendix 2) and ensure we tackle any health inequalities that we identify in doing so.

As part of the rollout of the Patient Safety Incident Response Framework (PSIRF) the mortality review template is being used as a learning response tool and the follow-up of safety action plans will be done via the Divisional Mortality Review Groups as well as the Mortality

Surveillance Group going forward. Any cases that are escalated as CESDI 2 and 3 are also brought to the weekly Initial Incident Review Group for a proportionate decision on learning response and approval by the executive team.

## 10. Glossary

10.1. **Medical Examiners** are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met.. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

10.2. **Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

10.3. **Child Death Overview Panel (CDOP)** is an independent review aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

10.4. P**erinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

10.5. **Learning from Life and Death Reviews** is a review of all deaths of patients with a learning disability/Austism. The Trust reports these deaths to the Local integrated care boards (ICBs) who are responsible for carrying out the reviews. Mortality reviews for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

## Appendix 1 - Performance Scorecard

| | Q2 24/25 | Q3 24/25 | Q4 24/25 | Q1 25/26 | Comments | National LfD min. requirement? |
|---|---|---|---|---|---|---|
| **Summary data** | | | | | | |
| Total no. deaths (adult and children) | 272 | 340 | 379 | 297 | Inpatients deaths only | |
| Total no. adult deaths | 272 | 338 | 375 | 296 | Inpatients over 18 years age | Y |
| Total no. child deaths | 0 | 2 | 4 | 1 | Inpatients over 28 days and less than 18 year only | |
| Total no. neonatal deaths | 10 | 15 | 11 | 14 | Inpatients livebirths under 28 days of age | |
| Total no. stillbirths | 10 | 15 | 13 | 15 | Inpatient not live births | |
| | | | | | | |
| Deaths reviewed by Medical Examiner | 100% | 99% | 99.7% | 100% | % of total deaths (row 3) | |
| Deaths referred for Level 2 review | 50% | 47% | 43% | 34% | % of total deaths (row 3) | |
| Level 2 reviews completed | 96% | 94% | 91% | 64% | % of total referrals this quarter | Y |
| | | | | | | |
| Requests made by a Medical Examiner (Potential learning identified) | 41% | 44% | 44% | 38% | % of total referrals | |
| Potential learning identified (Screening) | 45% | 38% | 37% | 46% | % of total referrals | |
| Concerns raised by family / carers (Screening) | 13% | 15% | 11% | 11% | % of total referrals | |
| Patients with learning disabilities (Screening) | 3% | 3% | 3% | 7% | % of total referrals | |
| Patients with severe mental health issues (Screening) | 0% | 0% | 1% | 0% | % of total referrals | |
| Unexpected deaths (Screening) | 9% | 14% | 19% | 11% | % of total referrals | |
| Requests made by speciality mortality leads through local Mortality and Morbidity review processes | 23% | 28% | 26% | 31% | % of total referrals | |
| Other reason (Linked SI, Inquest, Nosocomial Covid, DMRG request) | 7% | 4% | 5% | 1% | % of total referrals | |
| | | | | | | |
| CESDI 0 - No suboptimal care | 79% | 83% | 82% | 94% | % of cases reviewed (&closed) | |
| CESDI 1 - Some sub optimal care which did not affect the outcome | 18% | 15% | 15% | 6% | % of cases reviewed (&closed) | |
| CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) | 2% | 1% | 2% | 0% | % of cases reviewed (&closed) | |
| CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) | 0% | 0% | 0% | 0% | % of cases reviewed (&closed) | Y |

*Table 11. Trust mortality review data as at 13/08/2025*

## Appendix 2 – Ethnicity breakdown (for Total no. deaths adult and children)

| | Q2 24/25 | Q3 24/25 | Q4 24/25 | Q1 25/26 | Total |
|---|---|---|---|---|---|
| White - British | 131 | 149 | 166 | 142 | 588 |
| Other - Not Stated | 36 | 47 | 53 | 36 | 172 |
| Asian or Asian British - Indian | 18 | 30 | 37 | 23 | 108 |
| White - Any Other White Background | 17 | 27 | 26 | 29 | 99 |
| Asian - Any Other Asian Background | 15 | 14 | 23 | 27 | 79 |
| To be recorded | 11 | 16 | 25 | 10 | 62 |
| Other - Any Other Ethnic Group | 11 | 20 | 13 | 7 | 51 |
| Asian or Asian British - Pakistani | 14 | 10 | 4 | 7 | 35 |
| White - Irish | 3 | 5 | 11 | 5 | 24 |
| Black - Any Other Black Background | 4 | 3 | 10 | 3 | 20 |
| Black or Black British - Caribbean | 2 | 6 | 4 | 3 | 15 |
| Black or Black British - African | 5 | 5 | 4 | | 14 |
| Mixed - Any Other Mixed Background | 3 | 2 | | 3 | 8 |
| Other - Chinese | 1 | 3 | 1 | 1 | 6 |
| Mixed - White and Black African | 1 | 1 | 1 | | 3 |
| Asian or Asian British - Bangladeshi | | 1 | 1 | | 2 |
| Mixed - White and Black Caribbean | | | | 1 | 1 |
| Mixed - White and Asian | | 1 | | | 1 |
| Grand Total | 272 | 340 | 379 | 297 | 1288 |

NWL Acute Provider Collaborative Board in Common (Public)
21/10/2025
Item number: #
This report is: Public

# Learning from Deaths quarterly report – Quarter One 2025/2026

Author: Heena Asher & Shona Maxwell
Job title: General Manager & Chief of Staff

Accountable director: Professors Julian Redhead & Raymond Anakwe
Job title: Medical directors

## Purpose of report

Purpose: Assurance

This report presents the data from the Learning from Deaths programme for Quarter One (Q1) of 2025/26 for information. It is a statutory requirement to present this information to the Trust public board. This is achieved through presentation to our standing committee, with an overarching summary paper drawing out key themes and learning from the individual reports from the four NWL acute provider collaborative (APC) trusts presented to the APC quality committee and then Board in common. A glossary is provided at the end of the report.

## Report history

**Learning from deaths forum**
Various
The group discussed and agreed the content of this report, including themes for learning and improvement.

**Executive management board quality group and Executive Management Board (EMBQ and EMB)**
18/08/2025 & 26/08/2025
The committee noted the findings from our learning from deaths programme and approved the report for onward submission.

**Quality Committee and Standing Committee**
04/09/2025 & 07/10/2025
The report was noted and approved for onward submission.

## Executive summary and key messages

1.1. Mortality rates remain statistically significantly low.

1.1.1. At site level, there was an increase in HSMR at SMH and CXH, with both sites moving to within expected range. An initial review by Telstra Health did not identify any significant concerns, with the changes in methodology and the configuration of specialties on each site having an impact. SMH has subsequently returned to a low relative risk. CXH remains within the expected mortality risk range but is well below the NHS benchmark of 100 and is nearing the threshold for low HSMR.

1.2. All deaths this quarter underwent Medical Examiner review, with cases raising care quality concerns referred for Structured Judgement Review (SJR). Completed SJRs have identified examples of excellent team working and good communication with families. No new themes for improvement were identified with ongoing work to improve treatment for patients with signs of deterioration as part of our safety improvement programme.

1.3. There were five SJRs which identified some sub-optimal care which might or would reasonably have been expected to have made a difference to the patient's outcome. These are all investigated through the patient safety incident investigation framework (PSIRF) to confirm the learning response and any actions.

1.4. This level of scrutiny is important to ensure all issues are considered and questions from the bereaved are highlighted and answered. The low number of issues found that affected the outcome and our low mortality rates are positive reflections of the care delivered.

1.5. New statutory requirements relating to death certification came into effect in September 2024 with continued increase in referrals to the Medical Examiner service this quarter from community providers. We continue to improve our internal processes to make the service more effective for bereaved families and engage with community partners to ensure we can effectively embed the new ways of working required across the system.

## Impact assessment

☒ Quality

Improving how we learn from deaths which occur in our care will support identification of improvements to quality and patient outcomes.

## Strategic priorities

☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APC)

☒ Develop a sustainable portfolio of outstanding services (ICHT)

☒ Build learning, improvement and innovation into everything we do (ICHT)

## Key risks arising from report

The Committee is asked to note the Q1 2025/26 findings from our Learning from Deaths programme, with no new issues requiring escalation. Targeted efforts under our ongoing improvement plan, including the expansion of Medical Examiner capacity, have led to further progress in the timeliness of MCCD issuance and impact for bereaved families. We continue to monitor and build on these improvements.

# Main Report

## 2. Learning and Improvements

2.1. Learning from Deaths (LFD) is a standard monthly agenda item on all Divisional Quality and Safety meetings where investigations and learning are shared which is then disseminated to all the directorates and throughout the division.

2.2. 51 structured judgment reviews (SJRs) were completed in this quarter (49 for deaths which occurred in Q1, and 2 for deaths which occurred in Q4 24/25), 33 of which (60%) identified patients received good or excellent care. 17 (32%) specifically identified good communication with the next of kin, which is consistent with previous quarters. There was evidence of good documentation, teamwork and senior decision making.

2.3. Four cases highlighted issues with poor communication with next of kin and further demonstrated the importance of effective improved documentation. While there has been a reduction this quarter in cases involving suboptimal treatment of deteriorating patients, this remains an area for improvement identified through SJRs and continues to be a priority.

2.4. Five SJRs identified that sub-optimal care might have or would reasonably be expected to have made a difference to the patient's outcome (CESDI 2 and 3). They were in different specialties. No common themes have been identified but patient safety investigations are underway.

## 3. Key themes

### 3.1. Mortality rates

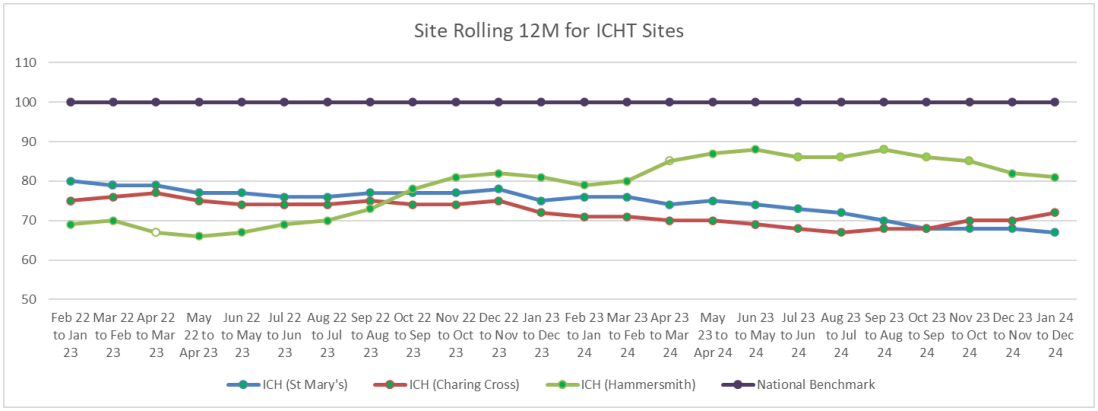
3.1.1 Our mortality rates remain statistically significantly low. The rolling 12-month HSMR has increased slightly to 77.6 (compared to 74.0 in the previous quarterly report) and is fifth lowest when compared nationally. Our SHMI was the second lowest at 71.18.

3.1.2 Following methodological changes that removed 'other perinatal conditions' as a diagnosis group, the maternity rate has remained at 0. WLCH initially saw an increase likely linked to these changes, there has been a reduction over the last two quarters as the methodology becomes established. Both directorates continue to be monitored. Crude death numbers have remained stable for WLCH throughout this period. There was a slight increase in the crude non-stabilised and unadjusted rates for neonatal deaths. Review of cases identified no immediate concerns, but there was an increase in the number of babies born at pre-term gestations with an antenatal diagnosis of congenital abnormalities.

3.1.3 At site level, there was an increase in HSMR at SMH and CXH, with both sites moving to within expected range. An initial review by Telstra Health did not identify any significant concerns, with the changes in methodology and the configuration of specialties on each site having an impact. SMH has subsequently returned to a low relative risk. CXH remains within the expected mortality risk range but is well below the NHS benchmark of 100 and is nearing the threshold for low HSMR.

3.1.4 We have previously noted a temporary increase in mortality rates at HH. This was associated with elevated HSMR in Cardiology following alerts in the acute myocardial infarction (AMI) diagnostic group, which was reviewed with no concerns identified. HH has now returned to a lower-than-expected rate, with Cardiology currently reporting an HSMR below 100. It is important to note that before the methodology changes, HH was within expected range.

3.1.5 QCCH is not included in reporting as the numbers of deaths are very low which causes too much variation for the data to be used effectively. Deaths at these sites are still reviewed through standard learning from deaths processes.




## 3.2. Diagnostic group reviews

3.3.1 No new diagnostic alerts were received in Q1. There are no alerts from previous quarters which remain under review.

## 3.3. Directorate reviews

3.3.2 Crude deaths reduced in Q1 (n=440), following elevated figures in Q3 (n=512) and Q4 (n=518). The increases were reviewed through the LFD forum and are linked to seasonal variation. The number of deaths had returned to normal levels by February/March 2025.

3.3.3 There has been a recent increase in deaths in the urgent and emergency care directorate which is being reviewed via the Learning from Deaths (LFD) forum. Findings will be summarised in the next report.

## 3.4. Medical Examiner reviews

3.4.1. The Medical Examiner (ME) service continues to provide independent scrutiny of non-coronial inpatient deaths. Of the 440 deaths this quarter, 331 cases were reviewed by the Medical Examiner, and 109 deaths were referred to the coroner. This is a slight reduction from 118 cases in the previous quarter. Twenty-seven will be taken forward for inquest.

3.4.2. The largest percentage of coronial referrals were death resulting from violence, trauma, or injury (35%), reflecting the major trauma centre at SMH, slightly lower than last quarter.

3.4.3. The second most common reason was death associated with medical procedures or treatments (32%). This has increased from last quarter (19%). Several of these cases involved patients who had undergone procedures or treatments at other hospitals prior to transfer to ICHT. All such cases are reviewed to determine whether incidents requiring further investigation have occurred. While no issues currently require escalation, this continues to be monitored.

3.4.4. Weekly review continues of all new cases to ensure investigations and file preparation can begin as early as possible where required. The increase in referrals and inquest listing over the last 3 years continues to cause resource implications, delays in response submission and adjournment requests.

3.4.5. Following the recent team restructure, resource allocation adjustments are now being implemented, with additional support mechanisms being considered to optimise processing timelines.

3.4.6. The Medical Examiner service continue to scrutinise all non-coronial deaths in community boroughs of Hammersmith & Fulham and Westminster. This quarter, the service reviewed 259 non-acute deaths, a sustained increase (n=243 last quarter) as more primary care and independent providers engaged with the process.

3.4.7. This quarter, the service issued 74% of urgent MCCDs within 24 hours of death and 71% of non-urgent MCCDs within three calendar days, showing improvement from last quarter of 73% for urgent and 57% for non-urgent. Efforts to enhance timeliness included implementing a new rota, monitoring and escalating delays to directorate leadership. The focus remains on managing the increasing community referrals while ensuring timely

reporting and we are working with the ICB on the governance of the outcomes for the non-acute deaths.

### 3.5. Structured Judgement reviews (SJR)

3.5.1. The percentage of inpatient deaths referred for a SJR remains similar to last quarter (12% compared to 14% in Q4) with 'unexpected deaths' the most common reason (40%).

3.5.2. 78% of SJRs (n=40) found no suboptimal care (CESDI 0) similar to previous quarters. Reviews have identified evidence of excellent care and good communication in many cases.

3.5.3. A further 12% of reviews (n=6) found some suboptimal care but this did not affect the patient outcome (CESDI 1) compared to 7% in Q3 and 19% in Q4. All CESDI 1 cases are reviewed to decide whether a further incident investigation is required and the final harm levels.

3.5.4. 8% (n=4) of deaths found suboptimal care that may have made a difference to the patient outcome (CESDI 2). No common themes were identified.

3.5.5. 1 review identified sub-optimal care which would reasonably be expected to have made a difference to the outcome (CESDI 3). This was in the Renal Directorate.

3.5.6. All cases with a CESDI 2 or 3 outcome automatically trigger an immediate incident review (IIR). Once all investigations have been completed, the case is discussed at the Death Review Panel (DRP), which triangulates and agrees an outcome, learning and improvements that need to be implemented.

3.5.7. In Q1, five SJRs were reviewed by the DRP alongside their IIR and PSII reports. The panel determined that in four cases poor care did not contribute to the patients' deaths. However, in one case the panel concluded that poor care was a contributing factor. The patient suffered complications post TAVI procedure. The PSII, confirmed as severe harm, found that there were missed opportunities to identify a major heart attack. Actions include implementation of a flow chart for the management of patients with chest pain and of the ward round pro forma.

## 4. Other mortality review processes

### 4.1. PMRT

4.2. There were 19 perinatal deaths reported to MBRRACE-UK, of which 15 (one late fetal loss, seven stillbirths and seven neonatal deaths) were eligible for full review under the Perinatal Mortality Review Tool (PMRT) framework.

4.3. Of the seven neonatal deaths, four were babies born between 23+5 and 28+5 weeks gestation; three babies had known congenital abnormalities.

4.4. Of the 15 cases, six were discussed across four multidisciplinary panel meetings and two received a grading of C (care issues which may have made a difference to the outcome), similar to previous quarters, although in one case the issues relate to care prior to birth at another Trust and rather than the care given by ICHT.

4.5. A neonatal death that occurred on day 6 of life following transfer of care during labour from the Birth Centre is under review by MNSI and was subject to an IIR, which highlighted key concerns around lack of perinatal pathologists input post-mortem and gaps in communication with the parents. Actions were around ensuring daily checks of resuscitaires, with appropriate escalation in place.

### 4.6. LeDeR

4.6.1. One patient with a learning disability died in Q1. The SJR has been completed which found no sub-optimal care. This case has been referred for a LeDeR by the safeguarding team.

4.6.2. One completed LeDeR panel report was shared with the Trust in June 2025, for a patient who died in September 2024. The review identified learning regarding documentation practices, particularly the need to maintain clear records of care levels, escalation plans,

and up-to-date next-of-kin details, especially concerning end-of-life discussions. The division has shared this learning with the relevant teams, with a specific focus on improving next-of-kin information documentation in patient records.

4.7. **CDOP**

4.7.1. There were 5 deaths reported in Q1 for WLCH. CDOP referrals have been made, and detailed investigations will now take place. These reviews can take several months.

## 5. Areas of focus

### 5.1. Ethnicity

5.1.1. Analysis conducted in 2024/25 of ethnicity data of patients who died in the Trust from 2017 to 2023 identified lower than expected mortality rates for all ethnic groups but that we had a slightly higher than average number of patients where ethnicity was unknown.

5.1.2. In quarter 3 of 24/25, work was completed to include ethnicity data from NWL Whole System Integrated Care (WSIC) platform into our data set with the aim of improving data quality and reducing unknown numbers and the percentage of deaths in 2024/25 where ethnicity was unknown reduced from 17% when only using data from Cerner to 9% for the combined data set. This improved to 5.6% for Q4, and 5.3% in Q1 2025/26 (Appendix B).

5.1.3. Work continues with the support of the Health Inequalities programme team to analyse this data from a population health perspective and to understand inequalities in services. The next steps are to include data relating to hospital services used by deceased patients to reveal any differences in healthcare access or use of services. We will also bring in additional demographic details, including age, gender, deprivation and primary language to expand the data set used and widen this analysis work. Further areas of focus are under discussion at the LFD forum and next steps will be confirmed in the quarter 2 report.

### 5.2. Specialty Mortality and Morbidity meetings

5.2.1. The LFD forum continues to monitor compliance with the Trust Specialty M&M guidance that was agreed and implemented in January 2024.

5.2.2. There is evidence in Datix that Specialty M&M meetings are being held regularly for several specialties, including Cardiology, Renal and Stroke and Neurosciences directorates. There have been recent improvements in Urgent & Emergency Medicine, Specialist Medicine (HH), Maternity and General Surgery & Vascular. Work continues to ensure outcomes are transferred and captured on Datix to accurately reflect the improvements.

5.2.3. Compliance across the Trust is continuing to improve. Focused work continues through Datix recording and actions from the learning from deaths forum. Divisional action plans are being monitored through the divisional performance and accountability review meetings. This requires additional focus into Q2.

## 6. Conclusion

6.1 Mortality rates across the Trust remain statistically significantly low. When considered with our harm profile and the outcomes of our SJRs we can provide assurance to the committee that we are providing safe care for the majority of our patients. Where care issues are found we have a robust process for referral for more in-depth review, the outcome of which is reported through the incident report and the quality function report to EMB and Quality Committee.

## 7. Glossary

7.1. **Medical Examiners (ME)** are responsible for reviewing every inpatient death before the MCCD is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

7.2. **Level 2 reviews** are additional clinical judgement reviews carried out on cases that meet standard criteria and which provide a score on the quality of care received by the patient during their admission.

7.3. **Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

7.4. **Child Death Overview Panel (CDOP)** is an independent review process managed by Local integrated care boards (ICBs) aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

7.5. **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

7.6. **Learning Disabilities Mortality Review (LeDeR)** is a review of all deaths of patients with a learning disability. The Trust reports these deaths to NHSE who are responsible for carrying out LeDeR reviews. Level 2 reviews for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

### Other Acronyms

Imperial College Healthcare NHS Trust – ICHT
North West London Acute Provider Collaborative – APC

### Sites

Charing Cross Hospital – CXH
Hammersmith Hospital – HH
Queen Charlotte's & Chelsea Hospital – QCCH
St Mary's Hospital – SMH
Western Eye Hospital – WEH

### External organisations

Maternity and Newborn Safety Investigation programme – MNSI
Mothers and babies: reducing risk through audits and confidential enquiries – MBRRACE-UK

**Committees and meetings**
Executive Management Board – EMB
Executive Management Board Quality Group – EMBQ
Morbidity and Mortality meetings – M&M
Multidisciplinary Team meeting – MDT

**Incident management and investigation terms**
Patient Safety Incident Response Framework – PSIRF
Patient Safety Incident Response Plan – PSIRP
After Action Review – AAR
Initial Incident Review – IIR
Multidisciplinary Team Review – MDT review
Patient Safety Incident Investigation – PSII

**Mortality/Inquests**
Perinatal Mortality Review Tool – PMRT
Prevention of Future Deaths – PFD
Hospital Standardised Mortality Ratio – HSMR
Summary Hospital-level Mortality Indicator – SHMI
Medical Certificate of Cause of Death – MCCD

## Appendix A – Performance scorecard

| Financial Year | 2024-2025 | | | | 2025-2026 |
|---|---|---|---|---|---|
| **Financial Quarter** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** |
| No. Deaths | 432 | 378 | 512 | 518 | 440 |
| No. Adult Deaths | 413 | 358 | 484 | 496 | 418 |
| Adult Deaths per 1000 Elective Bed Days | 0.03 | 0.03 | 0.04 | 0.05 | 0.04 |
| No. Child Deaths | 6 | 7 | 8 | 4 | 6 |
| No. Neonatal Deaths | 5 | 8 | 7 | 15 | 8 |
| No. Stillbirths | 8 | 5 | 13 | 3 | 8 |
| ME Reviewed Deaths (excl Stillbirths) in Qtr | 421 | 372 | 497 | 508 | 428 |
| % ME Reviewed Deaths - Deaths (excl Stillbirths) in Qtr | 99% | 100% | 100% | 99% | 99% |
| SJRs Requested for Deaths in Qtr | 52 | 49 | 48 | 67 | 51 |
| % SJRs Requested for Deaths in Qtr of total adult deaths in Qtr | 13% | 14% | 10% | 14% | 12% |
| No. SJRs Completed in period | 54 | 46 | 47 | 57 | 68 |
| SJRs Completed for Deaths in Qtr | 52 | 49 | 48 | 67 | 51 |
| % SJRs Completed for Deaths in Qtr | 100% | 100% | 100% | 100% | 100% |
| No. LeDeR Completed | 0 | 1 | 0 | 0 | 0 |
| Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr | 12 | 8 | 9 | 17 | 6 |
| % Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr | 23% | 16% | 19% | 25% | 12% |
| Concerns raised by family / carers - SJRs Requested for Deaths in Qtr | 13 | 9 | 12 | 17 | 13 |
| % Concerns raised by family / carers - SJRs Requested for Deaths in Qtr | 25% | 18% | 25% | 25% | 25% |
| Patients with learning disabilities - SJRs Requested for Deaths in Qtr | 5 | 4 | 7 | 7 | 1 |
| % Patients with learning disabilities - SJRs Requested for Deaths in Qtr | 10% | 8% | 15% | 10% | 2% |
| Patients with severe mental health issues - SJRs Requested for Deaths in Qtr | 1 | 2 | 2 | 6 | 4 |
| % Patients with severe mental health issues - SJRs Requested for Deaths in Qtr | 2% | 4% | 4% | 9% | 8% |
| Unexpected deaths - SJRs Requested for Deaths in Qtr | 17 | 25 | 17 | 15 | 20 |
| % Unexpected deaths - SJRs Requested for Deaths in Qtr | 33% | 51% | 35% | 22% | 39% |
| Elective admission deaths - SJRs Requested for Deaths in Qtr | 5 | 2 | 4 | 5 | 8 |
| % Elective admission deaths - SJRs Requested for Deaths in Qtr | 10% | 4% | 8% | 7% | 16% |
| Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for Deaths in Qtr | 0 | 2 | 2 | 3 | 2 |
| % Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for Deaths in Qtr | 0% | 4% | 4% | 4% | 4% |
| CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr | 45 | 39 | 39 | 50 | 40 |
| % CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr | 87% | 80% | 81% | 75% | 78% |
| CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr | 6 | 7 | 4 | 13 | 6 |
| % CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr | 12% | 14% | 8% | 19% | 12% |
| CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs | 1 | 3 | 3 | 3 | 4 |
| % CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs for Deaths in Qtr | 2% | 6% | 6% | 4% | 8% |
| CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) - Completed SJRs for Deaths in Qtr | 0 | 0 | 2 | 1 | 1 |
| % CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) - Completed SJRs for Deaths in Qtr | 0% | 0% | 4% | 1% | 2% |

## Appendix B – Ethnicity data

| | Cerner Data | | Combined data set (WSIC and Cerner) | |
|---|---|---|---|---|
| **Financial Year** | 2025-2026 | | 2025-2026 | |
| **Ethnicity_Cerner** | No. Deaths | % Deaths | No. Deaths | % Deaths |
| Totals | 588 | 100.0% | 588 | 100.0% |
| - | 11 | 1.9% | 10 | 1.7% |
| Asian - Any Other Asian Background | 40 | 6.8% | 43 | 7.3% |
| Asian or Asian British - Bangladeshi | 3 | 0.5% | 4 | 0.7% |
| Asian or Asian British - Indian | 39 | 6.6% | 42 | 7.1% |
| Asian or Asian British - Pakistani | 7 | 1.2% | 7 | 1.2% |
| Black - Any Other Black Background | 11 | 1.9% | 15 | 2.6% |
| Black or Black British - African | 16 | 2.7% | 19 | 3.2% |
| Black or Black British - Caribbean | 29 | 4.9% | 30 | 5.1% |
| Mixed - Any Other Mixed Background | 2 | 0.3% | 5 | 0.9% |
| Mixed - White and Asian | - | - | 2 | 0.3% |
| Mixed - White and Black African | 4 | 0.7% | 3 | 0.5% |
| Mixed - White and Black Caribbean | 1 | 0.2% | 5 | 0.9% |
| Other - Any Other Ethnic Group | 99 | 16.8% | 72 | 12.2% |
| Other - Chinese | 1 | 0.2% | 3 | 0.5% |
| Other - Not Known | 8 | 1.4% | 8 | 1.4% |
| Other - Not Stated | 72 | 12.2% | 29 | 4.9% |
| White - Any Other White Background | 62 | 10.5% | 97 | 16.5% |
| White - British | 167 | 28.4% | 167 | 28.4% |
| White - Irish | 16 | 2.7% | 28 | 4.8% |

NWL Acute Provider Collaborative Quality Committee
Select meeting date
Item number: #
This report is: Public

# London North West University NHS Trust

# Learning from Deaths Report Quarter 1 2025/26

Author: Laila Gregory
Job title: Head of Clinical Effectiveness

Accountable director: Jon Baker
Job title: Chief Medical Officer

## Purpose of report (for decision, discussion or noting)

Purpose: Assurance

This report presents the data from the Learning from Deaths programme for 2025/26 quarter 1 (Q1). It is a statutory requirement for Trusts to present this information to their boards; this is achieved through the presentation of this report to the LNWH Quality & Safety Committee and the submission of overarching learning drawn from across the acute provider collaborative (APC) to the APC Quality Committee and Board in common.

## Report history

Outline committees or meetings where this item has been considered before being presented to this meeting.

| **Trust Executive Group** | **Trust Quality & Safety Committee** |
|---|---|

## Executive summary and key messages

The HSMR for the 12-month period April 2024 to end March 2025 is 94.5 which is statistically significantly low. SHMI remains statistically low across the rolling 12-month at 84.4.

During the 12-month period to end of June 2025; 100% in-hospital adult and child deaths were recorded within the Trust's mortality review system (Datix), of these 100% have been screened and 417 have undergone level 2 in-depth review.

During Q1 20254/26; 11 cases had areas of sub-optimal care, treatment or service delivery identified at time of reporting. The Trust places significant value on case discussion and learning undertaken within specialty and divisional multi-disciplinary teams; for this reason, teams are given

4 months to complete level 2 mortality review, therefore 8% of cases occurring in Q1 remain open and within review timeframe.

Where potential for improvement is identified learning is shared at Divisional Boards / groups and presented to the Trust-wide Learning from Patient Deaths Group; this ensures outcomes are shared and learning is cascaded.

## Impact assessment

Tick all that apply

- ☐ Equity
- ☒ Quality
- ☐ People (workforce, patients, families or careers)
- ☐ Operational performance
- ☐ Finance
- ☐ Communications and engagement
- ☐ Council of governors

Click to describe impact

## Reason for private submission (For Board in Common papers only)

Tick all that apply [*delete section if not applicable*]

- ☐ Commercial confidence
- ☐ Patient confidentiality
- ☐ Staff confidentiality
- ☐ Other exceptional circumstances

If other, explain why

## Strategic priorities

Tick all that apply

- ☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity (APC)
- ☐ Support the ICS's mission to address health inequalities (APC)
- ☐ Attract, retain, develop the best staff in the NHS (APC)
- ☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APC)
- ☐ Achieve a more rapid spread of innovation, research, and transformation (APC)
- ☐ Help create a high-quality integrated care system with the population of north west London (ICHT)
- ☐ Develop a sustainable portfolio of outstanding services (ICHT)
- ☐ Build learning, improvement and innovation into everything we do (ICHT)

# Key risks arising from report

# Main Report

## 1. Learning and Improvements

The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed. This report provides a Trust-level quarterly review of mortality learning for Q1 2025/26.

All in-hospital deaths are scrutinised by the Trust's Medical Examiner Service; this initial screening provides an independent review of care and is the basis for triggering cases for enhanced (level 2) review by the Consultant Mortality Validators and the specialities involved.

The Trust undertakes in-depth (level 2) mortality review for cases meeting the following criteria:

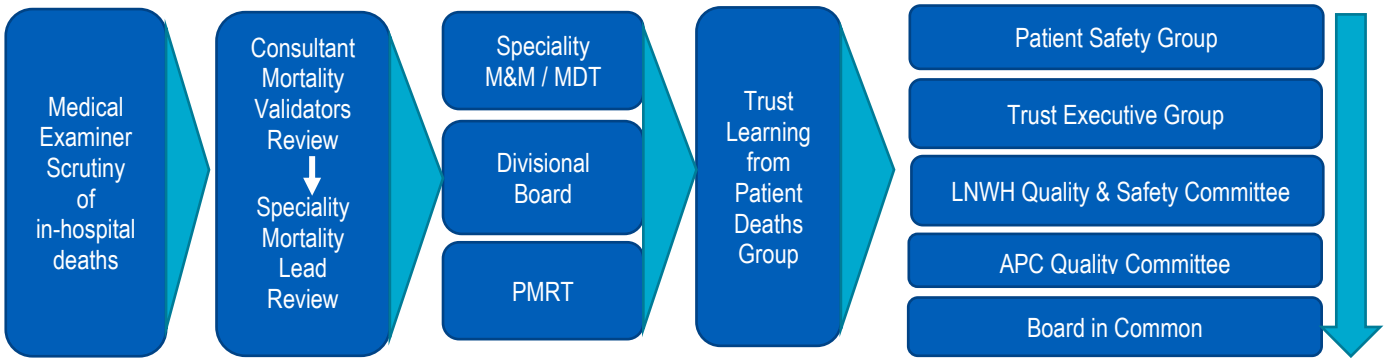
National triggers:

- Potential learning identified at Medical Examiner scrutiny.
- Significant concerns raised by the bereaved.
- Deaths of patients with learning disability
- Deaths of patients under a mental health section
- Unexpected deaths
- Maternal deaths
- Deaths of infants, children, young people, and still births
- Deaths within a specialty or diagnosis / treatment group where an 'alarm' has been raised (e.g. via the Summary Hospital-level Mortality Indicator or other elevated mortality alert, the CQC or another regulator)

Additional Local triggers:

- Deaths post elective surgery (at most recent admission)
- Deaths accepted by the coroner for inquest / investigation.

The Learning from Patient Deaths Group (LfPDG) challenges assurance regarding performance and outcomes from the Trust's learning from deaths approach as outlined below:



The Learning from Patient Deaths Group (LfPDG) provides leadership to this programme of work and is supported by standing items on relative risk of mortality, potential learning from medical examiners, learning from inquests, and divisional learning from mortality review. The LfPDG is a sub-group of the Patient Safety Group and is aligned to the remit of the Quality and Safety Committee.

## 2. Relative Risk

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. Both tools are used to determine the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths; this provides a relative risk of mortality ratio.

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI and HSMR are designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality, the Trust is able to make comparisons between peer organisations and seek to identify improvement areas where there is variance.

### 2.1. Summary Hospital-level Mortality Indicator (SHMI)

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 on the basis of average England figures, given the characteristics of the patients treated there. The SHMI calculation includes 100% of in-hospital deaths (excluding still-births) and those deaths that occur within 30 days of discharge. The SHMI is composed of 144 different diagnosis groups, and these are aggregated to calculate the overall SHMI value for each organisation.

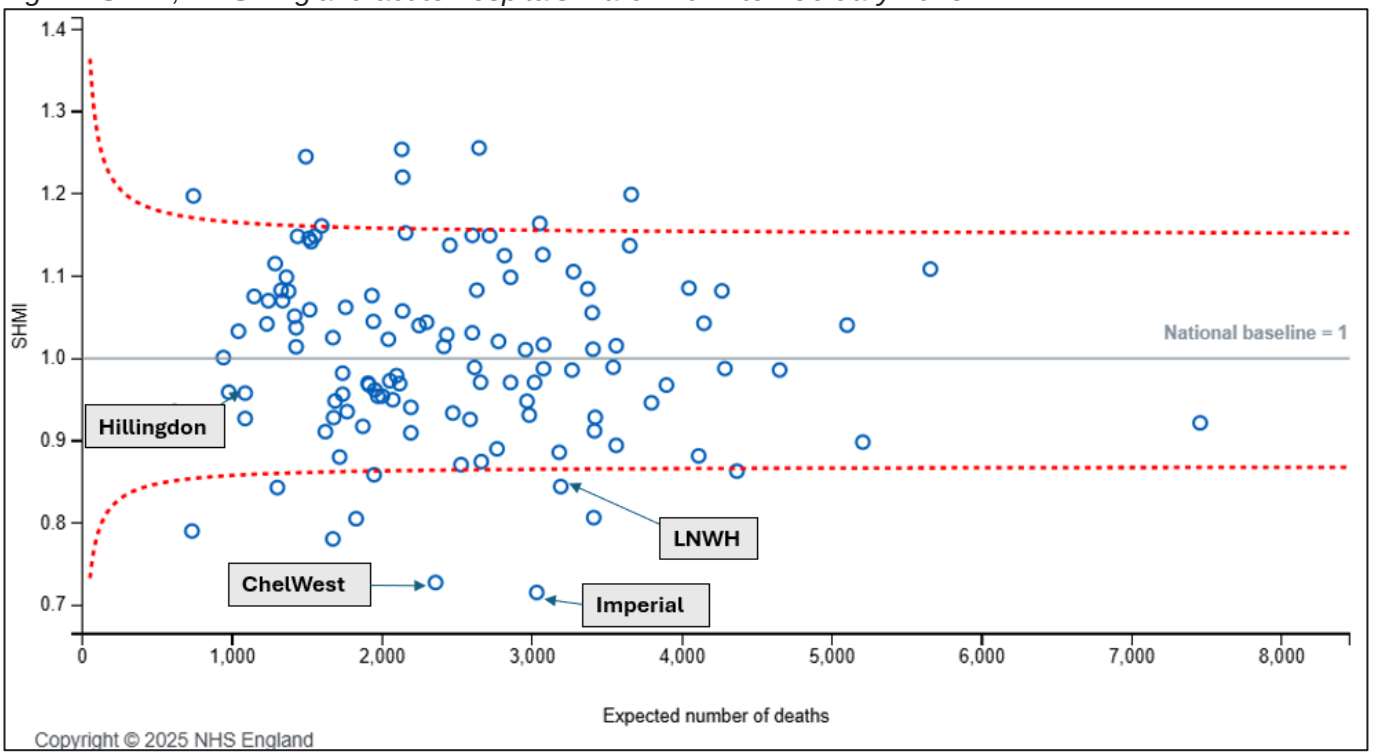
The Trust remains 8th best performing acute provider in England in relation to the SHMI relative risk of mortality indicator. The Trust-wide SHMI for the period March 2024 – February 2025 is 0.84 (where a number below 1 represents lower than expected risk of mortality).

North West London Acute Collaborative SHMI indicators

| Trust | SHMI | Observed Deaths | Expected Deaths | Provider Spells | % mortality: elective admission | % mortality: Palliative care coding | % mortality: 30 days post discharge |
|---|---|---|---|---|---|---|---|
| LNWH | 0.84 | 2,695 | 3,190 | 105,675 | 0.0% | 42% | 28% |
| CWH | 0.73 | 1,715 | 2,355 | 96,590 | 0.0% | 53% | 28% |
| ICH | 0.72 | 2,165 | 3,030 | 119,310 | 0.0% | 64% | 24% |
| THH | 0.96 | 935 | 975 | 52,590 | 0.0% | 56% | 29% |

*Tab 2, Data Source: NHS England, SHMI, March 2024 – February 2025, published 10/07/2025.*

*Fig 1 – SHMI, NHS England acute hospitals March 2024 to February 2025*




This positive assurance is reflected across the Trust as the organisation's principal sites continue to operate below the nationally expected relative risk of mortality:

- Northwick Park Hospital: 0.88 (2,130 expected, 1,875 observed, 77,865 provider spells)
- Ealing Hospital: 0.77 (1,035 expected, 795 observed, 23,885 provider spells)
- Central Middlesex Hospital: (15 expected, 10 observed, 1,530 provider spells).

The Trust continues to operate significantly below the national relative risk of mortality and SHMI remains low across the last year of rolling 12-month updates.

### 2.2. Hospital Standardised Mortality Ratio (HSMR)

The HSMR compares the number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on the type of cases treated. The HSMR calculation includes about 80% of in-hospital deaths (including still-births), it excludes deaths post discharge. The model no longer adjusts for palliative care as a variable in the model.

The Trust's HSMR is 94.5, where a number below 100 represents lower than expected risk of mortality, for reporting period April 2024 – March 2025.

North West London Acute Collaborative HSMR based on top 41 diagnostic groups:

| Trust | HSMR | Observed Deaths | Expected Deaths | Volume |
|---|---|---|---|---|
| LNWH | 94.5 | 1,563 | 1,654.7 | 55,086 |
| CWH | 81.0 | 990 | 1,222.9 | 41,370 |
| ICH | 78.6 | 1,255 | 1,596.0 | 51,670 |
| THH | 107.8 | 555 | 514.7 | 20,755 |

*Tab 3: HSMR (41 diagnostic groups) by APC provider, April 2024 to March 2025, Source: Telstra*

*LNWH HSMR Trend (41 diagnostic groups)*

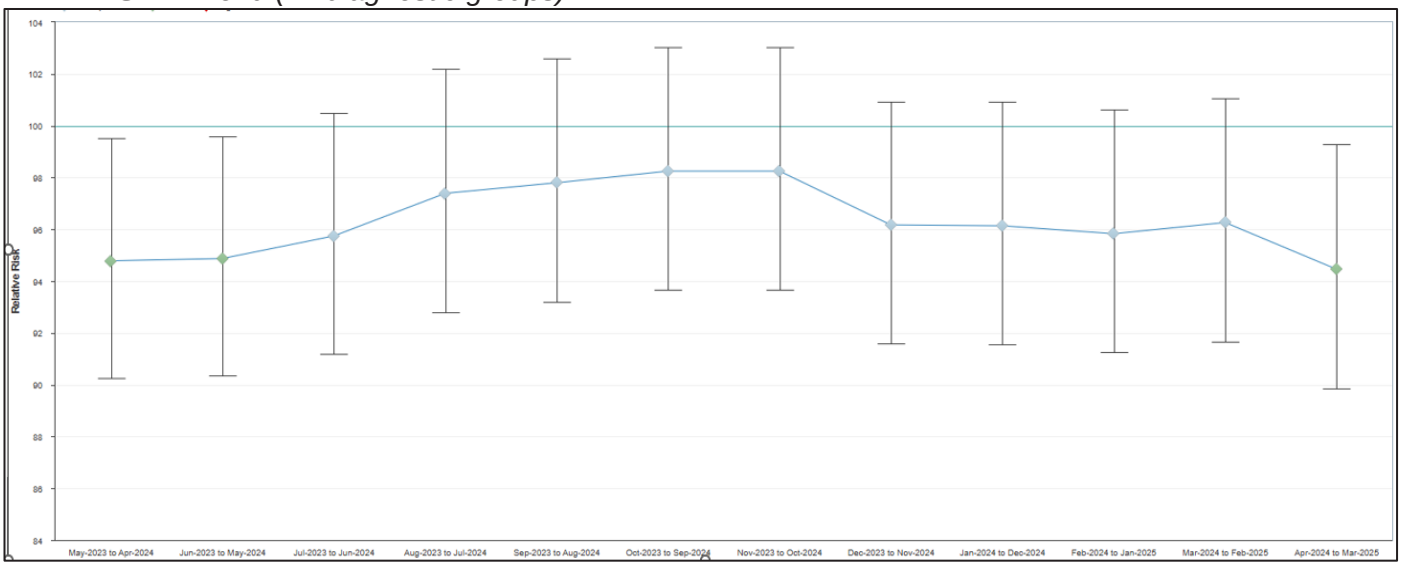



*Fig 2: Data Source: Telstra, HSMR trend (41 diagnostic groups), April 2024 to March 2025.*

The HSMR metric outlined above is made up of the 41 diagnostic groups; these are aggregated to calculate the Trust's overall relative risk of mortality. As can be seen all the monthly HSMRs for the Trust have been within the expected range. The Learning from Patient Deaths Group monitors expected and observed deaths across diagnostic groups; where statistically significant variation (triggering repeated CUSUM alerts) is identified the group undertakes coding and / or care review to identify any themes or potential improvement areas. There were no end of year diagnostic alerts.

## 2.3 CUSUM Diagnosis Alerts

A cumulative sum (CUSUM) statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time (on spell discharge). The chart has upper and lower thresholds and breaching this upper threshold triggers an alert at either a 99% or 99.9% detection threshold. These alerts tigger with a given month rather than reflecting on the whole year, as follows:

**Cardiac Arrest and Ventricular Fibrillation diagnosis** group is in the HSMR basket of 41 high mortality diagnosis groups. LNWUH had 23 deaths against an expected 18.4 across the year. The alert referred to the 3 deaths that occur in January 2025. All three were investigated and found to have received no sub-optimal care, one of which had an out of hospital cardiac arrest.

**Other Psychoses** diagnosis group is not in the HSMR basket of 41 high mortality diagnosis groups. LNWUH had 6 deaths against an expected 3 across the year.
The alert refers to 3 deaths that occurred in January 20205. All three were investigated and found to have received no sub-optimal care and the principal presentations were disorientation, that was unspecified.

## 3.0 Mortality Review

### 3.1 In-depth (level 2) mortality review

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through the Divisional Quality Boards / Governance Groups and the Trust-wide Learning from Patient Deaths Group (LfPDG).

During the 12-month period July 2024 to June 2025, 2,357 in-hospital adult or child deaths were recorded within the Trust's mortality review system (Datix), of these 100% have been screened. Screening identified 434 (18%) cases that would benefit from in-depth (level 2) review. Of these 946 have completed this in-depth review process, which is 2% higher since the last report.

| | No. of deaths | No. of cases screened | No. of cases flagged for level 2 review | No. case with completed level 2 review | % cases Screened | % of level 2 reviews completed |
|---|---|---|---|---|---|---|
| **Q2 24/25** | 556 | 556 | 139 | 135 | 100% | **97%** |
| **Q3 24/25** | 600 | 600 | 95 | 93 | 100% | **98%** |
| **Q4 24/25** | 667 | 667 | 96 | 93 | 100% | **97%** |
| **Q1 25/26** | 534 | 534 | 104 | 96 | 100& | **92%** |
| **Totals** | **2,357** | **2,357** | **434** | **417** | **100%** | **96%** |

*Tab 4: Adult & child mortality review status by financial quarter, July 2024 to 30 June 2025*

The Consultant Mortality Validators undertake level 2 in-depth mortality reviews and identify cases that need Speciality Mortality Leads to conduct a further in-depth review. Speciality Mortality Leads have 4 months from the date of death to complete these reviews. Compliance is monitored by the Divisional Boards / Governance meeting, Learning from Patient Deaths Group, and overseen by the Trust Executive Group and Quality & Safety Committee.

| Hospitals | No. of deaths | No. of cases screened | No. flagged for level 2 review | No. of completed level 2 reviews | % cases Screened | % of level 2 reviews completed |
|---|---|---|---|---|---|---|
| **Northwick Park & St Marks** | 1,562 | 1,562 | 295 | 280 | 100% | **95%** |
| **Ealing** | 790 | 790 | 136 | 134 | 100% | **99%** |
| **Central Middlesex** | 5 | 5 | 3 | 3 | 100% | **100%** |
| **Totals** | **2,357** | **2,357** | **434** | **417** | **100%** | **96%** |

*Tab 5: Adult & child mortality review status by site, July 2024 to 30 June 2025*

The following key trends arising from process compliance monitoring have been noted:

- This quarter the proportion of in-patients identified for in-depth (Level 2) review has increased to 19% this quarter (Q1) in comparison to the previous quarter at 14%. This rise is in line with yearly trends but will continue to be monitored.

- 'Medical Examiner Requests' was the most common trigger for an in-depth mortality review accounting for 28% (29 cases) of requests. This was followed by 'Unexpected Deaths' at 24% (25 cases). However, the rate of 'Unexpected Deaths' has continued to decrease each quarter as the trust continues to educate staff around the use of this classification.

- Of 96 mortality reviews conducted for Q1 deaths, 86% found no sub-optimal care (CESDI Grade 0), comparable to 81% the previous quarter.

The Divisional Mortality Leads provide scrutiny to mortality cases to identify themes and escalate any issues of concerns. Key themes / issues identified via mortality review this quarter, which are consistent with the previous quarters learning:

- **Clinical Decision-Making and Escalation of care:** the importance of timely escalation, intervention, and the recognition of deterioration remained a consistent theme. With Delays in ITU review, missed opportunities for early palliative care and under-recognition of illness severity remaining a recurring issue.

- **Communication with Families and Next of Kin (NOK):** highlights of good practice were shared, with regular updates being given to families and clear explanations of care being provided. There were still cases where communication with families could have been more timely or comprehensive, particularly around end-of-life care and after patient deaths.
- **Specialist Input and Multidisciplinary Collaboration:** strong evidence of good MDT involvement was a positive theme throughout the reviews this quarter, especially in the management of patients with frailty, comorbidities and complex cases. However, there was evidence of handover failures and a lack of continuity between teams (e.g. between acute and specialist teams), which can lead to missed opportunities or sub-optimal care.

- **End-of-Life Care and Use of Palliative Pathways:** many examples of early recognition of dying and appropriate use of palliative care pathways this quarter. There is still a need for more palliative care involvement in some cases and more general use of Treatment Escalation Plans / DNACPR forms being completed by staff to support end-of-life care.

### 3.2 CESDI Grading of Care

Outcome, avoid ability and / or suboptimal care provision is defined using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories that have been adopted by the Trust for use when assessing deaths:

- Grade 0: No suboptimal care or failings identified, and the death was unavoidable.

- Grade 1: A level of suboptimal care identified during hospital admission, but different care or management would NOT have made a difference to the outcome and the death was unavoidable.
- Grade 2: Suboptimal care identified, and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable.
- Grade 3: Suboptimal care identified, and different care WOULD REASONABLY BE EXPECTED to have made a difference to the outcome, i.e. the death was probably avoidable.

**CESDI grades July 2024 to end June 2025**

| Period | CESDI 0 | CESDI 1 | CESDI 2 | CESDI 3 |
|---|---|---|---|---|
| Q2 24/25 | 94 | 35 | 4 | 2 |
| Q3 24/25 | 71 | 19 | 3 | 0 |
| Q4 24/25 | 75 | 17 | 1 | 0 |
| Q1 25/26 | 83 | 12 | 1 | 0 |
| Total | 323 | 83 | 9 | 2 |

*Tab 5: Closed mortality cases by CESDI grade, July 2024 to 30 June 2025*

During this 12-month period 9 cases of sub-optimal care that might have made a difference to the patient's outcome (CESDI 2) and 2 cases where sub-optimal care would reasonably be expected to have made a difference to outcome were identified. All cases graded as CESDI 2 or 3 are presented to the Trust's Emerging Incident Review Group for confirmation of learning response (e.g. SI / PSII).

The graph below illustrates the distribution of CESDI grades across the three sites, reflecting the nature of events being reviewed by Mortality Leads. As in previous quarters Northwick Park & St Marks has the highest number of sub-optimal care with 66 cases, followed by Ealing with 27 cases and 1 case in Central Middlesex. This suggests that the majority of cases where different care might have made a difference to outcome were focused on the Northwick Park / St Mark's site, reflecting the spells this site delivers.

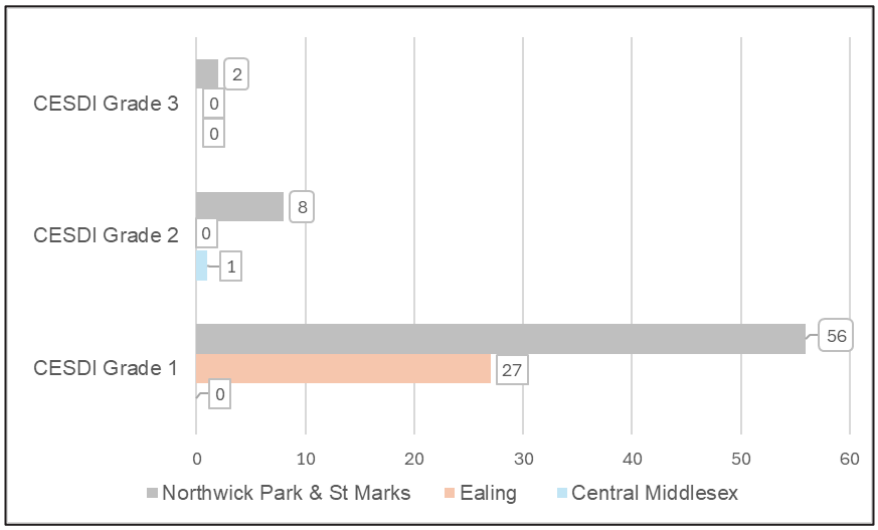



*Fig 7 – CESDI Grade by Site, July 2024 to 30 June 2025*

## 4.0 Ethnicity & Gender

The ethnicity data shows a consistent picture in terms of the proportion of deaths by ethnicity during Q1 2025/26 as in previous quarters. Further analysis is provided in appendix B.

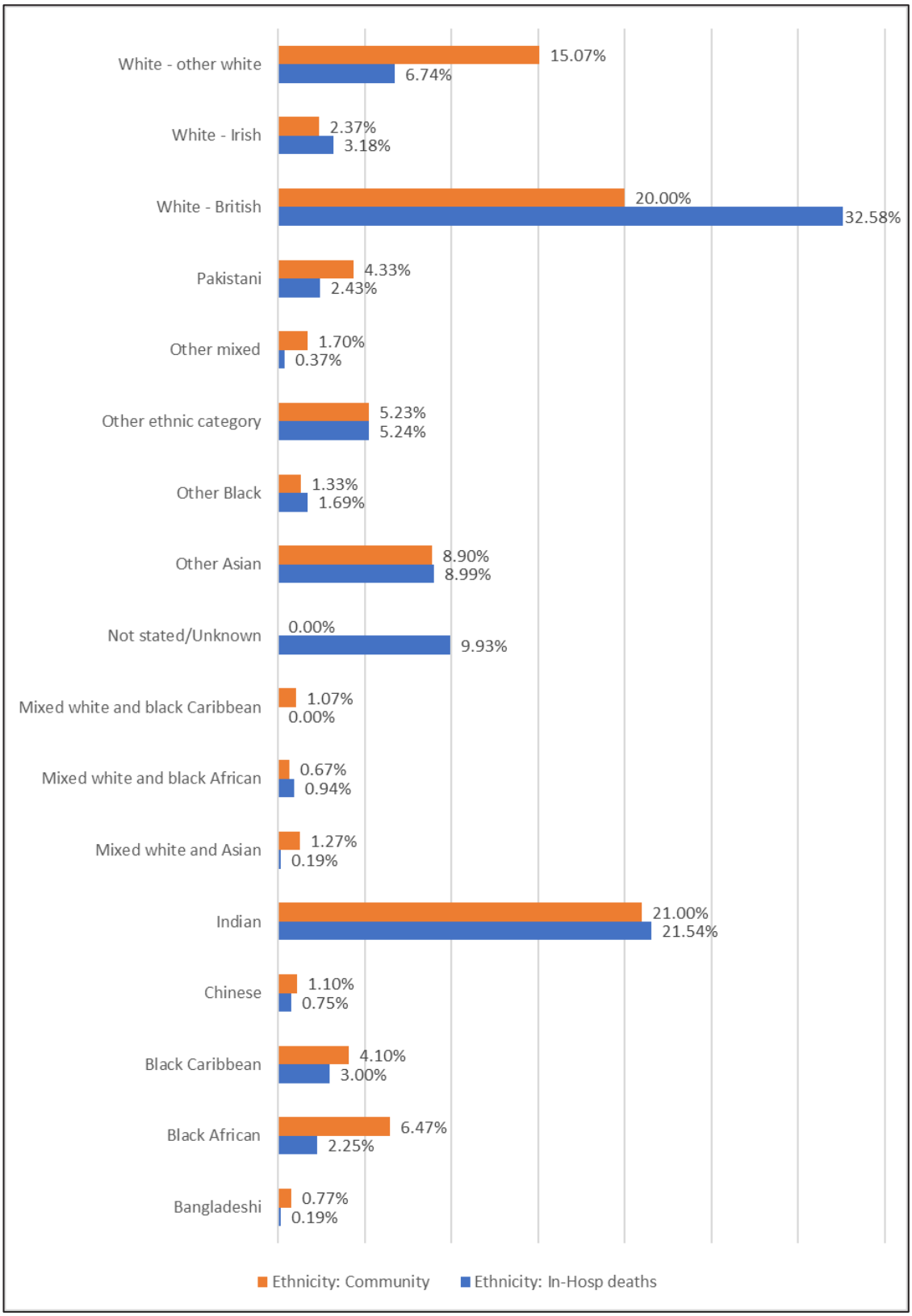



*Fig 8 – Ethnicity breakdown, Q1 2025/26*

In proportion to the community population for Brent, Ealing and Harrow, there remains more in-hospital mortality in the White British, Other Asian and Other Black demographic groups than others.

As in previous quarters White British remains is the most frequently identified ethnicity associated with in-hospital mortality, account for 32.58% during Q1, this is lower than during Q4 which was 35.59%. We continue to note that the local populations of Brent, Ealing, Harrow recognises only 20% of the population as having this ethnicity. This suggests a higher rate of in-hospital deaths compered to community deaths for this group. Other Asian is the second most frequent ethnicity associated within in-hospital death at 8.99%, consistent with the last quarter at 10.06%.

All other ethnic groups had in-hospital mortality rates that were either proportional or lower than their community representation.

During this 12-month period, the CESDI Grade 1 cases continue to predominantly involve individuals of White British ethnicity followed by Indian. However, the profile of CESDI Grade 2 cases are currently White British, Other Asian, not known. These findings align with the demographic composition of the population in Brent, Ealing, and Harrow, where Indian and White British groups are the largest resident populations. CESDI Grade 3 is evenly split with just two cases, one is Other Asian and one White British.

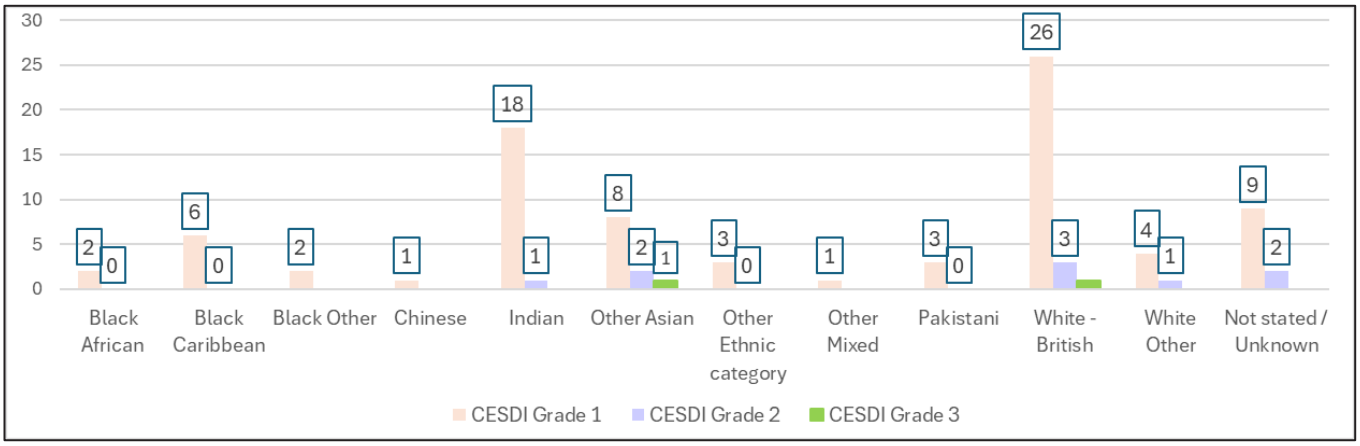



*Fig 9: Closed mortality cases by CESDI grade and Ethnicity, April 2024 to 31 March 2025*

Analysis of CESDI grades by gender indicates the same trend as is the previous 12-month period, that the care of male patients is more likely to have elements of sub-optimal care identified than female patients.

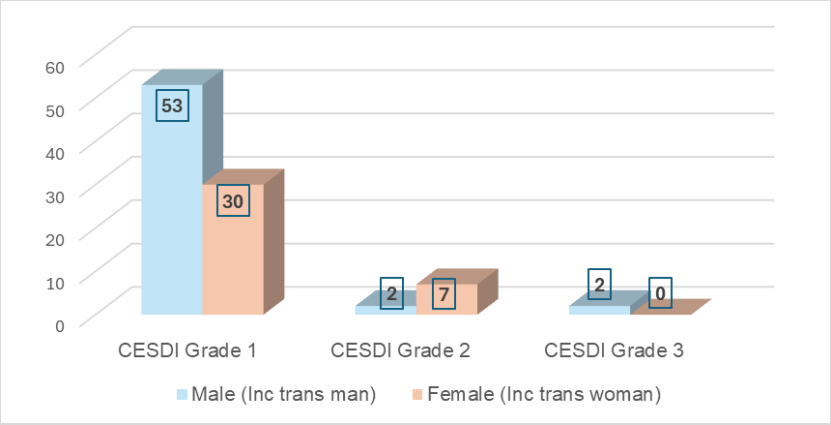



*Fig 10: Closed mortality cases by CESDI grade and Gender, July 2024 to 30 June 2025*

## 9.0 Conclusion

The outcome of the Trust's mortality surveillance programme continues to provide a rich source of learning that is supporting the organisations improvement objectives. The Trust continues to be recognised as having a low relative risk of mortality (SHMI) across NHS England.
We can provide assurance to the committee that we are providing safe care for the majority of patients. Where care issues are found, we have robust processes for referral for more in-depth review and these processes are triangulated against other data provided within the trust under the PSIRF framework.

Efforts to enhance and standardise our processes for learning from patient deaths are ongoing. We are also actively working in partnership with other members of the APC to ensure consistency, facilitate shared learning, and identify opportunities for collective improvement.

## 10. Glossary

**Medical Examiners** are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

**Structured Judgement Review (SJR)** is a clinical judgement-based review method with a standard format. SJR reviewers provide a score on the quality of care provided through all applicable phases of care and will also identify any learning. The SJR will be completed within seven days of referral.

**Structured judgement reviewers** are responsible for conducting objective case note reviews of identified cases. They will seek, when required, specialist input and advice from clinical colleagues, including members of the multi-disciplinary teams to ensure high quality, comprehensive review is undertaken, using the full range of medical records available to them.

**Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

**Child Death Overview Panel (CDOP)** is an independent review aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

**Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

**Learning Disabilities Mortality Review (LeDeR)** is a review of all deaths of patients with a learning disability. The Trust reports these deaths to the Local integrated care boards (ICBs) who are responsible for carrying out LeDeR reviews. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

## Appendix A – Acute Provider Collaborative performance scorecard

| | 2024-25 | | | 2025-26 |
|---|---|---|---|---|
| | Q2 | Q3 | Q4 | Q1 |
| Total No. Deaths | 556 | 600 | 667 | 534 |
| Total No. Adult Deaths | 552 | 596 | 665 | 530 |
| No. Child Deaths | 4 | 4 | 2 | 4 |
| No. Neonatal Deaths | 1 | 2 | 2 | 0 |
| No. Stillbirths | 4 | 2 | 2 | 0 |
| | | | | |
| ME Reviewed Deaths in Qtr. | 556 | 600 | 667 | 534 |
| % ME Reviewed Deaths - Deaths (excluding Stillbirths) in Qtr. | 100% | 100% | 100% | 100% |
| Deaths referred for Level 2 Review in Qtr. | 139 | 95 | 96 | 104 |
| % Level 2 Reviews Requested for Deaths in Qtr. of total deaths in Qtr. | 25% | 16% | 14% | 19% |
| | | | | |
| Level 2 Reviews Completed for Deaths in Qtr. | 135 | 93 | 93 | 96 |
| % Level 2 Reviews Completed for Deaths in Qtr. | 97% | 98% | 97% | 92% |
| | | | | |
| No. LeDeR Completed | 12 | 12 | 10 | 7 |
| Requests made by a Medical Examiner | 47 | 10 | 19 | 29 |
| % Requests made by a Medical Examiner | 34% | 11% | 20% | 28% |
| Concerns raised by family / carers | 25 | 13 | 16 | 20 |
| % Concerns raised by family / carers | 18% | 14% | 17% | 19% |
| Patients with learning disabilities | 12 | 12 | 10 | 7 |
| % Patients with learning disabilities | 9% | 13% | 10% | 7% |
| Patients with severe mental health issues | 6 | 6 | 3 | 1 |
| % Patients with severe mental health issues | 4% | 6% | 3% | 1% |
| Unexpected deaths | 51 | 36 | 29 | 25 |
| % Unexpected deaths | 37% | 38% | 30% | 24% |
| Elective admission deaths | 11 | 6 | 6 | 5 |
| % Elective admission deaths | 8% | 6% | 6% | 5% |

| | 2024-25 | | | 2025-26 |
|---|---|---|---|---|
| | Q2 | Q3 | Q4 | Q1 |
| Requests made by speciality mortality leads/through local Mortality & Morbidity review processes | 9 | 2 | 2 | 2 |
| % Requests made by speciality mortality leads/through local Mortality & Morbidity review processes | 6% | 2% | 2% | 2% |
| Service or diagnosis alarms as agreed by APC mortality surveillance group | n/a | n/a | n/a | n/a |
| % Service or diagnosis alarms as agreed by APC mortality surveillance group | n/a | n/a | n/a | n/a |
| | | | | |
| CESDI 0: No suboptimal care (cases reviewed & closed) | 94 | 71 | 75 | 83 |
| % CESDI 0: No suboptimal care (cases reviewed & closed) | 70% | 76% | 81% | 86% |
| CESDI 1: Some suboptimal care which did not affect the outcome (cases reviewed & closed) | 35 | 19 | 17 | 12 |
| % CESDI 1: Some suboptimal care which did not affect the outcome (cases reviewed & closed) | 26% | 20% | 18% | 13% |
| CESDI 2: Suboptimal care: different care might have made a difference to outcome (possible avoidable death) (cases reviewed & closed) | 4 | 3 | 1 | 1 |
| % CESDI 2: Suboptimal care: different care might have made a difference to outcome (possible avoidable death) (cases reviewed & closed) | 3% | 3% | 1% | 1% |
| CESDI 3: Suboptimal care: would reasonably be expected to have made a difference to the outcome (probably avoidable death) (cases reviewed & closed) | 2 | 0 | 0 | 0 |
| % CESDI 3: Suboptimal care: would reasonably be expected to have made a difference to the outcome (probably avoidable death) (cases reviewed & closed) | 1% | 0% | 0% | 0% |

*Trust mortality reviewed data as at 11/07/2025

## Appendix B: Ethnicity Q2, Q3, Q4 2024-25 and Q1 20254/26

| | 2024/25 | | | | | | 2025/26 | | | | Community population |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 n | Q2 % | Q3 n | Q3 % | Q4 n | Q4 % | Q1 n | Q1 % | Total n | Total % | Brent, Ealing, Harrow |
| **Bangladeshi** | 0 | 0% | 1 | 0% | 1 | **0.15%** | 1 | **0.19%** | **3** | **0.13%** | 0.77% |
| **Black African** | 18 | 3% | 15 | 3% | 19 | **2.85%** | 12 | **2.25%** | **64** | **2.72%** | 6.47% |
| **Black Caribbean** | 15 | 3% | 25 | 4% | 26 | **3.90%** | 16 | **3.00%** | **82** | **3.48%** | 4.10% |
| **Chinese** | 1 | 0% | 2 | 0% | 0 | **0.00%** | 4 | **0.75%** | **7** | **0.30%** | 1.10% |
| **Indian** | 112 | 20% | 147 | 25% | 118 | **17.72%** | 115 | **21.54%** | **492** | **20.90%** | 21.00% |
| **Mixed white and Asian** | 1 | 0% | 4 | 1% | 1 | **0.15%** | 1 | **0.19%** | **7** | **0.30%** | 1.27% |
| **Mixed white and black African** | 2 | 0% | 0 | 0% | 0 | **0.00%** | 5 | **0.94%** | **7** | **0.30%** | 0.67% |
| **Mixed white and black Caribbean** | 1 | 0% | 0 | 0% | 0 | **0.00%** | 0 | **0.00%** | **1** | **0.04%** | 1.07% |
| **Not stated/Unknown** | 53 | 10% | 56 | 9% | 73 | **10.96%** | 53 | **9.93%** | **235** | **9.98%** | N/A |
| **Other Asian** | 56 | 10% | 50 | 8% | 67 | **10.06%** | 48 | **8.99%** | **221** | **9.39%** | 8.90% |
| **Other Black** | 15 | 3% | 11 | 2% | 14 | **2.10%** | 9 | **1.69%** | **49** | **2.08%** | 1.33% |
| **Other ethnic category** | 13 | 2% | 17 | 3% | 24 | **3.60%** | 28 | **5.24%** | **82** | **3.48%** | 5.23% |
| **Other mixed** | 2 | 0% | 4 | 1% | 4 | **0.60%** | 2 | **0.37%** | **12** | **0.51%** | 1.70% |
| **Pakistani** | 13 | 2% | 15 | 3% | 12 | **1.80%** | 13 | **2.43%** | **53** | **2.25%** | 4.33% |
| **White - British** | 204 | 37% | 195 | 33% | 237 | **35.59%** | 174 | **32.58%** | **810** | **34.41%** | 20.00% |
| **White - Irish** | 9 | 2% | 9 | 2% | 12 | **1.80%** | 17 | **3.18%** | **47** | **2.00%** | 2.37% |
| **White - other white** | 41 | 7% | 45 | 8% | 58 | **8.71%** | 36 | **6.74%** | **180** | **7.65%** | 15.07% |
| **No value** | 0 | 0% | 2 | 0% | 0 | **0.00%** | 0 | **0.00%** | **2** | **0.08%** | N/A |
| **Total** | 556 | 100% | 598 | 100% | 666 | **100.00%** | 534 | **100.00%** | **2354** | **100.00%** | |
| | | | | | | | | | | | |
| **More in hospital mortality in the Chinese, other Asian, and white British demographic groups than the community population for Brent, Ealing and Harrow** | | | | | | | | | | | |

NWL Acute Provider Collaborative Quality Committee
Select meeting date
Item number: #
This report is: Public

# The Hillingdon Hospital NHS Foundation Trust Learning from Deaths Report Quarter 1

Author: Paula Perry
Job title: Clinical Governance Facilitator for Mortality

Accountable director: Stella Barnes
Job title: Deputy Chief Medical Officer

## Purpose of report (for decision, discussion or noting)

Purpose: Information or for noting only

This report presents the data from the Learning from Deaths programme for Quarter One (Q1) of 2025/26 for information. It is a statutory requirement for Trusts to present this information to their boards. This is achieved through presentation of this report to the Hillingdon Hospital Quality & Safety Committee and the submission of overarching learning drawn from across the four NWL acute provider collaborative (APC) trusts to the APC Quality Committee and Board in common.

## Report history

Outline committees or meetings where this item has been considered before being presented to this meeting.

| **Trust Quality and Safety Executive Committee** | **Quality and Safety Committee** | **Mortality Surveillance Group** |
|---|---|---|
| 11/08/2025 | 19/08/2025 | 10/09/2025 |
| To be presented | To be presented | To be presented |

## Executive summary and key messages

- Following the update to the new Hospital Standardised Mortality Ratio (HSMR) model, now HSMR+, Hillingdon's HSMR has exceeded 100 although it remains within the statistically expected range, at 107 for year April 2024 to March 2025, indicating that the changes in methodology and how the data is captured rather than care quality were the primary drivers of this shift.

- Standardised Hospital Mortality Indicator (SHMI) for year to January 2025 is 97.35 and remains below the NHS benchmark of 100. There had been a slight consistent rise over the last year with the last year to October 2024 being 98.94 and previous year to July 2024 being 97.95.

- During the 12-month period July 2024 to June 2025; 717 in-hospital adult deaths were recorded within the Trust's mortality review system, of these 100% have had medical examiner (Level 1) screening. Level 1 screening identified 9% of cases that would benefit from in-depth structured judgement review (SJR). Of these 89% have completed this in-depth structured judgement review.

- For the 12-month period July 2024 to June 2025 there have been no cases of sub-optimal care identified (CESDI 2) where different care might have made a difference to the outcome and (CESDI 3) where different care would reasonably be expected to have made a difference to the outcome.

- A new learning system has been procured which will see an improvement in how the data and learning is captured whilst triangulating information with coroners inquest and learning from incidents and complaints. This will improve the monitoring of completion of SJRs whilst strengthening the learning and improving patient care and experience.

## Impact assessment

Tick all that apply

☐ Equity
☒ Quality
☐ People (workforce, patients, families or careers)
☐ Operational performance
☐ Finance

☐ Communications and engagement
☐ Council of governors

Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes and experience for patients and their families

## Strategic priorities

Tick all that apply

☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity (APC)
☐ Support the ICS's mission to address health inequalities (APC)
☐ Attract, retain, develop the best staff in the NHS (APC)
☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APC)
☐ Achieve a more rapid spread of innovation, research, and transformation (APC)
☐ Help create a high quality integrated care system with the population of north west London (ICHT)
☐ Develop a sustainable portfolio of outstanding services (ICHT)
☐ Build learning, improvement and innovation into everything we do (ICHT)

## Main Report

### 1. Learning and Improvements

This report provides a Trust-level quarterly review of mortality learning for Q1 2025/26 with performance scorecard (see Appendix 1 and 2 reflecting all quarters of the financial year.

All in-hospital deaths are scrutinised by the Trust's Medical Examiner Service; this initial screening provides an independent review of care and is the basis for triggering cases meeting the criteria for Structured Judgement Review.

### 2. Relative Risk of Mortality

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI and HSMR are designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector.

### 2.1. Summary Hospital-Level Mortality (SHMI) Indicator

SHMI captures all deaths which occurred in hospital (excluding stillbirths) and those deaths that occur within 30 days of discharge in the community and is a wider measure of mortality than HSMR.

The Trust participates in the Same Day Emergency Care (SDEC) service under the aegis of NHSE, of which currently only 39/119 trusts have so far made the change to provide. It is acknowledged by NHSE that including this provision may result in detrimental effects on SHMI performance and it has increased the SHMI by about 5 points. This is because it removes a high volume of low-risk spells from the Admitted Patient Care dataset from which the SHMI was derived. The Trust made the provision of same day care for emergency patients in September 2023 and the increase of SHMI occurs at that time. Even with this, Hillingdon SHMI remains below the NHS benchmark of 100 and has been for two years.

The SHMI for year to January 2025 is 97.35, with 960 deaths observed against an expected 990 given case mix and adjusted for wider NHS performance. Hillingdon outperforms the NHS benchmark (100) but is not significantly low. The last reporting period year to October 2024 was 98.94 and previous year to July 2024 was 97.95.

## 2.2. Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths. The new model for HSMR (HSMR+) looks at 46 diagnostic groups rather than 51. A more sophisticated comorbidity measure is used to capture more conditions and an adjustment to frailty has been introduced. Stillbirths have been removed from the new metrics. Across the APC, the new methodology has impacted Hillingdon Hospital the most with an increase in the HSMR but remains within expected statistical range.

The HSMR for year April 2024 to March 2025 is 107, with 572 deaths observed against an expected 534.5 predicted in the model when adjusted for Hillingdon case mix given case mix. It is still within expected range (not high relative risk) but is very close to breaching high HSMR.

Hillingdon HSMR has likely been inflated by improvements in data processing which have the inadvertent effect of inflating the metric. Previously, Hillingdon had an issue with Residual Codes- placeholder codes that don't fit into the traditional ICD diagnostic code structure and hence can't be accurately weighted in our HSMR model. There were 80 such deaths with this status in Jan 2025 HSMR, which is down to 5 in this update. These have now been reallocated in the data, and this has led to an increase in HSMR.

A significant amount of this data was reallocated to Pneumonia, which is a new diagnosis group alert for Hillingdon and represents a significant amount of mortality within the HSMR (and Pneumonia accounts for a much higher % of Hillingdon cohort than the average NHS cohort)

## 2.3. Trust response to HSMR and SHMI alerts

The Mortality Surveillance Group monitors expected and observed deaths across diagnostic groups and where statistically significant variation is identified the group undertakes coding and care review to identify any themes or potential improvement areas.

A working group has been established to explore factors that may be influencing the data. Given that both the SHMI and HMSR models are showing an increase, the common factor being considered is the coding of co-morbidity, which requires further investigation. The data indicates that THH is coding a smaller proportion of patients with the co-morbidities that significantly impact the model.

The first focus of the group is a review into two diagnostic groups; Pneumonia (n=152, we are looking into 33) and Fracture of neck of femur (n=17, we are looking into 13) where there have been higher observed deaths than expected

An update on these reviews will be given in the Q2 2025/26 report.

## 3. Thematic Review

The Mortality Surveillance Group (MSG) challenges assurance regarding the opportunity and outcomes from the Trust's learning from deaths approach.

MSG provides leadership to this programme of work; it is supported by bi-monthly updates of relative risk of mortality, potential learning from medical examiners following level 1 scrutiny and divisional learning following Morbidity & Mortality Meetings and completed Structured Judgement Reviews which is then disseminated to all the directorates and throughout the divisions.

### 3.1. Medical Examiner's Service

The Medical Examiner Service in Hillingdon is responsible for scrutinising all deaths in the borough and identifying learning points, or deaths needing to be referred to the Coroner.

- The Hillingdon Hospital Medical Examiner Service has scrutinised 150 hospital deaths during quarter one 2025/6, this number includes 2 cases where the death occurred in quarter four 2024/25. This represents 39.6% of our total caseload, with 229 referrals (60.4%) from the London Borough of Hillingdon sources, specifically residential care [104 (45.5%)]. expected natural deaths at home [103 (45%)], and hospice [22 (9.5%)].
- The funding model predicts 45% Hospital and 55% Community deaths.
- Our median time from death to transmission of documentation to the Register office is 1 day for hospital deaths, and 3 days for non-Hillingdon Hospital deaths. This is on a par with the best national figures.
- For Hillingdon Hospital patients we had 26/150 (17%) interactions with the coroner, 19 (12.6%) actual referrals and 7 ME-MCCD requests) with 13 (8.6%) retained for investigation. These are low coroner referral rates compared to historical national rates. For completeness, our corresponding non-THH figures are 29/229 (12.7%), 25 (10.9%) and 4/229(1.7%).

- Our weekend on-call medical examiner service for urgent registrations, with medical examiner availability corresponding to Register Office hours, seems to be working well, with some (but not all) challenges overcome.

**Challenges:**

- There are still difficulties with timely attendance of Attending Practitioners to complete the required registration paperwork, as per their continuing duty of care to the deceased.
- There are still occasions where ward staff and doctors are giving the wrong information to the bereaved about our capacity to cater for urgent (e.g. faith-based) weekend registrations.
- Assuring that GPs get an accurate Discharge Summary after a patient has died (including Cause, or even fact, of Death) seems to be beyond the capability of our current Cerner EHR system. There has been no progress on effectively escalating this to a point where the faulty discharge process is remediable for the deceased.
- Weekly reported data quality issues seem to arise from the fact that Cerner EHR has not been effectively modernised since the advent of the medical examiner system, and so our processes are not accounted for.

**Improvements:**

- This has been the second full quarter in which medical examiner scrutiny has been statutory. We have consolidated our excellent working relationships with all stakeholders, and have been invited to the national and regional meetings of Funeral Directors and Crematorium Managers to demonstrate and reassure with efficient ways of working,
- The Springboard dashboard function, which allows rapid access to the Cerner record of all hospital patients with a confirmed death, has finally been rolled out to all the staff that need this, having initially been only for clinical staff (i.e. not medical examiner officers or the bereavement office).

**Recommendations:**

- Further education to all Trust staff on the processes around statutory scrutiny and the importance of timely registration of patient deaths.
- Access to higher level mechanisms for modernisation of our version of the Cerner EHR, including discharge processes and internal consistency.

### 3.2. Structured Judgement Review

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

In-hospital adult deaths are screened by the Medical Examiner team using the Level 1 Review form. This supports the identification of cases that would benefit from Structured Judgement Review. Deaths are then discussed by the divisions for their oversight, through their specialty M&M meetings and through the unplanned Care M&M forum. Plans are that all specialities within Unplanned Care hold regular M&M meetings as part of their governance process which Care of the Elderly commenced in March 2025 and Respiratory are now in the process of establishing. A dedicated Cerner list has been created for them to support this.

There have been no prevention of future deaths (PFD) notices issued in this quarter.

During the 12-month period July 2024 to June 2025; 717 in-hospital adult deaths were recorded within the Trust's mortality review system, of these 100% have had Level 1 medical examiner screening. The Level 1 screening identified 65 (9%) cases that would benefit from in-depth structured judgement review (SJR). Of these 89% have completed this in-depth structured judgement review.

| Period | No. of Adult deaths | No. of cases screened | No. of cases flagged for SJR | No. of cases with completed SJR | % Cases screened | % SJRs completed |
|---|---|---|---|---|---|---|
| Q2 24/25 | 162 | 162 | 17 | 17 | **100%** | **100%** |
| Q3 24/25 | 201 | 201 | 15 | 14 | **100%** | **93%** |
| Q4 24/25 | 209 | 209 | 23 | 21 | **100%** | **91%** |
| Q1 25/26 | 145 | 145 | 10 | 6 | **100%** | **60%** |
| Totals | **717** | **717** | **65** | **58** | **100%** | **89%** |

*Table 1: Adult mortality review status by financial quarter, July 2024 to June 2025*

'Family/Carer' concerns was the most frequent trigger for structured judgement review in quarter one at 60% (6 cases) which is a decrease for the same trigger in quarter four at 65% (17 cases).

The percentage of in-patient deaths identified for structured judgement review in quarter one decreased to 9%, it was 12% in quarter four.

| Care Division | No. of Adult deaths | No. of cases screened | No. of cases flagged for SJR | No. of cases with completed SJR | % Cases screened | % SJRs completed |
|---|---|---|---|---|---|---|
| Unplanned | 583 | 583 | 43 | 40 | **100%** | **93%** |
| Planned | 134 | 134 | 22 | 18 | **100%** | **82%** |
| Totals | **717** | **717** | **65** | **58** | **100%** | **89%** |

*Table 2: Adult mortality review status by division, July 2024 to June 2025*

Completion of Structured Judgement Reviews are monitored by the divisions by way of a monthly SJR status report and regular monthly meeting for oversight of compliance.

### 3.2.1 CESDI Grading of Care

Outcome, avoidability and / or suboptimal care provision is graded using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories:

- Grade 0: No sub-optimal care or failings identified and the death was unavoidable
- Grade 1: A level of sub-optimal care identified during hospital admission, but different care would NOT have made a difference to the outcome and the death was unavoidable
- Grade 2: Sub-optimal care identified and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable
- Grade 3: Sub-optimal care identified and different care WOULD REASONABLY BE EXPECTED to have made a difference

All cases graded as CESDI 0 and CESDI 1 are sent to divisional leads for oversight and to ensure that there is discussion and presentation at appropriate specialty and morbidity and mortality meetings where learning can be shared.

All cases graded as CESDI 2 or CESDI 3 are discussed in the Incident Review Group for a decision on appropriate learning response.

During the 12-month period July 2024 to June 2025, 58 structured judgement reviews have been completed.

| Period | CESDI 0 | CESDI 1 | CESDI 2 | CESDI 3 |
|---|---|---|---|---|
| Q2 24/25 | 9 | 7 | 1 | 0 |
| Q3 24/25 | 8 | 5 | 1 | 0 |
| Q4 24/25 | 19 | 2 | 0 | 0 |
| Q1 25/26 | 6 | 0 | 0 | 0 |
| Total | **42** | **14** | **2** | **0** |

*Table 3: Completed mortality cases by CESDI grade, July 2024 to June 2025*

Cases received during Q1:

- Two cases were graded as a CESDI 1.
- Fifteen cases were graded as a CESDI 0.

Following review of the two cases graded CESDI 1, key themes and issues identified were:

- Better documentation maintained regarding the Treatment Escalation Plans when changes are made and outlining the reason for the change.
- Treatment Escalation Plan – Not for CPR. Lack of documentation on the form or ward round notes about DNACPR with patient (who had capacity) or relatives at the time of the decision on the post take ward round.
- Medication: Importance of timely supplementation of calcium in cardiovascular unstable patients based on blood gases results.
- Timely drug review of the deteriorating patient in order to omit potentially harmful medications.

Actions are identified in line with the learning to support improving patient care.

Evidence of excellent care has been recognised during patients' phase of care in three of the reviews completed (n=3):

- Admission and Initial management (n=0)
- Ongoing care (n=1)
- Care during procedure (n=0)
- Perioperative care (n=0)
- End of Life care (n=2)

Themes of excellent care highlighted included:

- **Specialist Input and Multidisciplinary Collaboration:** Effective MDT input in a complex medical patient. Evidence of multidisciplinary involvement of different specialties for a patient with 1:1 nursing instituted when the patient developed worsening delirium.
- **Communication with Families and Next of Kin (NOK):** Good communication with NOK and regularly kept up to date with patient's progress, explaining patient's poor oxygenation and ward-based care. Multiple discussions with the family regarding the Treatment Escalation Plan and appropriate teams each time the patient deteriorated. Family constantly updated which was well documented in the medical notes (updates provided to several family members on one occasion in EMCU) and they were clearly appreciative of the care received in EMCU. Palliative team were
- **Clinical Decision-Making and escalation of care:** Patient's care was appropriately escalated on several occasions with repeated reviews from the medical, on-call as well as ITU teams. Palliative team were only involved on the last day before the patient died, however family were in agreement with active treatment up till that time point and recognition of the patient dying may have been challenging due to her ongoing delirium. Correct and timely diagnosis of sepsis was made.

### 3.2.2 Ethnicity

The ethnicity data shows a consistent picture in terms of the proportion of deaths by ethnicity during Q1 2025/26 as in previous quarterly reports. The percentage of deaths where ethnicity is not known has continuously decreased during the last two quarters 3% in quarter four to 2% in quarter one. Further analysis by ethnicity is provided in appendix B.

This quarter 'White British' remains the most frequently identified ethnicity associated with in-hospital mortality, accounting for 64% of deaths occurring during Q1 2025/26. It is noted that 42% of 'White British' people make up the resident population for the London Borough of Hillingdon. 'Asian – or Asian British Indian' was again recognised as the second largest ethnic group in this quarter associated with in-hospital deaths, accounting for 11% of deaths and which aligns with the demographic composition of our local population.

As in the previous quarter the 'White British' group made up the highest number of referrals, 80% in quarter one and aligning with previous quarters.

In this quarterly period 50% of completed SJRs received with a CESDI 0 were for 'White British' deaths and 17% were for 'Asian – or Asian British Indian' aligning with the demographic

composition of the population. The two CESDI 1 graded cases were for individuals of ‘‘Asian – or Asian British Indian’ and ‘Mixed – White and Asian’ ethnicity.

We will include community deaths for the next report using data over the last 12-month period which will allow for some comparison of in-hospital deaths against community deaths for the groups.

### 3.3. Perinatal Mortality Review Tool (PMRT)

The Perinatal Mortality Review Tool (PMRT) is a national mandatory monitoring and assurance dataset developed by MBRRACE-UK. It is used to collect very detailed information about the care mothers and babies have received throughout pregnancy, birth and afterwards. The purpose of the PMRT is to support hospital learning from deaths by providing a standardised and structured review process. The PMRT is designed to support the review of:

- All late fetal losses (22 weeks + 0 days to 23 weeks + 6 days).
- All antepartum and intrapartum stillbirths.
- All neonatal deaths from birth at 22 weeks + 0 days to 28 days after birth.

During quarter one:

- There were five stillbirths and one late fetal loss (reporting only).
- Out of the five stillbirths, one case was a mother who was referred to the Emergency Gynaecology Assessment Unit (EGAU) by the GP with abdominal pain and found to have suffered a stillbirth at 25+2 weeks. One case was a mother who booked late at 27 weeks with a complex history and who delivered out of hospital two weeks later.
- The crude stillbirth rate is 5.51 per 1000 births which is an improvement from the previous year and indicates a positive trajectory.
- There were two expected neonatal deaths and one early neonatal death.
- There was one termination of pregnancy for congenital abnormalities in quarter one 2025/26 which required reporting to MBRRACE only.

**Challenges:**

- Although aspirin risk factors are undertaken at the patient’s booking appointment this is not always correctly completed. There is an ongoing working group to discuss the variations between the assessments and understanding of aspirin risk which will support the process moving forward.
- At booking the midwife needs to refer to the WHO birthweight centile charts to ascertain whether the patient’s previous baby was above or below the 10$^{th}$ centile. This is still an ongoing action as the correct WHO birthweight centile chart on Cerner has not yet been updated
- There are issues surrounding missed postnatal investigations being taken and also incorrect information being documented when sending placental histology.

- Language needs are still not always being identified and captured at the time of booking.

**Improvements made:**

- An audit has been completed by the bereavement midwife looking at the use of partogram which is a labour monitoring tool during labour for stillbirths. This was presented at the labour ward forum to disseminate the learning from it and actions identified.

**Recommendations:**

- Following a recurring theme of either missed or incorrect IUFD investigations being sent, bereavement champions are being implemented on the labour ward from September 2025.
- The bereavement midwife will also be carrying out targeted training.
- The consistent lack of the bereavement checklist on Cerner being used will be raised at the Maternity Governance Group.

### 3.4. Child Death Overview Panel (CDOP)

During quarter one there were five deaths in children under the age of 18 years reported, all were either stillborn or died within the neonatal period.

The two neonatal deaths were in babies with life limiting illnesses, and both had early palliative care involvement.

**Challenges:**

One stillbirth occurred in a 29/40 born out of hospital to a mother with significant antenatal social concerns. It was noted that there could have been improved documentation regarding any counselling given regarding risks of maternal drug use in pregnancy.

**Improvements:**

Recent teaching event for Emergency Department Senior Doctors procedures was well received.

**Recommendations:**

To continue to be aware of and to document social concerns and their specific risk to the unborn child; and to include details on the Child Death Notification Form.

### 3.5. Learning Disabilities Mortality Review (LeDeR)

From January 2022, LeDeR reports have included death of autistic people without a learning disability. In response to this change and following stakeholder engagement, the new name for the LeDeR programme is ’Learning from Life and Death Reviews – people with a learning disability and autistic people’.

The Trust report one death to LeDeR in Q1.

| Month of death | SJR review status | Specialty | CESDI grade |
|---|---|---|---|
| June | Closed | Care of the Elderly | CESDI 0 |

*Table 4: LeDeR cases reported from April – June 2025*

The LeDeR programme seeks to coordinate, collate and share information about the deaths of people with learning disabilities and autistic people so that common themes, learning points and recommendations can be identified and taken forward at both local and national levels. The Trust is committed to ensuring deaths of patients with known / pre-diagnosed learning disabilities and / or autism are reported to the LeDeR programme and reviewed accordingly.

## 4. Areas of focus

### 4.1. Cerner EPR

Although there is still a discrepancy with some of the data being captured by the Digital Services Team which is caused by Cerner workflows around deaths not being followed, recent data received has shown a consistent improvement in the number of discrepancies identified. Issues identified around deaths and being monitored are:

- Patients are not discharged off Cerner – These patients are then not counted towards deaths dataset.
- Patients are discharged with an incorrect discharge method (should always be 4-died or 5-stillbirth). These patients are then not considered as deaths/stillbirths.
- Patients not discharged on the day that they died (the date of death is different to the discharge date). Some of these deaths are reported in different month/week, based on their discharge date.
- Confirmation of death form is not always recorded.

We need to ensure our mortality data accurately reflects the correct figures. A weekly mortality data quality report, which includes each of the issues identified, highlighted patients and areas is continuing to be sent to the Divisional Directors and Chief Nurse Information Officer for dissemination to the affected areas. We need to continue to ensure that there are processes in place within the divisions to ensure that feedback is given to the appropriate teams to make sure that the teams strive for improvement.

### 4.2. Monitoring of compliance, learning and actions

As outlined in previous reports the Trust does not have a digital platform for mortality. We are currently waiting for the InPhase system to be implemented across the APC which will support with monitoring compliance, triangulation of data and learning from incidents, audits and complaints and mortality for us all. This will support with improving the completion of SJRs, monitoring and evidencing the learning that is identified as part of the Structured Judgement Review.

### 4.3. Morbidity & Mortality

There is evidence that specialty Morbidity & Mortality (M&M) meetings are being held regularly in a number of specialties with Care of the Elderly establishing a new M&M meeting in March 2025. There is divisional ask within Unplanned Care that all specialties now undertake M&M meetings as part of their normal governance processes which Respiratory are now also in the process of establishing. A dedicated Cerner list has been created for them to support this.

Work will continue with the specialty M&M meetings to ensure that outcomes and learning from the meetings are captured to accurately reflect actions and improvements required. Outcomes and learning from the M&M meetings will be included in the divisional exception reports presented to the Mortality Surveillance Group for overview and assurance.

### 4.4. Mortality Leads

As previously reported there remains vacant posts for a mortality lead in Medicine and Surgery.

## 5. Conclusion

The Trust's mortality review programme provides a standardised approach to case reviews designed to improve understanding and learning about problems and processes in healthcare associated with mortality, and also to share best practice.

The outcome of the Trust's mortality surveillance programme continues to be a rich source of learning that is supporting the organisation's safety improvement objectives.

The Trust is committed to better understanding the distribution of mortality according to the breakdown of our patient demographics (Appendix 2) and ensure that we tackle any health inequalities that we identify in doing so.

## 6. Glossary

a. **Medical Examiners** are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.
b. **Structured Judgement Review (SJR)** is a clinical judgement based review method with a standard format. SJR reviewers provide a score on the quality of care

provided through all applicable phases of care and will also identify any learning. The SJR will be completed within seven days of referral.

c. **Structured judgement reviewers** are responsible for conducting objective case note reviews of identified cases. They will seek, when required, specialist input and advice from clinical colleagues, including members of the multi-disciplinary teams to ensure high quality, comprehensive review is undertaken, using the full range of medical records available to them.
d. **Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.
e. **Child Death Overview Panel (CDOP)** is an independent review aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.
f. **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

**Learning Disabilities Mortality Review (LeDeR)** is a review of all deaths of patients with a learning disability. The Trust reports these deaths to the Local integrated care boards (ICBs) who are responsible for carrying out LeDeR reviews. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

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**Date:** 04/07/2025

**List of appendices**

Appendix 1 – Performance Scorecard

Appendix 2 – Ethnicity

Appendix 3 – Flow Chart referral to LeDeR

## Appendix 1 – Performance Scorecard

| | Q2 | Q3 | Q4 | Q1 | Comments | National LfD minimum requirement? |
|---|---|---|---|---|---|---|
| **Summary data** | | | | | | |
| Total no. deaths (adult and children, including neonatal and excluding stillbirths) | 164 | 204 | 210 | 148 | Inpatient deaths only | |
| Total no. adult deaths | 162 | 201 | 209 | 145 | Inpatients over 18 years age | Y |
| No. adult deaths per 1,000 non-elective bed days | TBC | TBC | TBC | TBC | | |
| Total no. child deaths | 1 | 3 | 0 | 0 | Inpatients over 28 days and less than 18 year only | |
| Total no. neonatal deaths | 1 | 0 | 1 | 3 | Inpatients livebirths under 28 days of age | |
| Total no. stillbirths | 3 | 5 | 2 | 5 | Inpatient not live births | |
| **Review summary** | | | | | | |
| Deaths reviewed by Medical Examiner | 164 | 204 | 210 | 148 | | |
| % Deaths reviewed by Medical Examiner | 100% | 100% | 100% | 100% | % of total deaths | % of row 1 |
| Deaths referred for Level 2 review | 17 | 15 | 23 | 10 | | |
| % Deaths referred for Level 2 review | 10% | 7% | 11% | 7% | % of total adult deaths | % of row 2 |
| Level 2 reviews completed | 17 | 14 | 21 | 6 | | |
| % Level 2 reviews completed | 100% | 93% | 91% | 60% | % of total referrals this quarter | Y |
| Total Deaths Reviewed Through the LeDeR Methodology | 1 | 2 | 3 | 1 | | |
| **Level 2 referral reason breakdown** | | | | | | |
| Requests made by a Medical Examiner | (9) 50% | (6) 40% | (6) 23% | (1) 10% | % of total referrals | |
| Concerns raised by family / carers | (3) 17% | (5) 33% | (17) 65% | (6) 60% | % of total referrals | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Patients with learning disabilities | (1) 6% | (2) 13% | (3) 12% | (1) (10%) | % of total referrals | |
| Patients with severe mental health issues | (2) 11% | (3) 20% | (4) 15% | (2) 20% | % of total referrals | |
| Unexpected deaths | (1) 6% | (1) 7% | (0) 0% | (2) 20% | % of total referral | |
| Elective admission deaths | (1) 6% | (0) 0% | (0) 0% | (0) 0% | % of total referrals | |
| Requests made by speciality mortality leads / through local Mortality and Morbidity review processes | (1) 6% | (0) 0% | (0) 0% | (0) 0% | % of total referrals | |
| Service or diagnosis alarms as agreed by APC mortality surveillance group | (0) 0% | (0) 0% | (0) 0% | (0) 0% | % of total referrals | |
| Random selection of deaths for SJR review | (3) 17% | (0) 0% | (0) 0% | (0) 0% | | |
| **Level 2 review outcomes** | | | | | | |
| CESDI 0 - No suboptimal care | 9 | 8 | 19 | 6 | % of cases reviewed | Total Figure |
| CESDI 1 - Some sub optimal care which did not affect the outcome | 7 | 5 | 2 | 0 | % of cases reviewed | Total Figure |
| CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) | 1 | 1 | 0 | 0 | % of cases reviewed | |
| CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) | 0 | 0 | 0 | 0 | % of cases reviewed | Y |
| **SHMI and HSMR** | | | | | | |
| SHMI 12-month rolling | | | | | Provided by Telestra Health UK | |
| HSMR 12-month rolling | | | | | Provided by Telestra Health UK | |
| Palliative Care SHMI 12-month rolling | | | | | Provided by Telestra Health UK | |
| Palliative Care HSMR 12-month rolling | | | | | Provided by Telestra Health UK | |

## Appendix 2 – Ethnicity

| | | 2024/25 | | | 2025/26 | 2024/25 | | | 2025/26 |
|---|---|---|---|---|---|---|---|---|---|
| | **Total** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** |
| **Asian - Any Other Asian Background** | 40 | 11 | 13 | 10 | 6 | 6.71% | 6.47% | 4.74% | 4.14% |
| **Asian or Asian British - Bangladeshi** | 3 | 0 | 1 | 1 | 1 | 0.00% | 0.50% | 0.47% | 0.69% |
| **Asian or Asian British - Indian** | 86 | 27 | 19 | 24 | 16 | 16.46% | 9.45% | 11.37% | 11.03% |
| **Asian or Asian British - Pakistani** | 12 | 1 | 4 | 4 | 3 | 0.61% | 1.99% | 1.90% | 2.07% |
| **Black - Any Other Black Background** | 2 | 0 | 0 | 2 | 0 | 0.00% | 0.00% | 0.95% | 0.00% |
| **Black or Black British - African** | 11 | 2 | 1 | 2 | 6 | 1.22% | 0.50% | 0.95% | 4.14% |
| **Black or Black British - Caribbean** | 7 | 1 | 3 | 3 | 0 | 0.61% | 1.49% | 1.42% | 0.00% |
| **Mixed - Any Other Mixed Background** | 3 | 1 | 1 | 1 | 0 | 0.61% | 0.50% | 0.47% | 0.00% |
| **Mixed - White and Asian** | 2 | 1 | 1 | 0 | 0 | 0.61% | 0.50% | 0.00% | 0.00% |
| **Mixed - White and Black African** | 3 | 1 | 2 | 0 | 0 | 0.61% | 0.99% | 0.00% | 0.00% |
| **Mixed - White and Black Caribbean** | 2 | 1 | 1 | 0 | 0 | 0.61% | 0.50% | 0.00% | 0.00% |
| **Other - Any Other Ethnic Group** | 25 | 3 | 11 | 6 | 5 | 1.83% | 5.47% | 2.84% | 3.45% |
| **Other - Chinese** | 1 | 0 | 0 | 0 | 1 | 0.00% | 0.00% | 0.00% | 0.69% |
| **Other - Not Known** | 31 | 3 | 19 | 6 | 3 | 1.83% | 9.45% | 2.84% | 2.07% |
| **Other - Not Stated** | 0 | 0 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| **White - Any Other White Background** | 67 | 35 | 3 | 20 | 9 | 22.56% | 1.49% | 10.43% | 6.20% |
| **White - British** | 415 | 75 | 121 | 126 | 93 | 45.73% | 60.20% | 59.72% | 64.14% |
| **White - Irish** | 7 | 0 | 1 | 4 | 2 | 0.00% | 0.50% | 1.90% | 1.38% |
| **Total** | 717 | 162 | 201 | 209 | 145 | 100.00% | 100.00% | 100.00% | 100.00% |

**APPENDIX 3 – Flow Chart referral to LeDeR**