



**North West London
Acute Provider Collaborative**

NORTH WEST LONDON ACUTE
PROVIDER COLLABORATIVE BOARD IN
COMMON - PUBLIC



NORTH WEST LONDON ACUTE PROVIDER COLLABORATIVE BOARD IN COMMON - PUBLIC

 21 October 2025

 11:00 GMT+1 Europe/London

 The Oak Suite, W12 Conference Centre, Hammersmith Hospital



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**North West London Acute Provider Collaborative
Board in Common - Public
Tuesday 21 October 2025, 11:00 – 13:30
The Oak Suite, W12 Conference Centre, Hammersmith Hospital**

Members of the public are welcome to join this meeting in person or by Microsoft Teams, via the following link: [Click here to join the meeting](#) (please do not join on any previous meeting teams links) The Chair will invite questions at the end of the meeting. It would help us to provide a full answer if you could forward your questions in advance to lnwh-tr.trustsecretary@nhs.net but this is not a requirement, you can ask new questions on the day. Any questions that are submitted in writing but due to time are not addressed in the meeting will be answered in writing on the Acute Provider Collaborative website.

A G E N D A

Time	Item No.	Title of Agenda Item	Lead	Enc
11:00	1.0	Welcome and Apologies for Absence	Chair in Common Matthew Swindells	Verbal
	1.1	Declarations of Interest	Matthew Swindells	Verbal
	1.2	Minutes of the previous NWL Acute Provider Collaborative Board Meeting held on 15 July 2025	Matthew Swindells	1.2
	1.3	Matters Arising and Action Log	Matthew Swindells	1.3
11:05	1.4	Patient Story: Interpreting Services	Michelle Dixon	1.4
2. Report from the Chair in Common				
11:20	2.1	Report from the Chair in Common <i>To note the report</i>	Matthew Swindells	2.1
	2.2	Board in Common Cabinet Summary <i>To note any items discussed at the Board in Common Cabinet meetings</i>	Matthew Swindells	2.2
3. Decision Making and Approvals				
11:30	3.1	Provider Capability Assessments <i>To approve the Provider Capability Assessments for the four Trusts</i> <i>For BiC members, individual Trust reports can be found in the TeamEngine Reading Room. For members of the public these can be found in the appendix document on the NWL APC website</i>	Peter Jenkinson	3.1
4. Discussion Items				
11:40	4.1	National Oversight Framework <i>To discuss the National Oversight Framework</i>	Peter Jenkinson	4.1

5. Integrated Quality and Performance Report				
-	5.0	Integrated Quality, Workforce, Performance and Finance Report <i>To note the revised integrated performance report</i>		5.0
5.1 Quality				
11:50	5.1.1	Quality – Integrated Quality and Performance Report (anything by exception)	Pippa Nightingale	5.0
	5.1.2	Learning from Deaths Quarter 1 Report <i>To note the report</i> <i>For BiC members, individual Trust reports can be found in the TeamEngine Reading Room. For members of the public these can be found in the appendix document on the NWL APC website</i>	Jon Baker	5.1.2
	5.1.3	Collaborative Quality Committee Chair Report <i>To note the report</i>	Matthew Swindells	5.1.3
5.2 People				
12:10	5.2.1	People – Integrated Quality and Performance Report (anything by exception) <i>To receive the report</i>	Pippa Nightingale	5.0
	5.2.2	Collaborative People Committee Chair Report <i>To note the report</i>	David Moss	5.2.2
5.3 Finance and Performance				
12:25	5.3.1	Finance and Performance – Integrated Quality and Performance Report (anything by exception) <ul style="list-style-type: none"> • Emergency • Elective • Cancer • Diagnostics 	Lesley Watts	5.0
	5.3.2	Financial Performance Report <i>To receive the financial performance report</i>	Bimal Patel	5.3.2
	5.3.3	Winter Plans <i>To note final winter plans</i>	James Walters	5.3.3
	5.3.4	Collaborative Finance and Performance Committee Chair Report <i>To note the report</i>	Carolyn Downs	5.3.4
6. Data and Digital				
12:45	6.1	Collaborative Data and Digital Committee Report <i>To note the report</i>	Matthew Swindells	6.1
7. Estates and Sustainability				

12:50	7.1	Collaborative Strategic Estates, Infrastructure and Sustainability Committee Report <i>To note the report</i>	David Moss	7.1
8. Chief Executive Officers				
12:55	8.1	Acute Provider Collaborative Executive Management Board (EMB) Summary <i>To note any items discussed at the APC EMB meetings</i>	Tim Orchard	8.1
	8.2	Reports from the Chief Executive Officers and Trust Standing Committees <i>To note the reports</i> <ul style="list-style-type: none"> • London North West University Healthcare NHS Trust • The Hillingdon Hospitals NHS Foundation Trust • Imperial College Healthcare NHS Trust • Chelsea and Westminster Hospital NHS Foundation Trust 	Pippa Nightingale Lesley Watts Tim Orchard	8.2
9. Reports for Information Only				
	9.1	None		
10. Any Other Business				
13:15	10.1	Nil Advised		
11. Questions from Members of the Public				
13:20	11.1	The Chair will initially take one question per person and come back to people who have more than one question when everyone has had a chance, if time allows.	Matthew Swindells	Verbal
Close of the Meeting				
Date and Time of the Next Meeting				
20 January 2026, 09:30 – 12:00 W12, Hammersmith Hospital				
Representatives of the press and other members of the public will be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admissions to Meetings) Act 1960)				

1. WELCOME AND APOLOGIES FOR ABSENCE

● Information Item

👤 Matthew Swindells

🕒 11.00

1.1 DECLARATIONS OF INTEREST

● Information Item

👤 Matthew Swindells

1.2 MINUTES OF THE PREVIOUS NWL APC PUBLIC BOARD MEETING HELD

ON 15 JULY 2025

 Decision Item

 Matthew Swindells

REFERENCES

Only PDFs are attached

 01.2 BiC PUBLIC Minutes 15 July 2025 DRAFT.pdf

North West London Acute Provider Collaborative Board in Common

Meeting in Public

Tuesday 15 July 2025, 09:30-12:30

The Oak Suite, W12 Conferences Centre, Hammersmith Hospital

Members Present

Mr Matthew Swindells	Chair in Common
Mr Robert Alexander	Vice Chair (ICHT) & Non-Executive Director (LNWH)
Mrs Carolyn Downs CB	Vice Chair (THHFT) and Non-Executive Director (CWFT)
Mr David Moss	Vice Chair (LNWH) & Non-Executive Director (ICHT)
Mr Nick Gash	Non-Executive Director (ICHT & THHFT)
Ms Vineeta Manchanda	Non-Executive Director (CWFT & THHFT)
Mr Simon Morris	Non-Executive Director (THHFT & LNWH)
Ms Sim Scavazza	Non-Executive Director (ICHT & LNWH)
Mr Mike O'Donnell	Non-Executive Director (CWFT & THHFT)
Dame Helen Stephenson	Non-Executive Director (CWFT & ICHT)
Mr Loy Lobo	Non-Executive Director (LNWH & ICHT)
Mr Martin Lupton	Non-Executive Director (LNWH & THHFT)
Professor Tim Orchard	Chief Executive Officer (ICHT)
Ms Pippa Nightingale	Chief Executive Officer (LNWH)
Ms Lesley Watts CBE	Chief Executive Officer (CWFT & THHFT)
Dr Roger Chinn	Chief Medical Officer (CWFT)
Mr Bimal Patel	Chief Financial Officer (LNWH)
Mr James Walters	Chief Operating Officer (LNWH)

Members present via Teams

Ms Patricia Gallan	Vice Chair (CWFT) & Non-Executive Director (THHFT)
Ms Linda Burke	Non-Executive Director (THHFT & ICHT)
Mr Ajay Mehta	Non-Executive Director (CWFT & LNWH)
Dr Syed Mohinnudin	Non-Executive Director (LNWH & CWFT)
Ms Catherine Williamson	Non-Executive Director (ICHT & CWFT)
Ms Sarah Burton	Chief Nursing Officer (THHFT)
Mr Robert Bleasdale	Chief Nursing Officer (CWFT)
Mr Simon Crawford	Deputy Chief Executive (LNWH)
Ms Virginia Massaro	Chief Financial Officer (CWFT & THHFT)
Ms Jazz Thind	Chief Financial Officer (ICHT)
Mr Raymond Anakwe	Medical Director (ICHT)
Professor Julian Redhead	Chief Medical Officer (ICHT)
Mr Ian Bateman	Chief Operating Officer (ICHT)
Mr Jason Seez	Chief Infrastructure & Redevelopment Officer (THHFT & CWFT)

In Attendance

Mr Kevin Croft	Chief People Officer (ICHT, CWFT & THHFT)
Mr Peter Jenkinson	Director of Corporate Governance (ICHT, CWFT and THHFT)
Ms Alexia Pipe	Chief of Staff to the Chair (APC)
Mrs Dawn Clift	Director of Corporate Affairs (LNWH)

Ms Tracey Beck

Director of Communications (LNWH)

Present via Teams

Ms Tracey Connage

Ms Emer Delaney

Ms Laura Bewick

Chief People Officer (LNWH)

Director of Communications (CWFT)

Hospital Director & Deputy Chief Operating Officer (CWFT)

Apologies for Absence

Ms Baljit Ubhey

Professor Janice Sigsworth

Mr Aman Dalvi

Dr Alan McGlennan

Dr Jon Baker

Ms Lisa Knight

Non-Executive Director (LNWH & THHFT)

Chief Nursing Officer (ICHT)

Non-Executive Director (CWFT & ICHT)

Managing Director / Chief Medical Officer (THHFT)

Chief Medical Officer (LNWH)

Chief Nursing Officer (LNWH)

Minute Ref		Action
1.0 1.0.1	<p>Welcome and Apologies for Absence</p> <p>Matthew Swindells (MS), the Chair, welcomed everyone to the meeting and advised the meeting was being recorded and would be published online.</p> <p>The Chair noted the apologies as above and informed the Board that the Care Quality Commission (CQC) was onsite at London North West University Healthcare NHS Trust (LNWH) Emergency Departments that day to undertake an unannounced inspection.</p>	
1.1 1.1.1	<p>Declarations of Interest</p> <p>There were no declarations of interest in addition to those published on the NWL APC website.</p>	
1.2 1.2.1	<p>Minutes of the Meeting held on 29 April 2025.</p> <p>The minutes from the meeting held on 29 April 2025 were approved as an accurate record.</p>	
1.3 1.3.1	<p>Matters Arising and Action Log</p> <p>The updates to the action log were noted.</p>	
1.4 1.4.1 1.4.2	<p>Staff Story: Advanced Care Practitioner</p> <p>The Board viewed a film on the role of Advanced Care Practitioners (ACPs), specifically at Chelsea and Westminster NHS Foundation Trust (CWFT), who played a vital role in patient safety, diagnostics and managing long-term conditions, as well as improving flow and supporting early discharge through the hospital.</p> <p>The Board heard that ACPs were registered professionals (nurses, physiotherapists, occupational therapists) with prescribing rights and professional registration, and would benefit from a more consistent, cross professional approach across the patch. A North West London ACP Group had been established to ensure that the collaborative was following the national framework for advanced practice and the maturity matrix for ACPs.</p>	

1.4.3	The discussion highlighted the need to align ACP workforce planning with the NHS 10 Year Plan and upcoming workforce plans from NHS England. It was emphasised that tailoring workforce models to the specific needs of each community was also important, using strategic planning to ensure the right mix of roles and skills.	
1.4.4	Resolution: The Board in Common acknowledged the positive impact of ACPs as an essential part of the workforce. The Board supported the ongoing strategic work development and integration of this cohort of staff.	
2.	Report from the Chair in Common	
2.1	Report from the Chair in Common	
2.1.1	The Chair congratulated the four Trusts for the achievement of good segmentation scores for the new NHS Oversight Framework 2025/26 and reported that CWFT and Imperial College Healthcare NHS Trust (ICHT) had achieved segment 1, London North West University Healthcare NHS Trust (LNWH) had achieved segment 2, and THHFT had achieved segment 3.	
2.1.2	Other highlights included: <ul style="list-style-type: none"> • The Hillingdon Hospitals NHS Foundation Trust (THHFT) CQC inspection report had been published and showed improvements but also identified areas for development • Assurance had been given to the NHS England (NHS E) Regional Director that the annual Fit and Proper Persons Test of the Directors on the Boards forming the APC had been undertaken and had been found to be compliant. • Teams from across the collaborative had been shortlisted for the Health Service Digital Awards and CWFT had won the Digital Clinical Safety Award for Artificial Intelligence (AI) powered dermatology. • Robert (Bob) Alexander was congratulated for receiving an OBE in the Kings Honours • Ian Bateman was welcomed as Interim Chief Operating Officer at ICHT. 	
2.1.6	Resolution: The Board in Common noted the report.	
2.2	Board in Common Cabinet Summary	
2.2.1	The Chair provided a summary of discussions held at the Board in Common (BiC) Cabinet meetings held on 15 May 2025 and 11 June 2025. The Board discussed the growing role of technology in delivering hospital-level care at home and anticipated further expansion of virtual wards in the future.	
2.2.2	Resolution: The Board in Common noted the report.	
3.	Decision Making and Approvals	
3.1	Future of Minor Injuries Provision across The Hillingdon Hospitals NHS Foundation Trust (THHFT)	
3.1.1	Lesley Watts presented – for the consideration of the THHFT Board – the proposal for the future of minor injuries provision at THHFT. The THHFT Trust Standing Committee had scrutinised the plans in detail and made a	

<p>3.1.2</p> <p>3.1.3</p> <p>3.1.4</p>	<p>recommendation to the BiC to approve the proposal to consolidate the services into a single, clinically robust and financially sustainable model.</p> <p>The proposal focussed on making the best use of scarce expert staff, ensuring financial sustainability, and improving access for underserved populations. Under twos would have 24 hour access to services at the Hillingdon Urgent Treatment Centre (UTC) which was not currently available at the Mount Vernon Hospital.</p> <p>In respect of workforce implications, it was noted that no redundancies were anticipated. The Board welcomed the extensive engagement that had been undertaken with staff, patients, residents, political leaders, and Healthwatch.</p> <p>Resolution: The Board of THHFT: a) Approved the closure of the Mount Vernon Urgent Care Nurse Practitioner Service; b) Supported the transition of staff to the Hillingdon UTC; and c) Endorsed the implementation of a single-site urgent care model that would be clinically sustainable, financially viable, and aligned with Trust and system-wide priorities.</p>	
<p>4.</p>	<p>Integrated Quality, Workforce, Performance and Finance Report</p>	
<p>4.0</p> <p>4.0.1</p> <p>4.0.2</p>	<p>Integrated Quality, Workforce, Performance and Finance Report</p> <p>Tim Orchard introduced the evolving Integrated Quality and Performance Dashboard, which was being developed to align with national data and oversight metrics. The Board welcomed the new approach and the inclusion of set targets. It was suggested that those metrics without set targets should be assigned a clear figure once the measurement was agreed.</p> <p>Updates on the sections within the report were provided under the relative agenda items (see below).</p>	
<p>4.1</p>	<p>Quality</p>	
<p>4.1.1</p> <p>4.1.1.1</p> <p>4.1.1.2</p> <p>4.1.1.4</p>	<p>Quality – Integrated Quality and Performance Report (anything by exception)</p> <p>Pippa Nightingale presented the quality section of the IQPR. Positive patient experience metrics were reported across the APC with 97% of metrics meeting targets.</p> <p>Maternity reporting was moving to a rolling 12 month position to give a more accurate reflection of performance. The APC Quality Committee had commissioned a review across the four trusts on stillbirth rates, neonatal deaths, and hypoxic injuries, for which terms of reference were in development. The NWL system was reporting below the national average for the crude stillbirth rate (the only system in London to do so) which was credited to the targeted work in communities with higher stillbirth rates that had helped to address language barriers and access.</p> <p>Resolution: The Board in Common noted the update.</p>	
<p>4.1.2</p>	<p>Learning from Deaths Quarter 4 Report</p>	

4.1.2.1	Roger Chinn presented the Quarter 4 report and confirmed that mortality ratios (HSMR and SHMI) remained better than expected across all four trusts, although there had been a fluctuation in data from a change in methodology for HSMR. The Board heard that there were robust scrutiny processes in place with the medical examiner process now covering all deaths.	
4.1.2.2	In response to a question about the reliability and meaningfulness of mortality data, it was explained that the different criteria of HSMR and SHMI provided reassurance around any inconsistencies in coding. In addition, internal learning from deaths processes allowed for detailed review of diagnostic bundles and themes.	
4.1.2.3	Resolution: The Board in Common noted the report.	
4.1.3	Clinical Pathways Programme Update	
4.1.3.1	Good progress had been made in Phase 1 with implementation plans in place for 27 out of the 28 pathways. An event was scheduled on 15 July 2025 to bring together operational and clinical leads to share learning on Phase 1 of the programme and plan for the next phase.	
4.1.3.2	The Board noted the importance of operational and clinical collaboration, standardising data collection, and enabling clinicians to work in a more mobile way across the collaborative. There was concern about the agility and interoperability of digital systems across the patch and capacity in Business Intelligence and IT teams to support the work.	
4.1.3.3	There was agreement that it would be beneficial to take a more targeted approach for Phase 2 by focusing on fewer pathways.	
4.1.3.4	Action: To present the terms of reference for Phase 2 of the Clinical Pathways Programme to the Board in Common meeting in October 2025 for approval.	PJ / JBL
4.1.3.5	Resolution: The Board in Common noted the report.	
4.1.4	Collaborative Quality Committee Chair Report	
4.1.4.1	The Board received the report. It was highlighted that the Committee had commenced a deep dive on mental health to improve care for patients with mental health issues and address pressures in Emergency Departments.	
4.1.4.2	Resolution: The Board in Common noted the report.	
4.2	People	
4.2.1	People – Integrated Quality and Performance Report (anything by exception)	
4.2.1.1	Kevin Croft presented the report and confirmed that the People Committee had oversight of the planned resident doctors' strike.	
4.2.1.2	The Board discussed Equality, Diversity and Inclusion (EDI) and what was being done to deliver the required outcomes. An expectation had been issued for staff at all levels of the organisation to agree a specific EDI objective as part of their PDR. Work was underway to embed the process and establish how to demonstrate improved EDI.	

4.1.2.3	Resolution: The Board in Common noted the update.	
4.2.2 4.2.2.1 4.2.2.2 4.2.2.3	<p>Collaborative People Committee Chair Report</p> <p>David Moss presented the report and highlighted the need to prioritise the development of a dashboard to support EDI delivery.</p> <p>The Board heard that there had been good progress made on reducing reliance on bank and agency staff, however there was work to do to align people, finance and operational teams to understand the impact of these reductions.</p> <p>Resolution: The Board in Common noted the report.</p>	
4.3	Finance and Performance	
4.3.1 4.3.1.1	<p>Finance and Performance – Integrated Quality and Performance Report (anything by exception)</p> <p>The Board noted continued progress across key areas of performance:</p> <ul style="list-style-type: none"> • Elective: Laura Bewick reported that Referral To Treatment (RTT) performance had improved at 57.6% with a target of at least 60% by year-end. A slight increase in 52 week waits was being managed through improvement plans. The Board noted the focus on maximizing available capacity for urgent and long-waiting patients, increasing patient-initiated follow-up, and improving theatre productivity. The Elective Recovery Fund (ERF) cap limited additional elective activity, so efforts were focused on using existing resources efficiently. • Diagnostics: Ian Bateman highlighted significant challenges with diagnostics performance at 24.2% against a 5% target. Issues included reliance on the ERF, staffing, and old MRI equipment causing downtime. Recovery plans were underway and a deep dive into community diagnostic centre capacity was being conducted. • Cancer: James Walters noted that the Faster Diagnosis Standard (FDS) had been exceeded, and 62-day performance remained above the national ask at 77.2%, against a target of 85%. Capacity, especially in breast and urology, remained a challenge and additional resilience funding was being used to support these pathways. • Urgent and Emergency Care: Emergency performance had slightly worsened, which was attributed to higher activity, but Hillingdon showed notable improvement. The aim was to maximize summer activity to prepare for winter, however there had been an impact on performance from the extreme hot weather experienced in the last weeks. Long waits had improved, although capacity constraints had persisted at all sites, especially for mental health patients. Discharge improvement and collaboration with system partners were ongoing priorities. <p>Resolution: The Board in Common noted the report and that operational improvements were occurring despite the challenges discussed.</p>	

<p>4.3.2 4.3.2.1</p>	<p>Financial Performance Report Bimal Patel introduced the item reporting an £11.7m deficit at the end of May 2025, against a deficit plan of £4.4m. All four trusts in the collaborative were adverse to plan, predominantly driven by the requirement to phase Cost Improvement Plans (CIPs) in equal twelfths across the year. In respect of elective activity, there was an over performance of £5.2m against the ERF which had been capped for 2025/26. The cash position had improved for the collaborative at £295.1m, which was an increase of £34.1m since the end of March 2025, however the cash balance for LNWH remained a significant challenge. The Board noted that the sector as a whole was one of the only in London to breakeven, however if actual activity exceeded the ERF cap, costs must be reduced accordingly to maintain financial balance.</p> <p>Resolution: The Board in Common noted the report.</p>	
<p>4.3.3 4.3.3.1 4.3.3.2</p>	<p>Collaborative Finance and Performance Committee Chair Report Carolyn Downs presented her report and encouraged Board Members to read the appended Productivity Report which could help to inform the prioritisation of future clinical pathways work.</p> <p>Resolution: The Board in Common noted the report and agreed that the consolidated productivity and efficiency report was a valuable resource and should be routinely included in future finance updates.</p> <p>Action: To include the productivity and efficiency report as part of financial reporting in future.</p>	<p>BP</p>
<p>5.</p>	<p>Data and Digital</p>	
<p>5.1 5.1.1 5.1.2 5.1.3</p>	<p>Collaborative Digital and Data Committee Report The Chair presented the Digital and Data Committee report, noting two key areas for the Board's attention: the need to align with national solutions for communications and advice/guidance services to GPs, and the associated risk of requiring extended licenses for current tools while awaiting NHS England's delivery of new systems.</p> <p>Overall, it was reported that progress on digital initiatives was positive, with ongoing efforts to address technical challenges and ensure effective data integration across the collaborative.</p> <p>Resolution: The Board in Common noted the report.</p>	
<p>6.</p>	<p>Estates and Sustainability</p>	
<p>6.1 6.1.1 6.1.2</p>	<p>Collaborative Strategic Estates, Infrastructure and Sustainability Committee Report Robert (Bob) Alexander presented the item and highlighted three main areas: improved benchmarking of estate performance across the four trusts, progress in explaining variations, and the establishment of a baseline for further analysis.</p>	

6.1.3	<p>The Board heard that the collaborative estates work plan was in development and focused on areas that could deliver hard cost avoidance or real cash savings.</p> <p>Resolution: The Board in Common noted the report.</p>	
7.	Chief Executive Officers	
7.1	<p>Acute Provider Collaborative Executive Management Board (EMB) Summary</p> <p>7.1.1 Tim Orchard provided an update on recent EMB activities, noting progress in coordinating self-starting groups across the collaborative, including a focused discussion on robotic surgery to ensure a sector-wide, coordinated approach and potential procurement advantages.</p> <p>7.1.2 An update was given on ophthalmology, with ongoing discussions involving Moorfields Eye Hospital NHS Foundation Trust and the regional director regarding a London single point of access for ophthalmology services.</p> <p>7.1.3 Virginia Massaro was thanked for revitalising the Corporate Transformation Board, which was identifying opportunities for consolidation and digitisation of corporate functions, with Kevin Croft leading efforts to improve and digitise HR processes.</p> <p>7.1.4 Resolution: The Board in Common noted the report.</p>	
7.2	<p>Reports from the Chief Executive Officers and Trust Standing Committees</p> <p>7.2.1 <u>London North West University Healthcare NHS Trust (LNWH)</u> <i>Presenter: Pippa Nightingale</i> <ul style="list-style-type: none"> • On track to identify and deliver its efficiency plans. • Redesigning the clinical model for Accident & Emergency, including piloting a new discharge-ready ward model. • New Green Plan launched and £5.8m secured for decarbonisation at Ealing Hospital. • Received recognition the work on the Equity Index. • All three sites had achieved JAG (Joint Advisory Group on Gastrointestinal Endoscopy) Accreditation. • Actions underway in response to a national letter received regarding the maternity and neonatal review. <p>Standing Committee Update: The Board in Common noted the report.</p> <p>7.2.2 <u>The Hillingdon Hospitals NHS Foundation Trust (THHFT)</u> <i>Presenter: Lesley Watts (with comments from CD)</i> <ul style="list-style-type: none"> • Significant improvements in A&E performance. • Successful staff recognition events. • Voted as best acute trust in the country for food. • Achieved Gold Standard Award for the National Joint Registry. <p>Standing Committee Update: Received an update on the work on RTT performance recovery and the opening of new day surgery unit. The Board in Common noted the report.</p> </p></p>	

7.2.3	<p><u>Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)</u> <i>Presenter: Lesley Watts</i></p> <ul style="list-style-type: none"> • Ongoing work to improve RTT performance due to a high elective target. • Progress made in recovering diagnostic performance. • Research, Innovation and Quality Improvement Event held to show case significant innovative work. <p>Standing Committee Update: The Board in Common noted the report.</p> <p><u>Imperial College Healthcare NHS Trust (ICHT)</u> <i>Presenter: TO (with comments from BA)</i></p>	
7.2.4	<ul style="list-style-type: none"> • Good performance against key quality measures, including long waits and RTT. • 38% reduction in “failure to rescue” incidents. • Reviewing all dashboard metrics to ensure they are sentinel and meaningful. • Leadership changes included Claire Hook’s departure, and Ian Lush stepping down as Chief Executive of the Imperial Health Charity. Gail Scott Spicer had been appointed as his successor. <p>Standing Committee Update: A fire incident on 1 May 2025 had resulted in an enforcement notice from the London Fire Brigade. Immediate actions had been completed and the Trust was confident that it would meet all the required actions ahead of the deadline. It was noted that assurance statements would be sought from all Trusts and reported to the Collaborative Strategic Estates, Infrastructure and Sustainability Committee. The Board in Common noted the report.</p>	
8.	Reports for Information Only	
8.1	None	
9.	Any Other Business	
9.1	<p>The potential consolidation of Integrated Care Boards (ICBs) across London was discussed with concerns about the implications of merging with other ICBs, particularly the risk that North West London, currently underfunded, could lose out if funding was averaged with overfunded areas. The importance of maintaining strong representation for the local population was emphasised. Local authorities had agreed to redistribute funding across London, with significant changes expected for some boroughs, such as Hounslow. The Board in Common agreed that this was a significant issue that would require further discussion over the coming months.</p>	
10.	Questions from Members of the Public	
10.1	<p>Question Summary: Gaynor Lloyd asked about the use of Ambient Scribe pilots, focusing on patient consent, clinician responsibility, and the Cerner system freeze.</p> <p>Response Summary: Tim Orchard explained that Cerner freezes were periods when system changes could not be made due to updates. It was confirmed that any AI or scribe tool must meet safety and consent</p>	

<p>10.2</p> <p>10.3</p> <p>10.4</p>	<p>requirements, with clinicians retaining responsibility for the clinical record. Pilots were tightly controlled and required patient consent.</p> <p>Question Summary: Robin Sharp inquired about the plans for hospital redevelopments across St Mary’s, Hammersmith and Charing Cross hospitals and whether delays were due to local or national issues. Response Summary: Tim Orchard clarified that Westminster City Council was very supportive of the plans for redevelopment at St Mary’s, and the main challenge was securing funding for large hospital projects within national capital constraints. Work was ongoing to secure planning consent and explore alternative funding models.</p> <p>Question Summary: Linda Hirst asked if the Mount Vernon unit could return to an open-door minor injury service, noting reduced capacity since moving to appointment-only. Response Summary: Leslie Watts responded that the decision to maintain appointment-only access was made by the NWL ICB aligning with the 10-year plan’s focus on consolidating acute services and ensuring sustainable, equitable care. The decision considered staff and community feedback.</p> <p>Additional written questions from the public were acknowledged, with a commitment to provide written responses and post them with the meeting minutes.</p>	
	<p>The Chair drew the meeting to a close and thanked the Board in Common and members of public for joining.</p>	

1.3 MATTERS ARISING AND ACTION LOG

● Information Item

👤 Matthew Swindells

REFERENCES

Only PDFs are attached

 01.3 BiC - Action Log Public.pdf

North West London Acute Provider Collaborative

Board in Common (public) Action Log

Matters Arising and Action Log

Status: For noting

Meeting Date: 15 July 2025

Lead Responsibility and Paper Author: Matthew Swindells

Purpose

1. This paper provides the North West London Acute Provider Collaborative Board in Common (public) with the progress made on actions from the last meeting along with any other actions which are outstanding from previous meetings. This paper also identifies those actions which have been completed and closed since we last met.

Part 1: Actions from Previous Meetings Remaining Open

	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
5.2.3 (21/01/25)	Collaborative Safeguarding Annual Report 2023/24	To standardise the safeguarding reports across all four Trusts.	Janice Sigworth	We have had discussions about how we further align the services & reports with safeguarding leads. The safeguarding teams already share good practice & policies and have an informal network.	Further discussion between ICB CNO and ICHT CNO planned for the end of October where a

	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
				<p>We recommended before further work was undertaken we would await the outcome of the statutory & mandatory training review (which reported in March 25) and changes to the ICB role & function. The ICB play a key role in safeguarding assurance.</p> <p>The ICB CNO is undertaking a review to ensure statutory & regulatory responsibilities are discharged whilst removing duplication and streamlining processes. The APC is supporting this review which should be completed by the Autumn. We will then further align our safeguarding services to meet the needs of the new model.</p>	finalised date will be agreed.
4.1.3.4 (15/07/25)	Clinical Pathways Programme Update	To present the terms of reference for Phase 2 of the Clinical Pathways Programme to the Board in Common meeting in October 2025 for approval.	Peter Jenkinson / James Biggin-Lamming	The programme was discussed at the APC EMB meeting on 9 October 2025 at which it was agreed that planning for Phase 2 would	Oct 2025 Jan 2026

	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
				commence, with the medical directors, chief nurses and chief operating officers to meet to consider the approach. It is likely that Phase 2 will be a blended approach including continuation of pathways selected by joint specialties and services selected by the APC as being services strategically important to delivery of improved care for the population. The aim will be for Phase 2 to start in 2026/27, so we will present proposals at the next meeting (January 2026).	

Part 2: Actions previously outstanding but now completed

	Subject Matter	Action	Lead	Progress Updates, Notes	Date of Completion
1.1	Declaration of interests	To annotate the register to reflect that directors at LNWH and THHFT are automatically trustees of the charity, ensuring this interest is accurately declared and the register remains complete. To publish the register of interest on the collaborative website.	PJ PJ	Completed Completed	July 2025 July 2025
4.1.9 (15/10/24)	IQPR	The Board asked for a further focus on where the APC is performing well, where there is improvement required, where there is variation – so the focus should be on exceptions and where attention and action is needed rather than all of the detail covered in committee and other meetings.	TO	IQPR was on the agenda and was picked up in the meeting. To note the IQPR is currently under review to align with the 2025/26 business planning priorities from NHSE.	July 2025
4.3.3.2 (15/07/25)	Financial Reporting	To include the productivity and efficiency report as part of financial reporting in future.	Bimal Patel	The productivity and efficiency report is a standing item for the APC Finance and Performance Committee and escalated via its highlight report to the Board-in-Common.	Oct 2025

1.4 PATIENT STORY: INTERPRETING SERVICES

● Discussion Item

👤 Michelle Dixon

🕒 11:05

REFERENCES

Only PDFs are attached

 01.4 BIC Interpreting staff and patient story October 2025.pdf

NWL Acute Provider Collaborative Board in Common (Public)

21/10/2025

Item number: 1.4

This report is: Public

Staff and patient story

Author: Lorraine Brown
Job title: Interpreting improvement programme manager and Head of PALS

Accountable director: Michelle Dixon
Job title: Director of engagement and experience

Purpose of report

Purpose: Information or for noting only

Report history

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

Committee name	Committee name	Committee name
Click or tap to enter a date. What was the outcome?	Click or tap to enter a date. What was the outcome?	Click or tap to enter a date. What was the outcome?

Executive summary and key messages

Interpreting was one of the first areas for improvement identified through engagement with our local communities, catalysed by the pandemic and then developed as a formal programme. There was a clear message that patients who can't understand spoken English well often feel unwelcome and unsupported in our hospitals. We commissioned an external review of our interpreting provision which also highlighted safety risks and a range of inefficiencies. This led to an organisational improvement programme and in, January 2024, we appointed a manager to lead transformation as well as to manage and improve our current services.

The programme manager is supported by a steering group including two lay partners and a patient safety partner with lived experience. There are three key workstreams:

- stabilising and improving current professional interpreting service provision
- empowering staff to make professional interpreting more accessible through better information, training and guidance and ensuring patients and local communities know what they should be able to expect and how to access interpreting

- co-designing future services with patients, staff and partners, including re-specifying and tendering for external supplier(s) and/or establishing in-house provision.

Developments so far include establishing new contractual terms and ways of working with our existing interpreting services supplier, overhauling information and guidance for staff, adding questions on interpreting to our Friends and Family Test and expanding interpreting options and support equipment, such as interpreting-only mobile phones. Interpreter birth plans have been introduced in maternity and work is underway to embed a digital version within Cerner. More recently, we have been drawing on guidance from NHS England to develop a risk-based framework for using AI and machine learning. Previous guidance had effectively ruled out its use due to issues of complexity, safety and lack of oversight but we are now encouraged to explore how it can supplement professional interpreting services in lower risk situations.

Our face-to face interpreting has increased by 14 per cent, and telephone interpreting by 27 per cent since January 2024, and regular monitoring and oversight of our external supplier has led to significant improvements in engagement, efficiency and responsiveness.

In a joint project with the Helix Centre, we have been gathering staff and patient insights about communications and engagement needs and how we can best meet them. As well as supporting our interpreting programme, this work is also helping to shape a related project to:

- systematically gather, coordinate and respond to patient communication preferences across all channels (starting with digital/print, Easy Read and large type, and ultimately all types of communications needs in line with the accessible information standard)
- create, store and manage high quality patient information content to be surfaced consistently across all relevant patient letters, leaflets and portals
- tailor 'customer care' support for groups with additional support needs.

We are also increasingly working in collaboration with APC and other partners. This includes our involvement in a current sector-wide project led for the APC by London North West University Healthcare to explore the potential of CardMedic, a digital language platform that provides pre-translated (and quality controlled) scripts for thousands of common clinical interactions as well as machine learning functionality.

In terms of the development of a comprehensive interpreting strategy, all of this work is pointing us towards a blended approach, drawing on multi-modal, professional interpreters (and potentially advocates), AI and machine learning apps as well as other types of communications aids, including better visual design. It is also making clear the importance of excellent cultural awareness amongst staff and investment in patient and community relationship building.

The short video we will play at the Board in Common focuses on a recent development in our interpreting services. It illustrates the overarching interpreting needs of patients and staff as well as specific needs in urgent and emergency care. We are currently trialling ten 'interpreter on

wheels' across our maternity services and A&E departments, providing instant, hands-free, video or telephone access to professional interpreters at the bedside.

Strategic priorities

Tick all that apply

- Achieve recovery of our elective care, emergency care, and diagnostic capacity
- Support the ICS's mission to address health inequalities
- Attract, retain, develop the best staff in the NHS
- Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
- Achieve a more rapid spread of innovation, research, and transformation

[Click to describe impact](#)

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

Tick all that apply

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

If other, explain why

2. REPORT FROM THE CHAIR IN COMMON

🕒 11:20

2.1 REPORT FROM THE CHAIR IN COMMON

● Information Item

👤 Matthew Swindells

REFERENCES

Only PDFs are attached

 02.1. Chairs Report NWL APC Public BiC 21 September 2025 final.pdf

NWL Acute Provider Collaborative Board in Common (Public)

21/10/2025

Item number: 2.1

This report is: Public

NWL Acute Collaborative Chairs Report

Author: Matthew Swindells

Job title: Chair in Common

Accountable director: Matthew Swindells

Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

The Board in Common is asked to note the report.

Report history

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

N/A

Executive summary and key messages

This report provides an update from the Chair in Common across the North West London Acute Provider Collaborative (APC).

Strategic priorities

Tick all that apply

- Achieve recovery of our elective care, emergency care, and diagnostic capacity
- Support the ICS's mission to address health inequalities
- Attract, retain, develop the best staff in the NHS
- Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
- Achieve a more rapid spread of innovation, research, and transformation

Click to describe impact

Chair's Report

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

Tick all that apply

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

If other, explain why

Equity and Inclusion

I wanted to start my report by recognising that over recent weeks and months, many of our colleagues have been subject to intimidation, abuse and even overt racism, as discussions around challenging issues such as immigration and national identity have become increasingly polarised.

Recently, the appalling terrorist attack on a synagogue in Manchester has also caused fear and grief among our Jewish communities, and I welcome the response from staff across the APC, which has been one of unity and support.

The NHS is brought to you by a culturally and ethnically diverse workforce representing 216 nationalities and with ethnic minority (global majority) staff making up half of hospital and community health services doctors and one third of nurses. We are determined to maintain a safe and supportive environment for our staff to work and our patients to be treated. We will not tolerate behaviour from anyone that threatens this.

These issues have been brought home to us recently in a powerful letter to the Observer from Ealing Hospital consultant surgeon Sala Abdalla, published in full on [LNWH's website](#), written in response to the growing tide of intolerance towards refugees in the UK, and reflecting her deep personal experiences as a child refugee fleeing political persecution in Sudan

It is a compelling reminder that the NHS has always thrived on the talent, compassion and commitment it has found both among those born here in the UK and among those have joined us from across the globe.

In north west London, we are proud to serve some of the most diverse communities in the country and continue our work to address health inequalities, with some initiatives recently recognised at national awards.

We are equally proud that colleagues across our four Trusts are so representative of these communities, and are conscious of our responsibilities to ensure that each of us has fair access to opportunities, a kind and respectful working environment, and full support when subjected to unacceptable language or behaviour.

We remain committed to equity and inclusion, and continue our work in partnership with patients and staff to make a fairer NHS for everyone.

North West London and North Central London Integrated Care Boards (ICBs) Merger

Last month Mike Bell was announced as the new Chair and Frances O'Callaghan as the Chief Executive Officer (CEO) for North West London and North Central London Integrated Care Boards (ICBs). Mike will Chair and Frances will lead both organisations and will eventually become the Chair and CEO of the newly merged ICB when it comes into effect in April 2026. On behalf of the Board we look forward to working with them on delivering on the 10-year plan and achieving better health outcomes for our population.

We welcome and look forward to working with Mike and Frances. One key area for partnership working will be the transition to 'fair share' financial allocations, NHSE's new approach to ensuring allocations reflect population need fairly and consistently and phase out 'ad hoc' support. North West London is currently significantly under its 'fair share' allocation and we are in discussions with NHS England's London Regional Office to ensure that the merger with North Central ICB does not stop the appropriate increase in funding

from coming to our local NHS.

National Oversight Framework (NOF)

As I outlined in my report at the last Board in Common (BiC), NHS England (NHSE) introduced a new National Oversight Framework (NOF) in June 2025 to promote consistent, transparent assessments of the performance of NHS organisations, and encourage improvement in areas prioritised by the national planning guidance. The first comparative scores were published for NHS Trusts in September 2025. Congratulations to Imperial for making it into category 1. There is a paper at today's meeting which provides the details on each Trusts position.

Digital transformation

The North West London Acute Provider Collaborative (NWL APC) is driving digital transformation to enhance patient care, operational efficiency, and health equity across our four Trusts. By addressing challenges such as financial constraints, legacy systems, and workforce skill gaps, the APC is aiming to implement agile strategies, strategic investments, and a robust data governance.

A key achievement is the successful implementation of a unified electronic patient record (EPR) system across 12 hospitals, enabling seamless real-time data sharing, improved clinical decisions, operational efficiency, and patient outcomes. Additionally, the APC prioritises patient empowerment through digital engagement, integrating tools like the NHS App to facilitate easy access to health information, appointments, and provider communication, fostering greater self-management and reducing health inequalities.

Complementing these achievements, the collaborative is at the NHS's work to develop a clinically safe federated data platform (FDP), leveraging cutting edge technology and building the foundations for the AI revolution. This transformative platform will facilitate intelligent orchestration of care pathways, providing multidisciplinary teams with actionable insights for coordinated, responsive, and personalised patient care. This not only ensures optimal resource utilisation but also consistently improves clinical and operational outcomes by enhancing interoperability across health and social care ecosystems.

The APC is seen as a leading innovator in digital transformation and we have hosted a number of visits over the last few months, especially looking at how we are utilising the FDP to support all our staff in how they deliver care. We welcomed the, then, Secretary of State for Science, Innovation and Technology, the Rt Hon Peter Kyle MP, to CWFT to showcase how we are using AI to enhance patient care and support our clinical teams. Also at CWFT, His Excellency Mansoor bin Ebrahim bin Saad Al Mahmoud, Minister of Public Health of Qatar visited to see first-hand the work the Trust is doing to deliver healthcare with the support of AI. LNWH hosted Penny Dash, Chair and several Non-Executive Directors (NEDs) at NHSE to again showcase the digital innovation happening at the Trust.

Board Change

Helen Stephenson, NED at ICHT and CWFT is sadly stepping down at the end of this calendar year and this BiC will be her last Board meeting. On behalf of the Board, I wanted to thank her for a contribution across the APC and especially as Chair of the Quality Committee at ICHT.

2.2 BOARD IN COMMON CABINET SUMMARY

● Information Item

👤 Matthew Swindells

REFERENCES

Only PDFs are attached

 02.2 BiC Cabinet Committee Summary 11 September 2025 Final.pdf

NWL Acute Provider Collaborative Board in Common (Public)

21/10/2025

Item number: 2.2

This report is: Public

Board in Common Cabinet - Summary

Author: Philippa Park
Job title: Executive Assistant to the Chair

Accountable director: Matthew Swindells
Job title: Chair in Common

Purpose of report

Purpose: Information or noting only

This paper provides an update on items discussed at the Board in Common Cabinet held on 11 September 2025. The August meeting was not convened due to no urgent business needing to be discussed

Report history

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

Board in Common Cabinet	Committee name	Committee name
11/09/2025	Click or tap to enter a date.	Click or tap to enter a date.
What was the outcome?	What was the outcome?	What was the outcome?

Executive summary and key messages

In line with the reporting responsibilities of the Board in Common Cabinet, as detailed in its Terms of Reference, a summary of the items discussed since the last meeting of the Board in Common is provided in this report.

The key items to note from the Board in Common Cabinet meeting held on 11 September 2025 were:

1. Winter Plans

The Cabinet reviewed the draft plans that were due for sign-off and submission to NHSE by 30 September. It was noted that other system partners' plans had not yet been shared and there would need to be assumptions in place that would address any gaps. The

Cabinet discussed the plans, noting it was important to consider the sensitivity to the plans to external factors or additional operational pressures. For assurance, it was considered worthwhile adding to the plans that, with the assumptions, the plans would be consistent with the resource allocation for the financial year. It was necessary to be comfortable locally and at the collaborative level. Consideration was also given to what might happen if the assumptions happened with all the plans failing at the same time. It was noted that flu vaccinations for staff would take place but not for the whole population. It might be necessary to look at the mitigations that were needed, noting the current very difficult flu season in Australia with high levels of admission that were occurring.

2. NHSE Planning Framework and 5-year plans

It was noted that the National Planning Guidance was due to be published in October, with the current submission deadline for plans in December. The Cabinet discussed how the Board in Common Development Session in November might be used to articulate for the Board what the National, Regional, and APC's responsibilities were. It was noted that the APC's requirement to work on the 5-year plan was urgent and it was important to be clear what work needed to be done in the next few months. It was further noted that it was important to have the whole Board's support on the formulation of the 5-year plans, ahead of submission by the end of December.

3. Acute Provider Collaborative Executive Management Board Update

The Cabinet received a brief update on the Acute Provider Collaborative Executive Management Board and noted the items discussed.

4. CEO Update

The Chief Executives briefed the Cabinet on significant areas and issues within their respective Trusts. This briefing included:

ICHT

- The Cabinet noted a recent never event. Noted immediate actions had been taken to ensure patient safety across the Trust and an incident investigation would follow to ensure lessons are identified and improvements made.

5. NWL and NCL ICB merger - allocations formula agreement

The Cabinet discussed the merger of the north west and north central ICBs, and potential risks to the APC, including current funding allocations. The cabinet noted that APC concerns had been discussed at the NWL ICB Board and that CEOs would continue to make the point that the separate allocation that would be provided in 2026/27 must continue to happen. It was also noted that specialised provisioning funding was underfunded in NWL and overfunded in NCL, and that this was a very real financial risk that would impact on the 5-year plan. It was recommended that written, confirmed assurance was sought about how this would be handled going forwards. The Cabinet were assured that all the CEOs from NWL would write a letter in this regard.

6. Finance Paper

The Cabinet discussed a finance paper prepared by the CFOs on estimated activity and income variance at Month 4. There was a detailed discussion on elective activity, income and over-performance. It was noted that by the time of the Collaborative Finance and Performance Committee and the Board meeting in October, there needed to be a clear narrative. If the APC had not delivered enough of its Cost Improvement Plans (CIPs) then this needed to be addressed, or the Board needed to know whether increased demand had been greater than had been set out at the start of the year.

7. Update on a Collaborative Approach to ensuring Fire Safety Compliance

The Cabinet received assurance that an update across the four Trusts, on where they were with their fire reviews and fire safety, was going to be presented to the APC Estates and Sustainability Collaborative Committee the following week. That response would form the basis for the assurance report back into Board in Common.

Strategic priorities

Tick all that apply

- Achieve recovery of our elective care, emergency care, and diagnostic capacity
- Support the ICS's mission to address health inequalities
- Attract, retain, develop the best staff in the NHS
- Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
- Achieve a more rapid spread of innovation, research, and transformation

Click to describe impact

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

Tick all that apply

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

If other, explain why

3. DECISION MAKING AND APPROVALS

🕒 11:30

3.1 PROVIDER CAPABILITY ASSESSMENTS

● Decision Item

👤 Peter Jenkinson

REFERENCES

Only PDFs are attached

-  03.1 Provider capability self-assessment cover sheet Board in Common October 2025 final.pdf
-  03.1a CWFT return Provider-capability-self-assessment.pdf
-  03.1b ICHT return Provider-capability-self-assessment.pdf
-  03.1c LNWH return Provider-capability-self-assessment.pdf
-  03.1d THHFT return Provider-capability-self-assessment.pdf

NWL Acute Provider Collaborative Board in Common (Public)

21/10/2025

Item number: 3.1

This report is: Public

Provider capability self-assessments

Author: Jessica Hargreaves
Job title: Deputy Director of Corporate Governance

Accountable directors: Peter Jenkinson & Dawn Clift
Job title: Director of Corporate Governance ICHT, CWFT, THHFT/Director of Corporate Affairs, LNWH

Purpose of report (for decision, discussion or noting)

Purpose: Decision or approval

Each of the four Trust Boards are asked to approve their Trust's Provider Capability self-assessment ahead of submission to NHS England on 22 October 2025.

Report history

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

Trust Standing Committees
October 2025
For discussion

Executive summary and key messages – linked to the section above, please update this to include key discussion points and actions agreed at previous meetings

In August 2025, NHS England (NHSE) introduced a new requirement for all providers to complete and submit a 'provider capability self-assessment' by the end of October 2025 as part of the refreshed national oversight framework. The template produced by NHSE is a high-level document, with a response of either 'Confirmed', 'Partially Confirmed' or 'Not Met' required against each of the criteria, which must be approved by each trust's board. A 'Not Met' response must be accompanied by actions to ensure any areas of non-compliance are addressed.

To support the Trust boards in agreeing the response to NHSE, a summary document including RAG rated assurance statements and a list of evidence was provided to each Trust's Standing Committee in October for review and consideration. These statements have all been reviewed and updated following the discussions held at the Trust Standing Committee's and are available in the reading room.

All four Trusts are each submitting a fully 'Confirmed' return against the six domain criteria contained within the high-level self-assessment:

- * Strategy, leadership and planning
- * Quality of care
- * People and culture
- * Access and delivery of services
- * Productivity and value for money
- * Financial performance and oversight

Each Trust Board is asked to review and approve the relevant self-assessment for onward submission to NHSE. Once approved, the relevant documents will be submitted by the Chair to NHSE.

References, including the template to be submitted can be found here:

- [NHS England Guidance for NHS trust boards](#)
- [NHS Providers - assessing provider capability – guidance for boards](#)

Impact assessment

- Equity
- Quality
- People (workforce, patients, families or careers)
- Operational performance
- Finance
- Communications and engagement

Strategic priorities

- 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 (IC)

Provider Capability - Self-Assessment Template

Chelsea and Westminster Hospital NHS Foundation Trust Board is satisfied that...

(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)

<p>Strategy, leadership and planning</p>	<p>The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSIE The board has the skills, capacity and experience to lead the organisation The trust is working effectively and collaboratively with its system partners and provider collaborators for the overall good of the systems and population served</p>	<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>
<p>Quality of care</p>	<p>Having had regard to relevant NHS England guidance supported by Care Quality Commission information, its case 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 Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board</p>	<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>
<p>People and Culture</p>	<p>Staff feedback is used to improve the quality of care provided by the trust Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels Staff can express concerns in an open and constructive environment</p>	<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>
<p>Access and delivery of services</p>	<p>There are in place to improve performance against the relevant access and waiting times standards The trust can identify and address inequalities in access/waiting times to NHS services across its patients Appropriate population health targets have been agreed with the ICB</p>	<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>
<p>Productivity and value for money</p>	<p>Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the helpful board and other guidance as relevant</p>	<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>
<p>Financial performance and oversight</p>	<p>The trust has a robust financial governance framework and appropriate contract management arrangements Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outlook</p>	<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>
<p>In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.</p>		<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>

Sign on behalf of the board of directors

Signature: _____

Name: _____

Date: _____

Provider Capability - Self-Assessment Template

The Imperial College Healthcare NHS Trust Board is satisfied that...		(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)	
Strategy, leadership and planning	<ul style="list-style-type: none"> The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSIE The board has the skills, capacity and experience to lead the organisation The trust is working effectively and collaboratively with its system partners and provider collaborators for the overall good of the systems and population served 	Confirmed	<p>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 NHSIE, as regulator, needs to know:</p>
Quality of care	<ul style="list-style-type: none"> Having had regard to relevant NHS England guidance (approved by Care Quality Commission) information, its case 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 Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board 	Confirmed	<p>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 NHSIE, as regulator, needs to know:</p>
People and Culture	<ul style="list-style-type: none"> Staff feedback is used to improve the quality of care provided by the trust Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels Staff can express concerns in an open and constructive environment 	Confirmed	<p>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 NHSIE, as regulator, needs to know:</p>
Access and delivery of services	<ul style="list-style-type: none"> There are in place to improve performance against the relevant access and waiting times standards The trust can identify and address inequalities in access/waiting times to NHS services across its patients Appropriate population health targets have been agreed with the ICB 	Confirmed	<p>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 NHSIE, as regulator, needs to know:</p>
Productivity and value for money	<ul style="list-style-type: none"> Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the helpful board and other guidance as relevant 	Confirmed	<p>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 NHSIE, as regulator, needs to know:</p>
Financial performance and oversight	<ul style="list-style-type: none"> The trust has a robust financial governance framework and appropriate contract management arrangements Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outlook 	Confirmed	<p>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 NHSIE, as regulator, needs to know:</p>
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			<p>Signed on behalf of the board of directors</p> <p>Signature</p> <p>Name</p> <p>Date</p>

Provider Capability - Self-Assessment Template

The London North West University Healthcare NHS Trust Board is satisfied that...

(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)

<p>Strategy, leadership and planning</p>	<p>The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSIE The board has the skills, capacity and experience to lead the organisation The trust is working effectively and collaboratively with its system partners and provider collaborators for the overall good of the systems and population served</p>	<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>
<p>Quality of care</p>	<p>Having had regard to relevant NHS England guidance supported by Care Quality Commission information, its case 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 Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board</p>	<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>
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Signed on behalf of the board of directors

Signature _____

Name _____

Date _____

Provider Capability - Self-Assessment Template

The Hillingdon Hospitals NHS Foundation Trust Board is satisfied that...

(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)

<p>Strategy, leadership and planning</p>	<p>The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSIE The board has the skills, capacity and experience to lead the organisation The trust is working effectively and collaboratively with its system partners and provider collaborators for the overall good of the systems and population served</p>	<p>Confirmed</p>	<p>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 NHSIE, as regulator, needs to know:</p>
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Sign on behalf of the board of directors

Signature: _____

Name: _____

Date: _____

4. DISCUSSION ITEMS

🕒 11:40

4.1 NATIONAL OVERSIGHT FRAMEWORK

● Discussion Item

👤 Peter Jenkinson

REFERENCES

Only PDFs are attached

 04.1a National Oversight Framework NOF Scores - Cover paper.pdf

 04.1b National Oversight Framework - APC NOF Rating briefing.pdf

NWL Acute Provider Collaborative Board in Common (Public)

21/10/2025

Item number: 4.1

This report is: Public

National Oversight Framework

Author: James Biggin-Lamming
 Job title: Director of Strategy and Transformation, LNWH

Accountable director: Tim Orchard
 Job title: CEO, Imperial College Healthcare and Chair of APC EMB

Purpose of report

Purpose: Discussion

Discuss the APC NOF ratings and actions to support future improvements

Report history

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

APC Exec Management Board	Committee name	Committee name
08/10/2025	Click or tap to enter a date.	Click or tap to enter a date.
What was the outcome?	What was the outcome?	What was the outcome?

Executive summary and key messages

The National Oversight Framework (NOF) was introduced in June 2025 to promote consistent, transparent assessments of the performance of NHS organisations, and encourage improvement in areas prioritised by the national planning guidance. The first comparative scores were published for NHS Trusts in September 2025

APC trusts were each rated in a different segment:

Trust	NOF Segment	Adjusted position	Organisational delivery score (and unadjusted position)
Imperial College	1	11 th (3 rd highest non-specialist trust)	1.82 (15 th)
LNWH	2	23 rd	2.21 (49 th)

Chelsea and Westminster	3	28 th	1.68 (<i>highest non-specialist trust</i>)
Hillingdon Hospitals	4	105 th	2.62

Compared to the NHS, the APC has relative strengths in our SHMI and implied productivity, but relative weaknesses in patients waiting over 18 weeks and 52 weeks from referral to treatment, patients waiting more than 12 hours in an emergency department, and infection control rates.

For APC trusts to have the best chance to all move into the top two segments:

- collaborative efforts are needed on improving these areas of relative weaknesses
- all trusts will need to maintain and/or return to their financial plan
- LNWH and THH also need to make improvements in other areas including faster diagnostic standard, higher proportion of emergency department patients admitted or discharged within 4-hours, and NHS staff survey scores on raising concerns.

Strategic priorities

Tick all that apply

- Achieve recovery of our elective care, emergency care, and diagnostic capacity
- Support the ICS's mission to address health inequalities
- Attract, retain, develop the best staff in the NHS
- Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
- Achieve a more rapid spread of innovation, research, and transformation

[Click to describe impact](#)

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

Tick all that apply

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

If other, explain why

NHS Oversight Framework (NOF): APC trust scores and next steps

APC Board – October 2025

What is the NOF and how is it scored?

- The National Oversight Framework (NOF) was introduced in June 2025 to promote consistent, transparent assessments of the performance of NHS organisations, and encourage improvement in areas prioritised by the national planning guidance. The first comparative scores were published for NHS Trusts in September 2025. They will be published quarterly.
- The NOF is made up of thirty scored metrics across five domains. Twenty-two of these metrics apply to the APC. Each metric is individually scored with a number from 1 (best performing) to 4 (worst performing). Details of the metrics and their individual scoring methodology can be found in the appendix. In general, scores are influenced by the relative ranking on a metric compared to all other trusts. This means that you must improve faster than other trusts to improve your score on any metric.
- An “organisational delivery score” is then calculated as the average across all metric scores to determine each trust’s segment from 1 (highest) to 5 (lowest). The closer a trusts average score is to 1 the higher its overall segment. Each unadjusted segment will have a roughly equal number of trusts. There is then a financial override so that any trusts in segment 1 or 2 are downgraded to segment 3 if they are either in receipt of deficit support funding, and/or has a planned annual deficit, and/or have a negative variance from its plan at this current point that could result in an annual deficit. This financial override exists to reflect national planning guidance that this year “achieving a financial reset is a priority”. In the APC, this downgrade impacted Chelsea and Westminster Hospital which moved from its unadjusted segment 1 to its final NOF 3 rating because its year-to-date variance from its financial plan triggered this financial override.
- The NOF assessment is a starting point on how NHSE will work with organisations. It will be complemented by a leadership capability self-assessment which is being approved by each trusts board. An organisations NOF score will inform its ability for extra freedoms, such as future FT-applications which will initially only be open to organisations from NOF 1 and NOF 2, or enforcement proceedings. This approach should also align with the CQC.
- This financial year is a transitional year focused on the 2025/26 operating plan and its supporting metrics. This means that different metrics could influence overall scoring in future financial years.
- Segmentation data will be reviewed at least quarterly, though it could be updated at any time based on emerging information.
- Further information on the methodology, and details of scoring is available:
 - **Publicly accessible including details of metric calculations:** <https://data.england.nhs.uk/dashboard/nofacute>
 - **Model Hospital for NHS staff:** either <https://model.nhs.uk/compartments/e8741099-bcfc-49b3-892c-a23e1c1ec567> or go via the Model Hospital main page, click “Browse” and then “NHS Oversight Framework” on the top left of the contents list. The information is the same as the publicly accessible website.
 - **Written guidance:** <https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/> and <https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26-methodology-manual/>

How did APC organisations score?

	CWFT	ICHT	LNWH	THH
Access to services domain score	1	1	2	3
Effectiveness and experience domain score	1	2	3	2
Patient safety domain score	2	2	3	4
People and workforce domain score	1	1	1	3
Finance and productivity domain score	1	1	1	2
Breakeven financial plan	No	Yes	Yes	No
Organisational delivery score	1.68	1.82	2.21	2.62
Unadjusted segment	1	1	2	4
Rank before adjustments	8 th <i>Highest non-specialist trust</i>	15 th <i>5th highest non-specialist trust</i>	49 th	105 th
Final NOF segment (after financial override)	3	1	2	4
Final published position out of 134	28 th	11 th <i>3rd highest non-specialist trust</i>	23 rd	105 th

What are our relative strengths and opportunities to align best practice?

Domain	APC has relative strength compared to NHS	Variation across APC	APC has relative weakness compared to NHS
Access to services <i>1 – LNWH and ICHT only</i>	<ul style="list-style-type: none"> Difference between planned and actual 18ww performance % patients waiting over 52 weeks – community¹ 	<ul style="list-style-type: none"> FDS – % patients with 4 week diagnosis Cancer – patients treated within 62 days ED < 4hours 	<ul style="list-style-type: none"> % patients waiting >18 weeks % patients waiting over 52 weeks - acute ED over 12 hours
Effectiveness and experience	<ul style="list-style-type: none"> SHMI 	<ul style="list-style-type: none"> CQC inpatient satisfaction survey Average number of days from discharge ready date to actual date 	
Patient safety		<ul style="list-style-type: none"> NHS Staff Survery - raising concerns sub score 	<ul style="list-style-type: none"> MRSA infections C-Diff infection rate E-Coli infection rate
People and workforce		<ul style="list-style-type: none"> Sickness absence rate NHS Staff Survey - Engagement theme sub-score 	
Finance and productivity	<ul style="list-style-type: none"> Planned surplus/deficit score Implied productivity level 	<ul style="list-style-type: none"> Combined finance score Variance year-to-date financial plan score 	

N.B. One metric not scored yet at any APC trust yet – CQC safety inspection

Where should APC trusts focus on improvements to give the best chance of being in the top two segments?

- Alongside reflecting high performance within an organisation, the advantage of being in the top two NOF segments are that these organisations will be the first eligible to apply for the refreshed Foundation Trust status announced in the NHS 10 Year Plan.
- It is impossible to forecast future Organisational Delivery Scores or future ranking with accuracy because:
 - Scores for many metrics depend on relative performance compared to other NHS organisations, whose performance will be changing
 - Overall segment placement depends on the ranking of Organisational Delivery Score (average of all metrics) relative to other NHS organisations, that will also be changing
- However, we can use the most recently published information to focus in on areas where APC organisations have greatest scope for further improvement. Metrics that have the greatest potential to change their score by a large amount and that are updated most frequently are underlined, as they will have the most significant impact on quarterly rankings. See the appendix for details.

Trust	Improvements anticipated to be required
APC wide	<ul style="list-style-type: none"> • Finance & Performance: <u>18 week Referral to Treatment time</u>, <u>patients waiting more than 52 weeks</u>, ED 12-hour waits, and <u>average number of days from discharge ready date to actual date</u> • Quality: Infection control (MRSA, E-Coli and C-Diff rates)
CWFT	<ul style="list-style-type: none"> • <u>Return to in-year financial plan</u>, which will most likely move trust automatically back to Segment 1 in line with its unadjusted segment position
ICHT	<ul style="list-style-type: none"> • <u>Maintain in-year financial plan</u>
LNWH	<ul style="list-style-type: none"> • <u>Maintain in-year financial plan</u> • Local improvements in FDS, ED<4 hours, CQC Inpatient Satisfaction Survey, and NHS staff survey raising concerns sub-score
THH	<ul style="list-style-type: none"> • <u>Return to in-year financial plan</u> • Local and/or APC mutual aid enabled improvements in FDS, % patients treated for cancer within 62 days, ED<4 hours, NHS staff survey – raising concerns and engagement scores

Appendix - How individual metric calculations get made

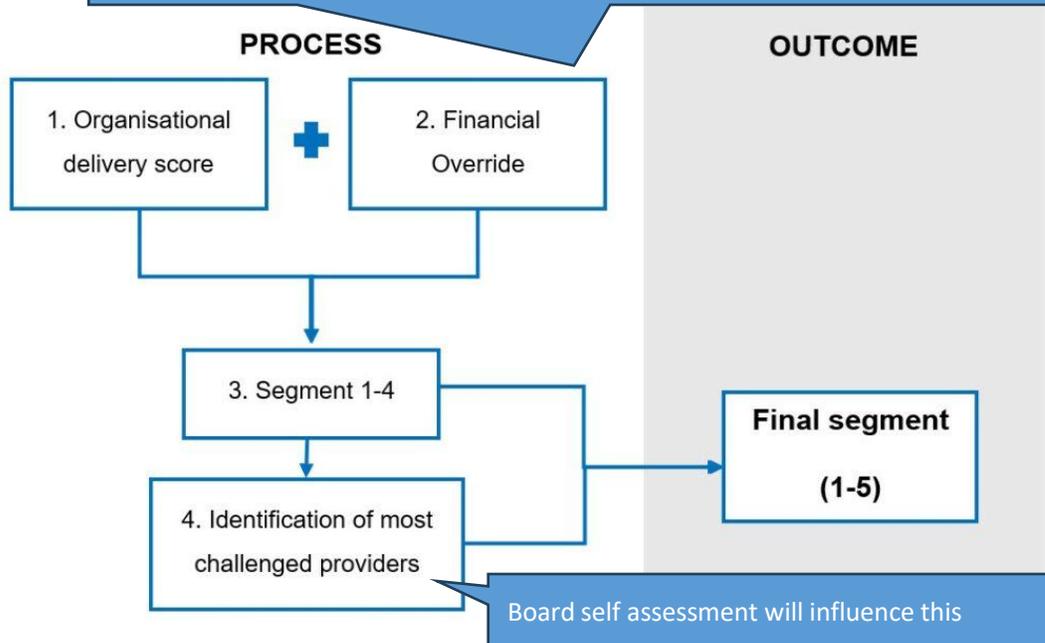
Scoring model	Method	Metric (scoring method if nuance)	Frequency score updated
Metric with performance standard	<ul style="list-style-type: none"> Hit standard = 1.00 Worst = 4.00 Rest ranked best to worst, from 2.01 to 3.99 	<ul style="list-style-type: none"> Difference between planned and actual 18-week weeks or less for elective treatment performance (0% or improved compared to plan = 1, then ranked) Percentage of cases where a patient is waiting more than 52 weeks for elective treatment ACUTE (<1% of PTL = 1, then ranked) Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks (>80% = 1, then ranked) Percentage of patients treated for cancer within 62 days of referral (>75% = 1, then ranked) Percentage of emergency department attendances admitted, transferred or discharged within 4 hours (>78% = 1, then ranked) MRSA (no MRSA = 1, then ranked on absolute number of cases) – 12 month rolling Rate of C.Diff (at or below threshold =1, then ranked) – 12 month rolling Rate of E.Coli ((at or below threshold =1, then ranked) 	<ul style="list-style-type: none"> Latest month in the period Latest month in the period Aggregated quarterly Aggregated quarterly Aggregated quarterly 12-month rolling 12-month rolling 12-month rolling
Metric required to improve from baseline	<ul style="list-style-type: none"> Fail to improve on baseline = 4.00 Best = 1.00 Rest ranked worst to best, from 3.99 to 1.01 	<i>N/A – none currently for acute trusts</i>	
No standard set	<ul style="list-style-type: none"> All ranked best to worst Best = 1.00 Worst = 4.00 Rest ranked from 1.01 to 3.99 	<ul style="list-style-type: none"> Percentage of cases where a patient is waiting 18 weeks or less for elective treatment Percentage of emergency department attendances spending over 12 hours in the department Average number of days from discharge ready date to actual discharge date (including zero days) – Latest month in period Implied productivity level NHS Staff Survey – Raising concerns sub-score NHS Staff Survey – Engagement theme score Percentage of cases where a patient is waiting more than 52 weeks for elective treatment COMMUNITY - <i>Currently only applicable to ICHT and LNWH</i> Sickness absence rate 	<ul style="list-style-type: none"> Latest month in the period Aggregated quarterly Latest month in the period In-year figure to latest month vs same period in previous year Annual Annual End of period Quarterly – aggregated monthly figures
Bespoke scoring tiers	<ul style="list-style-type: none"> Defined brackets 	<ul style="list-style-type: none"> CQC inpatient survey satisfaction rate (1 = better or much better; 2 = somewhat better or as expected; 3 = somewhat worse; 4 = much worse) Summary Hospital Level Mortality Indicator (1 = lower than expected;) CQC safe inspection within last 2-years (1=outstanding, 2 = good, 3 = RI, 4 = Inadequate, no score if no inspection within last 2 years) – <i>Not applied to any APC trust currently</i> Planned surplus/deficit (1 = 0% or surplus, 2 = <1% deficit, 3 = between 1-2% deficit, 4 = >2% deficit) Variance on year-to-date finance plan (1 = on plan or better, 2 = <0.5% variance; 3 = 0.5%-1% variance; 4 = >1% variance) Combined finance – combination of Planned Surplus/Deficit and Variance scores – see Methodology under https://model.nhs.uk/metrics/856c5689-6f85-46ea-a671-c6dc8389a2a7?domainId=65f6d25c-9f06-498e-8c36-ab8aa45f8078&compartmentId=e8741099-bcfc-49b3-892c-a23e1c1ec567 	<ul style="list-style-type: none"> Annual 12 month rolling Periodic inspection Annual plan Year to date Year to date

Appendix - How segments get decided

Before this flow chart:

- All metrics get an individual score
- Average score across organisation calculated for organisation (organisational delivery score)

1. Is organisation in receipt of deficit support funding (Y/N)? – *Automatic cap at Segment 3*
2. Does the organisation have a planned annual deficit (Y/N)? – *Automatic cap at Segment 3*
3. Does organisation have negative variance from plan at the current point? (Y/N) – *If Y then determined if variance would result in overall planned deficit and automatic cap at Segment 3*



Segment	Description
1	The organisation is consistently high-performing across all domains, delivering against plans.
2	The organisation has good performance across most domains. Specific issues exist.
3	The organisation and/or wider system are off-track in a range of domains or are in financial deficit.
4	The organisation is significantly off-track in a range of domains.
5	The organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve. or The organisation is a challenged provider where NHS England has identified significant concerns.

Appendix – Detailed APC trust metric scores

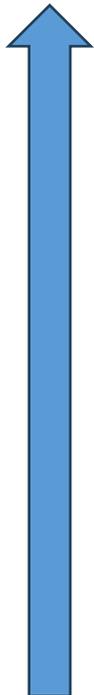
Domain	Metric	LNWH	CWFT	ICHT	THH	APC
Access to services	Adjusted NOF score	2	1	1	3	1.75
	Domain score	2.17	1.62	1.8	2.79	2.10
	% patients waiting <18 weeks	3.49	2.59	2.41	3.42	2.98
	Difference between planned and actual 18ww performance	1	1	1	2.17	1.29
	% patients waiting over 52 weeks - Acute	2.97	2.18	2.42	2.12	2.42
	% patients waiting over 52 weeks - Community	1		2.05		1.53
	FDS - % patients with 4 week diagnosis	2.52	1	1	3.62	2.04
	% patients treated within 62 days	1	2.02	2.38	2.82	2.06
	ED <4hours	2.14	1	1	2.34	1.62
	ED over 12 hours	3.21	1.52	2.13	3.02	2.47
Effectiveness and experience of care	Adjusted NOF score	3	1	2	2	2.00
	Domain score	2.45	1.78	1.97	1.91	2.03
	CQC inpatient survey satisfaction rate score	4	2	2	2	2.50
	SHMI	1	1	1	2	1.25
	Average number of days from discharge ready date to actual date	2.34	2.34	2.92	1.74	2.34
Patient safety	Adjusted NOF score	3	2	2	4	2.75
	Domain score	2.98	2.25	2.28	3.4	2.73
	NHS Staff Survey - raising concerns sub score	2.53	1.45	1.72	3.3	2.25
	MRSA infections	3.72	3.01	3.48	2.63	3.21
	C-Diff rate	2.99	3.78	2.4	3.95	3.28
	E-Coli rate	3.57	2.38	2.67	3.93	3.14
	Adjusted NOF score	1	1	1	3	1.50
People and workforce	Domain score	1.87	1.21	1.53	2.88	1.87
	Sickness absence rate score	1.68	1.06	1.5	2.49	1.68
	NHS Staff Survey - Engagement theme sub-score	2.06	1.36	1.56	3.28	2.07
	Adjusted NOF score	1	1	1	2	1.25
Finance and productivity	Domain score	1.63	1.65	1.51	2.05	1.71
	Combined finance score	1	2	1	3	1.75
	Planned surplus/deficit score	1	1	1	1	1.00
	Variance year-to-date to financial plan score	1	3	1	4	2.25
	Implied productivity level	2.26	1.29	2.02	1.09	1.67
Average metric score		2.21	1.68	1.82	2.62	Overall page 57 of 247

Appendix – ODS score sensitivity to individual metric moves

Though each metric has an equal weighting, the overall score will be most sensitive to these metrics as they are updated each time ODS is calculated and an organisation can move one or more integers in its metric score between periods based on its absolute performance

Scoring method:

Potential for larger score moves between periods



Independent scoring levels – whole integer point movements can happen independent of other NHS organisations

Definite top score – potential to move to score 1 independent of other NHS organisations by achieving target performance

Ranking only – score determined by position relative to others

<ul style="list-style-type: none"> CQC inpatient satisfaction survey CQC Safety Inspection 		<ul style="list-style-type: none"> Planned surplus/deficit score Combined finance score Variance year-to-date financial plan score
<ul style="list-style-type: none"> MRSA infections C-Diff infection rate E-Coli infection rate 	<ul style="list-style-type: none"> FDS – % patients with 4 week diagnosis Cancer – patients treated within 62 days ED < 4hours 	<ul style="list-style-type: none"> Difference between planned and actual 18ww performance % patients waiting over 52 weeks - acute % patients waiting over 52 weeks – community
<ul style="list-style-type: none"> SHMI NHS Staff Survey - raising concerns sub score NHS Staff Survey - Engagement theme sub-score 	<ul style="list-style-type: none"> ED over 12 hours Sickness absence rate 	<ul style="list-style-type: none"> % patients waiting >18 weeks Average number of days from discharge ready date to actual date Implied productivity level

Annual or 12-month rolling

Aggregated quarterly

Monthly or year to date

Frequency metric is updated: Greater potential for metric scores to change between NOF publication

5. INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

- Discussion Item

REFERENCES

Only PDFs are attached

 05.0a CS - Integrated Performance Report - Oct-25.pdf

 05.0b BIC Performance Report - August 2025.pdf

NWL Acute Provider Collaborative Board in Common (Public)

21/10/2025

Item number: 5

This report is: Public

Integrated Performance Report

Author: Mathew Towers
Job title: Deputy CIO – Business Intelligence, LNWH and THH

Accountable director: Professor Tim Orchard
Job title: CEO, ICHT

Purpose of report (for decision, discussion or noting)

Purpose: **Assurance**

The *Integrated Performance Report* has been reviewed in line with the NHS Operating Plan for 25/26 and APC priorities with feedback from Board members to ensure the scope of the report remains relevant and focused.

Report history

**NWL APC Executive
Management Board**
09/10/2025
Reviewed

Committee name
Click or tap to enter a date.
What was the outcome?

Committee name
Click or tap to enter a date.
What was the outcome?

Executive summary

The scope of KPIs for reporting to the Board in Common was finalised at BIC Cabinet on June 11th, 2025 and work is ongoing to add further indicators requested as definitions and data collection arrangements are being finalised. Three new metric pages were reviewed this month by the APC Executive Management Board for appropriateness and presentation. The status of these and the remaining metrics to developed have been updated in the Main Report section.

Additional work has been undertaken to create a summary view of the KPIs included in this report against the National Oversight Framework. The new summary page sets current performance against the most recently published quartile thresholds. The summary aims to provide an indicative forward view of the likely segmentation ranking, and for that month, the performance improvement needed to reach the next quartile.

Impact assessment

- Equity
- Quality
- People (workforce, patients, families or careers)
- Operational performance

- Finance
- Communications and engagement
- Council of governors

Strategic priorities

- 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)

Main Report

National Oversight Framework Summary Page

The National Oversight Framework (NOF) was introduced in June 2025 to promote consistent, transparent assessments of the performance of NHS organisations, and encourage improvement in areas prioritised by the national planning guidance.

Whilst the first comparative scores were published for NHS Trusts in September 2025, they relate to data no more recent than June 2025.

This summary in this IPR provides an indicative forward view of the likely segmentation result, and the performance improvement needed to reach the next quartile. As such this summary does not replicate the NOF metric scorings; its purpose is to highlight latest relative position with acute trusts nationally, acting as a prompt for further discussion. For each relevant IPR metric, it shows:

- Latest performance: The most recent actual performance figure as per the IPR
- National quartile position: Colour-coded boxes indicate the latest performance position within national quartile ranges. The top quartile, shaded dark green, is the best-performing 25% and the bottom quartile, shaded red, is the worst-performing 25%.
- Improvement to next quartile: Shows the improvement score, where needed, to move to the next best performing quartile. The table illustrates the colour of the 'target' quartile.
- Segmentation override (provided for information): Some metrics are adjusted in the NOF. Within the *Access to Services* domain, hitting a national target will place the Trust into the top segment.

The data shown in this proposal is aligned to the latest IPR where possible; there will be some work required to ensure alignment and presentation of the existing KPIs in the IPR with the NOF. The performance figures have been taken from the published Model Hospital view where further work is required.

Integrated Performance Report

August 2025 data

(Cancer, Maternity & Op Plan Performance = July 2025)

received by EMB and BIC October 2025

Performance Summary

Link to Slide	Section KPI	Expected	Actual	Improvement Trend	Assurance
---------------	---------------	----------	--------	-------------------	-----------

Section 1a: Performance - Elective Care

●	Referral to treatment waits < 18 weeks	≥60%	59.0%	▲	!
●	Referral to treatment waits > 52 weeks	</=1%	2.0%	▲	!
●	Inequity in Longest Waits for Treatment	95-105	106	○	○
●	Access to diagnostics > 6 Weeks	</=5%	24.4%	○	!
●	Access to Cancer Care (Faster Diagnosis) < 28 days	≥75%	79.7%	○	✓
●	Referral to Cancer Treatment Pathways < 62 days	≥85%	76.1%	▲	!

Section 1b: Performance - Emergency Care

●	Waits in urgent and emergency care < 4 hours	≥78%	77.0%	▲	!
●	Waits in urgent and emergency care > 12 hours	</=2%	4.1%	▼	!
●	Good experience reported for emergency depts.	≥74%	80.4%	○	✓
●	ED Patients with Mental Health conditions > 12 hours	<24%	29.4%	○	!

Section 1c: Performance - Maternity and Neonatal Care

●	Neonatal Crude Deaths (per 1,000 births)	<0.94	0.9	○	○
●	Crude still birth rate (per 1,000 births)	<3.3	3.1	○	○
●	Pre-Term births (per 1,000 births)	<8	6.8	○	○
●	Rate of suspected neonatal intrapartum brain injuries	<1.8	0.0	○	○
●	Good experience reported for maternity services	≥90%	89.5%	○	○

Section 2a: Finance

●	Financial Performance	-£5.3M	-£11.5	○	○
●	Temporary Staffing Expenditure	£22.9M	£21.0M	○	○

▲ ▼	Statistically significant improvement or deterioration in monitored trend
✓ !	Statistically likely or very unlikely to meets the desired level of performance

Link to Slide	Section KPI	Expected	Actual	Improvement Trend	Assurance
---------------	---------------	----------	--------	-------------------	-----------

Section 2b: Productivity and Flow

●	Ambulance handover waits < 15 minutes	≥65%	49.6%	○	!
●	Patient Initiated Follow Up	≥5%	4.0%	▲	!
●	Theatre Utilisation (Hrs)	≥85%	89.3%	○	○
●	Long Length of Stay for Emergency Patients	<78.4%	77.7%	○	○
●	Discharge Performance (no Criteria to Reside)	n/a	593	○	○

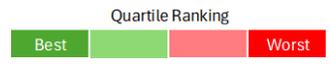
Section 3: Workforce

●	Sickness Absence Rate	≤4%	4.3%	▼	!
●	Voluntary Turnover Rate	≤12%	7.8%	▲	✓
●	Vacancy Rate	≤10%	7.2%	○	✓
●	Non-medical appraisals	≥95%	86.9%	▼	!
●	Core skills compliance	≥90%	92.6%	○	✓
●	Model Employer Goals	≥61%	41.9%	▼	!

Section 4: Statutory and Safety Reports

●	Healthcare associated c. Diff Infections (per 100,000 bed days)	n/a	19.43	○	○
●	Healthcare associated E. coli BSIs (per 100,000 bed days)	n/a	32.73	○	○
●	Healthcare associated MRSA BSI (per 100,000 bed days)	0	1.02	○	○
●	Pressure ulcers (per 1,000 bed days)		0.07	○	○
●	Inpatient falls (per 1,000 bed days)		0.09	○	○
●	VTE Risk Assessments Completed	≥95%	97.2%	○	✓
●	SHMI (as expected or better)	<100	4 / 4	○	○
●	Good experience reported by inpatients	≥94%	95.2%	○	✓

National Oversight Framework Summary



National Oversight Framework	Direction	Source	NOF Assessment period	Segmentation override	Latest Performance Assumed Quartile				Inferred improvement needed to next quartile			
					CW	ICH	LNW	THH	CW	ICH	LNW	THH
Access to Services Elective Care												
Referral to treatment waits < 18 weeks	Higher is better	Local analysis	Latest month in period		60.0%	60.70%	58.0%	55.0%	0.7%	0.0%	2.7%	1.9%
Variance from 18 week performance plan	Higher is better	Model Hospital	Latest month in period	On plan or better	1.27%	3.02%	2.25%	-0.10%	1.8%	0.03%	0.8%	1.0%
Referral to treatment waits > 52 weeks	Lower is better	Local analysis	Latest month in period	< 1%	1.80%	1.50%	2.40%	2.80%	0.5%	0.2%	1.1%	0.4%
Referral to treatment waits > 52 weeks (community)	Lower is better	Model Hospital	Latest month in period		n/a	0.18%	0.0%	n/a		0.2%		
Access to Services Cancer Care												
Access to Cancer Care (Faster Diagnosis) < 28 days	Higher is better	Local analysis	Quarterly aggregate	>80%	80.7%	80.8%	81.4%	71.60%				5.3%
Referral to Cancer Treatment Pathways < 62 days	Higher is better	Local analysis	Quarterly aggregate	>75%	76.20%	71.00%	83.6%	72.30%		0.1%		2.7%
Access to Services Urgent and Emergency Care												
Waits in urgent and emergency care < 4 hours	Higher is better	Local analysis	Quarterly aggregate	>78%	76.8%	76.1%	75.7%	81.8%	1.2%	1.9%	2.3%	
Waits in urgent and emergency care > 12 hours	Lower is better	Local analysis	Quarterly aggregate		2.3%	4.0%	6.7%	2.0%			2.6%	
Effectiveness and experience of care Patient Experience												
CQC inpatient survey satisfaction rate score	Higher is better	Annual survey	Annual									
SHMI	Lower is better	NHS Digital	Twelve-month rolling		Lower	Lower	Lower	As Expected				
Effectiveness and experience of care Effective flow and discharge												
Discharge Performance (average days)	Lower is better	Model Hospital	Latest month in period		0.7	0.9	0.7	0.5	0.2	0.2	0.2	-0.1
Patient Safety												
NHS Staff survey - raising concerns sub-score	Higher is better	Annual survey	Annual		6.70	6.61	6.42	6.22				
Healthcare associated c. Diff Infections v threshold	Lower is better	Model Hospital	Twelve-month rolling	On plan or better	1.61	1.11	1.25	2.08	0.25	0.04	0.02	0.72
Healthcare associated E. coli BSIs v threshold	Lower is better	Model Hospital	Twelve-month rolling	On plan or better	1.07	1.12	1.35	1.67	0.02	0.07	0.03	0.35
Healthcare associated MRSA BSI	Zero tolerance	Model Hospital	Twelve-month rolling		4	6	8	3	0.50	0.50	2.50	1.50
People and workforce Retention and Culture												
Sickness Absence Rate	Lower is better	Local analysis	Quarterly aggregate		3.8%	4.3%	4.4%	5.2%				0.4%
NHS Staff Survey engagement	Higher is better	Annual survey	Annual		7.17	7.11	6.95	6.70				
Finance and productivity Finance												
Planned surplus/deficit	Higher is better	Model Hospital	Annual plan		0.0%	0.0%	0.0%	0.0%				
Variance to YTD plan	Higher is better	Model Hospital	Year-to-date		-0.83	0	0	-1.43				
Finance and productivity Productivity												
Implied productivity level	Higher is better	Model Hospital	Latest month in period		6.6%	4.1%	3.4%	10.6%				

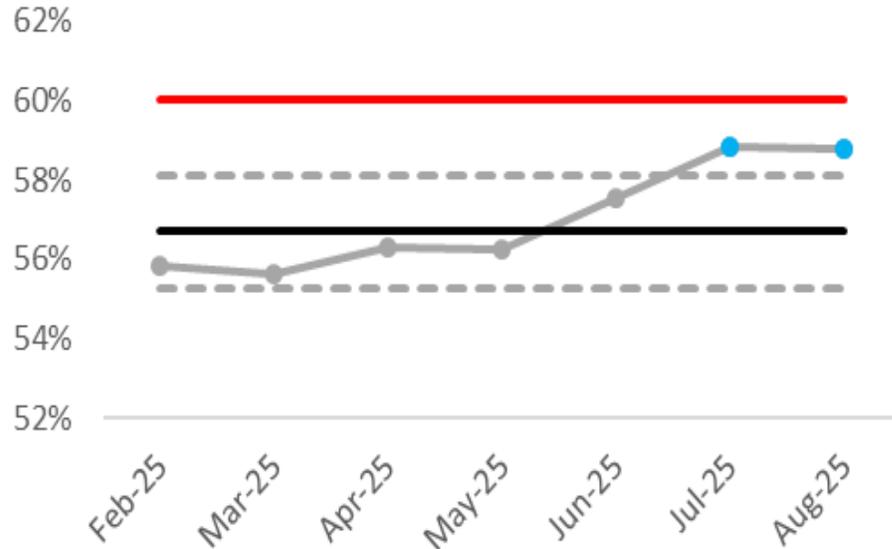
Section 1a: Performance Elective Care

August 2025, except Cancer service metrics July 2025

Referral to Treatment Waits

TREND

Wait for treatment: % < 18 week standard



60%

STANDARD

59.0%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Performance against the 18-week target remained stable in Aug, with the APC achieving the target for 59%. Compliance against RTT standards is being monitored through at sector level and Trusts continue to address factors impacting long waits for patients. THH remains the lowest performing trust in the sector and has robust improvement plans.

Recovery plan: Each Trust has a comprehensive action plan to improve RTT performance and maintain safe levels of care.

Improvements: There has been a gradual improvement in performance.

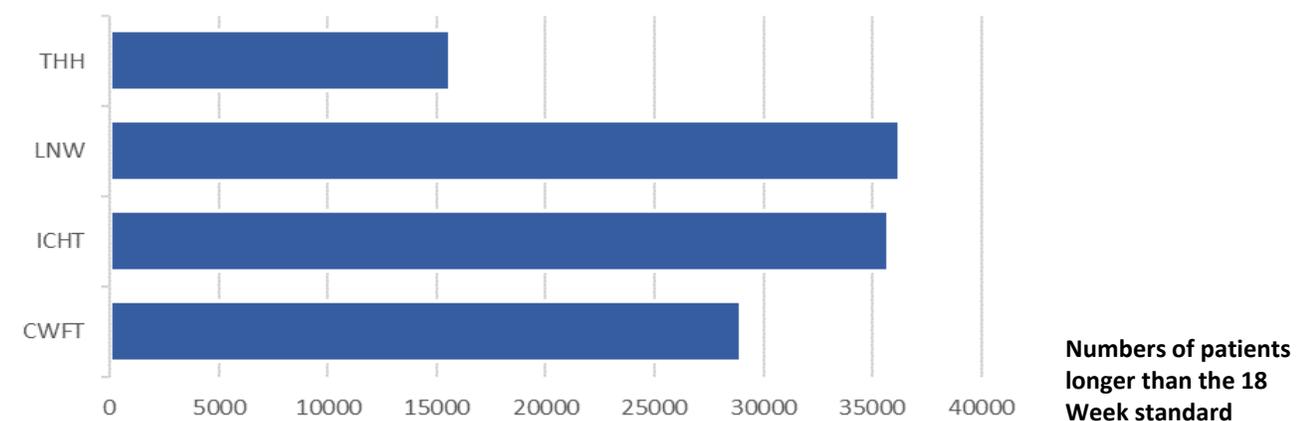
Forecast risks: Risks to RTT reduction include overall capacity shortfalls, reduction in ERF, reduction in investment of additional activity, industrial action

CURRENT PERFORMANCE

Wait for Treatment: 18 Week standard Aug-25

	Total Waiting List	Waits < 18 weeks	Difference from target	Waits < 18 weeks	Wait for first Appointments Total	PWFA <18 Weeks
CWFT	72327	60.0%	0.0%	43383	52495	61.6%
ICHT	91122	60.7%		55356	60658	66.5%
LNW	86498	58.1%	-1.9%	50233	55967	59.2%
THH	34621	55.0%	-5.0%	19028	19990	56.5%
APC	284568	59.0%	-1.0%	168000	189110	61.9%

STRATIFICATION



GOVERNANCE

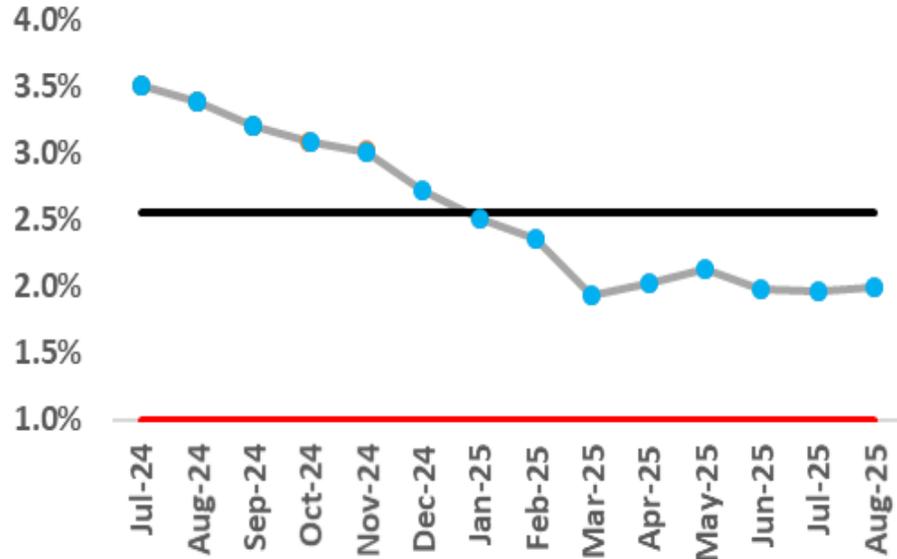
Senior Responsible Owner: Laura Bewick, Managing Director, Chelsea and Westminster
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Planned Care Board. These figures are validated ahead of a monthly performance return before publication by NHSE.

Referral to Treatment Long Waits

TREND

% of Waits > 52 Weeks



1.0%

ALLOWANCE

2.0%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Sector wide, all Trusts are committed to the operating plan targets and have internal trajectories to meet the requirement by March 2026. 52-week performance has increased for the sector, growth seen at CWFT and THH. The backlog cohorts of 78ww continues to improve.

Recovery: Trusts are focusing on improving productivity and efficiency as the majority of additional clinical activity (insourcing and waiting list initiatives) have ceased. Improvements in validation through the NHSE Validation Sprints are also supporting RTT.

Improvement: There has been a sustained reduction in long-waiting patients.

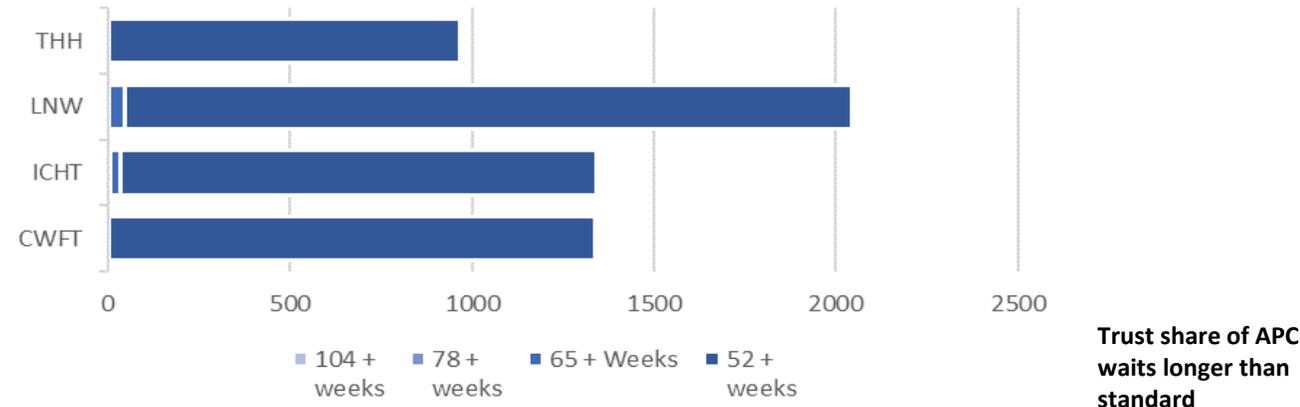
Forecast Risks: Risks to RTT reduction include overall capacity shortfalls, anaesthetic staffing shortages, reduction in ERF, high volumes of trauma and priority 2 patients.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 18-Week Standard Aug-25

	Total Waiting List	Waits > 52 weeks	Difference from target	52 + weeks	Of which			Impacted by	Impacts on
					65 + Weeks	78 + weeks	104 + weeks	OTDCs not booked < 28 days	PWFA < 18 Weeks
CWFT	72327	1.8%	-0.8%	1337	39	0	0	0	61.6%
ICHT	91122	1.5%	-0.5%	1341	35	1	1	10	66.5%
LNW	86498	2.4%	-1.4%	2045	44	0	0	0	59.2%
THH	34621	2.8%	-1.8%	965	0	0	0	0	56.5%
APC	284568	2.0%	-1.0%	5688	118	1	1	10	61.9%

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Laura Bewick, Managing Director, Chelsea and Westminster

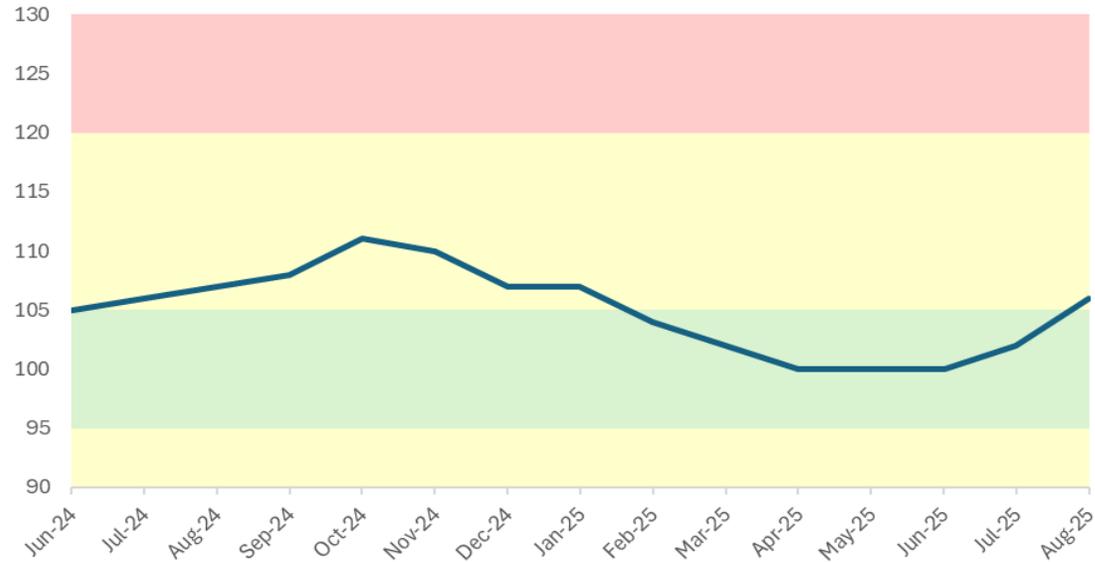
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Planned Care Board. These figures are validated ahead of a monthly performance return before publication by NHSE.

Inequity in Longest Waits for Treatment

TREND

Inequalities in RTT Waiting Times (IMDQ1 vs IMDQ2-5)



NARRATIVE

Performance: Suggested limits for inequity monitoring <95 over-performance; 95-105 equity achieved; 105-120 Moderate inequity; >120 Significant inequity

Recovery: To be confirmed

Improvement: Performance data is provisional and supplied for review against its intended purpose and for alignment on definition. Further investigation is being carried out on CWFT and THH waiting lists.

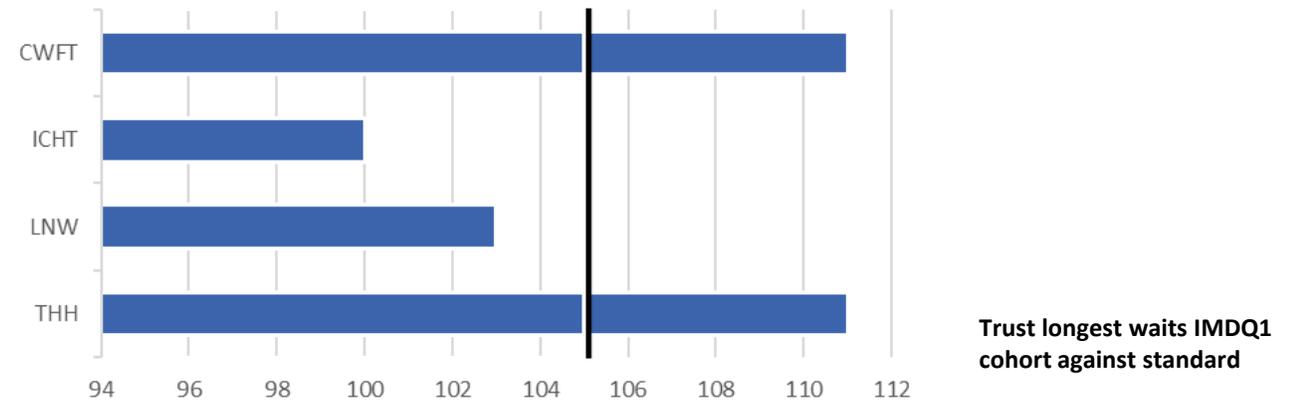
Forecast Risks: To be confirmed

CURRENT PERFORMANCE

Inequity in Longest Waits for Treatment: August-25

	Total Waiting List	Standardised Performance	% of Longest Waits		Waits > 40 Weeks		Total Waiting	
			IMDQ1	IMDQ2-5	IMDQ1	IMDQ2-5	IMDQ1	IMDQ2-5
CWFT	70,825	111	10.2%	9.1%	829	5,709	8,165	62,660
ICTH	90,726	100	8.4%	8.4%	710	6,913	8,480	82,246
LNW	79,913	103	10.9%	10.5%	1,133	7,300	10,440	69,473
THH	34,376	111	11.5%	10.3%	234	3,344	2,040	32,336
APC	275,840	106	10.0%	9.4%	2,906	23,266	29,125	246,715

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: To be confirmed

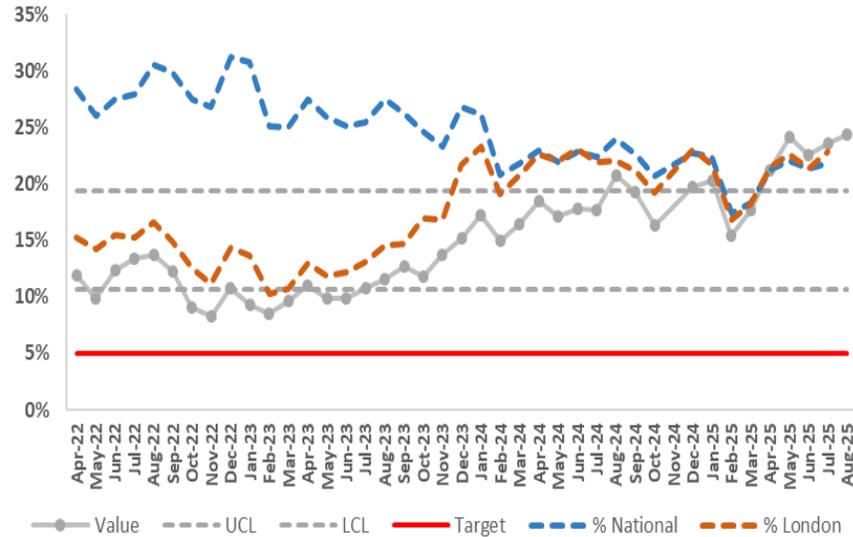
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Provisional figures provided for review and comment.

Access to Diagnostics

TREND

% of Breaches > 6 Weeks (Diagnostics)



5.0%

ALLOWANCE

24.4%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Overall delivery remains below target with a slight decrease in performance. Sector performance showing deteriorating trend and is now in line with both London and National performance.

Recovery Plan: Recovery plans in place. Additional capacity offered by CDCs has not delivered. Alternatives to be explored.

Improvements: Demand review required to ensure limited capacity is being used to best effect.

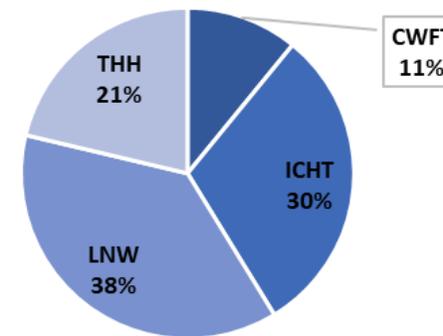
Forecast Risks: MRI capacity continues to be a risk across the sector. Other challenged modalities include Endoscopy, Audiology, Neurophysiology, Echocardiography and Ultrasound which face capacity challenges due to staffing shortages and ageing equipment.

CURRENT PERFORMANCE

Waits for Diagnostic Tests: 6-Week Standard Aug-25

	Total Waiting List	Waits > 6 weeks	Difference from target	6 + weeks	Of which 13 + weeks
CWFT	11432	13.9%	-8.9%	1591	361
ICHT	18564	24.0%	-19.0%	4448	1811
LNW	20923	26.2%	-21.2%	5481	2134
THH	9124	34.1%	-29.1%	3114	797
APC	60043	24.4%	-19.4%	14634	5103

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Ian Bateman, Chief Operating Officer ICHT

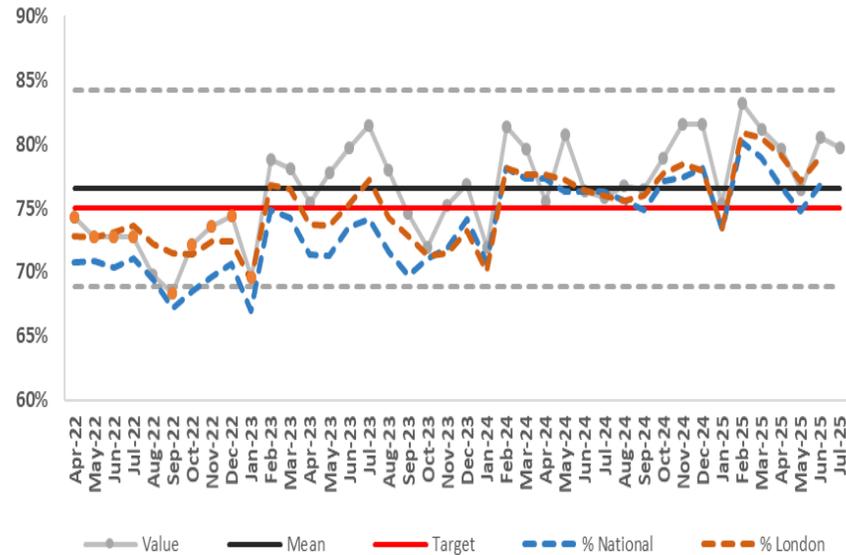
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Planned Care Board. These figures are validated ahead of a monthly performance return before publication by NHSE.

Access to Cancer Care (Faster Diagnosis)

TREND

% Contacted within FDS Cancer standard



75%

STANDARD

79.7%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: NWL overall were compliant with the FDS standard in Jul-25 with a whole provider position being posted of 79.7% against the 75% target. All providers met the standard in-month with the exception Hillingdon where performance is predominantly driven by challenges in Lower GI and Urology. Hillingdon performance has slightly improved in Jul compared to Jun.

Recovery Plan: Continued collaboration with all Trusts to enhance the delivery of cancer pathways in line with the standard. The top 5 challenged tumour sites and actions to improve performance were discussed at the RMP NWL Cancer board in Sept-25. An internal deep dive was also completed at Hillingdon in Sept to identify actions to improve performance.

Improvements: Focus remains on ensuring continued compliance with the FDS standard at a sector level and working with Hillingdon to explore what further support is required to recover performance particularly for Lower GI and Urology. There are meetings planned with Hillingdon to discuss current use of CTVC which has delays predominantly due to reporting. Pathway revalidation has also been completed for the Urology service with findings shared with the team at Hillingdon in September to support actions to improve performance. Breast FDS requires some focus due to dip in FDS with cancer for LNW and THH.

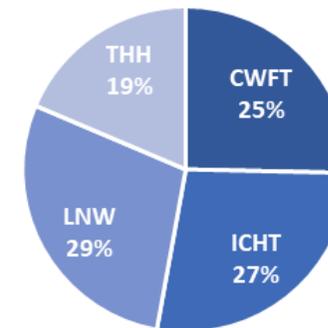
Forecast Risks: Continued planning of capacity for pinch points in pathways to protect cancer delivery as much as possible. Workforce and ability to run additional WLI's to meet demand are a key risk to performance. Diagnostic delays for radiology and Pathology TAT's also remain a risk.

CURRENT PERFORMANCE

Access to Cancer Care (Faster Diagnosis) Jul-25

	Total Contacts	Faster Diagnosis performance	Difference from target	28 + days	Of which 62 + days
CWFT	2985	80.7%		575	120
ICHT	3256	80.8%		624	0
LNW	3476	81.4%		648	101
THH	1487	71.6%	-3.4%	422	64
APC	11204	79.7%		2269	285

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

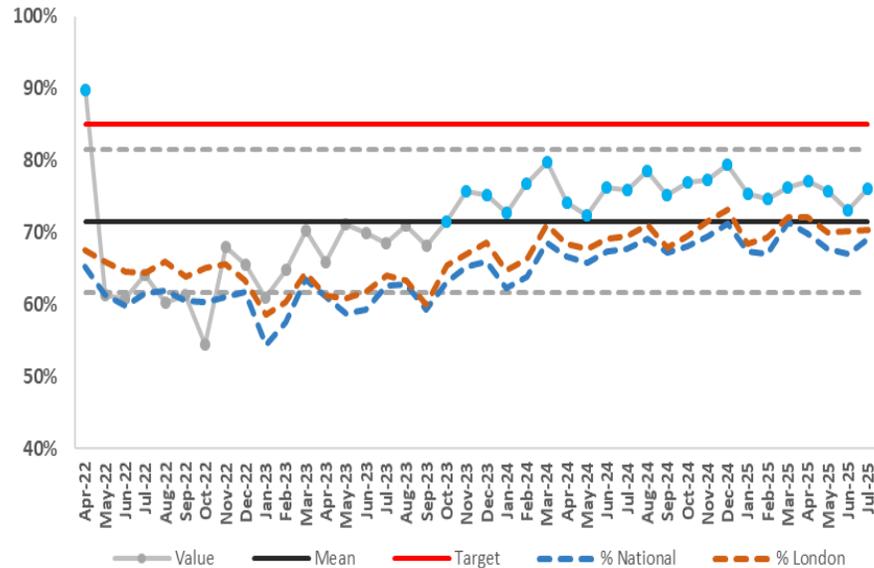
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Cancer Clinical Operational Board. These figures are validated ahead of a monthly performance return before publication by NHSE

Referral to Cancer Treatment Pathways

TREND

% Treated within 62 Day Cancer standard



85%

STANDARD

76.1%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Performance against the 62-day standard remains challenged against the 85% standard (75% national expectation). There are system-wide pressures that are contributing to this including delays in inter-Trust transfers. Imperial and THH have issues in Breast, Lower GI & Urology and the majority of the sector struggles with lung. However, NWL still remains one of the best performing ICBs nationally.

Recovery Plan. There are plans to address specialist diagnostic capacity for lung through EBUS, CTGB and navigational bronchoscopy. Prostate pathway re-validation has been completed to understand current bottlenecks for CWFT and THH. A Urology workshop is currently being planned for October 2025 for CWFT. Meetings are also scheduled to review Urology findings for Hillingdon and agree actions to address. Work underway for Breast to understand variations in performance for screening vs urgent GP referrals and current challenges impacting chemotherapy pathways. This will be discussed further at the RMP/ Provider meetings which commenced in September. THH performance improved in July and is now back above 70%. Recruitment to new consultant posts at Imperial will support with delivery of their 62-day recovery plan for Breast.

Improvements: Performance improved to above the 75% national expectation in July. Focus will be on sustaining improvements.

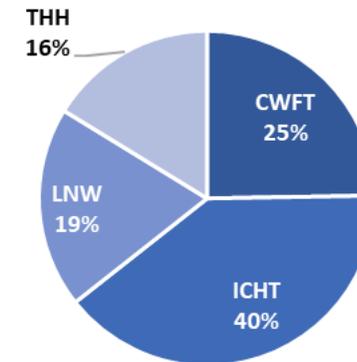
Forecast Risks: Lung diagnostics demand (particularly EBUS and navigational bronchoscopy) is likely to see additional challenges in this pathway. There are currently PET-CT tracer issues had resolved but have now resurfaced. NWL Pathology TAT's remain a risk.

CURRENT PERFORMANCE

Unacceptable Waits for the Treatment of Cancer: 62-day Combined Standard Jul-25

	Total Treated	62 day performance	Difference from target	62 + days	Of which	Impacts on
					104 + days	Backlog 104 + days
CWFT	195	76.2%	-8.8%	46.5	14	0
ICHT	257	71.0%	-14.0%	74.5	0	49
LNW	223	83.6%	-1.4%	36.5	9	25
THH	110	72.3%	-12.7%	30.5	6	3
APC	785	76.1%	-8.9%	188	29	77

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Cancer Clinical Operational Board. These figures are validated ahead of a monthly performance return before publication by NHSE

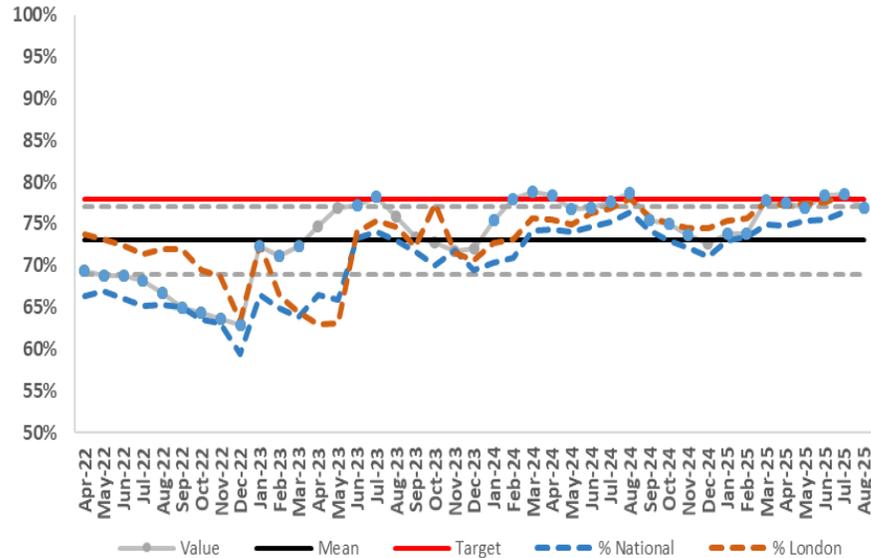
Section 1b: Performance Emergency Care

August 2025

Urgent & Emergency Department Waits

TREND

A&E 4 hour performance



78%

STANDARD

77.0%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: 77.0% of A&E patients were admitted, transferred, or discharged within four hours (from 78.6% in the previous month), dropping below the 78% operating standard. Total A&E attendances across the APC increased by 4.9% on the same month last year.

Recovery plan: Each Trust has a comprehensive action plan to improve four-hour performance and maintain safe levels of care. These plans align with the wider Northwest London UEC program, which aims to reduce demand and waits across the entire care system. Alongside finalising winter plans, the focus is on improving the position ahead of winter surge and confirming that trajectories can be delivered.

Improvements: All Trusts introduced further actions in spring 2025 to meet the four-hour performance standard which has led to improvement and the 78% standard was met for June and July 2025.

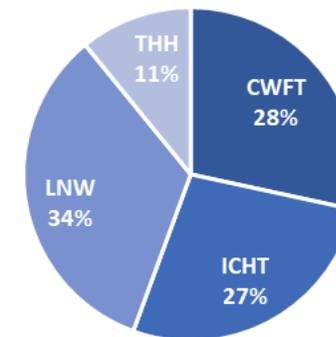
Forecast risks: Further increases in demand and continued delays with discharge for medically optimised patients.

CURRENT PERFORMANCE

Time spend in Emergency Department: 4-Hour Standard Aug-25

	Total attendances (All Types)	4 hour Performance	Difference from target	4 hour + delays (All Types)	Of which (Number and Performance)			Impacted by Referrals to SDEC	
					Type 1 / 2 breaches	Type 3 breaches			
CWFT	24677	76.82%	-1.2%	5720	5678	70.4%	42	99.2%	1533
ICHT	22939	76.1%	-1.9%	5479	5253	66.3%	226	96.9%	5490
LNW	27792	75.7%	-2.3%	6757	6568	51.6%	189	98.7%	2118
THH	12067	81.8%		2191	2127	61.8%	64	99.0%	2585
APC	87475	77.0%		20147	19626	63.6%	521	98.4%	11726

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Managing Director, Chelsea and Westminster

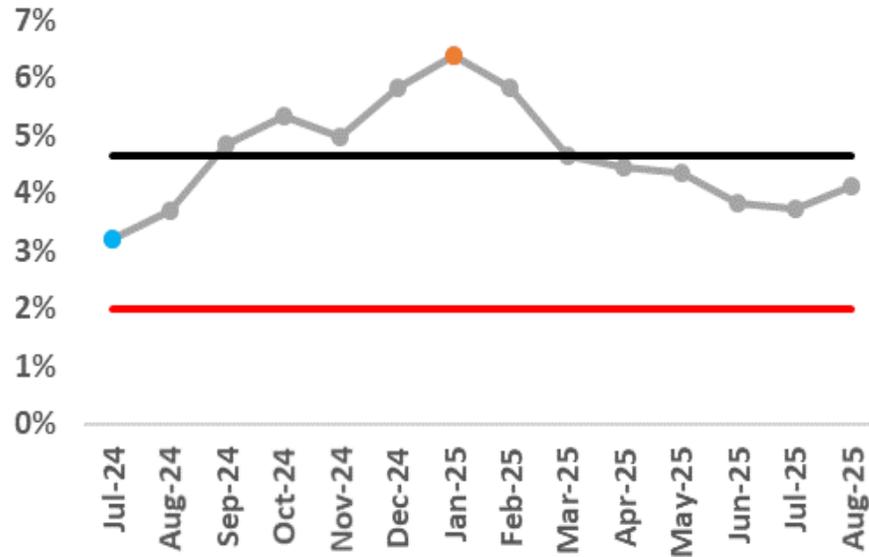
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Urgent and Emergency Care Board. These figures are validated ahead of a monthly performance return before publication by NHSE.

Urgent & Emergency Department Long Waits

TREND

% of Patients > 12 Hours



2.0%

ALLOWANCE

4.1%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: The proportion of patients waiting 12 hours or more following arrival to the emergency department increased to 4.1% from 3.7% in the previous month. Mental health delays remain a challenge for the sector with an overall impact on flow and the length of time spent in ED.

Recovery plan: Each site, through local protocols, continue to manage flow through a range of actions to recover performance and maintain safe levels of care. All Trusts are focused on improving patient flow, including escalation processes to minimise extended delays in ED.

Improvements: Ongoing implementation and enhancement of Trust specific UEC improvement plans. A developing workstream is now led by the Mental Health Collaborative. Plans will also include the use of the delayed discharge codes to improve discharge on wards, therefore reducing the long waits in ED.

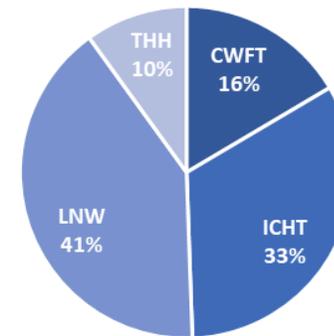
Forecast risks: Increases in demand, continued delays with discharge for medically optimised patients and continued delays for patients waiting for admission to mental health beds.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 12-Hour waits Aug-25

	Total attendances (All Types)	12 hour Performance	Difference from target	12 hour + delays	Of which		Impacted by
					Type 1 / 2 breaches	Type 3 breaches	12 hour DTA waits
CWFT	24677	2.3%	-0.3%	572	572	0	39
ICHT	22939	4.0%	-2.0%	925	925	0	388
LNW	27792	6.7%	-4.7%	1872	1872	0	517
THH	12067	2.0%	0.0%	247	247	0	8
APC	87475	4.1%	-2.1%	3616	3616	0	952

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Managing Director Chelsea and Westminster.

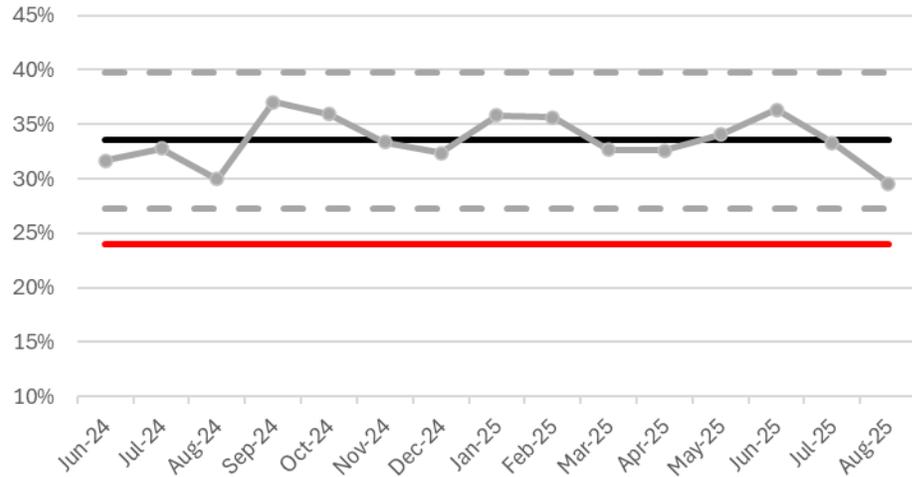
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Urgent and Emergency Care Board. These figures are validated ahead of a monthly performance return before publication (except 12hr+ waits from arrival) by NHSE

ED Patients with Mental Health conditions

TREND

% Patients with Mental Health in ED > 12 Hours



24%

ALLOWANCE

29.4%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Mental health delays remain a challenge for the sector with an overall impact on flow and the length of time spent in ED. This metric shows the proportion of patients in ED referred to psychiatric liaison services for a consultation and potentially a bed waiting 12 hours or more.

Recovery plan: To be confirmed

Improvements: A longer wait is indicative of system pressures and can also be linked to the inability to find a mental health bed. Performance data is provisional and supplied for review against its intended purpose and for alignment on definition.

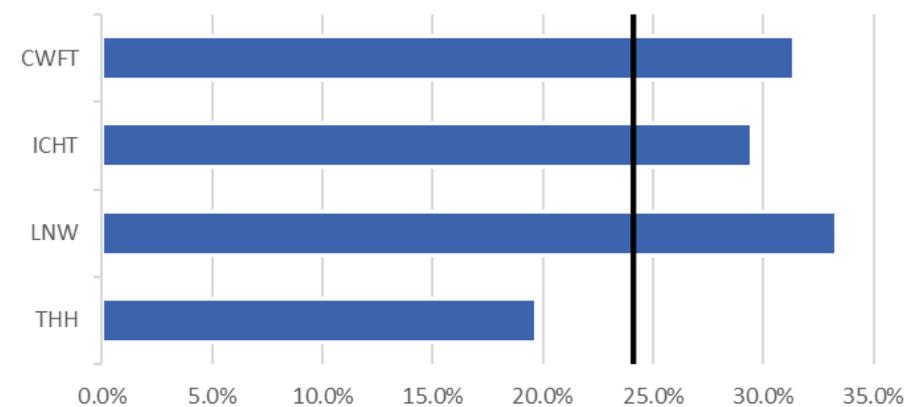
Forecast risks: To be confirmed

CURRENT PERFORMANCE

Unacceptable Waits for Mental Health patients in ED: 12-Hour waits Aug-25

	ED Attendances with Mental Health condition	Referrals to Pyschiatric Liaison	12 hour Performance	Difference from Provider Median	12 hour + delays
CWFT	411	TBC	31.4%	-11.4%	129
ICHT	499	499	29.5%	-9.5%	147
LNW	504	483	33.3%	-13.3%	168
THH	289	273	19.7%		57
APC	1,703	1,255	29.4%	-9.4%	501

STRATIFICATION



Current Trust waits shown against the national provider median

GOVERNANCE

Senior Responsible Owner: To be confirmed

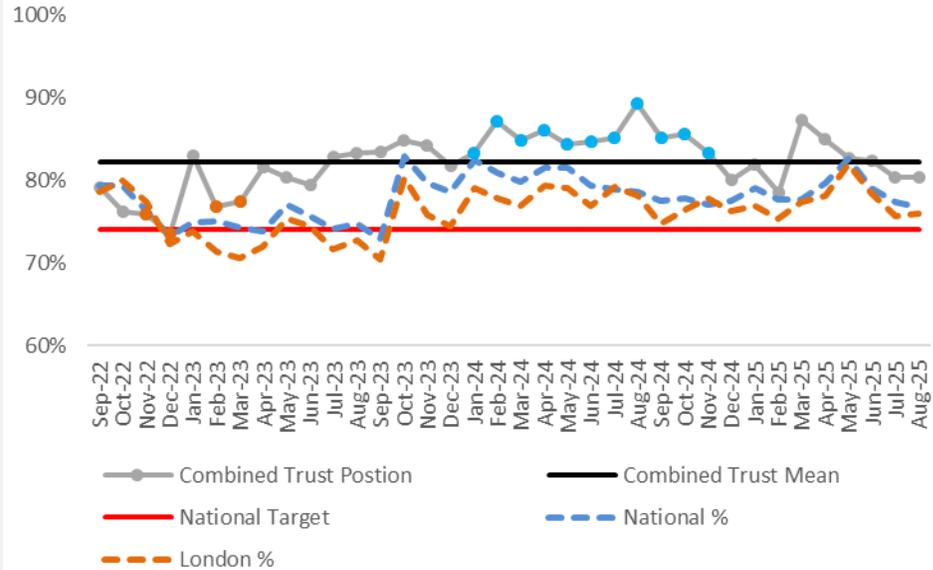
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Provisional figures provided for review and comment.

Emergency Dept Friends & Family Test

TREND

% good experience - ED



74%

STANDARD

80.4%

PERFORMANCE



TREND

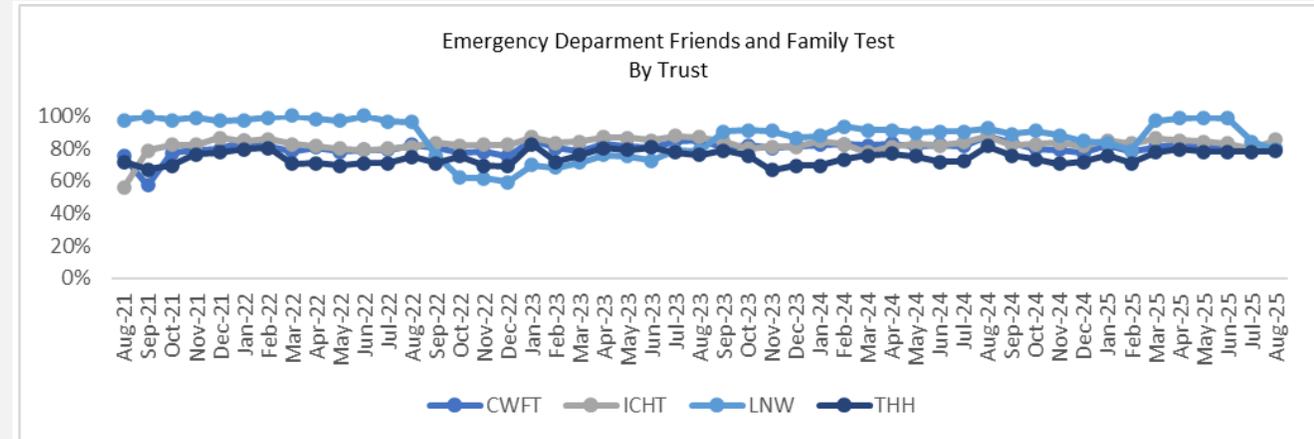


ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	1,711	80.1%		1,370	80.2%
ICHT	1,040	85.4%		888	83.3%
LNW	2,957	79.2%		2,342	87.7%
THH	639	78.4%		501	75.4%
APC	6,347	80.4%		5,101	83.0%

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of patients accessing our emergency departments who report a good experience has been consistently above standard since January 2023.

Recovery Plan: Not applicable.

Improvements: N/A

Forecast Risks: Continued operational pressures resulting in longer waits in ED may have a detrimental impact on patient experience, particularly as we move into winter.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

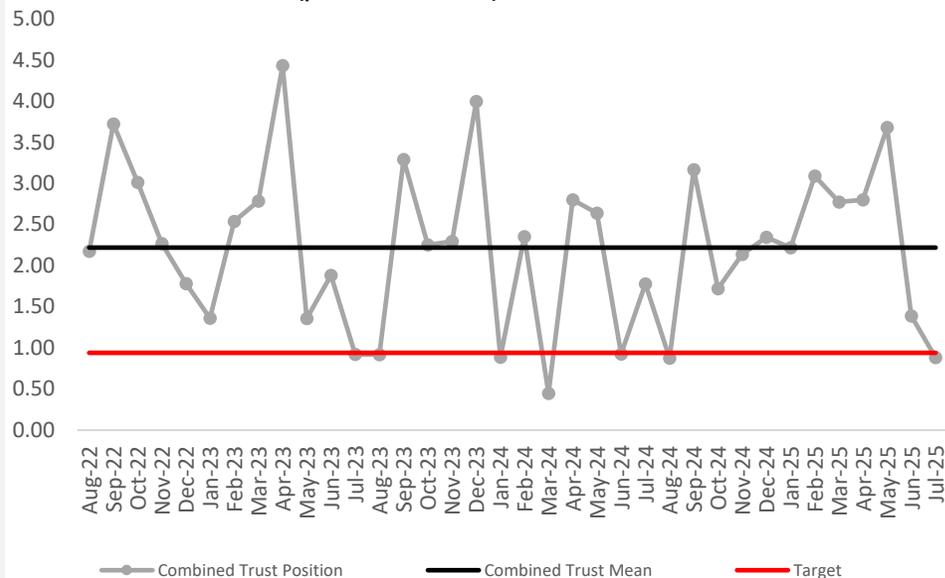
Section 1c: Performance Maternity and Neonatal Care

July 2025, except Friends and Family August 2025

Neonatal Crude Deaths (per 1000 births)

TREND

Crude neonatal death rate (per 1000 birth rate)



0.94

STANDARD

0.9

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: The crude neonatal death rate at APC level was below the standard in July but is above across the last 12 months. All cases are being appropriately investigated. Review of the small recent increase at ICHT has identified an increase in the number of babies born at pre-term gestations with an antenatal diagnosis of congenital abnormalities. Both cases at CWFT are being fully investigated and learning will be actioned- no recurring themes have been identified.

Recovery Plan: The Perinatal Mortality Review Tool (PMRT) is used for all cases to identify local learning & actions. The Neonatal CRG and the Trust teams will continue to monitor any new cases.

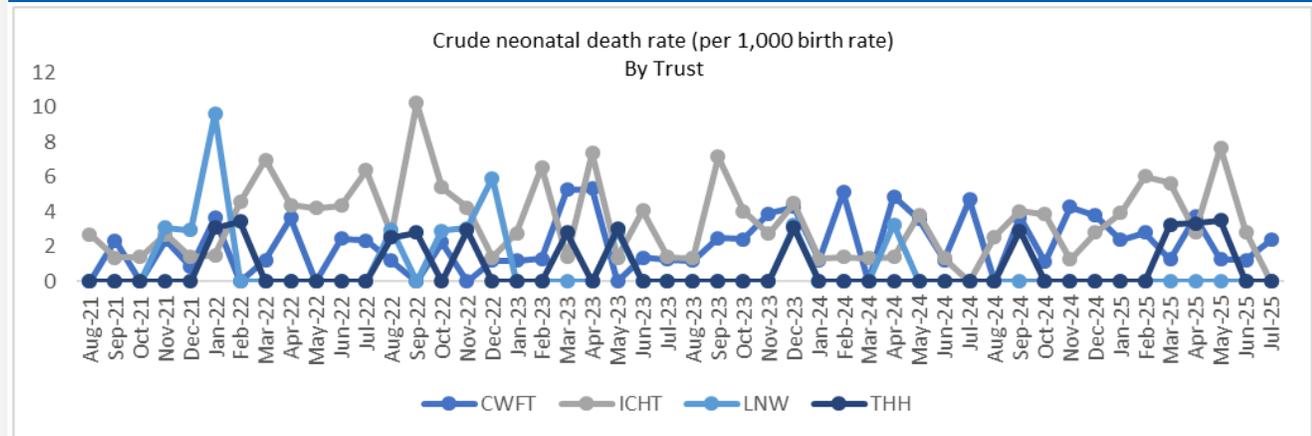
Improvements: Following a review at the March maternity and neonatal safety group, the following areas of improvement are being prioritised: reducing the number of birthing people who book late (a new metric will be added to this report going forward so that this can be monitored); care of birthing people who do not speak or understand English (translation working groups in each service/implementation and embedding card medic); standardising and improving PRMT practice through creation of a NWL SOP; review of bereavement support. A review of all neonatal deaths across the APC during 24/25 is planned to be completed by September to inform further improvements.

Forecast Risks: None identified.

CURRENT PERFORMANCE

	Number of Neonatal Deaths	Number of neonatal deaths (22+0- 23+6 weeks)	Number of neonatal deaths (24+0 - 40+ weeks)	Total Births	Crude neonatal death rate (per 1000 birth rate)	Difference from Threshold	Crude neonatal death rate (per 1000 birth rate) 12 months rolling
CWFT	2	0	2	831	2.4	1.5	2.34
ICHT	0	0	0	733	0.0		3.62
LNW	0	0	0	367	0.0		0.00
THH	0	0	0	333	0.0		1.07
APC	2	0	2	2264	0.9		2.24

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

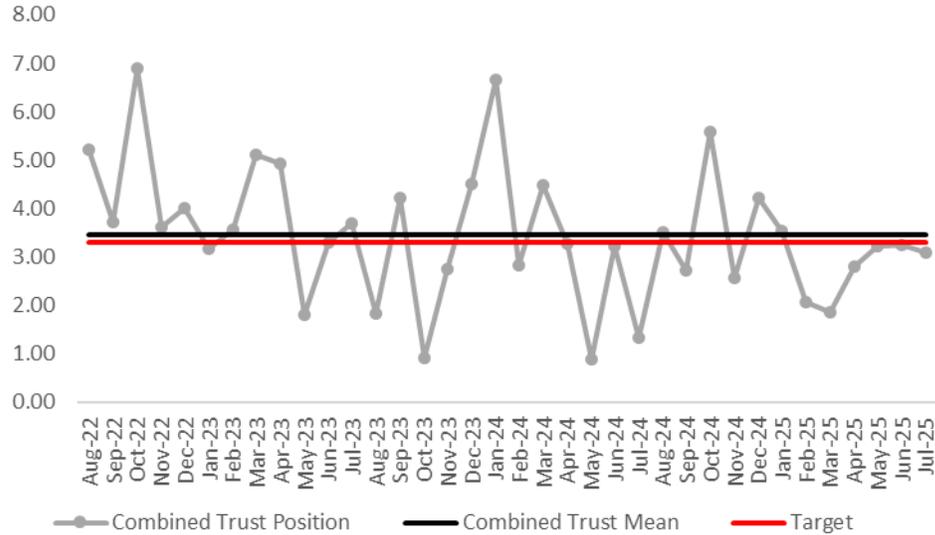
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Crude Still Birth Rate (per 1000 births)

TREND

Crude still birth rate (per 1000 birth rate)



3.3

STANDARD

3.1

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: The rate is based on stillbirths at 24+ weeks. Data on late fetal losses (between 22+ and 23+6 weeks) is included in the table for information and monitoring. The APC stillbirth rate was below the standard in month and across the last 12 months.

Recovery Plan: The Perinatal Mortality Review Tool (PMRT) is used for all cases to identify local learning & actions. A joint PMRT standard operating procedure has been drafted and will now go through local trust approvals processes prior to implementation- planned for go-live Nov 25

Improvements: Improvement work continues in response to key themes including review of the fetal medicine foundation tools for additional screening, review of translation tools, reviewing the dose of Aspirin to ensure consistency across providers (guidance has recently been updated), and implementing the maternal reducing inequalities care bundle. A review of all stillbirths across the APC during 24/25 is planned to be completed by October to inform further improvements (the delay is due to agreement of the TOR).

All trusts are working towards full achievement of Saving Babies' Lives Care Bundle version 3 (ICB assessed position in Q1- 83% for CWFT, 97.1% for ICHT, 84% for THH, 95% for LNW). The working group has concluded, and target and frequency of auditing has been agreed across NWL.

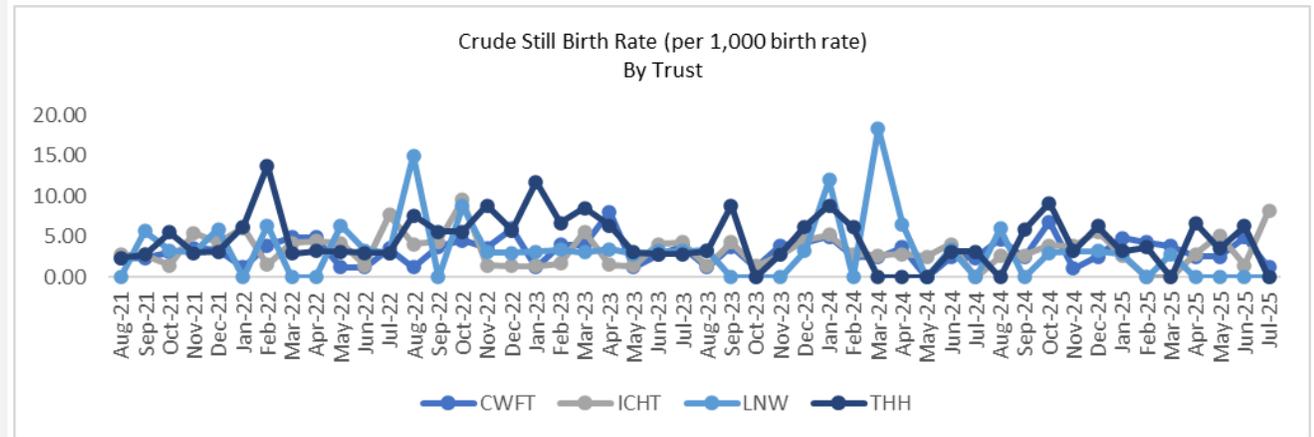
Forecast Risks: N/A

CURRENT PERFORMANCE

Crude still birth rate (per 1000 birth rate)

	Total Births	Total Still Births & Late Fetal Losses	Total Still Births	Total Late Fetal Losses	Crude Still Birth Rate	12 month rolling rate of Crude Still Birth Rate	Difference from Standard
CWFT	831	1	1	0	1.2	3.5	
ICHT	733	6	6	0	8.2	3.3	4.89
LNW	367	1	0	1	0.0	1.8	
THH	333	0	0	0	0.0	4.0	
APC	2264	8	7	1	3.1	3.22	

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

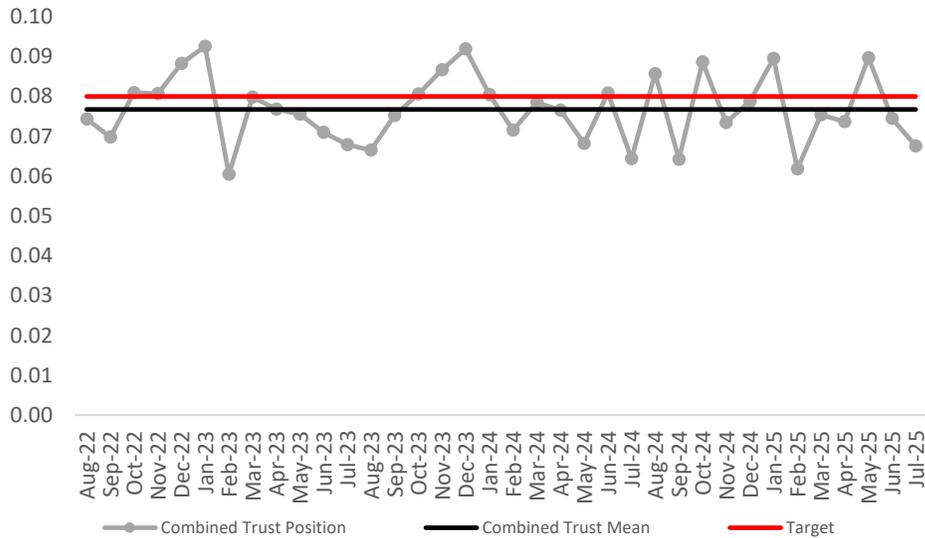
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Preterm Births (per 1000 births)

TREND

Pre-term Birth Rate



8%

STANDARD

6.8%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: The rate of pre-term births was below the standard in month at APC level and across three out of four Trusts, and remains below standard on rolling 12 month data. ICHT have the highest rate of the four trusts and were above the standard in month. They are a net importer of all categories of pre-term In-Utero transfers and Ex-utero transfers due to their status as a medical level 3 NICU. The rise in PTB rates for THH has been noted by the senior team and will continue to be monitored for trends.

Recovery Plan: Not applicable.

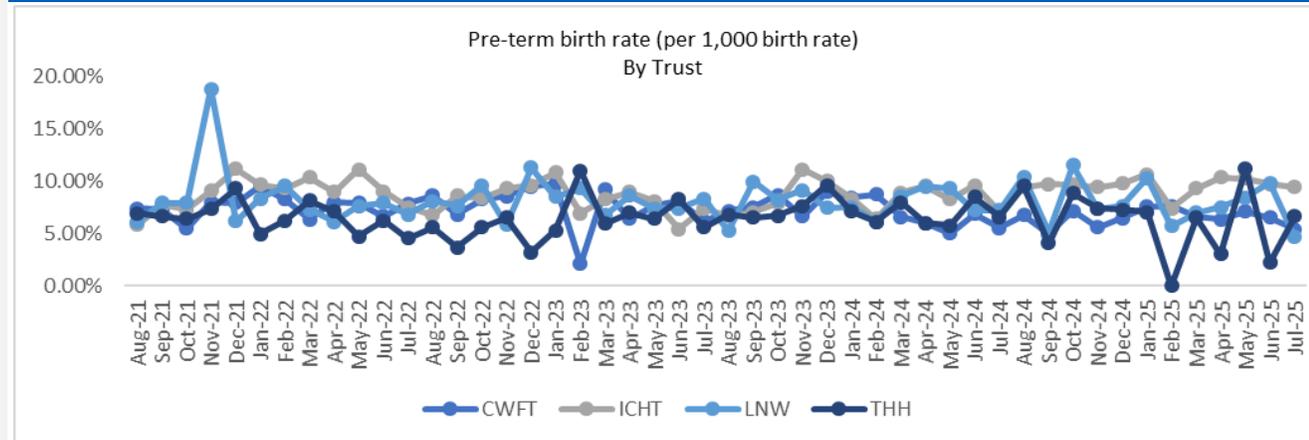
Improvements: An education programme has been rolled out at LNW with particular emphasis on personalised assessment to ensure correct maternity care pathway and referrals at booking. They are developing a digital referral to Pre-birth clinic to improve early assessment and intervention rates. THH continue to focus on prevention efforts and this is being driven by their newly established pre-term birth team, despite the increased rates the Trust has provided the assurance that antenatal and postnatal optimisation is in place. Sector-wide training took place in February and was well received. The level 2 Local Neonatal Unit re-designation from a Special Care Baby Unit has been agreed for West Middlesex and it is projected that the service will be in a position to go-live in 9-12 months.

Forecast Risks: No risks identified.

CURRENT PERFORMANCE

	Number of Pre-Term Births	Early Preterm births	Late Preterm births	Total Births	Pre-term Birth Rate	Difference from Threshold	12 month rolling rate of Pre-Term Births
CWFT	45	3	42	831	5.4%		6.5%
ICHT	69	11	58	733	9.4%	1.41%	9.6%
LNW	17	2	15	367	4.6%		8.0%
THH	22	3	19	333	6.6%		6.2%
APC	153	19	134	2264	6.8%		7.7%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

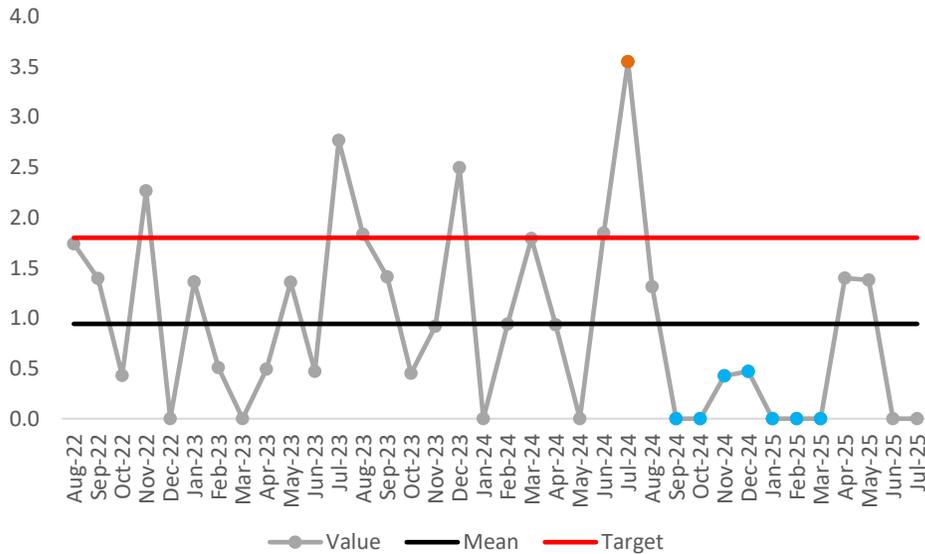
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Suspected neonatal Intrapartum brain injuries (per 1000 births)

TREND

Rate of neonatal intrapartum brain injuries as escalated to HSIB



1.8

STANDARD

0.0

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: We were below the standard in-month and over the last 12 months. There were no cases in month.

Recovery Plan: N/A

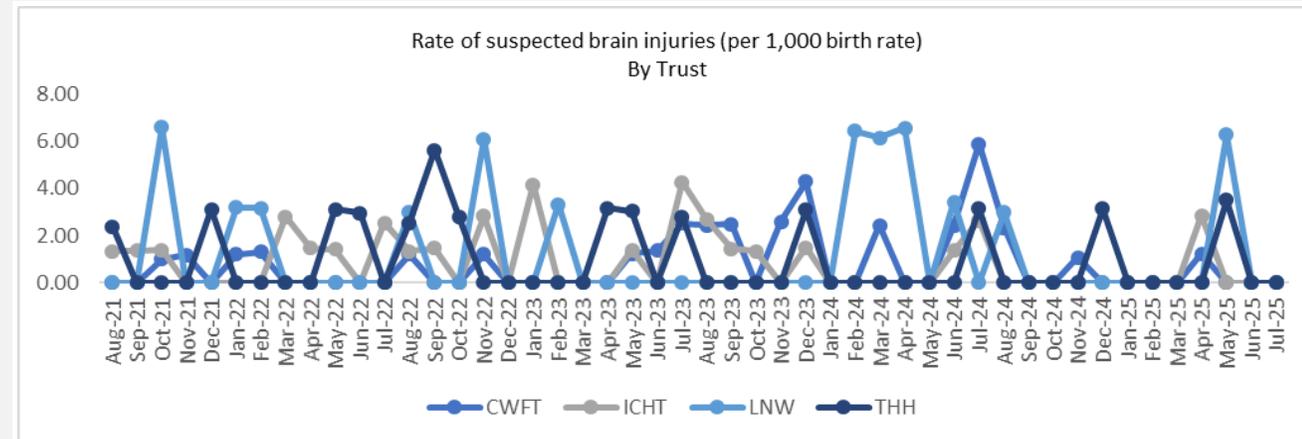
Improvements: Improvements are focused on the following key themes: clinical care and decision making, escalation / situational awareness and fetal heart monitoring and escalation. The Fetal monitoring practices are being streamlined across the APC and an escalation toolkit based on the one in place in CWFT is being reviewed in each Trust with a view to rolling it out across the APC in due course. LNW and THH are progressing with a plan to implement the escalation toolkit and Imperial will be on-boarding in October.

Forecast Risks: N/A

CURRENT PERFORMANCE

	Total Births	Suspected Brain Injuries in Month	Rate of suspected brain injuries	12 month rolling rate of Suspected Brain Injuries
CWFT	831	0	0.00	0.41
ICHT	733	0	0.00	0.23
LNW	367	0	0.00	0.75
THH	333	0	0.00	0.53
APC	2264	0	0.00	0.42

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

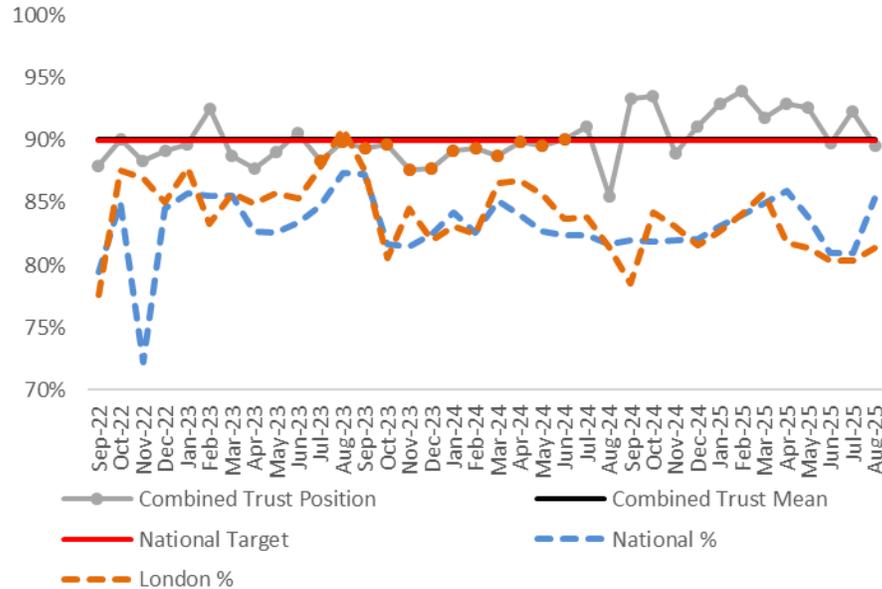
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Maternity Friends & Family Test

TREND

% good experience - Maternity



90%

STANDARD

89.5%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: At APC level, the percentage of maternity patients who report a good experience is improving. We are consistently above national and London averages and are above the 90% standard across the last 12 months of data. CWFT's percentage fell in month.

Recovery Plan: Actions are underway to improve the response rate at ICHT, which has recently reduced. Experience is being impacted across the sites of CWFT due to the activity and the acuity. The planned demand management will be implemented at the end of September and is expected to have a significant positive impact

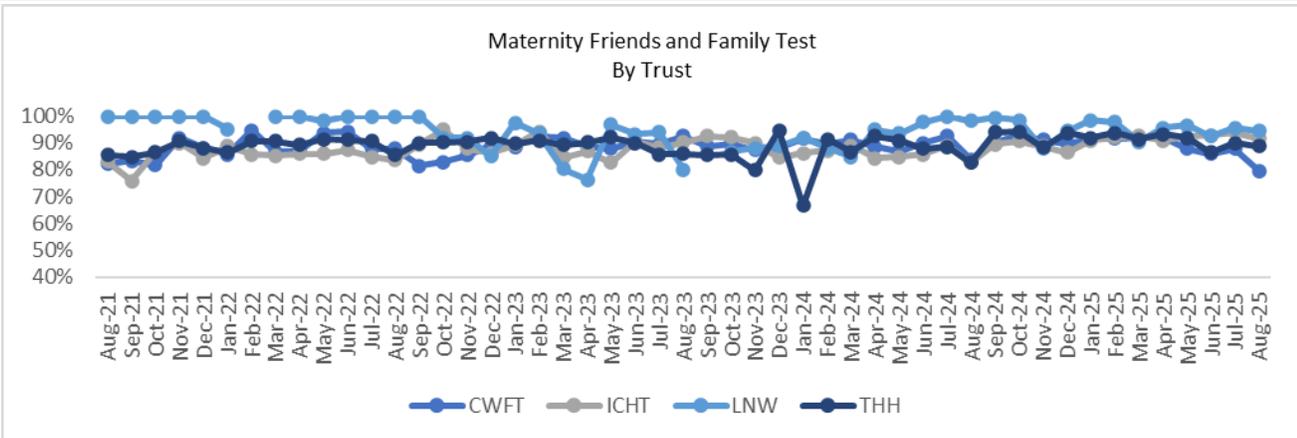
Improvements: The work to improve maternity care and patient experience within each organisation is ongoing. All services have a detailed Maternity and Neonatal Voices Partnership (MNVP) workplan in place to co-produce improvements in their services based on the results of the CQC maternity survey. They have completed their end of year report for 24/25 and have prepared their workplan for 25/26. These have been approved and will be reported on quarterly.

Forecast Risks: Maternity staffing continues to be a risk for all four Trusts, with mitigating actions in place in response. This is likely to have an on-going impact on patient experience.

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	137	79.6%	-10.4%	109	89.5%
ICHT	109	91.7%		100	90.8%
LNW	258	94.6%		244	95.1%
THH	279	88.9%	-1.1%	248	91.8%
APC	783	89.5%	-0.5%	701	92.0%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

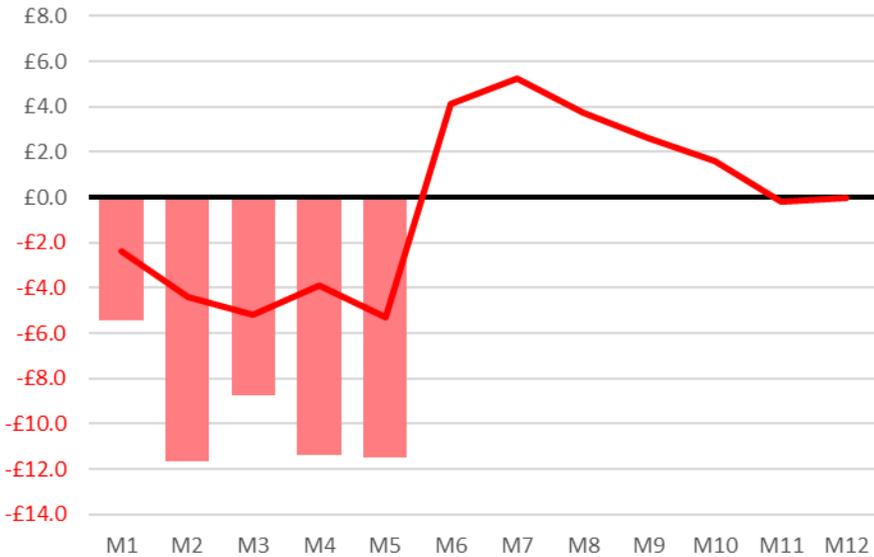
Section 2a: Finance

August 2025

Financial Performance

TREND

Financial Performance £M



-£5.3M

STANDARD

-£11.5M

PERFORMANCE

n/a

TREND

n/a

ASSURANCE

NARRATIVE

Performance: The APC reported a deficit of £11.4M in July against a deficit plan of £3.9M. This represents an adverse variance of £7.5M. All four Trusts are currently reporting adverse variances to plan.

Recovery Plan: A financial performance escalation process has been in place in the previous two financial years. The process has been updated and signed off by the EMB, and implemented from month 3..

Improvements:

Forecast Risks: Continuing under-delivery of efficiency programmes

CURRENT PERFORMANCE

Financial Performance YTD Variance to Plan Aug-25

	Annual Income £M	I&E Plan £M	I&E Actual £M	Difference from Plan	Forecast Outturn £M
CWFT	1,024	-1.0	-3.4	-2.4	0.0
ICHT	1,848	0.0	-0.7	-0.7	0.0
LNW	1,085	-4.3	-5.9	-1.5	0.0
THH	408	0.0	-1.5	-1.5	0.0
APC	4,365	-5.3	-11.5	-6.2	0.0

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Bimal Patel, Chief Financial Officer, LNWH

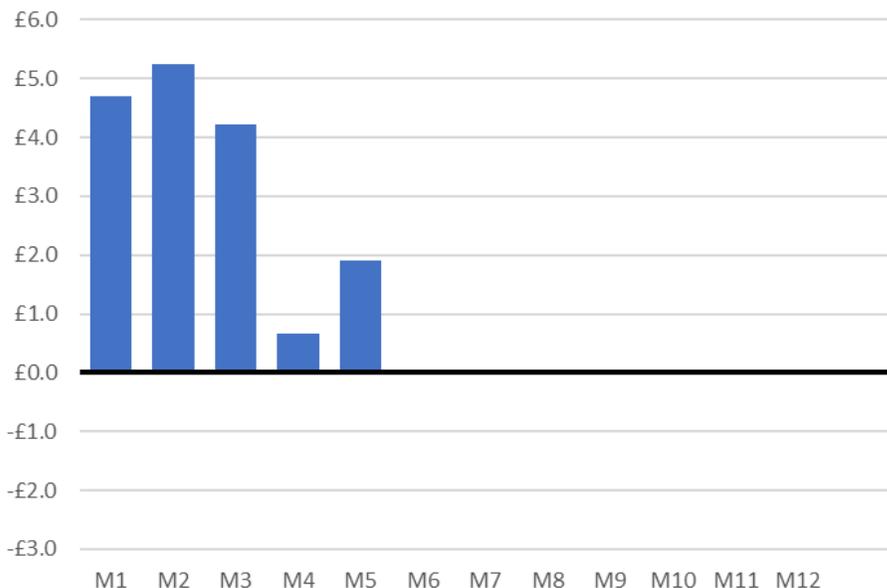
Committee: APC Finance and Performance

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Temporary Staffing Expenditure

TREND

Temporary Staffing Cost Variance to Threshold £M



£22.9M

ALLOWANCE

£21.0M

PERFORMANCE

n/a

TREND

n/a

ASSURANCE

NARRATIVE

Performance: Agency spend, as a proportion of overall pay bill, is a productivity measure with a collective target set at 2%. Reliance on agency workers is key for the delivery of some services, particularly where there is a national skills shortage such as for sonography, mental health nursing and cardiac physiologists and Trusts are working towards collective solutions in these areas.

Bank and agency expenditure reduction is a mandatory planning requirement for 2025/26 reflected in the 'threshold limits described above.

Recovery Plan / Improvements: Grip and control measures are in place across all Trusts for temporary staffing. Continued collaborative work on temporary staffing remains the focus for reducing agency expenditure overall. Harmonised and uplifted bank rates for AfC staff are in place across all four Trusts to attract more staff to work on the bank.

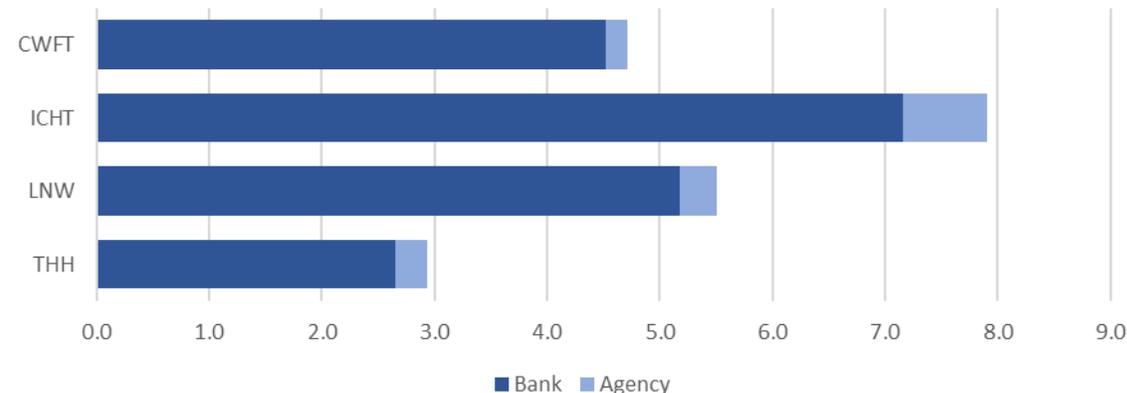
Forecast Risks: High levels of vacancies, puts additional pressure on temporary staffing demand

CURRENT PERFORMANCE

Cost of Temporary Staffing Aug-25

	Total Pay Bill £M	Temporary Staffing Threshold	Temporary Staffing Costs	Difference from Threshold	Agency Spend		Bank Spend		Substantive Staff Spend	
					£M	%	£M	%	£M	%
CWFT	49.6	5.3	4.7	0.6	0.2	0.4%	4.5	9.1%	44.9	90.5%
ICTH	95.9	8.0	7.9	0.1	0.7	0.8%	7.2	7.5%	88.0	91.8%
LNW	57.7	6.6	5.5	1.1	0.3	0.6%	5.2	9.0%	52.2	90.5%
THH	22.8	3.0	2.9	0.1	0.3	1.2%	2.7	11.7%	19.8	87.1%
APC	226.0	22.9	21.0	1.9	1.5	0.7%	19.5	8.6%	205.0	90.7%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Bimal Patel, Chief Financial Officer, LNWH

Committee: APC Finance and Performance

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

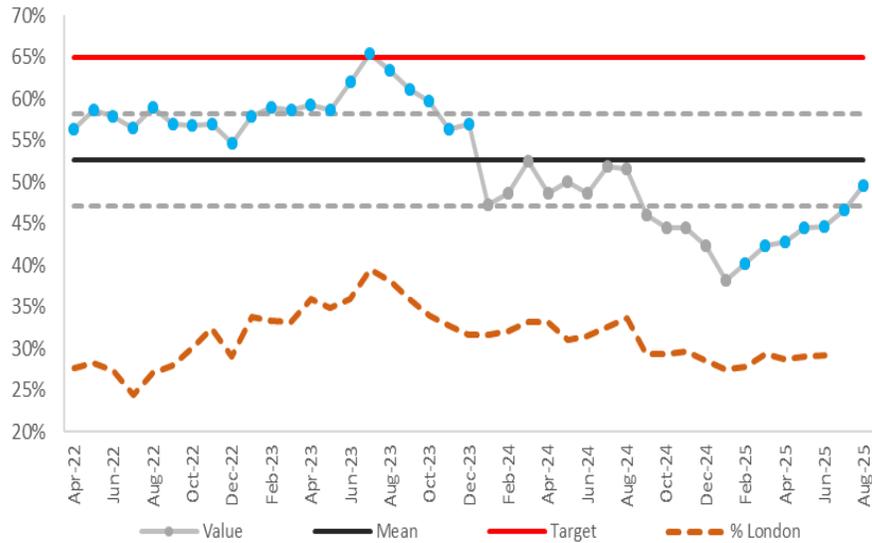
Section 2b: Productivity and Flow

August 2025

Ambulance Handover Waits

TREND

15 mins Breach Performance (LAS)



65%

STANDARD

49.6%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: NWL continues to have some of the best Ambulance handover times across London. In August, combined performance of completed handovers within 15 and 30 minutes increased, with 49.6% completed within 15 minutes (against the target of 65%) and 84.3% completed within 30 minutes (against the target of 90%). Ambulance handovers across the APC increased by 2.7% on the same month last year.

Recovery plan: The sector is working to maximize the use of alternatives to ED, avoid conveyancing, and enhance direct referral and booking routes. System escalation processes during peak pressure have been updated and all Trusts have workstreams designed to improve length of stay for patients on arrival which will directly support handover times.

Improvements: The acute collaborative was the first in London to pilot and implement the new LAS standard operating procedure for immediate handover at 45 minutes. The process is embedded as business as usual. At Hillingdon Hospital, changes to the ambulance handover process has resulted in significantly improved performance.

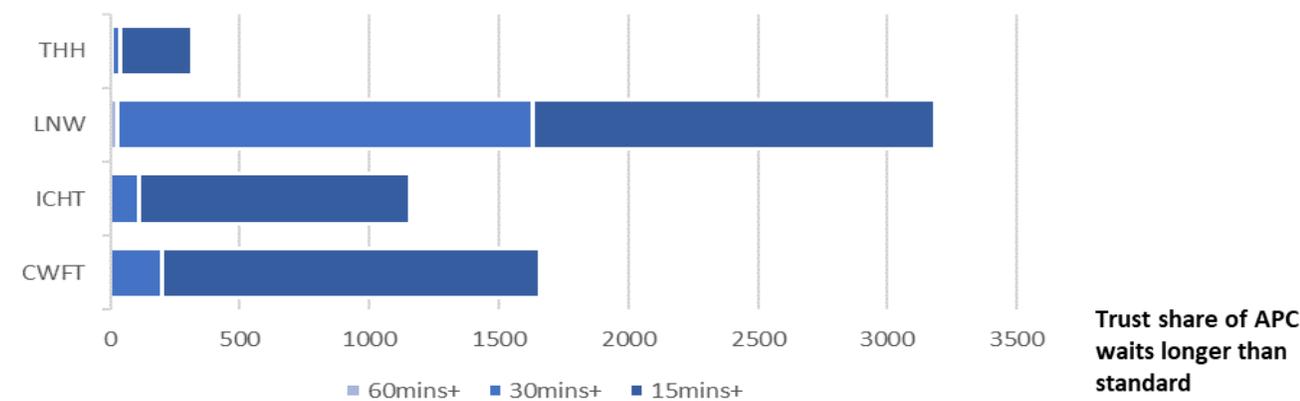
Forecast risks: Continued increases in the number of conveyances.

CURRENT PERFORMANCE

LAS Handover Waits within the fifteen minute standard Aug-25

	Total Handover	15mins Performance	Difference from target	15 min + delays	Of which		Impacts on
					30min + delays	60 min + delays	LAS time lost (hours)
CWFT	3314	50.0%	-15.0%	1658	198	0	213
ICHT	2995	61.3%	-3.7%	1158	108	0	133
LNW	4339	26.6%	-38.4%	3184	1630	29	1747
THH	1892	83.2%		317	38	1	55
APC	12540	49.6%	-15.4%	6317	1974	30	2147

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Managing Director, Chelsea and Westminster

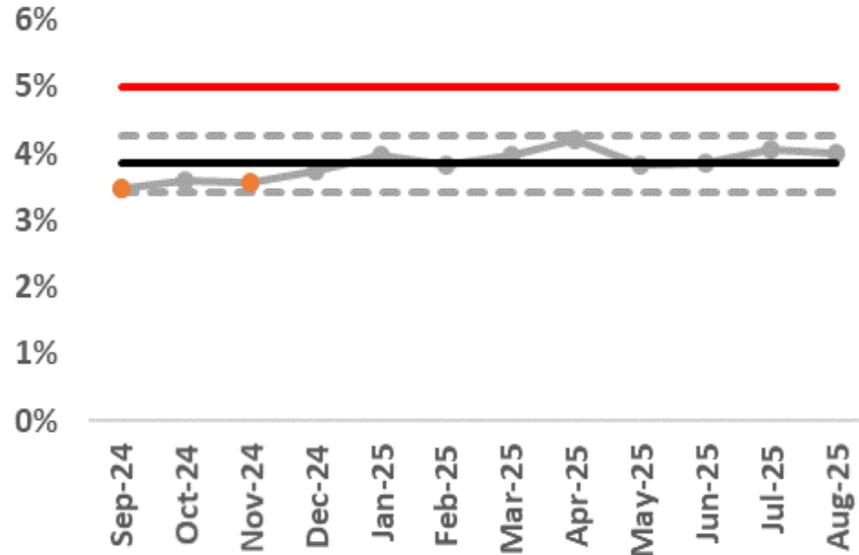
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Urgent and Emergency Care Board. These figures are provided by LAS

Patient Initiated Follow Up

TREND

Discharged to PIFU



5%
STANDARD

4.0%
PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Pathways discharged to PIFU remain under target but remains stable and above the 12-month average. PIFU usability on Cerner is to be improved to support clinical decisions. A clinical audit is being undertaken currently, with variation between specialities being reviewed.

Recovery plan: Outpatient improvement lead group is in place to standardise practice and increase PIFU to above the 5% target.

Improvement: The APC is above the peer average of 1.8% and is above the national average of 3.1%, however LNW remains an outlier.

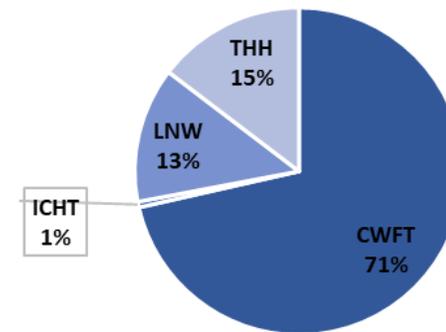
Future risks: Stability, usability and interoperability of digital infrastructure.

CURRENT PERFORMANCE

Outpatient Transformation Aug-25

	Total OP contacts	Discharged to PIFU	Difference from target	Moved / Discharged to PIFU	Impacts on		
					OPFA DNAs	OPFU DNAs	Virtual contacts
CWFT	60717	8.6%		5214	10.8%	7.6%	6997
ICHT	66348		-5.0%	41	10.8%	9.0%	16642
LNW	68642	1.4%	-3.6%	975	10.1%	9.5%	13864
THH	33495	3.6%	-1.4%	1067	7.0%	7.5%	4433
APC	229202	4.0%	-1.0%	7297	10.2%	8.7%	41936

STRATIFICATION



Trust share of APC discharges lower than standard

GOVERNANCE

Senior Responsible Owner: Laura Bewick, Managing Director, Chelsea and Westminster

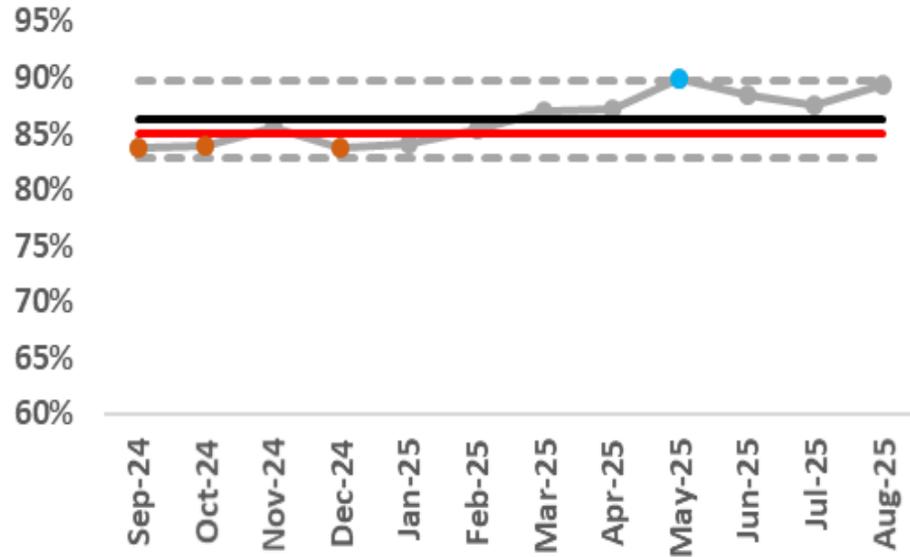
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Planned Care Board. Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Theatre Utilisation *(Uncapped)*

TREND

Theatre Utilisation



85%

STANDARD

89.3%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Marginal improvement in theatre utilisation at 89.3% in M5 against a target of 85%. All Trusts in the sector above the 85% target.

Recovery plan: No recovery required. Operational delivery is above standard.

Improvement: As part of the Productivity & Efficiency planning submissions, Trusts are looking at day case rates, cases per list and elective length of stay (LOS). Work continues on the implementation of the digital preoperative assessment questionnaire.

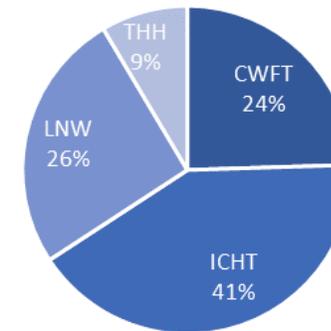
Future risk: Shortages in critical staffing groups.

CURRENT PERFORMANCE

Theatre Utilisation Aug-25

	Planned operating time (hours)	Theatre utilisation	Difference from target	Unused time (hours)
CWFT	2221	87.3%		283
ICHT	4429	89.2%		476
LNW	3156	90.6%		297
THH	954	89.7%		98
APC	10760	89.3%		1154

STRATIFICATION



GOVERNANCE

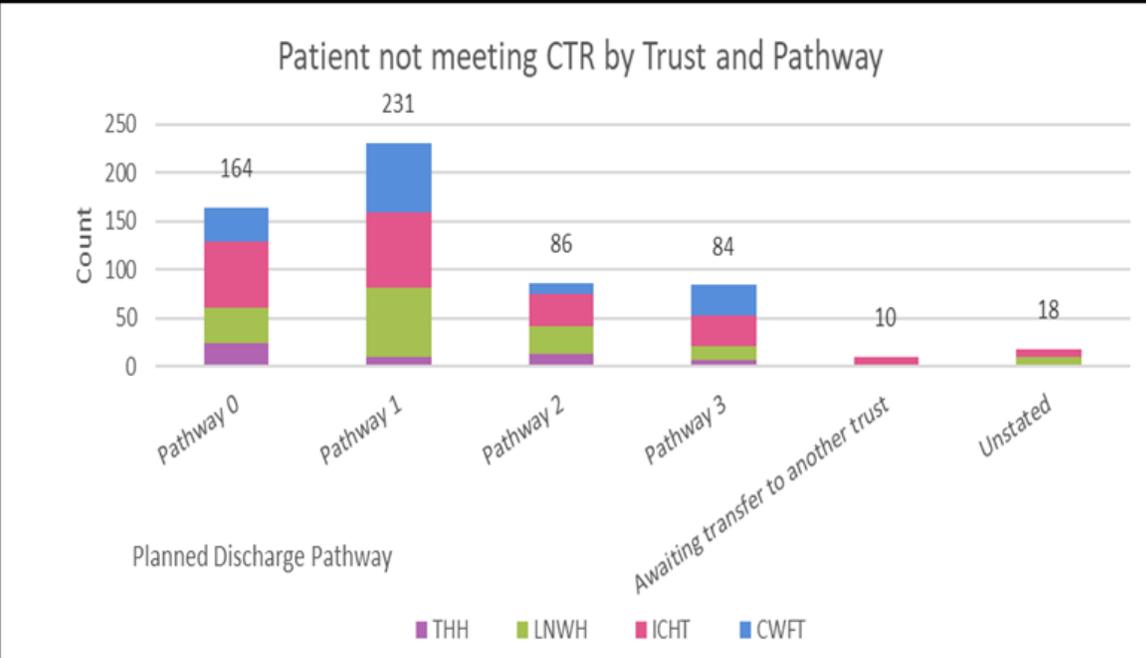
Senior Responsible Owner: Alan McGlennan, Managing Director, THH

Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Planned Care Board. Data is supplied by each trust individually and quality assured through each organisation's internal processes

Discharge Performance - no criteria to reside

TREND



NARRATIVE

Performance: There is Trust variation for discharges and bed occupancy for patients who do not meet the criteria to reside (NCTR) across NWL. LNW and CWFT have highest % of bed base occupied by no CTR patients in NWL; although this has varied over time.

Recovery: All sites to increase utilisation of virtual ward capacity. Escalation with borough leads in place. System to ensure bridging processes/P1 SOPs align with bridging KPIs. Review utilisation rates for bridging and maximise capacity usage.

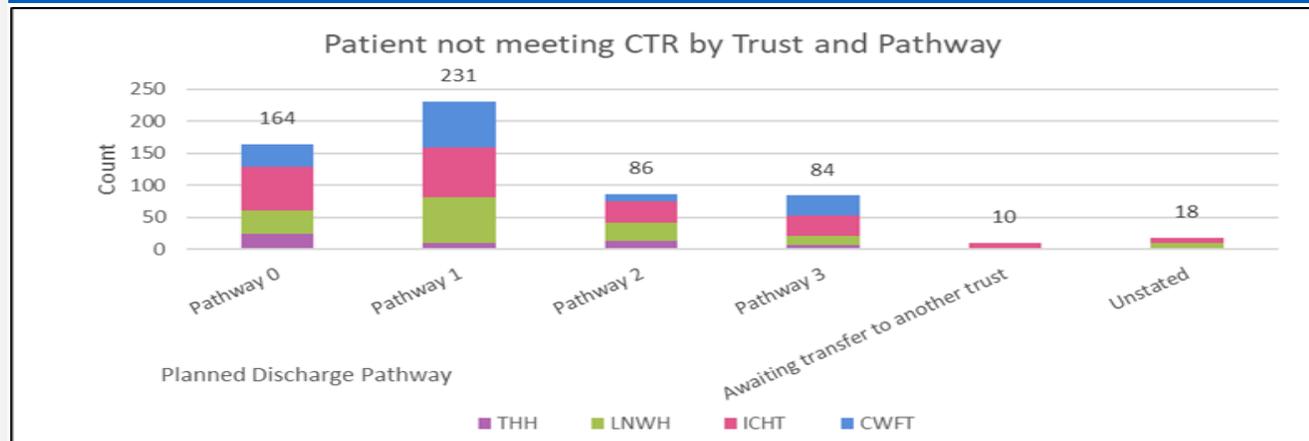
Improvement: Further opportunity for P0 and P2 rehab; exploring with providers. Optica rollout to LAS continues and will help boroughs with achieving targets proposed.

Forecast risks: Continued delays for patients waiting for admission to mental health beds. NCTR occupancy remains challenged.

CURRENT PERFORMANCE

Local Authority	CWFT	ICHT	LNW	THH	Total	List Size	Rate r per 10,000
Brent	2	34	46	0	82	388,755	2.11
Ealing	9	31	50	0	90	433,858	2.07
H&F	22	37	0	0	59	224,022	2.63
Harrow	0	2	43	0	45	256,630	1.75
Hillingdon	0	9	12	42	63	324,843	1.94
Hounslow	43	20	1	0	64	327,779	1.95
Kensington & Chelsea	20	17	0	0	37	268,576	1.38
Westminster	7	46	0	0	53	253,186	2.09
Out of area	47	32	8	13	100		
Total	150	228	160	55	593		

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Managing Director Chelsea and Westminster.

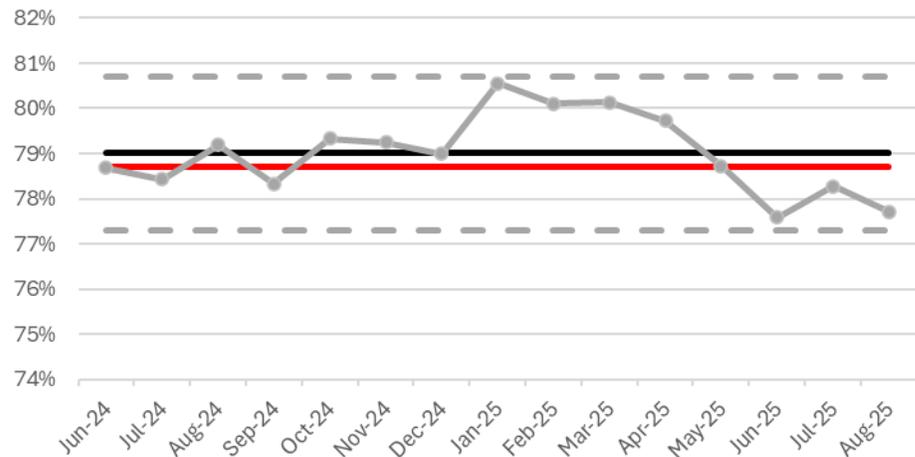
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Delivery through Urgent and Emergency Care Board. These figures come for the FDP via the ICB

Long Length of Stay for Emergency Patients

TREND

% Bed Days Emergency Patients > 6 days



78.4%

ALLOWANCE

77.7%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: This metric shows the proportion of bed days for emergency patients that have been attributed to emergency patients staying beyond 6 days.

Recovery plan: To be confirmed

Improvements: A high rate of bed days that are due to emergency patients staying beyond > 6 days that the organisation has a problem with stranded patients.

Performance data is provisional and supplied for review against its intended purpose and for alignment on definition.

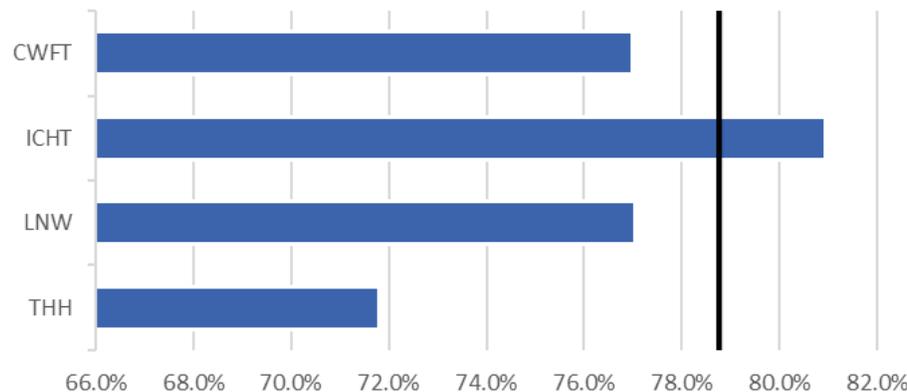
Forecast risks: To be confirmed

CURRENT PERFORMANCE

Bed days attributed to long-stay patients: August-25

	Total Emergency Bed Days	Long LOS Performance	Difference from Provider Median	Long LOS Emergency Bed Days
CWFT	19,072	77.0%		14,681
ICHT	26,729	80.9%	-2.2%	21,635
LNW	26,193	77.0%		20,181
THH	9,309	71.8%		6,683
APC	81,303	77.7%		63,180

STRATIFICATION



Current Trust waits shown against the national provider median

GOVERNANCE

Senior Responsible Owner: To be confirmed

Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Provisional figures provided for review and comment. CWFT data under internal review.

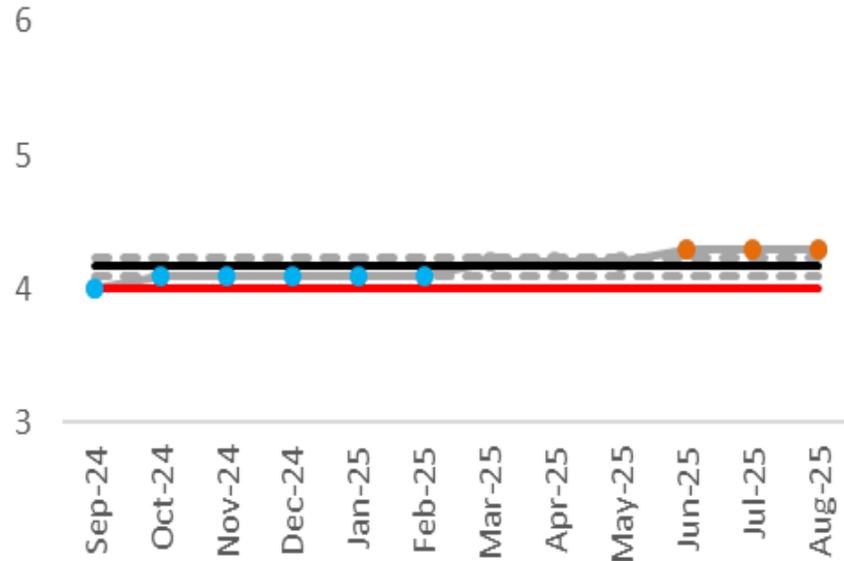
Section 3: Workforce

August 2025

Sickness Absence

TREND

Acute Collaborative - Rolling Sickness Rate %



=/ \leq 4%

STANDARD

4.3%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: We have seen an increase in sickness across the Trusts since March 2025 with current levels (4.3%) above the target of 4.0% and all Trusts are actively monitoring this. This metric is now flagging as a special cause for concern.

All Trusts have plans in place to manage absence, particularly long-term absence. For example, THH have been providing targeted training has been to managers and produced a sickness deep dive paper for their workforce committee.

Trusts continue to work locally to re-deploy staff and mitigate safe staffing risks as required, which can result in a higher reliance on temporary staff with increased numbers of bank and agency shifts being requested and filled to mitigate staffing gaps due to sickness absence.

Recovery Plan / Improvements: Access to staff psychology and health and wellbeing services are in place and supported across all Trusts with a wide-range of other staff support services in place with the cost of living for staff a continued focus for all Trusts.

Forecast Risks: Sickness absence levels which could be impacted by seasonal illness waves.

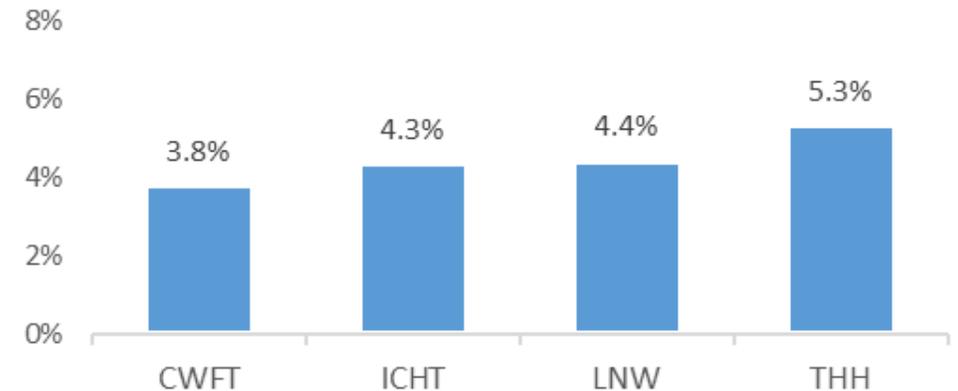
CURRENT PERFORMANCE

Rolling Sickness Absence

	Target %	Month 05 12 Month Rolling Sickness Absence Rate %	Variance to Target %	Month 05 In-Month Sickness Absence Rate %
CWFT	4%	3.8%	0.2%	3.9%
ICHT	4%	4.3%	-0.3%	4.4%
LNW	4%	4.4%	-0.4%	4.4%
THH	4%	5.3%	-1.3%	5.6%
APC	4%	4.3%	-0.3%	4.4%

STRATIFICATION

12 Month Rolling Sickness Absence Rate % across the APC Month 05



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

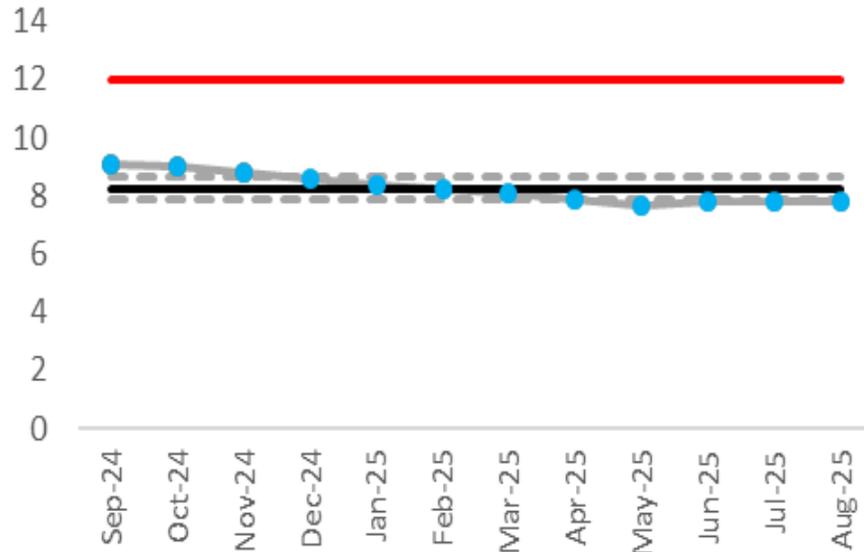
Committee: APC People Committee

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Voluntary Turnover

TREND

Acute Collaborative - Turnover Rate %



=/<12%

STANDARD

7.8%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Voluntary turnover continues as a special cause improving variation as, over the past year, there has been a steady reduction from 10.6% to the current position of 7.8% which is below the APC target of 12.0% (London position 10.0% and National position 9.0%).

APC CPOs have shared details of existing retention initiatives to inform planning for future local or collaborative action. Exit interviews and Stay Conversations continue with a particular focus on hotspot areas such as ICU, Midwifery and AHP staff. Feedback and insight is being fed back into Trust retention plans and actions.

Recovery Plan / Improvements: Staff wellbeing is a key enabler in improving retention and each Trust has a well-established package of wellbeing support, which has been shared and improved upon through the Collaborative platform, for all members of staff.

A prominent reason for leaving is cited as 'relocation' which is not something we can directly influence. In terms of reducing the number of leavers, but hindering analysis and interventions to reduce turnover, is the use of 'other/not known' as a leaving reason and we are working to improve the capture and recording of this data to inform retention plans.

Forecast Risks: The current cost of living issue is one which we are taking seriously, and our CEOs have agreed a common package of measures to support staff.

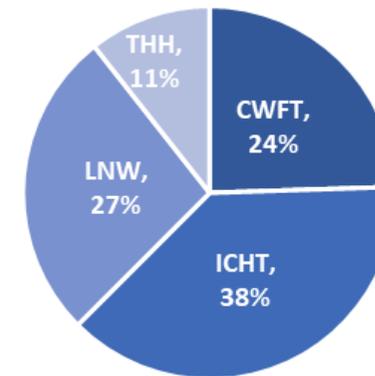
CURRENT PERFORMANCE

Voluntary Turnover

	Target %	Month 05 Turnover Rate %	Variance to Target %	Voluntary Leavers WTE (rolling 12 months)
CWFT	12%	8.8%	3.2%	538
ICHT	12%	7.1%	4.9%	836
LNW	12%	7.7%	4.3%	591
THH	12%	9.1%	2.9%	234
APC	12%	7.8%	4.2%	2,199

STRATIFICATION

Trust proportion of voluntary leavers wte (rolling 12 months) across the APC Month 05



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

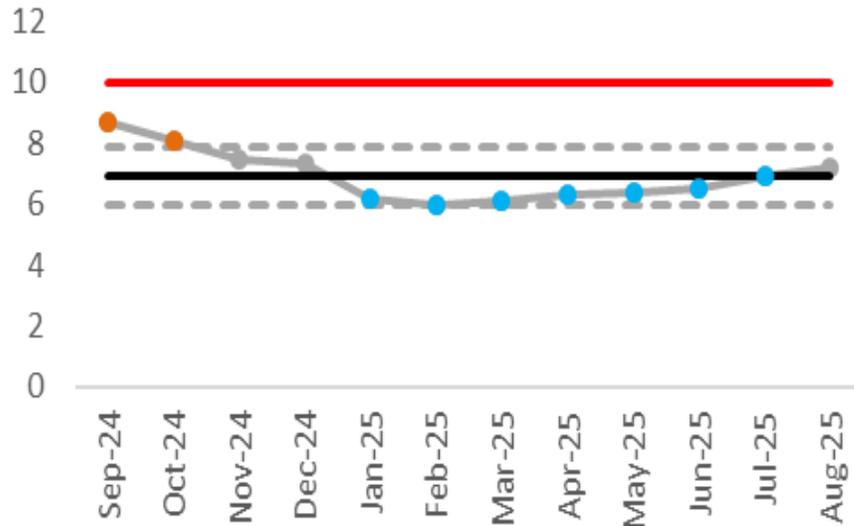
Committee: APC People Committee

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Vacancies

TREND

Acute Collaborative - Vacancy Rate %



=/ \leq 10%

STANDARD

7.2%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Vacancy rates at collaborative level are consistently hitting. Since January 2024, the collaborative vacancy level has maintained below the agreed target of 10.0% and in August 2025 was 7.2% (London position 7.5% and National position 6.8%). The THH vacancy increase since April was the outcome of their strategy to substantiate posts to reduce bank and agency usage.

Collaborative action is focussed on the hard to fill vacancies. Our top areas of concern are those hard to recruit roles due to a national shortage of qualified staff including; Operating Department Practitioners, Sonographers, Occupational Therapists and Mental Health Nurses. With a continuing reliance on temporary staffing and locums to fill the vacancy gaps and support service delivery and both local and collaborative work continues to improve this position.

Current overall, workforce performance for the APC is within the 25/26 WTE plan.

Recovery Plan / Improvements: Hard to recruit roles continue to receive focus to reduce vacancies and reduced reliance on agency resource to fill the roles. Robust governance and review of requests to recruit are managed at Trust level along with temporary staffing controls.

Forecast Risks: High levels of vacancies puts additional pressure on bank staffing demand.

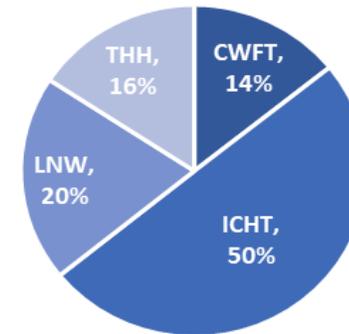
CURRENT PERFORMANCE

Vacancies

	Target %	Month 05 Vacancy Rate %	Variance to Target %	Vacancy WTE
CWFT	10%	5.0%	5.0%	378
ICHT	10%	8.4%	1.6%	1,323
LNW	10%	5.6%	4.4%	532
THH	10%	10.7%	-0.7%	418
APC	10%	7.2%	2.8%	2,652

STRATIFICATION

Trust proportion of vacant WTE across the APC Month 05



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

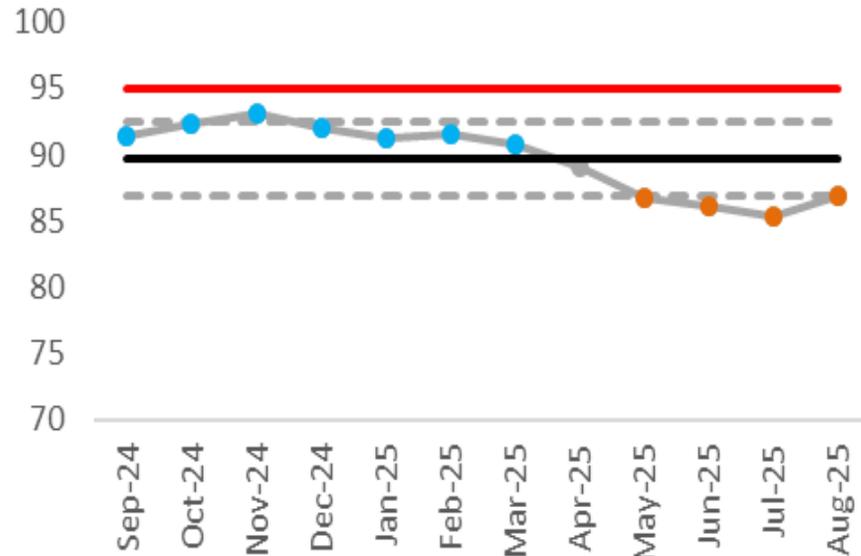
Committee: APC People Committee

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Non-Medical PDR

TREND

Acute Collaborative - PDR Completion Rate %



= / < 95%

STANDARD

86.9%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Completion rates for non-medical **Performance Development Reviews (PDR)**, is an area of continued focus. CWFT and ICHT have specified windows for PDR completions, and both are working in these at the moment. THH and LNWH work to a rolling programme.

For Medical Appraisals, the APC at Month 05 has a rate of 92.5%, which is split as follows CWFT 85.2%; ICHT 96.1%; LNWH 93.4% & THH 92.1%.

Recovery Plan / Improvements: Continued Executive monitoring and engagement with line managers and supervisors is in place to complete all reviews to ensure that all staff have this essential conversation with their manager.

Forecast Risks: Operational pressures continue to contribute to the challenge of conducting and completing the appraisal and PDR conversations as we go into increased winter pressure activity and potential further industrial action.

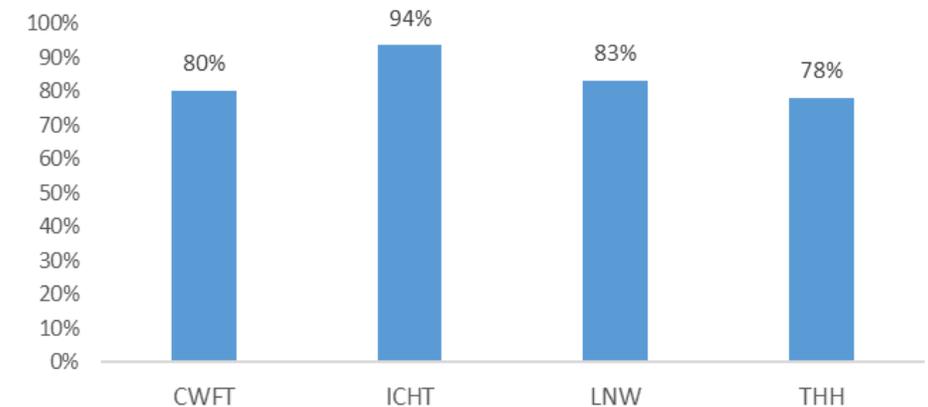
CURRENT PERFORMANCE

Non-Medical PDR

	Target %	Month 05 PDR / Appraisal Rate %	Variance to Target %
CWFT	95%	80.0%	-15.0%
ICHT	95%	93.5%	-1.5%
LNW	95%	83.3%	-11.7%
THH	95%	78.1%	-16.9%
APC	95%	86.9%	-8.1%

STRATIFICATION

Month 05 Non-Medical PDR Rate % by Trust across the APC



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNWH

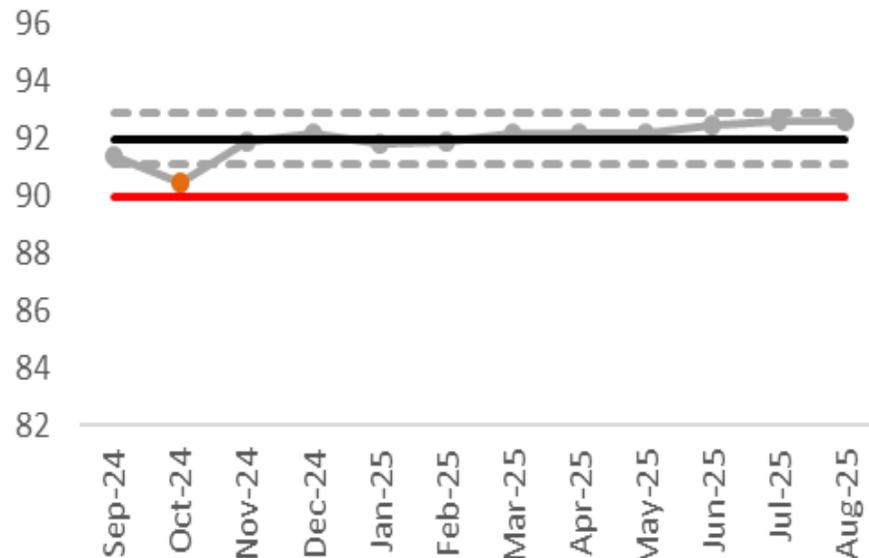
Committee: APC People Committee

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Mandatory Training Compliance

TREND

Acute Collaborative - Core Skills Rate %



=/ \leq 90%

STANDARD

92.6%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Mandatory training compliance is essential in the delivery of safe patient care as well as supporting the safety of staff at work and their ability to carry out their roles and responsibilities in an informed, competent and safe way. All Trusts across the APC continue to perform well against the target for Mandatory Training compliance and it is not an area of concern at collaborative level. However, the THH compliance data has reduced partly due to the post implementation review of all topics and denominators/audiences which were incorrect in the legacy system, and the standardization with the new Core skills Framework.

Recovery Plan / Improvements: Topic level performance monitoring and reporting is key to driving continual improvement with current areas for focus. The induction programmes for Resident Doctors includes time for them to complete the online elements of their mandatory training, which is essential during high rotation activity including August and February.

Where possible, auto-reminders are in place for both employees and their line managers to prompt renewal of core skills training as are individual online compliance reports as well as previous mandatory training accredited for new starters and doctors on rotation to support compliance.

Forecast Risks: None

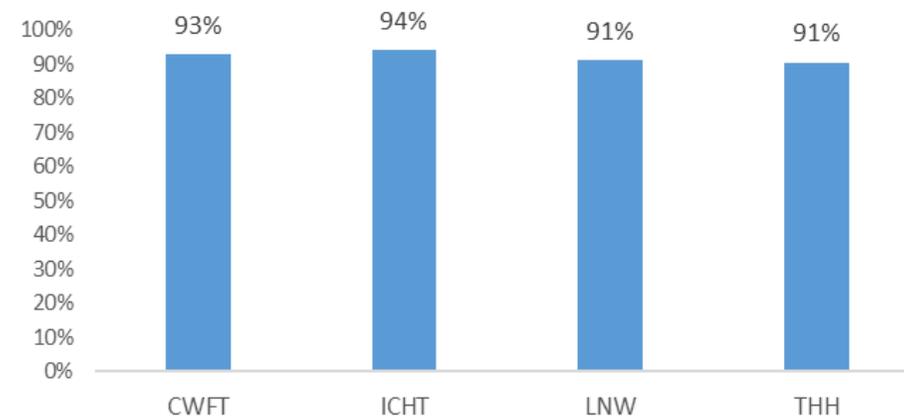
CURRENT PERFORMANCE

Mandatory Training Compliance

	Target %	Month 05 Mandatory Training Compliance Rate %	Variance to Target %
CWFT	90%	92.7%	2.7%
ICHT	90%	94.1%	4.1%
LNW	90%	91.2%	1.2%
THH	90%	90.5%	0.5%
APC	90%	92.6%	2.6%

STRATIFICATION

Month 05 Mandatory Training Compliance Rate % by Trust across the APC



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

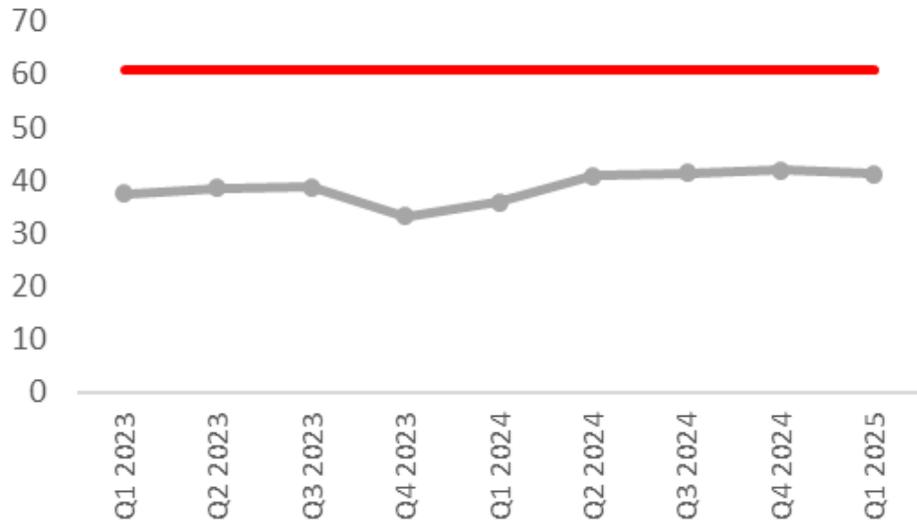
Committee: APC People Committee

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Model Employer Goals

TREND

Acute Collaborative - Model Employer Goals



= / < 61%

STANDARD

41.9%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Model Employer Goals (MEG) look at the level of recruitment required to achieve equity and representation of Black, Asian and minority ethnic people within the senior workforce (bands 8a to VSM). MEG uses the difference between the proportion of known ethnicities of an organisation against existing proportion of known ethnicities within each band.

Since August 2023(Q1), the collaborative MEG level has increased by 3.7% to 41.2% in June 2025(Q1).

Recovery Plan / Improvements: Actions being taken and developed to support MEG

Inclusive talent management strategies; Succession planning to enable identifying, support and promotion of talent; Inclusive recruitment means panels are gender-diverse and ethnically inclusive; Diverse recruitment panels for all roles above band 7; Regular monitoring and reporting on MEG targets; EQIA of planned workforce reductions to identify and minimise adverse impact on BME progression.

Forecast Risks: None

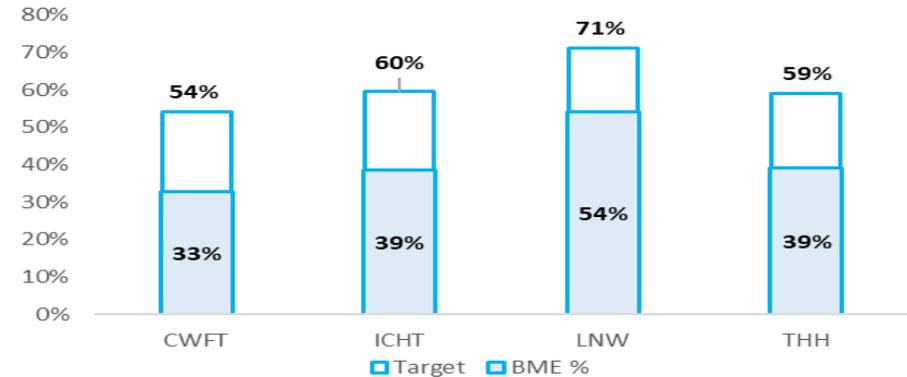
CURRENT PERFORMANCE

Model Employer Goals

	Target %	Month 05 Model Employer Goals %	Variance to Target %
CWFT	54%	32.7%	-21.3%
ICHT	60%	38.7%	-20.9%
LNW	71%	54.2%	-16.8%
THH	59%	39.0%	-20.0%
APC	61%	41.2%	-19.8%

STRATIFICATION

Month 05 Model Employer Goals % by Trust across the APC



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: APC People Committee

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

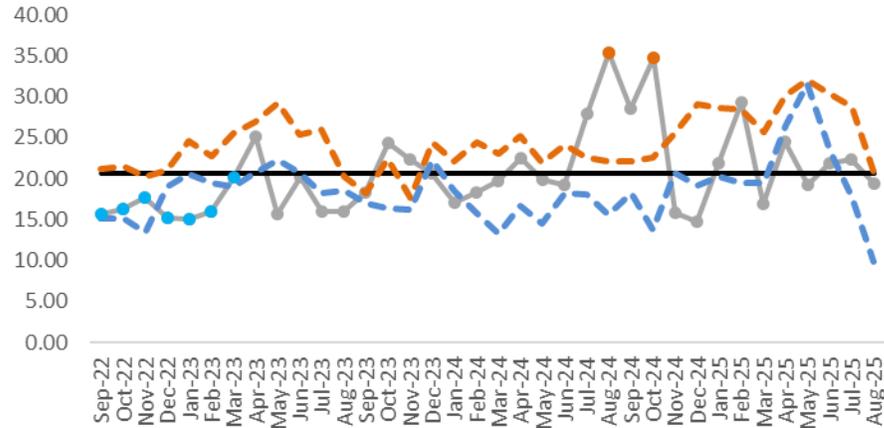
Section 4: Statutory and Safety Reports

August 2025

Healthcare Associated C.Difficile Infections

TREND

Healthcare Associated c. Difficile Infections



Trust Specific

STANDARD

19.43

PERFORMANCE



TREND

ASSURANCE

NARRATIVE

Performance: In August there was a small reduction in the number of cases reported (n=19). All trusts, except LNW, are exceeding trajectories based on their annual thresholds

Recovery plan: Every case is reviewed for any lapses in care or opportunities for improvement, including peer and APC review. Improvement work is underway in all Trusts resulting in a reduction of cases compared to 2024/25. Themes include inappropriate sampling, delays in isolation and stool chart inaccuracy. THH has the highest rate - learning is being shared across all divisions and additional training provided.

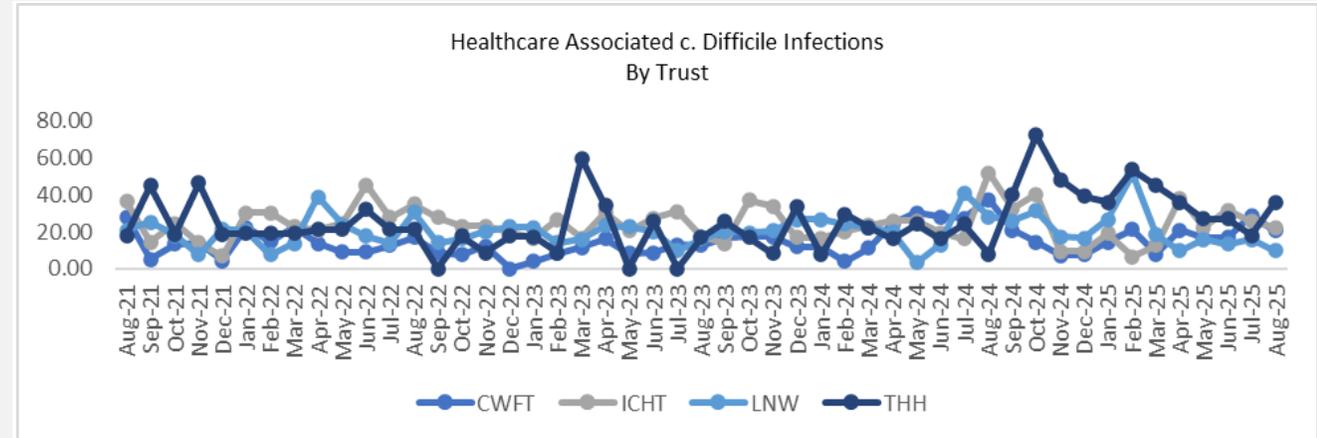
Improvements: Ongoing work with system /ICB partners. All organisations are working on better sampling and continue to review each case with the clinical teams and cascade learning, and action plans are subsequently developed to address lessons learnt which are monitored through local trust governance processes. Work on strengthening guidance and policies continues.

Forecast Risks: National rates continue to rise in community and hospital acquired and may breach thresholds given current trajectory. Each Trust is set a different threshold not necessarily reflective of the size or patient complexity of their organisation.

CURRENT PERFORMANCE

	Total bed days (in month)	Count of c.Diff cases (in month)	Rate of c. Difficile Infections per 100,000 bed days (in month)	12 Month rolling rate of c. Difficile Infections per 100,000 bed days	Count of c.Diff cases in year (FY 25/26)	Trust Threshold (FY 25/26)	Difference from Threshold
CWFT	24,463	5	20.44	16.15	25	33	
ICHT	31,486	7	22.23	22.44	44	81	
LNW	30,690	3	9.78	20.83	20	73	
THH	11,132	4	35.93	40.27	16	26	
APC	97,772	19	19.43	22.42	105	213	

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

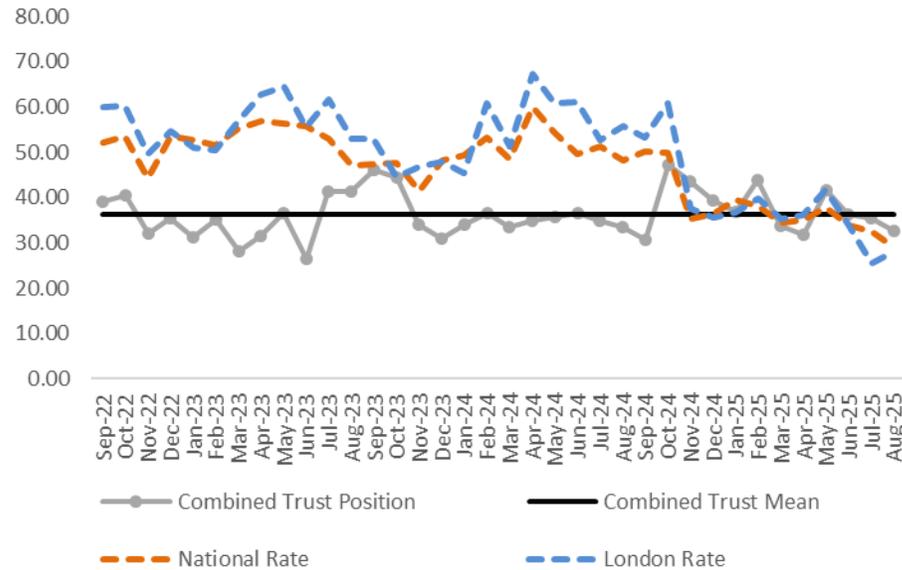
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Healthcare Associated E. coli Infections

TREND

Rate of Healthcare Associated E. Coli Infections



Trust Specific

STANDARD

32.73

PERFORMANCE



TREND

ASSURANCE

NARRATIVE

Performance: 32 cases reported in month, a small reduction. LNW and THH are exceeding their trajectories for the financial year based on their annual thresholds.

Recovery Plan: Learning is fed back to the clinical teams and incidents submitted for further investigation where appropriate. The ICB is focused on reduction of E.coli BSIs in line with the NHS Long Term Plan. A regular ICS-led Gram-negative blood stream infection meeting is in place to drive improvement as a significant proportion are attributed to community acquisition, it is important that there is a greater understanding of the risk factors for those attributed to acute organisations. Each organisation reviews cases with themes and trends presented at the IPCG. THH, ICHT and CWFT note a reduction in their cases with active input and LNW is working with colleagues to implement the shared learning from peers. Ongoing work continues focused on ensuring best practice for line and device care and improving use of the catheter passport and urinary catheter audits.

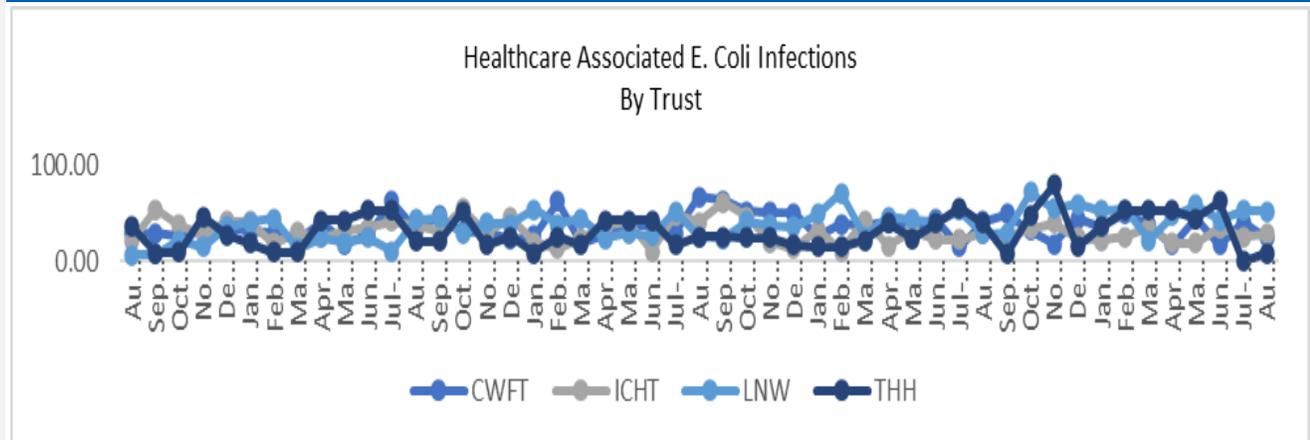
Improvements: Impact of actions taken through local and ICS reduction plan are monitored in each Trust and reported through the GNB BSI ICS group and APC group. All organisations are continuing the active review of trends and sources to ensure ongoing reduction in cases and improved patient care with data showing that urinary tract and hepatobiliary remain the leading causes of E.coli BSI.

Forecast Risks: N/A

CURRENT PERFORMANCE

	Total bed days (in month)	Count of E.Coli BSIs in month	Rate of E. Coli Infections per 100,000 bed days (in month)	12 Month rolling rate of E. Coli Infections per 100,000 bed days	Count of E.Coli BSIs in year (FY 25/26)	Trust Threshold (FY 25/26)	Difference from Threshold
CWFT	24,463	6	24.53	34.61	35	99	
ICHT	31,486	9	28.58	27.98	40	94	
LNW	30,690	16	52.13	50.05	80	132	
THH	11,132	1	8.98	38.83	19	39	
APC	97,772	32	32.73	37.79	174	364	

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

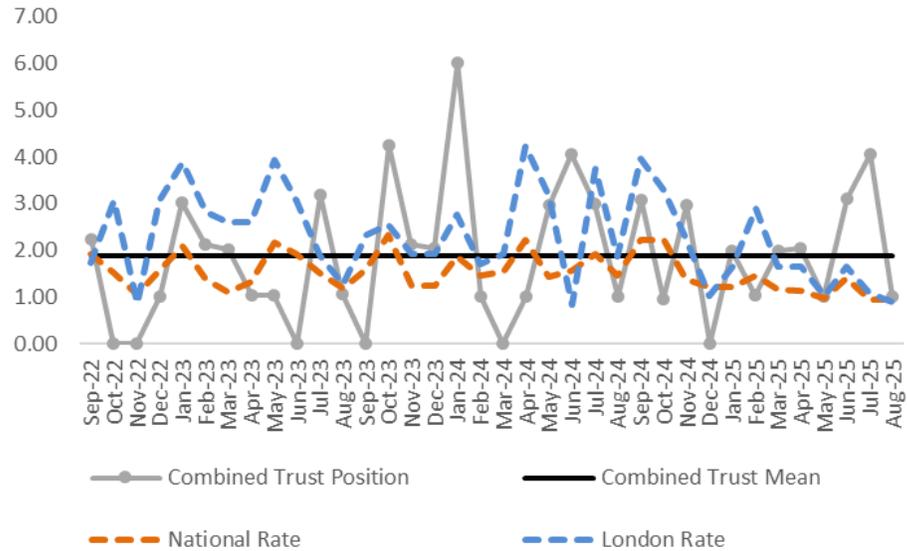
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Healthcare Associated MRSA Infections

TREND

Rate of Healthcare Associated MRSA Infections



0
STANDARD

1.02
PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: 1 MRSA BSI reported in August at CWFT. There have been 11 cases so far this financial year with each Trust reporting at least one. Two of the three cases at ICHT were part of a wider outbreak in neonates at QCCH which was confirmed as closed in September 2025 following actions to improve the environment, cleaning and decontamination, IPC practice including hand hygiene and screening, and reviewing cot spacing.

Recovery Plan: Robust processes for managing and investigating cases, and on-going improvement work are in place across all Trusts, with a focus on improving routine IPC practice. All cases are reviewed to identify any lapses in care or learning opportunities. All organisations are focussing on improving line and device care and hand hygiene compliance.

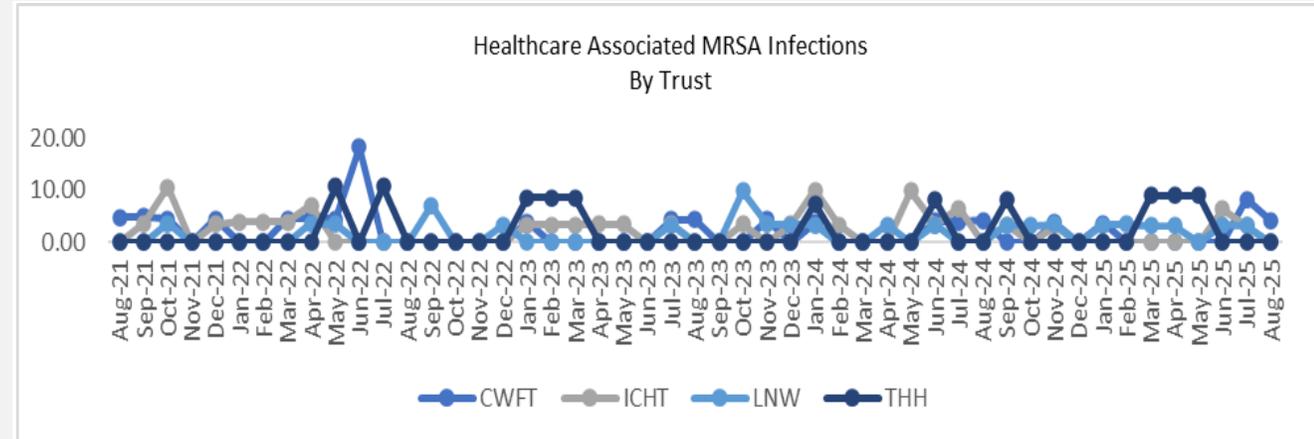
Improvements: Learning from cases is regularly shared across the APC to support identification of collective action or learning. Key focuses for improvement are screening, isolation and decolonisation, and improvements to hand hygiene, aseptic non-touch technique (ANTT), and line and device care.

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Total bed days (in month)	Count of MRSA BSIs in month	Rate of MRSA Infections per 100,000 bed days (in month)	12 Month rolling rate of MRSA Infections per 100,000 bed days	Count of MRSA BSIs in year (FY 25/26)	Trust Threshold (FY 25/26)	Difference from Threshold
CWFT	24,463	1	4.09	1.65	3	0	-3.0
ICHT	31,486	0	0.00	1.32	3	0	-3.0
LNW	30,690	0	0.00	2.43	3	0	-3.0
THH	11,132	0	0.00	2.88	2	0	-2.0
APC	97,772	1	1.02	1.93	11	0	-11.0

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

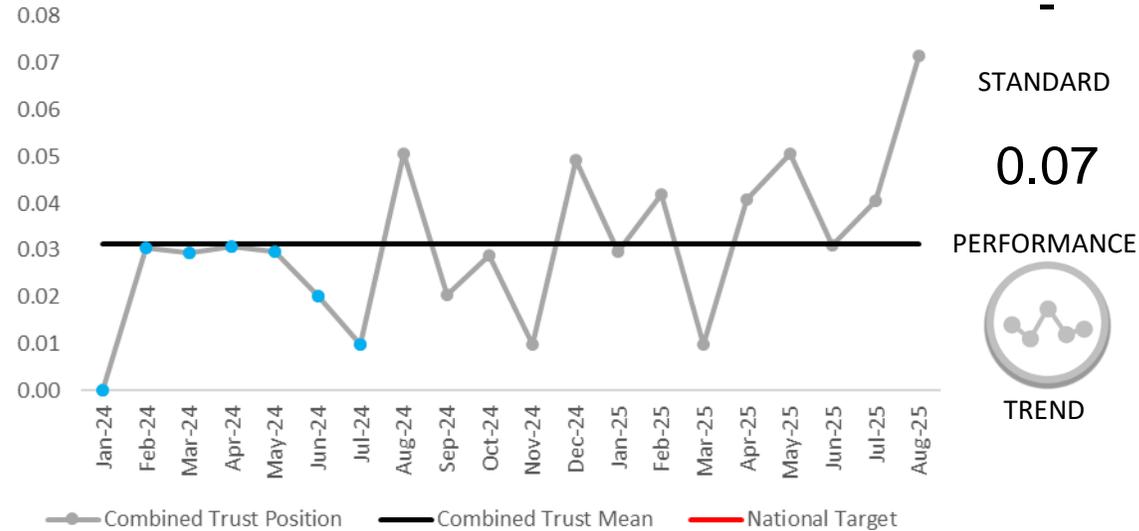
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Pressure Ulcers (per 1000 bed days)

TREND

HA cat 3+ pressure ulcers per 1000 bed days



STANDARD
0.07
PERFORMANCE
TREND

ASSURANCE

NARRATIVE

Performance: This metric shows the rate of hospital acquired (HA) pressure ulcers graded as category 3 and 4. The figures are based on data reported in the Trusts' incident reporting systems, and it is not risk adjusted. The increase in August 2025 is driven by ICHT (although their rolling 12-month rate remains comparable).

Recovery Plan: Cases are being reviewed by each organisation to identify learning which will feed into local safety improvement programmes. The ICHT increase is primarily in critical care with an MDT review underway of all cases since Jan 2025 and a cross-divisional T&F group in place to consider additional actions to reduce device related PU's— with a focus on safer delivery of oxygen. CWFT have the highest annual rate although no new cases reported since July. Improvement work is ongoing, with targeted interventions and focused support for wards at WM, where previous high reporting trends were identified.

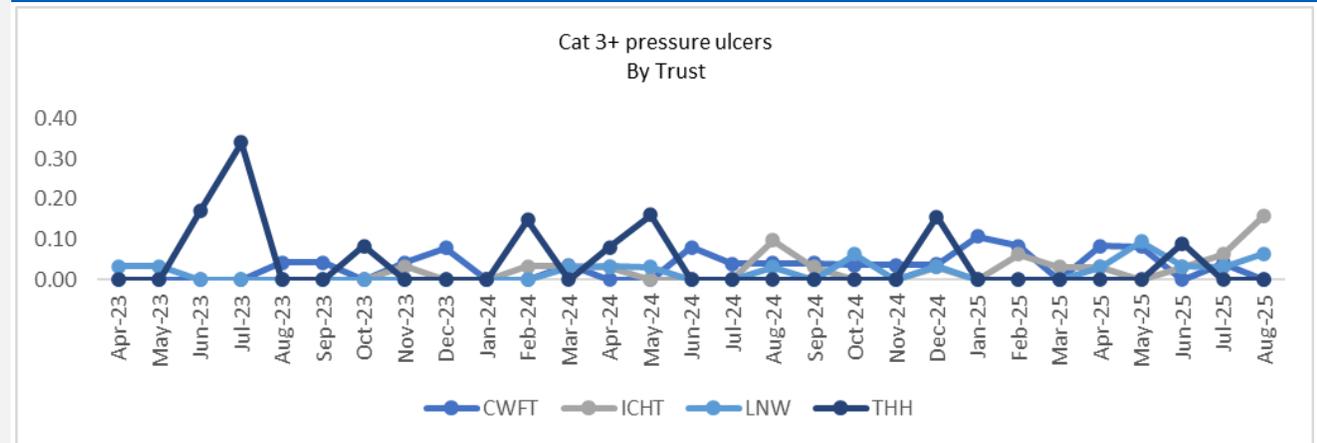
Improvements: All Trusts have improvement plans in place focused on pressure ulcer prevention.

Forecast Risks: There is on-going outreach underway with community services and borough partners.

CURRENT PERFORMANCE

	Total bed days	HA cat 3+ pressure ulcers per 1000 bed days (in month)	Number of HA cat 3+ pressure ulcers (in month)	12 month rolling number of HA cat 3+ pressure ulcers	12 month rolling rate of HA cat 3+ pressure ulcers per 1000 bed days
CWFT	24,463	0.00	0	14	0.05
ICHT	31,486	0.16	5	14	0.04
LNW	30,690	0.07	2	11	0.03
THH	11,132	0.00	0	3	0.02
APC	97,772	0.07	7	42	0.04

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

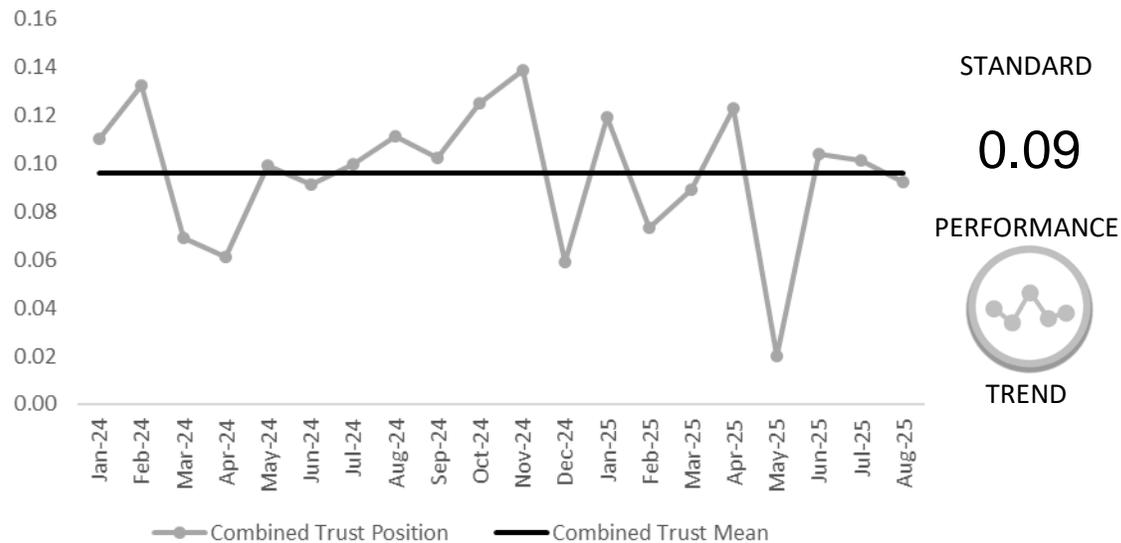
Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Inpatient falls (per 1000 bed days)

TREND

Inpatient fall with moderate or above harm per 1000 bed days



STANDARD

0.09

PERFORMANCE



TREND

ASSURANCE

NARRATIVE

Performance: This metric shows the rate of falls reported as causing moderate or above harm to patients per 1000 bed days, which is consistently below 0.2 with small numbers overall. Data is not risk adjusted. National benchmarking data is not currently available. There were 9 cases reported in August. No issues to escalate.

Recovery Plan: The cases are being reviewed via each organisation's PSIRP to identify learning which will feed into local safety improvement programmes.

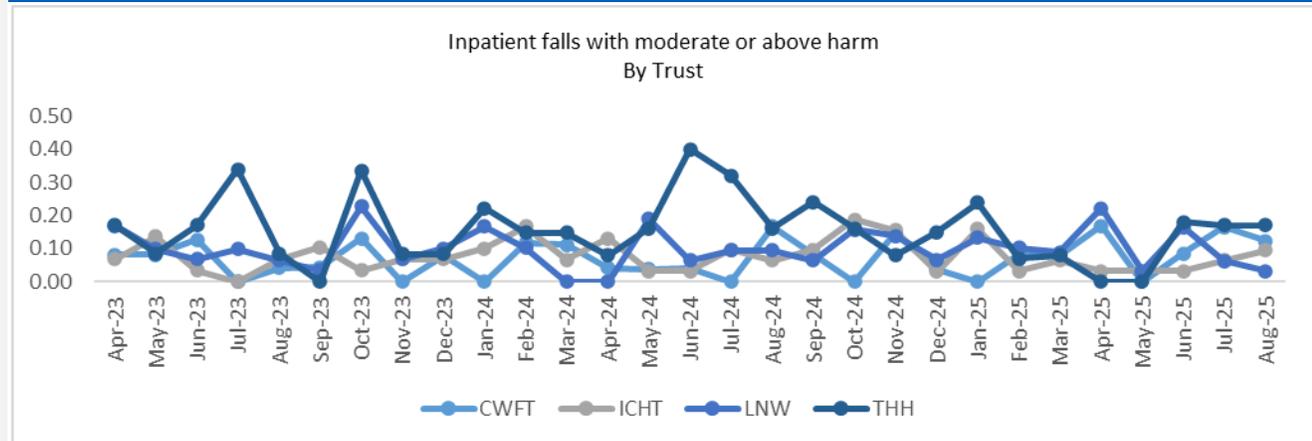
Improvements: All Trusts have safety improvement programmes in place to support prevention of falls with harm, including specific projects with high falls frequency areas, thematic reviews and improvements to risk assessments.

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Total bed days (in month)	Inpatient falls with moderate or above harm per 1000 bed days (in month)	Number of inpatient falls with moderate or above harm (in month)	12 month rolling number of inpatient falls with moderate or above harm	12 month rolling rate of inpatient falls with moderate or above harm per 1000 bed days
CWFT	24,463	0.12	3	24	0.08
ICHT	31,486	0.10	3	31	0.08
LNW	30,690	0.03	1	39	0.11
THH	11,132	0.18	2	20	0.14
APC	97,772	0.09	9	114	0.10

STRATIFICATION



GOVERNANCE

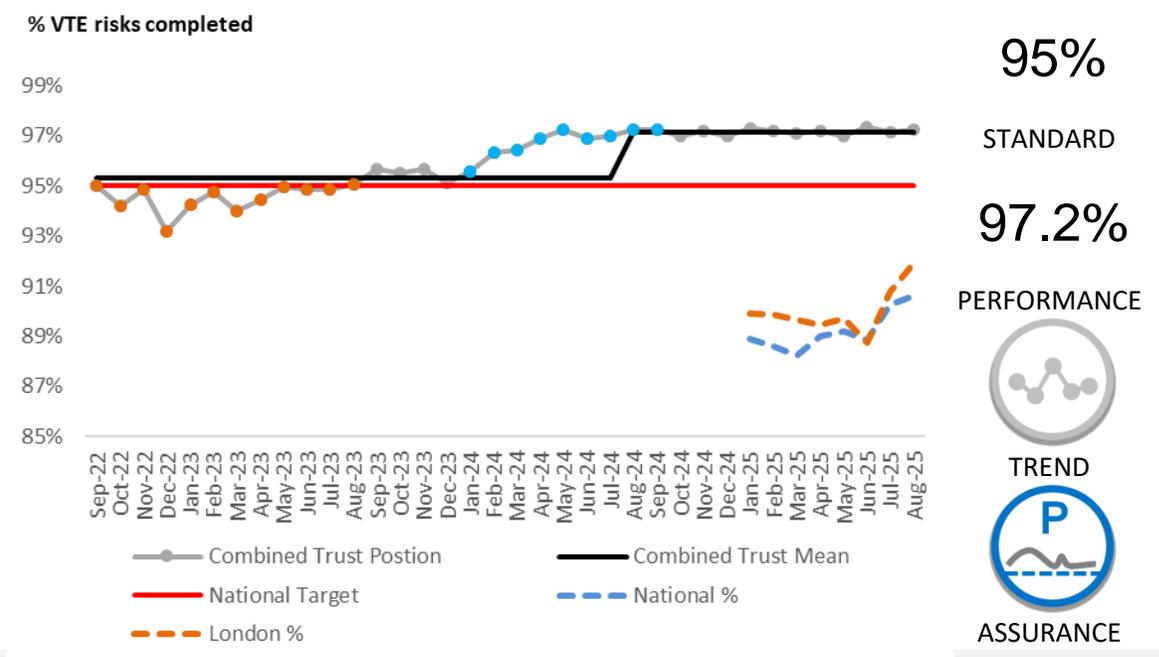
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

VTE Risk Assessments

TREND



NARRATIVE

Performance: Benchmarking data from June 2024 onwards is now available for this metric and shows we are performing considerably better than the London and national rates. We are above the standard across the last 12 months in all Trusts.

Recovery Plan: Not applicable

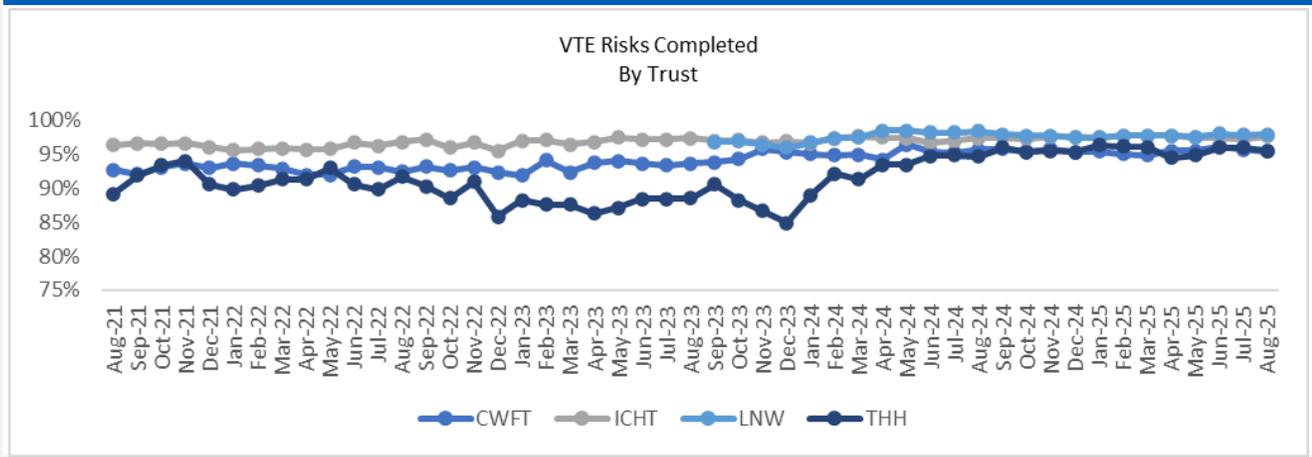
Improvements: Not applicable

Forecast Risks: Not applicable

CURRENT PERFORMANCE

	Total Inpatient Admissions	VTE Risk Assessments	Difference from Target	Count of Inpatients With Completed Risk Assessments	12 Month Rolling VTE Risk Assessments
CWFT	7,236	95.5%		6,908	95.5%
ICHT	16,053	97.7%		15,683	97.6%
LNW	13,364	98.0%		13,101	97.8%
THH	3,428	95.6%		3,276	95.9%
APC	40,081	97.2%		38,968	97.2%

STRATIFICATION

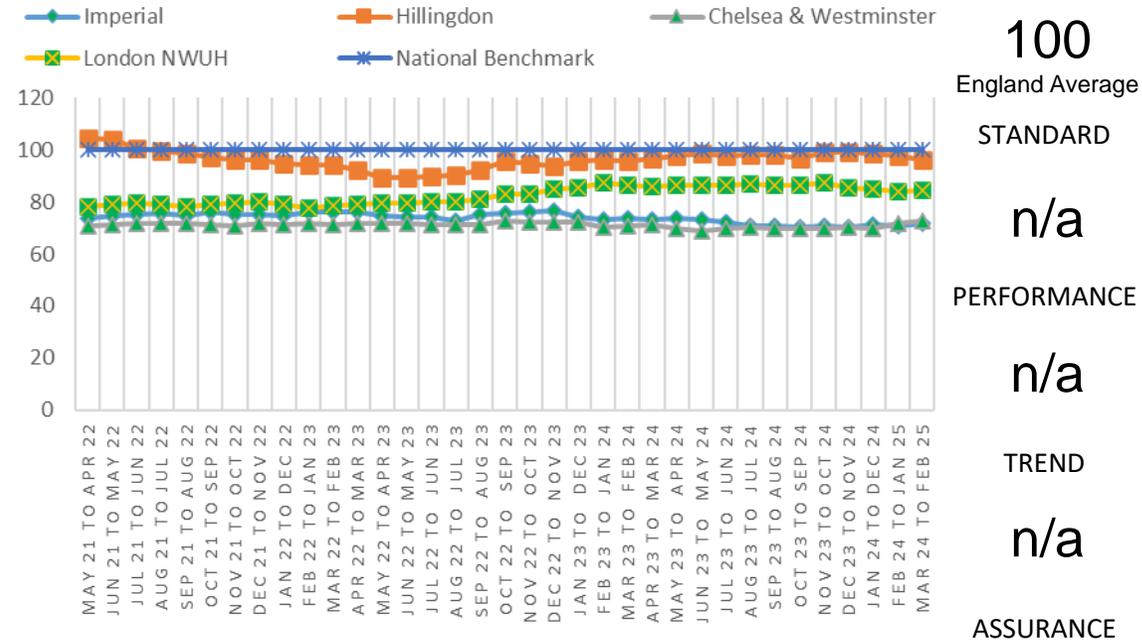


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Summary Hospital-level Mortality Index

TREND



NARRATIVE

Performance: For three of the four trusts (CWFT, ICHT and LNW), the rolling 12-month SHMI remains lower than expected with the most recent data available (March 2024 to February 2025). THH's rate is consistently 'as expected'.

Recovery Plan: Not applicable.

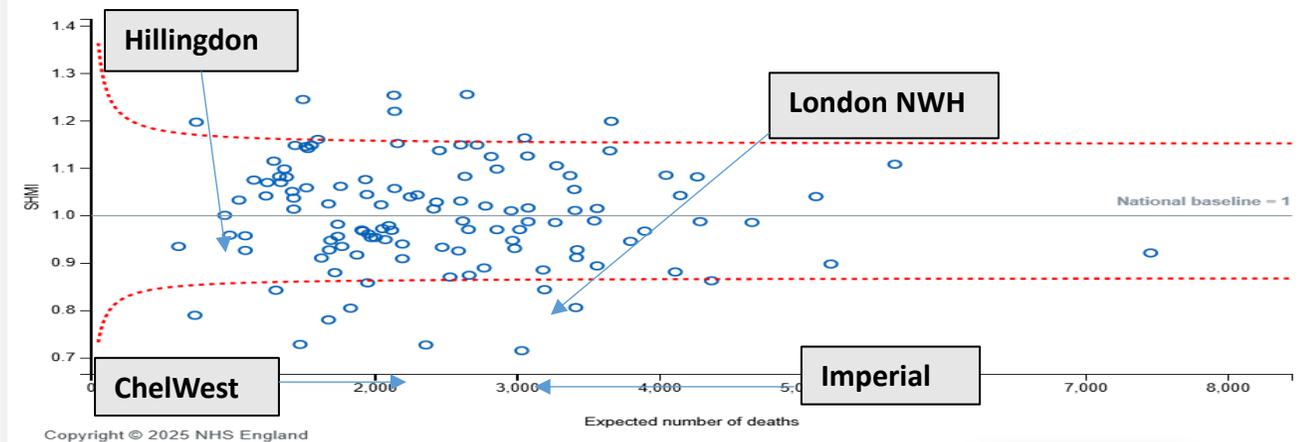
Improvements: All Trusts investigate variations between observed and expected deaths by diagnostic group. Reviews for quarter one are summarised in the learning from deaths report presented separately to APCQC.

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	96590	72.75	Lower than expected
ICHT	119310	71.54	Lower than expected
LNW	105675	84.42	Lower than expected
THH	52590	95.90	as expected

STRATIFICATION



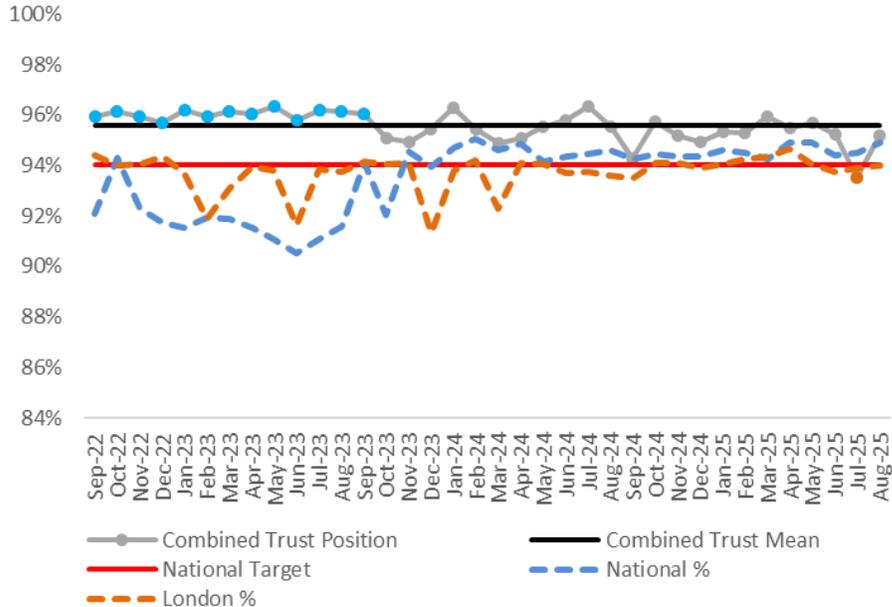
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Data is supplied and quality assured by Telstra Health

Inpatient Friends & Family Test

TREND

% good experience - Inpatients



94%

STANDARD

95.2%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: At APC level, the percentage of inpatients reporting a good experience increased in August following a drop below the target in July, likely linked to the disruption caused by the implementation of the new survey provider. All Trusts except THH are above target in month and across the last 12 months.

Recovery Plan: THH are focusing on improving the number of responses, which is resulting in a greater spread of feedback provided. The patient engagement team are working with staff to evaluate feedback received and how this is responded to.

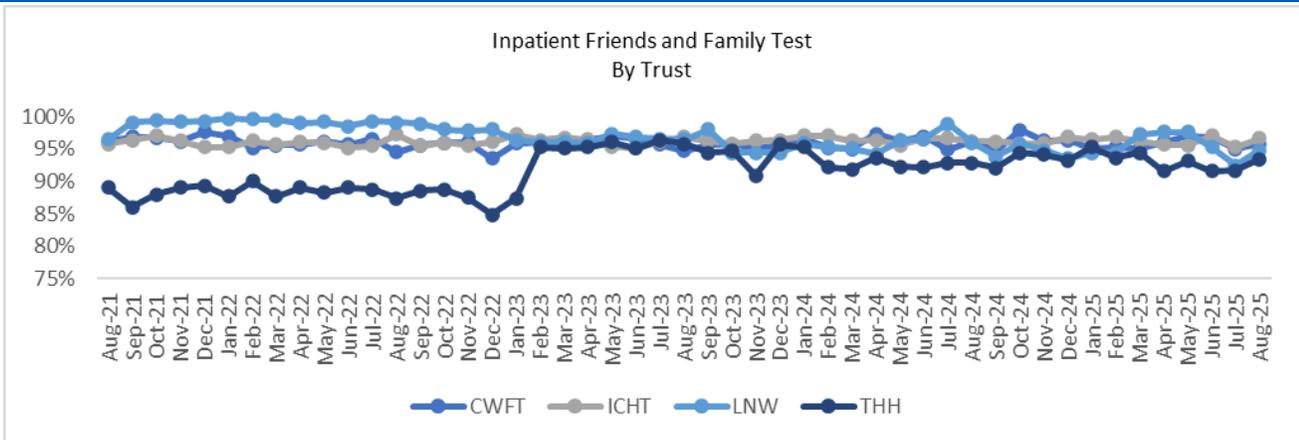
Improvements: A new patient survey platform was implemented in July across the APC, which will support better identification of areas for collaborative improvement once embedded.

Forecast Risks: Continued workforce and operational pressures may have a detrimental impact on patient experience, particularly as we move into winter.

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	786	95.8%		753	95.8%
ICHT	1,794	96.7%		1,734	96.2%
LNW	2,652	94.8%		2,514	94.8%
THH	1,111	93.4%	-0.6%	1,038	93.2%
APC	6,343	95.2%		6,039	95.2%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: APC Executive Management Board (Chair: Tim Orchard)

Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

5.1 QUALITY

🕒 11:50

5.1.1 QUALITY IQPR (ANYTHING BY EXCEPTION)

● Discussion Item

👤 Pippa Nightingale

See Appendix 5.0

5.1.2 LEARNING FROM DEATHS QUARTER 1 REPORT

● Information Item

👤 Jon Baker

REFERENCES

Only PDFs are attached

 05.1.2 APC learning from deaths Q1.pdf

NWL Acute Provider Collaborative Board in Common (Public)

21/10/2025

Item number: 5.1.2

This report is: Public

Acute provider collaborative Learning from Deaths quarter one 2025/26 summary report

Author: Alex Bolton
Job title: Director of Quality and Patient Safety, LNWH

Accountable directors: Jon Baker, Alan McGlennan, Roger Chinn, Raymond Anakwe & Julian Redhead
Job title: Chief medical officers / Medical directors

Purpose of report

Purpose: Information or for noting only

Trusts are required to report data to their public board on the outcomes from their learning from deaths process. This is achieved through a detailed quarterly report to individual Trust quality committees, with this overarching summary paper drawing out key themes and learning from the four acute provider collaborative (APC) trusts. This report is presented to the APC quality committee and the Board-in-common with individual reports in the reading room.

Report history

Trust Quality Committees	APC Quality Committee
Various Individual trust reports were reviewed at each quality committee and approved for onward submission.	01/10/2025 Approved

Executive summary and key messages

- 1.1. In line with national guidance each Trust provides a quarterly report to their quality committee on mortality surveillance and other learning from deaths processes. This report presents a summary of the findings from the quarter one reports of 2025/26.
- 1.2. Individual Trust reports are in the reading room and provide assurance that deaths are being scrutinised in line with requirements and learning shared and acted upon through Trust governance processes.
- 1.3. The new model for HSMR (HSMR+) was introduced during this reporting period, the new metric 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
- 1.4. Our mortality rates continue to be lower than, or as expected, when compared nationally, with regular review of these occurring both internally and through the APC quality committee. London North West University Healthcare (LNWH), Imperial College Healthcare Trust (ICHT), and Chelsea and Westminster Hospital (CWFT) have a 'lower-than-expected' Hospital Standardised Mortality Ratio (HSMR) for the period April 2024 to March 2025. The Hillingdon Hospitals (THH) has an 'as expected' HSRM for this period of 107 (where 100 is the expected national benchmark).
- 1.5. There continue to be low numbers of cases where clinical concerns are identified through Level 2 reviews. There were five instances of sub-optimal care where different care might have made a difference and one case where sub-optimal care would reasonably be expected to have made a difference to the outcome. No common themes were identified across these cases and further improvement opportunities are being sought via the incident management process.
- 1.6. All Trusts continue to investigate variations between observed and expected deaths by diagnostic group. Reviews undertaken in quarter four identified no clinical concerns.

Strategic priorities

Tick all that apply

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

- Achieve a more rapid spread of innovation, research, and transformation

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

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 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.

Main report

2. Learning and Improvements

- 2.1. Each Trust has processes in place to ensure learning happens after all in-hospital deaths and that this is shared and actions implemented where required.
- 2.2. There are no issues for escalation to this committee.
- 2.3. The key theme for improvement from reviews undertaken in this quarter relates to effective communication with patient and their families / next of kin particularly. This theme is consistent with previous quarters with local trust work in place.
- 2.4. At individual trust level the reviews show evidence of improvements in some key areas, as well as some themes for improvement including:
 - **CWFT:** review highlighted areas for improvement around timely treatment escalation planning, management of medical outliers, inconsistent documentation practices, fast track discharge barriers, radiology / imaging delays, gaps in monitoring and telemetry, communication gaps between teams, and the need for earlier and more consistent communication with families.
 - **ICHT:** learning from review identified an area for improvement within a small number of cases around effective communication with patients and their families / next of kin. There has been a reduction this quarter in cases involving suboptimal treatment of deteriorating patients, but this remains an improvement priority.
 - **LNWH:** review highlighted areas for improvement regarding timely recognition and response to deterioration, effective communication with families / next of kin, and the involvement of other specialities and palliative care team.

- **THH:** review identified some areas of improvement relating to electronic patient record discrepancies and the recording of mortality review outcomes (currently not supported by a digital solution).

3. Thematic Review

3.1. A shared core data set has been created for use in all learning from death reports and is included in individual Trust reports.

3.2. Mortality rates and numbers of deaths

3.2.1 The new model for HSMR (HSMR+) was introduced during this reporting period, the new metric 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 the Trust remains within the expected statistical range.

3.2.2 APC provider mortality rates continue to be lower than, or as expected, when compared nationally, with regular review of these occurring both internally and through the APC quality committee. LNWH, ICHT, and CWFT have a 'lower-than-expected' Hospital Standardised Mortality Ratio (HSMR) for the period April 2024 to March 2025. THH has an HSRM of 107 for this period (where 100 is the expected national benchmark); this is within the 'as expected' range.

3.2.3 Data shows that each Trust continues to have a rolling 12-month SHMI below the national benchmark; with all other Trusts 'lower than expected' for this indicator for the period March 2024 to February 2025.

3.2.4 Trend and funnel plot visualisations of HSMR and SHMI mortality rates at Trust level are included monitor within individual Trust learning from death reports and reported up to the APC mortality surveillance group.

3.2.5 HSMR and SHMI diagnostic group data is reviewed by the APC mortality surveillance group, with variation noted. Providers regularly reviewing HSMR and / or SHMI diagnostic groups with a score above 100, or where HSMR is increasing, to understand the differences. Reviews undertaken in quarter one include:

- **LNWH:** Review into cases linked to 'cardiac arrest and ventricular fibrillation' (23 cases), and 'other psychoses' (6 cases) were completed during this reporting period following an increase in HSMR above the national benchmark of 100. Learning from this clinical review did not identify any elements of sub-optimal care within these groups.
- **THH:** During this reporting period reviews were commenced for diagnostic groups; 'Pneumonia' (152 cases, Trust is examining 33) and 'Fracture of neck of femur' (17 cases, Trust is examining 13). Review of these cases is on-going, outcomes will be reported in the Trust's Q2 learning from deaths report.

3.2.6 There were no diagnostic groups requiring further review identified at ICHT, CWFT, during this reporting period.

3.2.7 Trust level HSMR data is provided by Telstra Health UK. The table below shows most rolling HSMR between April 2024 and March 2025.

Provider Rolling 12 month HSMR	April 2024 – March 2025
CWFT	81.0
ICHT	78.6
LNWH	94.5
THH	107.8
National Benchmark	100.0

3.3. Medical examiner reviews

- 3.3.1 All Trusts have medical examiner services in place who scrutinise in-hospital deaths. All in-patient deaths were scrutinised by respective offices in quarter one.
- 3.3.2 All four Trusts continue to provide weekend ME scrutiny, prioritising urgent cases i.e. deaths requiring urgent body release. Learning from each Trust continues to feed into collaborative work with an aim to establish a shared weekend medical examiner service future.

3.4. Level 2 reviews

- 3.4.1 Deaths where there are concerns, or which meet agreed criteria, are referred by the medical examiner for a case note 'Level 2' review. The percentage of deaths referred during quarter four were 19% at LNWH, 7% at THH, 12% at ICHT and 34% at CWFT.
- 3.4.2 A shared set of 'triggers' for these reviews were implemented at the end of Q1 2024/25 to allow consistent reporting on themes. CWFT have also retained local triggers to be used where potential learning was identified at initial screening by consultants or for other local reasons such as requests from divisional mortality review groups, this explains the higher percentage referral data there.
- 3.4.3 All Trusts have implemented the CESDI scoring system to identify whether a death was avoidable in order to produce standard outputs from Level 2 reviews. Outcomes show low numbers of cases where definite issues are confirmed through Level 2 review which aligns with the lower-than-expected mortality ratios. Six cases where sub-optimal care would reasonably be expected to (CESDI 3) have or might have (CESDI 2) contributed to the patient's outcome were identified from completed reviews for deaths in this quarter which is a similar to the previous quarter.
- 3.4.4 For deaths which occurred in quarter one:
- **CWFT:** 64 Level 2 reviews completed with no cases of sub-optimal care that might have made a difference to the patient's outcome.
 - **ICHT:** 51 Level 2 reviews completed with one case of sub-optimal care that would reasonably be expected to have made a difference to the outcome and four cases of sub-optimal care that might have made a difference to the patient's outcome.
 - **LNWH:** 96 Level 2 reviews completed with one cases of sub-optimal care that might have made a difference to the patient's outcome.
 - **THH:** 6 Level 2 reviews have been completed, with no case of sub-optimal care that might have made a difference to the patient's outcome identified.

3.5. Other mortality reviews

- 3.5.1 A number of other national processes are in place for review of deaths for specific cohorts of patients. These include the Perinatal mortality review tool (PMRT), Learning disability

mortality review (LeDeR) and Child death overview panels (CDOP), which are described in the glossary below. Oversight of these processes is considered within Trust's and reported up to the APC Mortality Surveillance Group.

3.5.2 There were no LeDeR or CDOP reviews completed in quarter which identified significant concerns regarding the clinical care provided.

4. Conclusion

4.1. The individual reports provide assurance regarding each Trust's processes to ensure scrutiny of, and learning from, deaths in line with national guidance, with actions in place where the need to improve these further has been identified.

4.2. There continue to be low numbers of cases where clinical concerns are identified through Level 2 reviews. This aligns with mortality rates which are consistently good and small numbers of incidents reported overall where the harm to patients is confirmed as severe or extreme/death.

4.3. Local reviews into HSMR and SHMI diagnostic groups is overseen through trust governance process with themes shared at the APC mortality surveillance group and will continue to be summarised in this report going forward.

5. Glossary

- 5.1. **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 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.
- 5.2. **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.
- 5.3. **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.
- 5.4. **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.
- 5.5. **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.
- 5.6. **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. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

5.1.3 COLLABORATIVE QUALITY COMMITTEE CHAIR REPORT

● Discussion Item

👤 Matthew Swindells

REFERENCES

Only PDFs are attached

 05.1.3 APC Quality Committee Chair Report - Oct 2025.pdf

**North West London Acute Provider Collaborative (NWL APC)
Quality Committee Chair's Highlight Report to the NWL APC Board
in Common (BiC) – for discussion
1 October 2025**

Highlight Report

1. Purpose and Introduction

The role of the NWL APC Quality Committee in Common (CiC) is:

- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements.
- To identify, prioritise, oversee, and assure strategic change programmes to drive collaborative-wide and Integrated Care System (ICS) improvements.
- To draw to the NWL APC Board in Common's (BiC's) attention matters they need to agree, or note.

2. Key highlights

2.1. Progress Update: Single quality reporting and learning system

2.1.2. The Committee received an update on progress with the implementation of a single quality reporting and learning system, which had been delayed because of challenges relating to the procurement process. Full implementation has been pushed back to the end of Quarter 4 2025/26, however incremental module go-lives are planned from January 2026. A data migration sub-group is being established to oversee and manage the risks relating to the complexity and volume of the data migration to the new system.

2.2. Acute Collaborative Quality Performance Report

2.1.3. The Committee received the collaborative quality performance report which reported no escalations of concern and provided assurance that there were good controls in place across the domains. There have been improvements in pressure ulcer rates and maternity outcomes – including stillbirth and neonatal death rates – are being monitored closely across the trusts, with good processes in place for investigation and review. Collaborative learning and sharing of best practices are ongoing, with efforts to standardise risk assessment and referral pathways across all units.

2.2 Update on Quality Priorities 2025/26

2.2.1 Mental health in an acute setting workstream

2.2.2 An update was provided on the NWL APC Mental Health Strategy which focuses on providing safe and effective care to mental health patients in an acute setting. The Committee noted ongoing challenges with mental health patient flow and a lack of improvement in the length of time patients were

spending in emergency departments, which required better data and system-wide solutions to resolve. There was agreement at the meeting that the core issue was system collaboration with mental health trusts, and the matter was escalated to the North West London Integrated Care Board (NWL ICB) Chief Executives for consideration. In addition, a report was commissioned from the system mental health group on the proposals to address mental health patient flow.

2.2.3 Implement the standardised guideline for deteriorating patient and sepsis
Excellent progress has been made on the deteriorating patient and sepsis workstream, including the implementation of Martha's Rule, and the standardisation of patient pathways and staff training. The Committee heard that the collaboration was working well and all four trusts were compliant with national standards. It was reported that a small number of cases had been escalated, and teams were finding challenges around communications with patients and families, and misuse of the system. A shared learning event is to be held in November or December 2025 to review the two systems being piloted for patient well-being checks, and to discuss governance and the challenges encountered.

2.2.4 Align Clinical pathways to best practice across the APC
The Committee received an update on the work underway on clinical pathways and the outcomes of a recent clinical pathways event which had highlighted disparities in engagement across the trusts, a lack of consistent digital and Business Intelligence (BI) support, as well as a need to embed collaborative working as a core expectation for clinical leaders. The next phase of work will blend bottom-up and top-down approaches, with clear strategic aims and a programme management approach for major initiatives.

2.3 Updates on Quality Workstreams 2025/26

2.3.1 Implementation of NatSSIPs2
It was confirmed that all trusts recognised NatSSIPs2 standards and had standardised definitions and standard operating procedures, including how to audit and present data. Further digitisation and training will be paused until April 2026 to allow for local experience and governance processes to mature.

2.3.2 APC EDI Patient Equity Workstream
The Committee reviewed progress with Equity, Diversity and Inclusion (EDI) metrics, which included the implementation of sickle cell management and maternity booking indicators. Work was ongoing to resolve technical issues and standardise data collection.

2.3. Combined Risk Escalation Report from Local Trust Quality Committees

2.3.1. Committee members received the report which highlighted key points to note or areas of risk identified by each of the four Trust's Quality Committees where collaborative-wide interventions would speed up and improve the response. It was reported that there had been a number of never events, serious incidents and harm to patients across the collaborative, from which learning and actions had been shared. Assurance was provided that never-events are routinely reported to local Quality and Safety Committees.

The following additional escalations were reported by the trusts (by exception):

London North West University Healthcare NHS Trust (LNWH) reported the ongoing use of Temporary Escalation Spaces, with work underway with the Length of Stay Group to mitigate the risk through the establishment of a flow room.

Chelsea and Westminster NHS Foundation Trust (CWFT) flagged a risk in relation to ventilation in the new ambulatory diagnostic centre for which a resolution plan was in place.

There were no additional escalations from The Hillingdon Hospitals NHS Foundation Trust (THHFT) and Imperial College Healthcare NHS Trust (ICHT).

2.4. Maternity Intensive Scheme Quarter 2

2.4.1. An update was presented on progress with the Maternity Intensive Scheme and it was confirmed that all four trusts were on track for compliance, with actions at CWFT and THHFT requiring further evidence. It was confirmed that there were plans in place for these to be resolved by the end of the year. The Committee noted that a new standard operating procedure for the Perinatal Mortality Review Tool (PMRT) is in development.

2.5. Acute Provider Collaborative Learning from Deaths Quarter 1 summary report

2.5.1. The Committee reviewed the mortality metrics and noted that HSMR and SHMI remain low across all trusts except THHFT, where HSMR had risen above 100. Assurance was provided that the Trust had investigated the increase and no specific quality issues had been identified in the alerts or case reviews. It was confirmed that mortality reviews are conducted whenever there are spikes, and that overall, mortality remains low and under control.

2.6. Quarterly Complaints report for Q1 2025/26

2.6.1. An increase in complaints was reported across all four trusts, which was consistent with national trends and was reflective of the increased activity. The Committee discussed the need for standardised reporting, benchmarking and analysis of complaints outcomes.

2.7. Annual Infection Prevention Report

2.7.1. Despite improvements with Infection, Prevention and Control (IPC) metrics, there are ongoing performance challenges across the collaborative relating to Clostridium difficile, MRSA and E.coli, which will require collective action to improve. Future IPC reporting will include the National Oversight Framework (NOF) infection control scores to provide context around the collaborative's performance against national standards. A Board-in-Common development session will be held to ensure leaders understand the NOF metrics and how to improve scores.

3. Positive assurances received

- Assurance was received that any local risks and emerging issues were being managed within each Trust with improvement plans in place being monitored through the local quality committees.

4. Key risks / topics to escalate to the NWL APC BiC

- The new single reporting system will not be fully implemented until April 2026 because of delays caused by the procurement process.
- There is concern about the lack of progress with a system wide solution for mental health patient flow and experience.

5. Concerns outstanding

- There were no significant additional APC level concerns outstanding which required escalation to the Board.

6. Key actions commissioned

- A deep dive on the NOF quality metrics to be presented to the next meeting and a board development session to be arranged on the subject.
- A particular focus on the three infection control metrics to understand our comparative position to other hospitals and the actions to be taken if so indicated.
- Future reporting on the mental health in an acute setting workstream to include a comparison of performance year-on-year and year-to-date.
- Report to be commissioned from the system mental health group on the proposals detailing current proposals and strategic actions to address mental health patient flow and care in acute settings.

7. Decisions made

- There were no items for approval on the agenda.

8. Attendance

Members	October 2025 attendance
Patricia Gallan, Vice Chair (CWFT), Non-Executive Director (THHT) (Chair)	N
Syed Mohinuddin, Non-Executive Director (LNWH/CWFT)	Y
Linda Burke, Non-Executive Director (THHT/ICHT)	Y
Helen Stephenson, Non-Executive Director (ICHT/CWFT)	Y
Pippa Nightingale, Chief Executive (LNWH)	Y
Julian Redhead, Medical Director (ICHT)	N
Raymond Anakwe, Medical Director (ICHT)	Y
Roger Chinn, Medical Director (CWFT)	Y
Alan McGlennan, Chief Medical Officer (THHT)	Y
Jon Baker, Medical Director (LNWH)	Y
Sarah Burton, Chief Nurse (THHT)	Y
Robert Bleasdale, Chief Nurse (CWFT)	N
Janice Sigsworth, Chief Nurse (ICHT)	Y
Lisa Knight, Chief Nurse (LNWH)	N

5.2 PEOPLE

🕒 12:10

5.2.1 PEOPLE - IQPR (ANYTHING BY EXCEPTION)

● Discussion Item

👤 Pippa Nightingale

See Appendix 5.0

5.2.2 COLLABORATIVE PEOPLE COMMITTEE CHAIR REPORT

● Discussion Item

 David Moss

REFERENCES

Only PDFs are attached

 05.2.2 APC People Committee Chairs Highlight Report to the Board in Common Sept 25.pdf

North West London Acute Provider Collaborative Collaborative People Committee Chair's Highlight Report to the NWL APC Board in Common – for discussion

22 September 2025

Highlight Report

1. Purpose and Introduction

The role of the NWL APC Collaborative People Committee is:-

- To oversee and receive assurance that the Trust level People Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
- To draw to the Board in Common's attention matters they need to agree, or note

2. Key Highlights

- 2.1 **Staff Experience:** A member of staff from Imperial shared a comprehensive account of their journey through the Healthcare Leaders Fellowship, highlighting the transformative impact of the programme on their leadership development, the challenges faced by BME staff, and the importance of mentorship and networking.
- 2.2 **APC People KPIs:** the Committee discussed the EDI dashboard, debated the setting of annual diversity targets, and addressed the need for honest examination of institutional discrimination and the effectiveness of current actions. The Committee also reviewed vacancy rates, turnover, and sickness data across the four trusts, noting a slight uptick in vacancies due to cost controls, an increase in sickness (particularly at Hillingdon), and the introduction of standardised PDR windows. The importance of monitoring these metrics in the context of workforce reductions and cost improvement programmes was emphasised. The Committee noted the current workforce position including those highlighted areas requiring focus and improvement as well as the actions being taken to enable and drive that improvement
- 2.3 **Delivery of workforce plan and pay/WTE reduction:** The Committee noted WTE reductions and improved alignment with staffing plans, with pay overspend narrowing due to agency and bank cuts. Local finance committees will ensure activity reductions match spend cuts. Risks to patient experience from admin and corporate reductions should be monitored by Quality Committees. Short-term controls must continue until workforce transformation is achieved.
- 2.4 **Collaborative People Priority Transformation Updates:** The Committee examined workforce transformation initiatives, the alignment of workforce and financial plans, the challenges of headcount reduction, and the need for robust productivity metrics, with a focus on sustainable service reconfiguration and risk management. Concerns were raised about the impact of administrative and corporate staffing reductions on patient experience, noting that all headcount

reductions undergo equality impact assessments, with monitoring through Quality Committees to track any adverse effects on service quality and patient outcomes.

- 2.5 **Collaborative Workforce Risk Report:** The Committee agreed the main ongoing risk is achieving a financially sustainable workforce, with short-term pay controls and vacancy management as interim measures until strategic workforce changes are implemented. Risks from digital competency gaps, external environment impacts on staff engagement, and cultural challenges in transitioning to a group model were identified for explicit inclusion and monitoring in the strategic risk register. The risk of transitioning to a group model was noted as missing and should be clearly articulated.
- 2.6 **Board Assurance Framework BAF (collaborative strategic people risks):** The Committee reviewed the board assurance framework, emphasising the need to keep risks current and strategically focused on workforce transformation, financial sustainability, digital competency, external environment impacts, and the transition to a group model.
- 2.7 **APC Medium term Financial/Workforce plan principles:** The APC's medium-term plan focused on workforce affordability through service reconfiguration, pathway improvement, and estate consolidation, the Committee emphasised the need for clear milestones and accountability, balancing immediate cost controls with sustainable long-term changes.
- 2.8 **Medical Education Update:** The medical education update centred on GMC survey findings, the rollout of the national 10-point plan, and mechanisms for addressing identified issues, with the board seeking assurance on follow-up and national benchmarking. The GMC survey, involving thousands of resident doctors, highlighted concerns at Chelsea & Westminster, prompting trust-level actions and, where needed, NHS England quality visits. Trusts have submitted baseline data for the 10-point plan, which targets rota design, workload, and basic facilities, and must demonstrate progress within 12 weeks as they develop ongoing action plans. The Committee noted that red flags in the survey automatically lead to quality visits, and trusts are preparing accordingly. While the trusts generally fall within the national interquartile range, there was still scope for improvement.

3. Positive Assurances received

- Local People Committees across all four trusts focused a significant portion of their meetings on EDI, providing assurance that EDI is being actively discussed and progressed at the local level
- Quality impacts of workforce reductions are being monitored through established EQIA processes and Quality Committees, with metrics in place to track any adverse effects.
- The new workforce productivity metrics from Model Hospital will be brought to future meetings, allowing for benchmarking and assurance on productivity.
- Medical education survey results are being addressed at trust level, with action plans and preparations for NHS England quality visits where needed.
- The reduction in WTE (whole time equivalent) staffing is being managed in line with financial and activity plans, with local finance committees scrutinizing detailed plans.
- The EDI dashboard and progress will become a standing agenda item, ensuring ongoing monitoring and accountability

4. Key risks / topics to escalate to the NWL APC BiC

Key Risks:

- The main strategic risk identified is achieving a financially affordable workforce, with a focus on the need for structural service reconfigurations and pathway redesigns to reduce headcount sustainably.
- Short-term pay controls and vacancy management are being used as interim measures, but there is concern that these may disproportionately impact non-clinical roles and risk inefficiency if not managed carefully.
- There is a risk related to digital competency and capability within the workforce, especially as digital transformation accelerates. Ensuring staff are upskilled for new digital ways of working is seen as essential.
- External environmental risks, such as the impact of a hostile climate towards international and BME staff, were highlighted as potentially affecting workforce engagement and attendance.
- The transition to a group model and the associated cultural change is recognised as a significant risk, particularly in ensuring staff engagement and smooth integration.

Escalations:

- The Imperial People Committee specifically escalated concerns about diversity and representation on the executive team, linking this to broader EDI progress and the need for focused monitoring via the EDI dashboard.
- Hillingdon's vacancy rate was noted as a special cause for concern, with discussion about whether targets need to be reset to reflect changes in operational headcount.
- Chelsea and Westminster's medical education survey results showed a deterioration, triggering focused attention and likely NHS England quality visits.
- The need for reliable workforce productivity metrics was escalated, with a commitment to bring Model Hospital data to future meetings for better benchmarking and assurance.
- The Committee noted the importance of monitoring the impact of workforce reductions on patient experience, especially in administrative and corporate roles, and ensuring this is triangulated with quality metrics.

5. Concerns Outstanding

Concerns that the current headcount continues to exceed plan/budget.

6. Key Actions Commissioned

- Capture and follow up on actions from the EDI dashboard discussion, ensuring concrete steps are recorded and monitored.
- Monitor and report on the impact of workforce reductions, especially in administrative roles, on patient experience and service quality through EQIA processes and Quality Committees.
- Present detailed plans for achieving financial and workforce targets at local finance committees, including rescheduling operating plans and staff adjustments.
- Bring the new corporate workforce productivity metrics to future meetings for review and benchmarking across trusts.
- Develop and implement a coordinated communications campaign to support workforce diversity and counter negative external sentiment, with posters and personal stories across all sites.
- Add strategic risks related to digital competency and the transition to a group model to the risk register and assurance framework.

- Ensure ongoing monitoring and improvement actions for areas flagged in medical education surveys, with trust-level responses and preparation for NHS England quality visits.

7. Decisions Made

- To set and monitor annual EDI targets, with a focus on tracking progress and holding trusts accountable for improvements in workforce diversity at senior levels.
- Strategic risks related to digital competency and the transition to a group model will be added to the risk register and assurance framework
- Local finance committees will receive detailed plans for achieving workforce and financial targets, with regular updates and scrutiny.

8. Attendance

Members:	September attendance
David Moss, Non-Executive Director, LNWH (Chair)	Y
Sim Scavazza, Non-Executive Director, ICHT	N
Simon Morris, Non-Executive Director, THHFT	Y
Ajay Mehta, Non-Executive Director, CWFT	Y
Pippa Nightingale, Chief Executive (LNWH) and Collaborative Lead for People and Workforce	Y
Attendees:	
Matthew Swindells, Chair in Common	Y
Dawn Clift, Director of Corporate Affairs (LNWH)	Y
Tracey Connage, Chief People Officer, (LNWH)	Y
Kevin Croft, Chief People Officer (ICHT)	Y
Alexia Pipe, Chief of Staff to Chair in Common	Y
Jon Baker Chief Medical Officer (LNWH) (item 12)	Y
Shona Maxwell Chief of Staff, Office of Medical Director (item 12)	Y

5.3 FINANCE AND PERFORMANCE

🕒 12:25

5.3.1 PERFORMANCE - IQPR (ANYTHING BY EXCEPTION)

● Discussion Item

👤 Lesley Watts

See Appendix 5.0

5.3.2 FINANCIAL PERFORMANCE REPORT

● Discussion Item

● Bimal Patel

REFERENCES

Only PDFs are attached



05.3.2a CS - APC M5 Finance.pdf



05.3.2b NWL APC M5 financial performance.pdf

NWL Acute Provider Collaborative – Board In Common

21/10/2025

Item number: 5.3.2

This report is: Public

2025/26 NWL APC Financial Performance - (Month 5)

Author: Helen Berry
Job title: Associate Director of Finance, NWL APC

Accountable director: Bimal Patel
Job title: Chief Financial Officer, LNWH – on behalf of the Acute CFO Group

Purpose of report

Purpose: Assurance

Report history

This paper was considered by:

NWL Acute CFOs 03/10/2025 Noted and approved.	NWL APC EMB 19/10/25 Noted and approved
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Executive summary and key messages

- The report presents the financial performance of the NWL APC up to the end of Month 5 (August).
- Month 5 actual YTD performance is a deficit of £11.5m against a YTD plan of £5.3m, reporting a £6.2m YTD variance. In month, the position is an actual deficit of £76k against an in-month plan of £1.4m deficit, reporting a £1.4m favourable variance.
- All trusts reported favourable variances to their in-month plan in Month 5.
- Efficiency delivery is adverse to plan at £13.1m year to date, with £14.5m delivered in month 5.

- Two trusts, ICHT and LNWH continue to accrue ERF income over the YTD plan, at £1.2m and £7m respectively, totalling £8.2m.
- The forecast at Month 5 is to meet the annual plan (breakeven).
- The cash balance across the APC is £296.2m. This is £35.2m higher than the end of March and £85.8m above the cash plan for August.
- Capital spend YTD is £55.6m, reporting a £21.9m underspend to date, driven by capital schemes not yet commencing per the plan profile. The monthly rate of spend is up 21% compared to the first four months.

Strategic priorities

- Achieve recovery of our elective care, emergency care, and diagnostic capacity
- Support the ICS's mission to address health inequalities
- Attract, retain, develop the best staff in the NHS
- Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
- Achieve a more rapid spread of innovation, research, and transformation

Delivery of our financial plan is driven by – and supports - recovery of our elective, emergency and diagnostic capacity, and supports our objective of improvement in efficiency.

Impact assessment

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

Reason for private submission

N/A



Chelsea and Westminster
Hospital NHS Foundation Trust



The Hillingdon Hospitals NHS
Foundation Trust



Imperial College Healthcare
NHS Trust



London North West University
Healthcare NHS Trust

2025/26 NWL APC Financial Performance Month 5 (August 2025)

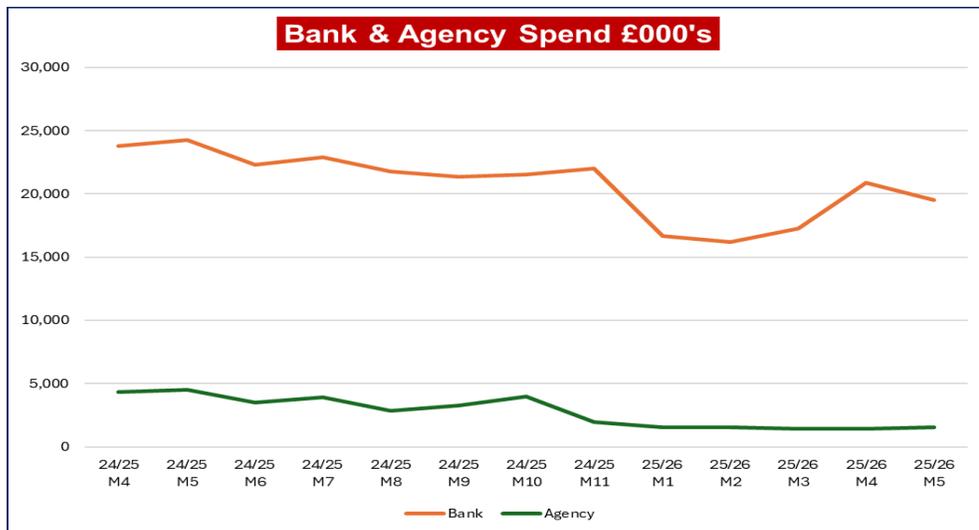
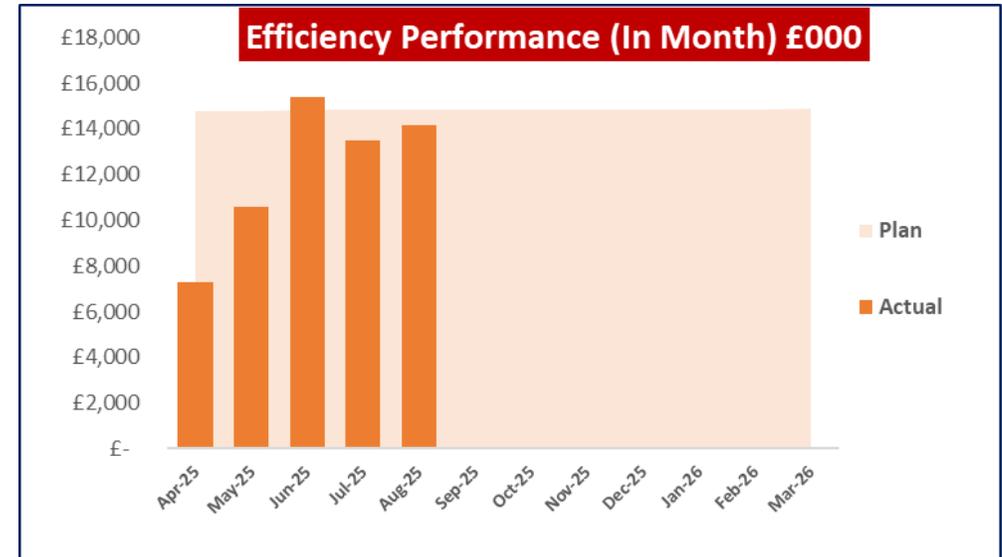
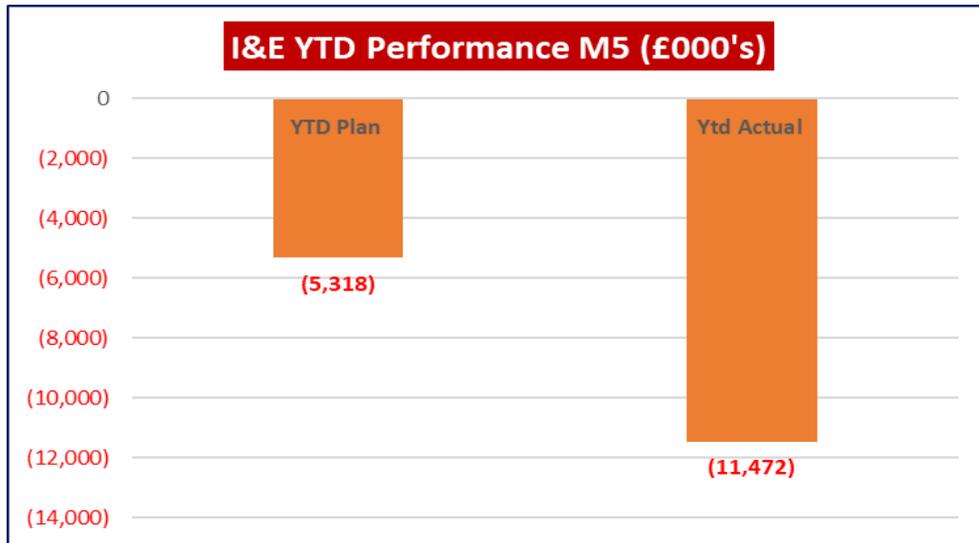
Helen Berry, Associate Director of Finance
For NWL APC CFO Group

Key Messages at Month 5

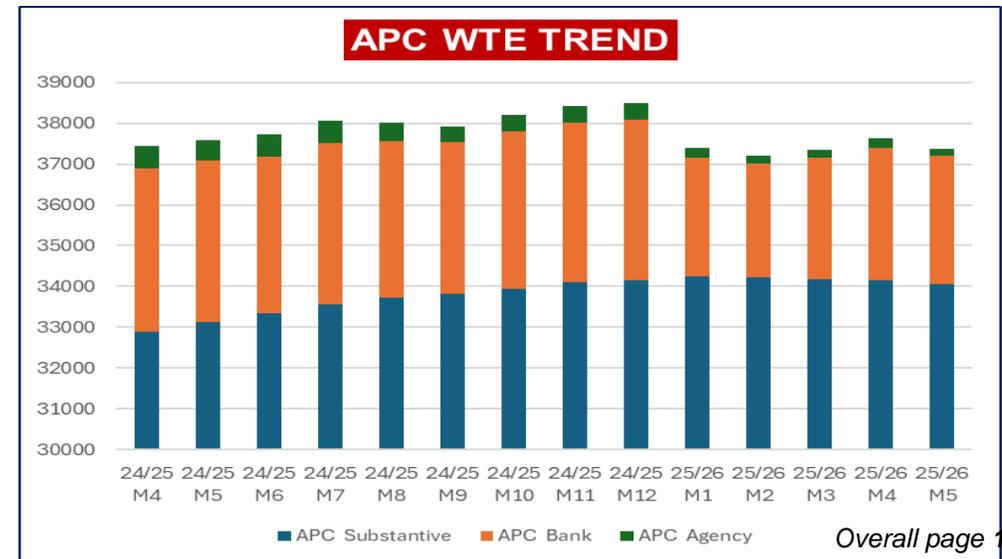
Key messages:

- Month 5 (August) actual YTD performance is a deficit of £11.5m against a YTD plan of £5.3m, reporting a £6.2m YTD variance. In month, the position is an actual deficit of £76k against an in-month plan of £1.4m deficit, reporting a £1.4m favourable variance.
- All trusts reported favourable variances to their in-month plan in Month 5.
- Efficiency delivery is adverse to plan at £13.1m year to date, with £14.5m delivered in month 5 (up from £13.5m the previous month) and better than the YTD monthly trend by £2.5m.
- Included in the YTD position is unplanned resident doctors' industrial action costs of £3.8m (in July – M4).
- Two trusts, ICHT and LNWH continue to accrue ERF income over the YTD plan, at £1.2m and £7m respectively, totalling £8.2m.
- The cash balance across the APC is £296.2m. This is £35.2m higher than the end of March and £85.8m above the cash plan for August, due in part to timing differences of planned capital spend vs actual.
- Capital spend YTD is £55.6m, reporting a £21.9m underspend to date, driven by capital schemes not yet commencing per the plan profile, mostly under the nationally funded schemes, where some schemes are awaiting final approval from the national team. The monthly rate of spend is up 21% compared to the first four months.
- To note: the values in the report are as reported in the Trusts' Provider Financial Monitoring Returns (PFR) to NHSE. There might be small differences to the variances reported within income, pay, non-pay and non-operating expenses when comparing to Trusts' internal reports which are run from the respective general ledgers. The PFR uses the Trust plans as submitted in April. Trusts may have made changes to the breakdown within the expense categories after the submission, for example when confirming the makeup of finalised efficiency schemes compared to those submitted in the plan. Importantly the bottom-line financial performance and overall reasons for variances to plan and are the same in this report and trust reports.

Key I&E Highlights at Month 5



Note: M4 includes impact of Resident Doctors' industrial action



I&E Performance – Month 5

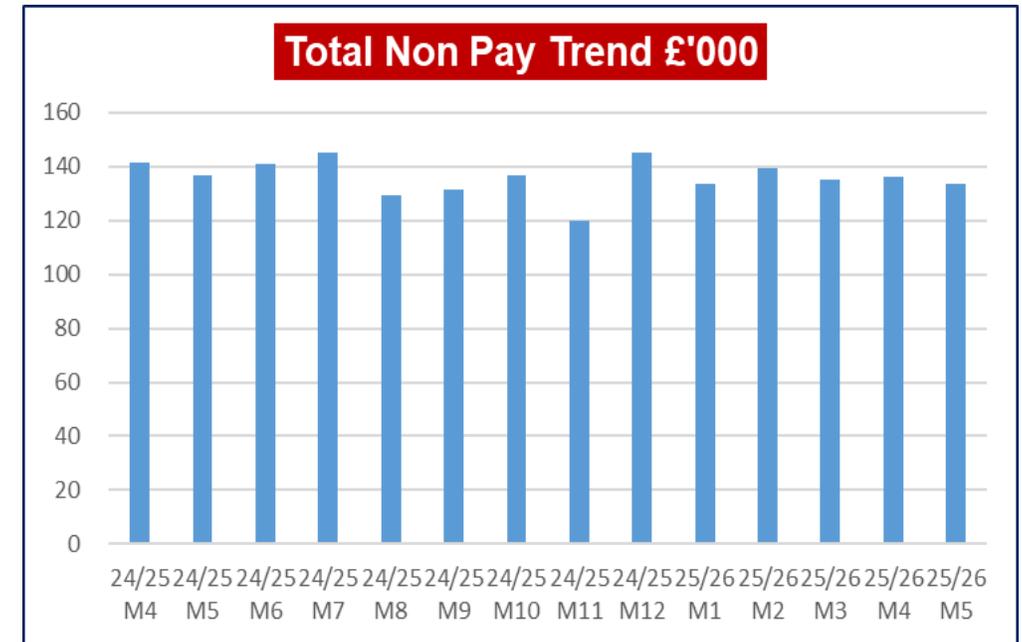
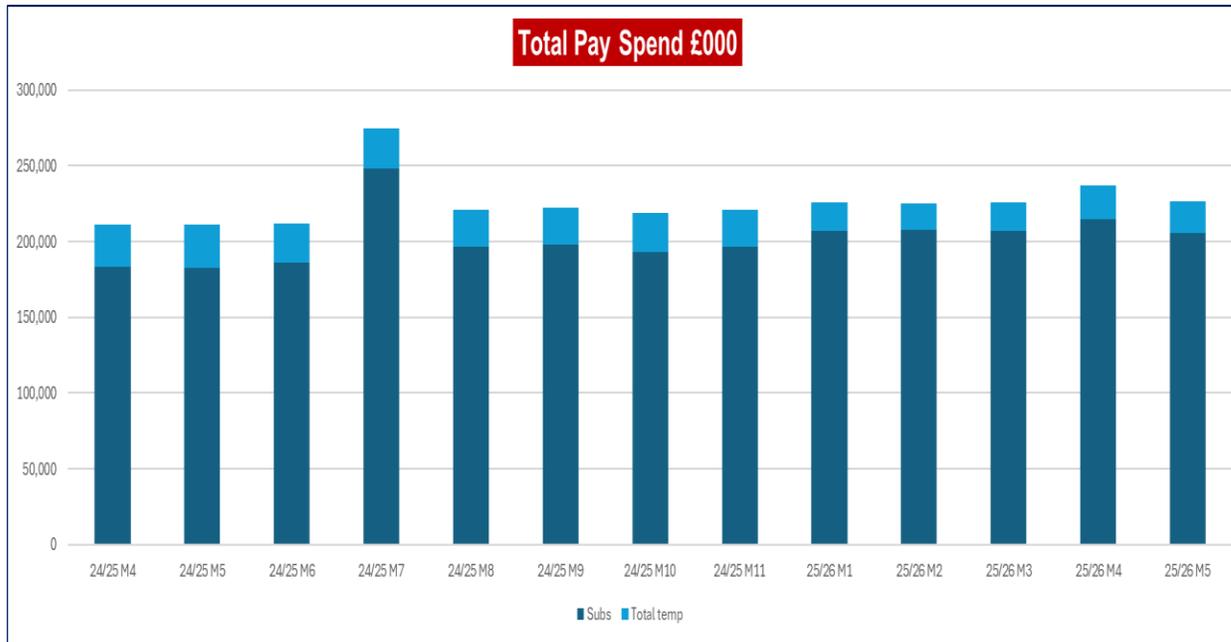
Performance by category	In-month			YTD			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income	359,172	363,935	4,763	1,799,352	1,828,316	28,964	4,330,397	4,346,985	16,588
Pay	(223,008)	(226,008)	(3,000)	(1,115,392)	(1,139,372)	(23,981)	(2,677,513)	(2,698,648)	(21,135)
Non-Pay	(132,040)	(133,565)	(1,525)	(663,285)	(677,844)	(14,559)	(1,590,006)	(1,587,732)	2,273
Non Operating Items	(5,558)	(4,438)	1,120	(25,993)	(22,572)	3,421	(62,878)	(60,604)	2,274
Total	(1,434)	(76)	1,358	(5,318)	(11,472)	(6,154)	(0)	(0)	(0)

Performance by Trust	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
CWFT	17	671	654	(979)	(3,364)	(2,385)	0	0	0
ICHT	0	434	434	0	(707)	(707)	0	0	0
LNWH	(1,452)	(1,433)	19	(4,339)	(5,865)	(1,526)	0	0	0
THH	1	252	251	0	(1,536)	(1,536)	(0)	0	0
Total	(1,434)	(76)	1,358	(5,318)	(11,472)	(6,154)	(0)	0	0

Performance by Trust - net of additional ERF	In-month					YTD				
	Plan	Actual	ERF adj	Revised Actual	Variance	Plan	Actual	ERF adj	Revised Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	17	671	0	671	654	(979)	(3,364)	0	(3,364)	(2,385)
ICHT	0	434	300	734	734	0	(707)	(1,200)	(1,907)	(1,907)
LNWH	(1,452)	(1,433)	(894)	(2,327)	(875)	(4,339)	(5,865)	(6,994)	(12,859)	(8,520)
THH	1	252	0	252	251	0	(1,536)	0	(1,536)	(1,536)
Total	(1,434)	(76)	(594)	(670)	764	(5,318)	(11,472)	(8,194)	(19,666)	(14,348)

- The tables show the year-to-date performance by category (first table) and by Trust (second table).
- Income reports a favourable YTD variance (£29m), primarily due to the accrual of income to account for the impact of the additional uplift for the 2025/26 pay award now included in tariff; the accrual of ERF income over plan in two trusts and the variable elements of the contract: drugs and devices (offset by an overspend on non-pay).
- Expenditure reports an overspend (£38.5m). This is driven primarily by the additional % uplift of the pay award, industrial action in July (£3.8m); the under delivery of efficiencies against an equally phased efficiency plan and the overspend on drugs and devices as above.
- The third table shows the overall position if all trusts had applied a consistent methodology for ERF income performance – assuming no additional income accrued. The APC position would be **£19.6m** deficit or **£14.3m** adverse variance to plan YTD.

Expenditure Trend – Month 5



- Pay has increased by 3.4% in absolute terms in 2025/26 compared to 2024/25.
- The 2025/26 pay award (3.6% AfC; 5.44% resident Drs and 4% consultants) and employers' NI increase of 1.8% is included, so there is a real terms decrease in average pay spend YTD: per WTE this decrease is estimated as 1.2%, primarily driven by lower bank and agency use in 2025/26.
- For Pay spend, in absolute terms agency is 61.3% lower, bank is 20% lower, substantive is 7.4% higher.
- Agency as a percentage of total pay is 1% in 2025/26, this compares to 2% for 2024/25.
- Bank as a percentage of total pay is 8% year to date, this compares to 10% for 2024/25.
- In October 2024 staff were paid the 2024/25 pay award including arrears, hence the spike here.
- Non-Pay : compared to the 2024/24 average, non-pay has increased marginally by £0.4m per month or 0.3%, there is a real terms decrease of 3.1% when factoring in the impact of inflation.

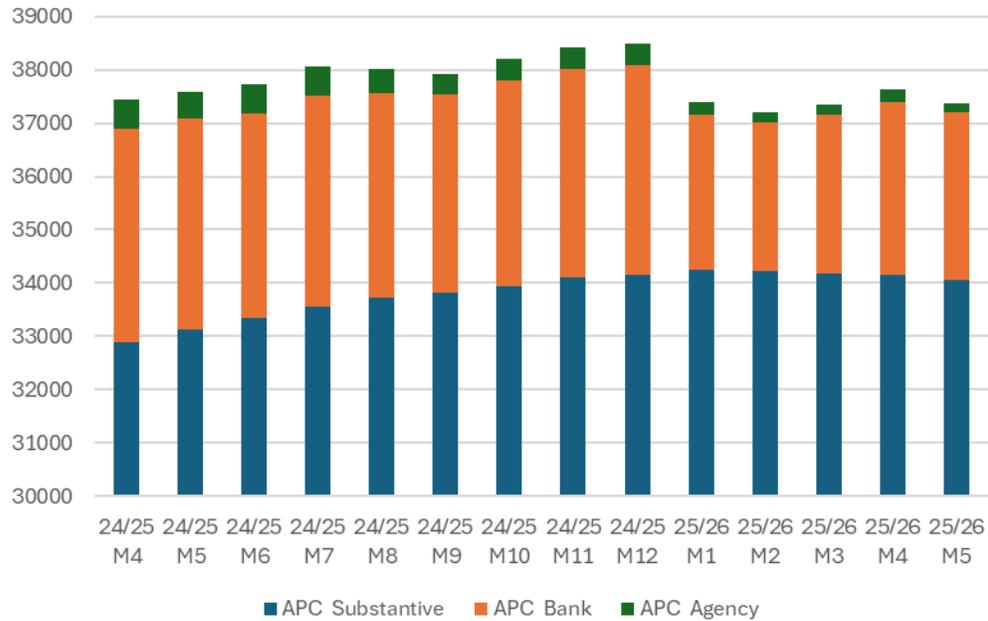
Month 5 WTE Trend

WTE Trend		24/25 M4	24/25 M5	24/25 M6	24/25 M7	24/25 M8	24/25 M9	24/25 M10	24/25 M11	24/25 M12	25/26 M1	25/26 M2	25/26 M3	25/26 M4	25/26 M5	% change to 25/26 average (m7-12)
APC	Substantive	32,895	33,123	33,336	33,557	33,734	33,826	33,944	34,100	34,145	34,260	34,228	34,173	34,154	34,062	0.9%
	Bank	3,999	3,959	3,842	3,961	3,821	3,703	3,847	3,910	3,941	2,905	2,789	2,988	3,251	3,136	-22.0%
	Agency	560	513	542	556	468	392	405	399	396	222	187	175	217	186	-54.7%
	Total	37,454	37,596	37,720	38,074	38,022	37,920	38,197	38,409	38,482	37,387	37,203	37,336	37,622	37,383	-2.1%
CWFT	Substantive	6,796	6,810	6,846	6,908	6,949	6,955	7,027	7,057	7,053	7,168	7,176	7,182	7,240	7,174	2.8%
	Bank	781	785	761	807	816	742	800	788	859	570	580	610	653	654	-23.5%
	Agency	128	101	89	88	84	76	85	80	72	28	26	24	28	26	-67.4%
	Total	7,705	7,696	7,696	7,803	7,849	7,773	7,911	7,925	7,984	7,767	7,782	7,817	7,920	7,854	-0.6%
ICHT	Substantive	14,001	14,094	14,224	14,298	14,379	14,437	14,437	14,569	14,594	14,598	14,567	14,532	14,506	14,492	0.6%
	Bank	1,579	1,619	1,507	1,570	1,514	1,495	1,495	1,526	1,645	1,030	1,073	1,171	1,308	1,315	-23.5%
	Agency	222	204	193	214	199	145	145	160	143	96	82	83	89	82	-48.5%
	Total	15,803	15,917	15,924	16,082	16,092	16,078	16,078	16,255	16,382	15,725	15,722	15,786	15,904	15,889	-2.2%
LNWH	Substantive	8,657	8,761	8,795	8,840	8,884	8,907	8,934	8,928	8,943	8,945	8,940	8,935	8,885	8,891	0.1%
	Bank	1,152	1,160	1,088	1,077	1,082	988	1,025	1,068	992	877	801	833	878	819	-19.0%
	Agency	123	106	90	79	67	61	58	53	50	43	42	50	54	44	-24.3%
	Total	9,932	10,027	9,973	9,996	10,033	9,956	10,017	10,050	9,986	9,866	9,783	9,818	9,817	9,754	-2.0%
THH	Substantive	3,440	3,458	3,471	3,511	3,521	3,526	3,546	3,545	3,555	3,548	3,545	3,525	3,523	3,505	-0.1%
	Bank	486	395	486	508	409	478	527	528	444	427	334	373	411	348	-21.5%
	Agency	87	102	170	175	118	109	118	106	130	55	36	18	47	34	-69.8%
	Total	4,014	3,956	4,127	4,194	4,048	4,113	4,191	4,178	4,130	4,029	3,916	3,916	3,981	3,887	-4.7%

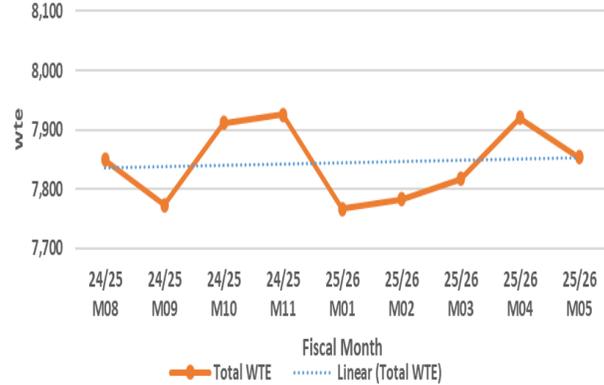
- The table shows the WTE trend from 2024/25.
- There has been a decrease in WTE M4 to M5, by 239 WTE (Substantive -92; Bank -115, Agency -32). The main driver of the reduction is attributed to industrial action in the previous month which increased WTE by a similar amount.
- The last column shows the percentage decrease (comparing H2 2024/25 average to present (average of first five months 2025/26)). An overall decrease of 2.1% is reported driven mainly by reductions in temporary staffing – bank and agency; as grip and control measures have been implemented in 2025/26 including restrictions on WLIs. Substantive WTEs are up marginally at 0.9%, with the largest increase reported at CWFT.

M5 WTE trend graphs

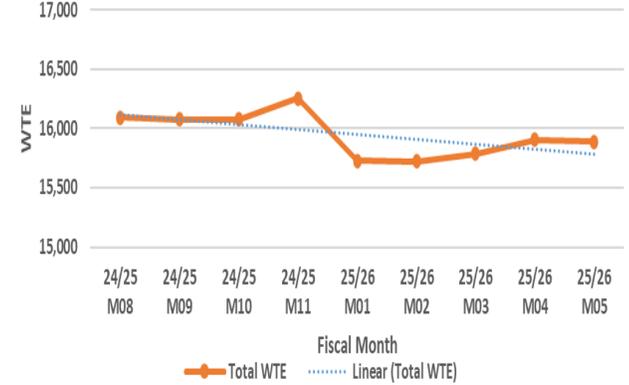
APC WTE TREND



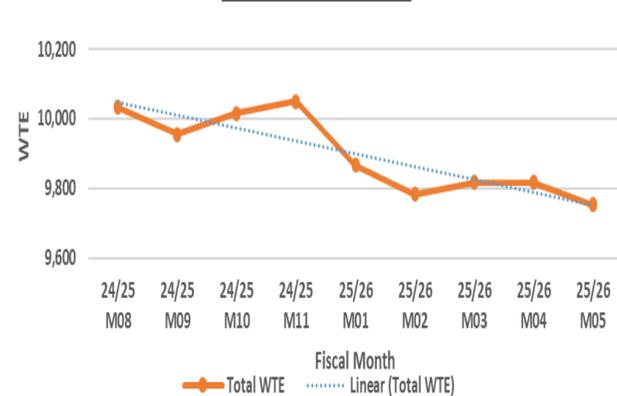
CWHFT Total WTE trend



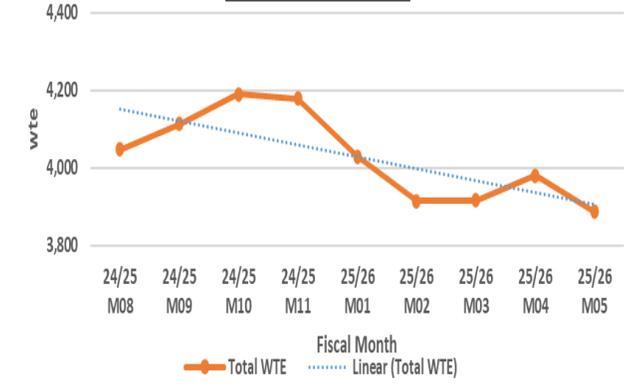
ICHT Total WTE trend



LNW Total WTE trend



THH Total WTE trend



M5 ERF Income

ERF Over / (under) performance (M5)	NWL ICB ERF	Spec Comm ERF	Non NWL ICB ERF	Total ERF (all commissioners)	Var reported in ledger	Var: ledger to o/p estimate	Annual plan (finance plan)	VWA plan (19/20 baseline)
Trust	£'000	£'000	£'000	£'000	£'000	£'000	£'000	%
CWFT	4,979	(1,393)	802	4,388	0	(4,388)	182,104	128%
ICHT	157	845	211	1,213	1,213	(0)	303,955	118%
LNWH	6,994	(247)	863	7,610	6,994	(616)	219,582	131%
THH	2,008	(75)	(267)	1,666	0	(1,666)	78,995	117%
Total APC	14,138	(870)	1,608	14,877	8,207	(6,670)	784,636	

- The elective income plans for 2025/26 have been set using 2024/25 outturn, less the prescribed reduction in ERF overperformance income as informed by NHSE. For NWL ICB this amounted to c35% reduction in overperformance income.
- For NHSE Spec Commissioning there is no % reduction in ERF overperformance.
- In 2025/26 there is a cap on elective activity income to the value in the annual contract plan. Plans were uplifted in month 4 to account for the additional % on the pay award.
- At Month 5, two trusts continue to account for income more than YTD plan (ICHT & LNWH) at £1.2m and £7m respectively. CWFT and THH assume elective income equals the plan.
- ERF overperformance is estimated at £14.9m per the above table; of which £8.2m is accounted for in the YTD financial position (at ICHT & LNWH), the premise being that future months will see activity being managed to slowdown in these trusts so that overall, the annual income will equal (or be less than) the cap (the annual plan). The APC trusts will model the required reduction in activity (and impact in income and costs) to factor into activity and financial forecasts.
- The overall I&E YTD variance is £6.1m adverse to plan, thus if all ERF overperformance (all trusts) were to be included this would be a £0.5m favourable variance to plan.

M5 Efficiency

Efficiency Month 5	YTD Plan			YTD Actual			YTD Var	In Month Plan	In Month Actuals	In Month Variance	Annual Plan			Annual Forecast			Fcast Variance
	R	NR	Total	R	NR	Total					Total	Total	Total	R	NR	Total	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	5,345	8,590	13,935	5,263	6,651	11,915	(2,020)	2,787	3,288	501	12,986	20,456	33,442	13,812	19,630	33,442	0
ICHT	10,404	22,905	33,309	13,105	18,307	31,412	(1,897)	6,681	5,895	(786)	25,035	55,099	80,134	41,357	38,776	80,134	(0)
LNWH	16,079	4,126	20,205	8,476	4,063	12,539	(7,666)	4,041	3,620	(421)	38,597	9,903	48,500	40,848	7,652	48,500	0
THH	4,376	2,166	6,542	3,778	1,233	5,012	(1,530)	1,308	1,344	36	10,501	5,199	15,700	12,938	2,762	15,700	(0)
Total	36,204	37,787	73,991	30,622	30,255	60,877	(13,114)	14,817	14,147	(670)	87,119	90,657	177,776	108,956	68,820	177,776	(0)
% delivery of plan				41%	41%	82%								61%	39%	100%	

- The APC's annual efficiency plan is £177.8m, up from £135.7m delivered in 2024/25. An increase of 32%.
- M5 in month delivery is £14.1m, an improvement compared to the first four months (the average monthly delivery was £11.7m). The month 5 delivery was under the monthly plan by £0.7m.
- The YTD delivery is £60.9m, of which £30.3m (41%) is non recurrent. The YTD plan is £74m, therefore reporting an under delivery of £13.1m to date.
- At this stage, the annual efficiency plan is forecast to be delivered in full.
- The 2025/26 efficiency plan profile is in 1/12^{ths} for all APC trusts.

Emerging Risks

- The APC has identified several risks to meeting the 2025/26 financial plan. These are listed in the table below: values are being quantified.

2025/26 APC financial risks		Value where known
1	Cost of elective and diagnostic performance (to meet Operating Plan targets); capped annual income & the ability to slow activity down in future months (where overperforming against plan).	£14.9m overperformance on ERF - £8.2m is accounted for to date and will need to be reversed out
2	A&G increasing over plan level and cost response (under capped income) .	
3	Potential growth in emergency activity (higher than plan (24/25 outturn))	
4	Industrial action cost	£3.6m
5	Efficiency shortfall	£13.1m to date
6	Potential shortfall on funding to cover pay and non pay inflation 25/26	
7	Supply Chain risk (subcontractor companies facing financial difficulty (e.g. previous UTC provider o/s bills; community equipment provider)	
8	Profit on land sale (LNWH)	£9m
9	Elective Orthopaedic Centre (contribution from APC trusts)	
10	NHSE Contract issues	

Month 5 Forecast

- The forecast is prepared by each trust, starting with the year-to-date actuals, removing one off income and expenditure (£10.5m) and then straight lining this normalised position to arrive at a projected year end position. To note included in the one-off adjustments is the ERF overperformance at ICHT and LNWH, at £1.2m and £7m to date; and industrial action costs of £3.9m across the APC.
- Run rate adjustments are made in future months (from month 6 to month 12) which adjust the monthly I&E where there is an expected change to the normalised run rate, for example planned non recurrent benefits, an uptick in the CIP recovery rate, other benefits or cost pressures.
- For the APC, the year-end forecast from the straight-line YTD normalised position is a deficit of £42.3m. Mitigating adjustments from month 6 to month 12 total £42.3m resulting in a breakeven forecast at month 5.
- The average run rate from month 6 moves to a £1.6m monthly surplus, from a £2.3m monthly deficit up to month 5, an improvement of 171%.
- Table 1 below summarises the position. LNWH presents with the highest normalised deficit which is mitigated by future planned changes to the same value.
- Table 2 is a list of the future expected run rate changes.
- Appendix 2 notes the APC and trust forecasts by month.

Table 1

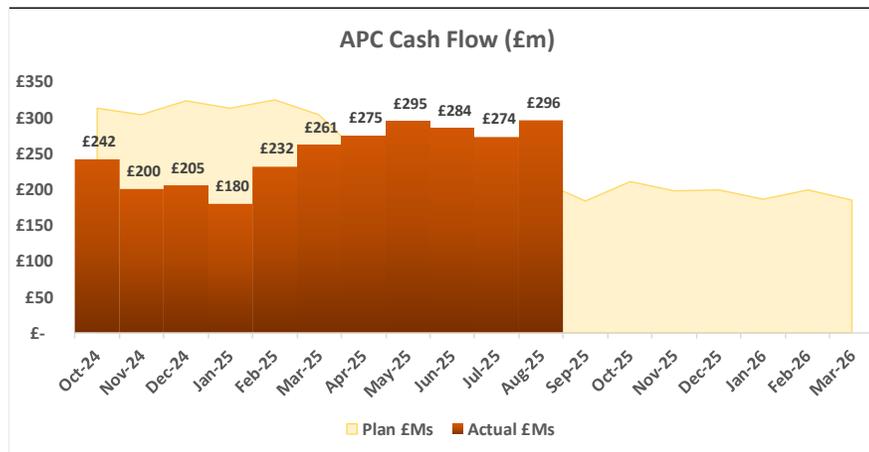
	M5 YTD Actual	One off Items	Normalised YTD	Normalised Straight Line Forecast (S/L)	Forecast Changes	Remaining Surplus/Deficit
	£'000	£'000	£'000	£'000	£'000	£'000
CWHFT	-3,366	-1,482	-1,884	-6,004	6,004	-0
ICHT	-707	-87	-620	-1,574	1,574	-0
LNWHT	-5,865	12,372	-18,237	-31,397	31,396	-0
THH	-1,536	-304	-1,232	-3,261	3,261	0
	-11,474	10,499	-21,973	-42,236	42,236	-0

Table 2

Forecast run rate changes M6-M12:	CWHT	ICHT	LNWHT	THH	Total
	£'000	£'000	£'000	£'000	£'000
Normalised Straight line Forecast	-6,004	-1,574	-31,397	-3,261	-42,236
CIP - Planned	0	1,574	24,032	3,666	29,272
CIP - Additional	3,091	0	0	0	3,091
Profiling	190	0	-6,338	0	-6,148
Balance Sheet	0	0	0	0	0
Technical adjustment	0	0	-1,615	0	-1,615
Other income	0	0	10,615	0	10,615
Increased Cost Pressure	0	0	0	-405	-405
Other cost	2,723	0	4,702	0	7,425
Total Adjustments	6,004	1,574	31,396	3,261	42,236
Remaining Surplus/ (Deficit)	-0	-0	-0	0	0

M5 Cash

NWL APC Cash Balance					
Trust	Mar-25	Aug-25	Movement to YTD	31 Aug 25 Cash Plan	Variance from plan
Trust	£m	£m	£m	£m	£m
CWFT	143.5	133.8	(9.7)	124.0	9.8
ICHT	92.9	108.5	15.6	47.0	61.5
LNWH	11.0	16.8	5.9	13.2	3.6
THH	13.7	37.1	23.4	26.2	10.9
Total	261.0	296.2	35.2	210.4	85.8
			13%		35%

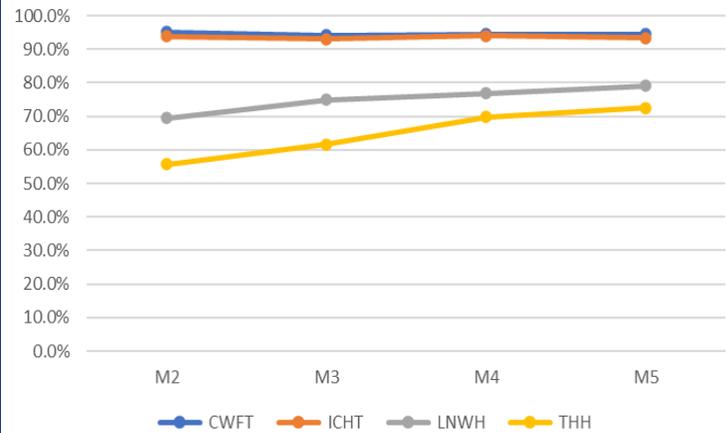


Trust	Op exp days	BPPC (£) Non NHS	BPPC (£) NHS	Debtor Days	Creditor Days
CWFT	52.0	94.5%	91.0%	26.2	122.3
ICHT	23.2	93.4%	87.5%	31.1	158.8
LNWH	5.9	79.2%	53.9%	28.2	130.0
THH	34.4	72.5%	57.7%	32.4	211.7

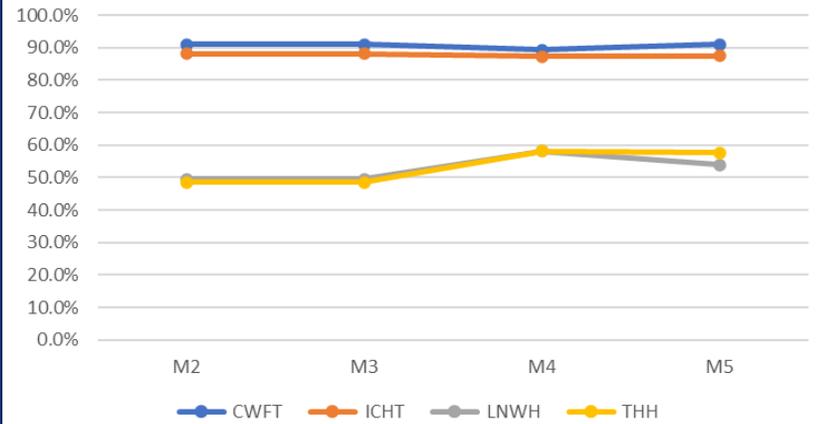
- The APC combined cash balance stood at £296.2m, up from £273.6m in July. This represents an increase of £35.2m since the end of March and £85.8m higher than the cash plan for Month 5.
- The tables and graph above show:
 - The end of August cash position against March 2025 and July plan positions (table on the left-hand side).
 - Cash flow V plan trend graph, showing in 2025/26 cash is higher than plan, in part due to capital spend profiling.
 - The table on the right-hand side shows:
 - Operating expense days :days of operating expenses that can be serviced by the cash balance at the end of the month.
 - The Better Payment Practice Code (BPPC) performance at the end of August : the % of creditor invoices that are paid (by £ value) within 30 days (YTD values).
 - Debtor days represents the average no of days for the trust to receive payment of its invoices. A lower no of days signals more efficient Accounts Receivable processes.
 - Creditor days represents the average no of days the trust takes to pay its creditor invoices. A higher number of days suggests the trust is taking longer to pay bills which could reflect on supplier relationships.
 - BPPC, debtor and creditor day measures are impacted by the cash position. A lower cash position (Op ex days) creates the impetus to chase debtors (lowering debtor days) and potentially delay the payment of creditors (higher creditor days).

M5 Liquidity Metrics : Graphs

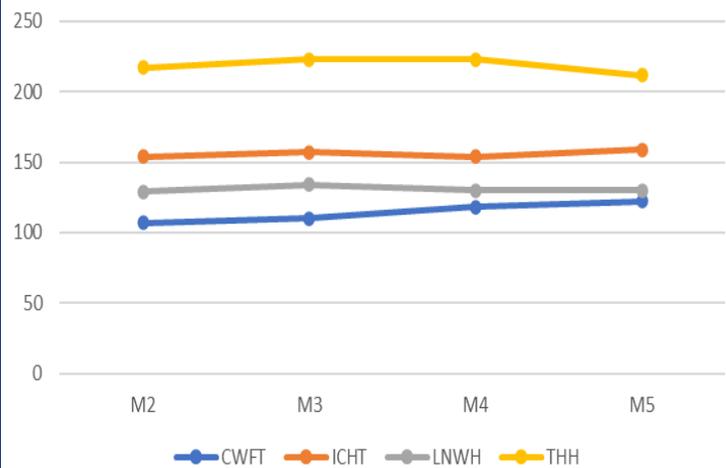
BPPC Non NHS : Trend



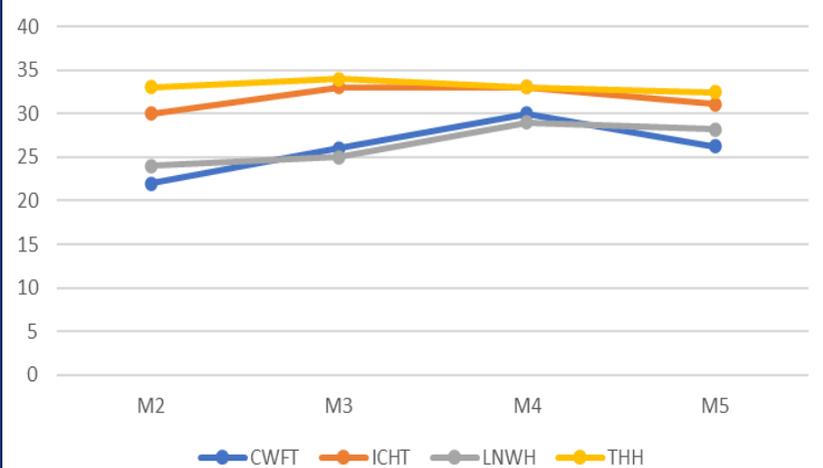
BPPC NHS : Trend



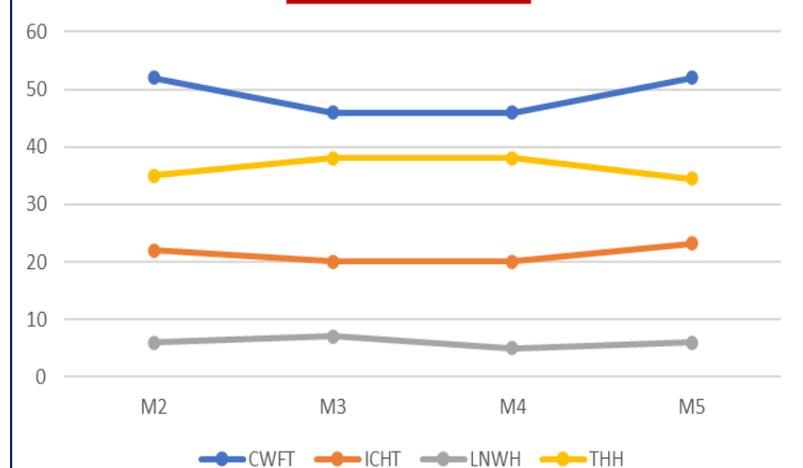
Creditor Days : Trend



Debtor Days : Trend



Op Ex Days : Trend



Month 5 Capital

		YTD			Forecast		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
CWFT	Core CRL	7,970	15,359	(7,389)	39,805	39,805	0
	Nat schemes	10,908	911	9,997	12,202	12,202	0
	Total	18,878	16,270	2,608	52,007	52,007	0
ICHT	Core CRL	23,111	26,177	(3,066)	83,293	83,293	0
	Nat schemes	12,585	3,583	9,002	42,540	46,917	(4,377)
	Total	35,696	29,760	5,936	125,833	130,210	(4,377)
LNWH	Core CRL	11,265	3,075	8,190	27,306	27,306	0
	Nat schemes	530	430	100	1,132	1,132	0
	Total	11,795	3,505	8,290	28,438	28,438	0
THH	Core CRL	2,775	1,416	1,359	14,778	14,778	0
	Nat schemes	8,364	4,673	3,691	37,781	28,455	9,326
	Total	11,139	6,089	5,050	52,559	43,233	9,326
APC	Core CRL	45,121	46,027	(906)	165,182	165,182	0
	Nat schemes	32,387	9,597	22,790	93,655	88,706	4,949
	Total	77,508	55,624	21,884	258,837	253,888	4,949

National PDC Capital	CWFT £'000	ICHT £'000	LNWHT £'000	THH £'000	APC £'000
Estates Safety		25,250		8,000	33,250
Other	2,202		1,032	1	3,235
Diagnostics		3,000			3,000
Electives	5,000	4,000			9,000
UEC	5,000	10,290	100	1,500	16,890
New Hospital Prog.				28,280	28,280
Total	12,202	42,540	1,132	37,781	93,655

- The annual capital plan (£258.8m) is made up of £165.2m internally funded; and £93.7m represents Nationally Funded PDC Capital Programmes (see breakdown in bottom table).
- To note, the constitutional standards schemes (Electives, Diagnostics & UEC Capacity) are still pending approval by the national team.
- The table on the top shows the year-to-date capital spend against the year-to-date plan and the forecast spend against the annual plan.
- The overall underspend to date is £21.9m. This underspend is driven by capital schemes under the National Capital programmes, which are yet to commence or will commence later than planned, whereas spend has been profiled in Q1. Core CRL (internally funded schemes are on tract at £0.9m overspent to date.
- During the year, additional PDC capital schemes are routinely put forward by NHSE for Trusts to bid for. The £4.4m forecast overspend at ICHT comprises MOUs received but not yet reflected in the capital delegated expenditure limit. The underspend at THH stems from estates safety and the New Hospital Programme under the National Capital Programmes.



Chelsea and Westminster
Hospital NHS Foundation Trust



The Hillingdon Hospitals NHS
Foundation Trust



Imperial College Healthcare
NHS Trust



London North West University
Healthcare NHS Trust

Appendix

NWL APC Trust I&E at M5

I&E Performance : CWFT

CWFT	In-month				YTD				Forecast			
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %
Income	84,101	84,164	63	0%	420,504	419,305	(1,199)	-0%	1,009,201	1,005,879	(3,322)	-0%
Pay	(49,365)	(49,628)	(263)	-1%	(246,825)	(249,324)	(2,499)	-1%	(592,371)	(595,048)	(2,677)	-0%
Non-Pay	(33,506)	(32,745)	761	2%	(168,678)	(167,837)	841	0%	(401,925)	(397,157)	4,768	1%
Non Operating Items	(1,213)	(1,120)	93	8%	(5,980)	(5,508)	472	8%	(14,905)	(13,674)	1,231	8%
Total	17	671	654		(979)	(3,364)	(2,385)		0	0	(0)	

- The Trust at M5 has a YTD £3.36m deficit which is £2.39m adverse against a planned deficit of £0.98m.
- The CIP Programme is now fully identified and has seen 2 positive months of delivery, in which M4 delivery achieved plan and M5 over-delivered by £500k. However, YTD delivery is £2.m behind plan caused by slippage in Q1. The CIP programme is forecast to deliver in full.
- Industrial action cost impact is £1.09m (net of deductions), which is unfunded.
- ERF activity is capped in 2025/26 and other activity is blocked. The ERF over performance seen to M5 is not recognised in the position.
- The forecast is still to achieve the breakeven plan; however, there is £2m of risk in the forecast due to the unfunded pay award NI impact (£0.9m) and industrial action (£1.09m), however this is assumed to be mitigated by unidentified non-recurrent savings.
- Forecast assumes full delivery of the CIP Programme.
- The cash balance at M5 is £133.80m.
- The YTD gross capital spend is £18.58m, net CDEL is £16.2m (after factoring donations & grants)

I&E Performance : ICHT

ICHT	In-month				YTD				Forecast			
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %
Income	152,021	151,853	(168)	-0%	760,111	773,328	13,217	2%	1,824,265	1,824,265	0	0%
Pay	(94,565)	(95,884)	(1,319)	-1%	(472,827)	(483,590)	(10,763)	-2%	(1,134,836)	(1,134,836)	0	0%
Non-Pay	(55,847)	(54,677)	1,170	2%	(280,951)	(285,865)	(4,914)	-2%	(674,309)	(674,309)	0	0%
Non Operating Items	(1,609)	(858)	751	47%	(6,333)	(4,580)	1,753	28%	(15,120)	(15,120)	0	0%
Total	0	434	434		0	(707)	(707)		0	0	0	

- The Trust is reporting a YTD deficit of £0.7m (£0.7m adverse to plan) and continuing to forecast break-even at year end.
- YTD adverse position continues to reflect - £1.2m of costs associated with the 5 days of Industrial Action; a lower than planned delivery of efficiencies and an overspend in medical staffing across clinical divisions; offset by - the reduction in bank & agency costs compared to run rate in the 24/25 financial year following the implementation of enhanced temporary staffing controls and the recognition of £1.2m of elective recovery over-performance income. Given the annual ERF Cap, the YTD over-performance is required to be mitigated by an equal level of under-performance and reduction in expenditure in the second half of the year.
- At month 5, the Trust has identified £79.5m of schemes (target £80.1m) and YTD delivered £31.4m against an equally phased efficiency target. This results in an YTD under delivery of £1.9m.
- At the end of Month 5, the Trust reported a cash balance of £108.5m, £61.5m higher than plan due to timing differences.
- The YTD gross capital spend is £37.3m against a YTD gross plan of £52.4m, resulting in an underspend of £15.1m. Of this, £29.8m of spend scores against the Capital Departmental Expenditure Limit (CDEL) of £35.7m, leading to an underspend of £5.9m against this target.

I&E Performance : LNWH

LNWH	In-month				YTD				Forecast			
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %
Income	88,850	92,284	3,434	4%	447,775	461,166	13,391	3%	1,086,579	1,101,289	14,710	1%
Pay	(56,490)	(57,727)	(1,237)	-2%	(282,825)	(291,693)	(8,868)	-3%	(679,290)	(696,148)	(16,858)	-2%
Non-Pay	(31,811)	(34,144)	(2,333)	-7%	(159,284)	(166,064)	(6,780)	-4%	(383,281)	(382,133)	1,148	0%
Non Operating Items	(2,001)	(1,846)	155	8%	(10,005)	(9,274)	731	7%	(24,008)	(23,008)	1,000	4%
Total	(1,452)	(1,433)	19		(4,339)	(5,865)	(1,526)		0	0	0	

- The Trust is reporting a YTD deficit of £5.9m, £1.5m adverse to plan.
- This includes accounting for £7.0m ERF overperformance income to M5. The assumption being there will be an equivalent underperformance and reduction in expenditure in the remaining months of the year. The ERF annual cap at the planned level remains unchanged.
- The driver of the variance to plan is predominantly the cost of Industrial Action, estimated at £1.3m, with CIP shortfall of £7.6m against equally profiled target offset by ERF over-performance.
- The actual CIP delivered was £12.6m against an identified value of £13.2m (a £0.6m shortfall against the identified). Original target of £48.5m is now fully identified and a further c£1.8m has been identified against the revised internal target of £54.5m.
- Other key drivers of overspends include continued EOC activity shortfall, emergency pressures and WLI / Outsourcing costs above planned levels.
- The M05 cash balance was £16.8m, compared to £14.1m last month. In August, the Trust received more cash from non-local ICBs in respect of pay award funding and LVA income than previously forecast and this enabled the Trust to further reduce the approved trade creditor invoice backlog.
- The Trust's current cash flow forecast indicates that the cash balance will reduce significantly in September due to the £7m PDC dividend payment and higher PAYE and pension payments relating to the pay award arrears processed in August and that cash management measures may need to be implemented in November to avoid a cash deficit. The Trust is in the process of formulating options to secure a
 - permanent increase in its liquidity position.
- M05 YTD capital expenditure is £4.6m against a YTD budget of £9.8m. The Trust needs to generate an underspend as it has over-programmed the capital budget by £6.5m (to counteract slippage). This is being managed through the capital review group (CRG). The CRG has identified reductions in capital expenditure which may be implemented to support the cash position, if necessary

I&E Performance : THH

THH	In-month				YTD				Forecast			
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %
Income	34,200	35,634	1,434	4%	170,962	174,517	3,555	2%	410,352	415,552	5,200	1%
Pay	(22,588)	(22,769)	(181)	-1%	(112,915)	(114,765)	(1,850)	-2%	(271,016)	(272,616)	(1,600)	-1%
Non-Pay	(10,876)	(11,999)	(1,123)	-10%	(54,372)	(58,078)	(3,706)	-7%	(130,491)	(134,134)	(3,643)	-3%
Non Operating Items	(735)	(614)	121	16%	(3,675)	(3,210)	465	13%	(8,845)	(8,802)	43	0%
Total	1	252	251		0	(1,536)	(1,536)		(0)	0	0	

- The Trust reported a £0.3m surplus against plan in Month 5, this improvement is attributable to one off benefits from additional Other Operating Income. The year-to-date position of £1.5m deficit is £1.5m adverse against the breakeven plan, of which £0.3m relates to costs to cover the industrial action in July.
- Within the Trust's breakeven plan is the expectation to deliver a £15.7m Cost improvement programme (CIP), and the plan assumed this would be delivered evenly throughout the year. The internal profile sees delivery increase throughout the year rather than be delivered evenly.
- Key drivers of the in-month position are largely driven by the CIP unidentified gap and CIP phasing and overspends on medical & nursing pay in certain areas. However, pay spend continues a downward trajectory as vacancy and temporary staffing review panels are delivering additional control and agency spend remains low in M5, representing 1.2% of total pay costs (1.4% YTD). The Trust has now fully identified it's CIP schemes.
- ERF activity is capped in 2025/26, and other activity is blocked. The YTD ERF over performance as at M5 is valued at £1.7m, however due to the cap this is not recognised within the position.
- The cash balance at M5 is £37.1m and the YTD gross capital spend is £6.1m.
- The Trust is forecasting a breakeven position. To achieve this, the Trust will need to fully deliver its efficiency plan, plus additional benefits to offset industrial action costs and any other arising cost pressures.



Chelsea and Westminster
Hospital NHS Foundation Trust



The Hillingdon Hospitals NHS
Foundation Trust



Imperial College Healthcare
NHS Trust



London North West University
Healthcare NHS Trust

Appendix

Forecast at Month 5

APC Forecast

	Normalised YTD Run Rate			Actual	Actual	Actual	Actual	Actual	Forecast							
	YTD Actuals	One of Items	Normalised run rate	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income (+)	1,828,318	8,649	1,819,668	358,291	362,312	368,258	375,521	363,934	363,934	363,934	363,934	363,934	363,934	363,934	363,934	4,375,853
Pay (-)	-1,139,373	-1,664	-1,137,709	-225,513	-225,117	-225,512	-237,233	-225,998	-227,542	-227,542	-227,542	-227,542	-227,542	-227,542	-227,542	-2,732,165
Non Pay (-)	-678,247	3,514	-681,761	-133,727	-139,152	-135,359	-136,364	-133,646	-136,352	-136,352	-136,352	-136,352	-136,352	-136,352	-136,352	-1,632,713
Non Operating Items (-)	-22,172	0	-22,172	-4,484	-4,278	-4,453	-4,590	-4,367	-4,434	-4,434	-4,434	-4,434	-4,434	-4,434	-4,434	-53,212
Surplus/ (Deficit)	-11,474	10,499	-21,973	-5,432	-6,234	2,934	-2,666	-77	-4,395	-42,236						
Forecast run rate changed by:				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
				£'000												
CIP - Planned				0	0	0	0	0	2,081	4,311	4,403	4,394	4,617	4,693	4,773	29,272
CIP - Additional				0	0	0	0	0	442	442	442	442	442	442	442	3,091
Profiling				0	0	0	0	0	687	1,012	-1,658	-1,514	-1,792	-2,321	-562	-6,148
Balance Sheet				0	0	0	0	0	0	0	0	0	0	0	0	0
Technical adjustment				0	0	0	0	0	0	-269	-269	-269	-269	-269	-269	-1,615
Other income				0	0	0	0	0	0	269	269	269	269	269	9,269	10,615
Reduced Cost Pressure				0	0	0	0	0	0	0	0	0	0	0	0	0
Increased Cost Pressure				0	0	0	0	0	0	0	-81	-81	-81	-81	-81	-405
Other cost				0	0	0	0	0	-299	-315	376	1,236	1,236	1,236	3,958	7,425
Total Adjustments				0	0	0	0	0	2,910	5,449	3,481	4,476	4,421	3,968	17,530	42,236
Remaining Surplus/ (Deficit)				-5,432	-6,234	2,934	-2,666	-77	-1,484	1,055	-913	82	26	-427	13,135	-0

CWFT Forecast

	Normalised YTD Run Rate			Actual	Actual	Actual	Actual	Actual	Forecast								
	YTD Actuals	One of Items	Normalised run rate	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Income (+)	419,305	324	418,981	82,501	82,390	82,835	87,415	84,164	83,796	83,796	83,796	83,796	83,796	83,796	83,796	83,796	1,005,879
Pay (-)	-249,324	-1,921	-247,404	-49,306	-48,871	-49,235	-52,285	-49,628	-49,481	-49,481	-49,481	-49,481	-49,481	-49,481	-49,481	-49,481	-595,690
Non Pay (-)	-167,838	115	-167,953	-33,129	-33,846	-33,156	-34,962	-32,745	-33,591	-33,591	-33,591	-33,591	-33,591	-33,591	-33,591	-33,591	-402,972
Non Operating Items (-)	-5,509	0	-5,509	-1,047	-1,075	-1,096	-1,170	-1,121	-1,102	-1,102	-1,102	-1,102	-1,102	-1,102	-1,102	-1,102	-13,222
Surplus/ (Deficit)	-3,366	-1,482	-1,884	-981	-1,402	-651	-1,002	670	-377	-377	-6,004						
Forecast run rate changed by:				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
CIP - Planned				0	0	0	0	0	0	0	0	0	0	0	0	0	0
CIP - Additional				0	0	0	0	0	442	442	442	442	442	442	442	442	3,091
Profiling				0	0	0	0	0	-65	-65	-65	-365	149	299	299	190	190
Balance Sheet				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Technical adjustment				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other income				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reduced Cost Pressure				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Increased Cost Pressure				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other cost				0	0	0	0	0	0	0	0	0	0	0	2,723	2,723	2,723
Total Adjustments				0	0	0	0	0	377	377	377	77	591	741	3,464	6,004	
Remaining Surplus/ (Deficit)				-981	-1,402	-651	-1,002	670	0	0	0	-300	214	364	3,087	-0	

ICHT Forecast

	Normalised YTD Run Rate			Actual	Actual	Actual	Actual	Actual	Forecast								
	YTD Actuals	One of Items	Normalised run rate	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Income (+)	773,329	1,200	772,129	152,943	155,130	156,663	156,740	151,852	154,426	154,426	154,426	154,426	154,426	154,426	154,426	154,426	1,854,310
Pay (-)	-483,590	-1,287	-482,303	-94,659	-95,990	-96,557	-100,500	-95,884	-96,461	-96,461	-96,461	-96,461	-96,461	-96,461	-96,461	-96,461	-1,158,815
Non Pay (-)	-285,866	0	-285,866	-57,969	-59,012	-57,834	-56,374	-54,677	-57,173	-57,173	-57,173	-57,173	-57,173	-57,173	-57,173	-57,173	-686,079
Non Operating Items (-)	-4,579	0	-4,579	-913	-829	-973	-1,008	-857	-916	-916	-916	-916	-916	-916	-916	-916	-10,991
Surplus/ (Deficit)	-707	-87	-620	-597	-701	1,299	-1,141	434	-124	-124	-1,574						
Forecast run rate changed by:				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	
				£'000	£'000	£'000											
CIP - Planned				0	0	0	0	0	225	225	225	225	225	225	225	225	1,574
CIP - Additional				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Profiling				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Balance Sheet				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Technical adjustment				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other income				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reduced Cost Pressure				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Increased Cost Pressure				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other cost				0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Adjustments				0	0	0	0	0	225	225	1,574						
Remaining Surplus/ (Deficit)				-597	-701	1,299	-1,141	434	101	101	-0						

LNWH Forecast

	Normalised YTD Run Rate			Actual	Actual	Actual	Actual	Actual	Forecast								
	YTD Actuals	One of Items	Normalised run rate	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Income (+)	461,166	7,653	453,513	88,473	89,781	94,233	96,395	92,284	90,703	90,703	90,703	90,703	90,703	90,703	90,703	90,703	1,096,084
Pay (-)	-291,693	1,985	-293,678	-58,475	-57,279	-57,291	-60,921	-57,727	-58,736	-58,736	-58,736	-58,736	-58,736	-58,736	-58,736	-58,736	-702,842
Non Pay (-)	-166,465	2,734	-169,199	-30,971	-34,473	-32,883	-33,914	-34,224	-33,840	-33,840	-33,840	-33,840	-33,840	-33,840	-33,840	-33,840	-403,344
Non Operating Items (-)	-8,873	0	-8,873	-1,825	-1,704	-1,791	-1,787	-1,766	-1,775	-1,775	-1,775	-1,775	-1,775	-1,775	-1,775	-1,775	-21,295
Surplus/ (Deficit)	-5,865	12,372	-18,237	-2,798	-3,675	2,268	-227	-1,433	-3,647	-31,397							
Forecast run rate changed by:				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	
				£'000													
CIP - Planned				0	0	0	0	0	1,391	3,621	3,631	3,622	3,845	3,921	4,001	24,032	
CIP - Additional				0	0	0	0	0	0	0	0	0	0	0	0	0	
Profiling				0	0	0	0	0	752	1,077	-1,593	-1,149	-1,941	-2,620	-861	-6,338	
Balance Sheet				0	0	0	0	0	0	0	0	0	0	0	0	0	
Technical adjustment				0	0	0	0	0	0	-269	-269	-269	-269	-269	-269	-1,615	
Other income				0	0	0	0	0	0	269	269	269	269	269	9,269	10,615	
Reduced Cost Pressure				0	0	0	0	0	0	0	0	0	0	0	0	0	
Increased Cost Pressure				0	0	0	0	0	0	0	0	0	0	0	0	0	
Other cost				0	0	0	0	0	-299	-315	376	1,236	1,236	1,236	1,235	4,702	
Total Adjustments				0	0	0	0	0	1,843	4,383	2,414	3,708	3,139	2,536	13,374	31,396	
Remaining Surplus/ (Deficit)				-2,798	-3,675	2,268	-227	-1,433	-1,804	735	-1,234	61	-508	-1,111	9,726	-0	

THH Forecast

	Normalised YTD Run Rate			Actual	Actual	Actual	Actual	Actual	Forecast								
	YTD Actuals	One of Items	Normalised run rate	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Income (+)	174,517	-528	175,045	34,374	35,011	34,527	34,971	35,634	35,009	35,009	35,009	35,009	35,009	35,009	35,009	35,009	419,580
Pay (-)	-114,765	-442	-114,324	-23,073	-22,976	-22,429	-23,528	-22,759	-22,865	-22,865	-22,865	-22,865	-22,865	-22,865	-22,865	-22,865	-274,818
Non Pay (-)	-58,078	665	-58,743	-11,658	-11,821	-11,486	-11,113	-12,000	-11,749	-11,749	-11,749	-11,749	-11,749	-11,749	-11,749	-11,749	-140,319
Non Operating Items (-)	-3,210	0	-3,210	-699	-670	-593	-625	-623	-642	-642	-642	-642	-642	-642	-642	-642	-7,704
Surplus/ (Deficit)	-1,536	-304	-1,232	-1,056	-456	19	-295	252	-246	-246	-3,261						
Forecast run rate changed by:				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
CIP - Planned				0	0	0	0	0	465	465	547	547	547	547	548	3,666	
CIP - Additional				0	0	0	0	0	0	0	0	0	0	0	0	0	
Profiling				0	0	0	0	0	0	0	0	0	0	0	0	0	
Balance Sheet				0	0	0	0	0	0	0	0	0	0	0	0	0	
Technical adjustment				0	0	0	0	0	0	0	0	0	0	0	0	0	
Other income				0	0	0	0	0	0	0	0	0	0	0	0	0	
Reduced Cost Pressure				0	0	0	0	0	0	0	0	0	0	0	0	0	
Increased Cost Pressure				0	0	0	0	0	0	0	-81	-81	-81	-81	-81	-405	
Other cost				0	0	0	0	0	0	0	0	0	0	0	0	0	
Total Adjustments				0	0	0	0	0	465	465	466	466	466	466	467	3,261	
Remaining Surplus/ (Deficit)				-1,056	-456	19	-295	252	219	219	220	220	220	220	221	0	
By recurrence:																	
Actual/normalised forecast RR				-1,056	-456	19	-295	252	-246	-246	-246	-246	-246	-246	-246	-3,261	
Recurrent changes				0	0	0	0	0	465	465	547	547	547	547	548	3,666	
Non-recurrent changes				0	0	0	0	0	0	0	-81	-81	-81	-81	-81	-405	
Remaining Surplus/ (Deficit)				-1,056	-456	19	-295	252	219	219	220	220	220	220	221	0	

5.3.3 WINTER PLANS

● Information Item

 James Walters

REFERENCES

Only PDFs are attached

 05.3.3 Winter Plans BIC- 21 October.pdf

NWL Acute Provider Collaborative Board in Common (Public)

21/10/2025

Item number: 5.3.3

This report is: Public

Update on the Winter Plans across the Acute Provider Collaborative

Author: Sheena Basnayake,
Job title: Managing Director Chelsea and Westminster NHS Foundation Trust; and APC Lead for Urgent and Emergency Care

Accountable director: Sheen Basnayake,
Job title: Managing Director Chelsea and Westminster NHS Foundation Trust; and APC Lead for Urgent and Emergency Care

Purpose of report

Purpose: Assurance

The purpose of this report is to provide an overview of winter preparedness across the Acute Provider Collaborative and assurance that we are collectively as prepared as possible for what will be a challenging period.

Report history

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

Committee name		
What was the outcome?	Acute Provider Collaborative Executive Management Board 04/09/2025 Noted	Board in Common Cabinet 11/09/2025 and NWL F&P 18/09/2025 Noted

Executive summary and key messages

Our preparations are based on ensuring the delivery of safe, efficient and high-quality care across all of our sites. The winter plans for each Trust provide a blueprint for how we will ensure resilience in our hospitals, safeguard patients and staff, and detail the operational actions that will underpin our response to increased pressures during this winter period.

Whilst we all know that yearly winter pressures can create exceptional challenges for us across the APC, we will continue to deliver to existing plans for both UEC and elective performance throughout this period. We have undertaken a comprehensive review of our plans and are confident that we have put in place the appropriate actions and or possible mitigations to keep our patients and staff safe.

In addition, we have endeavoured to align to all the relevant NHSE guidance and hence are as prepared as possible. Winter 2025/26 will present significant pressures across the APC and for individual Trusts. Spring and summer months have remained challenged around capacity and Industrial action and therefore we anticipate challenges across all areas of the system to increase over winter with potential further industrial action taking place. Urgent and Emergency care elective recovery; workforce availability and discharge capacity is likely to increase.

NHSE target of improving our ED waiting times, with a minimum of 78% of patients seen within four hours by March 2026 and ability to delivery our elective plan remains a risk with activity reductions. The capacity deficit will require us to operate at very high levels of bed occupancy and will mean some patients in our emergency departments have to wait longer than we would want inclusive of long waits for mental health patients.

Strategic priorities

- Achieve recovery of our elective care, emergency care, and diagnostic capacity
- Support the ICS's mission to address health inequalities
- Attract, retain, develop the best staff in the NHS
- Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
- Achieve a more rapid spread of innovation, research, and transformation

Impact assessment

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

Main Report

1. Purpose

- 1.1. The purpose of this paper is to provide an overview of winter preparedness across the Acute Provider Collaborative (APC) and assurance to The Board in Common that we are collectively as prepared as possible for what will be a more challenging 2025/26 winter period.

2. Context

- 2.1. As in previous years, our preparations are based on ensuring the delivery of safe, efficient and high-quality care across all of our sites. The winter plans for each Trust provide a blueprint for how we will ensure resilience in our hospitals, safeguard patients and staff, and detail the operational actions that will underpin our response to increased pressures during this winter period.
- 2.2. The plans are built upon the guidance issued by NHSE throughout 2025 as and will help to maintain patient and staff safety and meet operational targets.
- 2.3. In line with this guidance, our primary operational goals are to:
 - Improve A&E waiting times and ensure that a minimum of 78% of patients are seen within 4 hours by March 2026; and
 - Deliver the elective activity plan for 2025/26.

3. Working collaboratively with our partners in the Integrated Care System

- 3.1. NWL ICS adopted a proactive approach to winter planning and undertook an evaluation of the 2025/26 winter schemes in the spring. This early review allowed the system to assess which initiatives had delivered the greatest impact and influenced the allocation of funding for 2025/26.
- 3.2. Their overall approach has a dual focus: sector-wide initiatives (enhancing system-wide capacity and efficiency) and localised action plans (targeting prevention, admission avoidance, and community-specific needs), supported by a system-wide communication and engagement campaign. Using data from previous campaigns, the ICS is deploying targeted messages, ensuring residents have access to clear information to navigate healthcare services effectively and access the right care, in the right place.
- 3.3. In addition, the Integrated Care System (ICS) has prioritised reducing discharge delays for the most complex patients, including those requiring specialist placements, complex mental health support, or where commissioning gaps exist. All boroughs will be implementing ADF-funded schemes to facilitate earlier discharges for these groups. All improvements regarding discharge and system working challenges worked through via the NWL system Flow board.

4. LAS plan and system escalation arrangements

4.1. In developing their winter plan the London Ambulance Services (LAS) has worked through previous feedback with all plans prepared and agreed early, requiring system escalation that brings actions that can be taken at time of high pressure, including a balance of risk across the system with clear review of trigger points and joint decision along with a revised and robust safety plan. Their draft plan sets out how resources will be managed to support the whole system in mitigating risk and continuing to provide safe care.

4.2. Key system actions has four key elements:

- 1) Support the increase in operating hours and capacity of key community services and non-Emergency Department pathways, including:
 - Urgent Community Response
 - Urgent Treatment Centres
 - Same Day Emergency Care
- 2) Support the introduction of Integrated Care Coordination/Single Point of Access, enabling community clinicians and ambulance clinicians to access and refer into more acute and specialist services, pre and post ambulance dispatch.
- 3) Support the adoption of LAS as the Trusted Assessor and enable direct access into Same Day Emergency Care (SDEC) and Urgent Treatment Centre (UTC) pan London.

Aligned to the LAS winter plan, the NWL Surge Team has developed the 'NWL Guide for the LAS Patient Flow Framework'. This provides a common structure through which operational challenges will be escalated and managed at ICS level.

The framework details different levels of escalation and their associated criteria, approval and actions, and is designed to support consistency in the approach to escalation over time and between providers.

5. Trust winter plans summary

5. 1. Each Trust has conducted bed modelling and capacity-demand exercises for winter. All anticipate that demand for general and acute beds will exceed available capacity at certain points.

5.2. Trusts have implemented a range of actions to reduce bed demand and address shortfalls:

Increased use of SDEC, with all APC Trusts meeting minimum opening hours and refining criteria. Work continues to expand SDEC, especially for surgical and frail patients.

- Improved hospital flow, with efforts to reduce length of stay, streamline inpatient processes, increase frailty service access, and improve discharge efficiency. Collaboration with community and out-of-borough teams supports earlier discharge.

- Operational routines include established command structures, escalation processes, and alignment with the NHSE Operational Pressures Escalation Levels (OPEL) framework to manage pressures and maintain safety.

5.3. The capacity deficit will be most acute during peak weeks. Each organisation has triggers and plans for creating additional escalation capacity if needed.

5.4. Emergency Planning, Resilience, and Response plans are in place to manage severe weather, business continuity incidents, and influenza. The Trusts have been running focused flu vaccination programmes; in order that staff have the best, possible protection before winter arrives.

5.5. The main goal is to maintain high standards of care across the APC, ensuring patients are treated in the right place at the right time, especially during winter surges. Patient safety and staff wellbeing are prioritised, with proactive risk monitoring and use of corridor care and full capacity protocols. Governance frameworks support regular review of key indicators such as patient complaints, incidents, waiting times, and ED occupancy.

5.6. Emergency departments are seeing more patients with acute mental health needs, who wait twice as long as those with physical conditions do. Managing violent or challenging behaviours is a concern for patient and staff safety. In response, Trusts have:

- Strengthened escalation protocols and staff training
- Improved access to specialist mental health support and assessment capacity
- Streamlined pathways to reduce delays in assessment and transfer

5.7. Discharge delays risk-prolonging waits for patients needing admission. The APC is focused on minimising hospital stays for medically fit patients through coordinated discharge planning with primary and local authority partners, improving same-day discharge management, and internal initiatives to reduce delays and improve flow.

6. Trusts Winter Planning Risks, Mitigations and Governance

6.1 London North West NHS Trust

Risks	Mitigations	Governance
<ul style="list-style-type: none"> • Year-to-date, attendances of all types have increased by 3.1% compared to the previous year, with particularly notable spikes observed in July and August 2025 peaking at 7.8%. • The Sector LAS Integrated Care Coordination Hub is currently only 40% filled for October, may affect the management of system demand. • Mental health attendances and length of stay continue to be a challenge. • There are also increasing delays related to patients awaiting discharge with no criteria to reside. • Winter funding for the Trust has been reduced to £2 million, with an additional £0.7 million contingency, compared to £5.4 million last year. 	<p>Several measures have been introduced to address these risks. Changes in the Emergency Department include a new front door steaming process from October, followed by a new digital streaming system in November. The Emergency Department is participating in the sector wider rota for the ambulance demand management service based in Pinner. There is a continued improvement in the streaming of patients between Majors Emergency Department and the Urgent Treatment Centre.</p> <p>Same Day Emergency Care services across medical, surgical and gynaecological pathways have been expanded with increased chair capacity and revised admission criteria.</p> <p>Site flow improvements include the introduction of the Discharge Ready Unit and an Older Peoples Short Stay Unit, continuation of the Temporary Escalation Space process and a discharge improvement programme. 21 additional winter escalation bed capacity is available for use in Quarter 4 if needed. Daily ward discharge standards have been reset and increased. The Acute Medical Model implemented earlier this year expected to deliver benefits. Additional Mental Health capacity is planned for the end of December to support flow at Ealing site.</p>	<p>Governance arrangements include the Trust Flow Board, which has met fortnightly since June 2025, an executive huddle in August, TEG in September, and Trust F&P in September. The Board Assurance Statement signed by the CEO.</p>

6.2 The Hillingdon Hospital Foundation Trust

Key Risks	Mitigations	Governance
<ul style="list-style-type: none"> • Lack of frailty-specific senior decision makers at weekends, and frailty practitioner support is reduced on Sundays under the current staffing model. • The capacity of the Urgent Community Response (UCR) service is insufficient to support admission avoidance work in the Frailty Assessment Unit (FAU). • Lacks a frailty virtual ward or hospital-at-home service. 	<p>A significant amount of work is underway at the community level to improve frailty services, with involvement from the Clinical Speciality Lead for Elderly Medicine. This work will connect with the acute frailty service and the reactive care model, with the aim of launching some elements before winter. Improvement initiatives involving clinical, nursing, and site teams are also in progress to enhance patient flow in and out of Rockwood ward, targeting a length of stay of 72 hours. This will help ensure that patients that are more suitable can access short-stay frailty ward resources and improve the overall length of stay for frail patients. The number of patients with no criteria to reside (NCTR) remains consistently above 40, so a Nurse Led Discharge Ready Ward is being piloted to reduce length of stay, prevent deconditioning, foster independence, and provide focused discharge team input. A 26-bed discharge ready ward is being prepared for winter, with opening planned for the week commencing 1st September. Earlier this year, capacity was increased with the introduction of new pathways in Diabetes, Acute General Medicine, and Atrial Fibrillation, adding 30 beds.</p>	<p>Trust's winter plan Reviewed at Trust Cabinet 1 September 2025, Executive Management Board 3 September 2025. The Winter Plan including the QEIA will be presented to the Trust Standing Committee on 14 October 2025</p>

6.3 Imperial College Healthcare NHS Trust

Risks	Mitigations	Governance
<ul style="list-style-type: none"> • Local modelling shows that, without intervention, there could be a peak shortfall of approximately 125 general and acute beds across the three acute sites, with the upper risk estimated at 152 beds. This projection is based on 92% occupancy. The Trust, divisional teams, and community partners have developed plans to reduce this bed gap to fewer than 70 beds at peak demand, assuming 97% occupancy. However, some risk remains despite these efforts. <p>There are several ongoing risks.</p> <ul style="list-style-type: none"> • In the community, delays in P2 rehabilitation and borough step-down capacity persist, with average delays exceeding three days and an estimated delivery confidence of around 80%. • Mental health services continue to experience high levels of emergency department attendances. • Delayed discharges for patients who are clinically ready to leave but have no criteria to reside, resulting in high bed occupancy. Housing and social care remain the main drivers of discharge delays, particularly for Pathway 3, and these issues have not been resolved within current plans. • System-wide, extreme scenario testing indicates that demand may still exceed capacity, especially 	<p>To address these risks, local mitigations include refreshed escalation frameworks such as the Full Capacity Protocol, the Temporary Escalation Space Standard Operating Procedure, and the no criteria to reside framework. Additional measures include divisional decompression and surge triggers, strengthened elective protection, vaccination programmes, and operational command arrangements. These measures have been tested through divisional planning and summit exercises. Contributions from community and mental health partners provide further assurance, particularly in relation to attendance avoidance and improving discharge flow.</p>	<p>The Trust's winter plan presented to the Executive Management Board on 30 September for final formal approval, and to the Trust Standing Committee on 7 October.</p>

regarding emergency department attendances and discharge delays.		
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6.4 Chelsea and Westminster NHS Foundation Trust

Risks	Mitigations	Governance
<ul style="list-style-type: none"> • The Trust is facing increased challenges with capacity and resilience. • There has been a 4% rise in attendances, a 5% increase in non-elective admissions, and a 4% rise in ambulance conveyances compared to the previous year. • Mental health attendances and long stays continue to be an issue. • Service provision across the seven-day period is challenging, with a reduction in the number of patients discharged at weekends. 	<p>A command and control structure established from ward to command centre, with clear escalation pathways for any delays. The Trust is supporting the use of cross-site acute virtual wards to increase SDEC capacity and is implementing Elective Enhanced Recovery for colorectal and arthroplasty procedures. Criteria-led discharge being applied for some non-elective surgical procedures. A 28-bedded Discharge Ready Unit has opened at the Chelsea and Westminster site to replicate a successful model from the West Middlesex site. Integrated working with community and out-of-borough teams continues across sites to support earlier discharge. Access to Frailty services and Frailty SDEC increased and the Trust is contributing to the LAS Integrated Care Coordination Hub rota. A new MHCAS service is planned for winter and will be stepped up by Q4 by West London Trust.</p>	<p>The Trust's winter plan signed off Executive Management Board on 10 of September and Trust Standing Committee on 2 October.</p>

7. Conclusion

- 7.1. This winter will be particularly challenging, and demand on UEC pathways is likely to be greater than in previous years. We have undertaken a comprehensive review of our plans and have put in place the appropriate actions and mitigations to keep our patients and staff safe. The ICB have undertaken applying additional stress testing on each trust individual schemes.
- 7.2. In addition, we have endeavoured to adhere to relevant NHSE guidance and hence are as prepared as possible.
- 7.3. There is a greater risk that 2025/26 winter will be more challenged given spring and summer months have remained pressurised. The APC has worked hard to be prepared but there is a risk we will fall short in our ability to deliver the NHSE operational targets.
- 7.4. The target of improving our ED waiting times with a minimum of 78% of patients seen within four hours by March 2026, and deliver our elective activity plan will be challenging. The capacity deficit will require us to operate at very high levels of bed occupancy and will mean some patients in our emergency departments have to wait longer than we would want.

5.3.4 COLLABORATIVE FINANCE AND PERFORMANCE COMMITTEE CHAIR

REPORT

 Discussion Item

 Carolyn Downs

REFERENCES

Only PDFs are attached

 05.3.4 APC_FPC_Chair_Report_Oct_2025 - FINAL.pdf

North West London Acute Provider Collaborative Collaborative Finance and Performance Committee Chair's Highlight Report to the Board in Common – for discussion October 2025

Highlight Report

1.0 Purpose and Introduction

- 1.1 The purpose of this report is to provide the Board in Common (BiC) with assurance of the work undertaken by the Collaborative Finance and Performance Committee (FPC) at its last meeting held on 18 September 2025. The report is intended to provide any feedback to the BiC and request if further work within the Committee's remit is required.
- 1.2 The role of the Collaborative Committee, which has changed in light of the recent governance developments and establishment of Board Standing Committees, is:
- To identify, prioritise, oversee and assure strategic change programmes to support the delivery of the Acute Provider Collaborative (APC) strategy and to drive collaborative-wide and Integrated Care System (ICS) integrated improvements.
 - To identify areas of risk where collaborative-wide interventions would speed and improve the response.
 - To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
 - To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements

2.0 Key Highlights

2.1 Integrated Performance Report

The new format report was welcomed, but it was noted that some metrics and data were missing. These will be included next time.

Urgent and Emergency Care (UEC): Performance remains variable across the system. Four-hour wait targets showed improvement, though Imperial remains off target. Hillingdon demonstrated significant improvement, but more to do. Ambulance handovers and mental health-related 12-hour waits continue to be areas of concern. There is a push in all organisations to see more patients through same day emergency care (SDEC) and to prioritise use of pharmacy first. There was a discussion on how many of the sickest patients – heart attacks, strokes are going direct to receive optimal care but not appearing in the statistics, with more also being seen elsewhere – understating the amount seen within four hours.

Elective Care: RTT performance has declined as expected due to financial constraints. Trusts are prioritising long-waiting patients and improving new-to-follow-up ratios using getting it right first time (GIRFT) data and digital tools. Specialty-level reviews are underway to address productivity gaps and job planning issues. All are aiming to get to the minimum 60% target, with targets differing across the patch as relates to prior performance. It was noted that it will be a significant challenge for Hillingdon to achieve their target, but detailed focus by specialities of concern is ongoing. It was added that the level of capacity required in some specialties wasn't in the right place initially (e.g.

rheumatology) but through business cases the aim is to ensure the capacity is where it is required.

Diagnostics: Performance remains below standard, with ultrasound and MRI capacity as key issues. Recovery plans are in progress, including community diagnostic centre (CDC) capacity reviews and decision support tools for primary and secondary care. The issue regarding rising demand, aging equipment was discussed noting issues with securing funding from commissioners to address this. Further concerns on the level of commissioned resource given the demand levels. The Committee requested detailed analysis of demand, capacity, and funding impacts – including arrangements for mutual aid.

Cancer: Performance remains strong. The Faster Diagnosis Standard (FDS) is above 80%, and 62-day performance exceeds national expectations but falls short of the north west London (NWL) aspiration of 85%. Data validation and shared clinical leadership are being pursued to improve productivity and cost efficiency.

Cancer productivity

The report provided the position by trust. It was noted that there are some issues with bundled costs being included and attributed to oncology incorrectly for LNW and inpatient care through 19 side rooms at CWFT driving higher costs. Imperial showed more green indicators, in part due to use of nurse led clinics. Overall it was recognised that some of the specialist care provided in the APC drives the higher costs, but there is further work to do to increase productivity and better share learning across the patch. It was agreed to bring more detail to the next meeting with detail on how the APC can get closer to the average costs for care.

2.2 Winter Plan

The Winter Plan summary was presented, noting the detailed plans for each trust were available as appendices. The report emphasised maintaining elective activity and safety in emergency pathways. All organisations have clear escalation protocols and strengthened tactical oversight, including command and control measures.

Risks identified include corridor care, mental health pressures, staff sickness, and potential industrial action. Vaccination efforts for staff are expected to improve compared to last year. The plan has been reviewed locally, and board assurance statements are due for CEO, Chair and Board sign-off by the end of the month.

The importance of partnership discussions with local authorities was noted, along with alignment of resource plans with anticipated demand. Local finance and performance committees (FPCs) will explore this further and any items for escalation to be discussed at local and ICS level system meetings

2.3 Finance Report

Chief Finance Officers presented the M4 and M5 financial positions. M4 showed an £11.4m deficit year to date (YTD), with a £2.7m in-month deficit driven by industrial action. CIP delivery was £12.4m adverse to plan. Cash balance stood at £273m, above plan, with capital underspend due to pending approvals. Forecast remains break-even. Risks include reduced cash at LNW and industrial action impacts.

M5 showed improvement with an £11.5m deficit, favourable to plan. Efficiency plans are stabilising, and cash has grown. CD noted the positive trend and queried future

projections. FL reported a small surplus and highlighted CIP delivery risks. LL and BP discussed the strategic intent behind the financial plan and its impact on organisational focus. MS raised concerns about cash-flow predictability and the need for board-level discussions given the situation at LNW.

The importance of a medium-term financial plan was emphasised, with a further discussion on refinancing options and the need for structural changes. Actions included preparing a comprehensive paper on financial sustainability and engaging NEDs (BA and MOD) in a task and finish group.

2.4 Productivity Programme Update

The productivity programme, emphasising accountability for metrics and improvement actions consistent to maintain performance. MS requested analysis of current year data and queried why the most up to date information was not included. BP confirmed efforts to obtain local data for implied productivity metrics and advised that the info uploaded to the platform re model hospital data was used. MS added that the latest financial information was uploaded with the national oversight system (NOF) data a month ago so should be reviewed and utilised.

2.5 Medium Term Financial Strategy – Update

The base case financial model was presented noting it was developed prior to the formal requirement for a medium-term plan. The model outlines a consistent baseline across trusts and highlights a £252m underlying deficit. Four scenarios were discussed, considering inflation, efficiency, and population growth.

It was confirmed that cost improvement programme (CIPs) and emergency funding shifts would be included in future iterations. The need for timely governance sign-offs in line with planning guidance was emphasised along with a proposed board development session in November.

Committee members noted national requirements for 2% productivity and deficit resolution. The importance of accurate cost attribution and contract assumptions was reiterated. Actions included mapping governance steps and preparing for board discussions.

The need for fundamental service changes was recognised, which will require difficult decisions and careful stakeholder engagement. The approach was endorsed.

2.6 Update on NWL Finance and Procurement System Procurement

The Committee noted the updates from each local Trust. Imperial's patient transport concerns were addressed at the Strategic Estates and Sustainability Committee. BA confirmed resolution.

2.7 Escalation Report from Trust Finance and Performance Committees (FPCs)

The Committee noted the updates from each local Trust. Imperial's patient transport concerns were addressed at the Strategic Estates and Sustainability Committee and confirmed as resolved.

2.8 Collaborative Financial and Performance Risks and Assurance

The report indicated that diagnostics and finance remain high-risk areas. There was a proposal to adjust the risk rating next time for finance (year-end not med/longer term)

based on current forecasts. Partnership risks were deemed moderate at this point but this may rise once more difficult decisions need to be made re services.

3.0 Key risks / topics to escalate to the NWL APC BiC

- Performance challenges remain, particularly in diagnostics
- Concerns re rising demand and associated financial impact

4.0 Concerns outstanding

See above

5.0 Actions commissioned

- More detailed analysis on capacity vs demand for diagnostics and further detail on mutual aid plans
- Further detail on intentions for getting closer to average costs for cancer care
- Governance timeline for sign off of financial plans
- True-up for board papers (see below)

6.0 Decisions Made

6.1 Winter plans and APC wide approach to managing winter endorsed.

7.0 Attendance

Members:	Attendance
Carolyn Downs, Non- executive director (NED) of THHT F&PC - (Chair)	Y
Mike O'Donnell, NED, Chair of CWFT F&PC	Y
Bob Alexander, NED, Chair of Imperial F&PC	Y
Loy Lobo, NED, Chair of London North West (LNW) F&PC	Y
Lesley Watts, CEO, Chelsea and Westminster NHS FT (CWFT), The Hillingdon Hospitals NHS FT (THHFT) and Collaborative Lead for Finance and Performance	Y
Attendees:	
Matthew Swindells, Chair of NWL Board in Common and Collaborative	Y
Alan McGlennan, Managing Director - Hillingdon	Y
Ian Bateman, Chief Operating Officer – Imperial (interim)	Y
Jazz Thind, Chief Financial Officer - Imperial	N
Virginia Massaro, Chief Finance Officer – CWFT and THHFT	Y
Faheem Lunat, Deputy Chief Financial Officer - Imperial	Y
Laura Bewick, Hospital Director – CW - CWFT	Y
Sheena Basnayake, Hospital Director WM - CWFT	Y
James Walters, Chief Operating Officer - LNW	Y
Jason Antrobus, - Deputy Chief Operating Officer - LNW	Y
Bimal Patel, Chief Financial Officer - LNW	Y
Priya Ruda, Associate Director of Finance, NWL APC	Y
Peter Jenkinson, Director of Corporate Governance	Y
Marie Price, Deputy Director Corporate Governance - CWFT	Y
Alexia Pipe, Chief of Staff to the Chair	Y

6. DATA AND DIGITAL

🕒 12:45

6.1 COLLABORATIVE DIGITAL AND DATA COMMITTEE REPORT

 Matthew Swindells

REFERENCES

Only PDFs are attached

 06.1 Collaborative Digital Data Meeting Summary September 2025.pdf

North West London Acute Provider Collaborative (NWL APC) Digital and Data (D&D) Committee Chair's Highlight Report to the NWL APC Board in Common (BiC) – for discussion

September 2025

Highlight Report

1. Purpose and Introduction

The role of the Digital and Data Committee is:-

- To identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements.
- To prioritise, oversee and assure strategic change programmes to drive collaborative wide and ICS integrated improvements in the management of digital/data infrastructure.
- To draw to the NWL APC Board in Common's attention matters they need to agree or note.

2. Key Highlights

2.1 Data Strategy

2.1.1 EPR Ecosystem – Deep dive into one project's benefits (Alertive)

The Committee received the report which provided the Committee with an update on the project to move away from legacy beeps, including for internal emergencies. ICHT has now been successful "bleep free" for 2.5 years. The project has completed at CWFT, is underway at LNWH and due to complete at THH by December. Committee members noted that the Trust was eliminating the use of shadow tools, such as WhatsApp by delivering new digital functionality on Alertive. This includes peer to peer messaging which can write a universal URL back into the patient record on Cerner. Committee members were assured that Alertive had delivered significant improvements in clinical communication speed, security, and integration, with a clear roadmap for further expansion and optimisation across the Acute Provider Collaborative.

2.1.2 Federated Data Platform (FDP) 2025/26 delivery plan update

Committee members received an update on the Federated Data Platform (FDP) delivery plan which highlighted that all four Trusts had real time data flowing from Cerner into the FDP using Golden Gate change data capture, replacing legacy batch uploads and addressing long-standing latency. Committee members noted that the first product (Optical discharge tracking) was on track for delivery, with further products to follow based on operational priorities. Committee members noted the challenges which included technical dependencies and workforce constraints.

2.1.3 ICT Infrastructure 2025/26 delivery plan update

Committee members received the report which highlighted that the Acute Provider Collaborative service desk procurement was complete and a business case approval process was underway across the Trusts.

Committee members noted that planning for ICT management structure switchboard integration and a federated Active Directory solution to support joint system had commenced. Committee members discussed the long-term strategy for managed networks and security systems integration, with a view to future proofing infrastructure and enabling neighbourhood health centres.

2.1.4 Update on the Ambient Scribe Pilot

Committee members received an update on the Ambient Scribe Pilot. The update highlighted that the pilot was in progress and feedback so far was positive. It was noted that the pilot would conclude at the end of September 2025, where feedback from user experience will be gathered and quantified and a potential business case formed.

2.2 ICT Risk Management – Demonstration of third-party supplier information tool

Committee members received a presentation on the "One Trust" tool, which provides ongoing cybersecurity posture updates for critical suppliers, and discussed its integration with contract management and the challenges of covering smaller or niche vendors.

3. Key risks / topics to escalate to the NWL APC BiC

- The board will be updated on progress with ambient scribing technology, including the move to a business case and procurement, and the positive initial evaluation from clinicians.
- Significant progress on latency and two-way integration between the Federated Data Platform and Cerner will be reported, with a note that data analyst resource is now the rate-limiting factor for further progress.
- The need to discuss the implications of the ICB merger for the wider digital strategy will be raised for a future agenda.
- It was also suggested to register the need for a more strategic view on infrastructure investment and planning.

4. Concerns outstanding

- No additional APC level concerns which require escalation to the Board.

5. Key actions commissioned

- None noted.

6. Decisions made

- None

7. Attendance

Members	June 2025 attendance
Matthew Swindells (NWL APC Chair in Common) – Chair of the NWL APC D&D Committee	Y
Tim Orchard (Chief Executive, ICHT)	Y
Simon Crawford (Director of Strategy – LNWH & Senior Information Risk Owner (SIRO) Representative)	Y
Robbie Cline (Joint Chief Information Officer – LNWH/THHT/ICHT/C&WFT)	Y
Sanjay Gautama (Consultant anaesthetist & Chief Clinical Information Officer (CCIO) Representative)	Y
Bruno Botelho (NWL APC Programme Director & Operations Representative)	Y
Mathew Towers (Business Intelligence (BI) Representative)	N
Nick Gash (NED – ICHT/THHT)	Y
Mike O'Donnell (NED – CW&FT/THHT)	N
Loy Lobo (NED – LNWH/ICHT)	Y
In Attendance	
Alexia Pipe (Chief of Staff to the Chair in Common)	Y
Peter Jenkinson (Director of Corporate Governance)	Y
John Keating (Deputy CIO LNWH, THHT)	Y
Mathew Kybert (Deputy CIO, ICHT)	N

7. ESTATES AND SUSTAINABILITY

🕒 12:50

7.1 COLLABORATIVE STRATEGIC ESTATES, INFRASTRUCTURE AND SUSTAINABILITY COMMITTEE REPORT

● Discussion Item

 David Moss

REFERENCES

Only PDFs are attached

 07.1 Collaborative Strategic Estates and Sustainability Committee - September 2025 final.pdf

**North West London Acute Provider Collaborative (NWL APC)
Strategic Estates and Sustainability Committee Chair's Highlight Report to
the NWL APC Board in Common (BiC) – for discussion
September 2025**

Highlight Report

1. Purpose and Introduction

The role of the Collaborative Strategic Estates, Infrastructure and Sustainability Committee is:-

- To oversee and receive assurance that the Trust level processes governing estates maintenance and development are functioning properly and identify areas of risk where collaborative-wide interventions would accelerate and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements in estates optimisation and usage, and sustainability.
- To receive assurance regarding capital planning and prioritisation across the Collaborative, and to consider the relationship between capital and productivity.
- To oversee the development of an estates strategy across the Collaborative, including site optimisation and redevelopment, and to inform the design of the human resource required to deliver the strategy.
- To oversee the strategic consideration of opportunities across the Collaborative in relation to soft facilities management contracts.
- To oversee the strategic consideration of investment in major equipment across the Collaborative.
- Ensuring equity is considered in all strategic estates development.

2. Key highlights

2.1 The Strategic Estates and Sustainability Collaborative Committee met on 17 September 2025. The following papers were discussed.

2.2 APC Green Plans refresh

2.2.1 The paper brought together the refreshed Green Plans for each of the four Trusts within the collaborative. In line with NHSE requirements, each refreshed Green Plan had been completed by the deadline of 31 July 2024 for submission to NHSE Greener Team. Plans had been signed off through individual Trust governance processes and had been published on each Trust's website.

2.2.2 Key risks to deliver the green plans were consistent across the four Trusts including funding and capital availability for decarbonisation; scale and pace of change; and, redevelopment for The Hillingdon Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Trust.

2.2.3 Monitoring and reporting against delivery of objectives, and each Trust's trajectory towards net zero, would continue through Trust governance structures. As agreed with the Chair of the Committee, combined updates would be brought to the Collaborative Committee every 6 months. The next update would be brought to the December meeting and then to June 2026. The Committee expected the December report would include further alignment of data, however acknowledged that this was an ongoing

piece of work.

- 2.2.4 The Committee discussed areas to grow collaboration across the APC on sustainability including clinical pathways, theatres and research; work taking place around decarbonisation; links between air pollution and health; direct and indirect emissions. With regards to indirect emissions, the Committee noted NWL Procurement were due to attend the December meeting.
- 2.2.5 Members noted concern that sustainability was not as high on the political agenda, which could reduce the number of grants / bids available in the future. A watching brief was needed in this area.
- 2.2.6 Members considered an APC-wide internal audit on data quality for carbon emissions. It was suggested it may be helpful to work with ICL on data quality and explore national benchmarking through Shelford Group.
- 2.2.7 The Committee noted the approved plans.

2.3 APC Board Assurance Framework

- 2.3.1 The Committee reviewed the current strategic risks on the APC Board Assurance Framework associated with this committee:
- Poor condition of estates
 - Equipment / infrastructure
 - Sustainability
 - Accessibility
 - 10 year plan

2.3.2 The Committee made a number of suggested amendments to risks / risk descriptions.

2.3.3 The Committee noted the report.

2.4 Deep Dive: Business Rates 2026 Revaluation

2.4.1 The paper had previously been presented to the APC Executive Management Board (EMB) and provided an update on the management of 2026 revaluation exercise and the impact on the business rates liabilities for the four Trusts. Business rates were the subject of periodic revaluation reviews, where the Valuation Office Agency (VOA) assessed the rateable value of the property. That valuation was for a five-year period, however they could be open to interpretation and professional challenge. The paper included a proposal to engage a specialist firm to support the Trusts with the next round of business revaluation at a modest retain rate per Trust per year, with an award to incentivise negotiated discounts.

2.4.2 The Committee noted the report and endorsed the approach, however noted that each Trust were expected to use the framework and follow the scheme of delegation.

2.5 Mitigation of critical infrastructure, backlog maintenance and fire safety risk by capital investment 2025/26

2.5.1 The paper provided an update on how the Trusts' estates and capital project teams intended to invest in backlog maintenance to mitigate estate operational risks in 2025/26. There was a reliance on external grants to make in-roads into the underlying high level backlog maintenance.

2.5.2 Noting a recent fire at St Mary's Hospital, the Committee discussed leadership culture and ensuring safety was a high enough priority. Safety was discussed at a number of

Board / Collaborative Committees however noted the need for a holistic view of safety culture. It was agreed to extend some work, currently being undertaken at Imperial College Healthcare NHS Trust, to a wider-APC piece around health and safety compliance.

2.5.3 The Committee requested a joint report from finance and estates, to be brought to the December meeting, on backlog maintenance to include Estates Returns Information Collection (ERIC) data and financial analysis / projects to support discussions around capital allocations and prioritisation.

2.5.4 The Committee noted the report.

2.6 Benchmarking the APC Estate and Workplan

2.6.1 The Committee considered Project Initiation Documents (PIDs) on four workstreams which had the greatest potential to be cash releasing or cost pressure avoiding.

2.6.2 The Committee noted the report and looked forward to receiving the remaining outstanding PIDs.

2.7 The Hillingdon Hospitals NHS Foundation Trust redevelopment update

2.7.1 The Committee received a confidential update on the redevelopment plans for The Hillingdon Hospitals NHS Foundation Trust.

2.8 Imperial College Healthcare NHS Foundation Trust redevelopment update

2.8.1 The Committee received a confidential update on the redevelopment plans for Imperial College Healthcare NHS Trust.

2.9 Register of forward business cases

2.9.1 The register of forward business cases needed to dovetail with the business planning process. Chief Financial Officers would own the business case pipeline. An updated paper would be brought to the December meeting.

2.8 Summary report from the Estates and Sustainability Executive Group

2.8.1 The paper provided a summary of the Estates and Sustainability Executive Group discussions since June 2025.

3 Positive assurances received

3.1 The Committee noted the positive work on the green / sustainability plans.

4 Key risks to escalate

4.1 The condition of the estate across the Collaborative and cost of backlog maintenance remains a significant risk.

5 Key actions commissioned

5.1 The Committee asked for a number of papers to be brought to future meetings including:

- Potential options regarding private funding initiatives to support redevelopment schemes
- Joint report from finance and estates on backlog maintenance, including ERIC data and financial analysis to support discussions around capital allocations and prioritisation
- Regulatory compliance in health and safety matters across the four Trusts

6 Decisions made

6.1 N/A

7 Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	APC Green Plans refresh	To note	6.	THHFT strategy for redevelopment engagement	To note
2.	APC BAF	To note	7.	ICHT Redevelopment update	To note
3.	Deep Dive: Business Rates 2026 Revaluation	To note and endorse	8.	Register of forward business cases	Verbal
4.	APC contingency planning including fire safety	To note	9.	Summary report from the Estates and Sustainability Executive Group	To note
5.	Benchmarking the APC estate, further development of PIDs in the Collaboration Workplan	To note			

8. Attendance Matrix

Members:	June Meeting
Bob Alexander, Vice Chair (ICHT) (Chair)	Y
Aman Dalvi, NED (CWFT/ICHT)	Y
Vineeta Manchanda, NED (THHFT/CWFT)	Y
David Moss, NED (LNWH/ICHT)	Y
Matthew Swindells, Chair in Common	Y
Tim Orchard, Chief Executive (ICHT)	Y
Bob Klaber, Director of Strategy, Research and Innovation (ICHT)	Y
Virginia Massaro, CFO (CWFT)	Y
Gary Munn, Interim Director of Estates (LNWH)	Y
Janice Sigsworth, Chief Nurse (ICHT)	Y
Steve Wedgwood, Director of Estates (THHFT)	N (moved to a new role)
James Walters, Chief Operating Officer (LNWH)	Apologies
Jason Seez, Deputy CEO (THHFT)	Y
In attendance:	
Sam Bucknall, Head of Programme Governance and Business Management (Redevelopment) (ICHT) – for item 6.6	Y
Marie Courtner, Director of Estates and Facilities (CWFT and THHFT)	Y
Philippa Healy, Business Manager (minutes)	Y
Peter Jenkinson, Director of Corporate Governance (ICHT, CWFT and THHFT)	Y
Eric Munro, Director of Estates and Facilities (ICHT)	Y
Alexia Pipe, Chief of Staff – Chair's office	Y
Mark Titcomb, Managing Director of NWL EOC, CMH and Ealing Hospital, Executive Director for Estates and Facilities (LNWH)	Y

8. CHIEF EXECUTIVE OFFICERS

🕒 12:55

8.1 ACUTE PROVIDER COLLABORATIVE EXECUTIVE MANAGEMENT BOARD

(EMB) SUMMARY

 Discussion Item

 Tim Orchard

REFERENCES

Only PDFs are attached

 08.1 APC EMB Chair's Report - Oct 25.pdf

North West London Acute Provider Collaborative (NWL APC) Executive Management Board (EMB) Highlight Report to the Board in Common

October 2025

Highlight Report

1. Purpose and Introduction

The role of the NWL APC Executive Management Board (EMB) is:

- To oversee the delivery of the Collaborative strategy and business plan, including the financial and operational plan.
- To be the executive decision-making body for the Collaborative, commissioning and approving Collaborative programmes and associated resources, ensuring that the various programmes are aligned in their objectives and delivering against agreed milestones.
- To draw to the NWL APC Board in Common's (BiC's) attention matters they need to agree or note.

2. Key highlights

The APC EMB met on 7 July 2025, 4 September 2025 and 9 October 2025. Key discussion items are summarised below.

2.1. Performance reporting

At each meeting, the APC EMB reviewed quality, workforce, operational and financial performance across the Trusts, receiving assurance on outliers and activity ongoing to address variation.

2.2. Finance planning and performance

The APC EMB discussed the financial performance and forecast in detail. There was an update on the development of the APC medium-term financial plan, noting that the planning guidance was not yet published, as well as the proposed NWL APC financial performance escalation process. The APC EMB also reviewed and discussed the latest Productivity & Efficiency (P&E) Dashboard for the APC.

2.3. Business planning

The APC EMB received monthly updates on the 12 priority projects across the five work streams that support one or more of the system productivity, corporate consolidation and savings, and APC pathways.

The APC EMB discussed the requests for support in the various work streams including programme/transformation support, finance support, BI support and, within trusts, single APC reporting support.

2.4. APC clinical pathways

The APC EMB received regular updates on the APC clinical pathways

programme noting the focus on aligning good practice, ensuring equitable access and enhancing productivity.

APC EMB noted that most pathways were progressing in line with their implementation milestones, with minor timeline adjustments. Several pathways had already been implemented and were now measuring impact. Four pathways were highlighted as needing additional escalation and these would be discussed separately by the CEOs.

APC EMB members reflected on the clinical pathways forum that was held on 15 July which allowed colleagues including non-executive directors to hear directly from pathway members about progress, shared learning, and future plans.

2.5 Elective Orthopaedic Centre

The APC EMB received an update on the Elective Orthopaedic Centre noting that performance continued to be positive, particularly in relation to clinical outcomes and length of stay.

Collaborative working continued to progress particularly with THHFT and CWFT supporting an initiative to safely share and operate on long waiting LNWH patients, which demonstrated the shared commitment to improving equity of access and reducing surgical waiting times across the sector.

The APC EMB noted the continuing risk relating to the unresolved financial income risk following the 25/26 changes to the elective recovery fund (ERF) which continue to be escalated to the ICB.

APC EMB also noted the work to streamline the pre-op processes, roll out concentric e-consent and the Federated Data Platform development of a shared EOC PTL all continue at pace.

2.6 General Medical Council National Training Survey results

The APC EMB reviewed and discussed the resident doctor survey results which were generally positive for most trusts, with improvement plans underway/being developed where concerns had been highlighted, showing our commitment to training and improving the learning environment across the APC. Further improvements would be made through the implementation of the 10 point plan to improve resident doctors working lives. It was also agreed that there may be opportunities for programmes to collaborate where variance of experience exists across the APC. This would require a change in approach and would be considered once the initial action plans have been agreed through local trust governance.

2.7 Governance

The APC EMB received updates on the collaborative Board Assurance Framework (BAF), which were now aligned to the APC EMB executive representative. The risks within the BAF would be presented to the appropriate

APC committee.

2.8 Collaborative projects

The APC EMB receives monthly updates on progress in developing and implementing the Collaborative business plan and strategic priorities. These include the projects within the quality, workforce, finance and performance and digital transformation work streams.

The APC EMB were also provided with assurance and decisions on key collaborative projects. This included:

- **Ophthalmology:** A strategic update provides an overview of the progress, achievements, and ongoing challenges in implementing the North West London (NWL) Ophthalmology Model of Care.
- **Corporate transformation:** APC EMB received updates on the corporate transformation programme noting the progress against the work streams but highlighting the need to ensure a longer-term strategic vision for transformation opportunities across each function; a three year critical path was being developed. The Corporate Transformation Programme were pulling together a draft three year critical path which would be shared with the APC EMB for discussion once finalised.

An update on the finance systems procurement was received by the APC EMB and it was noted that the proposed timeline would deliver a supplier recommendation by November with Trust approvals to take place in December 2025 and January 2026.

- **Implementation of the joint reporting and learning system:** APC EMB members noted that overall good progress was being made with the design phase of the new system, although there had been some delays on both trusts' and the supplier's side. Data migration plans were being confirmed, and internal and external project timelines and resource agreed, with final implementation now anticipated in April 2026, well within the contract end dates with the current supplier.

3. Attendance of members

The APC EMB is attended by all 3 CEOs and a representative of each 'functional group' of executive roles. The current membership as of October 2025 is:

- **CEOs** – Tim Orchard, ICHT (Chair), Lesley Watts, CWFT & THHT, Pippa Nightingale, LNWH
- **Chief Financial Officer** representative – Bimal Patel, LNWH
- **Chief Operating Officer** representative – James Walters, LNWH
- **Chief Medical Officer** representative – Roger Chinn, CWFT
- **Chief Nurse** representative – Janice Sigsworth, ICHT
- **Chief People Officer** representative – Kevin Croft, CWFT, THHT, ICHT

- **Strategy lead** representative – Bob Klaber, ICHT
- **Chief Information Officer** representative – Robbie Cline, Collaborative
- **Collaborative Director of Corporate Governance** – Peter Jenkinson, Collaborative
- **Communications** representative – Tracey Beck, LNWH

8.2 REPORTS FROM THE CHIEF EXECUTIVES OFFICERS AND TRUST

STANDING COMMITTEES

8.2A LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST

● Information Item

👤 Pippa Nightingale / David Moss

REFERENCES

Only PDFs are attached

 08.2a LNWH Chief Executive Report.pdf

 08.2a LNWH TSC Report final.pdf

NWL Acute Provider Collaborative Board in Common (Public)

21/10/2025

Item number: 8.2a

This report is: Public

Chief Executive Officer's report

Author: Pippa Nightingale
Job title: Chief Executive Officer

Accountable director: Pippa Nightingale
Job title: Chief Executive Officer

Purpose of report (for decision, discussion or noting)

Purpose: Information or for noting only

Report history

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

Not applicable

Executive summary and key

Quarterly Trust update from the Chief Executive.

Impact assessment

Tick all that apply

- Equity
- Quality
- People (workforce, patients, families or careers)
- Operational performance
- Finance
- Communications and engagement

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)
- ☒ Provide high-quality, timely and equitable care in a sustainable way (LNWH)
- ☒ Be a high-quality employer where all our people feel they belong and are empowered to provide excellent services and grow their careers (LNWH)
- ☒ Base our care on high-quality, responsive, and seamless non-clinical and administrative services (LNWH)
- ☒ Build high-quality, trusted ways of working with our local people and partners so that together we can improve the health of our communities (LNWH)

Main Report

Executive summary and key messages

1. Key messages

- 1.1 Staff have been informed of the decision to transition from five divisions to three. This structure enhances support for integrated care pathways, more closely aligns divisions with peers across north west London and establishes the critical mass necessary to operate effectively within increased financial constraints over the coming years.
- 1.2 Clinical teams ensured the continued running of emergency care during the resident doctors' strike (25-30 July) while demonstrating respect for our colleagues' right to strike. Maternity services remained open as usual.

2. Quality and safety

- 2.1 The Care Quality Commission conducted an unannounced inspection on Tuesday, 15 July. The inspectors evaluated emergency departments and urgent treatment centres on all sites. The full report will be published later in the autumn.

3. Operational performance

- 3.1 The Trust continues to make steady progress across its priority areas, demonstrating both resilience and a strong commitment to patient-centred care, despite the ongoing operational challenges facing the health system. Over the past two months we have seen notable improvements in urgent care, Referral to Treatment (RTT), diagnostics, and particularly in reducing the cancer backlog, while maintaining strong safety and quality outcomes.
- 3.2 **Emergency department performance:** Performance in urgent and emergency care has continued to improve steadily, even with ongoing demand pressures. In July, the Trust achieved 78.2% compliance with the four-hour standard, marking a positive step forward.

Same Day Emergency Care (SDEC) activity reached 2,222 attendances, helping to reduce pressure on Emergency Departments and improve patient flow.

Onward focus will be on redesigning SDEC and ED pathways to speed up decision-making and flow, reducing 12-hour delays through earlier discharges and better use of escalation spaces, and completing winter preparations. These preparations include ward reconfiguration and closer system-wide coordination with community and social care partners to ensure we are ready to meet seasonal demand.

- 3.2 **Referral to treatment:** The Trust has sustained progress in RTT performance, despite some disruption caused by industrial action.

52-week breaches fell by 300 patients in July, a significant milestone in improving access to care. While 65-week breaches saw a slight rise to 43 patients, this was driven by temporary service disruptions. Encouragingly, 18-week RTT performance improved to 58%, exceeding the July trajectory and demonstrating the effectiveness of current interventions.

This progress has been underpinned by workforce development initiatives, improvements in productivity, and the rollout of digital tools such as Rova, which enhances patient scheduling and communication. The Trust also continues to play an active role in national recovery programmes aimed at further reducing waiting lists.

- 3.3 **Cancer services** remain a top priority for the Trust, and recent targeted actions are delivering measurable improvements.

Faster Diagnosis Standard performance in June reached 80%, exceeding the 75% target and sustaining an upward trajectory. While compliance with the Two Week Wait (2WW) standard remains below target at 62.2% (target 93%), work is underway to expand capacity and strengthen pathways.

Most encouragingly, the 62-day cancer backlog has reduced to 138 cases, including 23 patients waiting over 104 days, a clear improvement compared with earlier months. This reflects the impact of focused interventions such as intensified pathway tracking to accelerate treatment starts and closer collaboration with regional cancer networks to balance demand and optimise capacity. In addition, resilience plans are in place to prevent further backlog growth and to drive future improvements in 2WW performance.

- 3.4 **Inpatient Flow and Discharge:** Improving inpatient flow remains a key operational priority as it directly affects both patient experience and urgent care performance.

The proportion of discharges before 5pm held steady at 59.1%, just below the 60% London target. Temporary Escalation Spaces (TES) continue to be used to manage peaks in demand, with an average of 127 spaces occupied daily in ED and 17 in non-ED areas.

These measures are helping to relieve pressure on the system, but further work is required to consistently improve timely discharges and reduce bottlenecks.

3.5 **Diagnostics:** In diagnostics, capacity increases are beginning to deliver tangible improvements.

Compliance with the DM01 standard rose by 5% this month, driven primarily by additional non-obstetric ultrasound sessions and better scheduling across other imaging modalities. This progress strengthens our ability to meet rising demand and improve early diagnosis and treatment.

3.5 **Key priorities for the next quarter include:**

1. Accelerating improvements in 2WW compliance while sustaining reductions in the cancer backlog.
2. Preparing for winter demand, with pathway redesign, capacity planning, and flow optimisation.
3. Embedding digital innovation and strengthening the workforce to support sustainable improvements in RTT Performance.
4. Building system-wide resilience through closer collaboration with community, social care, and regional partners, to support with the winter pressures ahead.

4. Finance and estates

4.1 **Finance:** As previously stated, the Trust—together with other Acute Provider Collaborative partners—has established an ambitious breakeven plan for the 2025-26 financial year.

We continue to balance the demands of emergency services and RTT performance with necessary financial constraints. Nevertheless, as a system, we remain fully committed to delivering on our objectives.

We reported a deficit of £4.4 at M4 which is £1.5m off plan and includes £1.3m cost of industrial action.

We have recognised £6.1m in Elective Recovery Fund (ERF) overperformance income, though we anticipate that this amount will decrease in second half of the year. Overall pay costs remain stable, and both the vacancy freeze, and temporary staffing controls are still in effect.

Excluding the ERF overperformance, the primary reason for the variance relates to the Cost Improvement Programme (CIP), for which the target has been evenly profiled across the year at approximately £4m per month. Our actual delivery profile is weighted towards the final two quarters of the year. To July, we identified £9.2m in CIP and delivered £8.9m. For the year we have identified our full target of £48.5m in July.

The capital programme continues according to plan and remains within the allocated target. The Capital Review Group provides ongoing oversight to ensure strong financial discipline.

While we aim to maintain expenditure within approved limits, we continue to carefully monitor the cash position through the executive group and through the finance and performance committee. With the cash guidance out, we may need to apply for in year cash support to maintain reasonable level of creditor payment. That is driven by the slippage in timing of the land sale receipt.

Key financial risks are CIP delivery, containing activity within the cap to remain within expenditure budget and realise the land sale overage receipt as planned. These are being carefully managed and monitored and we continue to work very closely with our system partners.

- 4.2 **Estates and facilities:** A key achievement completed with Trust Standing Committee approval in July 2025 is the updated LNWH Green Plan (2025–2028). This comprehensive sustainability document has now been published; it sets the benchmark for the next three years and has been endorsed by NHSE.

The Green Plan aligns closely with future clinical planning initiatives addressing climate change and supports the NHS's broader goal of achieving net zero emissions by 2040. Much work is being delivered with Acute Provider Collaborative colleagues to minimise duplication, share best practices, and efficiently deliver benefits to both patients and staff. Implementation of initial deliverables is progressing, focusing on opportunities for financial sustainability, training, and integration with the wider Trust CIP.

As the 2025-26 period continues, the estates and facilities team have prioritised backlog maintenance and supporting improved patient flow and experience through several targeted clinical improvement programmes. With fewer major construction or refurbishment projects planned compared to the previous two years, resources are being shifted towards essential backlog and lifecycle works, as well as repairs such as lift maintenance, roof upgrades, and upkeep of frequently utilised clinical spaces.

Recent improvements have been completed in various clinical areas, including Fielding ward bays and side rooms at Northwick Park Hospital (NPH), enhancements to private patient facilities across the Trust, upgraded radiology rooms at Central Middlesex Hospital (CMH), and Same Day Emergency Care improvements at Ealing Hospital. These completed projects have delivered enhanced environments for both patients and staff.

The major procurement process for the Trust's soft facilities management contract continues to progress at pace and is nearing completion. This seven-year, circa £242 million contract will provide vital cleaning, portering, catering, and other support services across our main hospital sites and selected off-site facilities.

Since early 2025, the tender process has adhered to national procurement standards and Cabinet Office cost controls. It has recently advanced from the invitation to tender stage through bid evaluation, moderation, and assurance. The next step involves selecting a preferred bidder, submitting the full business case to the Cabinet Office for final cost

assurance, and awarding the contract in October or November 2025, ahead of a three-month mobilisation phase.

5. People

- 5.1 The Guinness Book of Records has recognised Beryl Carr as the world's oldest female volunteer. At the age of 103, she continues to volunteer once a week at the Friends Café in Ealing Hospital.
- 5.2 Applications for our mutually agreed resignation scheme closed on 18 August. Participation in the scheme was entirely voluntary.
- 5.3 Our occupational health psychology team marked World Suicide Prevention Day with a webinar to explain our new guidance for supporting colleagues.
- 5.4 The endoscopy team at Ealing Hospital to part in the Ealing Half Marathon on the 28 September to raise money for Meadow House Hospice.

6. Equity, diversity and inclusion

- 6.1 We marked South Asian and South East Asian Heritage month with events and talks throughout July.

7. LNWH updates

- 7.1 The hydrotherapy pool at NPH closed on the 30 August 2025. Two public engagement events were held prior to the closure, and alternative pathways for NHS patients established. Fee paying users were advised of alternative options.
- 7.2 In July we published our new occupational health and well strategy for 2025 to 2030.
- 7.4 More than 350 people attended our AGM on the 11 September.
- 7.5 We are working with AccessAble to produce detailed access guides for our hospitals.
- 7.6 In August our Martha's rule helpline service went live in our maternity department.
- 7.7 The Cross-Enterprise Platform Worklists on PACS (Picture Archiving and Communication System) was launched on the 4 August, allowing access to imaging from Chelsea and Westminster and Hillingdon Hospitals, and so providing a more streamlined approach to image sharing across trusts.
- 7.8 In July LNWH joined teams from across the APC at a forum to shape the next stage of our clinical pathways programme.

8. Research and innovation

- 8.1 The Trust is advancing an innovative approach to tympanoplasty—a surgical procedure for the repair of the eardrum and/or ossicles—which eliminates the requirement for general anaesthesia. This makes the treatment accessible to a broader patient population while optimising theatre capacity for more complex cases.

9. Stakeholder engagement

- 9.1 A paper on maternity provision on north west London was co-presented by CEO Pippa Nightingale at the North West London Joint Health Overview and Scrutiny Committee on the 17 July.
- 9.2 Gareth Thomas MP visited NPH on the 1 August to discuss the hydrotherapy pool closure and other matters with CEO Pippa Nightingale.
- 9.3 Pippa Nightingale met with Barry Gardiner MP on the 7 August to discuss the hydrotherapy pool closure and other matters.
- 9.4 Cllr Ketan Sheth, Chair of the NWL JHOSC held his monthly catch-up with Pippa Nightingale on the 7 August.
- 9.5 The Mayor of Brent, Cllr Hack, attending the launch of R.I.T.A (Reminiscence Interactive Therapy Activities) at NPH on the 7 August.
- 9.6 A paper detailing changes to the opening hours of the Urgent Treatment Centre at CMH was presented by CEO Pippa Nightingale at Brent Council's Community and Wellbeing Scrutiny Committee on the 17 September. Public involvement events are planned for later in October.
- 9.7 Harrow and Brent Adult Social Care teams visited the Discharge Ready Unit and Older People's Short Stay Unit at NPH on the 24 September.
- 9.9 Our Strength in Sickle Cell group event took place on the 9 September.

10. Recognition and celebrating success.

- 10.1 Our tissue viability team won a HSJ Patient Safety Awards in September.
- 10.2 LNWH has been highly commended for Best Peer-to-Peer Support and has won the Menopause Friendly Accredited Employer of the Year award.

North West London Acute Provider Collaborative (NWL APC)

London North West University Healthcare NHS Trust (LNWH Chair's Highlight Report to the NWL APC Board in Common (BiC) – for discussion October 2025

Highlight Report

1. Purpose and Introduction

1.1 The role of the LNWH Trust Standing Committee is:

- To oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

2. Key highlights

2.1 The LNWH Trust Standing Committee was held on 8 October 2025. The following papers were discussed.

2.2 Safeguarding – Board Responsibilities and Cultural Impact

2.2.1 The Committee received a presentation from the Head of Safeguarding on the safeguarding responsibilities of the Board, key risks and cultural initiatives. It was highlighted that Board Members have statutory accountability for safeguarding and should seek assurance on training, systems, and risk management. The Committee noted the How Safe Do You Feel? campaign and the Shine the Spotlight series, which are driving cultural change across the Trust.

2.3 Medium Term Financial Plan

2.3.1 The Committee noted the development of the medium-term financial plan and financial projections in readiness for the national submission later in the financial year.

2.4 Winter Plan 2025/26

2.4.1 The Committee received the approved Winter Plan for 2025/26. A non- recurrent budget of £2.0m has been allocated, plus an additional £0.7m contingency held by finance. For 2025/26, NHS England (NHSE) has set a requirement for each Trust to complete a Board Assurance Statement. The purpose of the statement is to ensure the Trust's Board has oversight that all key NHSE considerations have been met ahead of signing off the plan. The statement document will be submitted to NHSE following signature from Trust CEO and Chair.

2.5 Trust Performance Update and Alignment Plan

2.5.1 The Committee received an update on the Trust performance against the 2025/26 Operating Plan, the drivers of current operational and financial pressures, and the actions being taken to restore alignment. The Trust must address a £7.6m gap from over-performance, which is around 8% higher than the planned activity, driven by increased urgent and elective demand. Referral demand has risen by 13% (vs. 4% planned). This mismatch between demand, activity, and funding must be corrected to maintain financial viability.

2.5.2 The Committee discussed reducing temporary payments and elective activity to mitigate more than half of the expected over-performance, balancing financial and operational risks. The Committee agreed that the Trust should enact further reductions if no additional

funding is secured.

2.6 Board Committee Reports

2.6.1 The Committee received escalation reports from the Quality and Safety, Finance and Performance, People, Equity and Inclusion, and the Audit and Risk Committees, noting exceptions against key performance indicators and measures being taken to address areas of variance against target.

2.6.2 The Trust Standing Committee noted the following papers as approved by the relevant sub-committees:

- LNWH Income & Expenditure (I&E) and cash forecasts 2025/26
- 'Hard to Implement' Cost Improvement Plan Schemes
- M4 Finance Report
- M4 Integrated Quality and Performance Report
- Health, Safety, Security and Environment Annual Report 2024/25
- PALS and Complaints Annual Report 2024/25
- Infection Prevention and Control Annual Report
- Safeguarding Annual Report
- Workforce Equity, Diversity and Inclusion (EDI) Report and Gender Pay Gap Report
- Workforce Report
- 10 Point Plan to improve resident doctors working lives

2.7 Chief Executive's Report

2.7.1 The Committee noted highlights from the Chief Executive's Report.

2.8 Board Assurance Framework

2.8.1 The Committee reviewed and approved the Board Assurance Framework for Quarter 2. Four strategic risks have been closed: two people strategic risks will be replaced by new people risks aligned to the new People Strategy, and the QI risk and strategic partnership risks will become business as usual.

2.9 Provider Capability Assessment

2.9.1 NHS England have introduced a new requirement for all providers to complete and submit a 'provider capability assessment' by 21 October 2025. The Committee discussed the self-assessment and noted the summary of actions in place to ensure any areas of non-compliance are addressed. The Committee will be recommending approval of the updated document to the Board in Common at its meeting in October 2025.

3. Positive assurances received

3.1 In relation to safeguarding, the Trust achieved a 100% screening rate for children in emergency departments, has strong partnership working, and received national recognition for the "How Safe Do You Feel" campaign, which has positively impacted both staff and patients.

3.2 The internal audit for infection prevention and control received substantial ratings for both design and delivery.

3.3 There was positive recognition of staff engagement in transformation efforts, with clinical teams driving cost improvement schemes and active participation in contract evaluations.

4. Key risks / topics to escalate to the NWL APC Board in Common

4.1 LNWH's cash position remains challenging, alongside the ongoing financial deficit. There is a need for structural cost reduction and transformation to achieve long-term

viability.

4.2 If additional activity is not funded by the ICB, the Trust may need to reduce services, impacting performance targets and clinical risk.

4.3 Structural risks such as fire safety in temporary escalation spaces and infection risks in the emergency departments, especially during winter pressures.

4.4 Bed capacity and discharge challenges, especially at Northwick Park, affecting ambulance handover times and patient flow.

5. Concerns outstanding

5.1 There are no significant additional concerns outstanding which require escalation to the Board.

6. Key actions commissioned

6.1 To undertake an audit of Trust activities that are no longer funded for scrutiny at the future meetings of the Finance and Performance and Trust Standing committees.

6.2 To review and align the Provider Capability Assessment self-assessment with other trusts in the NWL APC before submission, focusing on clarity of impact and compliance.

6.3 Quality and Safety Committee to undertake a deep dive into the area of safeguarding.

7. Decisions made

7.1 The Committee:

7.1.1 Approved the move to reduce activity, balancing cost reduction and performance, with a clear steer that if additional funding is not secured, further reductions may be necessary.

7.1.2 Approved the updated Health and Safety policy.

7.1.3 Approved the Soft FM contract recommendation and supported progressing to the next stage in the process.

8. Attendance Matrix

Members:	October 2025 Meeting
David Moss	Y
Matthew Swindells	Y
Bob Alexander	Apologies
Loy Lobo	Y
Martin Lupton	Apologies
Ajay Mehta	Y
Syed Mohinuddin	Y
Simon Morris	Y
Sim Scavazza	Y
Baljit Ubhey	Y
Pippa Nightingale	Y
Simon Crawford	Y
Bimal Patel	Apologies
James Walters	Y
Jon Baker	Y
Lisa Knight	Y
In attendance:	
James Biggin-Lamming	Y
Tracey Beck	Y
Dawn Clift	Y

Tracey Connage	Y
Mark Titcomb	Y
Shekh Motin	Y
Ludmila Ibesaine	Y
Gary Munn	Y
Alexia Pipe	Y
Jonathan Manuel	Y

Strategic priorities

Tick all that apply

- Achieve recovery of our elective care, emergency care, and diagnostic capacity
- Support the ICS's mission to address health inequalities
- Attract, retain, develop the best staff in the NHS
- Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
- Achieve a more rapid spread of innovation, research, and transformation

[Click to describe impact](#)

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

Tick all that apply

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

If other, explain why

8.2B THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST

● Information Item

👤 Lesley Watts / Carolyn Downs

REFERENCES

Only PDFs are attached

 08.2b. THHFT CEO Board Report October 2025 Final.pdf

 08.2b THHFT SC Chairs Report October 2025.pdf

Chief Executive Officer's Report – The Hillingdon Hospitals NHS Foundation Trust

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

1.1 ED performance top performer in London

We have seen sustained improvements in our Urgent and Emergency Care (UEC) performance, placing us as the second best in London for UEC performance. Performance across all domains (UEC, cancer, diagnostics and elective recovery) remains a focus for all of us. This is not just a set of targets- it represents the experience of our patients, the safety and quality of care we deliver, and the confidence our community place in us. The improvement in UEC performance has been recognised by NHS England London region and we would like to thank the tremendous efforts of our staff who have worked to support this sustained improvement.

1.2 NHS Oversight Framework

NHS England has introduced a new Oversight Framework that publicly ranks NHS trusts across areas such as quality, safety, access, workforce, and efficiency. Our Trust has been placed in Segment 4 (out of 5). Factors that have influenced this rating include:

- A national rule that limits ratings for trusts reporting a financial deficit in Quarter 1, which automatically caps our overall rating regardless of clinical performance.
- Higher-than-expected rates of C. difficile and E. coli infections, which have impacted our patient safety score.
- Challenges in timely access to services, including referral-to-treatment (RTT) times, cancer diagnostic pathways, and long waits in emergency care.

Segment ratings are reviewed quarterly, and we are actively working to improve across all areas.

By domain (1 – high, 4 – low) the trust is scored as follows:

- access to services – 3
- effectiveness and experience of care - 2
- patient safety - 4
- people and workforce - 3
- finance and productivity - 2

1.3 Urgent Care Nurse Practitioner Service, Mount Vernon Hospital

The Urgent Care Nurse Practitioner Service at Mount Vernon Hospital has been reconfigured into the Urgent Treatment Centre at Hillingdon Hospital. The last patients were seen at the Urgent Care Nurse Practitioner Service on Friday 26 September.

By bringing services together, we are building a more resilient model of care that will improve patient experience and ensure we can provide the right care in the right place. This change is an important step in strengthening our urgent care services and ensuring we continue to deliver high quality, safe and responsive care for our communities.

1.4 Inclusion and Diversity at Hillingdon

As part of National Inclusion Week, our colleagues across Hillingdon shared their personal reflections on what inclusion means to them. Their stories remind us that inclusion isn't abstract—it's lived every day through respect, openness, and the value we place on one another.

We're also proud to have worked with *The New York Times* to shine a light on our international workforce and their stories. Our diversity is not just something we recognise—it's what makes us stronger, more connected, and better able to care for our community. Together, we continue to build a culture where every voice is heard and every contribution matters.

1.5 Preparing for winter and supporting our staff

We are preparing for 2025/26 winter with an operational plan that sets out the Trust's approach to performance, incorporating outputs of a whole-system approach, to detailing what needs to be in place to support our services, patients and staff through what is going to be another challenging winter period of seasonal pressures.

The plan builds on learning from the previous year, integrates updated Integrated Care Board and NHS England requirements, and outlines the Trust-wide actions taken to ensure safe, effective, and timely care during the most operationally challenging period of the year. Our winter preparations will require a Trust-wide proactive approach focusing on our clinical pathways.

2. Quality and Safety

2.1 In August 2025, there were 47 recorded inpatient falls. This is an increase on the 33 reported in July, but remains within expected limits. The rate of reported falls per 1000 bed days, both for August and the year to date, remains below the Trust threshold of 4.6.

2.2. August saw the Trust receive 36 formal complaints, down from 44 complaints in July. The complaints are based on patient/service user attendance/activity within the hospital and therefore reflect on the volume of formal complaints.

2.3 There were zero recorded 78+ week waits and for the first time there were zero 65+ week waiters. 52+ week waiters has increased significantly. This is driven by ENT and data quality.

3. Operational performance

3.1 The UEC improvement programme continues with 5 key areas of focus: Front Door, ED, Admissions, Discharges and Medical SDEC. All type performance exceeded the national target and operating plan delivering 81.8% against the 4-hour standard for August, the second month to hit the target.

3.2 The front door flow has improved to reduce crowding in ED, streaming only 22% of all attends to ED.

3.3 Delays in LAS handover at 30 minutes reduced significantly, with performance at 97.9% for 30 mins and 83.3% for 15 mins.

4. Financial performance

4.1. Year to Date (YTD) Deficit

The year-to-date position for the first three months of the year was a £1.5m deficit, £1.5m adverse against the breakeven plan, this includes £1.5m expected variance to plan due to the phasing of delivery for the Trust's cost improvement plans.

4.2 Income Performance

The Trust's income position is largely in line with our plan. Elective Recovery Fund (ERF) activity is capped in 2025/26 and other activity is blocked. The YTD ERF over performance as at Month 3 is valued at £1.2m, however due to the cap this is not recognised within the position.

4.3 Pay Costs and Use of Temporary Staffing

The Trust has continued to see the trend of reducing temporary staffing spend, with agency costs representing 1.4% of the total pay costs. As well as reducing pay costs due to delayed recruitment and reduced temporary cover. Pay costs remain over budget for Medical and HCA staffing groups, however this has reduced in Month 3 which is believed to be a result of the pay control panels, and the first month of this financial year without bank holidays.

4.4 Forecast

As at Month 3 the Trust is forecasting to deliver its plan, therefore there is a need to recover the £1.5m YTD deficit.

4.4 Cash and Better Payments Practice Code (BPPC)

Following funding received for 2024/25 activities, The Trust is in a stronger cash position at the start of this year. There is however a need to catch up on payments owed to suppliers. In the short term this will result in reduced performance for the BPPC as older invoices are reported as paid. This performance measure will improve later in the year.

5. People

5.1 Launching Great Big Thank You Week and Cheer Awards

We are launching a Great Big Thank You Week to celebrate our staff. This will be a week-long occasion at the start of December, packed with exciting events to celebrate the hard work and dedication of our staff and volunteers. We will also be hosting new Cheer Awards to recognise our staff with a number of awards and a celebration event.

5.2 New public-nominated CARES Award

Our CARES Awards are now open for public nomination, allowing patients and visitors to easily tell us if they have had a good experience and want our staff to be recognised for doing a good job. Nominations are accepted online, with staff recognised in a monthly recognition breakfast celebration with the Executive Team at the Trust.

5.3 Health, wellbeing and staff inclusion information event

Colleagues were invited to a Health and Wellbeing Event in September, with information and guidance from our Wellbeing Team, Freedom to Speak Up Guardian, Stop Smoking clinic and Health and Safety Team.

6. Equity, diversity and inclusion (EDI) update

6.1 National Inclusion Week

During National Inclusion Week, the Trust paid tribute to the wealth and expertise of our diverse team at our Trust by sharing the individual stories of staff reminding us of the role of inclusion in the work place and why it matters.

6.2 South Asian Heritage Month

We marked South Asian Heritage Month (from July to August) across the Trust with a celebration of diverse cultures, histories and identities. Our events included:

- **Flavours of Home** – an online culinary showcase with staff presenting a favourite South Asian dish, showing how it was made and reflecting on the story behind it.

- **Traditional Dress Day** – staff were invited to come to work wearing traditional South Asian dress to represent their South Asian heritage.
- **South Asian Menus in our restaurants** - South Asian-inspired dishes were available on our menus during the month of celebration.
- **Stories of Connection: a culture share webinar** - Staff from different South Asian backgrounds shared short stories about identity, heritage. Followed by a live Q&A and discussion.

7. Trust highlights

7.1 Summer event for our young cancer patients

Our Paediatric Oncology Team at Hillingdon Hospital hosted a heart-warming summer party for patients and families. The event was held in the facilities at Hewens College.

7.2 Hip patients benefit from our improvement work

Teamwork, excellent care, close monitoring and good data have helped drive significant improvements in our hip fracture care, making us second best in London and seventh in England. In addition, length-of-stay for our hip fracture patients is now below national average.

7.3 ‘Pharmacy First’ pilot exceeds expectations

We have led a London-first pilot to redirect patients from an Urgent Treatment Centre (UTC) pathway to our community pharmacists. The pilot measured the feasibility and effectiveness of a Pharmacy First referral pathway from a UTC setting.

The pilot involved staff leading a successful re-direction of patients with minor illness from urgent and emergency care services to community pharmacists. The pilot has already exceeded our expectations, demonstrating the potential to release UTC capacity, reduce pressure and waiting times, and improve access to timely care.

7.4 Additional translation tool supports better patient care

A new translation tool, CardMedic, is being used in our hospitals. It can help patients and staff overcome communication barriers, providing instant access to thousands of clinically interpreted interactions in over 50 languages and multiple accessible formats. This includes sign language, Easy Read, and Read Aloud, helping to create more inclusive and effective care.

7.5 Day of hernia surgery using Da Vinci surgical robot

Surgery teams cleared a High-Intensity Theatre List of seven hernias in a day, using the Trust’s Da Vinci surgical robot. The success of the day reduced

waiting lists of similar surgical cases through maximum efficiency in theatre and rapid throughput.

7.6 Laser prostate procedure is another first

Urology surgeons, anaesthetists, nurses, operating department practitioners and other colleagues performed a Thulium Laser Enucleation of the Prostate (ThuLEP), a minimally invasive process to treat an enlarged prostate. This can give the patient significant and lasting relief from symptoms.

The procedure, using the laser instead of making an incision to remove obstructive tissue, reduces the risk of bleeding with lower risk of complications. It was a first for our Trust and was carried out in the theatres at Hillingdon Hospital.

7.7 Annual Members' Meeting

Our Annual Members Meeting was held on Wednesday 16 July 2025, where Foundation Trust members, partners, stakeholders and members of the public were invited to attend. During the evening the presenters reflected on the past year and presented how the Trust is working to improve care and support our communities.

7.8 Formal opening of our Jubilee Rehabilitation Garden

Patients, staff and guests were invited to the Jubilee Rehabilitation Garden for its formal opening ceremony. The garden, created next to the Jubilee Building at Hillingdon Hospital, is the work of garden designer Tom Stuart-Smith, assisted by a team of Trust volunteers who helped with the planting and ongoing maintenance.

8. Updates from the Council of Governors (COG)

8.1 The Council of Governors (CoG) formally convened in public on 16 July 2025 as part of the Annual General Meeting. During the session, the CoG received the Annual Report and Accounts, the Auditor's Annual Report, and a summary of our performance and innovation throughout the 2024/25 financial year.

8.2. The Council of Governors (CoG) attended a well-received briefing on the Dementia pathway, which was positively received by attendees.

8.3 In September 2025 the CoG approved the extension to the terms of office for Non-Executive Director - Nick Gash. Nick will continue his tenure on the Hillingdon and Imperial Board until 13 October 2028, ensuring continuity and ongoing expertise for both Trusts.

8.4 The CoG and Hillingdon board approved a one year extension to those governors who were offered a two year term in the 2023 election process. This extension aligns all governor terms of office to 3 years and ensure

continuity as the NWL APC establishes a formal group structure with the appointment on a single accountable officer.

8.5 We would like to extend our sincere thanks to all our governors for their continued commitment and contributions. Recognition and celebrating success.

9. Recognition and celebrating success

9.1 London Maternity and Neonatal Excellence Awards 2025

Dr Tristan Bate, Consultant Neonatologist and Clinical Lead in the Trust, was nominated for the London Maternity Neonatal and Excellence Awards 2025 in the 'Compassionate leadership award' category. This award honours individuals who have demonstrated exceptional leadership in education, research, and training, inspiring the next generation and fostering a culture of kindness, inclusion, and continuous improvement.

9.2 Radiologist Allan Andi rated a top tutor

Dr Allan Andi has been recognised at the 2025 Imperial College School of Medicine Education Awards as one of three recipients of the Excellence in Tutoring Award. Nominated by students across the entire school, the award acknowledges tutors who have provided exceptional support, advice, and guidance throughout the academic year.

The Hillingdon Hospitals NHS Foundation Trust

Trust Standing Committee report to the North West London Acute Provider Collaborative Board in Common (BiC) – for discussion 21 October 2025

Highlight Report

1. Purpose and Introduction

1.1 The role of The Hillingdon Hospitals NHS Foundation Trust Standing Committee is: -

- 1.1.1 To oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

2. Key highlights from the Trust Standing Committee Meeting on 14 October 2025

2.1 Hillingdon Health and Care Partnership (HHCP) Transformation

- The Committee received an update on the HHCP transformation programme, focusing on reducing unnecessary hospital stays and improving patient discharge processes.
- All neighbourhood teams are now operational, with enhanced support for patients living with frailty.
- A pilot for mobile diagnostics in care homes will begin in November 2025.
- The Committee discussed ongoing challenges with timely social care referrals and the importance of early intervention.
- New escalation processes and multi-agency meetings have been introduced to improve patient flow and outcomes.
- The Committee agreed to monitor the impact of these initiatives and review progress at future meetings.

2.2 Chief Executive's Report

The Committee noted the CEO report, key highlights and messages. The CEO's full report is provided in the Board in Common papers.

2.3 Re-location of Urgent Care Nurse Practitioner Service (UCNPS)

- The Committee reviewed the relocation of the UCNPS to Hillingdon Hospital. Staff consultation and onboarding have been completed. The committee discussed lessons learned and will receive a full evaluation of the change at its meeting in

April 2026.

2.4 Winter Plan

- The Committee received and discussed the Trust Winter Plan, Winter Board Assurance Statements and the plan Quality and Equality Impact Assessment.
- The Committee discussed the impact of COVID-19 and influenza, vaccination uptake, and the importance of rapid outbreak management.

2.5 NHS Performance Framework & Provider Capability Self-Assessment

- The Committee discussed the new NHS performance framework and approved the provider capability self-assessment subject to revisions discussed as part of the item.
- Concerns were raised about the methodology for infection prevention and control (IPC) metrics and the impact on Trust ratings. An in-depth IPC report has been commissioned for a future meeting.

2.6 Falls with Fracture

- The Committee reviewed recent falls with fracture incidents. All cases are under investigation, and learning will be shared at the next meeting.
- Overall falls and falls with harm have decreased compared to the previous year, but a recent cluster is being closely monitored.

2.7 Redevelopment: H2A Alliance Agreement and Framework

- The Committee approved the signing of the New Hospital Programme (NHP) Hospital 2.0 Alliance Agreement. Concerning the Hospital 2.0 Alliance Framework the Committee discussed the key headlines, and that the NHP would issue a finalised version by the end of November. A Board development session would be organised for December to review the finalised version. NHP require Trust Board's to agree the Hospital 2.0 Alliance Framework by mid January 2026, and the finalised version will be presented to the 13th January 2026 Trust Standing Committee for approval.

2.8 Integrated Quality and Performance Report (IQPR) & Board Committee Reports

- The Committee received and discussed the IQPR, noting improvements in referral-to-treatment (RTT) performance, agency spend reductions, and positive staff survey trends.
- The Quality & Safety, People, Finance & Performance, and Audit & Risk Committee reports were noted. Key issues included infection control, sickness absence, and learning management system challenges.
- The Audit & Risk Committee

2.9 Finance and Cost Improvement Programme (CIP)

- At Month 6, the Trust reported a £0.4m surplus for the month and a year-to-date deficit of £1.1m, which is behind the breakeven plan. The Trust's breakeven plan includes delivery of a £15.7m Cost Improvement Programme (CIP), with delivery expected to increase in the latter part of the year. The year-to-date deficit includes £1.65m attributable to the timing of CIP delivery.
- Temporary staffing costs continue to fall, with agency spend now representing just 0.9% of total pay costs.
- CIP: At Month 6, there is favourable variance of £53k against the external plan and

£112k against the internal plan. Year to date CIP delivery was £1.48m adverse against the external plan and £165k favourable against the internal plan.

3. Positive assurances received

- Continued improvement in RTT and agency spend.
- Enhanced staff retention and wellbeing.
- Financial controls and cash management.
- Effective implementation of new models of care and discharge processes.
- Progress on the hospital redevelopment programme.

4. Key risks / topics to escalate to the NWL APC BiC

- Ongoing financial pressures.
- Infection prevention and control performance.
- Staff sickness and learning management system issues.

5. Concerns outstanding

- No significant additional concerns requiring escalation to the Board at this time. The Committee will continue to monitor the impact of service changes, IPC, and financial performance.

6. Key actions commissioned

- In-depth IPC report to be presented at a future meeting.
- Continued monitoring of falls with fracture and sharing of learning.
- Ongoing review of performance metrics for new models of care.
- Board development session on redevelopment risk and contract management.

7. Decisions made

- Approved the provider capability self-assessment subject to amendments discussed at the meeting.
- Noted and accepted the Winter Plan

8. Attendance 14 October 2025

Members	07 January 2025 attendance
Carolyn Downs, Vice Chair (Standing Committee Chair)	Y
Matthew Swindells, Chair – North West London Acute Provider Collaborative	Y
Baljit Ubhey, Non-Executive Director	Y
Martin Lupton – Non-Executive Director	Y
Linda Burke, Non-Executive Director	N
Nick Gash, Non-Executive Director	Y
Patricia Gallan, Non-Executive Director	Y
Simon Morris, Non-Executive Director	N
Mike O'Donnell, Non-Executive Director	Y
Vineeta Manchanda, Non-Executive Director	Y
Lesley Watts, Chief Executive Officer	Y

Alan McGlennan, Managing Director/Chief Medical Officer	Y
Jason Seez, Chief Infrastructure and Redevelopment Officer	Y
Virginia Massaro, Chief Finance Officer	Y
Sarah Burton, Chief Nursing Officer	Y
In attendance	
Peter Jenkinson, Director of Corporate Affairs	Y
Keving Croft, Chief People Officer	Y
Emer Delaney, Director of Communications	Y
Alexia Pipe, Chief of Staff to the Chair in Common	Y
Vikas Sharma, Trust Secretary	Y

8.2C IMPERIAL COLLEGE HEALTHCARE NHS TRUST

● Information Item

👤 Tim Orchard

REFERENCES

Only PDFs are attached

-  08.2c ICHT CEO Public Report - Oct 25 v5TO.pdf
-  08.2c ICHT TSC assurance report to BiC October 25.pdf

Chief Executive Officer's Report – Imperial College Healthcare NHS Trust

Accountable director: Professor Tim Orchard
Job title: Chief Executive Officer

1 Key messages

- 1.1 We are beginning to see the operational pressures of winter having an impact on our emergency departments and inpatient wards. We have developed our winter plan, which is being presented to the board today; that plan sets out the mitigations we have to manage the increased pressure and ensure we continue to deliver high quality care. We continue to achieve some of the best quality and safety performance in the NHS, which has contributed to the Trust being ranked among the top-performing acute trusts in England in the first NOF ratings, for the first quarter of this year. Sadly, we have also had two serious incidents in recent weeks, one of which has been reported formally as a 'never event' and the other is subject to a police investigation.
- 1.2 We continue to deliver some outstanding workforce initiatives, including key equality and diversity programmes and continue to enjoy excellent relationships with partners and lay members in developing our research strategy and the Paddington Life Sciences initiative. I'm very pleased to see the number of national awards our services or staff have won or shortlisted for.

2 Quality and safety

- 2.1 We continue to report strong performance against most indicators of quality and safety; mortality rates are consistently amongst the lowest in the NHS and incident reporting rates remain high with harm levels well below national averages, which is positive. Enhanced oversight and support continue in response to localised issues in some specialties, including through the quality review meeting (QRM) process.
- 2.2 We continue to see increased pressure across our emergency departments which are only set to grow as we head into winter, resulting in overcrowding, prolonged delays and a growing impact on both staff and patient experience. The high activity levels are also having an impact on our inpatient wards. Our teams continue to work incredibly hard to maintain safety and deliver excellent care and we have enhanced monitoring in place to identify any potential impact on outcomes. Targeted work is underway to expand nutrition and hydration support for those with long waits and a review of delayed diagnostic cases in our emergency departments is underway to consider whether any additional action/interventions are required.
- 2.3 We have seen an increase in hospital acquired pressure ulcers, particularly in critical care, where patients are at high risk due to their clinical conditions. Our pressure ulcer steering group is leading improvement work, focused on risk assessments and prevention strategies, additional actions include a review of all critical care cases since January to identify themes and further areas for improvement and a cross-divisional task and finish group to review practice in response to a rising trend in device-related pressure ulcers. In person practice checks will run through October to provide additional support and learning.

- 2.4 There are two serious incidents to note. The first is a never event where a patient was scalded in a shower which did not have a thermostatic mixing valve applied. All showers and baths across the Trust have been reviewed and a review of all sinks will be completed by 10 October. The other incident involves a patient who was assaulted by another patient and subsequently died. This is subject to a police murder investigation. We have begun a PSIII process and, as an immediate action to provide reassurance to patients and their families, we have extended our Call for Concern 24/7 telephone line for patients and their families to include concerns about the behaviour of other patients.
- 2.5 We are continuing to progress the wide-ranging action plan across our Neurosurgery services. The results of the General Medical Council's national training survey, published in July, have shown improvements resulting in the de-escalation of the GMC enhanced monitoring process implemented in 2025 in response to concerns about resident doctor experience, which is an encouraging marker of the progress being made.

3 **Operational performance**

The Trust has been ranked among the top-performing acute trusts in England in the 2025 NHS Oversight Framework (published by NHS England on 9 September), ranked 11th overall and third among non-specialist acute trusts - achieving Segment 1 status. This reflects strong performance across clinical and operational metrics, including urgent and emergency care and elective services.

Total A&E attendances during June 2025 to August 2025 exceeded seasonal expectations - 4% above the 2022–2024 seasonal baseline and 3% above the 2023–2024 seasonal baseline - with statistically significant increases in June and July. Ambulance conveyances also rose significantly above the expected level. This elevated demand aligns with national trends, with England recording its highest summer attendance levels, indicating broader system challenges and external factors.

We continue to deliver some of the best ambulance handover times in London, consistently ranking in the top five. In August, 76.1% of patients were admitted, transferred, or discharged from the emergency department within four hours – below the 78% operating standard that we are required to achieve by March 2026. The proportion of patients who are experiencing delays over 12 hours from arrival is higher than we would want. The Integrated Patient Flow Programme has been established and is central to how we will improve the UEC performance position, particularly addressing the issue of extended waits.

We continue to make sustained progress in reducing long waits for elective care. As of August 2025, the number of patients waiting over one year for treatment accounted for 1.5% of the total waiting list, as we work to bring this down to the planning target of 1% by March 2026. Performance against the 18-week referral to treatment standard remains ahead of trajectory.

Diagnostic performance remains under pressure, with 24% of patients waiting six weeks or more for a test. Action plans are in place across high-volume modalities to support recovery throughout the second half of 2025/26. The reopening of the MRI machine at the CDC has helped, and the waiting list for non-obstetric ultrasounds is reducing as a result of revised lists. In terms of cancer standards, we are meeting the faster diagnosis and 31-day treatment standards, however, achieving the 62-day constitutional standard of 85% remains one of the main challenges which we are managing through the Cancer Recovery Group.

The Trust is finalising its winter plans, with a focus on resilience, surge capacity, and patient flow. Planning is aligned with national and system-wide priorities and includes enhanced escalation protocols, workforce planning, and targeted interventions to manage seasonal pressures.

4 Financial performance

- 4.1 At the end of month 5 (August 2025) the Trust reported a year-to-date deficit of £0.7m against a breakeven plan. The position continues to include the unfunded financial impact associated with the five days of Industrial Action; reflects the delivery of £35.4m of efficiencies (£1.9m below the equally phased efficiency target but a significant improvement on the same time last year); offset by the reduction in temporary staffing costs following the implementation of enhanced temporary staffing controls, and the recognition of £1.2m of additional elective recovery income. The Trust continues to forecast the delivery of break even by the end of the financial year.
- 4.2 The Trust has identified 99% of its annual efficiency target of £80.1m.
- 4.3 Year to date, the Trust has spent £37.3m against £52.4m plan (£15.1m behind plan). This is primarily due to timing differences in expenditure with the Trust expecting to deliver the plan by the end of the financial year.
- 4.4 At 31st August 2025, the Trust had a cash balance of £108.5m, which is higher than plan and due to timing differences.

5 Workforce update

- 5.1 Our Occupational Health team has successfully won an 'NHS Health at Work' award for the transformation of Occupational Health. In addition, the team have been shortlisted for a Health Service Journal (HSJ) patient safety award for a project to improve the clinical management of Blood Bourne Virus Incidents which has brought an improved user experience for staff.
- 5.2 The 'Improvement through People Management' programme, which is our new 5 year programme to improve the skills, capabilities and confidence of our line managers, has been shortlisted for a National "Personnel Today" award. The awards take place in November and cover all private and public sector.
- 5.3 We are marking a full programme of Diversity festivals in the autumn for South East Asian Heritage month, Inclusion week and Black History month in October. Alongside our existing networks which continue to thrive, we launched a new "Faith and Belief network" in September.
- 5.4 We have been successful in a bid to the NHS Charities Together fund to secure £50K which will support a roll out of Cultural Intelligence training which is part of our EDI Strategy goals, following the publication of our Anti Racism and Anti-Discrimination commitments.
- 5.5 September saw the Graduation of our latest cohorts on the Healthcare Leaders Fellowship, a programme designed to support the career progression of clinical leaders above 8a. The leaders have completed a leadership apprenticeship and a wide range of learning experiences on the programme and some have obtained a promotion since the programme. We have been successful in a bid for funding from the "Once for London

Equity Initiatives fund" to continue to roll out the programme across the North West London and North Central London Integrated Care Systems in 2026.

6 Research and innovation

- 6.1 In May, the NIHR Imperial Biomedical Research Centre (BRC) conducted a major mid-term review of its scientific programmes and progress against objectives, with a view to preparing for, and informing, our BRC funding re-application in 2027. An eminent panel of external independent scientists spent a full day listening to presentations and questioning and challenging BRC leadership as a "critical friend". The panel have since finalised and circulated their report. This report is – first and foremost – a very positive reflection and commendation of the work being undertaken in the BRC. The panel have provided a list of 20 specific recommendations which we are now implementing through the BRC Director and BRC Office. This was a constructive and thought-provoking exercise, which will inform our strategic thinking and management of the BRC over the next 2-3 years.
- 6.2 With a view to meeting (as a minimum) the Prime Minister's challenge to NHS Trusts to open commercial clinical trials within 150 days (from March next year) we held a day-long workshop facilitated by IQVIA in their offices at Paddington. We also invited colleagues from across the Acute Provider Collaborative to join. With representation from across the clinical trials pathway at the Trust, we reviewed our existing processes and ways of working, to identify how we could do more in parallel and how we could take key decisions earlier in the process. Delivery of a "roadmap to 150 days" is an ongoing piece of work.
- 6.3 After internal engagement, including with our lay partners embedded in our research themes, we have finalised our dedicated Research Strategy for Imperial College Healthcare NHS Trust, which both guides our future research ambitions and is a key requirement for certain externally-funded grant applications. The strategy is based around 5 'pillars' – People, Premises, Performance, Patients and Partnerships – and focuses on the partnership approaches needed to widen access to research across the population of north west London. We are planning to formally launch this strategy in the coming months, in alignment with the new website for research and re-organisation of key functions within R&D.
- 6.4 We continue to deliver UK, European and global first patient recruits into commercial studies. The Trust recently recruited the first patient in the world to a next-generation cancer vaccine trial, sponsored by BioNTech. Fast set-up and earlier trial opening gives more of our patients' early access to these innovative study treatments and generates valuable revenue and cost savings. It also attracts more such studies to the UK and helps the government's agenda to increase commercial clinical research and investment in this country.
- 6.5 We are working with Pharmacy to increase their capacity and speed for opening clinical trials (including complex advanced therapy trials) – this is considering processes, team structures, skills mix, and information flows.
- 6.6 The NIHR Imperial Biomedical Research Centre (BRC) continues to support innovative experimental medicine research across Imperial College and Imperial College Healthcare NHS Trust. Recent BRC-funded projects making the news include:
- Imperial researchers, funded by the British Heart Foundation and supported by the NIHR Imperial BRC, have developed an artificial intelligence (AI) tool that can help doctors predict who might develop a potentially fatal heart condition, just from an

ECG. The tool uses AI to detect the earliest signs of a serious condition called 'complete heart block', which can be fatal if left untreated. The study was published in JAMA Cardiology.

- In a very “early” piece of translational research, work by BRC-funded PhD students in the Institute of Chemical Biology-Centre for Doctoral Training has revealed how four-stranded DNA structures, known as G-quadruplexes, could be targeted to reverse chemoresistance in ovarian cancer. This approach could potentially restore the effectiveness of chemotherapy in patients who no longer respond to treatment.

6.7 We continue to strengthen our approach to innovation and life sciences, in particular through the growing impact of Paddington Life Sciences, which has welcomed an additional member over the summer, the Japanese pharmaceutical company Shionogi. We have launched a joint Paddington Life Sciences x Imperial College Health Partners series of networking and learning events focused on supporting early-career professionals working in innovation, research and life sciences, and are actively working up plans for a series of careers events to support local young people in understanding opportunities within life sciences for London's Life Sciences Week in November.

7 Redevelopment update

7.1 Work is progressing well at St Mary's Hospital. In August 2025, the New Hospital Programme issued a draft Memorandum of Understanding to support further SMH redevelopment works in 2025/26. This has enabled work on the Masterplan to progress with the consultancy team, and design activities have also now commenced.

7.2 The St Mary's Redevelopment Funding Taskforce continues to look at options for financing a new SMH. A new Independent Chair, Simon Blanchflower, has been appointed to lead the Taskforce and to help guide the next phase of activity.

7.3 Engagements with key stakeholders, including a meeting with the Minister for Health (July 2025), have helped raise the profile of the project and its broader health and economic benefits, with support from Westminster City Council and Imperial College London. Constructive discussions have started with NHS England on alternative funding models. Representatives from DHSC came to view SMH on 11 September and were briefed on the current state of play and the actions by the Taskforce.

7.4 Funding has not yet been secured for the Charing Cross and Hammersmith hospital schemes. Engagements continue with Hammersmith and Fulham Council and Imperial College London to explore alternative development options.

7.5 The Fleming Centre project is progressing well. The first phase of public consultation was successfully completed in June/July 2025, and a second phase is planned for October 2025 following a similar schedule. The Outline Business Case is currently progressing through Trust governance with a view of an approval for continuation of work being granted in the not too distant future.

8 Estates update

8.1 As requested at the APC Estates, Infrastructure and Sustainability Committee, I will report all the estates-related incidents in the last quarter. For this report they include:

- On 9 July there was an external power failure which resulted in loss of many lifts at St Mary's old buildings and loss of call bell systems on several wards for two hours.
- On 19 Aug there was a small fire in the NWLP laboratory at Charing Cross resulting in staff evacuation, no patients were involved.
- On 18 Aug there was loss of hot water at Charing Cross due to a boiler failure.

- On 30 Aug cables to the temporary generator at Hammersmith providing the only back-up power to the A-block (HAC, theatres, imaging, part of ICU etc) were stolen resulting in major risk to patients should a power failure occur for two days until the replacement cables were sourced.

9 Stakeholder engagement and visits

9.1 Below is a summary of significant meetings I have had with stakeholders.

- 2 July – Cllr Ketan Sheth
- 9 July – Andy Slaughter MP and Ben Coleman MP
- 9 July – Cllr Bora Kwon
- 24 July – Cllr Helen Rowbottom
- 1 August – Simon Blanchflower CBE
- 6 August – Cllr Ketan Sheth
- 11 September – New Hospital Programme SROs
- 15 September – Cllr Ketan Sheth
- 18 September – Cllrs Nafsika Butler-Thalassis and Concia Albert
- 29 September - Hammersmith & Fulham Save Our NHS

10 Recognition and celebrating success

10.1 Five initiatives shortlisted for HSJ Awards

Five initiatives led by or involving Imperial College Healthcare have been shortlisted for the 2025 HSJ Awards, recognising healthcare excellence in the UK:

- a new system that allows patients to choose their outpatient appointment date, helping us to reduce cancellations and missed bookings (Performance Recovery Award)
- Call for Concern, a safety line for inpatients and their families worried that their local clinical team is not responding effectively to a deteriorating condition (NHS Communications Initiative of the Year Award)
- extended MRI scanning hours using remote technology (Driving Efficiency Through Technology Award)
- a digital prescribing tool that's reduced medication errors in children by 83 per cent (Medicines, Pharmacy and Prescribing Initiative of the Year)
- a nurse-led urology diagnostics programme that's speeding up prostate cancer diagnosis. (Modernising Diagnostics Award).

10.2 Open Britain exhibition

One of the portraits (Zubeid's) from the Open Britain x Imperial College Healthcare photography exhibition we launched last year has been selected to be part of the Taylor Wessing Photo Prize 2025 exhibition at the National Portrait Gallery which opens in November. Photographer JJ Keith spent time at our hospitals photographing migrant staff as part of his ongoing series, Open Britain: Portrait of a Diverse Nation. With the rise of divisive ideologies, we have been promoting the exhibition again – online and at its current physical location at Hammersmith Hospital - as a reminder of the huge gratitude the NHS owes to immigrants from around the world.

10.3 Centre for fetal care featured in ITV documentary

Our centre for fetal care, based at Queen Charlotte's and Chelsea Hospital, recently featured in the powerful ITV documentary, Ellie Simmonds: should I have children? The programme explored the difficult and emotional decisions faced by expectant parents when they learn their baby may be born with a disability, as well as the support available to them.

Imperial College Healthcare NHS Trust (ICHT) Trust Standing Committee Chair's Highlight Report to the North West London Acute Provider Collaborative Board in Common (BiC) – for discussion

October 2025

Highlight Report

1. Purpose and Introduction

The role of the ICHT Trust Standing Committee is:-

- To oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

2. Key highlights

2.1. Investment proposals requiring Board approval

Trust Standing Committee members reviewed and approved the following investment proposals: Linear accelerators LA9 & LA10, a neutral host distributed antenna system solution for the implementation of a 4G cellular system at the Hammersmith Hospital, St Mary's and Charing Cross Hospital, the replacement of the Angio scanner at St Mary's Hospital and investment in resource required for DM01 and reporting improvement in imaging diagnostics. They also approved the outline business case for the Fleming Centre and the non-emergency patient transport contract direct award recommendation which sought to bridge the period between the end of the existing contract, and the start of a new contract following a competitive procurement process.

2.2 Provider Capability Self-Assessment

The Standing Committee discussed the draft provider capability self-assessment, noting the requirement for an annual self-assessment as part of the national oversight framework. The committee agreed to recommend to the Board to submit a fully compliant submission but agreed that the narrative should be strengthened to include key achievements and outcomes. The revised document would be submitted to the board in common for approval.

2.3 Chief Executive's report

The Standing Committee received the chief executive's report and noted that the Trust was beginning to experience winter-related operational pressures across emergency departments and inpatient wards. Despite these challenges, the Trust continued to deliver some of the highest quality and safety performance in the NHS, contributing to ranking among the top-performing acute trusts in England in the first National Oversight Framework (NOF) ratings for Quarter 1.

Committee members were briefed on two recently reported serious incidents—one classified as a 'never event' and another currently under police investigation.

2.4 Well-led update

The Standing Committee discussed the current status and next steps in regards to preparation for a well-led inspection noting that with the Trust in the National Oversight Framework Segment 1, it was likely that an application to obtain Foundation Trust status would be possible and with that, a well-led inspection was likely given the aged ratings of the Trust. The committee discussed the importance of having a robust narrative and evidence base to support the ambition of achieving an 'outstanding' rating, acknowledging that the current narrative required significant strengthening to reflect the organisation's achievements and culture. It was noted that the Trust had achieved a rating of 'good' in its last well-led inspection in 2019.

It was noted that the executive team had begun a detailed review of the eight Well-led quality statements, which would be used to agree the self-assessed current rating, agree improvement actions required to get to 'outstanding' and to agree evidence required to support this. The importance of clear, accessible materials for non-executive directors was highlighted, as was the need to ensure all board members could confidently discuss all areas of the trust.

The Standing Committee agreed that outputs from each executive review session would be shared with the board for challenge and input, and that board development time would be scheduled to ensure collective ownership of the narrative.

2.5 West London Children's Healthcare

The Standing Committee discussed the progress made to date and the strategic direction of West London Children's Healthcare. It was noted that the programme aimed to address historical fragmentation in paediatric services across North West London, focusing on putting children and families at the centre and fostering a culture of collaboration among previously competitive institutions. The committee discussed the importance of recruiting staff with the right behaviours and the positive impact of integrating services, such as improved access to specialist care and enhanced staff and patient experience.

It was noted that while improvements had been made, there remained work to do, particularly in demonstrating measurable outcomes and the impact of collaborative working, as well as strengthening community links and transition care. The Committee discussed the significant research opportunities available due to the diverse population and the potential for West London Children's to act as an exemplar for integrated child health services across the group.

The Committee agreed that future proposals for scaling up integrated child health services across North West London should be developed and brought back for consideration at group level.

2.6 North West London Pathology

The Standing Committee discussed the evolution and current state of North West London Pathology, noting its origins as a joint venture between three trusts and the significant transformation achieved since its inception. It was noted that the consortium agreement had enabled the creation of a consolidated service, with standardised systems, improved governance, and substantial investment from the owner trusts. The committee discussed the challenges faced, including initial disparities in pricing, quality, and accreditation, as well as workforce shortages and the need for modern laboratory infrastructure.

Standing Committee members noted that the current partnership agreement was due to expire and agreed that this was an opportunity to review the options for the strategy for North West London Pathology and the governance model to support those strategic options. The committee noted the importance of evaluating options for the next phase, including the potential for a “super network” and the expansion to include additional trusts. Estate utilisation, particularly the possibility of relocating laboratory services off acute sites to free up clinical space, and addressing cyber risk were also discussed as strategic priorities.

The Standing Committee agreed that a strategic outline for the future of pathology services should be developed, considering group-wide needs, estate strategy, and partnership models. This outline would be brought back to the appropriate governance forum for further discussion and decision.

2.7 Board Assurance Framework

The Committee reviewed the Board Assurance Framework and updates from the discussions had at the September round of Board Committees. It was noted that the People Committee had discussed the risks regarding staff wellbeing and health & safety and agreed to consider adding an appropriate risk, in the context of the Committee’s role in overseeing health and safety, including fire safety.

2.8 Quality Assurance Report

The Committee received and noted the assurance report which summarised quality performance and emerging risks and actions / mitigations.

The Committee noted that the Trust continued to maintain good performance against key quality indicators with mortality rates consistently amongst the lowest in the NHS and incident reporting rates remained high which was a positive reflection of the safety culture at the Trust. Incident harm levels remained below the national averages. Committee members discussed the mechanisms and processes in place for interpreting and triangulating incident data.

Committee members received and noted the quarterly learning from deaths report noting that the Trust’s mortality rates remained statistically significantly low.

The Committee received and noted the following reports that had been reviewed and scrutinised at the Quality Committee:

- Learning from deaths quarterly report
- Annual Safeguarding report 2024/25
- Annual Complaints report 2024/25
- IPC and AMS annual report 2024/25
- End of life Annual report 2024/25
- Pressure Ulcer report 2024/25
- National mortuary review

2.9 Operational performance report including the Winter Plan 2025/26

The Committee received the operational performance report for month 5 noting the challenges in urgent and emergency care, with a 3.2% year-on-year increase in attendances and a 7.5% rise in Type 1 A&E attendances, leading to performance slightly

below plan. The trust remained ahead of plan for RTT and 52-week waits, with continuing efforts on clearing long waiters, especially in neurology.

Committee members reviewed and discussed the winter plan which outlined a modelled unmitigated bed gap of 125 beds at 92% occupancy, mitigated by system-level actions and the new Integrated Care Coordination Centre. Committee members noted the risks which included discharge delays, mental health, and housing issues and were assured that plans were in place to flex elective activity, focus on critical January weeks, and maintain current bed numbers with surge capacity if needed.

The importance of proactive engagement with system partners, especially social care, was stressed to address interface risks and ensure resilience.

2.10 Finance update

The Committee received and noted the forecast outturn position at month 5 and were pleased to note that the trust had achieved a break-even position at month 6, recovering losses from industrial action through focused cost control and staffing management..

2.11 People Assurance report

The Committee received and noted the People and Organisational Development (P&OD) assurance report. The report provided the Committee with an update on the Trust's performance against the Trusts workforce performance indicators, identifying areas requiring focus and improvement as well as actions being taken to enable that improvement.

2.12 NWL Acute Provider Collaborative (APC) Executive Management Board (EMB)

The Committee received and noted the summary of the key discussions held at the APC EMB on 7 July and 4 September 2025. Discussions included performance, finance and recovery, business planning, APC clinical pathways and collaborative projects.

2.13 Board Committee Reports

The Committee received summary reports from the Quality; Finance, Investment and Operations; People; Redevelopment & Estates and Audit, Risk and Governance Committee meetings that took place in September 2025. The Committee received assurance that key risks overseen by each Board Committee were being managed appropriately.

3. Positive assurances received

The Committee received the Annual Responsible Officer's Report 2024/25 and noted compliance with the Responsible Officer regulations.

The Committee received the Equality, Diversity and Inclusion (EDI) Annual Report 2024/25 and were assured by the progress made across the Trust in regards to EDI across the workforce and services, though it was acknowledged that there was still more to do to improve this. The positive impact from Trust programmes like engaging for equity and inclusion, the race equality staff network projects, inclusive recruitment and the bullying and harassment task and finish group, were noted.

The Committee received the Annual Safeguarding Report 2024/25 which provided a comprehensive overview of safeguarding activities at the Trust and noted that the Trust

continues to meet statutory duties outlined in Section 11 of the Children Act 2004 and the Care Act 2014, with all safeguarding policies up to date.

The Committee received the Annual Infection, Prevention and Control report 2024/25 which provided assurance of compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, the Care Quality Commission (CQC) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12 (2 (h)), regulation 15 (2), regulation 17 (2 (b)), and the National Infection Prevention and Control Manual for England (2022).

The Committee received the Annual End of Life Care report 2024/25 which summarised the achievements of the service over the year including full implementation of the national audit for care at the end of life (NACEL) processes including the bereavement survey.

4. Key risks / topics to escalate to the NWL APC BiC

There are no key risks which require escalation to the Board. However, the risk relating to data quality was discussed and a deep dive review of data quality including the related risk on the Board Assurance Framework would be discussed at the Audit, Risk and Governance Committee in November 2025.

5. Concerns outstanding

There are no significant additional concerns outstanding which require escalation to the Board.

6. Decisions made

Standing Committee members approved the proposed investment approvals that had been approved at the Finance, Investment and Operations Committee and supported the proposed fully compliant submission of the Provider Capability Self-Assessment which would be updated and presented to the Board in Common for approval.

7. Attendance

Members	January attendance
Bob Alexander, Non-Executive Director (Vice Chair)	Y
Matthew Swindells, Chair, Board in Common	Y (ex-officio)
Aman Dalvi, Non-Executive Director	Y
Nick Gash, Non-Executive Director	Y
Loy Lobo, Non-Executive Director	Y
David Moss, Non-Executive Director Designate	Y
Sim Scavazza, Non-Executive Director	Y
Helen Stephenson, Non-Executive Director	N
Catherine Williamson, Non-Executive Director	Y
Tim Orchard, Chief Executive Officer	Y
Jazz Thind, Chief Financial Officer	Y

Julian Redhead, Chief Medical Officer	Y
Janice Sigsworth, Chief Nursing Officer	Y
Ian Bateman, Chief Operating Officer (Interim)	Y

● Information Item

👤 Lesley Watts / Patricia Gallan

REFERENCES

Only PDFs are attached

 08.2d CW CEO Board Report October CW_final.pdf

 08.2d CWFT Standing Committee Chair's Report - Oct 2025.pdf

Chief Executive Officer's Report –Chelsea and Westminster Hospital NHS Foundation Trust

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

- 1.1 We welcomed the Secretary of State for Science, Innovation and Technology, the Rt Hon Peter Kyle MP, to our Chelsea site to showcase how we are using artificial intelligence (AI) to enhance patient care and support our clinical teams. This was part of a wider Government announcement on AI in public services for which Chelsea and Westminster Hospital is part of the National Exemplars Programme. The visit provided an overview of the impact it is having across the organisation and included demonstrations of AI diagnostics in dermatology, an AI-driven discharge summary prototype and Dora, the AI chatbot which is helping ophthalmology patients stay informed while reducing admin for clinicians. Coverage of this visit was covered across major broadcasters including BBC Breakfast, GB News, ITV news, LBC, The Guardian, The Telegraph and The Mirror.
- 1.2 NHS England launched its new Oversight Framework, which ranks trusts nationally across quality, safety, access, workforce and efficiency, with ratings published on a public dashboard. Our Trust is in segment 3 (of 4) due to a national rule linked to our financial deficit, which caps ranking regardless of clinical performance. Without this segmentation, we would be 8th nationally among acute trusts—instead, we are 28th. This highlights strong performance, but also the need to improve our financial position. Segmentation is reviewed quarterly and we are working hard to progress.

By domain (1 – high, 4 – low) the trust is scored as follows:

- access to services – 1
 - effectiveness and experience of care - 1
 - patient safety - 2
 - people and workforce - 1
 - finance and productivity - 1
- 1.3 The Paediatric Emergency Department at Chelsea reopened its newly refurbished waiting area and triage rooms. The project began in May, with

seven weeks of construction works. The redesigned space offers a more welcoming and child-friendly environment for young patients and their families. This transformation was made possible through close collaboration between the clinical team, CW+, White Arkitekter (designers of Neptune Ward), artist Gráinne Nagle and Capital Projects Team.

- 1.4 In August, we officially opened the Discharge Ready Unit (DRU) at Chelsea on our Rainsford Mowlem ward, supporting patients medically fit for discharge but awaiting external placement. This nurse-led unit builds on the success of the DRU at West Mid, reducing length of stay and improving patient functionality.

2. Quality and Safety

- 2.1 Friends and Family Test scores remain strong, with 97.3% of adult inpatients reporting they were treated with dignity and respect. Emergency Department (ED) experience scores are below Trust targets but align with the London average, with improvement work underway focusing on waiting times and communication. Feedback from Children and Young People is now reported separately, with lower response rates under review with West London Children's Healthcare to ensure the data is collected, considered and acted upon.
- 2.2 Infection control remains a priority, with five cases of *Clostridioides difficile* (*C. difficile*) reported this month—25 year-to-date against a threshold of 33—and one case of Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia, classified as Community Onset Hospital Acquired. All cases are being monitored through the Infection Control Committee.
- 2.3 Four incidents resulting in severe harm or death were reported this month and are currently under review in line with the Patient Safety Incident Response Framework (PSIRF) and the Trust's internal governance processes.
- 2.4 Medication safety and management targets continue to be met.
- 2.5 Venous thromboembolism (VTE) assessments exceed targets across both sites, though further analysis is required on Hospital Acquired VTE cases. Dementia screening declined due to challenges with staffing, however improvement discussions are ongoing.

3. Operational performance

- 3.1 Accident and Emergency (A&E) four-hour performance was reported at 76.82%, slightly below the 78% standard.
- 3.2 NHS England Cancer 28-Day Faster Diagnostics and 31-Day treatment standards were met, while the 62-Day standard was not achieved for July.
- 3.3 Elective activity targets have been met year-to-date, though outpatient activity is below plan due to the Elective Recovery Fund (ERF) cap and industrial action in July. Referral to Treatment (RTT) 18-week wait performance met the 60% national target, though backlog challenges persist, with 1,337 patients waiting over 52 weeks (+100) and 39 patients waiting over 65 weeks (+26). There are no patients waiting over 78 weeks. The new requirement of 65% is prioritised for delivery by year-end.
- 3.4 Diagnostic performance against the Diagnostic Imaging and Reporting (DM01) standard was 86.08%, below the 95% target. West Middlesex achieved 100% compliance for medically optimised patients with fractured neck of femur (NOF) taken to theatre within 36 hours, compared to 84.2% at Chelsea. Improvement plans are in place and monitored through the Executive Management Board.

4. Financial performance

- 4.1 The financial position remains challenging, however the position for month five shows an improving picture. Enhanced governance, scrutiny and focused actions continue to ensure the Trust returns to plan.
- 4.2 The Trust's adjusted financial position at Month 5 is a £3.36 million deficit, which is £2.39 million adverse to plan. This reflects ongoing operational pressures and reduced outpatient activity linked to ERF constraints and industrial action.

5. People

- 5.1 ISS night cleaners at both sites were celebrated in a powerful online photo story published by the Wellcome Collection. The photo exhibition was a tribute to the teams working behind the scenes to keep hospital environments safe, hygienic and operational through the night. The series features portraits and

interviews by photographer Lewis Khan, highlighting the lives, routines and vital roles of ISS Facility Services staff and unsung healthcare heroes.

- 5.2 We hosted PROUD and Long Service Award ceremonies, recognising colleagues and teams across all divisions. The PROUD Award winners were all nominated by their peers for their outstanding contributions. At the Long Service Awards in July we celebrated 23 long-serving colleagues, whose combined service totals 645 years—an incredible milestone.
- 5.3. The nominations for our annual Great Big Cheer Awards opened; giving colleagues a chance to celebrate the incredible work of our staff by nominating an outstanding colleague or team. Awards ceremonies will take place in December at Chelsea and West Mid hospitals as part of Great Big Thank You Week (8–12 December), a celebration of the amazing contributions of our staff and volunteers.
- 5.4 Senior leaders from across the Trust came together at a summit in September, to address what matters right now. The focus of the event was on tackling and problem-solving patient flow, outpatient productivity and theatre productivity, and on how, through our enablers of quality, people and technology, we will deploy immediate plans. These plans will be the foundation of our focus over the next 6–12 months.
- 5.5 We launched the NHS National Staff Survey (NSS 2025) with over 15% of staff completing it in its first week. This strong early response highlights how much colleagues value the opportunity to shape our organisation. The survey plays a vital role in improving staff experience and patient care, and we know that staff survey results are an important factor in us being a Trust where people want to work.

6. Updates from the Council of Governors (CoG)

- 6.1 The CoG formally met in public on 17 July 2025. The CoG received the annual report from the Chair of the Audit and Risk Committee, a briefing on future developments for the APC and received the Trust's annual report and accounts.

- 6.2 CoG members attended a briefing session to hear about the NHS Year Plan, and how this related to the APC and Trust Strategies. CoG members were also updated on the new NOF approach and what this meant for the trust.

7. Equity, diversity and inclusion

- 7.1 During National Inclusion Week, the Trust paid tribute to the wealth and expertise of our diverse team by sharing the individual stories of our staff, reminding us the role of inclusion in the workplace and why it matters. Stories were featured across the organisation and we hosted webinars for staff to attend.

8. Recognition and celebrating success

- 8.1 Our virtual ward work received national recognition, with the cardiac digital care team winning the *Harold Thimbleby Award* for Digital Transformation at the Royal College of Physicians' Excellence in Patient Care Awards 2025. The project, which supports patients remotely via virtual wards, was praised for its inclusive design and alignment with clinical pathways—improving outcomes and optimising NHS resources. It also supports patient flow and reduces admissions through early discharge.
- 8.2 Our Antimicrobial Stewardship (AMS) programme was highly commended at the HSJ Patient Safety Awards 2025, achieving second place nationally for improving medication safety. The team's proactive approach has reduced high-risk antibiotic use, lowered fluoroquinolone prescribing by 35%, and delivered over £200,000 in annual savings.
- 8.3 The Laparoscopic Surgical Skills Course at West Mid has been accredited by the Royal College of Surgeons (RCS), following excellent feedback from the RCS Quality Assurance panel. This reflects the high standards delivered by our surgical fellows, residents, consultants, and the wider West Mid team.

**Chelsea and Westminster NHS Foundation Trust (CWFT) Standing Committee
Chair's Highlight Report to the North West London Acute Provider Collaborative
(NWL APC) Board in Common (BiC) – for discussion
October 2025**

Highlight Report

1. Purpose and Introduction

Each Trust within the North West London (NWL) Acute Provider Committee (APC) has established a local Trust Standing Committee following a decision at the April 2024 Board in Common (BiC) meeting in line with the wider review of the APC and local Trusts' governance.

The Committee meets on a quarterly basis. The role of the Trust Standing Committee is to oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust level risks and issues relating to this are being managed.

2. Key highlights

2.1 Winter Planning

Overview

The Trust has developed a comprehensive winter plan to manage anticipated pressures and maintain patient flow during the most challenging period of the year. The plan focuses on system-wide collaboration, operational resilience, and proactive risk management, supported by clear assurance measures. Key initiatives include strengthening demand management pathways, enhancing discharge processes, and maintaining elective activity while ensuring emergency care capacity.

Key Measures

- The Trust is working closely with the System Flow Board to coordinate demand management strategies, including frailty services, acute care, and same-day emergency pathways to divert patients and maintain flow.
- Discharge-ready units are active across both sites, reducing reliance on medical input and accelerating patient discharge. Escalation beds will be opened if required.
- The Command & Control Centre remains operational, supported by digital systems and gold-level leadership.
- A targeted flu vaccination campaign aims to increase uptake by 5%, using both roaming and static teams.

Risks

The primary risk is the absence of additional funding, which may impact delivery. RTT performance also remains vulnerable due to external system factors.

Actions

The Trust will maintain the elective programme while redeploying staff to emergency pathways over the Christmas period. Work continues with community partners to mitigate system pressures.

Additional Highlights

- **Mental Health:** A new crisis unit opened in December, significantly improving ED flow.
- **Virtual Wards:** Concerns remain about cost-effectiveness; preference is for “hospital at home” models with strict selection criteria.
- **Vaccination Uptake:** Staff rates are improving from last year’s 38%, reflecting a positive shift in attitudes.
- **Dependencies:** Assurance exercises are underway for third-party providers, with funding disparities across boroughs flagged.
- **Other Notes:** Corridor care avoidance reaffirmed; early flu and COVID activity monitored; social prescribing pilot launched under EIC.
- **Board Decision:** The Board reviewed and signed off the assurance statement.

The Standing Committee reviewed the draft Board Assurance Framework statement and the EQIA.

2.2 Integrated Quality and Performance Report (IQPR) – Overview

The Month 05 IQPR provides a snapshot of performance, quality, workforce, and operational priorities. While progress is evident in several areas, challenges remain in meeting national targets and sustaining quality standards amid financial and workforce pressures. The report highlights key performance metrics, safety indicators, and workforce trends requiring continued focus.

Performance

- **Cancer:** The 28-day and 31-day standards were achieved in July; however, the 60-day pathway remains under pressure and requires further improvement.
- **Diagnostics:** Activity levels are below target but ahead of forecast, with the Elective Recovery Fund (ERF) cap continuing to influence funding allocations.
- **RTT:** Performance stood at 60% in August. Achieving the national year-end target of 65% will require significant additional activity, estimated at £3 million.
- **Emergency Department (ED):** Current performance is approximately 80%, with winter planning initiatives expected to support further improvement.

Quality and Safety

- Four severe harm incidents were reported and are under investigation.
- Infection Prevention and Control (IPC) performance is improving but remains below expectations; one MRSA case was community-onset.
- Falls, dementia screening, and NOF improvement programmes are ongoing.
- Friends and Family Test results were positive overall, though ED scores were lower due to operational pressures.

Workforce

- Safer staffing levels are currently good..
- Vacancy and turnover rates remain under close review.
- PDR compliance has reached 91%, exceeding the 90% target.
- Bank and agency usage continues to be affected by industrial action and increased demand from mental health patients.

Additional Notes

- A rise in formal complaints has been noted at the Chelsea site, which is under active review.
- Concerns have been raised regarding clarity in pressure ulcer risk assessments.

2.2.3 Quality Report

The report highlighted a continued focus on identifying thematic trends and conducting root cause analysis to drive quality improvements. Complaints received were primarily related to scheduling and communication issues, with fewer concerns raised about direct clinical care. Fire dampers and ventilation standards are currently under review, particularly in light of the transition to in-house facilities management services. Additionally, development is underway for an estates compliance dashboard to enhance oversight. Infection Prevention and Control (IPC) remains a top priority, with targeted staff engagement initiatives being implemented to strengthen compliance and awareness.

2.2.4 Finance Report

The Trust is currently reporting a year-to-date deficit for the first 5 months of £3.4 million, which is £2.4 million behind plan. This position is largely driven by £1.1 million in industrial action costs and a £1.3 million shortfall in cost improvement programme (CIP) delivery. However, The Trust reported a surplus of £0.7m in month 5, supported by improved CIP delivery. Key financial risks include the ongoing challenge of delivering recurrent CIP savings, with vacancy holding being used as a mitigation strategy. The Trust holds £134 million in cash and capital expenditure is currently slightly behind plan due to phasing of the programme, with the Ambulatory Diagnostics Centre project the largest scheme on the capital programme. Capital funding bids of £10 million have been submitted to NHS England and are pending approval.

The Trust approved and published its refreshed Green Plan for the next 3 years in September. This document outlines the Trust's ongoing commitment to enhancing its sustainability efforts and achieving net zero carbon emissions as well as celebrating the achievements of the progress since 2019/20. The Trust's carbon footprint has fallen from 26,289 to 19,377 tCO₂e between 2019/20 and 2023/24, supported by programmes such as LED lighting replacement, reducing PC power consumption, waste campaigns, ceasing use of Desflurane anaesthetic gasses and great staff engagement in local departmental sustainability schemes. There are 12 work streams underpinning the refreshed Green Plan, including sustainable models of care, digital transformation, Estates and Facilities and Medicines to continue the Sustainability Programme over the next 3 years.

2.2.5 People and Workforce

Progress continues towards establishing a unified workforce model. However, rising sickness rates—particularly related to stress—have prompted a renewed focus on staff wellbeing and retention. Completion rates for exit interviews remain low, and there is an increased emphasis on conducting “stay conversations” to proactively address staff concerns. Incidents of violence and aggression are being actively addressed, and the current staff survey response rate stands at 28.5%. The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) have been signed off, although concerns remain regarding the accuracy of leavers data. Alignment between workforce and finance teams is ongoing, with medical productivity under review.

Improvements in Personal Development Review (PDR) compliance were noted and commended.

2.3. Items for Assurance

2.3.1 Provider Capability Assessment

The self-assessment has been completed and formally signed off by the Board. Regional feedback is awaited, with succession planning and system triangulation identified as areas for improvement.

2.3.2 Board Assurance Framework

The latest version of the framework was reviewed and accepted, with further refinements to be made in due course.

2.3.3 Other Items

The forward plan was noted, and the current standing committee structure will be retained. Upcoming items include interviews for the Single Accountable Officer role, the CW+ Ward to Board meeting, updates on the NHS Art Programme, and a briefing on the ARC research collaboration, where cost pressures have been flagged.

3. Attendance

Members:	October attendance
Patricia Gallan, Vice Chair and Senior Independent Director (SID) - Chair	N
Matthew Swindells, Chair in Common, NWL APC Chair in Common	Y
Mike O'Donnell, Non-executive Director	Y
Vineeta Manchanda Non-executive Director	Y
Ajay Mehta Non-executive Director	Y
Dr Syed Mohinuddin Non-executive Director	Y
Carolyn Downs Non-executive Director	Y
Catherine Williamson Non-executive Director	N
Members:	October attendance
Aman Dalvi, Non-executive Director	Y
Dame Helen Stephenson, Non-executive Director	N
Lesley Watts CBE, Chief Executive Officer	Y
Roger Chinn, Chief Medical Officer	Y
Robert Bleasdale, Chief Nursing Officer	N
Virginia Massaro, Chief Financial Officer	Y
Kevin Croft, Chief People Officer	Y
Sheena Basnayake, Managing Director (West Mid - WM)	Y
Laura Bewick, Managing Director (Chelsea - CW)	Y
Jason Seez, Chief Infrastructure & Redevelopment Officer	Y
Osian Powell, Director of Transformation	Y

Natasha Singh, Board Adviser, Equality Diversity & Inclusion (EDI)	Y
Emer Delaney, Director of Communications	Y
Peter Jenkinson, Director of Corporate Governance	Y
Chris Chaney, Chief Executive Officer, CW+	Y
Attendees:	
Faye McLoughlin, Corporate Governance Officer	Y
Alexia Pipe, Chief of Staff to NWL APC Chair in Common	Y

9. REPORTS FOR INFORMATION ONLY

None.

10. ANY OTHER BUSINESS

● Information Item

🕒 13:15

Nil Advised.

11. QUESTIONS FROM MEMBERS OF THE PUBLIC

● Discussion Item

👤 Matthew Swindells

🕒 13:20

12. DATE OF THE NEXT MEETING: 20 JANUARY 2026