North West London
Acute Provider Collaborative

NORTH WEST LONDON (NWL) ACUTE PROVIDER COLLABORATIVE (APC) BOARD IN COMMON - PUBLIC

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15 July 2025

09:30 GMT+1 Europe/London

Oak Suite, W12 Conference Centre, Hammersmith Hospital, Du Cane Road, London, W12 0HS

AGENDA

0. AGENDA NWL APC BOARD IN COMMON - PUBLIC - 15 JULY 2025

REFERENCES

Only PDFs are attached

00.0 Agenda Board in Common July 2025 Public v8.pdf

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

North West London Acute Provider Collaborative
Board in Common - Public
Tuesday 15 July 2025, 09:30 – 12:05
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
09:30	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 29 April 2025	Matthew Swindells	1.2
	1.3	Matters Arising and Action Log	Matthew Swindells	1.3
09:35	1.4	Staff Story: Advanced Clinical Practitioners *To note and discuss the staff story*	Rob Bleasdale	1.4
2. Report from the Chair in Common				
09:50	2.1	Report from the Chair in Common *To note the report*	Matthew Swindells	2.1
	2.2	Board in Common Cabinet Summary *To note any items discussed at the Board in Common Cabinet meetings*	Matthew Swindells	2.2
3. Decision Making and Approvals				
10:00	3.1	Future of Minor Injuries Provision across The Hillingdon Hospitals NHS Foundation Trust (THHFT) *Board Members of THHT to approve the proposal to consolidate services*	Lesley Watts	3.1
4. Integrated Quality and Performance Report				
-	4.0	Integrated Quality, Workforce, Performance and Finance Report *To receive the integrated performance report*	Pippa Nightingale Lesley Watts	4.0

4.1 Quality				
10:15	4.1.1	Quality – Integrated Quality and Performance Report (anything by exception)	Pippa Nightingale	4.0
	4.1.2	Learning from Deaths Quarter 4 Report *To note the report* *For BiC members, individual Trust reports can be found in the TeamEngine Reading Room. For members of the public these can found in the appendix document on the NWL APC website*	Jon Baker	4.1.2
	4.1.3	Clinical Pathways Programme Update *To note the update*	Peter Jenkinson James Biggin-Lamming	4.1.3
	4.1.4	Collaborative Quality Committee Chair Report *To note the report*	Pat Gallan	4.1.4
4.2 People				
10:35	4.2.1	People – Integrated Quality and Performance Report (anything by exception) *To receive the report*	Pippa Nightingale	4.0
	4.2.2	Collaborative People Committee Chair Report *To note the report*	David Moss	4.2.2
4.3 Finance and Performance				
10:50	4.3.1	Finance and Performance – Integrated Quality and Performance Report (anything by exception) • Emergency 4.3.2a • Elective 4.3.2b • Cancer 4.3.2c • Diagnostics 4.3.2d *To receive the report*	James Walters	4.3.2
	4.3.2	Financial Performance Report *To receive the financial performance report*	Bimal Patel	4.3.4
	4.3.3	Collaborative Finance and Performance Committee Chair Report • Productivity Report *To note the report*	Carolyn Downs	4.3.5
5. Data and Digital				
11:10	5.1	Collaborative Data and Digital Committee Report *To note the report*	Matthew Swindells	5.1
6. Estates and Sustainability				

11:15	6.1	Collaborative Strategic Estates, Infrastructure and Sustainability Committee Report *To note the report*	Bob Alexander	6.1
7. Chief Executive Officers				
11:20	7.1	Acute Provider Collaborative Executive Management Board (EMB) Summary *To note any items discussed at the APC EMB meetings*	Tim Orchard	7.1
	7.2	Reports from the Chief Executive Officers and Trust Standing Committees *To note the reports* • 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	7.2
	7.3	NHS Ten Year Plan Update *To note NHS England has published the NHS Ten Year Plan*	Pippa Nightingale Lesley Watts Tim Orchard	Verbal
8. Reports for Information Only				
	8.1	None		
9. Any Other Business				
11:40	9.1	Nil Advised		
10. Questions from Members of the Public				
11:45	10.1	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				
21 October 2025, 09:30 – 12:30 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 | 09:30

Verbal

1.1 DECLARATIONS OF INTEREST

Information Item Matthew Swindells

Verbal

1.2 MINUTES OF THE PREVIOUS NWL APC PUBLIC BOARD MEETING HELD ON 29 APRIL 2025

Decision Item

Matthew Swindells

Paper

REFERENCES

Only PDFs are attached

01.2 Draft BiC PUBLIC Minutes 29 April 2025 (1).pdf

North West London Acute Provider Collaborative Board in Common
Meeting in Public
Tuesday 29 April 2025, 10:00-13:00
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 CBE	Vice Chair (THHFT) and Non-Executive Director (CWFT)
Ms Patricia Gallan	Vice Chair (CWFT) & Non-Executive Director (THHFT)
Mr Nick Gash	Non-Executive Director (ICHT & THHFT)
Mr Aman Dalvi	Non-Executive Director (CWFT & ICHT)
Ms Vineeta Manchanda	Non-Executive Director (CWFT & THHFT)
Mr Ajay Mehta	Non-Executive Director (CWFT & LNWH)
Mr Simon Morris	Non-Executive Director (THHFT & LNWH)
Ms Sim Scavazza	Non-Executive Director (ICHT & LNWH)
Ms Baljit Ubhey	Non-Executive Director (LNWH & THHFT)
Ms Catherine Williamson	Non-Executive Director (ICHT a& CWFT)
Mr Mike O'Donnell	Non-Executive Director (CWFT & THHFT)
Dame Helen Stephenson	Non-Executive Director (CWFT &ICHT)
Professor Tim Orchard	Chief Executive Officer (ICHT)
Ms Pippa Nightingale	Chief Executive Officer (LNWH)
Ms Lesley Watts CBE	Chief Executive Officer (CWFT & THHFT)
Mr Alan McGlennan	Managing Director / Chief Medical Officer (THHFT)
Ms Lisa Knight	Chief Nursing Officer (LNWH)
Mr Raymond Anakwe	Medical Director (ICHT)
Ms Jazz Thind	Chief Financial Officer (ICHT)
Mr James Walters	Chief Operating Officer (LNWH)

Members present via Teams

Dr Syed Mohinuddin	Non-Executive Director (LNWH & CWFT)
Ms Linda Burke	Non-Executive Director (THHFT & ICHT)
Mr Martin Lupton	Non-Executive Director (LNWH & THHFT)
Ms Sarah Burton	Chief Nursing Officer (THHFT)
Mr Simon Crawford	Deputy Chief Executive (LNWH)
Ms Claire Hook	Chief Operating Officer and Deputy Chief Executive (ICHT)
Ms Virginia Massaro	Chief Financial Officer (CWFT & THHFT)
Mr Bimal Patel	Chief Financial Officer (LNWH)
Professor Janice Sigsworth	Chief Nursing Officer (ICHT)
Professor Julian Redhead	Chief Medical Officer (ICHT)
Mr Jason Seez	Chief Infrastructure & Redevelopment Officer (THHFT & CWFT)
Dr Jon Baker	Chief Medical Officer (LNWH)
Dr Roger Chinn	Chief Medical Officer (CWFT)

In Attendance

Ms Janet Campbell	Associate Non-Executive Director (THHFT)
Mr Kevin Croft	Chief People Officer (ICHT, CWFT & THHFT)
Mr Peter Jenkinson	Director of Corporate Governance (ICHT, CWFT and THHFT)
Ms Emer Delaney	Director of Communications (CWFT)
Mr Vikas Sharma	Trust Secretary (THHFT)
Ms Alexia Pipe	Chief of Staff to the Chair (APC)

Present via Teams

Ms Tracey Connage	Chief People Officer (LNWH)
Mr Mark Titcomb	Managing Director NWL Elective Orthopaedic Centre, Central Middlesex Hospital & Ealing Hospital (LNWH)
Ms Michelle Dixon	Director of Engagement & Experience (ICHT)
Ms Laura Bewick	Hospital Director & Deputy Chief Operating Officer (CWFT)
Ms Tracey Beck	Director of Communications (LNWH)
Mr Piers Milner	Head of Strategy (LNWH)
Ms Hannah Franklin	Health Equity Programme Manager (ICHT)
Ms Marie Price	Deputy Director of Corporate Affairs (CWFT)

Apologies for Absence

Mr David Moss	Vice Chair (LNWH) & Non-Executive Director (ICHT)
Mr Loy Lobo	Non-Executive Director (LNWH & ICHT)
Mr Robert Bleasdale	Chief Nursing Officer (CWFT)
Mrs Dawn Clift	Director of Corporate Affairs (LNWH)

Minute Ref		Action
1.0	**Welcome and Apologies for Absence**	
1.0.1	Matthew Swindells (MS), the Chair, welcomed everyone to the meeting and advised the meeting was being recorded and would be published online. A warm welcome was extended to: • Catherine Williamson - Academic NED – (CWFT & ICHT) Appreciation was extended to members stepping down from their roles • Janet Campbell, Associate NED (THHFT) • Huda Asad, Associate NED (LNWH) • Claire Hook, Chief Operating Officer and Deputy Chief Executive (ICHT)	
1.1	**Declarations of Interest**	
1.1.1	Peter Jenkinson (PJ) introduced the register of interests, noting that it is updated throughout the year and presented publicly once a year. The register should reflect all current interests declared by the board members.	
1.1.2	It was noted that directors at London Northwest are automatically trustees of the charity, and this interest had not been declared on the register. It was decided to make an annotation regarding this trusteeship to ensure the register is accurate and complete. **Action: PJ**	**PJ**

1.1.3	The Board noted the register of interest and that it would be published on the collaborative website. **Action: PJ**	**PJ**
1.2 1.2.1 1.2.2	**Minutes of the Meeting held on 21 January 2025.** The minutes from the meeting held on 21 January 2025 were **approved** as an accurate record. **Matters Arising and Action Log** The updates to the action log were noted	
1.3 1.3.1 1.3.2 1.3.3 1.3.4	**Staff Story – Equity – Outpatient initiative** The Board received a presentation on an initiative where local volunteers call patients particularly from vulnerable and underserved groups to remind them of upcoming appointments. Introduced by Pippa Nightingale (PN) and supported by a video featuring Brent Care Centre's volunteering team, the programme aims to reduce DNAs and improve accessibility. Volunteers, often aspiring healthcare professionals, speak multiple languages and help address logistical barriers faced by patients. The initiative benefits both service users and volunteers, and plans are underway to expand and integrate it with broader community health efforts. Challenges such as language and mental health needs are being managed through tailored training and escalation pathways. **The Board welcomed** the staff story with strong support and commended on the positive impact on both patients and volunteers. Members recognised the value of the initiative while noting it should complement ongoing efforts to address wider structural issues, including systemic discrimination and cultural barriers. Emphasis was placed on measuring outcomes to ensure the service contributes to tackling health inequalities. The Board discussed opportunities to scale the programme across the APC and align it with existing health coaching and social prescribing roles. Ensuring long-term funding and sustainability was highlighted as a priority, with ongoing engagement with local authorities.	
2.	**Report from the Chair in Common**	
2.1 2.1.1 2.1.2	**Report from the Chair in Common** MS opened by thanking the leadership team for their dedication over the past year. Despite aiming for break-even, the Trust successfully met a challenging £50 million deficit target and delivered £75 million in unfunded work demonstrating operational efficiency. The Chair noted encouraging performance in hospital mortality data and highlighted that the group is among the strongest performers nationally, alongside achieving the largest growth in elective activity since pre-COVID levels.	

2.1.3	Looking ahead, the Chair acknowledged the ambitious 4% productivity improvement target set for the NHS which is the highest since 1948. MS stressed the need for a system-wide response to emergency demand.	
2.1.4	The Board recognised the departure of Tina Benson (COO, THHFT) and Tracey Cotterill (Interim CFO, THHFT), thanking them for their contributions.	
2.1.5	This was also the final Board in Common for Claire Hook (COO and Deputy Chief Executive, ICHT), who will leave in June 2025 to become COO at the Francis Crick Institute. The Board acknowledged her significant impact at ICHT.	
2.1.6	To support collaboration, the Board noted new joint executive appointments: Virginia Massaro as CFO (CWFT & THHFT), Jason Seez as Chief Infrastructure and Redevelopment Officer (THHFT & CWFT), Alan McGlennan as Managing Director for THHFT, alongside his role as Chief Medical Officer, and Kevin Croft as CPO (ICHT, CWFT, & THHFT).	
2.2	**Board in Common Cabinet Summary**	
2.2.1	MS presented the item which provided an update on items discussed at the Board in Common Cabinet committees held on 12 February and 12 March 2025.	
2.2.2	**The Board noted** the focus on the business plan for the year ahead, with particular emphasis on the importance of Quarter 1 in delivering the challenging objectives. Progress was highlighted in the clinical pathways programme, which is strengthening collaboration across the four trusts. The Board also discussed extending this collaborative model into non-clinical areas.	
3.1	**APC Financial, Operational and Workforce Business Plans 2025/26**	
3.1.1	Lesley Watts (LW) introduced the business plan for 2025/26, highlighting the significant financial challenges and the requirement to meet national performance targets in emergency care, ambulance handovers, and elective services.	
3.1.2	Jazz Thind (JT) provided a financial overview, outlining a break-even position supported by additional non-recurrent funding from North London ICB. The financial strategy relies on £178m in efficiencies across four organisations.	
3.1.3	The operational submission includes targets around referral to treatment times and other key metrics, with associated risks to delivery. The Board will be briefed on planned mitigations.	
3.1.4	The workforce plan includes a reduction of 1,260 whole-time equivalents, focused on reducing bank and agency staffing and controlling the overall pay bill.	
3.1.5	The capital plan for 2025/26 totals £284m, funded through internal resources and public dividend capital, excluding grant and charity contributions.	

3.1.6	Board members discussed the system-wide dependencies particularly the role of the ICB and local authorities in managing discharges and community-based care. They raised concerns about system reliability and the need for clear contractual arrangements to support delivery. Recognising the scale of the challenge, **each Trust Board (Imperial, Chelsea and Westminster, Hillingdon, and London North West) confirmed approval of the business plan. Members reaffirmed their commitment to delivering the agreed objectives while ensuring high-quality, sustainable care.**	
3.2 3.2.1 3.2.2	**Delegated Authorities to Provider Trust Committees 2024/25** PJ presented the item. The paper seeks Board approval to delegate authority for remaining year-end documents to local Committees, as outlined within the paper. Audit and Quality Committees already have delegated authority for annual reports and Quality Accounts. **The respective boards each approved the delegated authorities to the Audit Committee and Quality Committee for signing off the self-certifications, and modern slavery statements required for the year-end process.**	
4.	**Integrated Quality, Workforce, Performance and Finance Report**	
4.0 4.0.1 4.0.2	**Integrated Quality, Workforce, Performance and Finance Report** MS introduced the IQPR, noting that while the report remains in its previous format, a new forward-look slide has been added to highlight contracted targets for the year. He informed the Board that future board packs will be restructured to place greater emphasis on these targets, along with quality and statutory reporting. Board members received the Collaborative performance report which outlined quality, workforce, performance and finance metrics. [Updates provided below]	
4.1	**Quality**	
4.1.1 4.1.1.1	**Quality – IQPR – anything by exception** PN presented the quality section, highlighting a strong incident reporting culture with consistently low levels of moderate or severe harm. While infection control targets remain challenging, patient experience performance is strong across inpatient, emergency, and maternity services. **The Board in Common noted the update.**	
4.1.2.1	**APC Equity Improvement Plan – BiC action plan**	

4.1.2.2	Vineeta Manchanda (VM) introduced the Equity Improvement Plan supported by Hannah Franklin (HF) and Piers Milner (PM), which aims to address health inequalities across NW London using the London NW Equity Index.	
4.1.2.3	The Plan is centred around five key recommendations: 1. **Access** – Reduce DNAs in high-risk specialties such as ophthalmology, cardiology, and diabetes. 2. **Waiting Times** – Use the equity index to highlight and address disparities in access and waiting times. 3. **Outcomes** – Apply the equity index across the APC to improve outcome equity. 4. **National Alignment** – Align with the Core20PLUS5 framework to focus on the most deprived populations and priority clinical areas. 5. **Priority Populations** – Implement targeted actions in maternity care and sickle cell disease, including early maternity bookings and timely pain relief.	
4.1.2.4	During discussion, members highlighted the importance of fully understanding the equity index's influence on care delivery and ensuring regular monitoring and reporting to drive accountability. There was support for sharing the plan across other trusts to encourage collaboration and learning. Conclusion: The Board endorsed the Equity Improvement Plan and its potential to reduce health disparities through focused, data-driven actions. Continued oversight, integration into performance reporting, and system-wide collaboration were emphasised as critical to success. **The Board in Common noted the report.**	
4.1.3	**Learning from deaths quarter 3 report** John Baker (JB) presented the item.	
4.1.3.1	The Board received and noted the Learning from Deaths report covering data to July 2024. HSMR showed a temporary rise at THHFT, with LNWH moving into the "as expected" range; both have since returned to lower levels. CWFT, and ICHT remained below expected ranges.	
4.1.3.2	A change in HSMR methodology in December contributed to data fluctuations. SHMI remained within or below expected levels across all trusts. Level 2 reviews indicated low levels of harm, supporting the mortality data. ***HSMR**: Hospital Standardised Mortality Ratio – compares the expected and observed number of deaths in hospital.* ***SHMI**: Summary Hospital-level Mortality Indicator – includes deaths in hospital and within 30 days of discharge, adjusted for case mix.* **The Board in Common noted the report.**	
4.1.4	**Elective Orthopaedic Centre (EOC) update**	

4.1.4.1	PN and Mark Titcomb (MT) presented an update on the EOC, now operating for nearly a year, which has delivered high activity, strong clinical outcomes, and reduced orthopaedic waiting list inequalities across NW London through cross-trust collaboration. It was recently accredited by the *Getting It Right First Time* (GIRFT) programme, with a follow-up visit scheduled in 2027.	
4.1.4.2	Governance is overseen by a monthly partnership board reporting to the APC EMB. Key challenges include managing activity and financial flows, with funding discussions ongoing. In discussion, PN highlighted the EOC's role in improving pathways and patient experience; Carolyn Downs (CD) raised the need to balance referrals; and Mike O'Donnell (MO'D) called for more radical referral reforms to avoid cancellations.	
4.1.4.3	**The Board welcomed the EOC's progress** and endorsed continued operational and funding improvements. **Next steps:** • Progress funding discussions with the ICB • Standardise pre-op assessments and pool patients to boost throughput	
4.1.5	**Collaborative Quality Committee Chair Report** **The Board noted the report which report covered various quality-related topics discussed in the earlier part of the meeting.**	
4.2	**Workforce**	
4.2.1	**Workforce – IQPR – anything by exception**	
4.2.1.1	Kevin Croft (KC) presented the item, highlighting generally positive metrics across vacancies, staff turnover, agency use, core skills, and sickness rates, which are close to target.	
4.2.1.2	Areas requiring further attention include appraisal completion, particularly in light of the introduction of a new appraisal window at CWFT.	
4.2.1.3	KC also emphasised the importance of progressing toward model employer goals to strengthen workforce representation, supporting culturally responsive care. A key challenge remains the planned reduction in workforce numbers and the pay bill, in line with financial constraints.	
4.2.1.4	In discussion, the Board stressed the importance of staff morale and productivity during this transition, noting that clear communication and support for staff will be vital.	
4.2.1.5	The Board noted good performance against key metrics, acknowledged areas for improvement, and underscored the need to safeguard staff engagement and resilience amid workforce reductions**.**	

	The Board in Common noted the update.	
4.2.2	**Collaborative People Committee Chair Report**	
4.2.2.1	Sim Scavazza (SS) provided an update from the Committee, noting that workforce metrics remain broadly positive, with strong performance in vacancies, turnover, agency use, and core skills. However, ongoing concerns were flagged around staff experiences of violence, harassment, discrimination, and access to flexible working.	
4.2.2.2	The Committee is focused on maintaining staff morale and engagement during a period of workforce reductions, while also driving productivity to support safe and effective patient care. Emphasis was placed on the need for clear communication and robust support for staff amid ongoing financial pressures. **The Board in Common noted the report.**	
4.3	**4.3 Finance and Performance**	
4.3.1	**Performance report**	
4.3.1.1	The Board noted continued progress across key areas of performance:	
4.3.1.2	• **Emergency and Urgent Care**: Claire Hook (CH) reported improved performance against the 4-hour emergency department target, reaching 77.7% in March. The Trust recorded the best ambulance handover times in London, although challenges remain at LNWH. Efforts continue to enhance patient pathways and address mental health and community bed capacity pressures. The "Optica" system is being used to identify and remove discharge delays. • **Referral to Treatment (RTT) and Diagnostics**: Laura Bewick (LBw) reported a decrease in patients waiting over 52 weeks for treatment. However, pressure in certain specialties persists. Diagnostic performance remains below standard due to capacity constraints and dependence on insourcing and outsourcing. The Trust is working to improve productivity and expand use of Community Diagnostic Centres. • **Cancer**: James Walters (JW) shared strong performance on the Faster Diagnosis Standard (83% in February) and the 31-day target. The 62-day target remains a challenge, with continued efforts from RM Partners Cancer Alliance to drive improvements through prioritised pathways and workforce productivity. • **Discharge**: JW outlined ongoing use of digital tools—including the Federated Data Platform and Optica—to improve discharge processes and support continuity of care. Collaboration with community services,	

	local authorities, and GPs aims to standardise the community offer and strengthen integrated neighbourhood teams.	
4.3.1.3	In discussion, Simon Morris (SM) emphasised the importance of setting clear discharge targets in future planning cycles. Tim Orchard (TO) advocated for a deep dive into failed discharges and reinforced the need to intervene earlier in cancer pathways to support 62-day performance improvements. **The Board in Common noted the update.**	
4.3.4	**Finance – IQPR , Financial performance report & Collaborative Finance and Performance Committee Chair Report**	
4.3.4.1	These items were taken as read and considered jointly, in light of earlier finance-related discussions during the meeting.	
4.3.4.2	JT highlighted that the report noted a draft unaudited APC deficit of £49.8m, which is slightly better than the forecast £50m supported by £72m in elective recovery funding sustained throughout the year.	
4.3.4.3	The focus is on ensuring financial balance for the year 2025/26, with a significant emphasis on achieving efficiencies and managing costs. **The Board in Common noted the report.**	
5.	**Data and Digital**	
5.1	**Collaborative Digital and Data Committee Report** MS presented the item.	
5.2	The Board noted that the Digital and Data Committee has prepared a full draft business case for a data warehouse and is reviewing a comprehensive cybersecurity strategy.	
5.3	The committee also discussed the NHS app, emphasising the need for it to match existing tools, such as the Care Information Exchange and Doctor Doctor before full transition. **The Board in Common noted the report.**	
6.	**Estates and Sustainability**	
6.1	**Collaborative Strategic Estates, Infrastructure and Sustainability Committee Report** Robert (Bob) Alexander (BA) presented the item.	

6.2	The Board noted good progress in aligning green plan outputs across the four organisations, integrating economic factors into sustainability, enhancing capital planning detail, and prioritising estate contingency planning tailored to each Trust. **The Board in Common noted the report.**	
7.	**Chief Executive Officers**	
7.1	**Acute Provider Collaborative Executive Management Board (EMB) Summary**	
7.1.2	TO presented an update from the APC EMB, which has been focused on finalising the financial position for 2024/25 and preparing plans for 2025/26.	
7.1.3	Progress was noted on clinical transformation, with 27 out of 28 clinical pathways now supported by implementation plans and outcome metrics. The EMB will continue tracking delivery and determine the next wave of pathway priorities.	
7.1.4	Collaborative initiatives across the trusts were highlighted, including a joint courier contract, a regional data strategy, aligned Cerner electronic patient record training, shared learning from patient safety incidents, and the progress of the Elective Orthopaedic Centre.	
7.1.5	TO also noted a renewed emphasis on accelerating the integration of non-clinical corporate functions to improve efficiency and consistency across the system. **The Board in Common noted the report.**	
7.2	**Reports from the Chief Executive Officers and Trust Standing Committees**	
7.2.1	**<u>London North West University Healthcare NHS Trust (LNWH)</u>** *Presenter: PN* • High engagement at staff events addressing NHS changes and planned workforce reductions. • Four key priorities: reduce care in escalation spaces, improve RTT performance, enhance staff engagement and equity, and deliver the sustainability plan. • Designated as a Commercial Research Centre with £7m funding for 40 trials. • Cybersecurity team member received two national awards. **Standing Committee Update**: Reviewed financial and operational plans, quality and equity assessments, and staff survey results.	
7.2.2	**<u>The Hillingdon Hospitals NHS Foundation Trust (THHFT)</u>** *Presenter: LW (with comments from CD)*	

	• New executive team settling in well. • Awaiting CQC report and using findings for quality improvement. • Focus on emergency care and RTT performance. • Actions underway in response to staff survey feedback. **Standing Committee Update**: Covered financial plans, quality improvement, and staff survey results. Included a development session for deeper discussion.	
7.2.3	**Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)** *Presenter: LW (with comments from Patricia Gallan (PG))* • Executive team adapting to changes, with interim arrangements in place. • Continued focus on research achievements and innovation. • Working to address financial challenges while maintaining performance. **Standing Committee Update**: Reviewed staff survey outcomes, financial recovery plans, and quality improvement initiatives.	
7.2.4	**Imperial College Healthcare NHS Trust (ICHT)** *Presenter: TO (with comments from BA)* • Positive impact from changes to maternity self-referrals at Queen Charlotte's. • High response to staff survey showing improved morale and engagement. • Strong participation in NIHR studies and a positive mid-term review of the Biomedical Research Centre. • Managing incidents of violence linked to clinical conditions. **Standing Committee Update**: Discussed the Strategic Lay Forum, estate-related risks, and approach to organisational risk appetite.	
8.	**Reports for Information Only**	
8.1	**Use of the Trust Seal** The Board noted the annual report detailing use of the Trust Seal across the four Trusts in the Acute Provider Collaborative for FY 2024/25, in accordance with standing orders.	
9.	**Any Other Business** There were no other business matters raised.	
10.	**Questions from Members of the Public**	
10.1	**Question from Trevor Arnold**: • Trevor Arnold asked about the impact of the government's reprioritisation of the New Hospital Programme (NHP) schemes in January, the potential new approaches to PFI (Private Finance Initiative), and the idea of special purpose vehicles for moving forward with the much-needed hospital schemes.	

10.2	**Response from TO**: • TO explained that the Trust are working with the Department of Health and have received some funding to continue planning for the St. Mary's Campus. They are also exploring how to use the White City Campus effectively and are in discussions with the local council to integrate this into the broader biosciences corridor. TO acknowledged that there is interest in exploring new financing methods, including PFI and special purpose vehicles, to support these developments. **Question Summary:** Robin Sharp questioned the assumption in the business plan that demand would remain flat and asked how safe that assumption was given recent history. He also inquired about the reduction of around 1260 staff equivalents and whether this implied cuts in patient care if these were clinical staff. **Response Summary:** PN explained that the Board acknowledges the risk associated with the assumption that demand would remain flat as discussed earlier in the meeting. She explained that the reduction in staff primarily involves returning to the funded establishment levels, as the previous year saw overspending. The additional reduction is only about 1% on top of the funded establishment, and the focus is on living within their means rather than cutting patient care. PN also mentioned that the acute trusts are actively engaging with the solution by working with the Integrated Care Board (ICB) to initiate health neighbourhood teams. These teams are part of the strategy to manage demand and ensure that patient care is not compromised. TO added that the assumption of no growth in demand is indeed a risk and depends on the effectiveness of working with the ICB to deliver the left shift. He emphasized that the primary focus is on reducing the growth in non-patient-facing staff since 2018/19. TO also highlighted the importance of good management practices, such as effective rostering and managing leave, to achieve the necessary reductions without compromising patient care. **Question from Armelle Thomas:** Armelle asked about the positive improvements in patient care at Hillingdon since LW took over in January 2025. Armelle also inquired about the frequency of the Members newsletter, noting that only two had been received in the past year. **Response:** Alan McGlennan (AMG) emphasised the focus on urgent problems such as emergency care, maternity care, and balancing the books. Improvements have been seen in maternity and paediatric services, particularly in stillbirths and babies born outside of labour wards. Emergency department performance has also improved, with a 6% performance increase in Type 1 cases over the last three months. AMG also committed to addressing the frequency of the Members newsletter with the communications team.	
10.3		
10.4		
10.5		
10.6		

10.7 **10.8**	**Question from Robin Sharp (on behalf of Gaynor Lloyd):** Robin, on behalf of Gaynor Lloyd, asked about the problems mentioned in the papers regarding the EOC, specifically with Cerner and the Federated Data Platform (FDP), and whether these issues have been resolved. **Response from Pippa:** PN thanked Gaynor for her support with the digital pathways and feedback. PN explained that the issues with the FDP have been resolved, allowing for smooth patient transfer and management. However, the problem with clinicians accessing patient records across different platforms is still being addressed. Currently, clinicians can read patient records but cannot request tests if they are not on the same site as the patient. This issue is being worked on and is expected to be resolved soon.	
	The Chair drew the meeting to a close and thanked the Board in Common and members of public for joining the meeting.	

1.3 MATTERS ARISING AND ACTION LOG

Information Item Matthew Swindells

Verbal

REFERENCES

Only PDFs are attached

01.3 BiC - Action Log Public final.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

Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
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

Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
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 is on the agenda and will be 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
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. 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.	TBC following ICB review

Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
				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.	

Part 2: Actions previously outstanding but now completed

Meeting Date	Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes & Status
21/01/25	12.1 – Questions from members of the public	ICHT NHP	Statement about the New Hospital Programme to be published online	TO	Completed, statement published on the ICHT website.
15/10/24	10.1.1	EMB report	The Board noted the positive progress on clinical pathways and inquired about non-clinical pathways. There was a question about whether the non-clinical pathways were operating at their full potential, or whether there was a need for further expansion. It was agreed this would be sent out for discussion.	TO	Update provided at April 2025 BiC (item 7.1)
21/01/25	5.2	APC Improvement Plan – EDI Action Plan	The Board discussed the need to set challenging and measurable targets and ensure we address unconscious bias. Carolyn Downs (CD) suggested that we include the issue of measurement of local populations to ensure effective measurement of data.	PN	Action complete re stage one of EDI plan. Stage two presented to April 2025 BiC (item 4.1.2)

1.4 STAFF STORY: ADVANCED CLINICAL PRACTITIONERS

Discussion Item | Rob Bleasdale | 09:35

REFERENCES

Only PDFs are attached

01.4 Staff Story ACPs- Cover Sheet.pdf

NWL Acute Provider Collaborative Board in Common (Public)
15/07/2025
Item number: 1.4
This report is: Public

Staff Story – The role of Advanced Clinical Practitioner

Author: Robert Bleasdale
Job title: Chief Nurse

Accountable director: Lesley Watts
Job title: Chief Executive Officer

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.

Quality Committee 02/06/2025 Supported the case for change		

Executive summary and key messages

The film showcases the invaluable role of Advanced Clinical Practitioners and their impact across the North West London Acute Collaborative, specifically at Chelsea and Westminster NHS Foundation Trust (CWHFT).

Antonia Gerontati, Advanced Practice Lead at CWHFT, shares key aspects of the Advanced Practitioner role at the Trust, and features Dulce Grave, an Advanced Clinical Practitioner. Dulce shares her experiences and passion of working in the neonatal intensive care unit at the Trust.

Vision and Strategy for Advanced Practice

CWHFT has over 100 Advanced Practitioners (ACPs) working across more than 30 specialties, representing one of the most diverse and capable ACP workforces in the region. The vision is to

embed Advanced Clinical Practice at the heart of service transformation and workforce resilience. The aim is to grow not just the numbers, but the depth and breadth of impact, developing ACPs who are clinically excellent, systems-aware and capable of driving real change. This September, over 20 new ACP apprentices will begin their training, further strengthening the pipeline and supporting long-term sustainability.

CWHFT currently has 11 Consultant Practitioners in post, reflecting the maturity and ambition of the programme. CWHFT are committed to growing this Consultant body further, creating meaningful career progression and leadership capacity within clinical services. ACPs at the Trust are developed collaboratively and supported within robust governance structures. Structured supervision and capability-based progression ensures the delivery safe, high-quality, autonomous care aligned with national standards. Many also hold PhDs and academic appointments, contributing as lecturers and researchers both nationally and internationally. Their practice spans the four pillars of Advanced Clinical Practice: clinical practice, leadership, education and research, ensuring broad and lasting impact across the system.

What is Advanced Clinical Practice?

Advanced Clinical Practice is a defined level of practice underpinned by a master's-level qualification or equivalent, enabling experienced clinicians to manage complex care needs autonomously. It is not role-specific, but rather reflects a level of capability, accountability and influence in care delivery and service development.

ACPs bring expert clinical skills, independent judgement and the ability to lead innovation. They assess, diagnose, treat and manage patients independently within their scope of practice, while actively shaping services, supporting staff development and applying evidence to improve outcomes.

Principles of Advanced Clinical Practice

The foundation of Advanced Clinical Practice lies in autonomy, accountability, holistic care and evidence-based decision-making. ACPs manage undifferentiated presentations, lead teams and work across professional and organisational boundaries. With strong governance in place, they support safe, effective care even in high-pressure environments. They are life-long learners who drive improvement through education, leadership and innovation.

The Value and Impact of ACPs

Advanced Clinical Practitioners deliver measurable value across the healthcare system. They run independent clinics, manage long-term conditions, improve flow and support early discharge. In cancer pathways, they perform key diagnostic and staging procedures. In

emergency and acute care, they assess, manage and discharge patients, reducing avoidable admissions and improving patient experience.

Their contributions are also deeply embedded in specialised areas. In Neonatal Intensive Care, they manage patients autonomously. In Frailty, they review patients early and support admission avoidance. In Palliative Care, they ensure timely, high-quality support alongside medical teams. In Therapies, they manage conditions independently, allowing consultants to focus on complex or deteriorating cases. Across all specialties, they contribute to training, audit, research and quality improvement, ensuring practice remains evidence-based and responsive to evolving needs.

Advanced Clinical Practice is now a vital part of modern healthcare delivery. It offers an effective, flexible and sustainable model for delivering high standards of care while supporting workforce transformation at scale.

There have been tangible successes where ACPs have been introduced across the organisation. These successes have translated in improvements to cancer access standards in particular in urology where the patient pathway is managed by the ACP team up until the point of diagnosis including performing the diagnostics required. This success has seen FDS compliance rise from 40% to above 60% in less than one year.

The introduction of advanced roles also allows for the release of valuable Consultant resource. This can increase the potential income from Consultant new appointments, also improving waiting times for our patients. If an ACP were to undertake a clinic of 8 follow up appointments, this would free up four new slots for a Consultant to see new patients.

ACPs can also help improve access to services and timeliness of care in an outpatient setting by also delivering first/new appointments.

The opportunity for Advanced Clinical Practitioner roles as part of the wider multidisciplinary team in delivering sustainable healthcare has been recognised in the 10-Year plan. The strengthening of the roles will be delivered through the establishment of an advanced practice group across NWL.

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

Impact assessment

Tick all that apply

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

2. REPORT FROM THE CHAIR IN COMMON

09:50

2.1 REPORT FROM THE CHAIR IN COMMON

Information Item Matthew Swindells

Paper

REFERENCES

Only PDFs are attached

02.1. Report from the Chair in Common.pdf

NWL Acute Provider Collaborative Board in Common (Public)
15/07/2025
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

Impact assessment

Tick all that apply

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

The Acute Provider Collaborative

At the end of last month, NHS England (NHSE) published the new NHS Oversight Framework 2025/26 which describes a consistent and transparent approach to assessing integrated care boards (ICBs), NHS trusts and foundation trusts, the aim is to ensure public accountability for performance and providing a foundation for how NHSE works with systems and providers to support improvement.

The framework has been developed with the engagement and contributions from NHS leadership and staff, representative bodies and think tanks, including through two public consultations. This 1-year framework sets out how NHSE will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping to identify quickly where organisations need support.

NHSE will use the performance assessment process to measure delivery against an agreed set of metrics, we have been aligning our Integrated Performance Report to reflect this. The assessment will determine the segment score for each provider and identify where improvement is required. NHSE place every provider into a segment. This indicates its level of delivery from 1 (high performing) to 4 (low performing) and informs its support or intervention needs. Entry into segment 5 will be reserved for the most challenged organisations that require the most support to improve. The four Acute Trusts in NWL are expecting our scores from NHSE for the new framework imminently.

NHSE have said they want to move from annual to a three-year planning cycle, which will be very helpful to the NHS. This will help us take a more strategic view of how we improve both operational and financial performance. This also means changing how we think about money, focusing on how we use our resources, and resetting our approach to productivity, linking efficiency directly to better outcomes for patients.

THHFT CQC Inspection Reports

In June the Trust finally received the Care Quality Commission (CQC) inspection reports, as Lesley recently announced to staff, the latest CQC inspection has recognised significant improvements at our Trust, with enhanced ratings across all key areas and at both our hospitals. This is a real achievement for THHFT and a testament to the dedication and compassion of our staff. Mount Vernon is now rated ‘good’ for urgent and emergency care and surgery, and Hillingdon, while rated ‘requires improvement’, is now moving in the right direction as a direct result of the work everyone has contributed in creating a safer, more responsive hospital environment.

NHS 10 year plan

This month the Government published its new 10-year plan (10YHP) for the NHS in England, ‘Fit for the Future’, it outlines a transformative vision for the NHS, focusing on three core shifts: delivering care closer to home, empowering patients, and simplifying NHS operations.

The 10 YHP shows Acute Trusts playing a pivotal role in delivering more integrated, community-focused care. The plan prioritises shifting services closer to home through neighbourhood health centres, while acute providers are expected to lead on complex care, urgent and emergency services, and innovation. Health equity and workforce sustainability are also key areas of focus.

For Acute Trusts, key implications include:

- A renewed focus on elective recovery, with redesigned outpatient pathways, virtual wards, and AI-supported triage to reduce hospital demand.

- A new workforce plan aiming to reduce headcount growth, reform training, and eliminate agency staffing—posing both challenges and opportunities for acute workforce planning.

- The NHS app will offer a radical new way for patients to manage their health, from offering advice through AI to booking appointments and leaving feedback.

- The creation of new Foundation Trusts (FT) from 2026, and every trust is expected to become an FT by 2035. The highest-performing providers will become Integrated Health Organisations (IHOs) and will take responsibility for the health and budget of a whole population.

We await further details to really get a grip on these new reforms; however, the acute sector will be central to delivering the plan's ambitions. We will need to balance this while navigating significant financial and operational pressures, the good news is the priorities outlined by Government align closely with many of our local goals. The 10YHP will be key to having a thriving health service that has the best outcomes for our patients, staff and the population across North West London.

Redevelopment Update

THHFT will proceed as a wave 1 scheme as part of the National Hospital Programme (NHP), with construction expected to start 2027/28 and a capital envelope of £1-1.5bn, the Hillingdon Hospital's redevelopment will be part of the initial phase of hospital rebuilds and will act as a test-bed for future hospital redevelopments in England, this places an additional expectation and focus on this overall programme.

Following the government announcement, the Trust received a letter from the Minister of State for Health confirming its status as a wave 1 scheme and setting out the following expectations of the Trust:

- Develop a Hospital 2.0 compliant design (NHP's standardised approach to design)
- Engage and gain support from Local Authority planners for the H2.0 compliant design
- Move forward with the Outline Business Case (second stage of the three stage business case process for major construction schemes in the NHS) supported by a programme plan to be agreed by March 2025.

Work has progressed with the New Hospital Programme to align the schedule of accommodation with the budget available. Validation and sign off of this process is expected by mid-July 2025. Work has also started on enabling strategies: including the revised Digital Strategy, Facilities Strategy, and Workforce Strategy. Work is expected to commence on the Target Operating Model over summer 2025.

THHFT continues to engage with staff, patients, and the local community to gather input and provide updates on the hospital redevelopment. There has been support and collaboration on a broader engagement road map with input from Hillingdon Council, Healthwatch and wider voluntary charity sector leveraging on the local relationships.

As Tim has reported in his CEO report, ICHT have confirmed with the New Hospital

Programme (NHP) a funding allocation for the St Mary's Hospital (SMH) redevelopment for 2025/26 financial year, with funding beyond this period still to be confirmed. The Trust is working hard with partners to develop a revised delivery strategy that reflects the reduced budget. The NHP has also advised that there is currently no funding available to advance the Charing Cross and Hammersmith Hospitals redevelopment.

Annual General Meetings (AGMs)

Three of the four Trusts have their AGMs this month, this is a chance for the members of the public to hear from the Board and will cover each Trusts performance for the 2024/25 financial year, as well as a look forward to the 2025/26 year. Each Trust will provide presentations on key topics and there will be sufficient time for a questions and answers session. The details of each of the meetings are available on the Trust websites.

London Chairs meeting

I regularly attend the London Chairs meeting which is hosted by NHS England, London Region. It is a meeting which brings all the Chairs of Acute, Mental Health and Community providers from across London to discuss key areas and hot topics with Caroline Clarke the Regional Director for London. Last month was a joint meeting with Chairs and Chiefs Executives, we were joined by Penny Dash, Chair of NHSE and Tom Kibasi the new Director of Strategy at NHSE to discuss the latest on the NHS 10 Year plan.

Fit and Proper Persons Test Assurance

The "fit and proper person" test, specifically the Fit and Proper Person Test Framework (FPPT) in the NHS, is a process used to ensure that individuals appointed to leadership positions, particularly board members, are suitable and fit to discharge their duties effectively. It aims to prevent individuals who are not of good character, lack the necessary qualifications or skills, or have a history of misconduct from serving in these roles.

Key aspects of the FPPT include:

- **Assessing Good Character:**

  This involves evaluating the individual's honesty, integrity, and past behaviour.
- **Evaluating Qualifications, Competence, and Experience:**

  Ensuring the individual possesses the necessary skills and experience to perform the duties of the role.
- **Assessing Health and Ability:**

  Determining the individual's ability to perform the required tasks, taking into account reasonable adjustments.
- **Reviewing Past Conduct:**

  Investigating any prior misconduct or mismanagement, whether unlawful or not, in regulated activities.
- **Consideration of Grounds of Unfitness:**

  Evaluating whether any grounds specified in relevant regulations apply to the individual, such as financial instability or serious criminal convictions.

The FPPT is a crucial mechanism for maintaining public trust and ensuring the quality and safety of NHS services. As Chair in Common I can confirm that we have concluded our assurance testing of all Directors on the Boards forming the Acute Provider Collaborative and that we are compliant with all checks. I provided this assurance in written documentation to the NHSE Regional Director in late June 2025.

Acute Provider Collaborative Visits

On 16 May Dr Vin Diwaker, NHSE National Director of Transformation, visited Northwick Park Hospital. He was joined by other senior staff from the National Transformation Directorate to learn of our successes and challenges in adopting the NHS Federated Data Platform across NWL APC. Particular thanks must go to the LNWH validation team, staff on Fielding Ward (Timely Care Hub) and the LNWH FDP programme team who presented an overview of progress locally.

On the 27 May I joined Alan McGlennan, Chief Medical Officer and Managing Director at THHFT, we went on a visit to the Emergency Department, Ambulatory Medical Unit and Same Day Emergency Centre. We visited the discharge lounge seeing first hand the positive steps in getting patients home as quickly and smoothly as possible, which also supports pressure at the Trusts front door.

On the 13 June I had the pleasure of again joining the LNWH Research & Innovation Annual Conference, this event is one of my highlights of the year seeing the innovations that a wide range of individuals and teams are developing.

At this year's event I was especially impressed with a research project 'Helping to Ease Pain from Arm Spasticity' presented by Dr Stephen Ashford, Consultant Physiotherapist and MSK Sonographer at LNWH. The study followed nearly 1,000 people with upper limb spasticity over two years. It found that repeated botulinum toxin A (BoNT-A) injections significantly reduced pain, even after multiple treatment cycles. Pain relief was a key goal for many patients and over 70% achieved it. The treatment worked across different ages and conditions, showing consistent benefits in real-world care. These findings support BoNT-A as an effective option for managing spasticity-related pain and improving quality of life. Well done to all the staff who participated in the Research & Innovation Conference showcasing the work they are doing.

On 17 June I joined the Wellbeing Festival at Ealing hospital, the festival is to support staffs experience and wellbeing at work. It is always a fun event and well attended, I enjoyed my walk around the stalls hearing the innovative work staff are doing in their daily working life.

Citizens Advice

In another part of my life, I have the privilege of chairing the national Trustees for Citizen's Advice, a charity that works through 140 local organisations to provide financial, housing, employment and other advice to some of the poorest families in communities across England and Wales as well as advocating on their behalf. Wearing both that hat and my NHS one, I've had the opportunity in the past few weeks to visit two brilliant programmes where the local Citizens Advice and NHS are working together.

In Winchester, I visited the Mental Health Trust where Citizens Advice have imbedded case works on the acute mental health wards to work with patients to get their lives back together. I heard the story of a former patient who'd been rough sleeping when he had an acute episode. When the ambulance brought him to hospital he lost everything he owned, the plastic bags that were around him. The NHS helped him get his medications right and prepared him for discharge, Citizens Advice helped him get a bank account, his ID that he'd lost and somewhere to live. Now he's applying for jobs. The NHS spends £24,000 per year on the case worker, equating to £75 per patient, and calculates the saving due to short lengths of stay and fewer readmissions as £5000 per patient.

In Liverpool the ICB funds a programme called "Citizens Advice on Prescription" which enables any frontline healthcare professional who think their patient's health is being affected by poverty to refer them to Citizens Advice. Citizens advice help them with debt, housing, fuel bills and employment. A recent study by Liverpool University showed that for every £1 the ICB spends on this service, the NHS saves £2 in reduced medication, fewer GP consultations and fewer A&E visits.

I hope that in the month that the 10 Year Health Plan is published with the commitment that the new Neighbourhood Health Centres will "also offer services like debt advice, employment support …" we will see the ICBs turn their attention to more collaborative partnerships like these.

HSJ Digital Awards Ceremony

Last month I joined a panel at the HSJ Digital Awards 2025 for the Driving Change through AI and Automation Award. It was interesting to see all the work happening across the country in digital. I was especially proud with how many projects from across NWL APC were nominated:

- Digital Clinical Safety Award - winners – CWFT, Demonstrating the Clinical Safety of AI-Powered Teledermatology - Transitioning From Pilot to Sustainable Standard Practice. The trust partnered with Skin Analytics in 2022 to implement a skin cancer pathway using DERM, artificial intelligence as a medical device (AIaMD). Since launching, the service has undergone extensive post-market surveillance, continually demonstrating clinical safety and value. The pathway has safely discharged 2,600 patients and helped the trust to avoid 95 per cent of urgent face-to-face appointments, freeing up finite dermatology capacity for those with skin cancer. This collaboration has set a precedent for the safe deployment of AIaMD. Organisers say they have conducted pioneering research, developed clinical guidance, fostered national dialogue, and established a blueprint for the NHS.

- Digital Equality, Diversity and Inclusion Award – nominated – ICHT, EDI Improvement Project, delivering innovative interventions that are shifting the culture of the Information and Communications Technology division and introducing changes to policy and practice.

- Digital Leader of the Year – nominated – ICHT/CWFT, James Bird, chief nurse information officer at ICHT/CWFT, James was nominated for his constant desire to make electronic patient records meet the needs of clinical teams – and the significant impact his work at local and national level.

- Reducing Health Inequalities through Digital – nominated – LNWH, Equity Index,

which measures and tackles health inequalities. The index ensures the quality of care the Trust offers is consistent regardless of factors, such as gender, ethnicity, disability and social and economic circumstances. It aggregates differences in the quality of care across 30 indicators, covering areas like safety, effectiveness, patient experience, timeliness and access. These insights then help inform and drive improvements in service delivery.

- Improving Medicines Management and Pharmacy Through Digital – nominated – NWL APC, Therapeutic Duplicate Prescribing Alerts for Analgesia and Anticoagulants, this initiative ensures that alerts in the electronic patient record system display exactly (only when and where needed) to help prevent duplicate prescribing.

- Digital Literacy, Education and Upskilling Award – nominated – ICHT, The Impact of Digital Education at the Elbow, an innovative data-driven education approach that has significantly increased adoption of the electronic patient record by nursing staff.

- Driving Change through AI and Automation Award – nominated – ICHT, Artificial Intelligence in Radiotherapy, the use of deep learning auto-contouring in the treatment of cancer patients.

NHS Confed Expo

I attended the NHS ConfedExpo in early June. The conference, held this year in Manchester, is a significant event for the health and care sectors, focused on promoting innovation and enhancing patient and public care. I took part in two panel sessions, the first discussion involved a collaboration of healthcare leaders examining the implementation and impact of predictive data analytics and benchmarking by teams. In the second session, I joined Caroline Clarke discussing the role of artificial intelligence in NHS service delivery.

Board Change

I am delighted to confirm Ian Bateman has joined the Board in Common, as he has taken on the role of interim Chief Operating Officer at ICHT, on behalf of the Board I welcome Ian to his first BiC meeting.

Honours List

Finally, I would like to congratulate all staff across the APC who have been recognised in this year's Honour list. I was extremely delighted to see Bob Alexander was awarded an OBE for his service to the NHS. Bob is Vice Chair at ICHT and NED at LNWH and has over 30 years' experience in finance and accounting at board level across the public sector, including the NHS, civil service, and Metropolitan Police.

2.2 BOARD IN COMMON CABINET SUMMARY

Information Item Matthew Swindells

Paper

REFERENCES

Only PDFs are attached

02.2 BiC Cabinet Committee Summary - May and June 2025.pdf

NWL Acute Provider Collaborative Board in Common (Public)
15/07/2025
Item number: 2.2
This report is: Public

Board in Common Cabinet – Committee 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 for noting only

This paper provides an update on items discussed at the Board in Common Cabinet committees held on 15 May and 11 June 2025.

Report history

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

Board in Common Cabinet 15/05/2025	**Board in Common Cabinet** 11/06/2025	

Decisions made by the Board in Common Cabinet on behalf of the Board in Common

The Board in Common is asked to note the following decision made by the Board in Common Cabinet.

1. **The Hillingdon Hospitals NHS Foundation Trust (THHFT) Temporary Staffing Contract.**

Members of the THHFT Board approved the business case.

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 Committees held on 15 May and 11 June 2025 were:

Delivery and Assurance

The Chief Executives briefed the Cabinet on significant areas/issues within their respective Trusts and provided an update on the challenged financial position for the start of the year.

Acute Provider Collaborative Executive Management Board

The Cabinet received a brief update from the Acute Provider Collaborative Executive Management Board and noted the items discussed which included:

- Collective discussions on the North West London Elective Orthopaedic Centre (EOC) and support for increased activity.
- There was a helpful update on virtual wards: 300 were in use with 80% occupancy. There was scope to increase the number of beds and get a more unified approach to virtual wards. Important to see how the Trusts can keep people at home with virtual monitoring.

APC Remuneration Committee.

The Cabinet members discussed the NHS very senior managers pay framework which had recently been published by NHS England at the May 2025 meeting, noting the pay ranges and the operational guidance provided. The discussion centred around ensuring all four Trusts were aligned around the framework going forward.

Planning and Strategy

Progress update on the Clinical Pathways Programme.

At the June 2025 meeting, a progress update on the Clinical Pathways Programme was provided to the Cabinet, which showed that by April 2025, 27 out of 28 pathways were at the implementable stage. During the discussion, it was noted that learning from this tranche suggested management could be more prescriptive about how they are tracked and what the benefits are and more formulaic about the expectation of the outcome in the next

tranche, which was likely to be in the 1-year or 2-year timeframe. The pathways needed to demonstrate how collectively they are driving all of our departments to deliver in the most productive way, to the most up to date clinical guidelines for the best outcomes for patients. The Cabinet agreed the pathways needed metrics to support the clinicians in measuring success.

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

3. DECISION MAKING AND APPROVALS

10:00

3.1 THH MINOR INJURIES UNIT (MIU) SERVICE

Decision Item Lesley Watts

Paper

REFERENCES

Only PDFs are attached

03.1 Future of Minor Injuries Provision THHFT - Cover Sheet.pdf

03.1a THHFT UTC Proposal_v2.3.pdf

NWL Acute Provider Collaborative Board in Common (Public)
15/07/2025
Item number: 3.1
This report is: Public

Future of Minor Injuries Provision across The Hillingdon Hospitals NHS Foundation Trust (THHFT)

Author: Dr Alan McGlennan
Job title: Managing Director and Chief Medical Officer

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Purpose of report

Purpose: Decision or approval

The THHFT Trust Standing committee recommends that the Board of THHFT approve the consolidation of minor injuries services into a single, clinically robust and financially sustainable model. This proposal involves bringing together the standalone Urgent Care Nurse Practitioner Service (UCNPS) at Mount Vernon Hospital (MVH) with the Urgent Treatment Centre (UTC) at Hillingdon Hospital (HH), with the aim of optimising resources and enhancing access, safety, and equity of care across the borough.

Report history

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

CEO Cabinet 30/06/2025 Supported the case for change	**THHFT Trust Standing Committee** 03/07/2025 Supported the case for change and recommend the Board of THHFT approve

Executive summary and key messages

Strategic Rationale:

The Trust currently operates two minor injuries services with differing scopes and resilience. MVH UCNPS is a limited, appointment-only service, while HH UTC is a 24/7 walk-in facility with

broader clinical capabilities but workforce fragility. Consolidation addresses inequity, duplication, and inefficiency.

Key Benefits:

- Improved access for underserved populations
- Enhanced clinical safety and resilience
- Alignment with NHSE urgent care standards and Core20PLUS5 equity goals
- Supports NHS 10-Year Plan priorities: shifting care closer to communities, reducing health inequalities, and strengthening prevention-focused urgent care
- Recurrent savings of £1 million per annum

Workforce Impact:
All MVH staff will be offered redeployment to HH UTC, supported by a formal HR consultation. No redundancies are anticipated.

Financial Impact:
Consolidation eliminates premium agency costs and avoids capital investment at MVH. There is no expected change in Trust income or overall activity.

Engagement and Risk Mitigation:
Extensive engagement has been undertaken with stakeholders, including staff, community groups, and elected officials. A full Equality and Health Inequalities Impact Assessment (EQIA) and risk assessment have been completed.

The Board of THHFT is asked to:

- Approve the proposal to consolidate services
- Endorse implementation and communications plans
- Support staff consultation and transition planning

as recommended by the THHFT Trust Standing Committee

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

Impact assessment

Tick all that apply

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

Future of Minor Injuries Provision across The Hillingdon Hospitals NHS Foundation Trust

1. Purpose of the Paper

To seek approval from the Board of The Hillingdon Hospitals NHS Foundation Trust (THHFT) to consolidate minor injuries services into a single, clinically robust and financially sustainable model. This proposal recommends the relocation of the existing Urgent Care Nurse Practitioner Service (UCNPS) at Mount Vernon Hospital (MVH) to the Urgent Treatment Centre (UTC) at Hillingdon Hospital (HH). Our aim is simple: by strengthening and focusing our expertise, we can provide a more robust 24/7 urgent care service to the 310,000 people living in our borough.

The relocation of the UCNPS to the UTC at Hillingdon Hospital is a necessary and strategic step to improve urgent care provision.

2. Recommendation

The Board is asked to:

- Approve the closure of the Mount Vernon UCNPS
- Support the transition of staff to the Hillingdon UTC
- Endorse implementation of a single-site urgent care model that is clinically sustainable, financially viable, and aligned with Trust and system-wide priorities

3. Executive Summary: Strategic Rationale

Hillingdon Hospital faces significant constraints. We are responding to financial pressures, growing patient demand, and widening health inequalities, and we now must make carefully considered and equitable decisions about how we deliver care. Reconfiguring and fully optimising our services is no longer optional — it is essential to sustain safe, high-quality, and equitable healthcare for our local community.

Rising costs for staffing, infrastructure, and clinical supplies have outpaced available resources. Continuing to operate services in their current form is financially unsustainable. Hillingdon UTC serves a diverse population, including communities with higher levels of deprivation and poorer health outcomes than other similar areas in London. By centralising our clinical expertise and resources we will ensure the urgent care service we provide is more sustainable and equitable for the future.

The Trust currently operates two minor injuries services with significantly different scope, resilience, and reach:

- **Mount Vernon UCNPS**: A stable but limited service that does not meet the national specification for Urgent Treatment Centres (NHSE, October 2023). Activity trends and demographic analysis indicate suboptimal allocation of clinical resources (appendix 3&4).
- **Hillingdon UTC**: A broader, 24/7 walk-in service providing access to diagnostics and integrated emergency care — but hampered by chronic staffing challenges and over-reliance on agency cover.

This dual-site arrangement is inequitable and operationally inefficient.

Consolidating services at Hillingdon UTC would:

- Improve access for underserved populations
- Deploy a more stable, substantive workforce
- Deliver recurrent cost savings of £1 million per annum
- Eliminate unnecessary duplication
- Align services with NHSE urgent care standards and Core20PLUS5 equity objectives
- Support NHS 10-Year Plan priorities: shifting care closer to communities, reducing health inequalities, and strengthening prevention-focused urgent care

MVH will continue to provide cancer, outpatient, surgical and elective services. This proposal concerns only the reconfiguration of one urgent care pathway.

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4. Case for Change

a. Background and context

The Trust currently operates two minor injuries services with significantly different scope, resilience, and reach:

- **Mount Vernon UCNPS**: Appointment-based (8am – 8pm), excludes children under two, limited diagnostics, and predominantly serving lower-need populations. Mainly accepts minor injuries and limited minor illness. Has contact with approximately 40 to 50 patients per day. This is a more limited, appointment-only service, operating 8am–8pm, excluding children under two and offering only partial diagnostic access (e.g., X-ray until 5pm). Staffed by Emergency Nurse Practitioners (ENPs).
- **Hillingdon UTC**: A broader, 24/7 walk-in service providing access to diagnostics and integrated emergency care. Accepts all minor injury and illnesses. The service sees between 170 and 200 patients per day, with a midpoint estimate of 185. It operates 24/7, accepts walk-in patients, and provides full diagnostics and paediatric care. Staffed by GPs and ENPs (appendix 1,2 & 5).

b. Clinical Safety and Quality

- Hillingdon UTC delivers a broader clinical offer, co-located with an Emergency Department but with significant workforce fragility. Our aim is to strengthen this pinnacle service, ensuring our most vulnerable patients have the right expertise at the right time, in the right setting is potentially life-saving.
- A fifth of patients that come to UCNPS have to be diverted somewhere else, either because they should see their GP or because they need more complex support than MVH can offer. At HH, if patients present with more complex requirements or needs more sophisticated diagnostics, then the UTC is co-located with the main Emergency Department and emergency acute care provision.
- 45% of attendances in UCNPS could have been cared for in a primary care settings. Of these, 15% were dressing changes or minor illnesses better suited to redirection to GPs or pharmacies. The remaining 30% of patients required no treatment at all following assessment.

c. Equity and Access

It is vital that equity and access are at the heart of this decision, particularly for communities who may be disproportionately affected. The consolidation presents an opportunity to improve equity of clinical care by ensuring all patients - particularly the most vulnerable - can access a wider range of diagnostics and medical expertise in a single well-equipped setting.

Estimated travel times to drive to Hillingdon UTC from key wards such as Ruislip, Uxbridge, Ruislip Manor, West Drayton and Hayes Town range between 5 to 15 minutes.

Resource consolidation aligns with Core20PLUS5 and local Health Inequality Reduction strategies.

d. Workforce Resilience

- MVH benefits from a substantive, low-turnover Emergency Nurse Practitioner workforce.
- HH UTC is currently reliant on premium cost temporary staff (bank and agency).

e. Financial Efficiency (see appendix 6)

- The MVH service is a nurse practitioner led model, which sees c 14,000 attendances a year, at an average unit cost of £116 (2024/25 national cost collection average unit cost). The direct nursing workforce costs are £0.9 million annually.
- The Hillingdon Hospital urgent treatment centre sees c67,000 attendances per year at an average unit cost of £117 (2024/25 national cost collection average unit cost). The service at HH sees a higher acuity of patients than the service at MVH. The HH UTC service has a number of vacancies and therefore is currently reliant on premium cost temporary staff. HH bank & agency costs were £1.0 million in 2024/25.
- The net saving of consolidating services would be £1.0m recurrent benefit due to the consolidation of staffing at the Hillingdon site.

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5. Current Service Comparison

a. Hospital and Primary Care UTC Services in Hillingdon

Feature	**Hillingdon Hospital UTC**	**Mount Vernon UCNPS**	**Primary Care Same-Day Hubs (e.g. Pembroke, Uxbridge Civic Centre)**
Access	Walk-in, 24/7	Appointment only, 8am–8pm	Appointment only, extended hours
Staff	GPs + ENPs (agency reliant)	ENPs (permanent)	GPs, Advanced Nurse Practitioners, nurses
Diagnostics	Full (X-ray, labs)	Limited (X-ray until 5pm)	Minimal (e.g., phlebotomy only)
Children under 2	Yes	No	Varies by site
Local population	Higher deprivation	More affluent	Borough-wide catchment via referral
Patients seen daily	170–200	~50	Varies, often 20–50 per hub
Booking	Walk-in + NHS 111	Phone triage or referral	GP or NHS 111 referral only
CQC rating	Requires Improvement	Good	Not registered as UTCs individually

This comparison underscores the unique strategic importance of Hillingdon UTC as the only full-spectrum walk-in urgent treatment facility in the borough.

6. Options Appraisal

Option 1: Status Quo

- Maintains inequality in service access
- Sustains operational inefficiencies and staffing risk

Option 2: Reinvestment in Mount Vernon

- Requires capital investment in estate, radiology, and workforce development
- Duplicates provision without addressing HH fragility
- No additional funding available to expand capacity

Option 3: Consolidate at Hillingdon (Recommended)

- Improves access and equity
- Enhances workforce stability and skill mix
- Eliminates duplication and reduces agency dependence
- Releases £1m of recurrent savings
- The preferred option is to consolidate services at the Hillingdon Hospital site.

---

7. Anticipated Impact of Option 3

a. Patients

- Hillingdon UTC will absorb redirected activity with improved service resilience
- Alternative pathways via GP, pharmacy, or NHS 111 remain available
- Consolidation provides the opportunity to deploy a permanent, multi-skilled team at Hillingdon, ensuring consistent quality and resilience.

b. Workforce

- Merging services allows redeployment of experienced staff to under-resourced areas. HH UTC has sufficient vacancies to enable this transition without risk of either redundancy or over-establishment and would reduce the reliance on bank and agency staff. There are 9.4 WTEs of Emergency Nurse Practitioners working at the MVH MIU who would be redeployed into vacant posts at the HH UTC under this proposal. This would be subject to an HR-led staff consultation.
- All MVH staff offered roles into vacancies at HH UTC

- Full HR consultation in line with organisational change policies
- Supports standardisation of workforce terms and conditions

c. Financial and Contractual Considerations

- Consolidation of services and transferring the patients to Hillingdon will save £1m per year and allow us to replace agency staff with substantive nursing professionals from MVH, improving the quality of care for all patients.
- There would be a part year effect of the savings in 2025/26 due to timing and also some non-recurrent costs of transition.

Any change in provision of urgent care at Mount Vernon will be accommodated for at the Hillingdon Hospital site. Therefore, there is no change in income or overall activity for the Trust as a whole. Activity will be reviewed with NWL ICB as part of the quarterly true-up process.

d. Equity and Strategic Alignment

- Delivers against Core20PLUS5 ambitions
- Supports borough-wide UEC redesign and Trust redevelopment goals
- Delivers urgent care that meets NHS standards

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8. Engagement and Communications

Our approach to engagement was to gather views, feedback, and insight from a range of stakeholders to help inform the future model of care and ensure it meets the needs of the local population. We are very grateful to everyone for their time, contributions and input to this process.

The Trust conducted targeted engagement with:

- Community groups and residents
- Healthwatch Hillingdon
- Staff and clinical teams
- Council of Governors
- Elected members including parliamentary and councillor representatives
- NHS Leadership, NHSE region, ICB leadership
- Primary care leadership including GP Federations
- Hillingdon London Borough Council

Messages have been consistent:

- MVH Hospital is not closing
- The proposal is clinically led, evidence-based and equity-driven
- Transparency and co-design remain central to implementation

In undertaking this engagement, we worked closely with key stakeholders and residents who shared a number of views in support and against the proposal which are detailed in (appendix 7). We ensured the proposals met the Department of Health and Social Care 5 key tests for service change. These tests are designed to ensure that service changes are safe, sustainable, and in line with quality and outcomes.

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9. Risk Summary and Mitigations

A full risk assessment has been completed. An Equality and Health Inequalities Impact Assessment (EQIA) has also been undertaken to ensure that the proposed service changes do not disproportionately affect any specific population group. The EQIA has informed both the engagement approach, and the mitigation strategies outlined below. A full risk assessment has been completed. Key mitigations include:

- Public communications: Clarity that only one service is affected; reassurance on continued access.
- Staff engagement: HR-led consultation and structured redeployment plan.
- Access continuity: Alternative services (GP, pharmacy, NHS 111) remain in place and signposted.

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10. Conclusion

This proposal represents a clinically justified, financially prudent and strategically aligned change in minor injury provision. It enhances:

- Equity of access for underserved communities
- Clinical resilience and staff wellbeing
- Financial sustainability

It delivers on the Trust's obligations to deliver safe, equitable, and high-quality urgent care.

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11. Board Action Requested

The THHFT Board is asked to:

- **Approve the proposal to consolidate and strengthen the Mount Vernon UCNPS**
- **Endorse implementation plans and ongoing public/stakeholder communications**
- **Support consolidation of all urgent care services at Hillingdon UTC**
- **Support commencement of a staff consultation to enable redeployment**

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12. Next Steps if Approved

If the THHFT Board approves the proposal, the Trust will proceed with the following implementation actions:

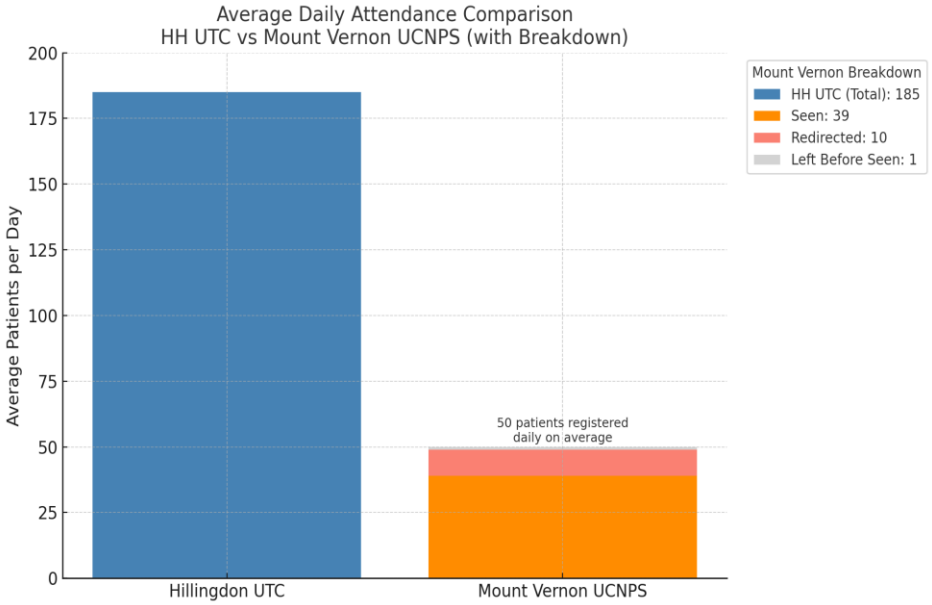
- Initiate formal staff consultation processes in line with HR policies and frameworks
- Develop and mobilise a detailed transition plan for service reconfiguration and workforce relocation
- Finalise and action internal and external communications, including updates to patients, public, and stakeholders
- Update service directories and pathways to reflect the change in provision (e.g. NHS 111, Directory of Services)
- Monitor and evaluate implementation impacts, reporting through appropriate governance structures
- Ensure ongoing visibility and responsiveness to patient experience and equity impacts during and after transition

Appendices

Appendix 1

This bar chart illustrates the comparative average daily attendance at the two minor injuries services within The Hillingdon Hospitals NHS Foundation Trust:

- **Hillingdon Hospital Urgent Treatment Centre (UTC)**: Sees between **170 and 200 patients per day**, with a midpoint estimate of **185**. It operates 24/7, accepts walk-in patients, and provides full diagnostics and paediatric care.
- **Mount Vernon Urgent Care Nurse Practitioner Service (UCNPS)**: Has **contact** with approximately **40 to 50 patients per day.** This is a more limited, appointment-only service, operating 8am–8pm, excluding children under two and offering only partial diagnostic access (e.g., X-ray until 5pm).



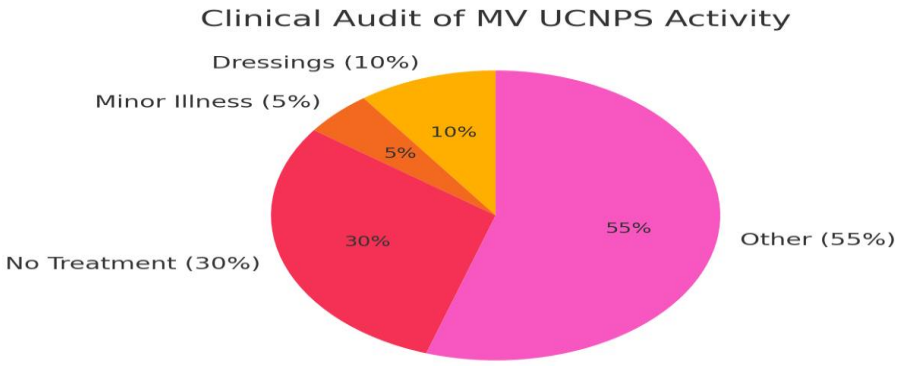
Appendix 2

Clinical Audit of MV UCNPS Activity

A recent clinical audit of patient presentations at Mount Vernon UCNPS found that:

- **10%** of attendances were for **dressing changes**, which are typically more appropriate for primary care settings.
- **5%** were minor illnesses better suited to redirection to **GPs or pharmacies**.
- **30%** of patients required **no treatment at all** following assessment.
- The remaining **55%** included a range of injuries suitable for urgent care, though not always requiring the MV-specific model.

This highlights opportunities for improved patient redirection and more efficient use of clinical time and resources.

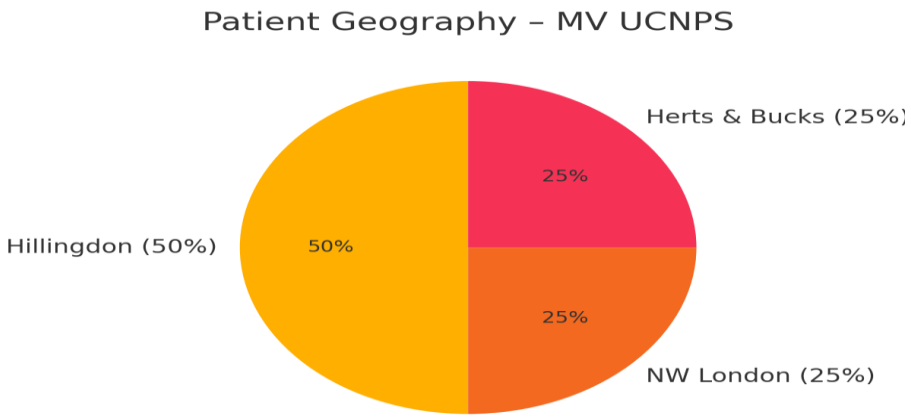


Appendix 3

Analysis of data shows that:

- 50% of patients using the Mount Vernon UCNPS live in the London Borough of Hillingdon.
- 25% are from the wider North West London area, reflecting cross-borough usage.
- The remaining 25% are from Hertfordshire and Buckinghamshire, likely due to geographic proximity.

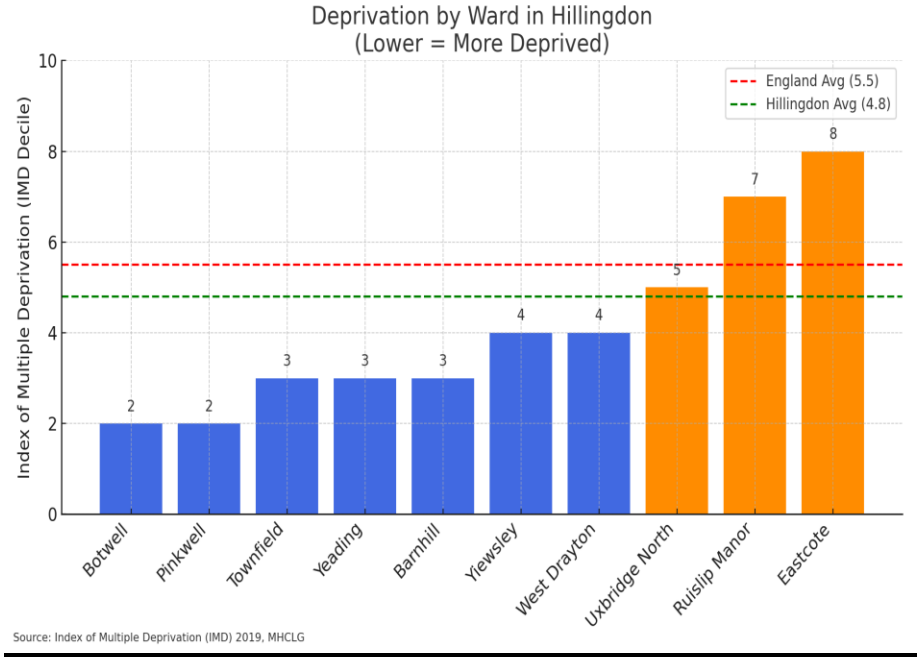
This broad, mixed catchment contrasts with the more deprived and higher-acuity population typically seen at Hillingdon Hospital UTC. It reinforces the case for focusing urgent treatment capacity where clinical need is greatest.



This chart shows the relative deprivation across selected wards in Hillingdon, based on the Index of Multiple Deprivation (IMD), where 1 = most deprived and 10 = least deprived.

- Highest deprivation is found in Botwell, Pinkwell, Townfield, Yeading, and Barnhill – all in the south of the borough and closer to Hillingdon Hospital.
- More affluent areas such as Eastcote and Ruislip Manor—located near Mount Vernon Hospital—score higher (less deprived).

This geographic disparity reinforces the strategic rationale for consolidating urgent care provision at Hillingdon Hospital, where both demand and clinical need are demonstrably higher.

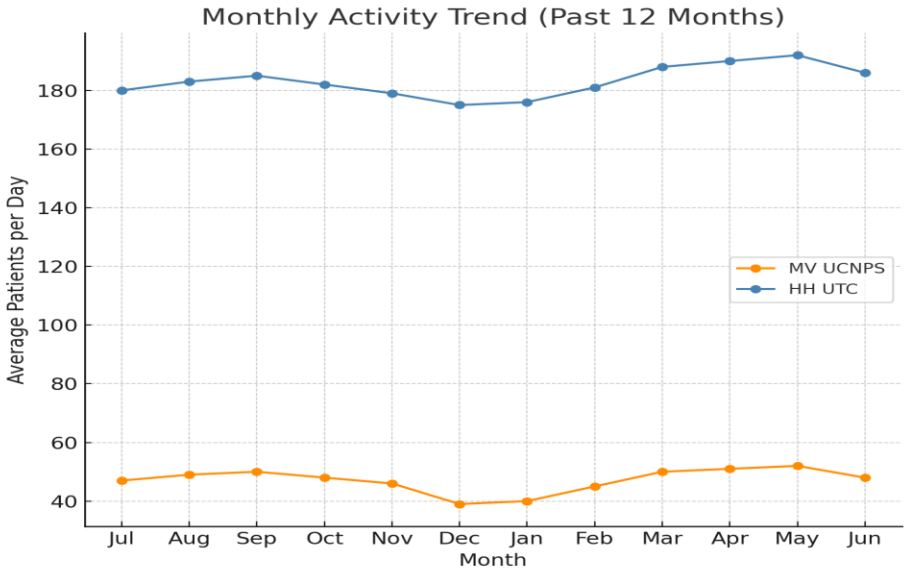


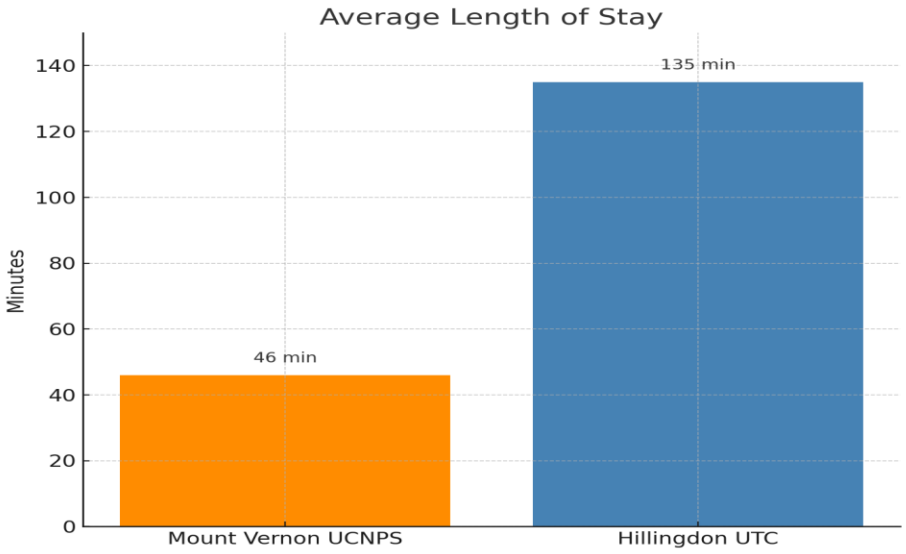
Appendix 4

Appendix 5

The first chart shows a stable pattern of daily activity across both sites. Mount Vernon UCNPS sees a consistent 45–50 patient contacts/day, with a seasonal dip in December–January. Hillingdon UTC consistently manages 175–190 patients/day, reflecting its broader clinical remit and walk-in model.

This stability demonstrates that the proposal is not driven by a sudden drop in demand, but by a strategic opportunity to streamline and improve care delivery.





Average Length of Stay

The second chart illustrates the significant difference in average patient journey time:

- Mount Vernon UCNPS: 46 minutes
- Hillingdon UTC: 135 minutes (2 hours 15 minutes)

This reflects:

- Greater complexity of cases at Hillingdon
- Broader scope of diagnostics and walk-in presentations
- A more pressured and high-demand clinical setting

These insights support the proposal to consolidate urgent care capacity at the site where clinical need is higher and resource reinforcement is most critical.

Appendix 6

This appendix outlines the financial analysis of the 3 options considered in this paper.

Option 1 – Status Quo

Based on 2024/25 expenditure, the direct nursing & non-pay costs are £1.0m for the MVH MIU service and £2.2m for the HH UTC service (excluding medical staffing costs), a total of £3.1m of direct nursing & non-pay costs across the 2 services.

Option 1: Status Quo

Description (24/25 Direct Costs)	MVH MIU (£000)	HH UTC (£000)	Total Direct Costs
Nursing staff costs	£903	£607	**£1,510**
Nursing agency & bank costs		£1,012	**£1,012**
Non-pay	£49	£548	**£597**
Total Cost	**£952**	**£2,167**	**£3,119**

Notes:

1. Excludes Medical & A&C staff

Option 2 – Reinvestment in MVH

This option includes the additional nursing staffing to open the MIU at Mount Vernon 24/7, but with no additional funding. The costs therefore increase by £0.9m compared to option 1 – status quo. This would also require significant capital investment to reinstate waiting room facilities lost during the pandemic; substantial changes to ENP training to enable minor illness and paediatric cover; a fundamental shift in primary care provision; and considerable effort and cost to recruit radiology staff. Importantly, this option would not improve the Hillingdon UTC service.

Option 2 - Reinvestment in MVH

Description (24/25 Direct Costs)	MVH MIU (£000)	HH UTC (£000)	Total Direct Costs
Nursing staff costs	£1,806	£607	**£2,413**
Nursing agency & bank costs		£1,012	**£1,012**
Non-pay	£49	£548	**£597**
Total Cost	**£1,855**	**£2,167**	**£4,022**
Movement From Option 1: Status Quo	**-£903**	**£0**	**-£903**

Notes:

1. Excludes Medical & A&C staff
2. Assumes no additional income

Option 3 – Consolidate at Hillingdon Hospital

In this option, the MIU staff are assumed to be redeployed to the HH UTC. Costs to run the HH UTC are expected to increase marginally (£60k) due to the increase in non-pay for the patients transferring to the service, but there is an overall saving of £1.0m due to the consolidation of the service and removal of premium bank and agency costs.

Option 3 - Consolidate at HH

Description (24/25 Direct Costs)	MVH MIU (£000)	HH UTC (£000)	Total Direct Costs
Nursing staff costs	£0	£1,510	**£1,510**
Nursing agency & bank costs		£0	**£0**
Non-pay	£0	£597	**£597**
Total Cost	**£0**	**£2,107**	**£2,107**
Movement From Option 1: Status Quo	**£952**	**£60**	**£1,012**

Notes:

1. Excludes Medical & A&C staff
2. Assumes no additional income
3. Figures are full year effect

Appendix 7

This appendix summaries stakeholder engagement and public/media interest in relation to the proposed changes to minor injuries provision at Mount Vernon Hospital and Hillingdon Hospital UTC. It includes positive feedback, concerns raised, and Trust actions in response.

Date	Stakeholder / Channel	Positive Feedback	Concerns / Queries	Actions / Response
Apr 2025 - June 2025	David Simmonds MP & Campaign		Concern about possible closure of MV UCNPS and impact on local access. Petition with over 12k signatories shows local support against the closure. The petition (c. 12,000 signatures) represents approximately 5% of the borough's estimated voting-age population (~240,000). While not a majority, it indicates significant local interest, particularly in affected areas.	Trust confirmed no plans to close hospital; ongoing engagement with MP.
May 2025	Council of Governors		Raised queries on whether it means MIU closing, what is the local offering for primary care concern	Agreed that there was a need for primary care offer to be clearly signposted and will bring to the attention to primary care providers.
May–Jun 2025	Community Groups Resident Associations	High levels of community engagement; shared interest in urgent care access.	Queries over perceived closure; confusion about MVH's future. More clarity needed on the Hillingdon primary care hubs	We have been engaging with local residents and Healthwatch Hillingdon on the proposal and are supporting more proactive signposting on the services available in the primary care hubs
Jun 2025	GP Federations, Hillingdon Health Partners Healthwatch Hillingdon	Supportive of consolidation and case for equity-driven service redesign.	Questions around diagnostics, transport and signposting for minor injuries.	Included letters of support for the proposal
Jun 2025	Elected Representatives	Interest reflects high public engagement and political accountability.	Concerns around visibility of community urgent care pathways.	The Trust is working with Hillingdon Health and Care Partners and Hillingdon Healthwatch, ICB on a stepped up proactive signposting on the hubs services- there is more work to be done to address the lack of awareness https://www.woodlanesurgery.nhs.uk/health-information/appointments/extended-access-hub/

For a number of years now, patients have increasingly reported to us long wait times to be seen in an overcrowded A&E department at the Hillingdon Hospital, drastically compromising patient safety and experience.

In the context of increased demand for urgent and emergency care, rising costs, workforce pressures, and the CQC reporting that Hillingdon's A&E department requires improvement, we must support quick and decisive action by the Hillingdon Hospitals NHS Trust to make the necessary improvements to ensure the sickest people, with the greatest need, receive high standards of care within the fastest amount of time.

We are assured by the Trust that the necessary Equalities Impact Assessments have been undertaken. However, whilst we accept the need for consolidating the Minor Injuries Unit at Mount Vernon to the Hillingdon site, we also acknowledge this change in service provision will be unpopular with residents in the north of the borough, and we have heard their concerns around the impact it may have on vulnerable residents.

Therefore, in mitigating any adverse impact of the proposed move, we strongly urge the Trust to work closely with their Health and Care Partners in Hillingdon to ensure residents requiring treatment for minor injuries and illnesses, in the north of the borough, are appropriately signposted to nearby alternative services, with clear communication about how and where those services can be accessed.

Healthwatch Hillingdon | 2 July 2025

Lynn Hill

Chair, Healthwatch Hillingdon

Hillingdon Health and Care Partners

On Behalf of Hillingdon Health and Care Partners

A decision to close the Minor Injuries Unit at Mount Vernon Hospital would align with the strategic shift in how Hillingdon Health and Care Partners plan to deliver urgent and emergency care across Hillingdon. Our local health and care system is evolving to deliver more **coordinated, neighbourhood-based care** that is **preventative, person-centred, and integrated across services** in line with the Governments recently published 10 Year Plan.

Rather than relying on fragmented, location-specific walk-in units, Hillingdon is implementing **three strategically located Neighbourhood Access Care Hubs (Super Hubs)**, one of which will be at the Pembroke Centre in Ruislip. These centres are designed to provide **same-day urgent care**, mobile diagnostics, and proactive support to patients closer to where they live—improving access, reducing duplication, and relieving unnecessary pressure on acute hospital settings.

Under the new model:

- Residents will benefit from **a 2-hour community crisis response** supported by integrated, multidisciplinary teams utilising mobile diagnostics
- Access to community based urgent care will be **more consistent**, with extended service hours, rapid assessment pathways, and seamless coordination with GPs, social care, and mental health services.
- The system aims to work together to **reduce pressure on the emergency department and the** Urgent Treatment Centre.

Maintaining a standalone Minor Injuries Unit at Mount Vernon would **duplicate services**, stretch limited clinical resources, and undermine efforts to consolidate care around fully integrated hubs that deliver **better outcomes and greater value for public investment**.

Furthermore, the transformation is in direct response to national policy imperatives from the **NHS Long Term Plan**, the **ICB Blueprint**, and the **London Neighbourhood Target Operating Model**, all of which call for the rationalisation of legacy services in favour of streamlined, integrated delivery at place and neighbourhood level.

Ultimately, the closure of the Minor Injuries Unit is not a loss of access but a **redesign of access**—part of a broader commitment to **safer, faster, and more equitable urgent care for all Hillingdon residents**.

Keith Spencer

Managing Director, Hillingdon Health and Care Partners

4. INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

Discussion Item Pippa Nightingale / Lesley Watts

Paper

REFERENCES

Only PDFs are attached

04.0 APC Integrated Performance Report - Cover Sheet.pdf

04.0a APC BIC Performance Report.pdf

NWL Acute Provider Collaborative Board in Common (Public)
15/07/2025
Item number: 4.0
This report is: Public

Integrated Performance Report

Author: Mathew Towers
Job title: Deputy CIO – Business Intelligence and Application Management

Accountable director: Prof. Tim Orchard
Job title: CEO, ICHT

Purpose of report (for decision, discussion or noting)

Purpose: Decision or approval

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. This report has been streamlined and re-structured. Targets for existing indicators have been updated where required.

In parallel, work is underway to streamline the production of this report and to create an online version for Board members and others leading on performance to be able to track operational and quality outcomes in a timelier fashion.

Report history

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

APC Executive Management Board 09/06/2025 Noted with minor amendments for accuracy requested	

Executive summary and key messages

The scope of Key Performance Indicators (KPIs) for reporting to the Board in Common (BiC) was finalised at BIC Cabinet on 11 June 2025. Work is ongoing to add further indicators requested as definitions and data collection arrangements are been finalised.

Impact assessment

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

Strategic priorities

Tick all that apply

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

Main Report

Progress in confirming the scope of the Integrated Performance Report for 2025/26 is shown in the following sections which contain the proposed KPI and the expected goal, the rationale for inclusions, the status and further notes on the proposed metric.

Section 1a | Performance | Elective Care

Key Performance Indicator	Target	Rationale for inclusion in 25/26	Status
RTT 18 Week Performance	>=60%/65% within18 weeks	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Elective care	Added Jun-25: Includes Waits for First Appointments
RTT Long Waits Performance	<=1% of total waiting list over 52 weeks	NHS Operating Plan 2025/26; Supports ICB segmentation in NHS Performance Assessment Framework	Retained
Inequity in Longest Waits for Treatment	Parity	Supports equity agenda	Expected Aug-25: Working to develop data collection, and assess data quality.
Access to Diagnostics	<=5% of diagnostic waits over 6 weeks	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework	Retained
Access to Cancer Care (Faster Diagnosis)	>=80% within 28 days	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Cancer care	Retained

Referral to Cancer Treatment Pathways	>=85% within 62 days	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Cancer care	Retained

Section 1b | Performance | Emergency Care

Key Performance Indicator	Target	Rationale for inclusion in 25/26	Status
ED Waiting Performance	>=78% within 4 hours	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Urgent and emergency care	Retained
ED Long Waits Performance	<=2% within 12 hours "better than 24/25"	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Urgent and emergency care	Retained
Waits for Mental health consult/bed in ED	TBC % over 12 hours	Acute Trust segmentation in NHS Performance Assessment Framework: Patient inequality	Working to develop data collection, target and assess data quality
Sickle cell analgesia	TBC with 30 minutes	Supports equity agenda	Working to develop data collection, target and assess data quality
Emergency FFT	>=74% ED attendees reporting good experience	Board priority	Retained

Section 1c | Performance | Maternity and Neonatal Care

Key Performance Indicator	Target	Rationale for inclusion in 25/26	Status
Referrals to MNSI Programme	Zero tolerance	Reportable to Maternity and Newborn Safety Investigations Programme; Includes subjective reporting of referral type; NHSE contract	Working to develop data collection, target and assess data quality
Neonatal Death Rate	<0.94 per 1,000 births	NHS Operating Plan 2025/26; Supports ICB segmentation in NHS Performance Assessment Framework; NHSE contract	Retained
Still Birth Rate	<3.3 per 1,000 births	NHS Operating Plan 2025/26; Supports ICB segmentation in NHS Performance Assessment Framework; NHSE contract	Retained
Pre-term births Rate	<0.8 per 1,000 births	NHS Operating Plan 2025/26; Supports ICB segmentation in NHS Performance Assessment Framework; NHSE contract	Retained
Rate of suspected neonatal intrapartum brain injuries	<1.8 per 1,000 births	Reportable to Maternity and Newborn Safety Investigations Programme	Retained
Neonatal Death Rate	<0.94 per 1,000 births	NHS Operating Plan 2025/26; Supports ICB segmentation in NHS Performance Assessment Framework; NHSE contract	Retained
Bookings <10 weeks	TBC	Supports equity agenda	Working to develop data collection, target, and assess data quality
Maternity FFT	>=90% mothers reporting good experience	Board priority	Retained

Section 2a | Finance

Key Performance Indicator	Target	Rationale for inclusion in 25/26	Status
APC Financial Performance	Balanced Financial Plan	NHS Operating Plan 2025/26	Added July-25; DRAFT layout for approval
Temporary Staff Cost Performance	Trust value based on 30%/40% reduction in agency and 10%/15% reduction in bank spend	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Productivity.	Added July-25: DRAFT layout for approval. Includes Agency and Bank KPIs
Cost weighted activity measure			Under discussion to confirm scope for inclusion
Productivity Opportunity Performance	Improve by 4%	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Productivity	Working to develop data collection and assess data quality
Workforce Productivity Growth	better than 19/20	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Productivity	Working to develop data collection and assess data quality

Section 2b | Productivity and Flow

Key Performance Indicator	Target	Rationale for inclusion in 25/26	Status
Ambulance Handover Waits	>=65% within 15 mins	NHS Operating Plan 2025/26	Retained
PIFU Performance	>=5% of all outpatient contacts	NHS Operating Plan 2025/26. "Optimise referral management"	Retained
Inequity in Outpatient DNA Rates	Parity	Supports equity agenda	Working to develop data collection, and assess data quality
Theatre Utilisation	>=85% of planned time	Supporting metrics related to measures that will be used to judge organisational financial delivery	Retained
Discharge Planning Performance		NHS Operating Plan 2025/26	Under discussion to confirm scope for inclusion. Discharge on CTR performance retained from 24/25 scope in the interim.
Long Length of Stay	“better than 24/25”	NHS Operating Plan 2025/26	Under discussion to confirm scope for inclusion
Readmission Rate	“better than 24/25”	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Outcomes	Working to develop data collection, target, and assess data quality

Section 3 | Collaborative Priorities | Workforce

Key Performance Indicator	Target	Rationale for inclusion in 25/26	Status
Sickness Absence Rate	≤4% of workforce	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework	Retained
Voluntary Turnover Rate	≤12% of workforce	Supporting metrics related to measures that will be used to judge organisational financial delivery	Retained
Vacancy Rate	≤10% of workforce	Board priority	Retained
Non-medical appraisals	≥95%	Board priority	Retained
Core skills compliance	≥90%	Board priority	Retained
Model Employer Goals	APC trajectory	Board priority	Development to move from snapshot to trend information in progress

Section 4 | Statutory and Safety Reports

Key Performance Indicator	Target	Rationale for inclusion in 25/26	Status
Rate of C. diff Infections	NC per 100,000 bed days	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Patient safety	Retained
Rate of E. Coli Infections	NC per 100,000 bed days	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Patient safety	Retained
Rate of MRSA Infections	Zero tolerance	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Patient safety	Retained
Pressure Ulcers	Not set	Board priority	Retained
Inpatient falls	Not set	Board priority	Retained
VTE Assessments	>=95% of admissions	Board priority	Retained
SHMI	<100	NHS Operating Plan 2025/26; Acute Trust segmentation in NHS Performance Assessment Framework: Outcomes	Retained
Inpatient FFT	>=94% patients reporting good experience	Board priority	Retained

NHS
North West London
Acute Provider Collaborative

Integrated Performance Report

April/May 2025 data

received by Board in Common July 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%	57.6%	▲	!
	Referral to treatment waits > 52 weeks	</=1%	2.1%	▲	!
	Access to diagnostics > 6 Weeks	</=5%	24.2%	○	!
	Access to Cancer Care (Faster Diagnosis) < 28 days	≥75%	79.6%	○	✓
	Referral to Cancer Treatment Pathways < 62 days	≥85%	77.2%	▲	!
Section 1b: Performance - Emergency Care					
	Waits in urgent and emergency care < 4 hours	≥78%	76.9%	▲	!
	Waits in urgent and emergency care > 12 hours	</=2%	4.3%	▼	!
	Good experience reported for emergency depts.	≥74%	82.8%	○	✓
Section 1c: Performance - Maternity and Neonatal Care					
	Neonatal Crude Deaths (per 1,000 births)	<0.94	2.3	○	○
	Crude still birth rate (per 1,000 births)	<3.3	2.8	○	○
	Pre-Term births (per 1,000 births)	<8%	7.4%	○	○
	Rate of suspected neonatal intrapartum brain injuries	<1.8	2.3	▲	○
	Good experience reported for maternity services	≥90%	92.6%	○	○
Section 2a: Finance					
	Financial Performance	-£4.4M	-£11.7M	○	○
	Temporary Staffing Expenditure	£22.0M	£17.6M	○	○

Link to Slide	Section | KPI	Expected	Actual	Improvement Trend	Assurance
Section 2b: Productivity and Flow					
	Ambulance handover waits < 15 minutes	≥65%	44.4%	○	!
	Patient Initiated Follow Up	≥5%	4.2%	▲	!
	Theatre Utilisation (Hrs)	≥85%	90.0%	○	○
	Discharge Performance (no Criteria to Reside)	n/a	14%	○	○
Section 3: Workforce					
	Sickness Absence Rate	≤4%	4.2%	○	!
	Voluntary Turnover Rate	≤12%	7.7%	▲	✓
	Vacancy Rate	≤10%	6.4%	▲	✓
	Non-medical appraisals	≥95%	86.6%	▼	!
	Core skills compliance	≥90%	92.2%	○	✓
Section 4: Statutory and Safety Reports					
	Healthcare associated c. Diff Infections (per 100,000 bed days)	n/a	19.22	○	○
	Healthcare associated E. coli BSIs (per 100,000 bed days)	n/a	41.47	○	○
	Healthcare associated MRSA BSI (per 100,000 bed days)	0	1.01	○	○
	Pressure ulcers (per 1,000 bed days)		0.05	○	○
	Inpatient falls (per 1,000 bed days)		0.02	○	○
	VTE Risk Assessments Completed	≥95%	97.0%	○	✓
	SHMI (as expected or better)	<100	4 / 4	○	○
	Good experience reported by inpatients	≥94%	97.0%	○	✓

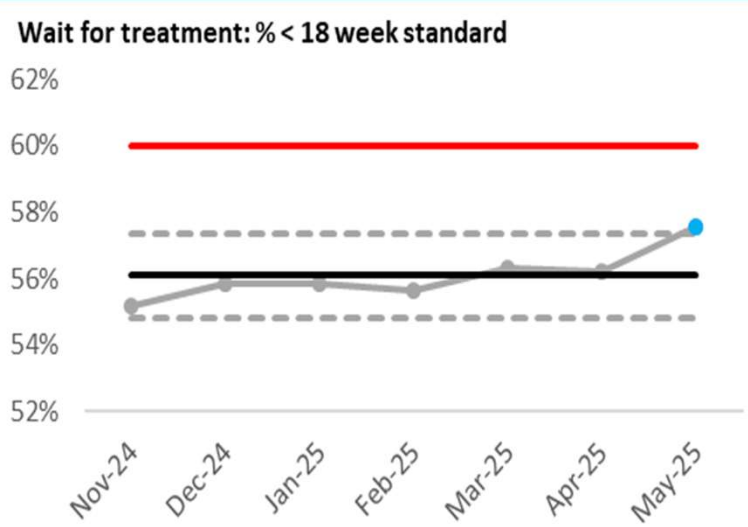
▲ ▼	**Statistically significant** improvement or deterioration in monitored trend
✓ !	**Statistically likely or very unlikely** to meets the desired level of performance

Section 1a: Performance
Elective Care

May 2025, except Cancer service metrics April 2025

Referral to Treatment Waits

TREND



60%

STANDARD

57.6%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: At the end of May, there were 268,904 patients waiting for treatment. 57.5% of these patients had been waiting for treatment within the 18-week constitutional standard. Trusts trajectories are geared towards achieving the Operating Plan target for 2025/26 by the end of March 2026. There has been a decrease in the PTL as Trusts continue with the NHSE Validation drive.

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.

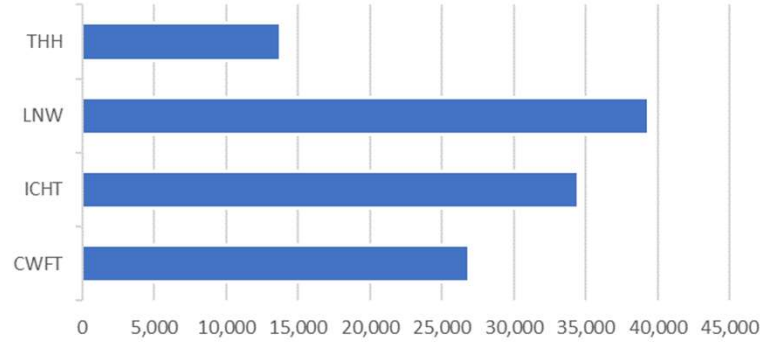
Forecast risks:. Risks to RTT reduction include overall capacity shortfalls, anesthetic staffing shortages, reduction in ERF, high volumes of trauma and priority 2 patients

CURRENT PERFORMANCE

Wait for Treatment: 18 Week Standard May-25

	Total Waiting List	RTT Waits < 18 weeks	Difference from target	RTT < 18 weeks	Wait for First Appointment	
					Total	% < 18 weeks
CWFT	66,800	59.8%	-0.2%	39,930	47,339	65.5%
ICHT	86,817	60.3%		52,362	58,303	68.8%
LNW	84,838	53.6%	-6.4%	45,502	54,255	55.1%
THH	30,449	54.8%	-5.2%	16,697	18,653	59.4%
APC	**268,904**	**57.5%**	-2.5%	**154,491**	**178,550**	**62.8%**

STRATIFICATION



Numbers of patients longer than the 18 Week standard

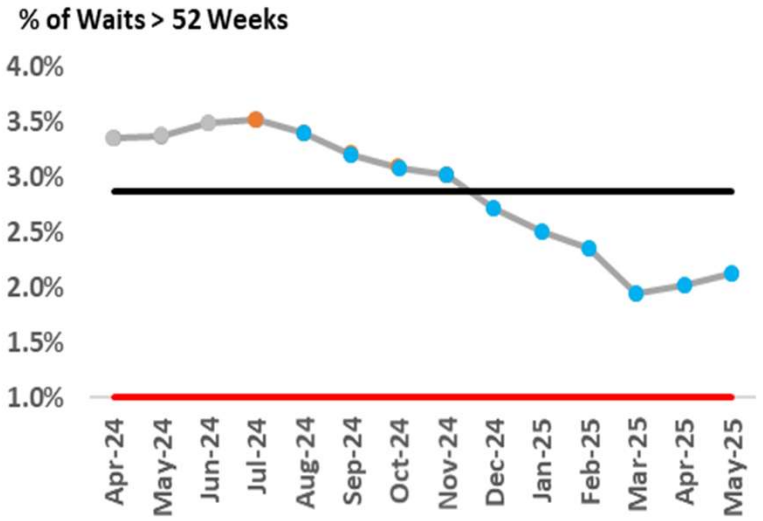
GOVERNANCE

Senior Responsible Owner: Laura Bewick, Hospital Director & Deputy Chief Operating Officer, CWFT
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Roger Chinn);
Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

4

Referral to Treatment Long Waits

TREND



1.0%

ALLOWANCE

2.1%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Long waits are being monitored at the patient level. All Trusts are committed to the operating plan targets. Reducing % of waits >52 weeks remains a special cause improvement, although there was a slight uptick in M2 2025/26. This likely reflects changes in ERF and reduced additional activity.

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.

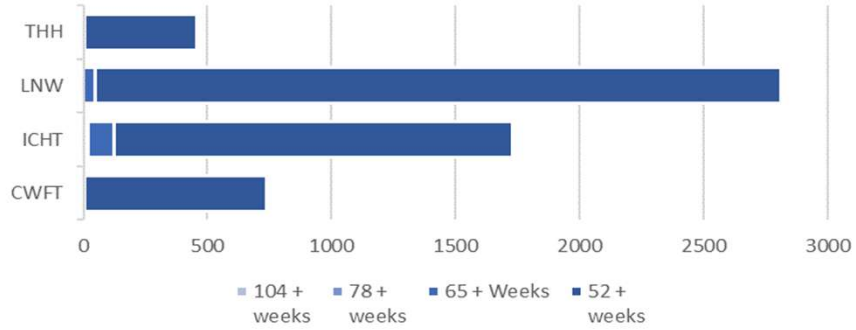
Forecast Risks: Risks to RTT reduction include overall capacity shortfalls, anaesthetic staffing shortages, reduction in ERF, high volumes of trauma and priority 2 patients.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 18-Week Standard May-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	66800	1.1%	-0.1%	738	6	0	0	0	65.5%
ICHT	86817	2.0%	-1.0%	1729	122	20	2	13	68.8%
LNW	84838	3.3%	-2.3%	2811	47	0	0	0	55.1%
THH	30449	1.5%	-0.5%	456	1	0	0	0	59.4%
APC	**268904**	**2.1%**	**-1.1%**	**5734**	**176**	**20**	**2**	**13**	**62.8%**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Laura Bewick, Hospital Director & Deputy Chief Operating Officer, CWFT

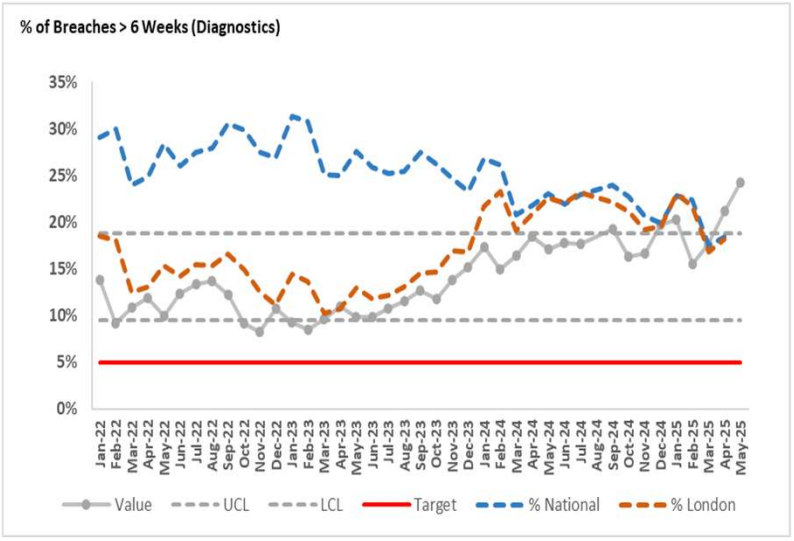
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Roger Chinn);

Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

5

Access to Diagnostics

TREND



5.0%

ALLOWANCE

24.2%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: Overall delivery remains below target with a deterioration noted in M2. Sector performance showing deteriorating trend, in contrast to the improving trend nationally (although in line with London).

Recovery Plan: Recovery plans in place at THH for endoscopy, ultrasound and audiology. Additional RMP funding also supporting cancer diagnostics across the sector.

Improvements: CDCs providing additional capacity wherever possible, along with some waiting list initiatives, particularly in cancer pathways. Productivity and efficiency being reviewed at all Trusts.

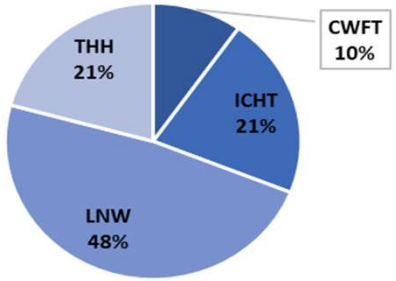
Forecast Risks: MRI capacity continues to be a risk across the sector. Other challenged modalities include Neurophysiology, Echocardiography and Ultrasound which face capacity challenges due to staffing shortages and ageing equipment.

CURRENT PERFORMANCE

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

	Total Waiting List	Waits > 6 weeks	Difference from target	6 + weeks	Of which 13 + weeks
CWFT	11721	14.2%	-9.2%	1666	209
ICHT	21141	17.1%	-12.1%	3621	749
LNW	25987	31.6%	-26.6%	8209	2551
THH	11519	30.7%	-25.7%	3541	314
APC	**70368**	**24.2%**	**-19.2%**	**17037**	**3823**

STRATIFICATION



rust share of APC
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GOVERNANCE

Senior Responsible Owner: Laura Bewick, Hospital Director & Deputy Chief Operating Officer, CWFT

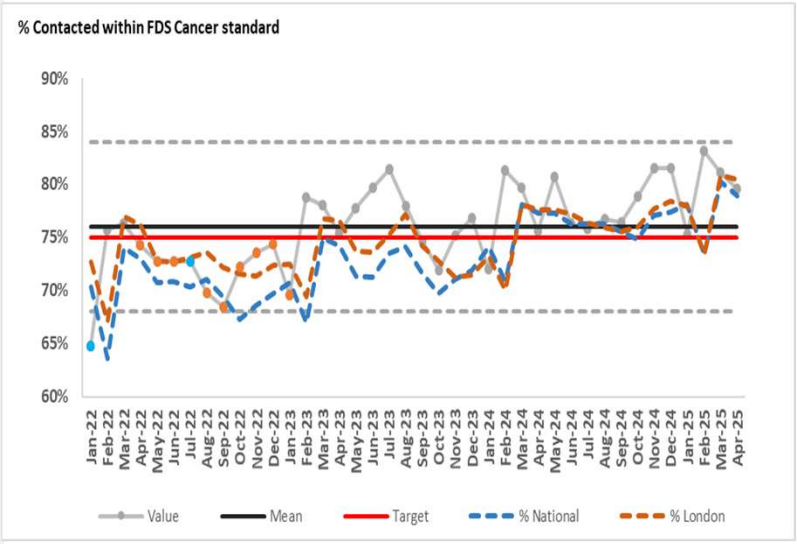
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Roger Chinn);

Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

6

Access to Cancer Care (Faster Diagnosis)

TREND



75%

STANDARD

79.6%

PERFORMANCE

TREND

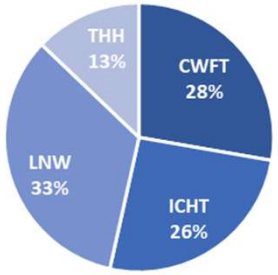
ASSURANCE

CURRENT PERFORMANCE

Access to Cancer Care (Faster Diagnosis) Apr-25

	Total Contacts	Faster Diagnosis performance	Difference from target	28 + days	Of which 62 + days
CWFT	2604	80.5%		507	74
ICHT	2830	81.1%		536	0
LNW	3196	79.8%		646	73
THH	1315	74.0%	-1.0%	342	27
APC	**9945**	**79.6%**		**2031**	**174**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: NWL overall exceeded the FDS standard again in Apr-25, with a whole provider position being posted of 79.6% against 75% target. All providers met the standard in-month with the exception of Hillingdon where drop in performance is predominantly driven by Lower GI and Urology compared to March.

Recovery Plan: Continued collaboration with all Trusts to enhance the delivery of cancer pathways in line with the standard. Each trust has provided RMP with their top improvement priorities for 25/26 and we are working to support trusts where possible. Summer resilience funding has also been provided to each trust to support with maintaining capacity and delivery of CWT standards over the summer period.

Improvements: Focus will be on ensuring continued compliance with the FDS standard at a sector level and working with working with Hillingdon to explore what further support is required to recover performance particularly for Lower GI.

Forecast Risks: Continued planning of capacity for pinch points in pathways to protect cancer delivery as much as possible. Reduced capacity throughout summer due to leave poses a potential risk. As above Summer resilience funds have been made available by RMP to mitigate and has been issued following a bidding process in June. NWL Pathology TAT's remain a risk to performance.

GOVERNANCE

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

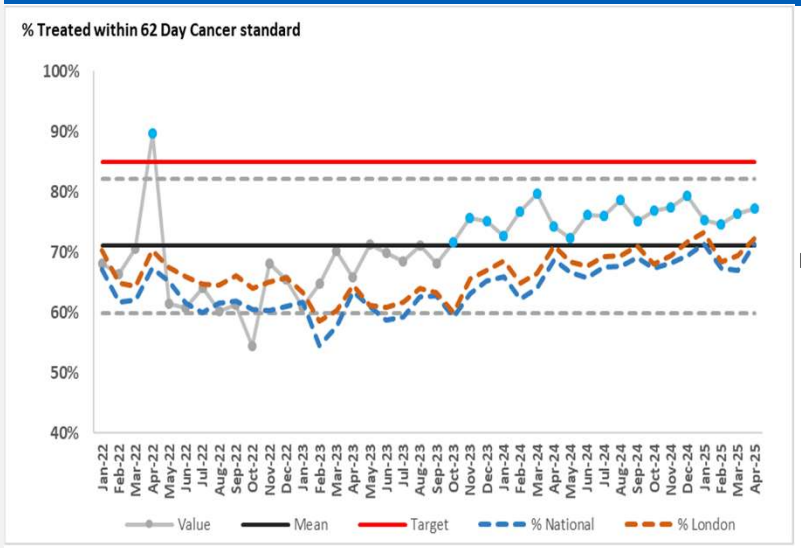
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Roger Chinn);

Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

7

Referral to Cancer Treatment Pathways

TREND



85%

STANDARD

77.2%

PERFORMANCE

H

TREND

F

ASSURANCE

NARRATIVE

Performance: Performance against the 62-day standard remains challenged against the 85% standard (70% 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 and 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 commenced to understand current bottlenecks for CWFT and THH. Work underway for Breast to understand variations in performance for screening vs urgent GP referrals and current challenges impacting chemotherapy pathways

Improvements: Performance continued to improve in Apr-25 compared and was our highest preforming month since December-24.

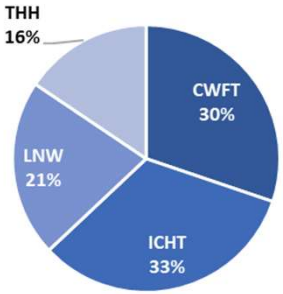
Forecast Risks: Lung diagnostics demand (particularly EBUS and navigational bronchoscopy) is likely to see additional challenges in this pathway. There are currently PET-CT tracer issues that won't be resolved until the end of May. NWL Pathology TAT's remain a risk.

CURRENT PERFORMANCE

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

	Total Treated	62 day performance	Difference from target	62 + days	Of which 104 + days	Impacts on Backlog 104 + days
CWFT	172.5	73.0%	-12.0%	46.5	17	0
ICHT	190	73.4%	-11.6%	50.5	0	48
LNW	217.5	84.8%	-0.2%	33	2.5	7
THH	95.5	74.9%	-10.1%	24	11	5
APC	**675.5**	**77.2%**	**-7.8%**	**154**	**30.5**	**60**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

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

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board:(Chair: Roger Chinn)

Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

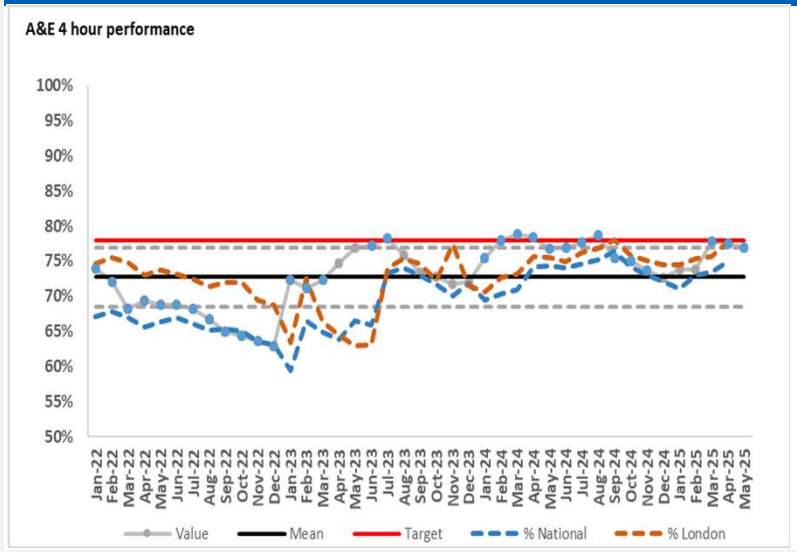
8

Section 1b: Performance Emergency Care

May 2025

Urgent & Emergency Department Waits

TREND



78%

STANDARD

76.9%

PERFORMANCE

H

TREND

F

ASSURANCE

NARRATIVE

Performance: In May, 76.9% of A&E patients were admitted, transferred, or discharged within four hours (from 77.7% in the previous month), maintaining special cause improvement. Efforts continue to improve performance and meet the national operating plan target for 2025/26 which is set at a minimum of 78% of patients seen within 4 hours by March 2026.

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.

Improvements: All Trusts introduced further actions in March 2025 to meet the four-hour performance standard which has led to some improvement. Improvement plans build on progress made during 2024/25 as well as national best practice guidance.

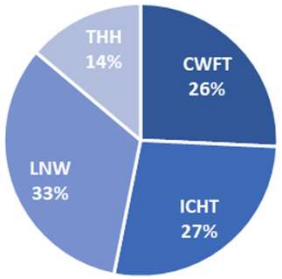
Forecast risks: Further increases in demand and continued delays with discharge for medically optimised patients.

CURRENT PERFORMANCE

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

	Total attendances (All Types)	4 hour Performance	Difference from target	4 hour + delays (All Types)	Of which (Number and Performance)				Impacted by
					Type 1 / 2 breaches		Type 3 breaches		Referrals to SDEC
CWFT	27313	79.47%		5608	5543	73.5%	65	99.0%	1675
ICHT	24340	75.5%	-2.5%	5968	5525	66.3%	443	94.4%	5201
LNW	29624	75.7%	-2.3%	7191	7049	49.8%	142	99.1%	2088
THH	13147	77.0%	-1.0%	3020	2946	52.1%	74	98.9%	2813
APC	**94424**	**76.9%**	-1.1%	**21787**	**21063**	**63.4%**	**724**	**98.0%**	**11777**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Ian Bateman, Chief Operating Officer, ICHT

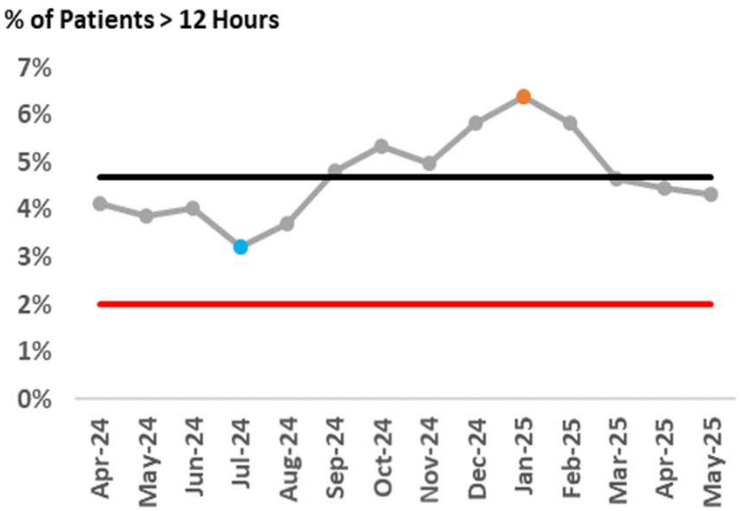
Committee: APC EMB (Chair: Tim Orchard); NWL UEC Board (Chair: Rob Hurd)

Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

10

Urgent & Emergency Department Long Waits

TREND



2.0%

ALLOWANCE

4.3%

PERFORMANCE

H

TREND

F

ASSURANCE

NARRATIVE

Performance: May 2025 saw a further improvement in performance for the proportion of patients waiting 12-hours or more following arrival to the Emergency Department. The sector continues to experience Mental health delays which impact overall 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. Improvements required to increase SDEC activity through the UEC pathway.

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.

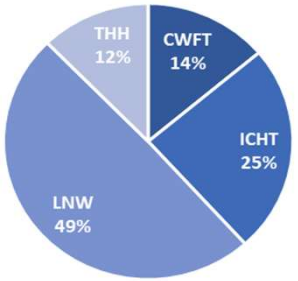
Forecast risks: Increases in demand, continued delays with discharge for medically optimised patients and continued delays for patients waiting for admission to mental health beds.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 12-Hour waits May-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	27313	2.1%	-0.1%	568	568	0	55
ICHT	24340	4.1%	-2.1%	1000	1000	0	366
LNW	29624	6.8%	-4.8%	2022	2022	0	403
THH	13147	3.8%	-1.8%	504	504	0	58
APC	**94424**	**4.3%**	**-2.3%**	**4094**	**4094**	**0**	**882**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Hospital Director & Deputy Chief Operating Officer, CWFT

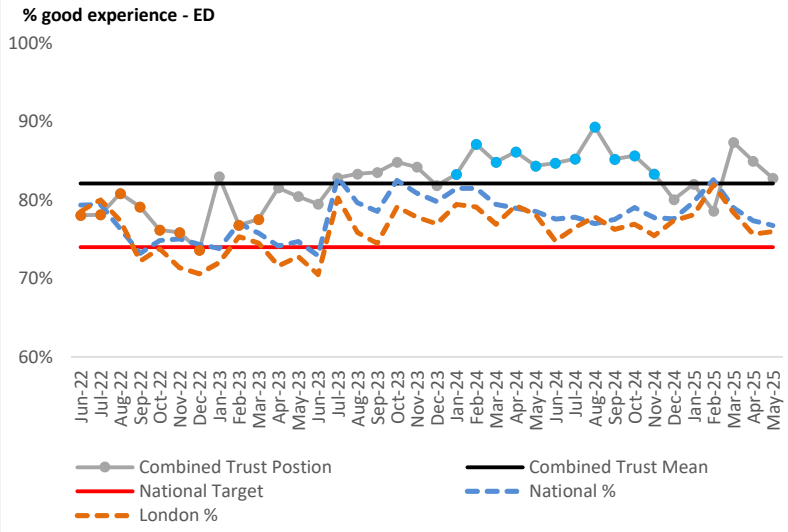
Committee: APC EMB (Chair: Tim Orchard); NWL UEC Board (Chair: Rob Hurd)

Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE (except 12hr+ waits from arrival)

11

Emergency Dept Friends & Family Test

TREND



74%

STANDARD

82.8%

PERFORMANCE

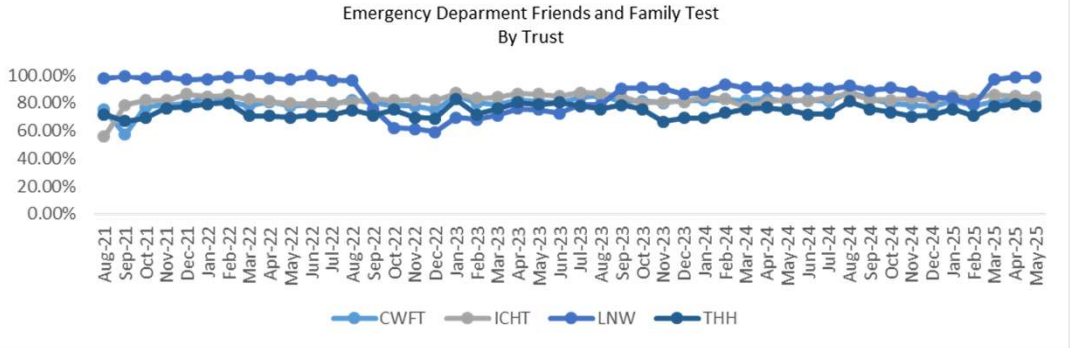
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	1,818	80.8%		1,469	81.3%
ICHT	1,313	84.0%		1,103	83.7%
LNW	399	98.7%		394	89.5%
THH	869	77.7%		675	74.8%
APC	**4,399**	**82.8%**		**3,641**	**84.4%**

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. The recent increase at LNW is due to changes to the method of FFT collection to paper-based while the Trust transitions to a new survey provider, which is impacting trends. The new system will be implemented by end of June 2025.

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.

GOVERNANCE

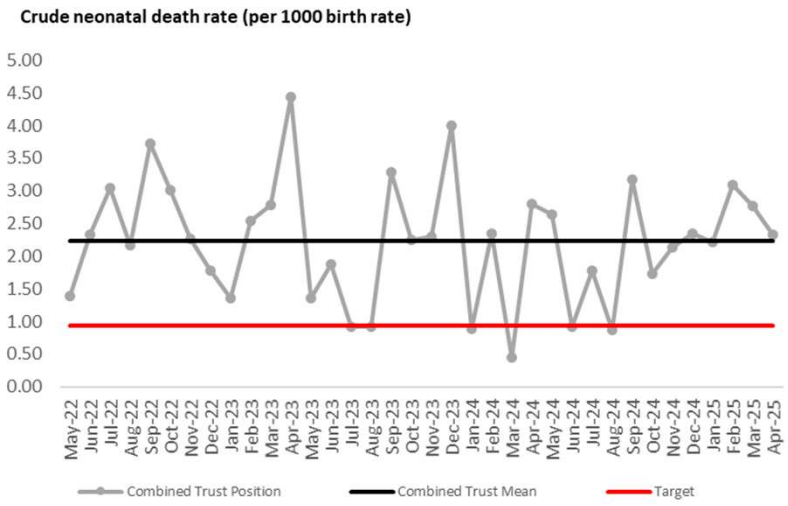
Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Section 1c: Performance
Maternity and Neonatal Care

April 2025, except Friends and Family May 2025

Neonatal Crude Deaths (per 1000 births)

TREND



0.94

STANDARD

2.3

PERFORMANCE

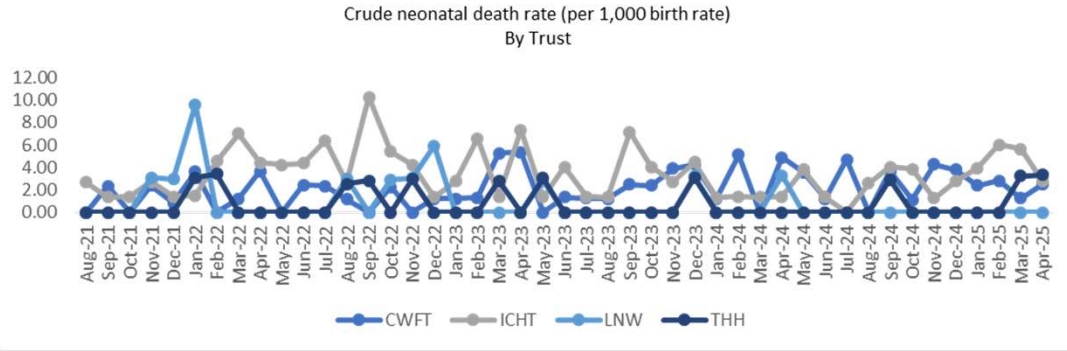
TREND

ASSURANCE

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	Neonatal Deaths FYTD	Crude neonatal death rate (per 1000 birth rate) FYTD
CWFT	2	2	0	807	2.5	1.5	2	2.5
ICHT	2	0	2	702	2.8	1.9	2	2.8
LNW	0	0	0	334	0.0		0	0.0
THH	1	0	1	300	3.3	2.4	1	3.3
APC	**5**	**2**	**3**	**2143**	**2.3**	**1.4**	**5**	**2.3**

STRATIFICATION



NARRATIVE

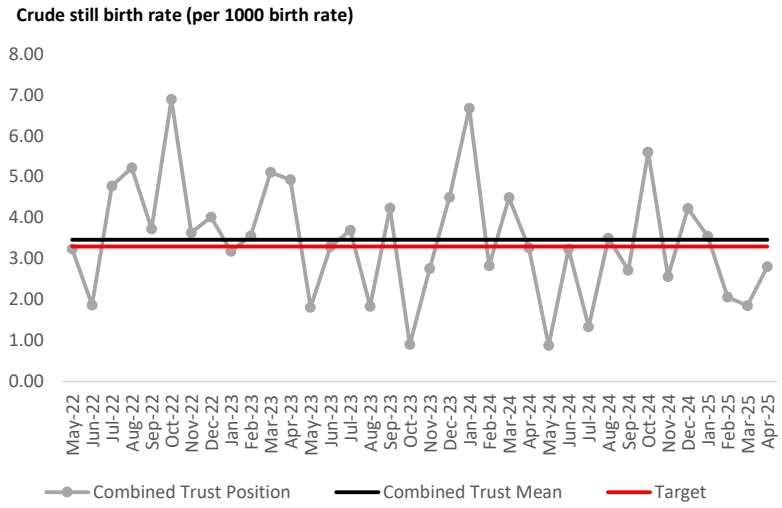
Performance: The crude neonatal death rate at APC level is above the standard in April. All cases are being appropriately investigated. The rate for 24/25 was 2.19, compared to 2.05 in 23/24. Review of the small recent increase at ICHT has identified an increase in the number of babies born at pre-term gestations with an antenatal diagnosis of congenital abnormalities.
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 thematic 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.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Crude still birth rate (per 1000 births)

TREND



3.3

STANDARD

2.8

PERFORMANCE

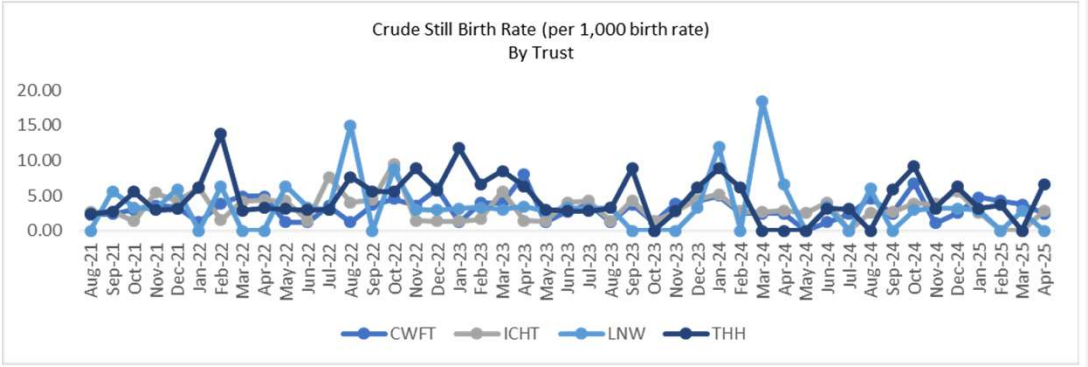
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total Births	Total Still Births & Late Fetal Losses	Total Still Births	Total Late Fetal Losses	Crude Still Birth Rate	Crude Still Birth Rate FYTD	Difference from Standard
CWFT	807	5	2	3	2.5	2.5	
ICHT	702	2	2	0	2.8	2.8	
LNW	334	0	0	0	0.0	0.0	
THH	300	2	2	0	6.7	6.7	3.37
APC	**2143**	**9**	**6**	**3**	**2.8**	**2.8**	

STRATIFICATION



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. Performance for 24/25 was 2.8, below the national standard and a reduction compared to 23/24 (3.52). We will include a rolling 12-month figure for this and all other metrics, rather than FYTD in the next report.

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.

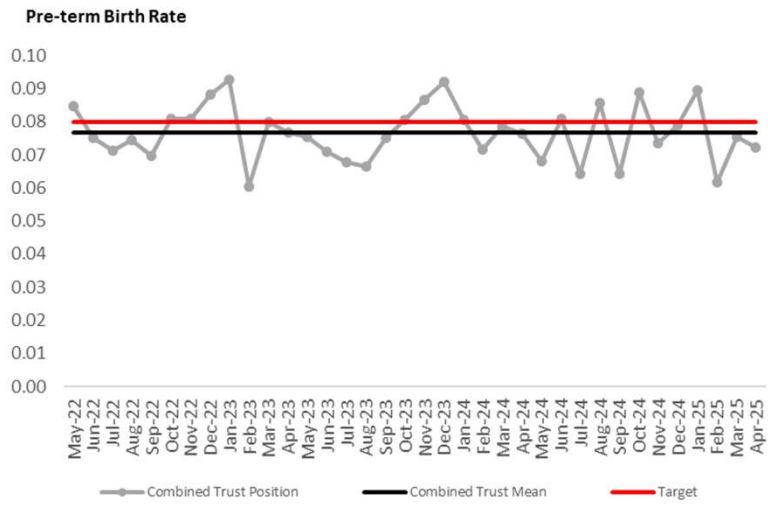
Improvements: Improvement work continues in response to key themes including review of the fetal medicine foundation tools for additional screening, review of translation tools, reviewing the dose of Aspirin to ensure consistency across providers (guidance has recently been updated), and implementing the maternal reducing inequalities care bundle. A thematic review of all stillbirths across the APC during 24/25 is planned to be completed by September to inform further improvements. All trusts are working towards full achievement of Saving Babies' Lives Care Bundle version 3 (ICB assessed position in March was 86% for CWFT and ICHT, 43% for THH, 93% for LNW). A working group across the LMNS is defining progress trajectories with each organisation.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Preterm Births (per 1000 births)

TREND



8

STANDARD

7.4

PERFORMANCE

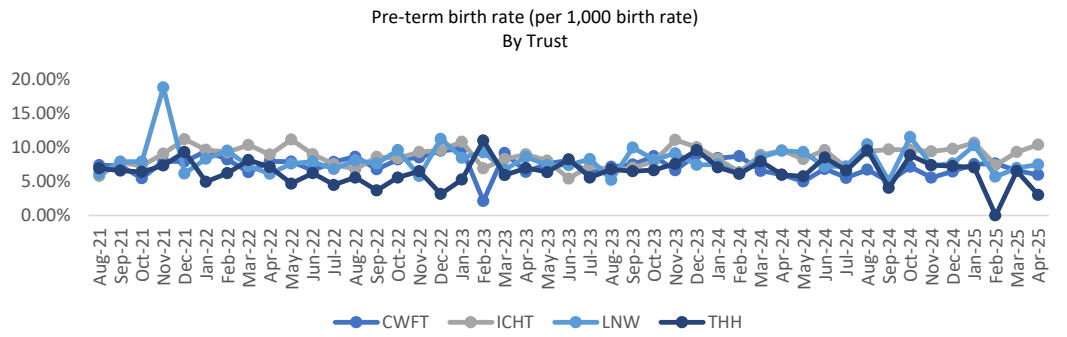
TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Pre-Term Births	Early Preterm births	Late Preterm births	Total Births	Pre-term Birth Rate	Difference from Threshold	Pre-Term Births FYTD	Pre-Term Births rate (per 1000 birth rate) FYTD
CWFT	51	5	46	807	6.3%		51	6.3%
ICHT	73	18	55	702	10.4%	2.40%	73	10.4%
LNW	25	5	20	334	7.5%		25	7.5%
THH	9	1	8	300	3.0%		9	3.0%
APC	**158**	**29**	**129**	**2143**	**7.4%**		**158**	**7.4%**

STRATIFICATION



NARRATIVE

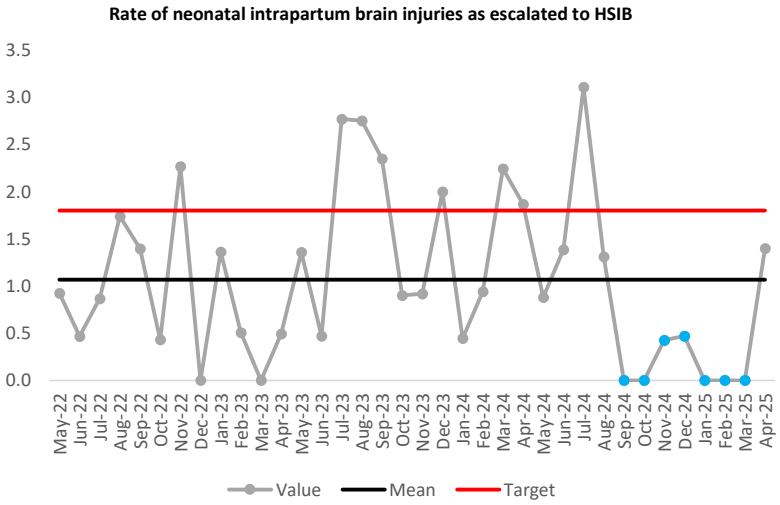
Performance: In month and during 24/25, the APC has a pre-term birth rate which is below the standard. ICHT have the highest rate of the four trusts and were above the standard in month. They are a net importer of all categories of pre-term In-Utero Transfers and Ex-utero Transfers due to their status as a medical level 3 NICU. There are no concerns to escalate.
Recovery Plan: Not applicable.
Improvements: CWFT and LNW have recently appointed dedicated pre-term birth leads and implemented preterm birth clinics. 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.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Suspected neonatal intrapartum brain injuries (per 1000 births)

TREND



1.8

STANDARD

1.40

PERFORMANCE

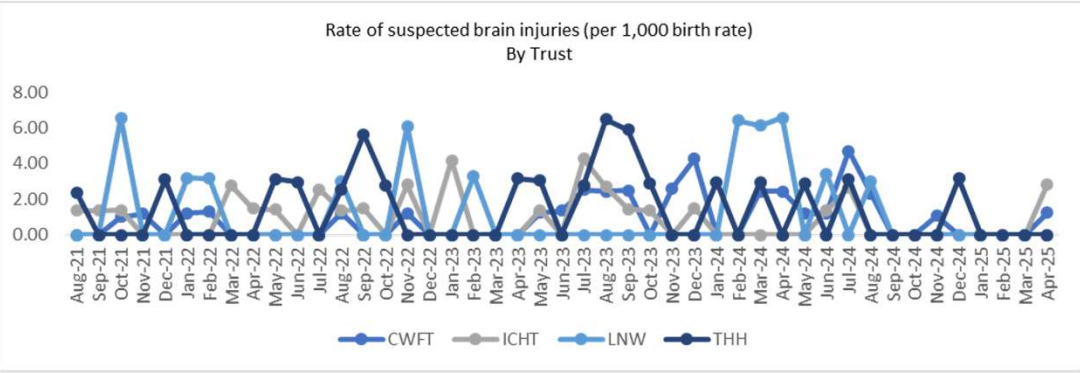
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total Births	Suspected Brain Injuries in Month	Rate of suspected brain injuries	Suspected Brain Injuries FYTD	Rate of Suspected Brain Injuries FYTD
CWFT	807	1	1.24	1	1.24
ICHT	702	2	2.85	2	2.85
LNW	334	0	0.00	0	0.00
THH	300	0	0.00	0	0.00
APC	**2143**	**3**	**1.40**	**3**	**1.40**

STRATIFICATION



NARRATIVE

Performance: We were below the standard in-month and across the last financial year, when there was a reduction of 16 cases compared to 23/24. Over half the cases reported in 24/25 occurred at CWFT (n=12) – of these cases 6 babies have had normal MRIs, 2 have moderate Hypoxic Ischaemic Encephalopathy (HIE) and 4 have severe HIE (5 of these cases went on to be reported as neonatal deaths).

Recovery Plan: Phase 2 of embedding the escalation quality improvement project at CWFT is in progress and will be rolled out to the neonatal services (June 25). A change in practice to move to physiological fetal monitoring interpretation will be implemented in July 25.

Improvements: Improvements are focused 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.

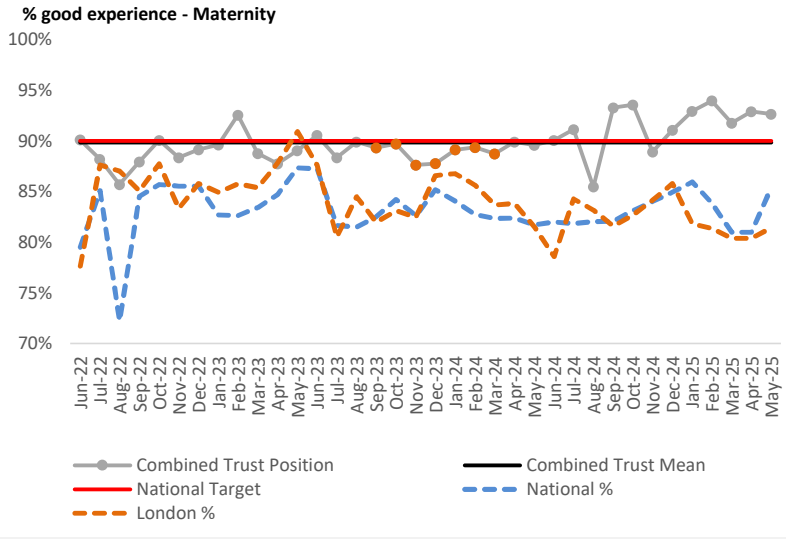
Forecast Risks: N/A

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Maternity Friends & Family Test

TREND



90%

STANDARD

92.6%

PERFORMANCE

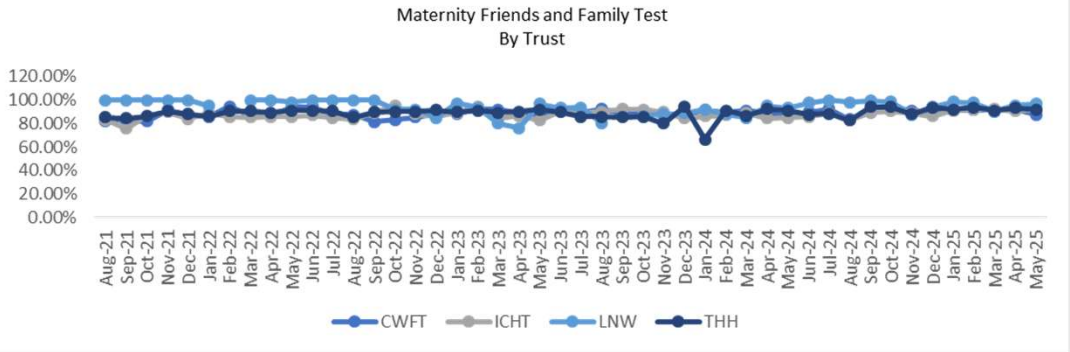
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	197	87.8%	-2.2%	173	90.4%
ICHT	144	92.4%		133	89.4%
LNW	271	96.7%		262	95.9%
THH	174	92.0%		160	91.3%
APC	**786**	**92.6%**		**728**	**91.6%**

STRATIFICATION



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.

Recovery Plan: N/A.

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.

GOVERNANCE

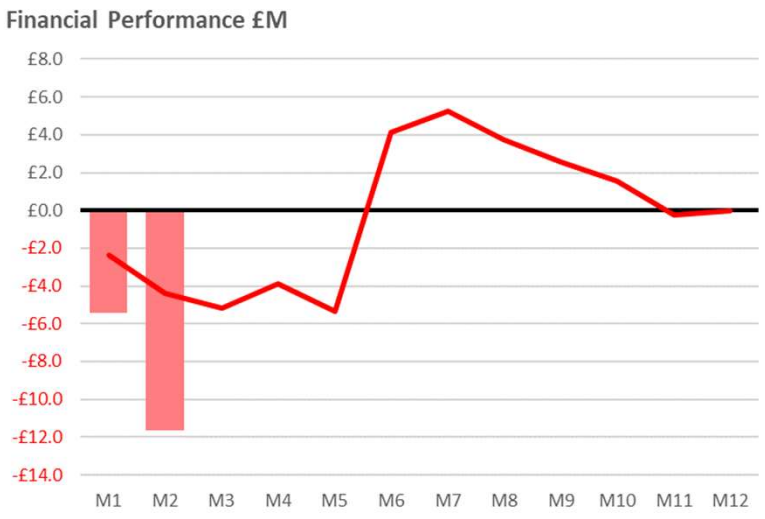
Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Section 2a: Finance

May 2025

Financial Performance

TREND



-£4.4M

STANDARD

-£11.7M

PERFORMANCE

n/a

TREND

n/a

ASSURANCE

NARRATIVE

Performance: The APC reported a deficit of £11.7M in May against a deficit plan of £4.4M. This represents an adverse variance of £7.3M. 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, it will be implemented from month 3..

Improvements:

Forecast Risks: Continuing under-delivery of efficiency programmes

CURRENT PERFORMANCE

Financial Performance YTD Variance to Plan May-25

	Annual Income £M	I&E Plan £M	I&E Actual £M	Difference from Plan	Forecast Outturn £M
CWFT	1,024	-0.7	-2.4	-1.7	0.0
ICHT	1,848	0.0	-1.3	-1.3	0.0
LNW	1,085	-3.7	-6.5	-2.7	0.0
THH	408	0.0	-1.5	-1.5	0.0
APC	**4,365**	**-4.4**	**-11.7**	**-7.3**	**0.0**

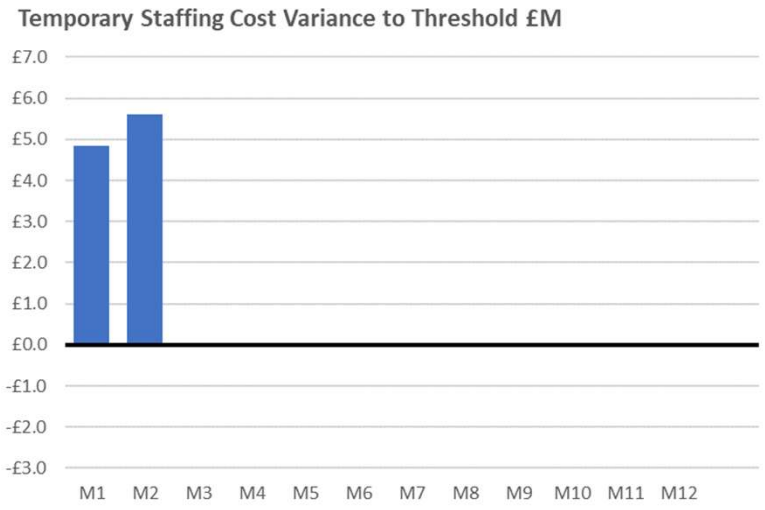
STRATIFICATION

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 internal processes.

Temporary Staffing Expenditure

TREND



£22.9M

ALLOWANCE

£17.6M

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.

Current performance for May 2025 was 0.7% and within target. 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.

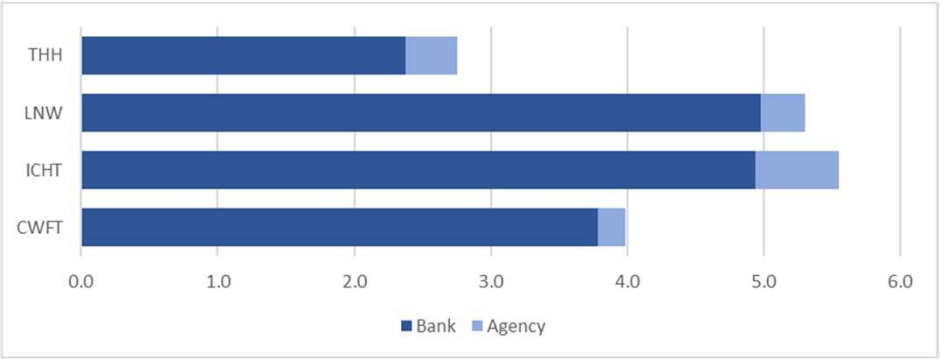
Forecast Risks: High levels of vacancies, puts additional pressure on temporary staffing demand

CURRENT PERFORMANCE

Cost of Temporary Staffing May-25

	Total Pay Bill £M	Temnpory Staffing Threshold	Temporary Staffing Costs	Difference from Threshold	Agency Spend		Bank Spend		Substantive Staff Spend	
					£M	%	£M	%	£M	%
CWFT	48.9	5.3	4.0	1.3	0.2	0.4%	3.8	7.7%	44.9	91.8%
ICHT	96.0	8.0	5.6	2.5	0.6	0.6%	4.9	5.1%	90.4	94.2%
LNW	57.3	6.6	5.3	1.3	0.3	0.6%	5.0	8.7%	52.0	90.7%
THH	23.0	3.0	2.8	0.3	0.4	1.6%	2.4	10.3%	20.2	88.0%
APC	**225**	**22.9**	**17.6**	**5.3**	**1.5**	**0.7%**	**16.1**	**7.1%**	**207.5**	**92.2%**

STRATIFICATION



GOVERNANCE

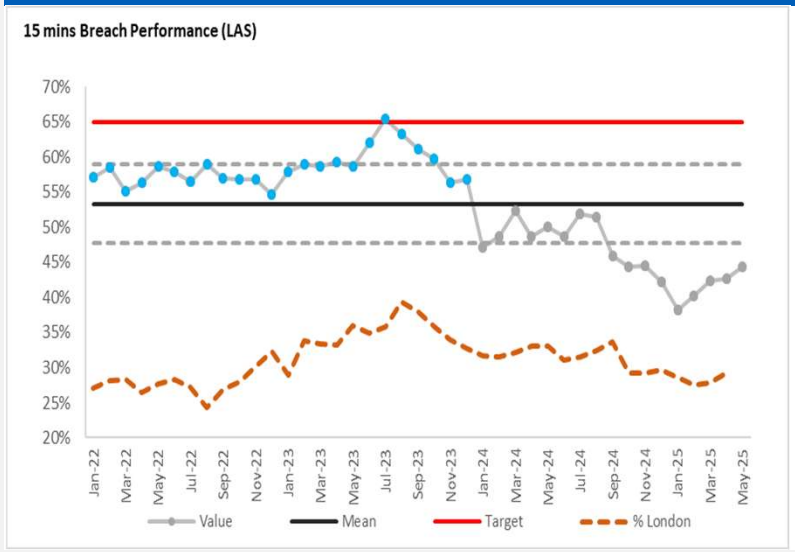
Senior Responsible Owner: Bimal Patel, Chief Financial Officer, LNWH
Committee: APC Finance and Performance
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Section 2b: Productivity and Flow

May 2025

Ambulance Handover Waits

TREND



65%

STANDARD

44.4%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: NWL continues to have some of the best Ambulance handover times across London. In May, combined performance of completed handovers within 15 and 30 minutes increased, with 44.4% completed within 15 minutes (against the target of 65%) and 80.4% completed within 30 minutes (against the target of 90%).

Recovery plan: The sector is working to maximize the use of alternatives to ED, avoid conveyancing, and enhance direct referral and booking routes. We have updated the system escalation process during peak pressure and have established new support for LAS. Northwick Park Hospital still has significant handover delays. The Trust is participating in a sector level demand management pilot, expected to conclude in July 2025 to inform next steps.

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.

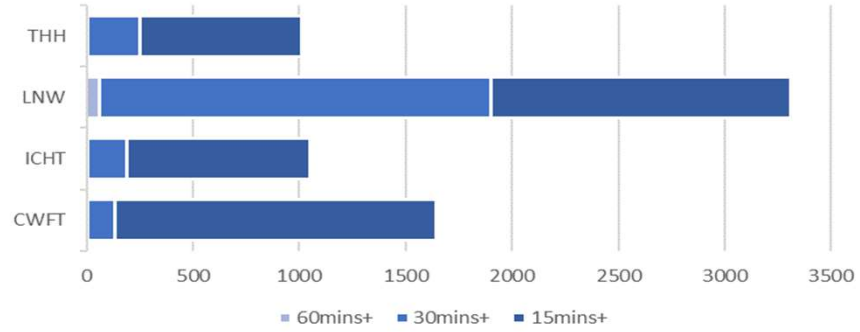
Forecast risks: Continued increases in the number of conveyances.

CURRENT PERFORMANCE

LAS Handover Waits within the fifteen minute standard May-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	3407	51.8%	-13.2%	1643	133	2	179
ICHT	2988	64.8%	-0.2%	1051	190	5	156
LNW	4306	23.2%	-41.8%	3309	1899	63	2023
THH	1925	47.3%	-17.7%	1014	249	3	217
APC	**12626**	**44.4%**	**-20.6%**	**7017**	**2471**	**73**	**2576**

STRATIFICATION



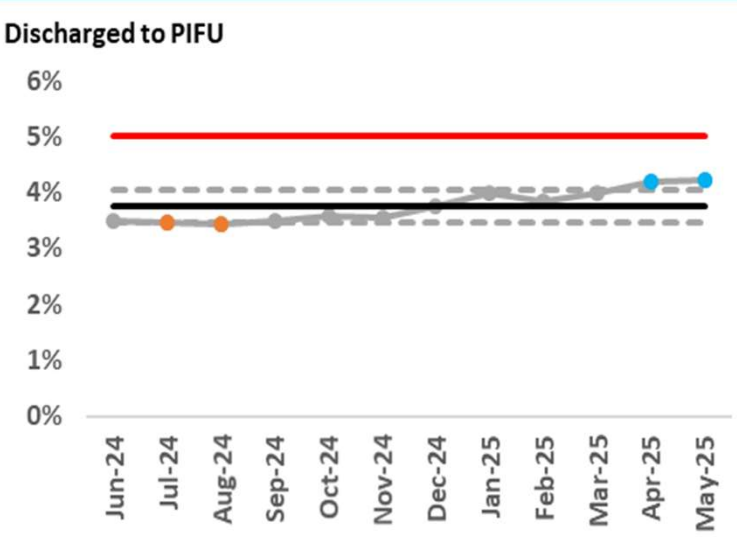
Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Ian Bateman, Chief Operating Officer, ICHT
Committee: APC EMB (Chair: Tim Orchard); NWL UEC Board (Chair: Rob Hurd)
Data Assurance: These figures are provided by LAS

Patient Initiated Follow Up

TREND



5%

STANDARD

4.2%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Pathways discharged to PIFU remain under target, although have continued to improve and are now only 0.8% below target. 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 a significant outlier at only 1.5%.

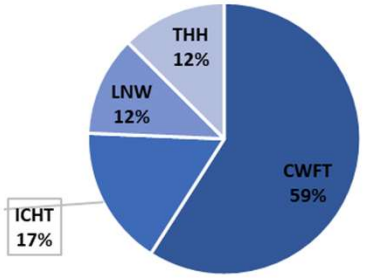
Future risks: Stability, usability and interoperability of digital infrastructure.

CURRENT PERFORMANCE

Outpatient Transformation May-25

	Total OP contacts	Discharged to PIFU	Difference from target	Moved / Discharged to PIFU	Impacts on		
					OPFA DNAs	OPFU DNAs	Virtual contacts
CWFT	68184	8.3%		5689	10.7%	7.7%	7694
ICHT	51558	3.1%	-1.9%	1601	10.8%	8.8%	18630
LNW	74891	1.5%	-3.5%	1142	9.4%	9.2%	14667
THH	33495	3.5%	-1.5%	1203	6.7%	7.5%	4896
APC	**228128**	**4.2%**	**-0.8%**	**9635**	**9.8%**	**8.5%**	**45887**

STRATIFICATION



Trust share of APC discharges lower than standard

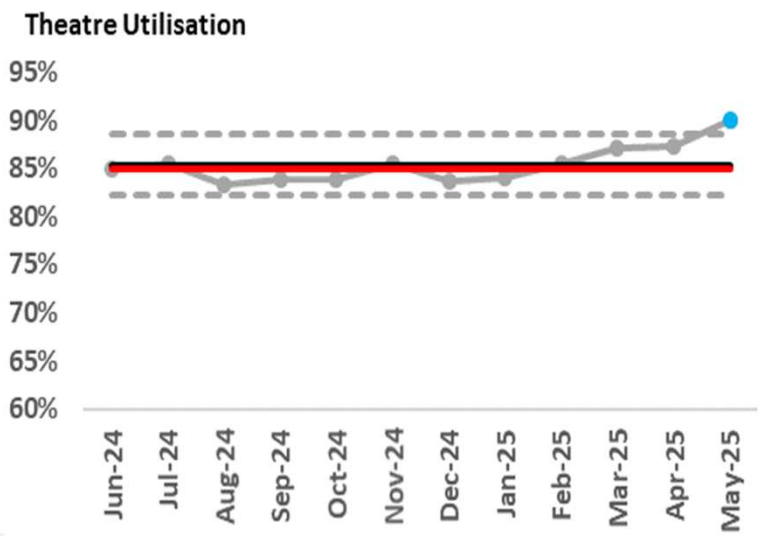
GOVERNANCE

Senior Responsible Owner: Laura Bewick, Hospital Director & Deputy Chief Operating Officer, CWFT
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Roger Chinn)
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

24

Theatre Utilisation *(Uncapped)*

TREND



85%

STANDARD

90.0%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Theatre utilisation improved for the fifth month in a row in M2, to 90% against a target of 85%. All trusts were above 85% for the first time.

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.

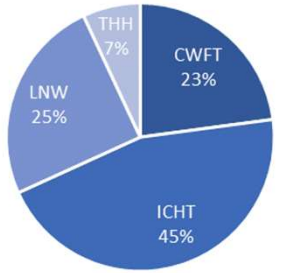
Future risk: Shortages in critical staffing groups.

CURRENT PERFORMANCE

Theatre Utilisation May-25

	Planned operating time (hours)	Theatre utilisation	Difference from target	Unused time (hours)
CWFT	2344	88.7%		266
ICHT	4846	89.1%		526
LNW	3312	91.3%		288
THH	1051	92.3%		81
APC	**11552**	**90.0%**		**1161**

STRATIFICATION

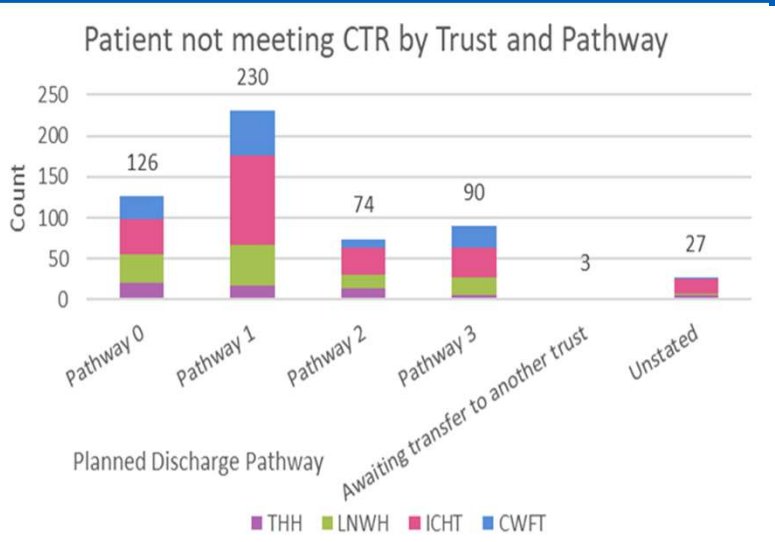


GOVERNANCE

Senior Responsible Owner: Laura Bewick, Hospital Director & Deputy Chief Operating Officer, CWFT
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Roger Chinn)
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Discharge Performance – no criteria to reside

TREND



STANDARD

14%

PERFORMANCE

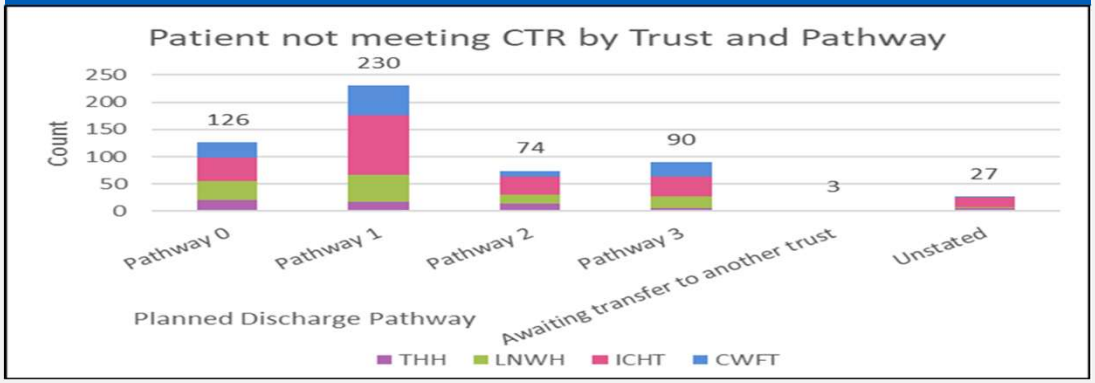
TREND

ASSURANCE

CURRENT PERFORMANCE

Local Authority	CWFT	ICHT	LNW	THH	Total	List Size	Rate r per 10,000
Brent	1	38	27	0	66	388,755	1.70
Ealing	4	26	50	5	85	433,858	1.96
H&F	9	51	0	0	60	224,022	2.68
Harrow	0	3	27	0	30	256,630	1.17
Hillingdon	2	7	9	55	73	324,843	2.25
Hounslow	31	18	1	0	50	327,779	1.53
Kensington & Chelse	14	30	0	0	44	268,576	1.64
Westminister	8	37	0	0	45	253,186	1.78
Out of area	53	31	9	4	97		
Total	122	241	123	64	550		

STRATIFICATION



NARRATIVE

Performance: NWL discharges and bed occupancy by no criteria to reside (NCTR) vary by Trust. LNW and CWFT have highest % of bed base occupied by no CTR patients in NWL; although this has varied over time, LNWHT position has improved in recent weeks. 14% of NWL Bed base was occupied by patient with No CTR and were NOT discharged compared to London 13%.

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 in June 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.

GOVERNANCE

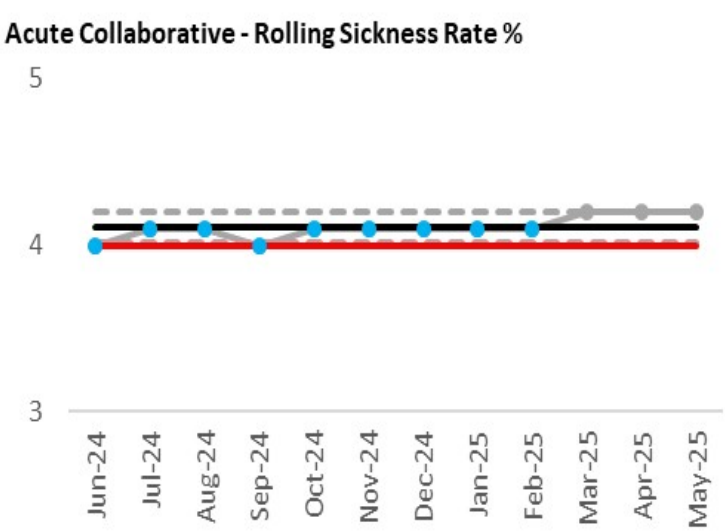
Senior Responsible Owner: Sheena Basnayake, Managing Director Chelsea and Westminster
Committee: APC EMB (Chair: Tim Orchard); NWL UEC Board (Chair: Rob Hurd)
Data Assurance: These figures come for the FDP via the ICB

Section 3: Workforce

May 2025

Sickness Absence

TREND



=/<4%

STANDARD

4.2%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: We have seen an increase in sickness across the Trusts since March 2025 with current levels (4.2%) above the target of 4.0% and all Trusts are actively monitoring this.

All Trusts have plans in place to manage absence, particularly long-term absence.

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.

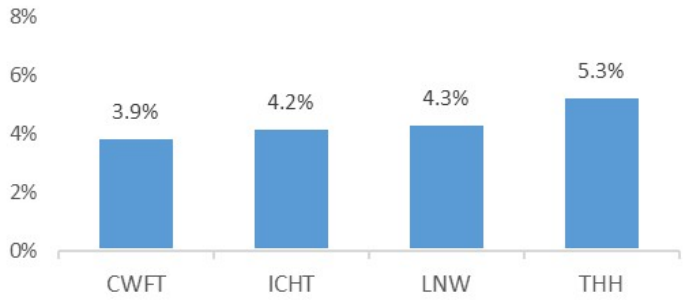
CURRENT PERFORMANCE

Rolling Sickness Absence

	Target %	Month 02 12 Month Rolling Sickness Absence Rate %	Variance to Target %	Month 02 In-Month Sickness Absence Rate %
CWFT	4%	3.9%	0.1%	3.3%
ICHT	4%	4.2%	-0.2%	4.2%
LNW	4%	4.3%	-0.3%	4.0%
THH	4%	5.3%	-1.3%	5.4%
APC	**4%**	**4.2%**	**-0.2%**	**4.1%**

STRATIFICATION

12 Month Rolling Sickness Absence Rate % across the APC Month 02

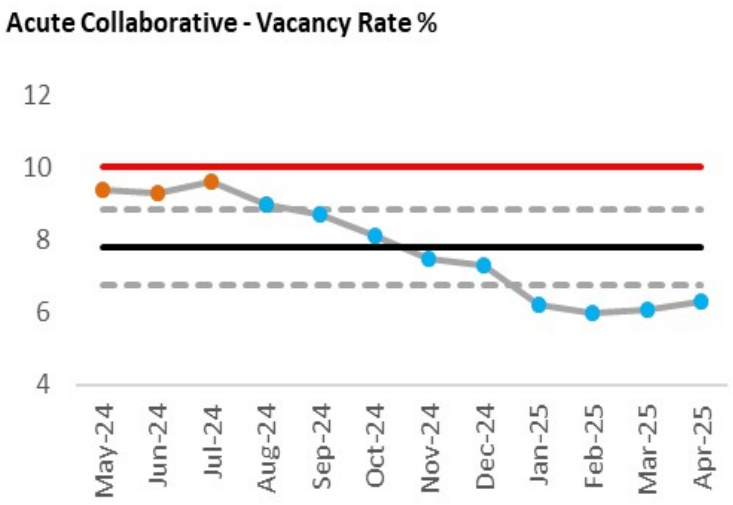


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC People and Organisational Development
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Vacancies

TREND



=/<10%

STANDARD

6.3%

PERFORMANCE

L

TREND

P

ASSURANCE

NARRATIVE

Performance: Vacancy rates at collaborative level are consistently hitting target and a special cause improving variation. Since January 2024, the collaborative vacancy level has maintained below the agreed target of 10.0% and in April 2025 was 6.3%. This performance is the result of targeted recruitment campaigns, both at home and abroad, with a continuing focus to maintain levels.

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; Operating Department Practitioners, Sonographers, Occupational Therapists, Middle Grades for Emergency Medicine 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.

Recovery Plan / Improvements: Hard to recruit roles continue to receive focus with planned international recruitment campaigns, rolling recruitment and targeted recruitment campaigns to reduce vacancies.

We continue to see increasing numbers of internationally appointed nurses, and this continues to have a positive impact on general nursing vacancies, and we have a strong pipeline to over the coming months. Also of continued focus is the recruitment of midwives and maternity staff, with appointments to preceptorship roles, new obstetric nurse roles and scrub/theatre nurses.

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

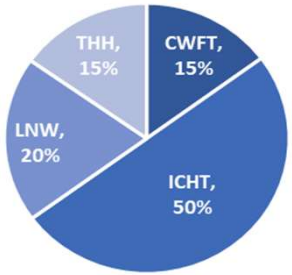
CURRENT PERFORMANCE

Vacancies

	Target %	Month 01 Vacancy Rate %	Variance to Target %	Vacancy WTE
CWFT	10%	4.6%	5.4%	344
ICHT	10%	7.3%	2.7%	1,157
LNW	10%	4.9%	5.1%	459
THH	10%	9.0%	1.0%	352
APC	**10%**	**6.3%**	**3.7%**	**2,312**

STRATIFICATION

Trust proportion of vacant WTE across the APC Month 01

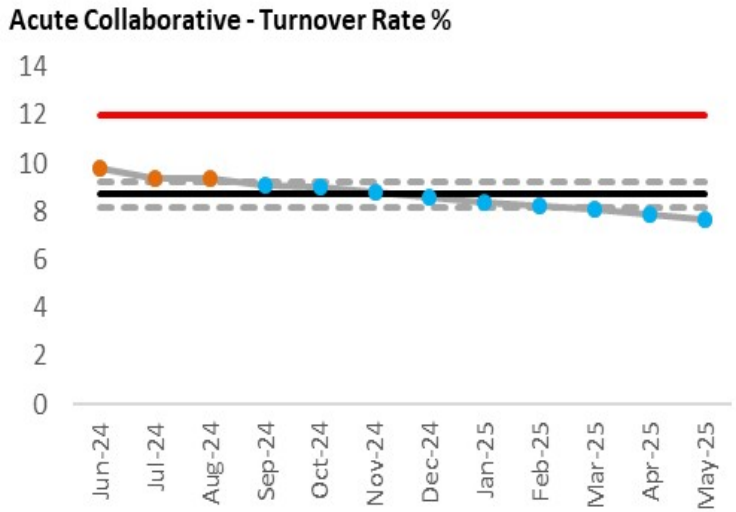


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC People and Organisational Development
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Voluntary Turnover

TREND



=/<12%

STANDARD

7.7%

PERFORMANCE

L

TREND

P

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 7.7% which is below the APC target of 12.0% and a special cause improving variation.

All Trusts have active retention projects and are part of a retention programme, supported by national resource, initiated across the NWL ICS. Acute Collaborative 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.

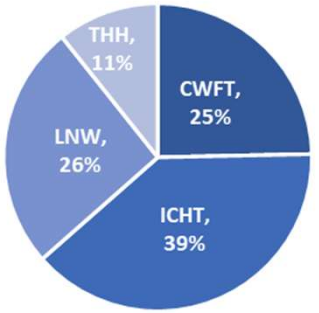
CURRENT PERFORMANCE

Voluntary Turnover

	Target %	Month 02 Turnover Rate %	Variance to Target %	Voluntary Leavers WTE (rolling 12 months)
CWFT	12%	8.5%	3.5%	543
ICHT	12%	7.4%	4.6%	856
LNW	12%	7.3%	4.7%	568
THH	12%	8.8%	3.2%	235
APC	**12%**	**7.7%**	**4.3%**	**2,203**

STRATIFICATION

Trust proportion of voluntary leavers wte (rolling 12 months) across the APC Month 02

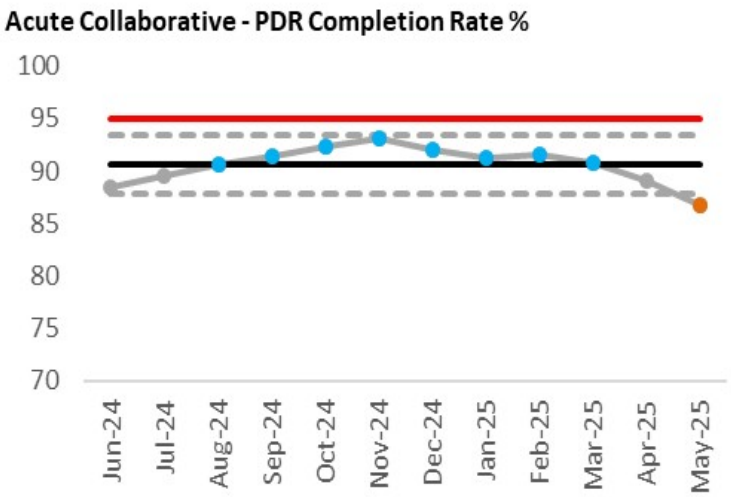


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC People and Organisational Development
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Non-Medical PDR

TREND



=/<95%

STANDARD

86.8%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Completion rates for non-medical **Performance Development Reviews** (PDR), is an area of continued focus.The APC at Month 02 has a medical PDR rate of 92.6%, which is split as follows CWFT 84.5%; ICHT 96.7%; LNW 82.1% & THH 83.8%.

CWFT and ICHT have specified windows for PDR completions and both are working in these at the moment. Once these windows close the PDR rates for both will be updated. THH and LNW work to a rolling programme.

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 through a period of heightened elective recovery activity and potential further industrial action.

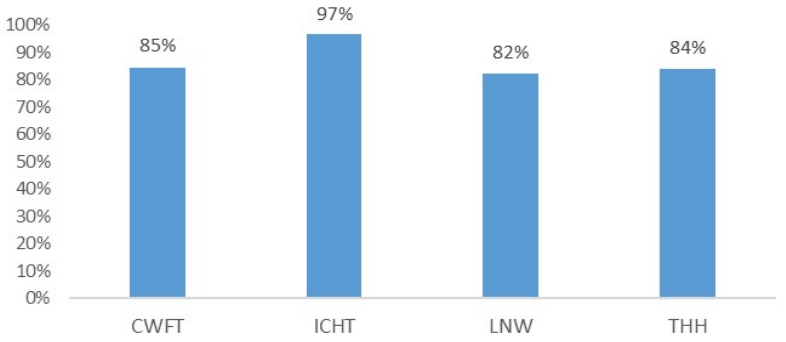
CURRENT PERFORMANCE

Non Medical PDR

	Target %	Month 02 PDR / Appraisal Rate %	Variance to Target %
CWFT	95%	84.5%	-10.5%
ICHT	95%	96.9%	1.9%
LNW	95%	82.1%	-12.9%
THH	95%	83.8%	-11.2%
APC	**95%**	**86.8%**	**-8.2%**

STRATIFICATION

Month 02 Non-Medical PDF Rate % by Trust across the APC

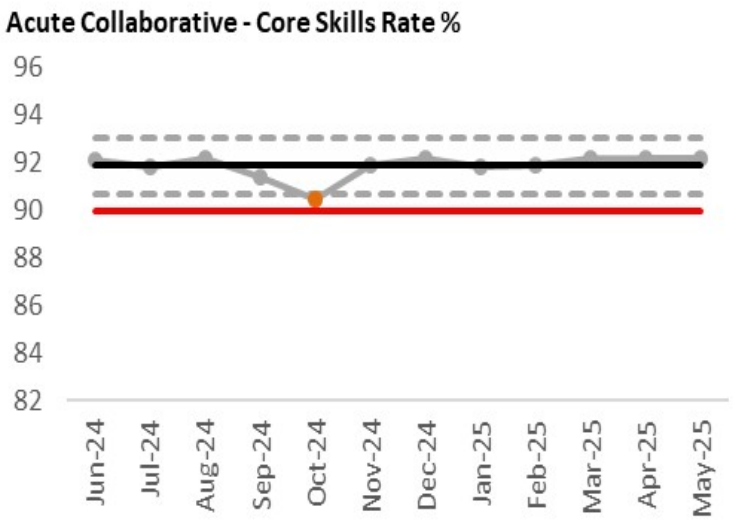


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC People and Organisational Development
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Core Skills Compliance

TREND



=/<90%

STANDARD

92.2%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Core Skills (statutory & 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 collaborative continue to perform well against the target for Core Skills compliance and it is not an area of concern at collaborative level.

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

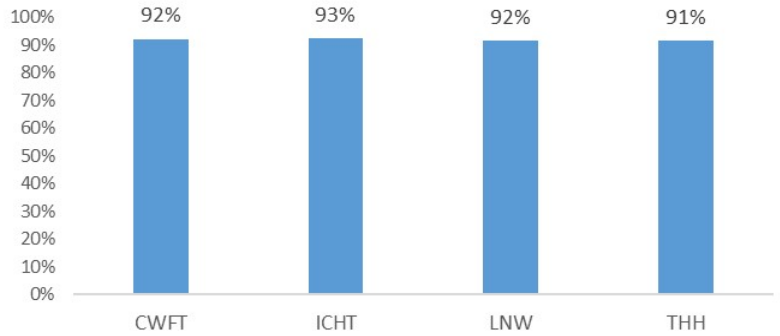
CURRENT PERFORMANCE

Core Skills Compliance

	Target %	Month 02 Core Skills Compliance Rate %	Variance to Target %
CWFT	90%	92.3%	2.3%
ICHT	90%	92.6%	2.6%
LNW	90%	91.7%	1.7%
THH	90%	91.5%	1.5%
APC	**90%**	**92.2%**	**2.2%**

STRATIFICATION

Month 02 Core Skills Compliance Rate % by Trust across the APC



GOVERNANCE

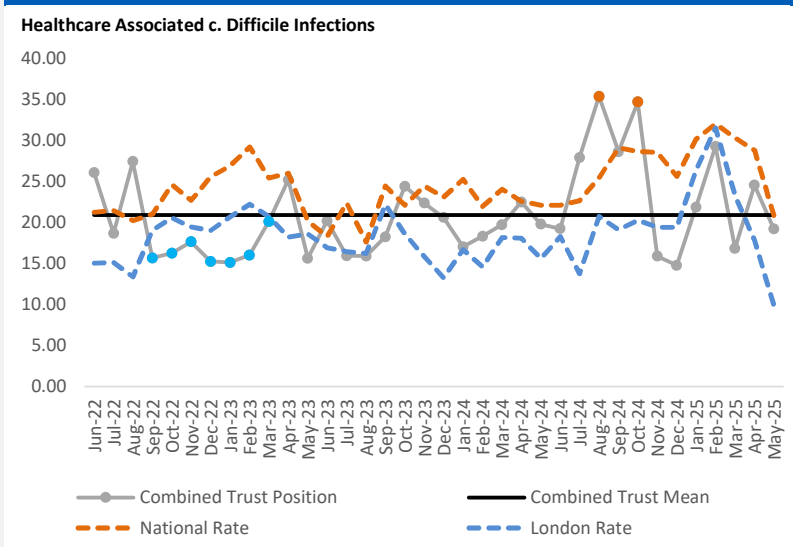
Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC People and Organisational Development
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Section 4: Statutory and Safety Reports

May 2025

Healthcare Associated C.Difficile Infections

TREND



Trust Specific

STANDARD

19.22

PERFORMANCE

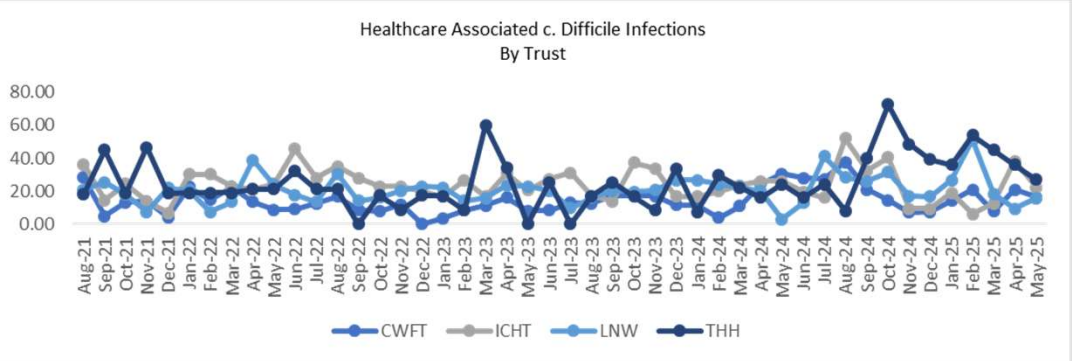
TREND

ASSURANCE

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	24,365	4	16.42	18.32	4	33	
ICHT	31,486	7	22.23	23.10	7	81	
LNW	31,883	5	15.68	24.52	5	73	
THH	11,130	3	26.95	37.07	3	26	
APC	**98,864**	**19**	19.22	**23.99**	**19**	**213**	

STRATIFICATION



NARRATIVE

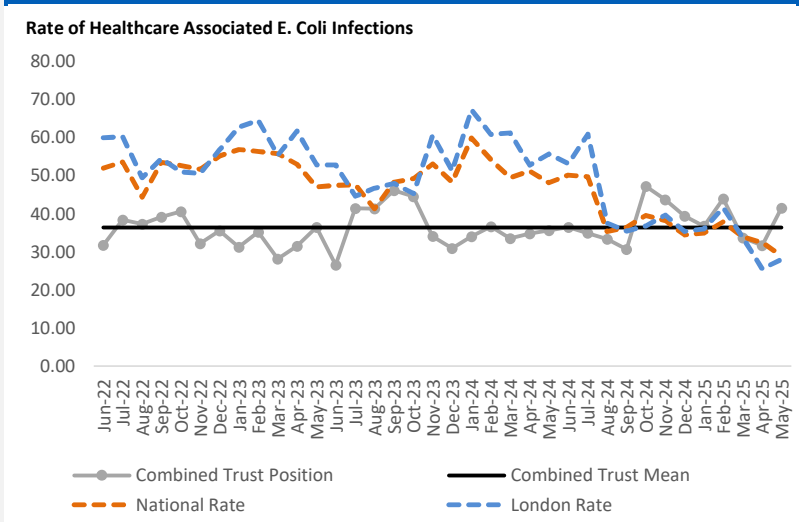
Performance: All Trusts exceeded their annual thresholds set by NHSE for financial year 2024/25. Thresholds for 2025/26 have now been published. Due to the increasing trends nationally these have either remained the same as 24/25 or are a 10% decrease on 2024 calendar year. All trusts are reviewing how to ensure that thresholds are not breached over the coming year. In May, there was a small reduction in the number of cases reported (n=19). There has been an overall increase at THH since September 2024. None of the cases were found to be linked on investigation. Actions were focused on reinforcing antimicrobial stewardship ward rounds in addition to c.difficile weekly MDT rounds and audits.
Recovery plan: Every case is reviewed to determine if there have been any lapses in care or opportunities for improvement, this includes peer and ICB review. Improvement work is underway using learning from case reviews at all Trusts. At ICHT the related policy has been updated to improve clarity on the actions to take when a case is suspected or identified, making the process easier to understand for clinical staff.
Improvements: There is ongoing work across all four trusts, as a collaborative and with system /ICB partners. Work is focussing on timeliness and appropriateness of sampling, isolating patients and strengthening guidance and policies. In addition there is further work to be done around stool charts and early recognition of cases.
Forecast Risks: National rates continue to rise and all Trusts have noticed a rise in numbers that are both community and hospital acquired.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Healthcare Associated E. coli Infections

TREND



Trust Specific

STANDARD

41.47

PERFORMANCE

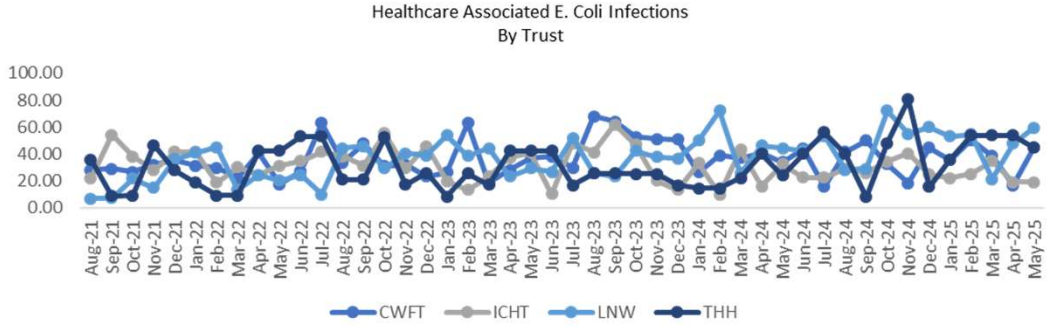
TREND

ASSURANCE

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	24,365	11	45.15	35.99	11	99	
ICHT	31,486	6	19.06	26.82	6	94	
LNW	31,883	19	59.59	47.97	19	132	
THH	11,130	5	44.92	44.06	5	39	
APC	**98,864**	**41**	41.47	**37.78**	**41**	**364**	

STRATIFICATION



NARRATIVE

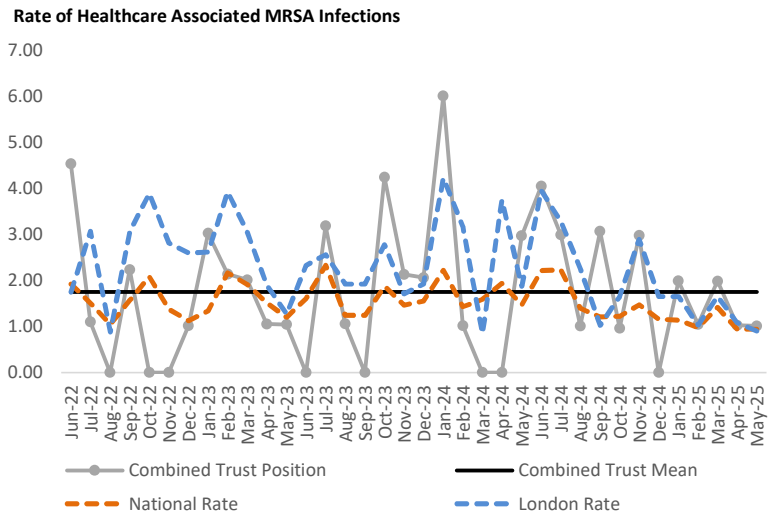
Performance: There was an increase in the number of cases reported (n=41) in month. LNW and THH exceeded the annual threshold set by NHSE for 2024/25. Some of the increases have been linked to urinary tract infections with working groups in place in both trusts in response. Thresholds have now been published for 2025/26 following the same principles as outlined in the previous slide.
Recovery Plan: 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. Action plans and along with community urine work is reviewed in the Gram-negative working group. Reduction therefore requires a whole health economy approach. Each organisation reviews their Gram-negative blood stream infections with some organisations having a working group in place and present their improvement plan at the ICS group, analysing trends and local risk factors that they are working on with clinical colleagues. Line and device care plan best practice plan is being reviewed through the APC.
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. Action plans were presented in May to the ICS including catheter audits, urine results and action plans to ensure learning shared across the sector and community.
Forecast RIsks: N/A

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Healthcare Associated MRSA Infections

TREND



0

STANDARD

1.01

PERFORMANCE

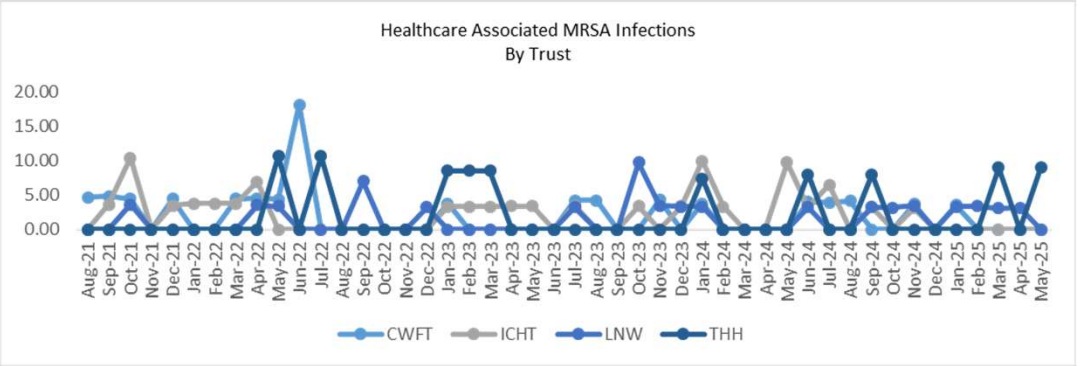
TREND

ASSURANCE

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	24,365	0	0.00	1.64	0	0	
ICHT	31,486	0	0.00	1.33	0	0	
LNW	31,883	0	0.00	2.16	0	0	
THH	11,130	1	8.98	3.50	1	0	-1.0
APC	**98,864**	**1**	1.01	**1.92**	**1**	**0**	**-1.0**

STRATIFICATION



NARRATIVE

Performance: There was 1 MRSA BSI reported in May, which occurred at THH.

Recovery Plan: Robust processes for managing and investigating cases, and on-going improvement work are in place, 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, with a new bacteraemia reduction group set up at ICHT focusing on effective MRSA eradication post surveillance, practice auditing, feedback and improvement plans focused on care of invasive lines. The APC group have reviewed MRSA screening to understand where there are opportunities for standardisation and are improving on hand hygiene practice and audits across each Trust

Improvements: A review of these cases will continue to feed into the APC priority workstream to support identification of collective action or learning. Each trust has improvement work in place in response to these infections, the outcomes of which will report into the APC workstream and any shared learning planned accordingly.

Forecast Risks: Not applicable.

GOVERNANCE

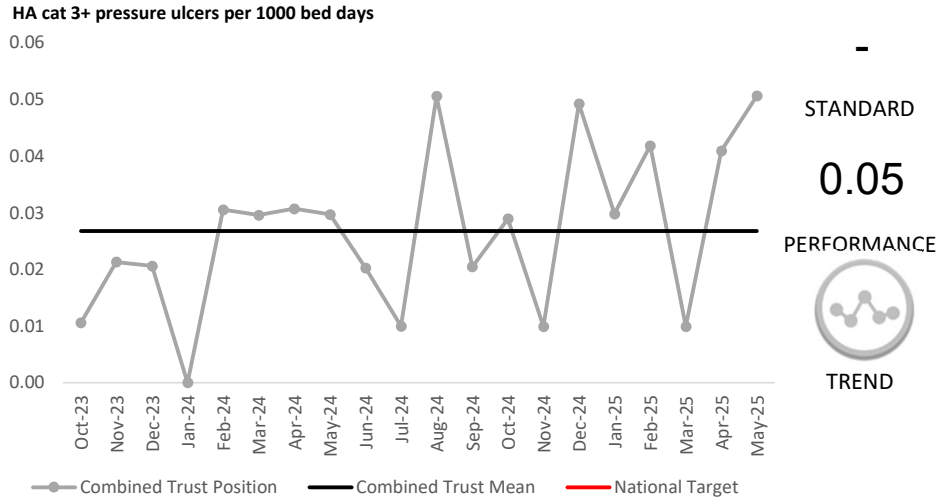
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: APC Quality and Safety

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

Pressure Ulcers

TREND



-

STANDARD

0.05

PERFORMANCE

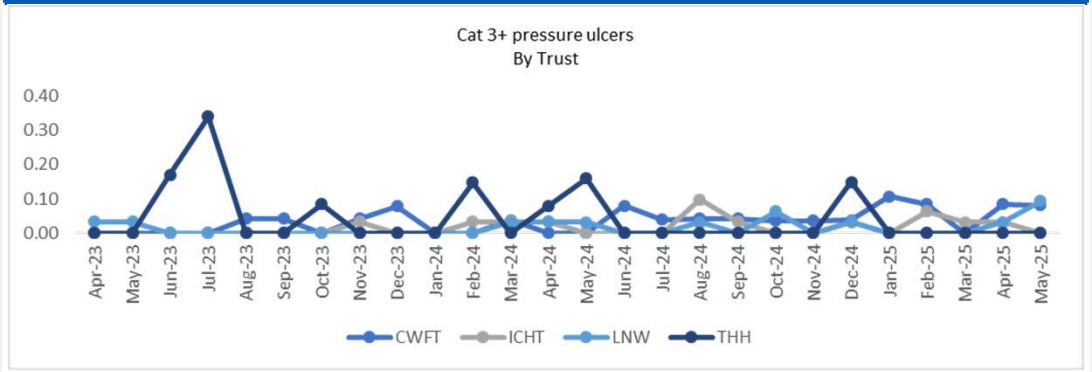
TREND

ASSURANCE

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	24,365	0.08	2	17	0.06
ICHT	31,486	0.00	0	9	0.02
LNW	31,883	0.09	3	8	0.02
THH	11,130	0.00	0	2	0.01
APC	**98,864**	**0.05**	**5**	**36**	**0.03**

STRATIFICATION



NARRATIVE

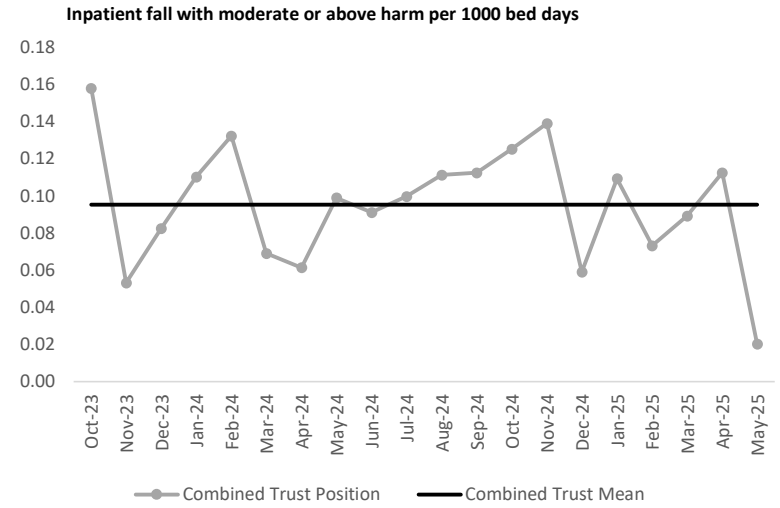
Performance: This metric shows the rate of hospital acquired (HA) pressure ulcers graded as category 3 and 4. The figures are based on data reported in the Trusts' incident reporting systems, and the data is not risk adjusted. There were five reported in May 2025. No risks identified for escalation.
Recovery Plan: The cases are currently being reviewed via each organisation's patient safety incident response plan (PSIRP) to identify learning which will feed into local safety improvement programmes. CWFT have the highest rate across the last 12 months, in addition to their on-going improvement work, focused support and targeted interventions are being provided to wards on the West Middlesex site where there have been an increase.
Improvements: The APC have reviewed and refreshed processes for pressure ulcer risk assessment. In quarter four all trusts completed the implementation of a single, evidence-based risk assessment tool. Reducing variation will support portability of skills and knowledge. 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.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

Inpatient falls

TREND



-

STANDARD

0.02

PERFORMANCE

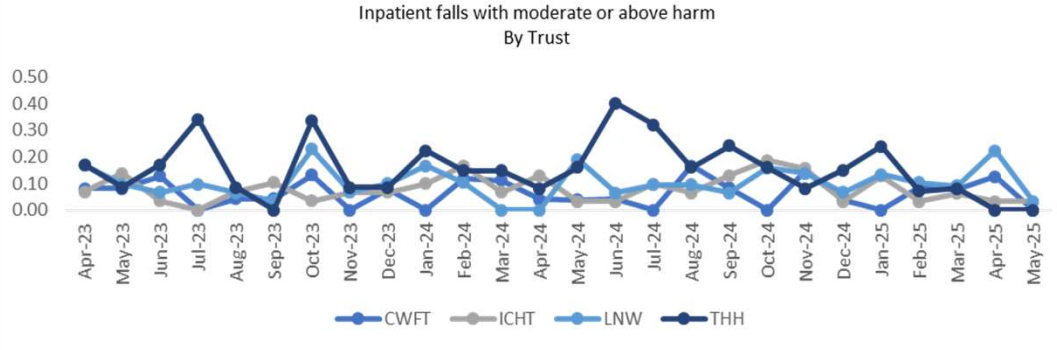
TREND

ASSURANCE

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	24,365	0.00	0	19	0.06
ICHT	31,486	0.03	1	31	0.08
LNW	31,883	0.03	1	39	0.11
THH	11,130	0.00	0	25	0.17
APC	**98,864**	**0.02**	**2**	**114**	**0.10**

STRATIFICATION



NARRATIVE

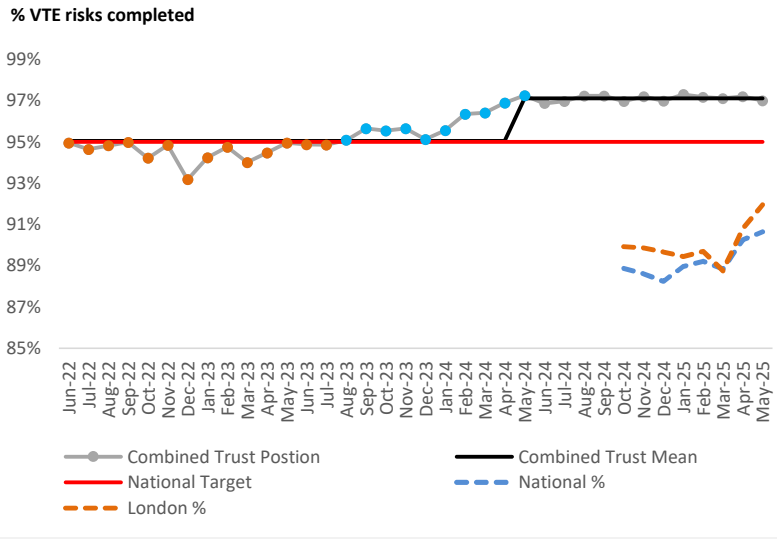
Performance: This metric shows the rate of falls reported as causing moderate or above harm to patients per 1000 bed days, which is consistently below 0.2 with small numbers overall. Data is not risk adjusted. National benchmarking data is not currently available. There was a reduction in May, with 2 cases reported.
Recovery Plan: The cases are currently 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. The APC deputy directors of nursing group are overseeing changes to the workflow in the electronic patient record so that this aligns to policy.
Forecast Risks: Not applicable.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Quality and Safety
Data Assurance: Data is supplied by each trust individually and quality assured through internal processes.

VTE Risk Assessments Completed

TREND



95%

STANDARD

97.0%

PERFORMANCE

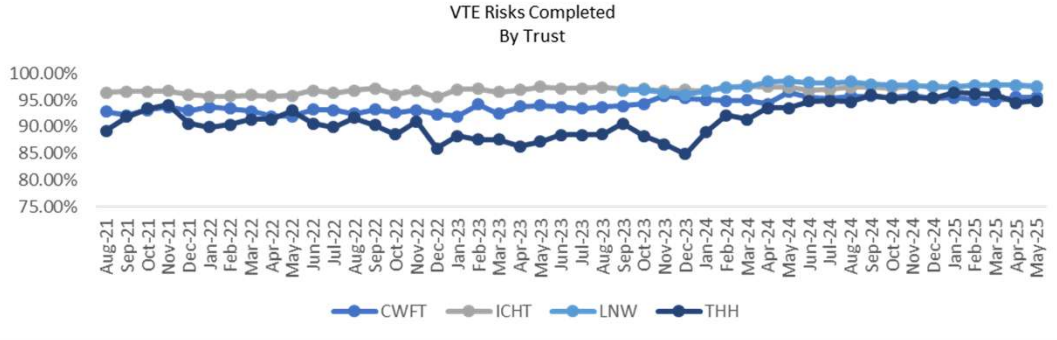
TREND

ASSURANCE

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	6,993	95.6%		6,683	95.5%
ICHT	16,402	97.6%		16,001	97.5%
LNW	13,899	97.6%		13,566	97.9%
THH	3,753	94.9%	-0.1%	3,562	95.6%
APC	**41,047**	**97.0%**		**39,812**	**97.1%**

STRATIFICATION



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.

LNW and THH are now reporting directly from Cerner which had resulted in an improvement at APC level. There was a slight dip below the target at THH, however we are above the standard across the last 12 months in all Trusts.

Recovery Plan: Not applicable

Improvements: Not applicable

Forecast Risks: Not applicable

GOVERNANCE

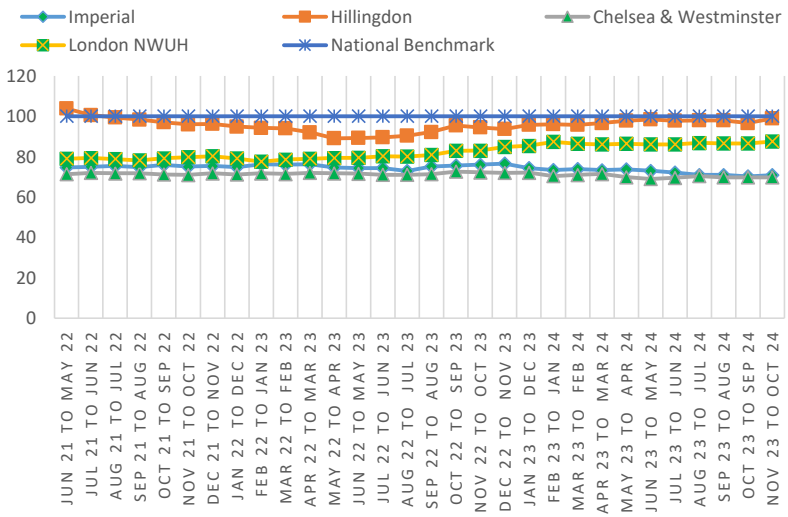
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: APC Quality and Safety

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

Summary Hospital-level Mortality Index

TREND



100
England Average

STANDARD

98.94

PERFORMANCE

n/a

TREND

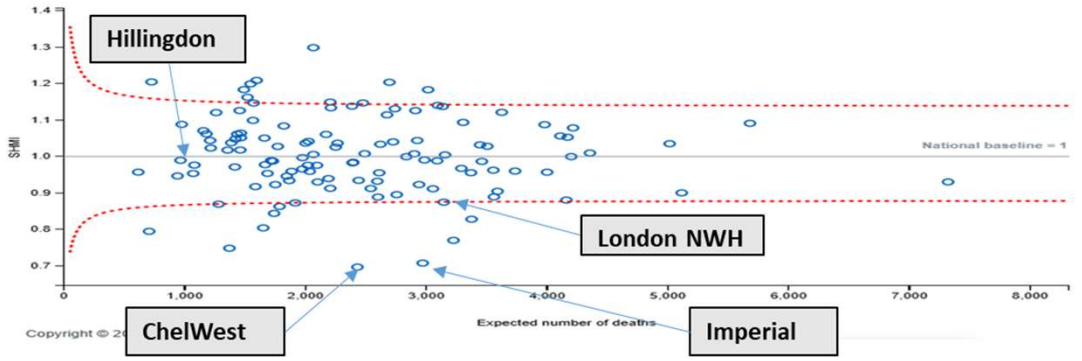
n/a

ASSURANCE

CURRENT PERFORMANCE

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	102675	69.67	Lower than expected
ICHT	117275	70.76	Lower than expected
LNW	107000	87.47	Lower than expected
THH	53025	98.94	as expected

STRATIFICATION



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 (October 2023 – September 2024). 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 three were summarised in the learning from deaths report presented to APCQC and BiC with no issues to escalate.

Forecast Risks: Not applicable.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

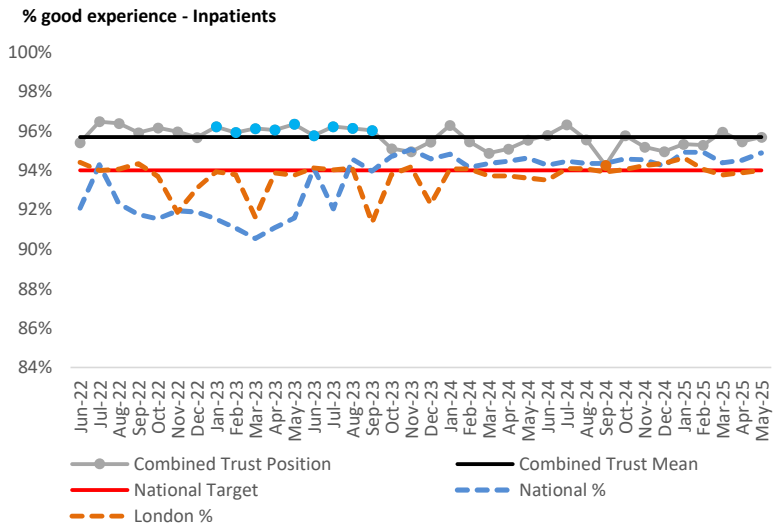
Committee: APC Quality and Safety

Data Assurance: Data is compiled from NHS Digital who combine HES and ONS mortality datasets to populate a standardised mortality model. Local Trust data is quality assured through internal processes.

40

Inpatient Friends & Family Test

TREND



94%

STANDARD

95.7%

PERFORMANCE

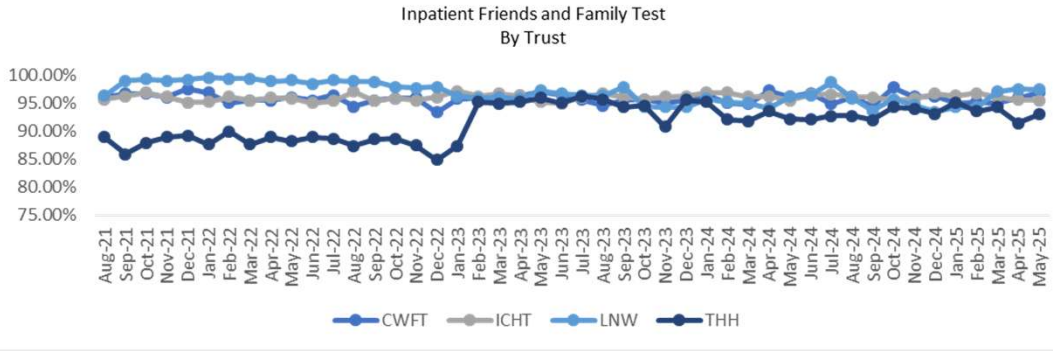
TREND

ASSURANCE

CURRENT PERFORMANCE

Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
940	97.0%		912	96.0%
2,562	95.6%		2,449	96.2%
1,440	97.6%		1,405	95.6%
1,451	93.1%	-0.9%	1,351	93.3%
6,393	**95.7%**		**6,117**	**95.5%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of inpatients reporting a good experience has consistently been above target and above national and London average.

Recovery Plan: Not applicable

Improvements: A joint procurement plan for a patient survey platform is now in place, which will support better identification of areas for collaborative improvement once implemented.

Forecast Risks: Continued workforce and operational pressures may have a detrimental impact on patient experience.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: APC Quality and Safety

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

4.1 QUALITY

10:15

4.1.1 QUALITY IQPR (ANYTHING BY EXCEPTION)

Discussion Item Pippa Nightingale

See Appendix 4.0

4.1.2 LEARNING FROM DEATHS QUARTER 4 REPORT

Information Item

Roger Chinn

REFERENCES

Only PDFs are attached

04.1.2 APC Learning from Deaths Report Q4.pdf

NWL Acute Provider Collaborative Board in Common (Public)
15/07/2025
Item number: 4.1.2
This report is: Public

Acute Provider Collaborative (APC) Learning from Deaths Quarter 4 2024/25 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 Various Individual trust reports were reviewed at each Quality Committee and approved for onward submission.	
Trust reports were reviewed and the contents of this paper discussed and agreed.	

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 four reports of 2024/25.

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. 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. All Trusts have a “lower than expected” hospital standardised mortality ratio (HSMR) for the period January 2024 to December 2024. The Hillingdon Hospitals NHS Foundation Trust (THH) has an “as expected” standardised hospital mortality indicator (SHMI), although this is below the national benchmark of 100, with all others remaining “lower than expected”.

1.4. There continue to be low numbers of cases where clinical concerns are identified through Level 2 reviews. There were four 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.

1.5. All Trusts continue to investigate variations between observed and expected deaths by diagnostic group. Reviews undertaken in quarter four identified no clinical concerns.

1.6. Work is ongoing to analyse ethnicity data for deceased patients.

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 care at the end of life, including recognition and timely referral to palliative care, agreement and documentation of advanced care planning/treatment escalation plans and the involvement of patients and families in these processes. 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:** reviews highlighted areas for improvement around symptom control at end-of-life, inconsistent documentation practices, communication gaps between teams at handover, and the need for earlier and more consistent communication with families particularly prognosis, treatment plans and advanced care planning.
- **ICHT:** learning from review identified an area for improvement within a small number of cases around the importance of effectively responding to patient deterioration; this is linked to an APC Quality Priority for 2025-26. Review also highlighted examples of excellent team working and good communication with families.
- **LNW:** review highlighted areas for improvement regarding timely recognition of dying patient and the involvement of other specialities and palliative care team. Excellence was noted in terms consultant led decisions and appropriate escalation pathways.
- **THH:** reviews identified strong multi-speciality decision making supporting responsive treatment planning and escalation. Some areas of improvement identified relating to the timely requesting / reviewing of investigations, inconsistent documentation practices, delayed recognition of full patient condition.

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 Data shows that each Trust continues to have a rolling 12-month HSMR below the national benchmark of 100 and are 'lower than expected' for the latest HSMR. THH remains 'as expected' for SHMI with all other Trusts 'lower than expected' for this indicator.

3.2.2 Trend and funnel plot visualisations of HSMR and SHMI mortality rates at Trust and APC level are included in the board in common clinical outcomes performance report and can be found in the appendix of this report.

3.2.3 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 two include:

- **ICHT:** Review into cases linked to acute myocardial infarction (AMI) and Asthma diagnostic groups continued into Q4. A review of non-AMI deaths in Cardiology (11 cases) has been completed during this reporting period following an increase in HSMR above the national benchmark of 100 in August 2024. Learning from this clinical review did not identify any escalation issues or avoidable deaths within this complex patient group.
- **THH:** During this reporting period reviews were undertaken into the following diagnostic groups; Allergic Reactions (n=2), Appendicitis & Other Appendiceal Conditions (n=2), and Multiple Myeloma (n=4). No elements of suboptimal care were identified within any of these cases these cases.

3.2.4 There were no diagnostic groups requiring further review at CWFT or LNWH during this reporting period.

3.2.5 Trust level HSMR data is provided by Telstra Health UK. The table below shows most rolling HSMR (41 diagnostic groups) between January and December 2024. All Trust sites are below 100.

Provider Rolling 12 month HSMR	January to December 24
CWFT	79.5
ICHT	77.6
LNW	94.8
THH	99.5
National Benchmark	100.0

3.3. Medical examiner reviews

3.3.1 All Trusts have a medical examiner service in place who scrutinise in-hospital deaths. All in-patient deaths were scrutinised by respective offices in quarter four.

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.

3.3.3 ICHT has continued work to improve the timeliness of issuing MCCDs for all deaths through a change in process. This quarter, the service issued 73% of urgent MCCDs within 24 hours of death and 57% of non-urgent MCCDs within three calendar days, showing improvement.

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 14% at LNW, 11% at THH, 12% at ICHT and 42% 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. Four cases where sub-optimal care might have 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 four:

- **CWFT**: 134 Level 2 reviews completed with no cases of sub-optimal care that might have made a difference to the patient's outcome.
- **ICHT**: 60 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 three cases of sub-optimal care that might have made a difference to the patient's outcome, being managed through the incident process.
- **LNW**: 87 Level 2 reviews completed with one cases of sub-optimal care that might have made a difference to the patient's outcome.
- **THH**: Four 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. Work has continued to align reporting of cases and outcomes from these processes in each Trust and data is now being presented in scorecards.

3.5.2 ICHT, THH and LNW have identified an area for improvement following PMRT reviews around better support for non-English speakers; this theme has well embedding improvement programme.

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

4. Areas of focus

4.1. All Trusts are reviewing ethnicity data relating to deceased patients and now include this data in their quarterly reports.

5. Conclusion

5.1. 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.

5.2. 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.

5.3. 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.

6. Glossary

6.1. **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.

6.2. **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.

6.3. **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.

6.4. **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.

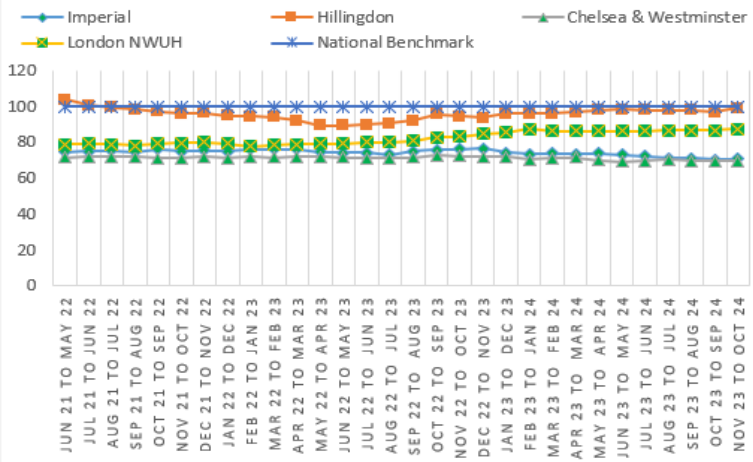
6.5. **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety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

6.6. **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.

Appendix – Clinical outcomes performance report mortality data

Summary Hospital-level Mortality Index

TREND



100
England Average

STANDARD

98.94

PERFORMANCE

n/a

TREND

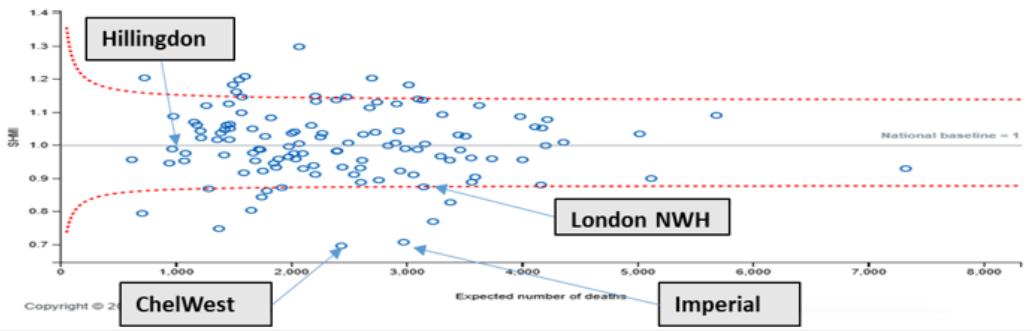
n/a

ASSURANCE

CURRENT PERFORMANCE

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	102675	69.67	Lower than expected
ICHT	117275	70.76	Lower than expected
LNW	107000	87.47	Lower than expected
THH	53025	98.94	as expected

STRATIFICATION



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 (October 2023 – September 2024). 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 three were summarised in the learning from deaths report presented to APCQC and BiC with no issues to escalate.

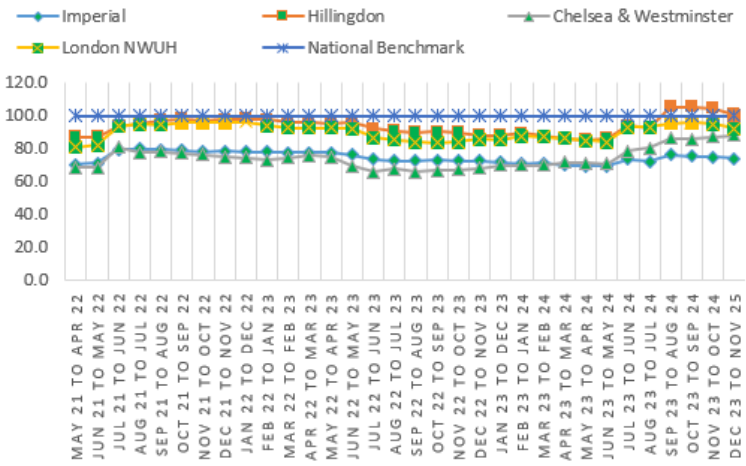
Forecast Risks: Not applicable.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board
Data Assurance: Data is supplied and quality assured by Telstra Health

Hospital Standardised Mortality Ratio

TREND



100
England Average

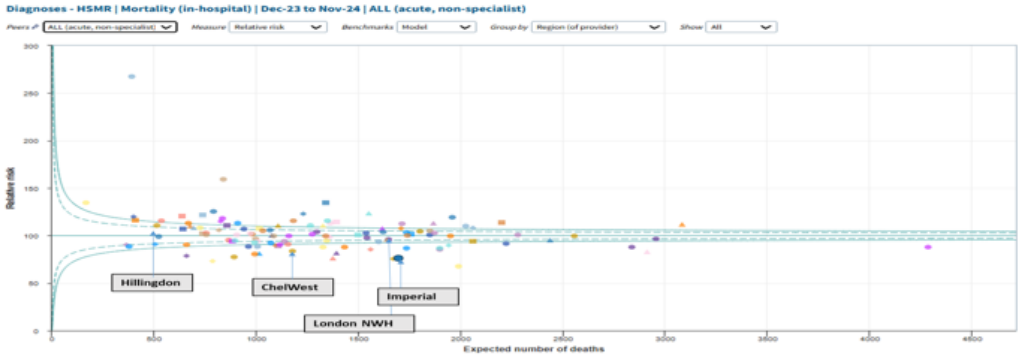
STANDARD

Where data point is green, this represents a low HSMR for the data period. Where data point is same as line colour, this represents an 'as expected' HSMR for the data period. Where data point is red, this represents a high HSMR for the data period.

CURRENT PERFORMANCE

	Provider Superspells	HSMR	HSMR- relative risk ranking
CWFT	42615	88.0	Lower than expected
ICHT	50239	74.0	Lower than expected
LNW	48809	92.2	Lower than expected
THH	20124	100.9	as expected

STRATIFICATION



NARRATIVE

Performance: Changes have been made nationally to the HSMR methodology which includes removal of the adjustment for palliative care coding and changes in the diagnostic groupings which make up the ratio. As expected this has resulted in increases in HSMR in all four trusts, and in most providers nationally. THH has increased above the national benchmark of 100, but is starting to reduce. Following an initial move to 'as expected' LNW has returned to 'lower than expected' in the latest data. CWFT and ICHT remain lower than expected.

Recovery Plan: The impact of the changes is being reviewed by each Trust, and within the APC mortality surveillance group. Potential issues with coding have been identified by LNW and THH. This is being reviewed to ensure accuracy.

Improvements: All Trusts investigate variations between observed and expected deaths by diagnostic group. Reviews for quarter three were summarised in the learning from deaths report presented to APCQC and BiC with no issues to escalate.

Forecast Risks: N/A

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board
Data Assurance: Data is supplied and quality assured by Telstra Health

4.1.3 CLINICAL PATHWAYS PROGRAMME UPDATE

Discussion Item

Peter Jenkinson / James Biggin-Lamming

REFERENCES

Only PDFs are attached

04.1.3 Clinical Pathways Programme Update.pdf

NWL Acute Provider Collaborative Board in Common
15 July 2025
Item number: 4.1.3
This report is: Public

NWL Acute Provider Collaborative (APC) Clinical Pathways Update

Author: Iona Twaddell, Peter Jenkinson
Job title: Senior Advisor to the CEO, ICHT, Director of Corporate Governance

Accountable director: Tim Orchard
Job title: ICHT CEO

Purpose of report

Purpose: Information or for noting only

To update on implementation of the APC clinical pathways project.

Report history

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

Board in Common Cabinet	**APC Quality Committee**	**APC EMB**
11/06/2025	19/06/2025	07/07/2025
Noted	Noted	Noted

Executive summary and key messages

The APC clinical pathways programme is a key component of the APC strategy. Each of 28 specialties across the APC are aligning a pathway to best practice led by a specialty leadership group with representatives from each trust and overseen by one of the APC Chief Executive Officers (CEOs).

The aim of this work was to build relationships across the four trusts and to make quality-focused changes in patient pathways that align to best practice across the four trusts. This has been a successful programme so far, bringing together clinicians and operational leaders across trusts who have not previously worked closely together.

The APC Executive Management Board (EMB) agreed to focus on implementation of phase 1 of the pathways programme over summer, with consideration of the ongoing approach, aligned to the 2025/26 environment, to follow afterwards. APC EMB receives regular updates on projects'

progress against the milestones they have set out and development of metrics to demonstrate benefits once the pathways are implemented.

We have organised an event on 15 July 2025 to bring together the operational and clinical leads from the pathways project to share learning on phase 1 and to discuss what would be useful for the next phase of the programme.

While progress has been made in meeting milestones to implement the programme, we are now focusing on the development of key metrics that we will use to measure successful implementation of the pathway changes. Challenges in determining these metrics include Business Intelligence (BI) capacity to support, particularly with requirements for manual data collection and data collected in different ways across trusts.

The Board is Common is asked to:

- **Note** the update on implementation on the clinical pathways programmes.

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

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

Main Paper

1. Background

1.1 The north west London acute provider collaborative (NWL APC) strategy was published in July 2024. The strategy sets out a guiding approach - to set and raise standards across the APC, improving patient outcomes through aligning all the Trusts' approaches so they all meet best practice.

1.2 Each of 28 specialties across the APC has chosen one pathway to align to best practice led by a specialty leadership group with representatives from each trust and overseen by one of the APC CEOs. Pathways were required to be 'implementable' by 1 April 2025.

1.3 The aim of the pathways programme was to build relationships across clinical and operational leaders across the APC, with a focus on improving quality, equity of access and outcomes. By their nature the pathways will lead to some improvements in productivity but this was designed as a programme primarily to improve quality and patient outcomes and we have other approaches that focus more specifically on improving productivity.

1.4 The programme also aimed to highlight any issues in working across the APC that we would need to resolve in future work. One issue this work has highlighted is the ability to collect and see real-time data for specific pathways across the APC and BI capacity for cross-APC work, which we are working to resolve.

1.5 Every pathway has made progress and 27 of the 28 pathways submitted implementation plans by the April deadline. The APC EMB is monitoring the pathways against their specified milestones for summer. As previously reported, pathways have identified benefits that these changes will bring and as we begin implementation, each pathway is developing appropriate metrics to demonstrate progress against these benefits.

1.6 We have developed a programmatic approach to this work, measuring each pathway against their agreed milestones and their work in developing metrics to demonstrate progress. As the implementation is ongoing, we are focusing on holding pathways to their milestones to ensure the pathway rollout is proceeding as planned.

1.7 A further phase of the programme will be developed following engagement with pathways leads on 15 July 2025, focusing specifically on the challenges of this financial year.

2. Update on implementation

2.1 There have been strong relationships built across clinical and operational teams across trusts who have not previously worked together, which provides a strong foundation for future work, which will continue to improve quality and also more directly impact efficiency.

2.2 **Milestones -** the majority of pathways are on track with the milestones listed in the implementation plans, with some amendments to timelines. Most pathways are due to be up and running by end of summer and we have agreed to focus the summer period on implementation. Some pathways have already completed implementation and are working to measure progress. However, some pathways

are reconsidering their planned change having done further work, for example pain, colorectal and rheumatology. Detail on progress against the milestones listed in the implementation plan in the table in annex 1.

2.3 **Metrics -** Pathways are particularly working on gathering metrics to demonstrate benefits and progress. 24 pathways have defined measurable metrics, with 15 having identified baselines for these. Oversight groups are working with pathway teams whose metrics need to be better defined to ensure progress is trackable. In annex 1 we set out the proposed and developing metrics for all the pathways.

2.4 Issues that pathways have faced in developing metrics and obtaining baselines have included: requirement for clinical audit to collect the data, waiting to clearly define the pathway change before defining metrics and BI capacity to support.

2.5 Despite this, some pathways have made progress against targets already as part of the work. The milestones show progress towards implementing positive change for patients, the metrics will show if we can make progress. Annex 2 has some deep dives into the pathways for more detail on the changes.

3. Next steps

3.1 **APC clinical pathways forum 15 July -** we have a clinical pathways forum on 15 July 2025, from 3pm-5pm at W12 conference centre. We have asked each pathway to send one clinician and one operational lead and all APC EMB members have been invited. All NEDs are welcome to join if available. The forum will be a chance to share progress on each pathway and for pathway members to discuss shared learning and lessons for the next phase of the programme.

3.2 All pathways are producing posters to detail their pathway change to share the work done so far. There will then be discussion on learnings from the work so far and what would be useful in future APC pathways work.

3.3 After this event, we will be able to set out more detail on what future pathways programmes will look like. It is likely to be a bit more proscriptive about what pathways are chosen to maximise the benefits, particularly productivity benefits.

4. Risks and issues

4.1 **BI capacity**: There is lack of capacity in BI teams for APC work, particularly given that manual data collection is required for many of the chosen metrics and it is difficult to get real-time metrics and monitoring. Developing an APC BI approach is a priority for this year.

4.2 **Data sharing**: There have been concerns from data teams about sharing patient-level information across trusts, or requiring further governance to share this data, which has limited the ability for pathways teams to collect measures and baselines. We are reviewing data sharing agreements to clarify what is already in place and what more might be needed to enable smoother information sharing.

4.3 **Engagement**: to address any risk of reduced engagement, we will use the pathways forum on 15 July 2025 to building momentum for future phases the project. We are also working with engagement colleagues on the best way to promote the work more widely across the trusts.

Annex 1: Progress on metrics and milestones

<table>
<tr><th>Specialty</th><th>Milestones</th><th>Metrics – baseline/targets</th><th>Baselines identified?</th><th>Targets identified?</th></tr>
<tr>
<td>Dermatology (CWFT)
Standardising triage protocols</td>
<td>
<table>
<tr><th>Milestone</th><th>Target date</th><th>Current progress/ notes</th></tr>
<tr><td>Agree stock answers</td><td>March 2025</td><td>Complete</td></tr>
<tr><td>Agree implementation approach</td><td>March 2025</td><td>Complete</td></tr>
<tr><td>Develop training and education</td><td>April 2025</td><td>Complete</td></tr>
<tr><td>Complete rollout</td><td>May 2025</td><td>Approach rolled out; evaluation planned in coming weeks on data/ outcomes</td></tr>
</table>
</td>
<td>
<table>
<tr><th rowspan="2">KPI</th><th colspan="4">Baseline</th><th rowspan="2">Target</th></tr>
<tr><th>CWFT</th><th>ICHT</th><th>LNWH</th><th>THH</th></tr>
<tr><td>Percentage of A&G responded to in 14 days</td><td>83.8%</td><td>Not available</td><td>79%</td><td>Not available</td><td>95%</td></tr>
<tr><td>Percentage of A&G diverted</td><td>94.6%</td><td>81.3%</td><td>89%</td><td>1.83%</td><td>90% (THH have an intermediate model)</td></tr>
<tr><td>Percentage of routine referrals triaged (of referrals received per month)</td><td>96%</td><td>100%</td><td>100%</td><td>Being validated</td><td>80%</td></tr>
<tr><td>Percentage of triaged referrals rejected</td><td>37.9%</td><td>51.9%</td><td>31%</td><td>0%</td><td>50%</td></tr>
</table>
</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes and endocrinology (CWFT)
Standardising how we identify and support high-risk patients</td>
<td>
<table>
<tr><td>Complete dashboard build</td><td>May 2025</td><td>Dashboard developed and undergoing testing this month</td></tr>
<tr><td>Develop SOP</td><td>May 2025</td><td>SOP in progress and undergoing minor revisions based on feedback</td></tr>
<tr><td>Implement dashboard</td><td>June 2025</td><td>In progress</td></tr>
<tr><td>Agreement from ICB to change Blueteq form</td><td>April 2025</td><td>Change approved by ICB; aiming to be in place in next few weeks</td></tr>
<tr><td>MDT dates agreed and in place</td><td>May 2025</td><td>Dates/times agreed and scheduling underway</td></tr>
</table>
</td>
<td>Progress will be demonstrated by:
• Number of patients who are appropriately started on an HCL system
• Number of patients discussed in a regional complex patient MDT
• Percentage of patients with hypoglycaemia who see a member of the Diabetes Team
• Reduction in readmissions with DKA and increased use of the diabetes Virtual Ward</td>
<td>Yes (1 of 4)</td>
<td>No</td>
</tr>
<tr>
<td>General Surgery (CWFT)
Standardising assessment, surgical pathways & follow up for hernia pathway</td>
<td>
<table>
<tr><td>Develop triage protocol</td><td>April 2025</td><td>IN PROGRESS – triage process developed, working on the digitisation of this</td></tr>
<tr><td>Complete assessment tool</td><td>March 2025</td><td>Complete</td></tr>
<tr><td>Develop patient information</td><td>April 2025</td><td>IN PROGRESS – templates drafted, working through digitisation of this</td></tr>
<tr><td>Complete digitisation of tool</td><td>June 2025</td><td>IN PROGRESS – as above</td></tr>
</table>
</td>
<td>
<table>
<tr><th rowspan="2">KPI</th><th colspan="4">Baseline</th><th>National Target</th></tr>
<tr><th>CWFHT</th><th>THH</th><th>ICUH</th><th>LNWH</th><th></th></tr>
<tr><td>Daycase rate for elective laparoscopic unilateral primary inguinal hernia repair</td><td>71.20%</td><td>80.80%</td><td>77.80%</td><td>57.50%</td><td>92.30%</td></tr>
<tr><td>Emergency readmission within 30 days following elective recurrent inguinal hernia repair</td><td>7.10%</td><td>4.80%</td><td>3.30%</td><td>2.60%</td><td>0.00%</td></tr>
<tr><td>Percentage of HVLC Inguinal hernia procedures</td><td>19.30%</td><td>13.50%</td><td>33.00%</td><td>70.40%</td><td>14.50%</td></tr>
</table>
</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</table>

<table>
<tr><th>Specialty</th><th>Milestones</th><th>Metrics – baseline/targets</th><th>Baselines identified?</th><th>Targets identified?</th></tr>
<tr><td></td><td></td><td>with an outpatient attendance within 90 days of discharge</td><td></td><td></td></tr>
<tr><td>HIV/GUM & ID (CWFT)
Standardising process for acute new HIV diagnosis</td><td>
<table>
<tr><td>Develop standard process</td><td>May 2025</td><td></td></tr>
<tr><td>Develop training and education</td><td>May 2025</td><td></td></tr>
<tr><td>Complete rollout</td><td>June 2025</td><td></td></tr>
</table>
</td><td>
<table>
<tr><th>Centre No.</th><th>% Late Diagnosis CD4 < 350 [ITT]</th><th>% Very Late CD4 <200 [ITT]</th><th>% CD4 within 1 month [ITT]</th><th>% start ART within 3/12 [ITT]</th><th>% undetectable after 1 year [ITT]</th><th>% on ART [ITT]</th><th>Retention at 1 year [ITT]</th></tr>
<tr><td>1</td><td>56</td><td>29</td><td>77</td><td>82</td><td>97</td><td>100</td><td>97</td></tr>
<tr><td>2</td><td>59</td><td>38</td><td>78</td><td>77</td><td>96</td><td>99</td><td>96</td></tr>
<tr><td>3</td><td>54</td><td>15</td><td>83</td><td>92</td><td>97</td><td>99</td><td>95</td></tr>
<tr><td>4</td><td>63</td><td>59</td><td>68</td><td>69</td><td>94</td><td>99</td><td>94</td></tr>
<tr><td>5</td><td>28</td><td>11</td><td>87</td><td>93</td><td>96</td><td>100</td><td>95</td></tr>
<tr><td>6</td><td>62</td><td>38</td><td>69</td><td>42</td><td>98</td><td>99</td><td>97</td></tr>
<tr><td>7</td><td>75</td><td>42</td><td>92</td><td>58</td><td>98</td><td>100</td><td>96</td></tr>
<tr><td>8</td><td>72</td><td>56</td><td>94</td><td>94</td><td>97</td><td>99</td><td>97</td></tr>
<tr><td>9</td><td>77</td><td>57</td><td>55</td><td>48</td><td>96</td><td>96</td><td>86</td></tr>
<tr><td>NWL Mean</td><td>61</td><td>38</td><td>78</td><td>73</td><td>97</td><td>99</td><td>95</td></tr>
<tr><td></td><td>Aim = <40%</td><td>Aim = <20%</td><td>Aim = >95%</td><td>Aim = >90%</td><td>Aim = >99%</td><td>Aim = >95%</td><td></td></tr>
</table>
</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Respiratory (CWFT)
Standardising the COPD discharge bundle</td><td>
<table>
<tr><td>Implement new form in Cerner</td><td>May 2025</td><td>Complete</td></tr>
<tr><td>Develop training and education</td><td>June 2025</td><td>Complete</td></tr>
<tr><td>Complete rollout</td><td>June 2025</td><td>Complete</td></tr>
</table>
</td><td>
<table>
<tr><th>Trust</th><th>CWFHT</th><th>ICHT</th><th>LNWH</th><th>THH</th><th>Target</th></tr>
<tr><td>Cases</td><td>307</td><td>208</td><td>202</td><td>227</td><td></td></tr>
<tr><td>Respiratory review within 24 hours of admission to hospital (%)</td><td>70.4</td><td>62.5</td><td>50</td><td>73.6</td><td>60%</td></tr>
<tr><td>Key elements of discharge bundle provided as part of discharge (%)</td><td>74.2</td><td>54.4</td><td>38.1</td><td>86.3</td><td>60%</td></tr>
</table>
</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Vascular (CWFT)
Standardising access and provision to vascular angiography</td><td>
<table>
<tr><td>Complete audit</td><td>May 2025</td><td>Completed</td></tr>
<tr><td>Develop implementation plan</td><td>July 2025</td><td>Meeting to finalise scheduled for 11th July</td></tr>
<tr><td>Complete rollout</td><td></td><td></td></tr>
</table>
</td><td>In development following completion of audit (delays due to data quality)</td><td>No</td><td>No</td></tr>
<tr><td>Paediatrics (CWFT)
Common approach and pathway to infected bone and joint</td><td>
<table>
<tr><td>Complete audit</td><td>May 2025</td><td>In progress</td></tr>
<tr><td>Draft guidelines and obtain agreement</td><td>April 2025</td><td>In progress</td></tr>
<tr><td>Complete education and training</td><td>May 2025</td><td></td></tr>
</table>
</td><td>Audit - Completion of audit and data collection by each site
Standardised pathway - review and finalization of unified guideline
Initial Presentation and Diagnosis - clinical outcome improvements to be demonstrated in a repeat audit (e.g. Sepsis 6 commenced, relevant baseline tests including MRSA swab, ESR, CRP, WCC, blood culture, plain radiographs)
Timely Interventions -- clinical outcome improvements to be demonstrated in a repeat audit (e.g. surgical intervention, IV antibiotics)</td><td>No</td><td>No</td></tr>
</table>

<table>
<tr><th>Specialty</th><th>Milestones
<table><tr><th>Milestone</th><th>Target date</th><th>Current progress/ notes</th></tr></table></th><th>Metrics – baseline/targets</th><th>Baselines identified?</th><th>Targets identified?</th></tr>
<tr><td></td><td></td><td>Follow-Up - clinical outcome improvements to be demonstrated in a repeat audit (e.g. length of IV antibiotics, switch to oral antibiotics)</td><td></td><td></td></tr>
<tr><td>End of life (CWFT)
Standardise and digitise end of life fast-track discharge form</td><td><table>
<tr><td>Complete design of digital form</td><td>April 2025</td><td>Build work on-going with digital form</td></tr>
<tr><td>Develop standard SOP</td><td>May 2025</td><td>Document in draft awaiting confirmation of the digital form</td></tr>
<tr><td>Develop training, communications and education</td><td>May 2025</td><td>Awaiting completion of digital form</td></tr>
<tr><td>Implement digital form</td><td>June/July 2025</td><td></td></tr>
</table></td><td>The team identified metrics for fast-track discharges but collating the numbers has been challenging due to multiple sources, data held at different levels and the ICB not routinely collecting data. Main deliverable will be digitisation of form to align across the APC</td><td>N/A metrics not possible</td><td>N/A metrics not possible</td></tr>
<tr><td>Anaesthetics (THHFT)
Clear guidelines for managing patients taking glucagon-like peptide-1 (GLP-1) and sodium-glucose cotransporter 2 (SGLT2) inhibitors prior to surgery</td><td><table>
<tr><td>GLP 1 agonist guideline – Final document.</td><td>30/04/2025</td><td>Completed</td></tr>
<tr><td>GLP 1 agonist guideline – roll out</td><td>01/05/2025</td><td>In Progress</td></tr>
<tr><td>SGLT 2 inhibitor pathway - Draft</td><td>21/3/25</td><td>Completed</td></tr>
<tr><td>SGLT 2 inhibitor pathway - Final</td><td>30/04/2025</td><td>Completed</td></tr>
<tr><td>SGLT 2 inhibitor pathway - Roll out</td><td>01/05/2025</td><td>In Progress</td></tr>
</table></td><td>Audits of complications arising from patients taking GLP1 agonists and SGLT2i’s.

No comprehensive guidelines across all Trusts in the APC. Pulmonary aspiration of gastric contents for patients on these medications is rare, but is documented in the literature. No adverse incidents related to pulmonary aspiration reported in the APC.</td><td>No</td><td>No</td></tr>
<tr><td>Breast (THHFT)
Standardise approach to family history referrals</td><td><table>
<tr><td>Complete standardised SOP</td><td>07/04/25</td><td>Completed</td></tr>
<tr><td>Local trust rollout</td><td>End of May</td><td>Imperial and LNW completed. THH and Chelwest in progress</td></tr>
</table></td><td>Outcome will be chemoprevention being offered as a service extension to family history
Considering appropriate workforce to deliver this.
Where will community follow up take place, pathway has engaged with Primary Care for follow up.</td><td>No</td><td>No</td></tr>
<tr><td>Haematology (THHFT)
Optimise MDTs/clinics for thrombosis</td><td><table>
<tr><td>Complete standardised SOP</td><td></td><td>Completed</td></tr>
</table></td><td>Metrics being formed around the following:
Waiting times in clinics, accurate capture of activity and RTT time
Accurate recording to Hospital Acquired thrombosis
Datix/SIs</td><td>No</td><td>No</td></tr>
</table>

<table>
<tr><th>Specialty</th><th>Milestones</th><th>Metrics – baseline/targets</th><th>Baselines identified?</th><th>Targets identified?</th></tr>
<tr><td></td><td>
<table>
<tr><th>Milestone</th><th>Target date</th><th>Current progress/ notes</th></tr>
<tr><td>Local Trust implementation plans completed</td><td>2nd June</td><td>In Progress</td></tr>
<tr><td>Local Trust implementation completed</td><td></td><td>TBC</td></tr>
</table>
</td><td>

Patient satisfaction surveys

</td><td></td><td></td></tr>
<tr><td>Ophthalmology (THHFT)
Single standard for diagnostic clinics for medical retina and glaucoma</td><td>
<table>
<tr><td>Complete standardised SOP</td><td>July 2025</td><td>In progress</td></tr>
<tr><td>Cerner change requests confirmed</td><td>July 2025</td><td>In progress</td></tr>
<tr><td>Local Trust plans</td><td>July 2025</td><td>Not started yet</td></tr>
</table>
</td><td>Pathway is a large complex change, but phase I metrics likely to include:

Aligning pathway flow
DNA rates
Size of waitlist
Number of referrals to ECLO
Current wait for follow-up and new glaucoma appointments
Patient Feedback
Staff Experience

</td><td>No</td><td>No</td></tr>
<tr><td>Pain Management (THHFT)
Optimise MDT approach for specialist pain management</td><td>The pathway is currently reevaluating their chosen pathway change.</td><td>Pathway has been fully analysed and due to the different make-ups of teams and services at present. There was broad consensus that the APC should consider the consolidation of all current SPM clinical services across Trusts into a combined clinical team & single point of access, which could optimise the utilisation of existing SPM resources. The pathway team are recommending this approach which could be developed and delivered as part of a phase two of this work.</td><td>No</td><td>No</td></tr>
<tr><td>Geriatrics and frailty medicine (THHFT)
Improvement in delirium pathway</td><td>
<table>
<tr><td>Complete standardised SOP</td><td></td><td>Completed</td></tr>
<tr><td>Local trust rollout</td><td>End of May</td><td>completed</td></tr>
<tr><td>Dashboard built with all Trust feeding data to evaluate progress</td><td>End of May</td><td>In progress. THH and LNW Live, Chelwest in progress. Imperial awaiting approval</td></tr>
</table>
</td><td>Rate of delirium assessment within 24 hrs of presentation (all non-elective admissions over 65yrs)

% of patients over 65y that have 4AT completed within 24hrs of presentation

Completion of Dashboard for data reporting including patient location (if assessment positive for delirium) to support future work and guide targeted support.</td><td>Yes apart from Imperial</td><td>Yes</td></tr>
<tr><td>Colorectal (LNWH)
Standardise external rectal prolapse pathway</td><td></td><td>Pathway option being re-scoped</td><td>No</td><td>No</td></tr>
</table>

<table>
<tr><th>Specialty</th><th>Milestones</th><th>Metrics – baseline/targets</th><th>Baselines identified?</th><th>Targets identified?</th></tr>
<tr>
<td>Ear, Nose and Throat (LNWH)
Straight to test pathway for tinnitus</td>
<td>
<table>
<tr><th>Milestone</th><th>Target date</th><th>Current progress/ notes</th></tr>
<tr><td>Socialise pathway with colleagues</td><td>May 2025</td><td>Complete</td></tr>
<tr><td>Communication to GPs</td><td>May 2025</td><td>Planned for July</td></tr>
<tr><td>Update ERS with new referral process</td><td>April 2025</td><td>Planned for July</td></tr>
<tr><td>Communication to Audiology and Radiology</td><td>April 2025</td><td>Planned for July</td></tr>
<tr><td>Assurance meeting to confirm pathway can go live</td><td>June 2025</td><td>Planned for July</td></tr>
</table>
</td>
<td>
<table>
<tr><th>KPI</th><th>Target</th></tr>
<tr><td>Reduction in number of appointments with an ENT specialist</td><td>TBC</td></tr>
<tr><td>Improved patient experience</td><td>N/A</td></tr>
<tr><td>Waiting list reduction</td><td>TBC</td></tr>
</table>
</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Gynaecology (LNWH)
Implement one stop clinics for long gynaecology waiters as per CWFT pathway (GLOW clinic)</td>
<td>
<table>
<tr><th>Milestone</th><th>Target date</th><th>Current progress/ notes</th></tr>
<tr><td>Confirm implementation of new model</td><td>April 2025</td><td>Complete</td></tr>
<tr><td>Set up clinic codes for Cerner</td><td>April 2025</td><td>Complete</td></tr>
<tr><td>Communications plan to socialise the new pathway</td><td>July 2025</td><td>In progress</td></tr>
<tr><td>GMs to decide inclusion, exclusion and referral criteria</td><td>April 2025</td><td>Complete</td></tr>
<tr><td>Implement model</td><td>July 2025</td><td>Partially complete - THH starting soon</td></tr>
<tr><td>Measure outcomes</td><td>July 2025</td><td>In progress</td></tr>
</table>
</td>
<td>
<table>
<tr><th>KPI</th><th>Target</th></tr>
<tr><td>Waiting time from ref to appt</td><td>18 weeks RTT</td></tr>
<tr><td>New: follow-up ratio</td><td>5:1</td></tr>
<tr><td>Waiting time from first appt to follow-up</td><td>6 weeks</td></tr>
<tr><td>No. patients d/c after first appt</td><td>TBC</td></tr>
<tr><td>No. patients treated after first appt</td><td>80%</td></tr>
<tr><td>DNA rate</td><td>TBC</td></tr>
</table>
Baseline metrics delayed by BI capacity and/or process
</td>
<td>Yes

LNWH only</td>
<td>Yes</td>
</tr>
<tr>
<td>Maternity / neonatology (LNWH)
Align to best practice in jaundice</td>
<td>
<table>
<tr><th>Milestone</th><th>Target date</th><th>Current progress/ notes</th></tr>
<tr><td>LMNS Neonatal working group meeting</td><td>March 2025</td><td>Complete</td></tr>
<tr><td>Picterus pilot study at ICHT postnatal ward</td><td>July 2025</td><td>Awaiting clinical engineering and IG approval</td></tr>
<tr><td>NWL Neonatal jaundice guideline to be developed and approved</td><td>July 2025</td><td>In progress – engagement from all units in NWL</td></tr>
</table>
</td>
<td>
<table>
<tr><th rowspan="2">KPI</th><th colspan="4">Baseline</th><th rowspan="2">Target</th></tr>
<tr><th>LNWH*</th><th>ICHT*</th><th>CWFT*</th><th>THH**</th></tr>
<tr><td>Number of babies treated for jaundice with phototherapy prior to discharge</td><td>41</td><td>129</td><td>159</td><td>18</td><td>TBC</td></tr>
</table>
</td>
<td>Yes</td>
<td>No

In progress</td>
</tr>
</table>

<table>
<tr><th>Specialty</th><th>Milestones</th><th>Metrics – baseline/targets</th><th>Baselines identified?</th><th>Targets identified?</th></tr>
<tr><td></td><td>
<table>
<tr><td>Engagement of all staff</td><td>September 2025</td><td>In progress – comms to be sent when new pathway confirmed</td></tr>
</table>
</td><td>
<table>
<tr><td>Number of jaundice-related readmissions</td><td>66</td><td>45</td><td>97</td><td>15</td><td>TBC</td></tr>
<tr><td>Number of infants treated for jaundice above the exchange transfusion level</td><td>0</td><td>0</td><td>0</td><td>0</td><td>TBC</td></tr>
<tr><td>Number of babies admitted to NICU for jaundice treatment</td><td>7</td><td>4</td><td>32</td><td>4</td><td>TBC</td></tr>
</table>
*Data for March – August 2024
**Data for August – September 2024
Targets to be set by neonatal working group
</td><td></td><td></td></tr>
<tr><td>Orthopaedics (LNWH)
Standardise elective joint replacement pathway for hip, knee and shoulder</td><td>
<table>
<tr><td>Notification to primary care re: pathway change</td><td>July 2025</td><td>In progress – applies to THH and LNWH only</td></tr>
<tr><td>Local SOPs updated in line with new pathway</td><td>July 2025</td><td>In progress</td></tr>
<tr><td>Develop single patient information leaflet</td><td>August 2025</td><td>To start in July – inform patients at Joint School in the interim</td></tr>
<tr><td>Develop guidance for GPs on wound management for this cohort of patients</td><td>August 2025</td><td>Wound care clinics available for high risk patients</td></tr>
</table>
</td><td>
<table>
<tr><th>KPI</th><th>Target</th></tr>
<tr><td>Release of medical capacity from wound care clinics (LNWH)</td><td>Need to cost</td></tr>
<tr><td>RTT improvement</td><td>TBC</td></tr>
<tr><td>Improved patient experience through fewer hospital visits</td><td>FTT and PROMs – target TBC</td></tr>
<tr><td>Reduction in umber of follow-up appointments</td><td>Reduce by 2-3 (need to cost)</td></tr>
<tr><td>No doctor-led wound care clinics at LNWH (unless by exception for high risk patients)</td><td>0</td></tr>
<tr><td>No 1 year follow-up appointment (5 year PIFU instead)</td><td>0</td></tr>
<tr><td>Reduction in number of post-op X-rays</td><td>TBC</td></tr>
<tr><td>Reduction in 30 day post-op admission (Model Health System)</td><td>TBC</td></tr>
</table>
</td><td>Yes

LNWH only</td><td>Yes</td></tr>
</table>

<table>
<tr><th>Specialty</th><th>Milestones</th><th>Metrics – baseline/targets</th><th>Baselines identified?</th><th>Targets identified?</th></tr>
<tr><td></td><td></td><td>Baseline metrics delayed by BI capacity and/or process</td><td></td><td></td></tr>
<tr><td>Rheumatology (LNWH)
Standardise pathway and improve access to scanning for early inflammatory arthritis</td><td>
<table>
<tr><th>Milestone</th><th>Target date</th><th>Current progress/ notes</th></tr>
<tr><td>Agree pathway</td><td>April 2025</td><td>Pathway undergoing re-scoping</td></tr>
<tr><td>Update SOPs</td><td>April 2025</td><td>To start in June</td></tr>
<tr><td>Train admin and GMs on new pathway</td><td>April 2025</td><td>To start in June</td></tr>
<tr><td>Implement new pathway</td><td>May 2025</td><td>To start in June</td></tr>
<tr><td>Measure outcomes</td><td>June 2025</td><td>To start in July</td></tr>
</table>
</td><td>
<table>
<tr><th>KPI</th><th>Target</th></tr>
<tr><td>Time from referral to appt</td><td>3 weeks</td></tr>
<tr><td>Time from referral to initiation of treatment</td><td>6 weeks</td></tr>
<tr><td>Reduction of inappropriate referrals</td><td>TBC</td></tr>
<tr><td>Reduction in follow-up appointments</td><td>TBC</td></tr>
</table>
</td><td>No</td><td>Yes</td></tr>
<tr><td>Urology (LNWH)
Implement APC virtual MDT and improve access for acute stone service</td><td>
<table>
<tr><td>Agree APC pathway</td><td>March 2025</td><td>Complete</td></tr>
<tr><td>Develop communications plan</td><td>August 2025</td><td>To start in July</td></tr>
<tr><td>Implement APC admin process for lithotripsy</td><td>August 2025</td><td>Further discussion needed</td></tr>
<tr><td>Implement virtual MDT</td><td>TBC – dependent on Cerner functionality</td><td></td></tr>
<tr><td>Implement stent registry</td><td>September 2025</td><td>Process mapping complete</td></tr>
<tr><td>First patient treated on new pathway</td><td>September 2025</td><td></td></tr>
</table>
</td><td>
<table>
<tr><th>KPI</th><th>Target</th></tr>
<tr><td>Improved equity re: treatment options</td><td>TBC</td></tr>
<tr><td>Improved quality re: care/outcomes</td><td>TBC</td></tr>
<tr><td>Release of theatre slots</td><td>N/A</td></tr>
</table>
</td><td>Yes</td><td>No</td></tr>
<tr><td>Cancer and oncology (ICHT)
Standardise approach to prostate sterotactic ablative radiotherapy (SABR) new treatment</td><td>
<table>
<tr><td>Waiting times all to target</td><td>TBC – hoping mid summer</td><td>Additional resource in post and wait times reduced sufficiently</td></tr>
<tr><td>Socialisation of pathway at Urology lMDT and sMDT</td><td>Underway at sMDT first. lMDT once backlogs resolved</td><td>Ongoing</td></tr>
<tr><td>Quality assurance approvals for NHSE</td><td>Completed</td><td>Completed</td></tr>
</table>
</td><td>
<table>
<tr><th>Metric</th><th>CWFHT</th><th>ICHT</th><th>LNWH</th><th>THH</th><th>Target</th></tr>
<tr><td>Equal opportunity for treatment offer</td><td>Not offered</td><td>Offered on trial</td><td>Not offered</td><td>Not offered</td><td>Available to all</td></tr>
<tr><td>Time to clinical</td><td>Baseline 84 days (WMUH)</td><td>11.7 days</td><td>7 days</td><td>28 days</td><td>Under 10 days</td></tr>
</table>
</td><td>Yes</td><td>Yes</td></tr>
</table>

<table>
<tr><th>Specialty</th><th>Milestones</th><th>Metrics – baseline/targets</th><th>Baselines identified?</th><th>Targets identified?</th></tr>
<tr><td></td><td>
<table>
<tr><td>Clinical oncologist training and sign off (for ICHT)</td><td>Completed</td><td>Completed</td></tr>
<tr><td>Implementation completed and pathway adopted</td><td>Following backlog resolution – summer</td><td></td></tr>
</table>
</td><td>
<table>
<tr><td>oncology opinion</td><td>Now 21 days</td><td></td><td></td><td></td><td></td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>Endoscopy & Gastroenterology (ICHT)
Standardise endoscopy direct access referral form</td><td>
<table>
<tr><td>Make agreed changes to direct access form</td><td>25/04/2025</td><td>Complete</td></tr>
<tr><td>Circulate new form with ICB and Primary Care colleagues</td><td>25/05/2025</td><td>Will circulate once DOS agreed</td></tr>
<tr><td>Install new form on GP systems and remove existing forms</td><td>25/06/2025</td><td>Aiming mid-end June</td></tr>
</table>
</td><td>
<table>
<tr><th>KPI</th><th>CWFHT</th><th>ICHT</th><th>LNWH</th><th>THH</th><th>Target</th></tr>
<tr><td>% of patients receiving a gastroscopy aged 17-65</td><td>41.1%</td><td>41.8%</td><td>39.8%</td><td>36.7%</td><td>Reduce to 35.5%</td></tr>
<tr><td>Direct access forms</td><td colspan="4">Over 4</td><td>1 across APC</td></tr>
</table>
</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Imaging (ICHT)
Standardise access to/process of hysterosaplingograms (HSG)</td><td>
<table>
<tr><td>Workshop 1 (in person) for process mapping/ alignment</td><td>May 2025</td><td>Workshop 9th June</td></tr>
<tr><td>Task and Finish groups as needed</td><td>May - July</td><td></td></tr>
<tr><td>Workshop 2</td><td>July 25</td><td></td></tr>
<tr><td>Workshop 3</td><td>September 25</td><td></td></tr>
<tr><td>Audit or images</td><td>Q1</td><td></td></tr>
<tr><td>Engagement:</td><td>March 25

September 25</td><td></td></tr>
</table>
</td><td>Exact metrics to be determined by pathway workshops but likely to include:
Reduced false positive results (ie diagnosing occluded tubes when they are open), reducing rates of inappropriate referral for repeat HSG and FTR. (audit)
Reduced need for repeat HSG (audit)
Reduced radiation dose.</td><td>Some baselines identified but further being collected</td><td>No</td></tr>
<tr><td>Neurology (ICHT)
Standardise triage protocol for general neurology</td><td>
<table>
<tr><td>Revised triage pathway written & disseminated</td><td>01 April 2025</td><td>Completed</td></tr>
<tr><td>Communication to Primary Care through Lead</td><td>01 April 2025</td><td>Leads attended GP forum 04/06. Regular updates scheduled.</td></tr>
<tr><td>A noted reduction in acceptance rate</td><td>01 July 2025</td><td>Working to get more regular reporting on acceptance rate</td></tr>
</table>
</td><td>
<table>
<tr><th rowspan="2">KPI</th><th colspan="4">Indicative baselines</th><th rowspan="2">Target</th></tr>
<tr><th>CWFHT</th><th>ICHT</th><th>LNWH</th><th>THH</th></tr>
<tr><td>Align referral management across NWL (% referrals accepted)</td><td>83%</td><td>100%</td><td>84%</td><td>100%</td><td>70%</td></tr>
</table>
</td><td>Yes</td><td>Yes</td></tr>
</table>

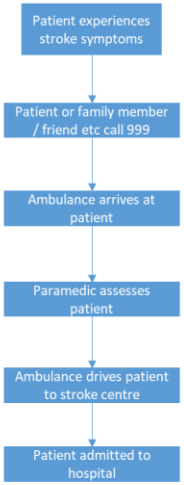
<table>
<tr><th>Specialty</th><th>Milestones</th><th>Metrics – baseline/targets</th><th>Baselines identified?</th><th>Targets identified?</th></tr>
<tr><td></td><td>
<table>
<tr><td>A reduction in waiting list size</td><td>30 October 2025</td><td>Working to get more regular reporting on waiting list size</td></tr>
</table>
</td><td>
<table>
<tr><td>Reduce waiting time to first OPA</td><td>17ww</td><td>33ww</td><td>40ww</td><td>48ww</td><td>40ww</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>Stroke (ICHT)
Extend access to virtual triage for stroke across NWL</td><td>
<table>
<tr><td>Lead Trusts (NWP & ICHT) develop business case for 4x ACPs</td><td>30 April 2025</td><td></td></tr>
<tr><td>bed day savings model and high level investment case ppt summary finalised</td><td>12 June (updated)</td><td></td></tr>
<tr><td>business case completed by 31 Augus</td><td>31 August (updated)</td><td></td></tr>
</table>
</td><td>
<table>
<tr><th>KPI</th><th>CWFHT</th><th>ICHT</th><th>LNWH</th><th>THH</th><th>Target</th></tr>
<tr><td>Time to treatment (% given thrombolysis)</td><td>7%</td><td>18%</td><td>15%</td><td>12%</td><td>20%</td></tr>
<tr><td>Admissions of stroke mimics on medical wards (patients diverted)</td><td>TBC</td><td>TBC</td><td>TBC</td><td>TBC</td><td>TBC.</td></tr>
<tr><td>Release of clinician time – reduced locum hours</td><td>0</td><td>25hrs per week</td><td>0</td><td>0</td><td>0 locum hours</td></tr>
</table>
</td><td>For 2 of 3 metrics</td><td>For 2 of 3 metrics</td></tr>
<tr><td>Cardiology (ICHT)
Standardise syncope pathway across APC</td><td>
<table>
<tr><td>Discussion and agreement with key stake holders on final SOP</td><td>07/03/24</td><td rowspan="2">Complete Pathway has been approved in north London ODN</td></tr>
<tr><td>Finalise implementation plan</td><td>30/04/25</td></tr>
<tr><td>Initial launch</td><td>Mid-May</td><td>Already live at ICHT, then NWP, then THHFT</td></tr>
</table>
</td><td>Baselines will be available once the digital solution is implemented in Cerner, but metrics will include:
Proportion of syncope /TLOC ED attendances that are admitted for >12 hours
Readmission within 30 days</td><td>No</td><td>No</td></tr>
<tr><td>Hepatology (ICHT)
Standardise pathway for hep B prophylaxis for chemotherapy and immunosuppressed patients.</td><td>
<table>
<tr><td>Create comprehensive list of drugs and provide to Cerner team</td><td>25/04/2025</td><td>List received from pharmacy - consists of > 5000 drugs all individually named (rather than category of drugs) - so working through them</td></tr>
<tr><td>Provide SACT board guidelines to upload as advice for prescribers</td><td>30/05/2025</td><td></td></tr>
<tr><td>Liaise with Cerner team to discuss protocol</td><td>30/05/2025</td><td>Not actioned</td></tr>
<tr><td>Cerner request for change</td><td>30/05/2025</td><td>Not actioned</td></tr>
</table>
</td><td>Progress will be shown by:
Increase % of patients on high risk drugs who have been screened for Hep B
Reduce no. of referrals related to Hep B</td><td>No</td><td>No</td></tr>
</table>

Specialty	Milestones			Metrics – baseline/targets	Baselines identified?	Targets identified?
	Milestone	**Target date**	**Current progress/ notes**			
	Make it a requirement that all new drugs put on to Cerner are assessed for HBV reactivation risk, prior to addition to Cerner. Develop a detailed timeline with clear milestones and their target dates for the most important steps and changes required to implement the pathway change.	01/08/2025	Local pharmacy lead contacted as will need to go through sector DTC			

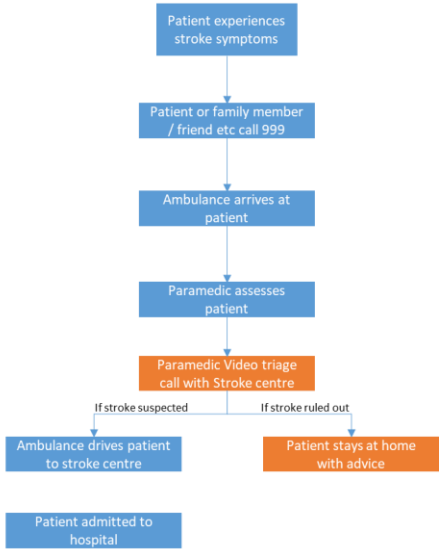
Annex 2: Pathways deep dives

Stroke

Current state pathway



APC future state pathway



The below table compares the costs of the two pathways for one patient. The costs are indicative for a patient who had stroke symptoms but didn't have a stroke. Research has shown that there is a high prevalence of patients who are admitted when a stroke hasn't occurred.

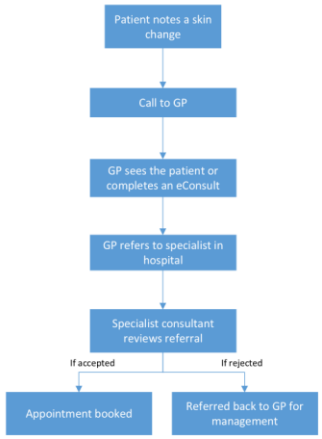
Pathway step	*Current state costs*	*APC future state costs*
Patient experiences symptoms	N/A	N/A
Patient / family member / friend call 999	£7	£7
Ambulance arrives at patient	£252	£180
Paramedic assesses patient		
Ambulance drives patient to stroke centre		N/A
Paramedic video triage call with stroke centre	N/A	£70
Patient admitted to hospital	£500 (1 day)	N/A
Total	**£759**	**£257**

Implementing video calls for stroke assessments has been shown to be cost-effective. A study in the East of England found that integrating telemedicine improved thrombolysis rates and resulted in NHS cost savings of approximately **£482,000** in the first year, with social care savings of **£1.7 million** over five years.

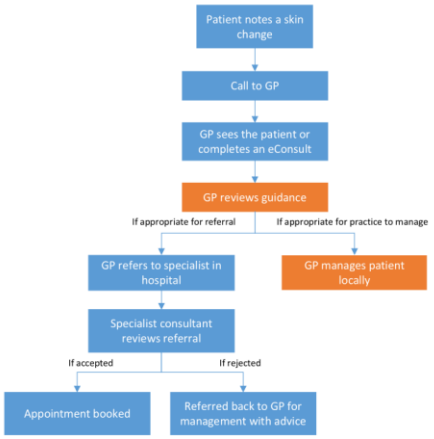
APC Derm pathway – current and future state

The below flow charts demonstrate the key steps and differences in the proposed future state pathway compared to the current state.

Current state pathway



APC future state pathway



NHS
North West London

APC Derm pathway – cost efficiencies

The approximate costs to see a single patient for a first appointment for a skin change: £262

Component	Approximate Cost*
Medical staff	£83
Nursing staff	£81
Pathology and pharmacy	£24
Clinic supply and services	£9
Insurance, overhead & depreciation	£65
Total	**£262**

Activity	Current performance**			Target	Improvement opportunity		
	CWFT	ICHT	LNWH		CWFT	ICHT	LNWH
Diversion rate for pre referral specialist advice (e.g. advice & guidance) in dermatology	94.6%	81.3%	89%	90% of A&G diverted	0%	8.7%	1%
Percentage of triaged referrals rejected	37.9%	51.9%	31%	50% of triaged referrals	12.1%	0%	19%

In bringing activity more closely in line with targets, Trusts could anticipate up to a 20% decrease in patients being booked inappropriately for first appointments. Based on a 12% reduction in first appointments at CWFT, this would be equivalent to roughly **£515,400 in indicative cost avoidance** in 2024/25. Clinician time and capacity could then be reinvested in more appropriate activities like advice and guidance.

*Calculated based on review of CWFT data
**Captures three of four Trusts only as THH follow an intermediate model that alter the pathway and potential calculations significantly

NHS
North West London

4.1.4 COLLABORATIVE QUALITY COMMITTEE CHAIR REPORT

Discussion Item Pat Gallan

REFERENCES

Only PDFs are attached

04.1.4 APC Quality Committee Chair Report.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 17 June 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. Deep Dive – Mental Health in an Acute Setting Workstream

The Committee commenced a deep dive into the mental health workstream focusing on improving care for patients with mental health issues in emergency departments and inpatient settings. Committee members noted that initial benchmarking of staff and care models had been conducted to identify gaps and refine practices across the Acute Provider Collaborative (APC). This involved comparing staffing models and care approaches across the four Trusts. Committee members noted that the transformation teams were developing a cost indicator to benchmark healthcare costs and identify efficient models. This involved understanding the financial impact of mental health care delivery and exploring cost effective staffing models. Committee members noted that the APC mental health strategy had been completed, focusing on setting objectives and measuring data to drive improvements in mental health care.

2.2. Acute Collaborative Quality Performance Report

2.1.2. The Committee received the collaborative quality performance report. Performance at acute provider collaborative level was similar to previous months with standards being met for the majority of metrics. Committee members noted that the all Trusts within the Acute Provider Collaborative had shown strong performance across several areas including safety, reporting culture and mortality data. Committee members noted that the Infection Prevention & Control measures metrics remained above national targets, however the APC were awaiting new targets for the current year. The Committee were assured that all areas of variance were being managed through action plans to support improvement.

2.2 Update on Quality Priorities 2025/26

2.2.1 **Procure and implement a joint reporting and learning system**
The Committee received an update on the progress of the implementation of the new Incident and Risk Management System. Committee members noted that the tender process and business case had been approved and completed across the Trusts, and an implementation group had been established to lead the standardisation and roll out process. Committee members noted that the Trusts were in the process of developing and standardising the modules based on best practices and alignment with existing processes.

2.2.2 **Implement the standardised guideline for deteriorating patient and sepsis**
Committee members received an update on the deteriorating patients work stream noting that there was a continued focus on the implementation of Martha's Rule with all four Trusts being selected and included as pilot sites for Martha's Rule supported by NHS England. Two approaches were being piloted to address patient and family feedback on their condition. Committee members noted that a Cerner build would be established to standardise guidelines into the Cerner system to improve the recognition and response to patient deteriorating across the Acute Provider Collaborative.

2.2.3 **Align Clinical pathways to best practice across the APC**
Committee members received a progress update noting that 27 out of 28 clinical pathway groups had submitted their implementation plans within the set millstones, these plans included the identification of benefits, risks and digital requirements, with some pathways already integrated into Cerner, such as the respiratory pathways. Committee members noted that that the focus would remain on the first phase of the implementation to ensure benefits are realised prior to expanding to additional pathways.

2.3 Updates on Quality Workstreams 2025/26

2.3.1 **Implementation of NatSSIPs2**
Committee members received a progress update against the priority work stream to implement the recently revised national safety standards for invasive procedures. Committee members noted that whilst good progress had been made with a gap analysis being completed for all 4 Trusts to assess their alignment with the NatSSIPs2 standard. Committee members noted that training analysis was conducted to identify local ownership and to develop common training materials to ensure all Trusts were aligned with the new standards. Work had commenced on integrating NatSSIPs2 standards into the Cerner system to facilitate easier compliance and monitoring.

2.3.2 **APC EDI Patient Equity Workstream**
Committee members received the report noting that the workstream was progressing, focusing on reducing inequalities in healthcare access and improving communication with patients. Committee members noted that two quality and inequality metrics had been identified which were maternity access and sickle cell management. Committee members noted that the metrics were being built into the new Integrated Quality and Performance Report and there was continued efforts to engage with the communities to improve data collection and reporting for the identified metrics.

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.

Chelsea & Westminster Hospital NHS Foundation Trust highlighted The Trust's Quality Committee identified four points for escalation for the Collaborative Quality Committee. These were: prevention of future death notices, the number of inquests which had doubled over the past year, the increased demand and pressure on maternity services, and the Trust's good practice on medicines management.

The Hillingdon Hospitals NHS Foundation Trust highlighted that the Trust had received the final CQC report. There were issues with extracting data from Cerner for Female Genital Mutilation (FGM) Data Reporting and, the Trust was not currently compliant with NHS reporting requirements. The compliance with the complaint's response target had been trending down due to adjustments in the unplanned care process.

The Imperial College Healthcare NHS Trust Quality Committee highlighted that the neurosurgery specialties continued to require significant support and enhanced governance to maintain safety and in response to multiple complex issues, including managing and mitigating a high number of long waiting patients for elective care, reviewing and improving the experience of doctors in postgraduate training. Continuing pressures on the maternity services were noted however the committee were assured that the teams were prioritising patient safety.

London North West University Healthcare NHS Trust highlighted that there was a risk that the volume of acutely unwell patients with complex mental health needs attending the emergency department and across our inpatient wards was impacting on patient outcomes and patient flow, alongside staff and patient experience. The Trust had encountered a number of incidents where patients had come to harm including a recent catastrophic incident. A systemwide solution to this risk was required.

The Committee noted that there were no issues escalated through this round of meetings however, noted that themes identified within the report were common across all four Trusts.

2.4. Acute Provider Collaborative Learning from Deaths Quarter 4 summary report

2.4.1. The Committee reviewed the combined NWL APC Q4 report incorporating all four Trusts which outlined the key themes and outcomes from the learning from deaths process.

2.5. Quarterly Complaints report for Q4 2024/25

2.5.1. Committee members received the quarter four complaints report noting that there had been an increase in complaints across three of the four Trusts, with the increase noted across a wide range of services. Committee members noted the trends within the report and noted the importance of triangulating data to identify areas for improvement.

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 continued pressure and clinical risks that exist in caring for mental health patients in an acute setting.
- The implementation of a new APC incident report system had commenced

5. Concerns outstanding

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

6. Key actions commissioned

- None noted.

7. Decisions made

- There were no agenda items for approval within the agenda.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Deep dive: Mental Health in Acute Settings Workstream	For discussion and noting	10.	Combined Risk Escalation report from local Trust Quality Committees	For noting
2.	Acute Collaborative Quality Performance Report	To discuss	11.	Acute Provider Collaborative Learning from Deaths Quarter 4 summary report	For discussion and noting
3.	Updates on Quality Priorities 2025/26	To discuss	12.	Quarter 4 Complaints report	To discuss
4.	Procurement and Implementation of a Joint reporting and learning system	To discuss	13.	Committee forward planner	For noting
5.	Implement and Standardised guidance for deteriorating patients and sepsis	To discuss	14.		
6.	Align Clinical Pathways to best practice across the APC	To discuss	15.		
7.	Updates on Quality workstreams 2025/26	To discuss and noting	16.		
8.	Implementation of NatSSIPS2	To discuss	17.		
9.	APC EDI Patient equity workstream	To discuss			

9. Attendance

Members	September attendance
Patricia Gallan, Vice chair (CWFT), Non-executive director (THHT) (Chair)	**Y**
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)	**Y**
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)	**Y**
Janice Sigsworth, Chief nurse (ICHT)	**Y**
Lisa Knight, Chief nurse (LNWH)	**Y**

4.2 PEOPLE

10:35

4.2.1 PEOPLE - IQPR (ANYTHING BY EXCEPTION)

Discussion Item Pippa Nightingale

See Appendix 4.0

4.2.2 COLLABORATIVE PEOPLE COMMITTEE CHAIR REPORT

Discussion Item David Moss

REFERENCES

Only PDFs are attached

04.2.2 APC People Committee Chair Report.pdf

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

15 July 2025

Highlight Report

1. Purpose and Introduction

1.1 The role of the People Collaborative Committee is:

- To identify areas of people 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 Integrated Care System (ICS) integrated improvements.
- To draw to the Board in Common's attention matters they need to agree or note.

2. Key Highlights

- The E-Rostering project at London North West University Healthcare NHS Trust (LNW) demonstrated strong outcomes, including an 80% satisfaction rate, a 1.2% reduction in sickness absence, and £330,000 in savings during the pilot phase.
- The Equality, Diversity and Inclusion (EDI) plan update included integration of EDI objectives into appraisals and progress on ethnicity pay gap regulations.
- The Board Assurance Framework (BAF) was reviewed with a focus on aligning it more closely with strategic people objectives.
- Workforce planning showed reductions in bank and agency spend, with ongoing consultations to reduce substantive headcount.
- Updates were provided on the HR digital transformation and the development of a single recruitment function.
- The Key Performance Indicator (KPI) report highlighted improvements in Personal Development Review (PDR) completion and reductions in bank and agency usage but also flagged a rise in vacancy rates at The Hillingdon Hospitals NHS Foundation Trust (THH).
- The horizon scan identified upcoming challenges including industrial action and legislative changes.
- The committee approved the updated Terms of Reference and discussed the need for an AI usage policy.

3. Positive Assurances Received

- The E-Rostering project is on track and has received national interest. Committee members expressed strong support for the project's expansion to other staff groups.
- Reduction in bank and agency staff usage was acknowledged as a positive trend.
- Approval was granted to explore a digital transformation partnership, and progress is being made on the single recruitment function.

4. Key Risks to Escalate

- Misalignment between workforce data and financial performance could obscure the true impact of staffing changes.
- Challenges remain in developing an employee dashboard to support EDI initiatives.
- The BAF currently lacks sufficient focus on strategic risks such as future workforce needs and vertical integration.
- Potential industrial action by resident doctors and the Royal College of Nursing (RCN) poses operational risks.

5. Concerns Outstanding

- The pace of substantive workforce reduction is slower than anticipated due to lengthy consultation processes.
- The need for a robust digital platform to support recruitment transformation remains unresolved.

6. Key Actions Commissioned

- KC to confirm current E-Rostering arrangements across THH, Chelsea and Westminster Hospital NHS Foundation Trust (CWFT), and Imperial College Healthcare NHS Trust (ICHT).
- Development of an EDI dashboard with support from Business Intelligence and transformation teams.
- Review and align the BAF with the APC strategy and business plan.
- Align HR and finance data and project workforce reductions.
- Present a timeline and milestones for the digital transformation programme.
- Develop an implementation plan for the single recruitment function by April 2026.
- Adopt a common PDR window across all trusts.
- Prepare contingency plans for potential industrial action.

7. Decisions Made

- The Committee approved the minutes of the previous meeting and noted the action log as complete.
- Agreement to explore the potential to adopt the self-rostering project across the Collaborative.
- Approval to adopt a common PDR completion window across all trusts.
- Approval of the updated Terms of Reference with a minor amendment.
- Agreement to review and share an AI usage policy across the collaborative via the Data and Digital Committee.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Self Rostering Project	Assurance	6.	Collaborative People KPI Report	Assurance
2.	APC Board Workforce EDI Plan	Assurance	7.	Strategic People Horizon Scan	Noting
3.	Board Assurance Framework	Assurance	8.	Local Trust People Committee Escalation Report	Assurance
4.	Workforce Plan	Assurance	9.	Terms of Reference	Approval
5.	Collaborative People Transformation Project Updates	Assurance			

9. Attendance

Members:	December attendance
David Moss, Non-Executive Director, LNWH (Chair)	Y
Sim Scavazza, Non-Executive Director, ICHT	Y
Simon Morris, Non-Executive Director, THHFT	N
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
Kevin Croft, Chief People Officer (ICHT, Chelwest, THHT))	Y
Tracey Connage, Chief People Officer, (LNWH)	Y
Dawn Clift, Director of Corporate Affairs (LNWH)	Y
Alexia Pipe, Chief of Staff to Chair in Common	Y

4.3 FINANCE AND PERFORMANCE

10:50

4.3.1 PERFORMANCE - IQPR (ANYTHING BY EXCEPTION)

Discussion Item Lesley Watts

See Appendix 4.0

4.3.2 FINANCIAL PERFORMANCE REPORT

Discussion Item Bimal Patel

REFERENCES

Only PDFs are attached

04.3.2 Financial Performance Report - Cover Sheet.pdf

04.3.2a NWL APC M2 Financial Performance.pdf

NWL Acute Provider Collaborative – Board in Common

15/07/2025
Paper
This report is: Public

2025/26 NWL APC Financial Performance (Month 2)

Author: Helen Berry
Job title: Associate Director of Finance, NWL Acute Provider Collaborative (APC)

Accountable director: Bimal Patel
Job title: Chief Financial Officer (CFO), London North West University Healthcare NHS Trust (LNW) – on behalf of the APC CFOs

Purpose of report

Purpose: Assurance

Report history

This paper was considered by:

NWL Acute CFOs 27/06/2025 Noted and approved.	NWL Executive Management Board 07/07/2025 Noted and approved.

Executive summary and key messages

The report notes the financial performance of the Acute Provider Collaborative (APC) to the end of May 2025.

Income & Expenditure (I&E), Cash and Capital are reported.

Summary:

- The APC reported a year-to-date (YTD) deficit of £11.7m to the end of May 2025 against a deficit plan of £4.4m, an adverse YTD variance of £7.3m.

- All four trusts report adverse variances to plan.

- In month, the deficit is £6.4m, against a deficit plan of £2m, a £4.2m adverse in-month variance.

- The cash balance across the APC is £295.1m, up from the £274.8m at the end of Month 1. This is £34.1m higher than the end of March.

- Capital spend is £15.2m, reporting a £15.8m underspend to date, driven by capital schemes not yet commencing per the plan profile, mostly under the nationally funded schemes.

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

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


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 2 (May 2025)

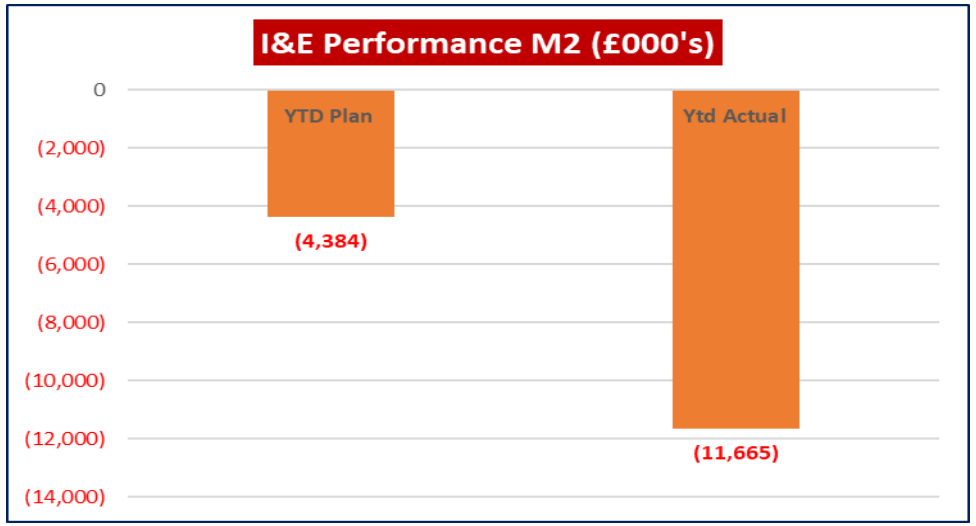
Helen Berry, Associate Director of Finance

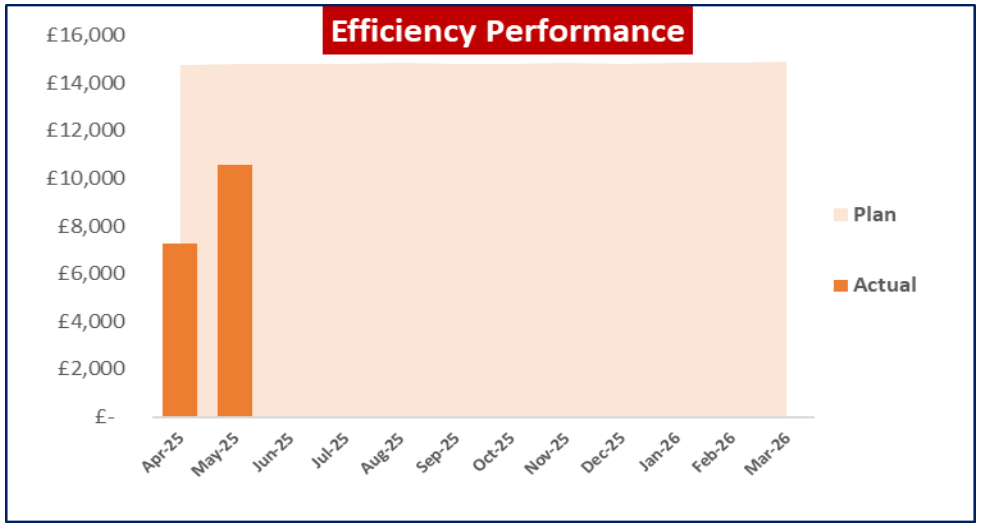
For NWL APC CFO Group

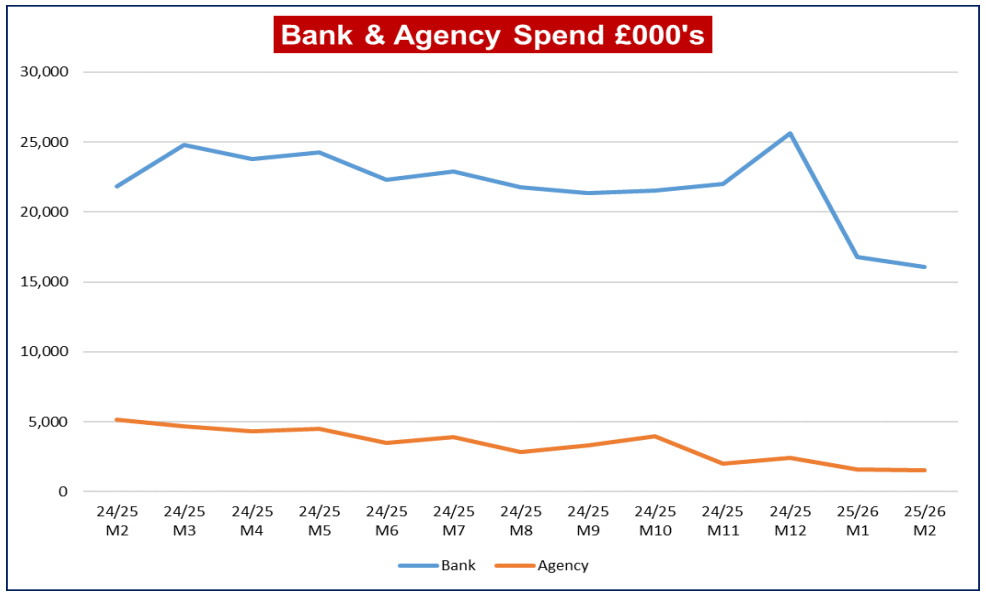
Key Messages at Month 2

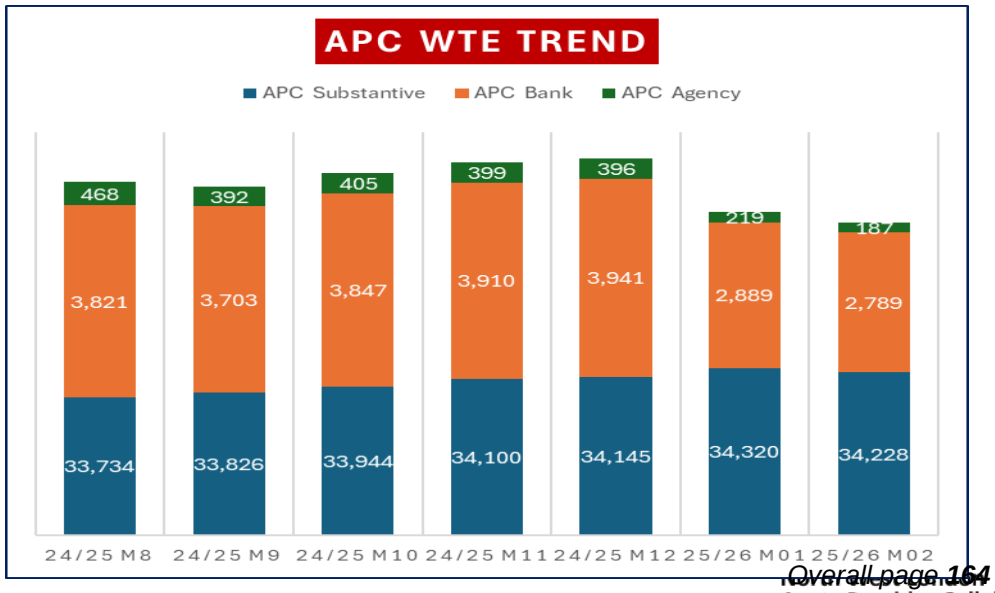
- The APC reported a year-to-date (YTD) deficit of £11.7m to the end of May against a deficit plan of £4.4m, an adverse YTD variance of £7.3m. All four trusts report adverse variances to plan.
- In month, the deficit is £6.4m, against a deficit plan of £2m, a £4.2m adverse in month variance.
- The main driver of the net adverse in-month variance is the under delivery on the efficiency programme amounting to £11.7m.
- Elective (ERF) income: YTD to month 2 the APC Trusts continue to only recognise ERF income up to the elective cap.
- The cash balance across the APC is £295.1m, up from the £274.8m at the end of Month 1. This is £34.1m higher than the end of March and £73.8m above the cash plan for May and due mainly to timing differences of planned capital spend vs. actual.
- Capital spend is £15.2m, reporting a £15.8m underspend to date, driven by capital schemes not yet commencing per the plan profile, mostly under the nationally funded schemes.
- A financial performance process utilised in the previous two financial years, has been updated to include additional financial metrics and was signed off by the APC Executive Management Board (EMB) and will be implemented from month 3.
- To note: the values in the report are as reported in the Trusts Provider Financial Monitoring Returns (PFR) to NHS England (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 2025. 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 2









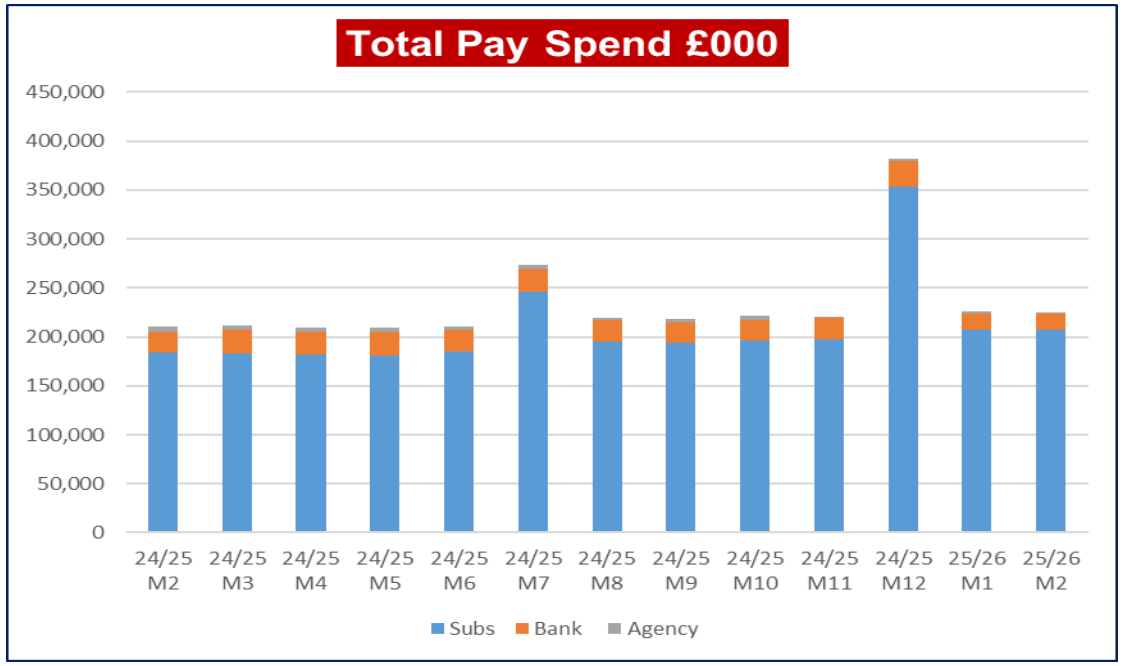
I&E Performance – Month 2

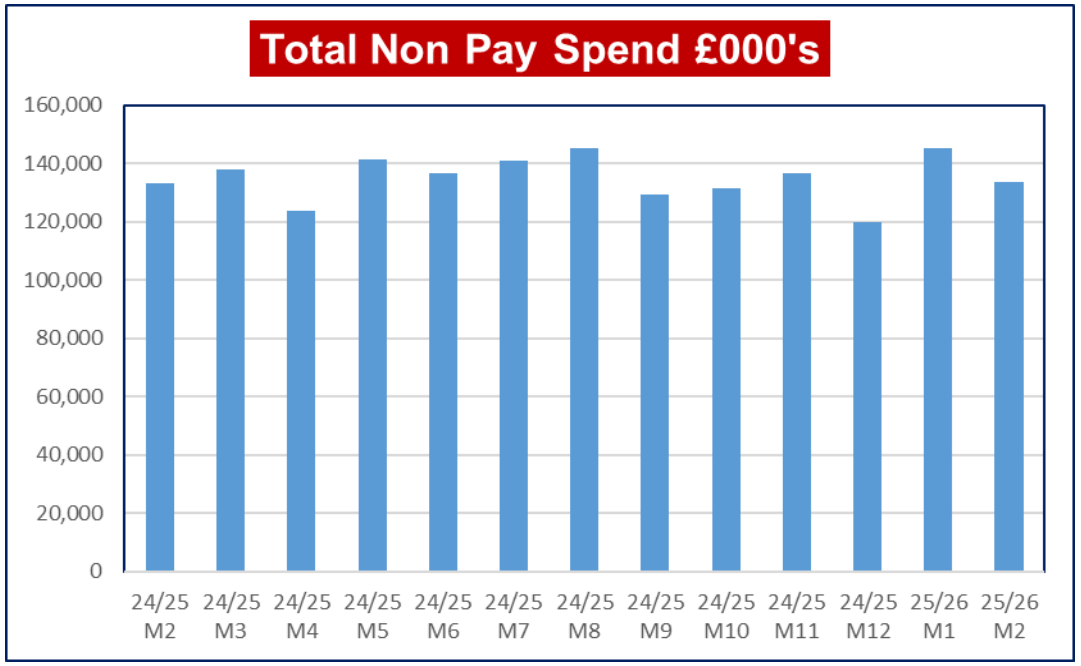
Performance by category	In-month Plan £'000	In-month Actual £'000	In-month Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Forecast Plan £'000	Forecast Actual £'000	Forecast Variance £'000
Income	357,358	362,312	**4,954**	715,078	720,603	**5,525**	4,310,878	4,320,878	**10,000**
Pay	(221,280)	(225,131)	**(3,851)**	(442,751)	(450,627)	**(7,877)**	(2,654,183)	(2,654,184)	**(1)**
Non-Pay	(133,156)	(138,992)	**(5,836)**	(266,554)	(272,720)	**(6,166)**	(1,594,065)	(1,604,817)	**(10,752)**
Non Operating Items	(4,954)	(4,437)	**517**	(10,157)	(8,920)	**1,237**	(62,630)	(61,877)	**753**
Total	**(2,033)**	**(6,249)**	**(4,216)**	**(4,384)**	**(11,665)**	**(7,280)**	**0**	**0**	**0**

Perfomance by Trust									
CWFT	(312)	(1,417)	**(1,105)**	(655)	(2,382)	**(1,727)**	0	0	**0**
ICHT	0	(701)	**(701)**	0	(1,299)	**(1,299)**	0	0	**0**
LNWH	(1,721)	(3,675)	**(1,954)**	(3,729)	(6,472)	**(2,743)**	0	0	**0**
THH	(0)	(455)	**(455)**	(0)	(1,511)	**(1,511)**	0	0	**0**
Total	**(2,033)**	**(6,249)**	**(4,216)**	**(4,384)**	**(11,665)**	**(7,280)**	**0**	**0**	**0**

- The tables show the year-to-date performance by category (first table) and by Trust (second table)
- Income reports a favourable YTD variance, primarily due to the variable elements of the contract: drugs and devices (offset by an overspend on non-pay) and some of the variable elements of the Specialised Commissioning contracts such as chemotherapy.
- Expenditure reports an overspend, mostly against pay costs due to the under delivery of efficiencies against an equally phased efficiency plan.

Expenditure Trend – Month 2





- Pay has decreased by 3% in absolute terms in 2025/26 compared to 2024/25. Agency is 59% lower, bank is 28% lower, substantive is 1% higher.
- The 2025/26 pay award (at the planned value of 2.8%) and employers' NI increase of 1.8% is accounted for in 2025/26.
- 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 7% year to date, this compares to 10% for 2024/25.
- Total Pay Spend - March 25 values include additional spend for employers' pension contributions, offset by equivalent income.
- In October 2024, staff were paid the 2024/25 pay award including arrears, hence the spike here.
- Non-Pay: compared to the 2025/26 average non pay has increased by £4.5m per month or 3%.

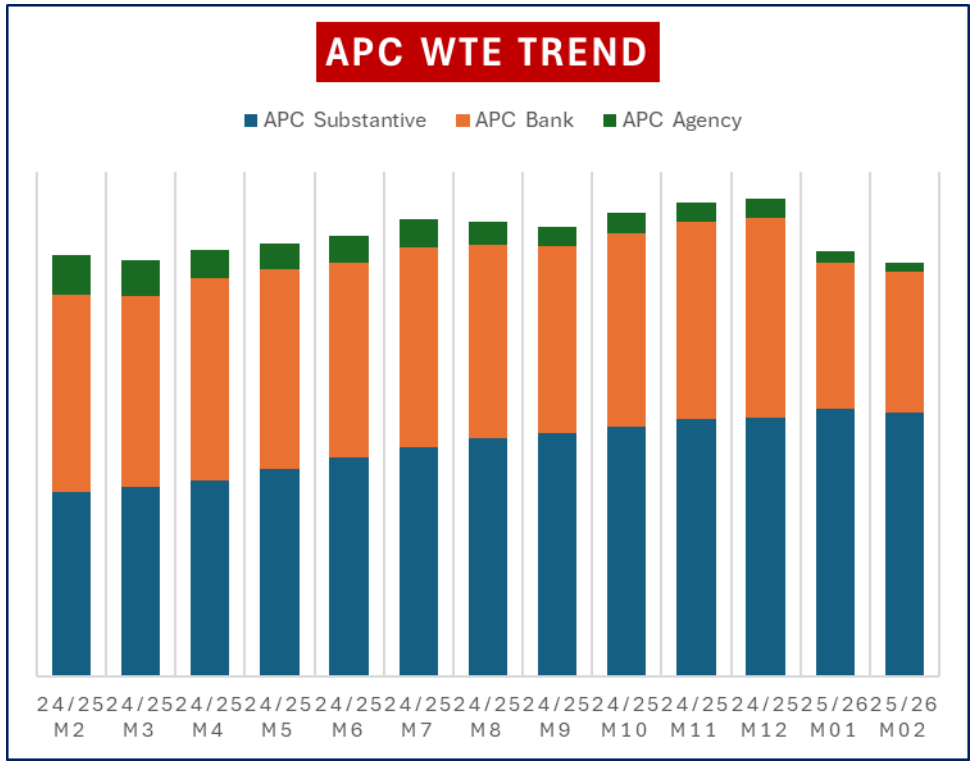
Month 2 Whole Time Equivalent (WTE) Trend

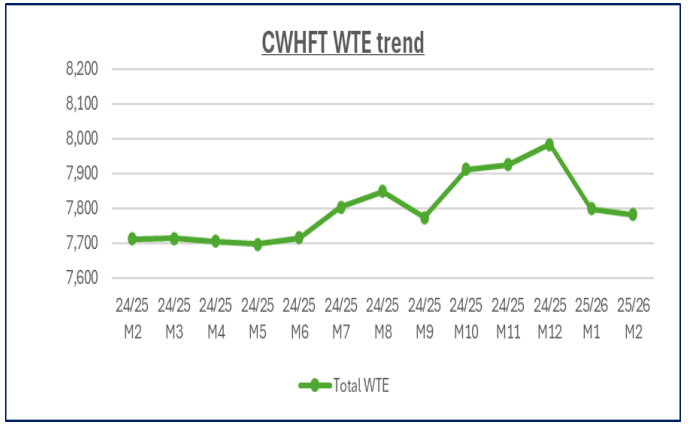
WTE Trend		24/25 M2	24/25 M3	24/25 M4	24/25 M5	24/25 M6	24/25 M7	24/25 M8	24/25 M9	24/25 M10	24/25 M11	24/25 M12	25/26 M01	25/26 M02	% change to 25/26 average
APC	Substantive	32,671	32,776	32,895	33,123	33,336	33,557	33,734	33,826	33,944	34,100	34,145	**34,320**	**34,228**	**1.2%**
	Bank	3,892	3,781	3,999	3,959	3,860	3,961	3,821	3,703	3,847	3,910	3,941	**2,889**	**2,789**	**-26.5%**
	Agency	806	692	560	513	542	556	468	392	405	399	396	**219**	**187**	**-53.5%**
	Total	37,369	37,248	37,454	37,596	37,738	38,074	38,022	37,920	38,197	38,409	38,482	**37,427**	**37,204**	**-2.3%**
CWFT	Substantive	6,719	6,735	6,796	6,810	6,846	6,908	6,949	6,955	7,027	7,057	7,053	**7,219**	**7,176**	**2.9%**
	Bank	835	836	781	785	779	807	816	742	800	788	859	**554**	**580**	**-29.3%**
	Agency	157	142	128	101	89	88	84	76	85	80	72	**24**	**26**	**-68.8%**
	Total	7,712	7,712	7,705	7,696	7,714	7,803	7,849	7,773	7,911	7,925	7,984	**7,798**	**7,782**	**-1.1%**
ICHT	Substantive	13,926	13,942	14,001	14,094	14,224	14,298	14,379	14,437	14,437	14,569	14,594	**14,599**	**14,567**	**0.9%**
	Bank	1,491	1,435	1,579	1,619	1,507	1,570	1,514	1,495	1,495	1,526	1,645	**1,030**	**1,073**	**-31.8%**
	Agency	254	218	222	204	193	214	199	145	145	160	143	**96**	**82**	**-47.0%**
	Total	15,671	15,595	15,803	15,917	15,924	16,082	16,092	16,078	16,078	16,255	16,382	**15,725**	**15,722**	**-2.7%**
LNWH	Substantive	8,574	8,640	8,657	8,761	8,795	8,840	8,884	8,907	8,934	8,928	8,943	**8,945**	**8,940**	**0.4%**
	Bank	1,111	1,113	1,152	1,160	1,088	1,077	1,082	988	1,025	1,068	992	**877**	**801**	**-19.2%**
	Agency	168	149	123	106	90	79	67	61	58	53	50	**43**	**42**	**-30.2%**
	Total	9,854	9,902	9,932	10,027	9,973	9,996	10,033	9,956	10,017	10,050	9,986	**9,866**	**9,783**	**-1.8%**
THH	Substantive	3,452	3,459	3,440	3,458	3,471	3,511	3,521	3,526	3,546	3,545	3,555	**3,557**	**3,545**	**0.5%**
	Bank	455	397	486	395	486	508	409	478	527	528	444	**427**	**334**	**-21.0%**
	Agency	227	183	87	102	170	175	118	109	118	106	130	**55**	**36**	**-63.8%**
	Total	4,133	4,039	4,014	3,956	4,127	4,194	4,048	4,113	4,191	4,178	4,130	**4,039**	**3,916**	**-4.0%**

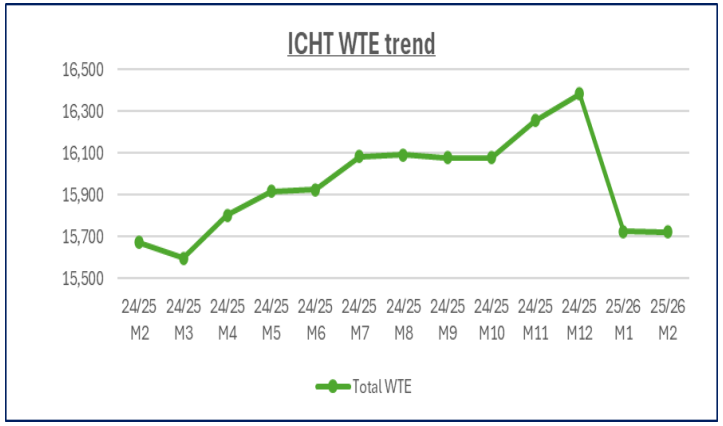
The table shows the WTE trend from 2024/25.

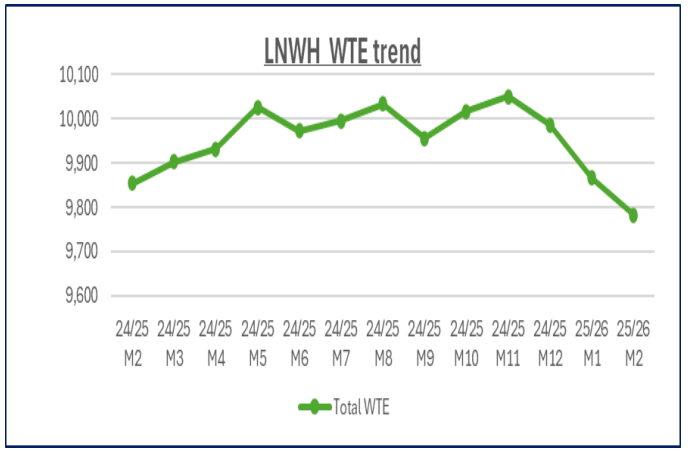
The last column shows the percentage decrease (comparing H2 2024/25 average to present (average of first two months 2025/26)). An overall decrease of 2.3% is reported driven mainly by reductions in temporary staffing – bank and agency; as grip and control measures have been implemented including restrictions on WLIs. Substantive WTEs have increased marginally across the APC at 1.2%, the largest increase reported at CWFT.

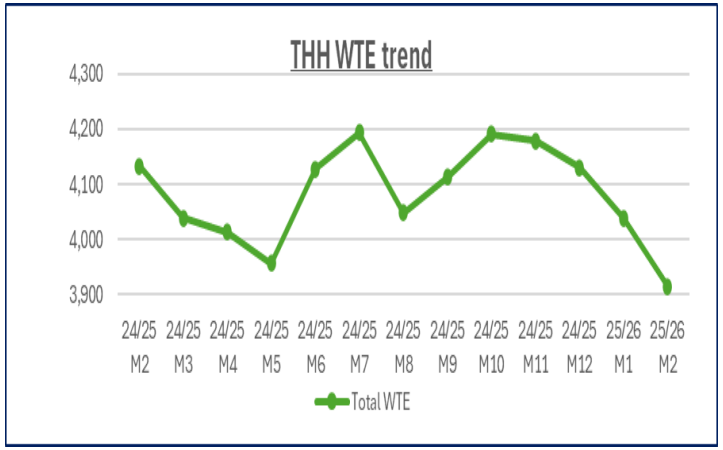
M2 WTE trend graphs











M2 Elective Recovery Fund (ERF)

ERF Over / under performance (M2)	NWL ICB ERF	Spec Comm ERF	Non NWL ICB ERF	Total ERF (all commissioners)	Var reported in ledger		Annual plan (finance plan)	VWA
Trust	£'000	£'000	£'000	£'000	£'000		£'000	%
CWFT	1,333	(273)	275	**1,336**	**0**		**180,969**	**128%**
ICHT	367	2,258	17	**2,642**	**0**		**300,036**	**117%**
LNWH	590	351	1	**942**	**0**		**219,582**	**131%**
THH	713	(10)	(445)	**258**	**0**		**80,360**	**120%**
Total APC	**3,003**	**2,326**	**(152)**	**5,178**	**0**		**780,948**	

- 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 over-performance of elective recovery income.
- For NHSE Specialist Commissioning there is no % reduction in elective recovery over-performance.
- The ERF income value is included in the financial plan and contract. Income is capped to the annual plan value for 2025/26. As such for the year-to-date financial position, trusts have assumed patient care contract income equals the year-to-date plan, reporting no over or underperformance.
- The table shows that the estimated overperformance at month 2 is £5.2m and if ERF was paid for under a cost and volume (variable) arrangement as was the case in 2024/25 this would be an upside to the current reported year to date deficit.
- The table also shows the annual planned ERF and the % VWA (against 2019/20 baseline).

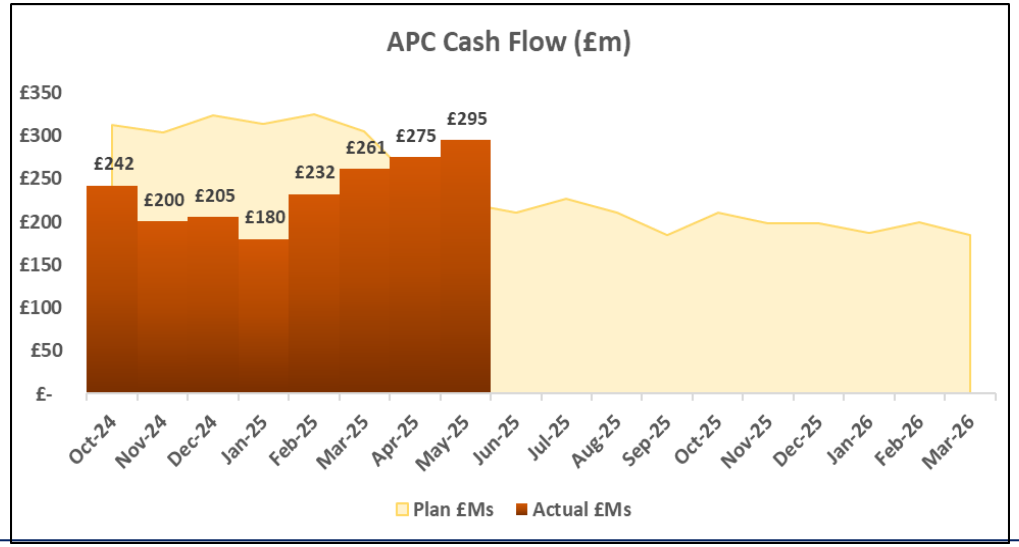
M2 Efficiency

Efficiency Month 2	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	R	NR	Total	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	2,114	3,460	5,574	1,780	1,648	3,428	(2,146)	2,787	1,948	(839)	12,986	20,456	33,442	13,905	19,537	33,442	0
ICHT	4,153	9,122	13,275	3,316	6,166	9,481	(3,794)	6,644	5,704	(940)	25,035	55,099	80,134	44,463	35,670	80,134	(0)
LNWH	6,432	1,650	8,082	2,283	1,283	3,566	(4,516)	4,041	2,042	(1,999)	38,597	9,903	48,500	38,597	9,903	48,500	0
THH	1,750	866	2,617	1,116	248	1,364	(1,253)	1,309	885	(424)	10,501	5,199	15,700	15,000	700	15,700	0
Total	**14,449**	**15,098**	**29,548**	**8,494**	**9,345**	**17,839**	**(11,709)**	**14,781**	**10,579**	**(4,201)**	**87,119**	**90,657**	**177,776**	**111,966**	**65,810**	**177,776**	**(0)**
% delivery of plan				**29%**	**32%**	**60%**								**63%**	**37%**	**100%**	

- The APC efficiency plan is £177.8m, up from £135.7m delivered in 2024/25. An increase of 32%.
- YTD M2 delivery is £17.8m against a £29.5m plan, an £11.7m under delivery. This is driven by some schemes not yet commencing at the beginning of the financial year and the unmitigated efficiency gap to month 2.
- The 2025/26 efficiency plan profile is in 1/12^{ths} for all APC organisations.

M2 Cash

NWL APC Cash Balance					
	Mar-25	May-25	Movement to YTD	31 May 25 Cash Plan	Variance from plan
Trust	£m	£m	£m	£m	£m
CWFT	143.5	134.4	(9.0)	123.6	10.8
ICHT	92.9	106.7	13.8	59.6	47.1
LNWH	11.0	16.5	5.6	3.9	12.6
THH	13.7	37.5	23.8	34.2	3.3
Total	**261.0**	**295.1**	**34.1**	**221.3**	**73.8**
			13%		**30%**



Trust	Days of cash on hand	BPPC
CWFT	49.5	94.7%
ICHT	21.1	93.8%
LNWH	5.6	71.7%
THH	32.8	57.9%

- The APC combined cash balance stood at £295.1m at the end of Month 2, an increase of £34.1m since the end of March and £73.8m higher than the cash plan for Month 2.
- Trusts' cash flow benefited from the payment in May of end of year income outturn by NWL ICB.
- The tables and chart above show:
  - The cash position against March 2025 and May plan positions
  - Cash flow V plan trend
  - Days of cash in hand (operating expenses) for the Trusts and BPPC performance at the end of May. Note LNWH is flagging as an outlier here in terms of days of cash at hand. Cash is being reviewed by the APC CFOs with a view to supporting the cash balance.

Month 2 Capital

		YTD			Forecast		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
CWFT	Core CRL	2,716	4,991	(2,275)	61,309	61,309	0
	Nat schemes	4,361	361	4,000	12,202	12,202	0
	Total	**7,077**	**5,352**	**1,725**	**73,511**	**73,511**	**0**
ICHT	Core CRL	11,034	6,923	4,111	83,293	83,293	0
	Nat schemes	4,208	0	4,208	42,540	42,540	0
	Total	**15,242**	**6,923**	**8,319**	**125,833**	**125,833**	**0**
LNWH	Core CRL	4,506	1,037	2,371	30,498	30,498	0
	Nat schemes	172	172	1	1,132	1,132	0
	Total	**4,678**	**1,209**	**2,372**	**31,630**	**31,630**	**0**
THH	Core CRL	604	6	598	14,778	14,778	0
	Nat schemes	4,498	1,701	2,797	37,781	38,024	(243)
	Total	**5,102**	**1,707**	**3,395**	**52,559**	**52,802**	**(243)**
APC	Core CRL	18,860	12,957	4,805	189,878	189,878	0
	Nat schemes	13,239	2,234	11,006	93,655	93,898	(243)
	Total	**32,099**	**15,191**	**15,811**	**283,533**	**283,776**	**(243)**

The total Capital Departmental Expenditure Limit (CDEL) per the 30 April 2025 Plan submission is £283.5m for the APC (66% of the total NWL ICS capital limit).

£189.9m (67%) of the system capital is internally funded; and £93.7m (33%) of the total represents Nationally Funded Public Dividend Capital (PDC) Programmes.

To note CWFT's system capital allocation includes £30.2m of system reserves held on behalf of the ICS which is yet to be apportioned out. To note the ICB has been informed that this bonus will be adjusted downwards to £18.1m. This currently being queried by the ICB with the NHSE and there will be further updates when information is received.

The table on the LHS 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 £15.8m, split £4.8m against the core Capital Resource Limit (CRL) (internally funded) and £11m against the national funded schemes.

The underspend is due to some capital schemes yet to commence, whereas spend has been profiled in Q1.

During the year, additional PDC capital schemes are routinely put forward by NHSE for Trusts to bid for. The £243k forecast overspend is one such scheme - Net Zero scheme at THH for which a Memorandum of Understanding (MoU) has been received.

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


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 M2

I&E Performance: CWFT

CWFT	In-month			YTD			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	83,647	82,390	**(1,257)**	167,294	164,891	(2,403)	1,003,769	1,003,769	**0**
Pay	(48,914)	(48,887)	**27**	(97,828)	(98,177)	**(349)**	(586,928)	(586,928)	**0**
Non-Pay	(33,948)	(33,846)	**102**	(67,773)	(66,975)	**798**	(401,936)	(401,936)	**0**
Non Operating Items	(1,097)	(1,074)	**23**	(2,348)	(2,121)	**227**	(14,905)	(14,905)	**0**
Total	**(312)**	**(1,417)**	**(1,105)**	**(655)**	**(2,382)**	**(1,727)**	**0**	**0**	**0**

Key Messages :

- The Trust at M2 has a £2.38m YTD deficit which is £1.73m adverse against a planned deficit of £0.66m.
- The Trust Cost Improvement Plan (CIP) target of £33.44m has under-delivered against the M2 plan by £2.15m YTD.
- Key drivers of the in-month position is largely driven by the CIP unidentified gap, under-delivery against identified plans, medical pay and non-pay.
- WTEs and nursing/ other pay continue to reduce in M2.
- ERF activity is capped in 2025/26 and other activity is blocked. The ERF over performance seen in M2 is not recognised in the position.
- The Trust's plan is a breakeven position, and the Trust is forecasting to breakeven.
- The cash balance at M2 is £134.44m.

I&E Performance: ICHT

ICHT	In-month			YTD			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	151,322	155,129	**3,807**	302,644	308,072	**5,428**	1,815,865	1,815,865	**0**
Pay	(93,865)	(95,989)	**(2,124)**	(187,730)	(190,647)	**(2,917)**	(1,126,436)	(1,126,436)	**0**
Non-Pay	(56,278)	(59,012)	**(2,734)**	(112,577)	(116,982)	**(4,405)**	(674,309)	(674,309)	**0**
Non Operating Items	(1,179)	(829)	**350**	(2,337)	(1,742)	**595**	(15,120)	(15,120)	**0**
Total	**0**	**(701)**	**(701)**	**0**	**(1,299)**	**(1,299)**	**0**	**0**	**0**

Key Messages:

- The Trust is reporting a YTD deficit of £1.3m, which is a £1.3m adverse to the break-even plan.
- Key highlights underpinning the position include:
  - NHS clinical patient care income being accrued to plan to month 2 (in line with the treatment agreed across the APC).
  - £3.8m under-delivery of efficiencies against an equally phased plan. The Trust efficiency target is £80.1m for 2025-26 with £67m (84%) now identified with efforts focussed on mobilisation and delivery of plans.
  - Bank & agency costs continue to show a downward trend (compared to previous quarters) following the implementation of enhanced temporary staffing controls.
  - Over recovery of income and overspends in non-pay are linked to pass-through drugs and devices.
- The cash balance at M2 is £106.7m., due to timing differences with the higher than planned cash not an indicator of 'free cash'.
- The YTD gross capital spend is £13.0m against a YTD gross plan of £22.0m, showing an underspend of £9.0m. Of this, £6.9m scores against the Capital Departmental Expenditure Limit of £15.2m (an underspend of £8.3m).

I&E Performance: LNWH

LNWH	In-month			YTD			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	88,415	89,781	**1,366**	177,101	178,254	**1,153**	1,082,985	1,092,985	10,000
Pay	(56,132)	(57,279)	**(1,147)**	(112,370)	(115,754)	**(3,384)**	(671,896)	(671,896)	**0**
Non-Pay	(32,059)	(34,313)	**(2,254)**	(64,458)	(65,284)	**(826)**	(387,081)	(398,081)	**(11,000)**
Non Operating Items	(1,945)	(1,864)	**81**	(4,002)	(3,688)	**314**	(24,008)	(23,008)	**1,000**
Total	**(1,721)**	**(3,675)**	**(1,954)**	**(3,729)**	**(6,472)**	**(2,743)**	**0**	**0**	**0**

Key Messages

- The Trust is reporting a YTD deficit of £6.5m that is £2.7m off plan.
- The driver of the variance to plan is predominantly driven by CIP shortfall of £4.5m against equally profiled target that is partly offset by early implementation of planned non-recurrent technical benefits of £2.3m.
- The £48.5m CIP is profiled equally across the year with a monthly target c£4m. The actual CIP delivered was £3.5m against an identified value of £3.8m (a £0.3m shortfall against the identified). At the end of May 2025, £34m of the £48.5m target has been identified with a further £6m being verified. The expectation is for the full target to be identified by the end of June 2025. Divisions with largest gaps against target have been are given additional focused support through dedicated executive directors.
- Other key drivers include the Elective Orthopaedic Centre (where further work required to ensure income is correctly mapping for LNWH activity), emergency pressures, increased maternity costs and WLI/Outsourcing costs above planned levels.
- The M02 cash balance was £16.5m, compared to £18.8m last month. In May 2025, NWL ICB paid the Trust £4.1m income recognised in the 2024/25 reported outturn. This cash inflow enabled the Trust to further reduce the approved trade creditor invoice backlog. The Trust's current cash flow forecast indicates revenue cash support will not be required in quarter one but that the cash position will tighten in September following the payment of the pay award arears in August.

I&E Performance: THH

THH	In-month			YTD			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	33,974	35,012	**1,038**	68,039	69,386	**1,347**	408,259	408,259	**0**
Pay	(22,369)	(22,976)	**(606)**	(44,823)	(46,049)	(1,226)	(268,923)	(268,924)	**(1)**
Non-Pay	(10,871)	(11,821)	**(950)**	(21,746)	(23,479)	(1,733)	(130,739)	(130,491)	**248**
Non Operating Items	(733)	(670)	**63**	(1,470)	(1,369)	101	(8,597)	(8,844)	**(247)**
Total	**(0)**	**(455)**	**(455)**	(0)	(1,511)	(1,511)	**0**	**0**	**0**

Key Messages

- At M2, the Trust is reporting a deficit for the year to date of £1.5m, which is adverse to the breakeven plan.
- 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. To date the CIP plan is £1.3m behind plan, this is in part due to the variance between CIP profiling in the submitted plan and the internal plan.
- Reduction in the pay run rate continues, including reduced temporary spend. Bank is 16% lower than the 2024/25 H2 average and agency is 44% lower than the 2024/25 H2 average. However, the Trust is overspent against its YTD pay plan, in part due to ED medical costs, nursing costs on medical wards, planned care Women's services and within Facilities; Cleaning, Portering & Security as well as the CIP gap.
- Total non-pay is overspent against budget by £1.7m, including undelivered CIP and drugs and clinical supplies for which there is passthrough income

4.3.2 COLLABORATIVE FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT

Discussion Item Carolyn Downs

REFERENCES

Only PDFs are attached

- 04.3.3 APC Finance and Performance Committee Chair Report.pdf
- 04.3.3a APC Productivity and Efficiency Update - Cover Sheet.pdf
- 04.3.3a APC Productivity and Efficiency Update.pdf

North West London Acute Provider Collaborative
Collaborative Finance and Performance Committee Chair's Highlight Report to the Board in Common – for discussion
June 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 19 June 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

2.1.1 Urgent and Emergency Care (UEC): Performance remains variable across the system but there was improvement in four hour wait target achievement overall. UEC performance in April was slightly below the 78% target, with all trusts implementing improvement plans. Ambulance handovers remained challenged at London North West Healthcare NHS Trust (LNW) and the Hillingdon Hospitals NHS Foundation Trust (THHFT). Mental health (MH) related 12-hour waits continue to be a concern, with a need to further understand and break down the data. The Committee agreed that the issue should be escalated to MH trusts, ICS leadership and partners given the impact of patients waiting too long in an environment that is not appropriate and brings risks to them and with the respective organisations.

The LNW 'circuit breaker' previously put in place in March 2025 to manage Accident & Emergency (A&E) pressures was noted. It was acknowledged as a helpful intervention to manage ambulance handover delays and flow pressures. Following a review by the North West London Urgent and Emergency Care (UEC) Sector Team it was agreed to realise the benefits of the 'circuit break' in future through another model and actions to reduce conveyance and improve flow. The Committee noted the update.

2.1.2 Elective care: Referral to treatment (RTT) performance has declined, as anticipated and outlined in each Trust's plan for 2024/25 given the financial envelope and elective recovery fund (ERF) limit. The focus remains on treating those who have waited

the longest first. Improving the new-to-follow-up ratio is a priority and using best practice data – for example through 'getting it right first time (GIRFT)' and comparing productivity is informing planning for clinics.

2.5.3 Cancer: Cancer performance continues to be strong. The 62-day standard is improving but not yet consistently achieved. The 28-day 31-day standard is being maintained, and the system is performing above national and London averages.

2.5.4 Diagnostics: Diagnostics performance remains below standard overall, with ultrasound and MRI capacity being key issues.

The further risk to achievement of performance metrics should there be industrial action was noted.

2.2 Finance Report

The APC reported an adverse to plan position in April (£5.4m deficit), which had increased to £11.7m in May. Delivery of efficiencies is behind trajectory, with 82% of cost improvement plans (CIPs) identified. Cash remains a concern for LNW. Mitigations in relation to the financial position continue, including vacancy freezes and reductions in non-clinical spend. There is a shared recognition of the need for more radical changes beyond traditional efficiencies given the current position and challenge for the year ahead. Committee members discussed the need for considerable scrutiny and focus at the next round of local Finance and Performance Committees (FPCs) with a need to ensure forecasts were realistic and achievable.

2.3 Efficiency and productivity position – Trust and APC – Update

The Chief Financial Officers (CFOs) presented the further work on efficiency and productivity. The data showed a productivity improvement of 5.7%, above the 2% national average for 2024/25, though still 2.5% below pre-pandemic levels. Variation exists across trusts, with some performing better in terms of productivity based on the data outlined (Chelsea and Westminster NHS Foundation Trust (CWFT) and Imperial Healthcare NHS Foundation Trust (ICHT)), with LNW and THHFT data indicating more scope for improvements in productivity.

Deep dives are underway, and a cultural shift toward multi-year CIP planning is being encouraged. The metrics will be further developed, with an update for the next meeting, including a specific report on the productivity gains to be made across the APC from oncology which scores low on productivity measures in all four trusts.

The work to date in developing the approach was commended. The report presented to the Committee is attached at Appendix A.

2.4 Medium Term Financial Strategy – Update

The Chief Financial Officers updated on the work underway to develop a standardised Medium-Term Financial Plan (MTFP) model across the four APC Trusts, aimed at supporting both Trust and APC-level financial strategy and scenario planning. The model will feature consistent input templates aligned with national and ICB returns, and will include forecasting capabilities for income and expenditure, balance sheet, cash flow, capital, activity, and workforce. It will be based on the 2024/25 out-turn position and allow for service development inputs and scenario planning (core, best, and downside).

Progress to date includes agreement on the model structure, assumptions, and reporting requirements. The next phase will focus on populating base year data, calibrating the model, and developing scenarios over summer 2025, with an initial output expected by September 2025.

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

2.5 Update on NWL Finance and Procurement System Procurement

The procurement process has restarted using the Crown Commercial Services framework. Formal procurement will begin next month, with the contract award expected by February 2026. It was reconfirmed that CWFT will host the shared service. There is strong market interest, and alignment with digital governance and plans will be ensured. A further update will be shared at the next meeting.

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

The Committee heard the updates from each local Trust. Local FPCs will further scrutinise CIP delivery and forecast positions. There is concern about the pace of recovery and the need for realistic projections. All trusts are expected to identify and implement further savings to close the year-end gap.

2.7 Collaborative Financial and Performance Risks and Assurance

Key risks include under-delivery of CIPs, financial sustainability, and performance pressures in diagnostics and UEC. It was requested that the risk register be updated to reflect the increasing challenge and need for urgent action on mental health delays and financial recovery. The Committee agreed that the risk relating to partnerships should be reviewed and potentially the risk score increased given the need for considerable service change, which may generate strong local stakeholder views.

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

- The financial position and need for radical action.
- To note the progress on the approach to productivity and the MTFP developments.
- The need for continued focus on CIP delivery and assurance.
- Performance challenges in diagnostics and UEC.
- Long waits for patients with mental health needs and in mental health crisis.
- Further risk to performance should there be industrial action.

4.0 Concerns outstanding

See above

5.0 Actions commissioned

- To raise the issue of long waits for patients with MH needs with ICS partners and the ICB.
- Local FPCs to scrutinise financial recovery and CIP delivery
- A general update on progress with the productivity work, along with a specific report on the productivity gains to be made across the APC from oncology which scores low on productivity measures in all four trusts – for the next committee meeting.

6.0 Decisions Made

6.1 No items for decision, but progress on the MTFP noted.

7.0 Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Integrated Performance Report and operational performance updates on UEC, elective care, cancer	To note	5.	Update on NWL Finance and Procurement system procurement	To note
2.	Finance Report Includes: Cost Improvement Programme Delivery	To note	6.	Escalation report from local Trust committees	To note
3.	Efficiency and productivity position – Trust and APC – Update	To note	7.	Collaborative Financial & Performance Risks and Assurance	To note
4.	Medium term financial strategy – update	To note	8.	Review of Forward Planner	To note

8.0 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	Y
Virginia Massaro, Chief Finance Officer – CWFT and THHFT	Y
Laura Bewick, Hospital Director – CW - CWFT	Y
Sheena Basnayake, Hospital Director WM - CWFT	Y
James Walters, Chief Operating Officer - LNW	N
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	N
Marie Price, Deputy Director Corporate Governance - CWFT	Y
Alexia Pipe, Chief of Staff to the Chair	Y

NWL Acute Provider Collaborative Board in Common
15/07/2025
Item number: 4.3.3
This report is: Public

APC Productivity & Efficiency Metrics Update

Author: Priya Ruda
Job title: Associate Director of Finance NWL APC

Accountable director: Jazz Thind, Bimal Patel, Virginia Massaro
Job title: APC Chief Financial Officers

Purpose of report (for decision, discussion or noting)

Purpose: Information or for noting only

The committee is asked to note this report.

Report history

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

NWL APC Finance & Performance Workstream	
13/06/2025	
Noted	

Executive summary and key messages

1. What this report covers

This report presents the latest **Productivity & Efficiency (P&E) Dashboard** for the NWL Acute Provider Collaborative (APC), anchored around **nationally defined metrics** with several **locally agreed relevant additions** by the APC Finance and Performance workstream (e.g. National Cost Collection Index (formerly the Reference Cost Index) and Outpatient DNAs).

The dashboard benchmarks P&E performance across the four Trusts and national medians, providing a shared view of progress, variation, and improvement opportunities at a high level.

2. Understanding the Dashboard Metrics

Ref	Metric	What it Measures	Why it Matters
#1a	**Implied Productivity - year-to-date compared to last year**	This metric compares **activity growth** to **cost (inflation adjusted) growth** over the current financial year-to-date (YTD), relative to the same period in the previous year (e.g. Month 11 YTD 2024/25 vs. Month 11 YTD 2023/24).	Indicates whether we are delivering more for less – a key national measure. The target is to see positive year on year change in this value and reduce / eliminate any negative distance from the same value calculated for same period last year.
#1b	**Implied Productivity Growth (year-to-date compared to 2019/20)**	This metric compares **activity (cost weighted) growth** to **cost (inflation adjusted) growth** over the current financial year-to-date (YTD), relative to the same period in 2019/20 (e.g. Month 11 YTD 2024/25 vs. Month 11 YTD 2019/20).	The target is to see positive year on year change in this value and reduce / eliminate any negative distance from the same value calculated for same period in prior year v 2019/20.
#2	**Cost per Weighted Average Unit (WAU)**	A standard national measure used within Model Health System (MHS) for Cost per “weighted activity unit”. Metric is benchmarked in quartiles, where Quartile 4 is least cost efficient.	Helps identify cost efficiency by specialty; Shows how efficient Trusts are at delivering care compared to peers and national medians
#3	**National Cost Collection Index (NCC)**	Compares Trust cost profiles to the national average (100). Used to be called the Reference Cost Index	Lower than 100 = more cost-efficient than average
#4	**Operational Driver Metrics**	Includes metrics like average length of stay, day case rates, theatre utilisation, bed occupancy for clinically ready to discharge patients, Outpatient DNAs	Links to both cost efficiency and patient experience
#5	**Workforce Productivity**	Measures how efficiently the workforce is deployed relative to activity. Includes: Implied workforce productivity metric and admission and attendances per WTE	Workforce is the largest cost driver – productivity here is critical
#6	**Workforce Driver Metrics**	Tracks underlying workforce conditions and pressures that influence productivity. Includes: Temporary pay spend (agency and bank); Staff turnover; Sickness absence rates; Care Hours Per Patient Day (CHPPD)	These indicators help diagnose workforce stability, sustainability, and pressure points

Ref	Metric	What it Measures	Why it Matters
#7	**Non-Pay Metrics**	Metrics that look at non-staff costs benchmarks (e.g. Medicine savings and estates costs)	Ensures value for money across other areas of spend
#8	**Quality indicator**	Summary Hospital-level Mortality Indicator (SHMI)	Quality indicators are essential to ensure productivity is not achieved at expense of quality.

Data is primarily sourced from the Model Health System (MHS), except for:

- Implied productivity data: direct from the NHSE Efficiency Team (due to MHS publication timing lag).
- National Cost Collection Index: Publicly available on the NHSE Costing website, only available once a year with a significant time lag.

This quarter, the report includes a **deep dive into key areas**, including trend performance data that provides comparison to national and peer medians for:

- Implied Productivity
- Specialty-level cost per WAU analysis
- Operational driver metrics.

Next quarter's focus will shift to workforce driver and workforce productivity measures.

3. Key Headlines

- **APC-wide productivity has improved**: +5.7% improvement in 2024/25 (M11 YTD) vs the prior year, compared to a +2% national average (Ref #1 in dashboard table).
- **Still recovering post-COVID**: Productivity remains 2.5% below pre-pandemic (2019/20) levels, but that's significantly better than the national position (which is 10.9% lower) (Ref #1 in dashboard table).
- **Cost indices are favourable**: Most NWL Trusts have NCC Index scores below 100, indicating efficient delivery of care (Ref #2 in dashboard table).
- **Cost per WAU highlights variation by specialty:** Many Trusts have 5–10 specialties in Quartile 4 (least efficient), e.g. Oncology and Orthopaedics (Ref #3 in dashboard table).
- **Operational metrics show mixed performance**: Variation persists across length of stay, theatre use, day case rates, bed occupancy and DNA rates—pointing to potential areas for improvement (Ref #4 in dashboard table).

- **Workforce Productivity & Driver metrics** – deep dive scheduled for next quarter (Ref #5 and #6 in dashboard table).

4. Our Local Strategy for enhancing Productivity Insights

Given the limitations of national data (e.g. time lags, lower relevance for in-year management), the APC in collaboration with NWL ICB Productivity Improvement Group has begun to develop a **local implied productivity model**.

This will enable more timely, accurate and actionable insights and allow the APC to:

- **Replicate national metrics using local data (SLAM-based activity used for tracking income)** to monitor more 'real-time' productivity shifts (aim to align to financial reporting datasets).
- **Triangulate across cost, activity and workforce** to build a better picture of Trust-level and APC level P&E performance.
- **Test additional locally relevant metrics** (e.g. bespoke workforce and non-pay indicators).
- **Use insight to inform financial sustainability efforts**, identify areas for improvement, and target variation.

The locally developed metrics will complement national data and are intended to support both short-term decisions and longer-term transformation strategies.

5. Next Steps

- Deep dive into **workforce productivity metrics** in the next quarterly update
- Finalise and test the **local productivity model** – results expected by Q2 2025/26
- Develop **individual Trust profiles** to support their respective Finance Committees and Boards

The Acute Provider Collaborative Finance & Performance Committee is asked to note the report and approach to monitoring productivity and efficiency metrics.

Impact assessment

Tick all that apply

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

Click to describe impact

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

Tick all that apply

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

If other, explain why

Strategic priorities – Amend to align to your local 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

Key risks arising from report

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


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

Productivity & Efficiency Metrics Update

NWL APC FPC 19TH June 25

AdoF NWL APC, Priya Ruda

Executive Summary

1. Purpose of report:

- This report presents the latest **Productivity & Efficiency (P&E) Dashboard (slide 7)** for the NWL Acute Provider Collaborative (APC), anchored around **nationally defined metrics** with several **locally agreed relevant additions by the APC Finance and Performance workstream** (e.g. National Cost Collection Index and Outpatient DNAs).

- The dashboard benchmarks P&E performance across the four Trusts and national medians, providing a shared view **of progress, variation, and improvement opportunities at a high level**.

Executive Summary

2. Understanding the dashboard metrics:

Ref	Metric	What it Measures	Why it Matters
#1a	**Implied Productivity - year-to-date compared to last year**	This metric compares activity growth to cost (inflation adjusted) growth over the current financial year-to-date (YTD), relative to the same period in the previous year (e.g. Month 11 YTD 2024/25 vs. Month 11 YTD 2023/24).	Indicates whether we are delivering more for less – a key national measure. The target is to see positive year on year change in this value and reduce / eliminate any negative distance from the same value calculated for same period last year.
#1b	**Implied Productivity Growth (year-to-date compared to 2019/20)**	This metric compares activity (cost weighted) growth to cost (inflation adjusted) growth over the current financial year-to-date (YTD), relative to the same period in 2019/20 (e.g. Month 11 YTD 2024/25 vs. Month 11 YTD 2019/20).	The target is to see positive year on year change in this value and reduce / eliminate any negative distance from the same value calculated for same period in prior year v 2019/20.
#2	**Cost per Weighted Average Unit (WAU)**	A standard national measure used within Model Health System (MHS) for Cost per "weighted activity unit". Metric is benchmarked in quartiles, where Quartile 4 is least cost efficient.	Helps identify cost efficiency by specialty; Shows how efficient Trusts are at delivering care compared to peers and national medians
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#4	**Operational Driver Metrics**	Includes metrics like average length of stay, day case rates, theatre utilisation, bed occupancy for clinically ready to discharge patients, Outpatient DNAs	Links to both cost efficiency and patient experience
#5	**Workforce Productivity**	Measures how efficiently the workforce is deployed relative to activity. Includes: Implied workforce productivity metric and admission and attendances per WTE	Workforce is the largest cost driver – productivity here is critical
#6	**Workforce Driver Metrics**	Tracks underlying workforce conditions and pressures that influence productivity. Includes: Temporary pay spend (agency and bank); Staff turnover; Sickness absence rates; Care Hours Per Patient Day (CHPPD)	These indicators help diagnose workforce stability, sustainability, and pressure points
#7	**Non-Pay Metrics**	Metrics that look at non-staff costs benchmarks (e.g. Medicine savings and estates costs)	Ensures value for money across other areas of spend
#8	**Quality indicator**	Summary Hospital-level Mortality Indicator (SHMI)	Quality indicators are essential to ensure productivity is not achieved at expense of quality.

Data is primarily sourced from the Model Health System (MHS), except for:

- Implied productivity data: direct from the NHSE Efficiency Team (due to MHS publication timing lag).
- National Cost Collection Index: Publicly available on the NHSE Costing website.

Appendix F provides further information on definitions and methodology for each metric within this report.

Executive Summary

This quarter, the report includes a **deep dive into key areas**, including trend performance data that provides comparison to national and peer medians for:

- Implied Productivity
- Specialty level cost per WAU analysis
- Operational driver metrics

Key observations for each of the selected trend metrics are summarised on slides 8-11.

Next quarter's focus will shift to workforce driver and workforce productivity measures.

3. Key Headlines

- **APC-wide productivity has improved**: +5.7% improvement in 2024/25 (M11 YTD) vs the prior year, compared to a +2% national average (Ref #1 in dashboard table).
- **Still recovering post-COVID**: Productivity remains 2.5% below pre-pandemic (2019/20) levels, but that's significantly better than the national position (which is 10.9% lower) (Ref #1 in dashboard table).
- **Cost indices are favourable**: Most NWL Trusts have NCC Index scores below 100, indicating efficient delivery of care (Ref #2 in dashboard table).
- **Cost per WAU highlights variation by specialty:** Many Trusts have 5–10 specialties in Quartile 4 (least efficient), e.g. Oncology and Orthopaedics (Ref #3 in dashboard table).

Executive Summary

- **Operational metrics show mixed performance**: Variation persists across length of stay, theatre use, day case rates, bed occupancy and DNA rates—pointing to potential areas for improvement (Ref #4 in dashboard table).
- **Workforce Productivity & Driver metrics** – deep dive scheduled for next quarter (Ref #5 and #6 in dashboard table).

4. Our Local Strategy for enhancing Productivity Insights (see Appendix E for project summary)

Given the limitations of national data (e.g. time lags, lower relevance for in-year management), the APC in collaboration with NWL ICB Productivity Improvement Group has begun to develop a local implied productivity model.

This will enable more timely, accurate and actionable insights and allow the APC to:

- Replicate national metrics using local data (SLAM-based activity used for tracking income) to monitor more 'real-time' productivity shifts (aim to align to financial reporting datasets).
- Triangulate across cost, activity and workforce to build a better picture of Trust-level and APC level P&E performance.
- Test additional locally relevant metrics (e.g. bespoke workforce and non-pay indicators).
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The locally developed metrics will complement national data and are intended to support both short-term decisions and longer-term transformation strategies.

Executive Summary

5. Next Steps

- Deep dive into workforce productivity metrics in the next quarterly update
- Finalise and test the local productivity model – results expected by Q2 2025/26
- Develop individual Trust profiles to support their respective Finance Committees and Boards

The Acute Provider Collaborative Finance & Performance Committee is asked to note the report and approach to monitoring productivity and efficiency metrics.

APC Productivity and Efficiency Metric Dashboard

Key
- Quartile 4/1
- Quartile 3/2
- Quartile 2/3
- Quartile 1/4

Ref	Metric Grouping	Headline Metric	Metric detail - dates	Target	National Average	NWL APC	CW	ICHT	LNWH	THH	Comments
#1a	Overall Productivity Metric *	New Implied Productivity Growth (year-to-date compared to last year)	24-25 v 23-24 M11		2.50%*	5.72%	7.11%	4.40%	3.40%	12.65%	See Appendix A for Trust trends (slides 12-16)
#1b	Overall Productivity Metric *	New Implied Productivity Growth (year-to-date compared to 2019/20)	24-25 v 19-20 M11		-11.10%*	-2.53%	2.16%	-4.73%	-6.79%	2.86%	
#2	Efficiency Metric	Model Health System Cost per WAU (Mff adjusted)	2023/24		£3,538	£3,428	£3,264	Tbc	£3,722	£3,410	See Appendix B for details
#2	Efficiency Metric	Model Health System Cost per WAU (Mff adjusted)	2022/23		£3,506	£3,405	£3,234	£3,371	£3,444	£3,823	
#2	Efficiency Metric	Model Health System Cost per WAU (Mff adjusted)	2021/22		£3,500	£3,490	£3,327	£3,428	£3,566	£3,902	
#3	Efficiency Metric	23-24 National cost collection index (Mff adjusted)	2023/24		100	98	93	99	104	95	
#3	Efficiency Metric	22-23 National cost collection index (Mff adjusted)	2022/23		100	96	92	98	94	105	
#3	Efficiency Metric	21-22 National cost collection index (Mff adjusted)	2021/22		100	98	94	99	98	112	
#4	Operational Drivers	Ave LOS of elective admissions (excluding day cases) - rolling 6mths	Feb-25		2.9	3.5	3.3	3.5	3.5	4.1	See slide 24 for trend info
		Ave LOS of emergency admissions(excluding short stays) - rolling 6mths	Feb-25		10.3	11.0	11.8	11.7	10.5	9.4	See slide 25 for trend info
		Bed occupancy classed as clinically ready for discharge (%, acute)	01/06/2025		24.10%	25.60%	26.20%	23.50%	25.20%	18.60%	See slide 26 for trend info
		Capped theatre Utilisation %	18/05/25	78.40%	81.30%	86.6%	84.8%	88.90%	81.80%	94.30%	Data LNWH 25/08/24. see slide 27
		Day case rates for BADS procedures (3mths to month end) %	Feb-25	85.1%	84.60%	84.30%	86.40%	84.90%	82.10%	86.00%	See slide 28 for trend info
		Missed outpatient appointments (DNAs) rate %	Apr-25		6.50%	8.60%	8.10%	9.50%	9.70%	7.40%	See slide 29 for trend info
#5	Workforce productivity	New Implied Workforce Productivity Growth (ytd compared to last year)	24-25 v 23-24 M10		4.30%	6.30%	7.50%	3.70%	6.60%	12.10%	
		New Implied Workforce Productivity Growth (ytd compared to 2019/20)	24-25 v 19-20 M10		-8.00%	-6.40%	4.20%	-19.20%	1.70%	3.20%	
		Non-elective admissions per clinical WTE	Feb-25		1.3	1.1	1.2	0.8	1.5	1.1	
		Elective admissions per clinical WTE	Feb-25		1.7	1.8	1.8	1.8	2.1	1.8	
		Outpatient attendances per consultant WTE	Feb-25		94.3	86.1	79.1	83.1	97.4	86.9	
		A&E attendances (Type 1 and 2) per Emergency Medicine consultant	Feb-25		408.3	624.2	544.9	0	352.5	487.3	
#6	Workforce drivers	Overall Temporary Staff Spend as a % of Total Spend	Mar-25	TBC	8.50%	11.00%	13.00%	10.00%	13.00%	17.00%	
		Overall Agency Spend as a % of Total Spend	Mar-25	3.2%	2.00%	2.00%	2.00%	1.00%	1.00%	5.00%	
		Bank as a proportion of pay costs %	Mar-25	TBC	8.00%	9.00%	11.00%	8.00%	12.00%	12.00%	
		Registered Nurses: Sickness absence rate	Mar-25	TBC	5.40%	5.30%	4.00%	5.10%	5.00%	6.00%	
		Medical and Dental, Sickness absence rate	Mar-25	TBC	2.00%	1.60%	0.90%	1.50%	1.70%	2.30%	
		Turnover rate %	Mar-25	12.0%	15.30%	15.10%	18.30%	15.50%	17.40%	16.30%	
		Care Hours per Patient Day - Registered Nurses and Midwives	Mar-25		5		6.00	7.5	5.8	5.9	See slide 31 for trend info
#7	Non Pay & Corporate Efficiency	Top 10 Medicines – Savings Delivered	To Mar 25		£1.71M	£9.53M	£1.9M	£4.61M	£1.65M	£1.08M	
		Estates and facilities costs per square metre	2023-34		£495.67		£624.89	£634.70	£716.79	£539.96	
#8	Quality Indicators	Summary Hospital-level Mortality Indicator (SHMI)	Dec-24		0.87-1.15		0.7	0.71	0.85	0.99	

Notes -
Source – Model Health System data and NHSE publication of National cost collection data
* Implied productivity National averages to M10

Key Observations (1 of 4)

Metric	Key observations	Slide No.
Implied productivity, Inflation adjusted expenditure and cost weighted activity growth trends – By Trust	• **Overall NWL APC productivity has improved** in 2024/25 (YTD M11) by **+5.7% vs 2023/24**, outperforming the national system average of +2%. Compared to the pre-COVID baseline (2019/20), productivity remains **2.5% below** previous levels, though this is still **better than the national decline of 10.9%**. • **CWFT** strongest performance overall (**+7.1%** year on year (YoY)) and also exceeds its pre-COVID productivity (**+2.2%**). • **ICHT–** positive YoY trend (**+ 4.4%)** but still under pre-covid baseline (**-4.7%**)**.** • **LNWH –** lowest gain YoY compared to others (**+3.4%**) and under pre-covid baseline (**-6.8%**). However upward YoY trend. • **THH -** shows the strongest year-on-year productivity gain (**+12.6%**) and above pre-covid baseline (**2.9%**). However downward trend notable since M9.	8-12
Cost per Weighted Activity Unit (WAU)- updated to 23-24 (v 22-23)	• **CWFT** remained most cost-efficient (Quartile 1) - below the national and peer median. • **ICHT** - WAU data missing in latest release – under escalation for resolution. • **LNWH** deteriorated to Quartile 3 from Quartile 2 in 22-23 . Higher than national and peer medians. • **THH** has improved to Quartile 2 from Quartile 4 in 22-23. Below national and peer medians. **Specialty-level cost opportunities** identified in high-cost (Quartile 4) areas across all Trusts (see slides 14-18) – • **CWFT** had **two specialties in Quartile 4** for cost per WAU: Dentistry and Oncology. In 2022/23, CWFT had four Quartile 4 specialties : Dentistry, Dermatology, Oncology, Paediatrics. Paediatrics and Dermatology have improved to Quartile 3 in 2023/24, indicating positive progress in managing cost and efficiency in those areas. • **ICHT** – had **five specialties Quartile 4** for cost per WAU: General Surgery, Geriatric Medicine, Gynaecology, Oncology, Orthopaedic Surgery. These same five specialties were also in Quartile 4 in 2022/23, indicating persistent high relative cost. • **LNWH -** had **seven specialties in Quartile 4** for cost per WAU : Gastroenterology, General Surgery, Oncology, Neurology, Ophthalmology, Orthopaedic Surgery, Vascular Surgery. In 2022/23, five specialties were in Quartile 4: Gastroenterology, Oncology, Neurology, Ophthalmology, Orthopaedic Surgery. General Surgery and Vascular Surgery have newly deteriorated to Quartile 4 in 2023/24, indicating worsening cost efficiency in those areas. • **THH -** had **ten specialties in Quartile 4** for cost per WAU: Breast Surgery, ENT, Emergency Medicine, Oncology, Neurology, Ophthalmology, Orthopaedic Surgery, Respiratory Medicine, Rheumatology, Urology. In 2022/23, 13 specialties were in Quartile 4: The above list plus Cardiology, Gynaecology, and Stroke Medicine. This reflects a net improvement of 3 specialties moving out of Quartile 4, suggesting some progress in cost efficiency in Cardiology, Gynaecology, and Stroke Medicine. All 4 Trusts are in Quartile 4 in Oncology and 3 of 4 Trusts in Quartile 4 in Orthopaedics.	14-18

Key Observations (2 of 4)

Metric	Key observations	Slide No.
National cost collection (NCC) index (Mff adjusted) - (benchmarks cost efficiency. National average = 100. Below 100more efficient))	• **CWFT** – Consistently strong cost efficiency. Best across APC. NCC index gone to 93 in 23/24 from 92 in 22/23 (slight deterioration) and 94 in 21/22. • **ICHT –** consistently around the national average level – slight deterioration to 99 in 23/24 from 98 in 22/23 and 99 in 21/22. • **LNWH -** deterioration in 23-24 to 104 in 23/24 from 94 in 22/23 and 98 in 21/22 • **THH** – Significant improvement to 95 in 23/24 from 105 in 22/24 and 112 in 21/22 • **APC average** - Slightly better than national average over the years (98 in 23-24 vs 96 in 22/23 and 98 in 21/22); stable system-wide cost performance.	See dash-board (slide 3)
Average LOS for elective admissions (excluding day cases) - rolling 6 months	**Length of stay for elective admissions varies significantly across NWL Trusts**, with all above national median of 2.9 days, and three of four above the peer median. As of **Feb 2025**: • **LNWH** and **ICHT** have the **longest average elective LoS** at **3.5 days** • **CWFT** sits slightly above the peer median at **3.3 days**. LOS relatively stable. • **THH** is an outlier — recent LoS spikes have pushed the average to **4.1 days**, well above both peers (**2.3 days**) and the national median	20
Average LOS of emergency admissions, excluding short stays - rolling 6 months	National median for emergency LoS is 10.3 days. Peer median across NWL Trusts ranges from 10.3 to 10.6 days, depending on the provider group. All Trusts except THH are at or above the national median. Three of the four Trusts are above both the national and peer medians As of **Feb 2025**: • **CWFT** - (**11.8 days**) highest LoS across APC. Has gradually increased since 2022. Sustained trend above benchmarks. Exceeds national median by +1.5 days • **ICHT** (**11.7 days**) – LoS has increased since early 2023. Sustained trend above benchmarks. Exceeds national median by +1.4 days • **LNWH (10.5 days)** - closest to benchmarks; relatively stable but has not improved. Opportunity for marginal gains. • **THH (9.4 days) –** Consistently below both peer and national medians.	21
Bed occupancy classed as clinically ready for discharge (%, acute)	As of **01.06.25**, (**national median 24.1%**) • **CWFT** (**26.2%**) – Highest across APC (Quartile 3). Exceeds national and peer medians. Statistical Process Chart (SPC) line shows frequent variation. Increased volatility and special cause variation from late 2023 into 2024, including multiple spikes. The recent trend is persistently above the national and peer medians, with a clear shift to a new higher mean, The process is no longer stable. • **ICHT** (**23.5%**) – (Quartile 2) slightly above peer average, and below national median. The chart shows a upward shift in mid 2022, where delays remained persistently high. Following a peak, step change downward around late 2023. Current variation is mostly common cause, with data points consistently below 25% and several below 22%. Process now appears more stable, but still not optimal. • **LNWH (25.2%)** – (Quartile 3) exceeds national and peer medians. A long period of common cause variation below 22% until mid 2023. A clear special cause shift upward in late 2023, with sustained values above 25%. The upward step change appear to have established a new elevated baseline, with continued high variation. • **THH (18.6%) –** best across APC (Quartile 1). A clear sustained reduction from mid 2023 onwards, with consistent improved performance. The process has stabilised well below both peer and national medians for an extended period. Points are largely with control limit, suggested stable processes.	22

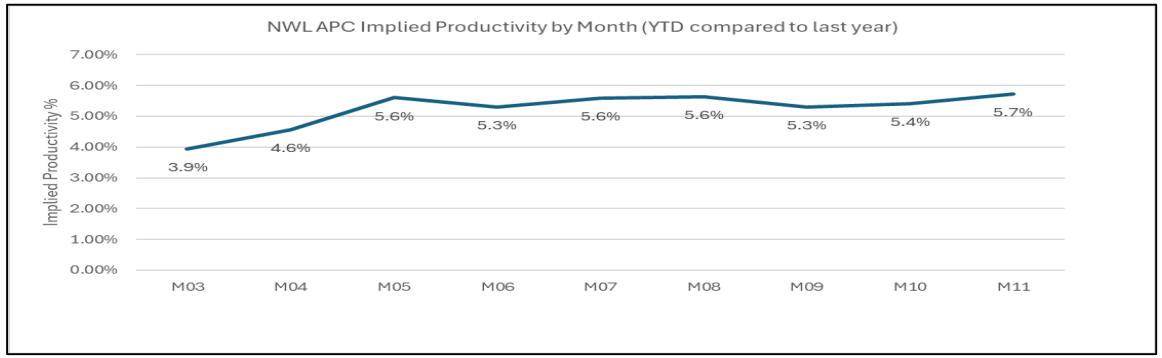
Key Observations (3 of 4)

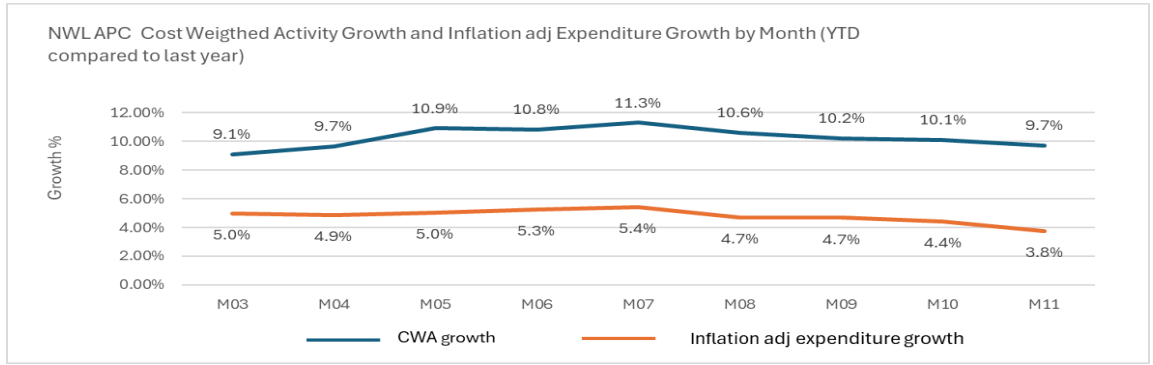
Metric	Key observations	Slide No.
Capped Elective Theatre Utilisation %	• All four Trusts are performing above the **national median (81.3%).**Variation exists between high and lower performers (~13%). As of **18.05.25** : • **CWFT – (84.8% - Quartile 4)** - higher than national and peer medians. Improving positive trends. Slightly volatile but stabilising. • **ICHT – (88.9% - Quartile 4)** - higher than national and peer medians. Very strong consistent improvement trend. High utilisation sustained. • **THH – (94.3% - Quartile 4) –** Best performing across the APC. Higher than national and peer medians. Sustained high performance. **As at 25.08.24** • **LNWH – (81.8% - Quartile 3)** – Slightly above national median (79.8%) and peer median (76.5%). Recent data (which is out of sync with other providers), shows some upward movement, but performance remains below former baseline, with higher volatility and signs of instability.	23
Day case rates for BADS procedures (3mths to month end)	As of **Feb 2025** (**national median 84.6%)** • **CWFT** - (**86.4% - Quartile 3**) – Above national and peer medians. Consistently strong performance, and highest across APC. • **ICHT** (**84.9% - Quartile 3**) –slightly above national median and slightly below peer medians. Improved significantly since early 2022. • **LNWH (82.1% - Quartile 2)** – Below national and peer medians. Initial strong position above 86% in 2021. A clear decline during 2022 falling to ~ 80% and not recovering meaningfully since. From late 2023 onward, performance plateaus and then declines, falling back to 82.1%. • **THH – (86% - Quartile 3) –** Above national and at peer median. Notable cyclical variation from 2021 through mid-2023, hovering between ~76–81%. From mid-2023, a clear upward shift begins, culminating in a sustained run at or just above 86% by early 2025.	24
Missed outpatient appointments (DNAs) rate	As of **April 2025 (national median 6.5%)** • **CWFT – (8.1% Quartile 3) –** Above national and peer medians. Slight downward trend from 2023 peak but still elevated and static above 8% • **ICHT – (9.4% Quartile 4) –** above national and peer medians. Amongst highest across APC. Declining steadily since late 2022 but above both benchmarks. • **LNWH – (9.5% - Quartile 4) –** Highest across APC and above national and peer medians. After 2022 spike, DNA rates fell sharply but have now plateaued at persistently high levels. • **THH – (7.4% - Quartile 3)** – Above national and slightly above peer medians. Clear downward trend from a 2023 peak. Converging with peers.	25
Care Hours per Patient Day – (CHPPD) Registered Nurses and Midwives	As of **March 2025 (national median 5.1)** • **CWFT (CHPPD 6.0) –** Above national and peer medians. Stable since mid 2022, with consistent delivery around 6-6.5 hours per day. • **ICHT (CHPPD 7.5) –** Significantly above national and peer medians. Highest across APC. Consistent SPC line. • **LWNH (CHPPD 5.8) –** Above both national and peer medians. Generally stable but SPC shows occasional sharp drops. • **THH – (CHPPD 5.9) –**Above both national and peer medians. Recent uplift since mid 2023, trending consistently after a prolonged lower plateau.	27

Appendix A – Implied Productivity, Cost Weighted Activity and Inflation adjusted expenditure growth trends

NWL APC: Implied Productivity, Cost Weighted Activity and Inflation adjusted expenditure growth trends

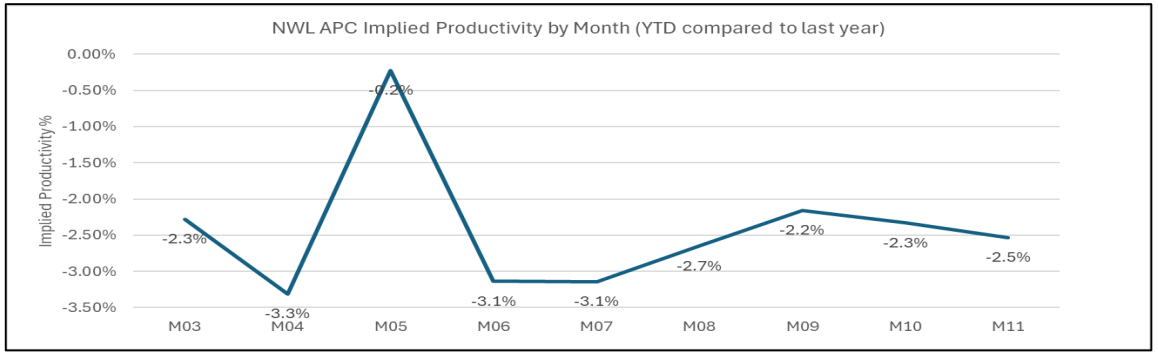
2024-25 vs 2023-24

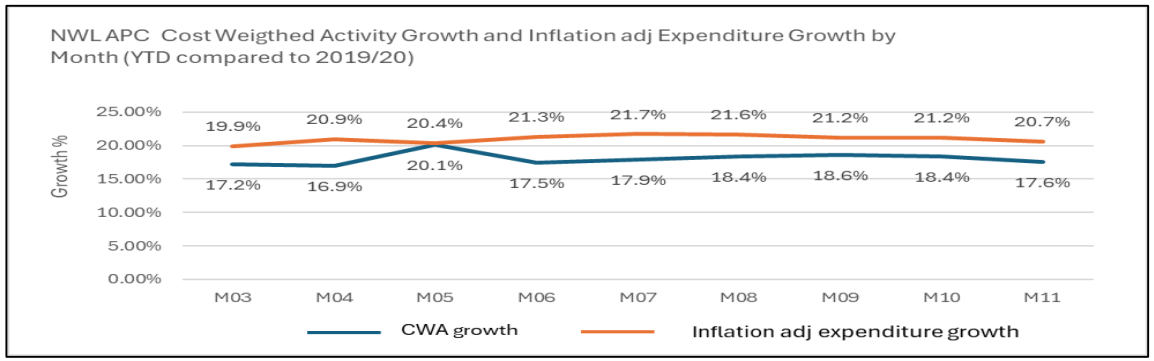




- Implied Productivity position ytd M11 (24-25 v 23-24) improved by +5.7% (compared to national system average of +2%*).
- Cost weighted activity growth of 9.7% outstripped inflation adjusted expenditure growth of 3.8%, hence an improvement in implied productivity.

2024-25 vs 2019-20



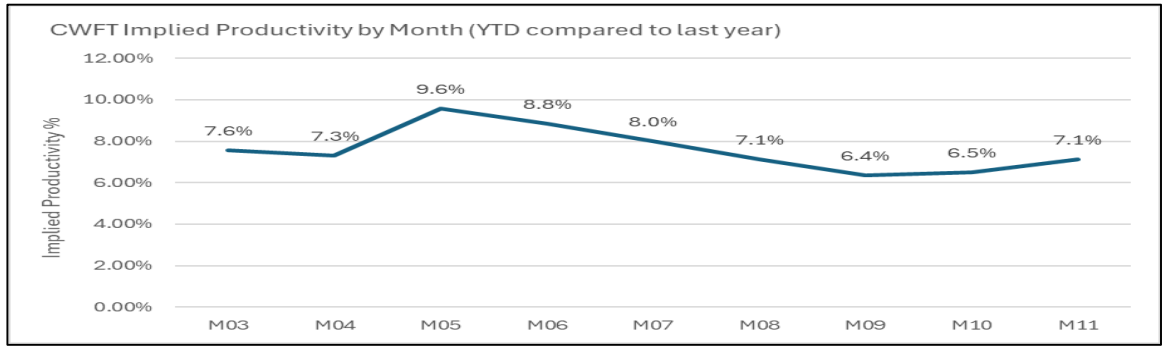


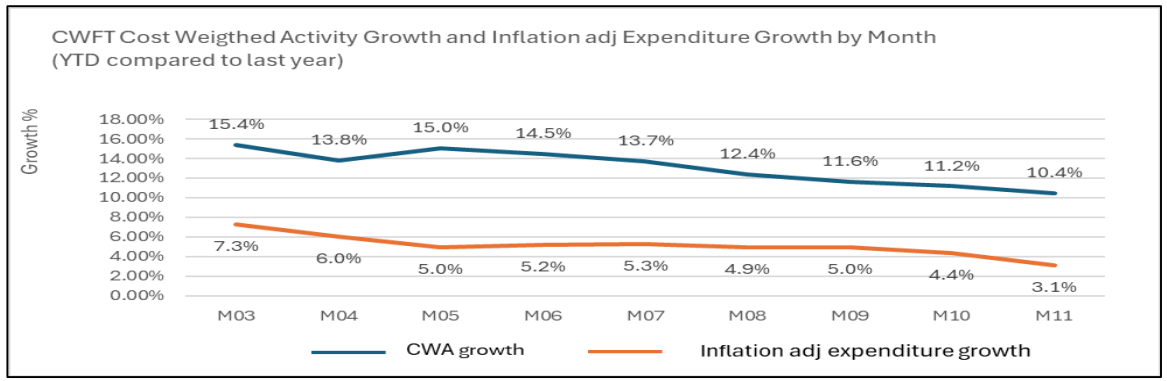
- Implied Productivity position ytd M11 (24-25 v 19-20) was a decline of -2.5% (compared to national system average of - 10.9%).
- Inflation adjusted expenditure growth of 20.7% outstripped the cost weighted activity growth of 17.6%, hence a fall in implied productivity.

Source – NHSE Efficiency team
Note - The first 2 months are made to equal to M3 in MHS due to data quality.
*National system averages to M10.

CWFT: Implied Productivity, Cost Weighted Activity and Inflation adjusted expenditure growth trends

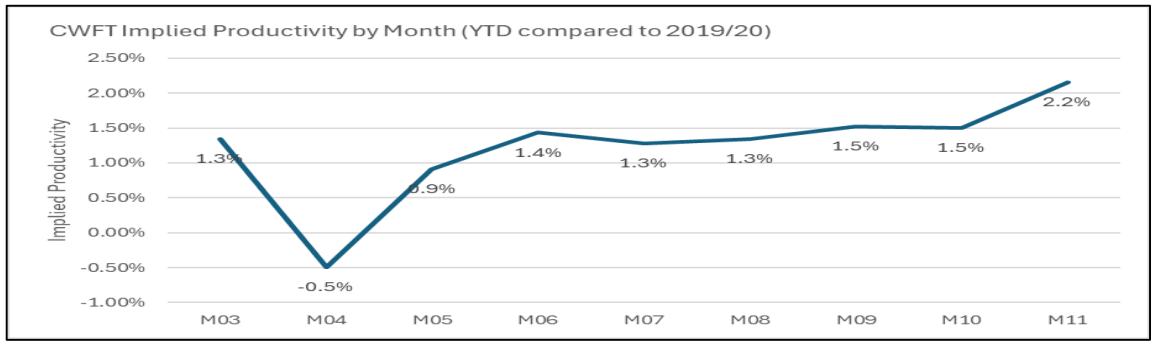
2024-25 vs 2023-24

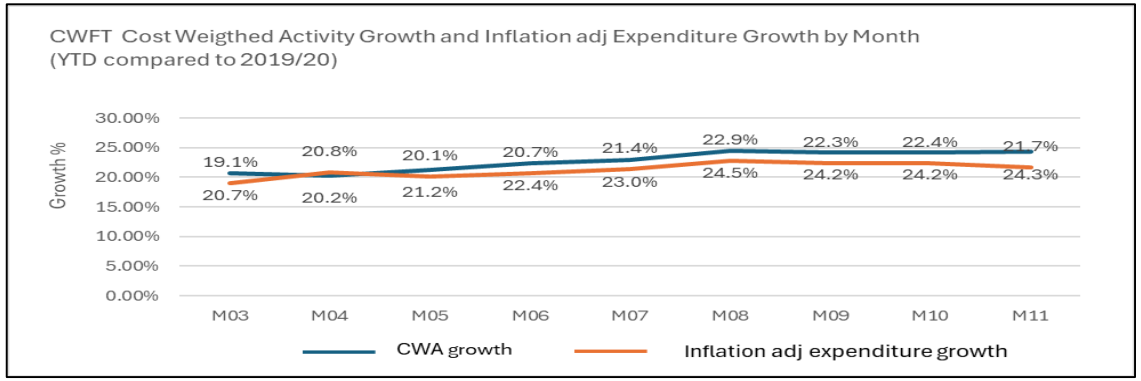




- Implied Productivity position ytd M11 (24-25 v 23-24) improved by 7.1% (compared to national provider average of +2.5%).
- Cost weighted activity growth of 10.4% outstripped inflation adjusted expenditure growth of 3.1%, hence an improvement in implied productivity.

2024-25 vs 2019-20



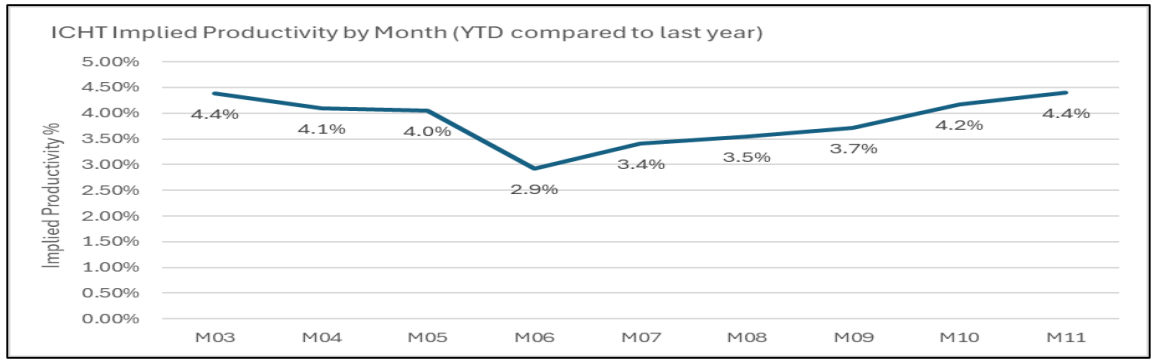


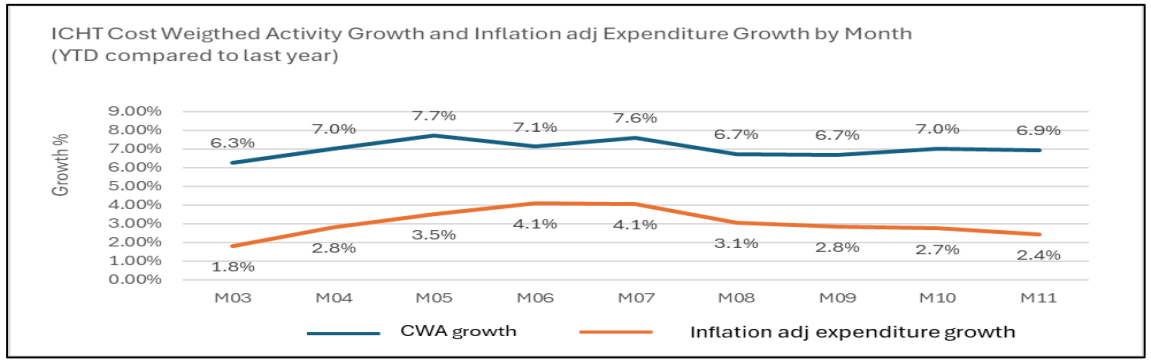
- Implied Productivity position ytd M11 (24-25 v 19-20) improved by 2.2% (compared to national provider average of -11.1%).
- Cost weighted activity growth of 21.7% outstripped inflation adjusted growth expenditure of 24. 3%, hence an improvement in implied productivity.

Source – NHSE Efficiency team
Note - The first 2 months are made to equal to M3 in MHS due to data quality.
*National averages to M10.

ICHT : Implied Productivity, Cost Weighted Activity and Inflation adjusted expenditure growth trends

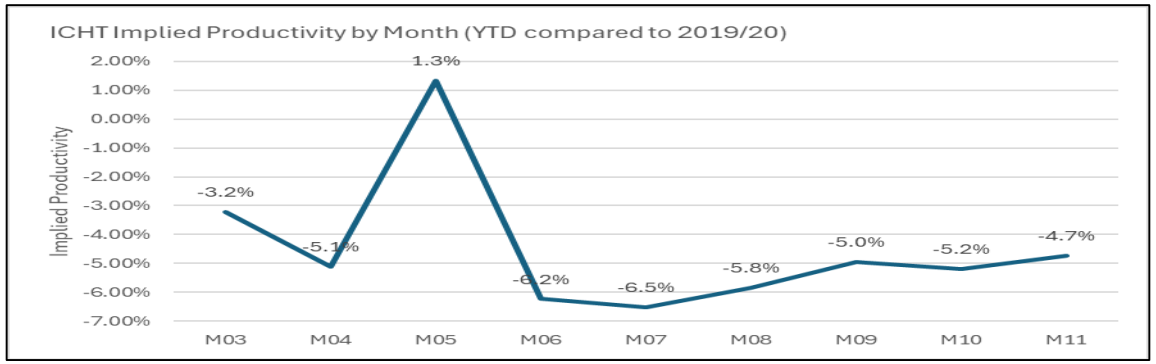
2024-25 vs 2023-24

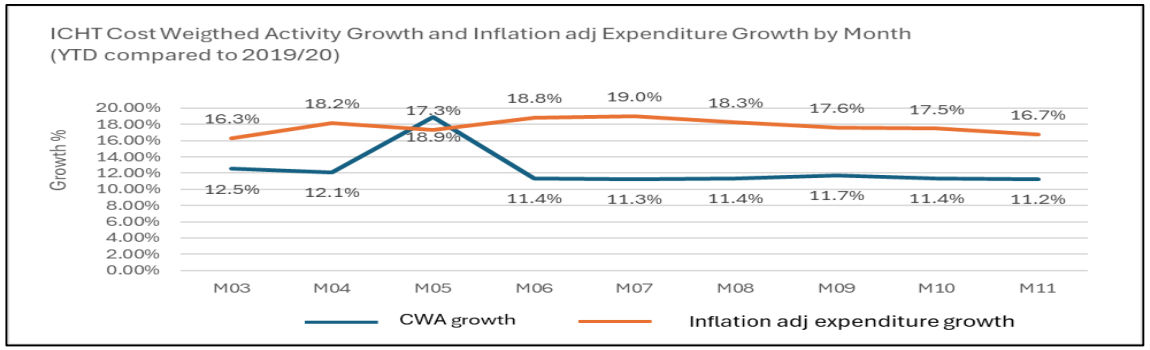




- Implied Productivity position ytd M11 (24-25 v 23-24) improved by 4.4% (compared to national provider average of +2.5%).
- Cost weighted activity growth of 6.9% outstripped inflation adjusted expenditure growth of 2.4%, hence an improvement in implied productivity.

2024-25 vs 2019-20





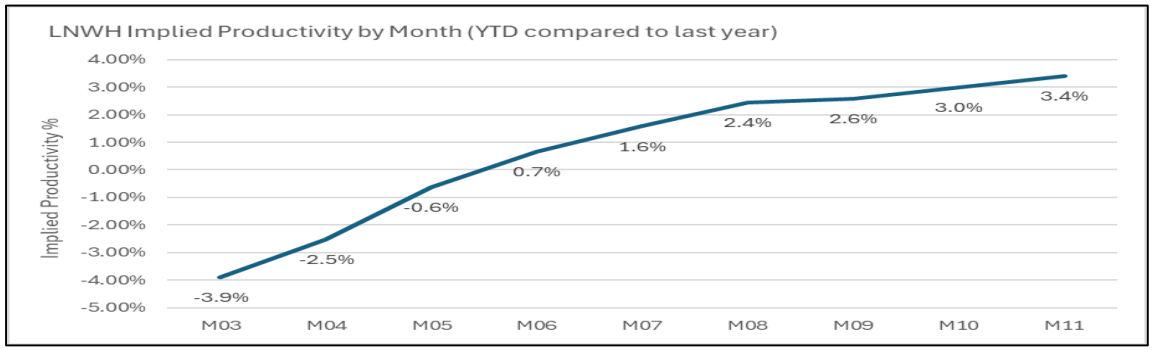
- Implied Productivity position ytd M11 (24-25 v 19-20) deteriorated by -4.7% (compared to national provider average of -11.1%).
- Inflation adjusted expenditure growth of 16.7% outstripped the cost weighted activity growth of 11.2%, hence a fall in implied productivity.

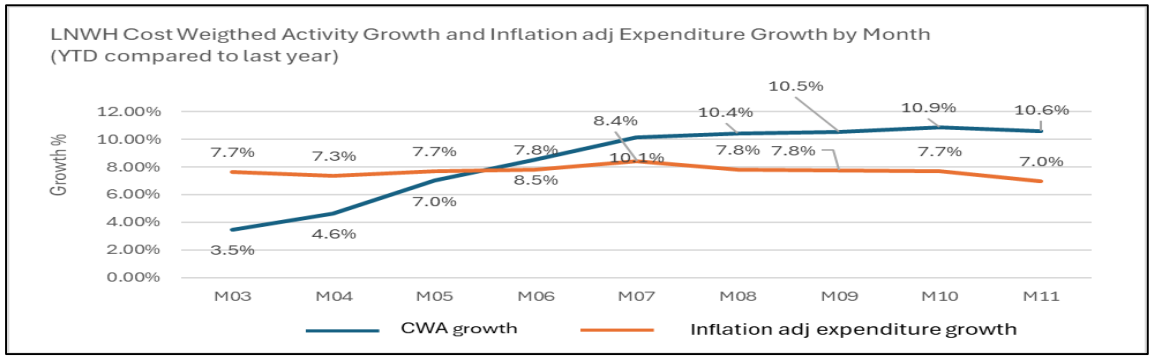
Source – NHSE Efficiency team
Note - The first 2 months are made to equal to M3 in MHS due to data quality.
*National averages to M10.

NHS North West London Acute Provider Collaborative

LNWH : Implied Productivity, Cost Weighted Activity and Inflation adjusted expenditure growth trends

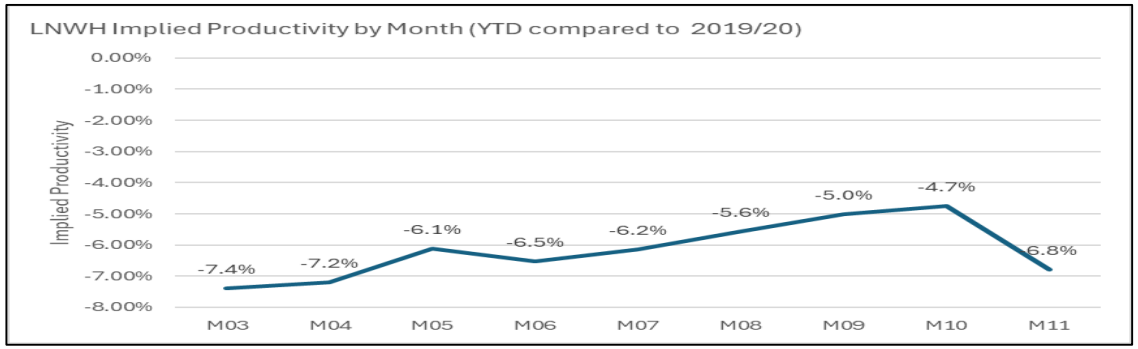
2024-25 vs 2023-24

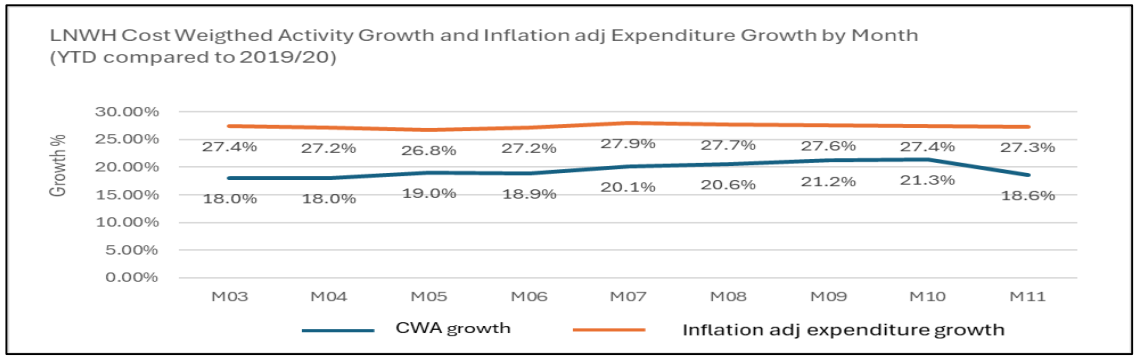




- Implied Productivity position ytd M11 (24-25 v 23-24) improved by 3.4% (compared to national provider average of +2.5%).
- Cost weighted activity growth of 10.6% outstripped inflation adjusted growth of 7.0%, hence an improvement in implied productivity.

2024-25 vs 2019-20



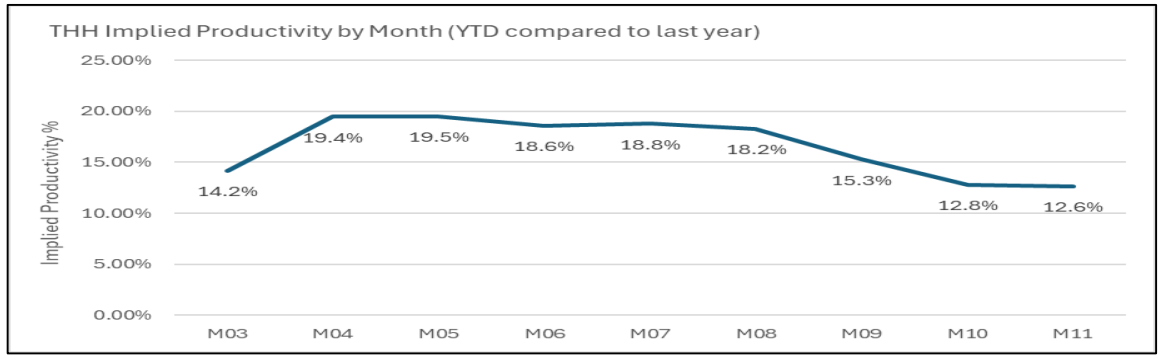


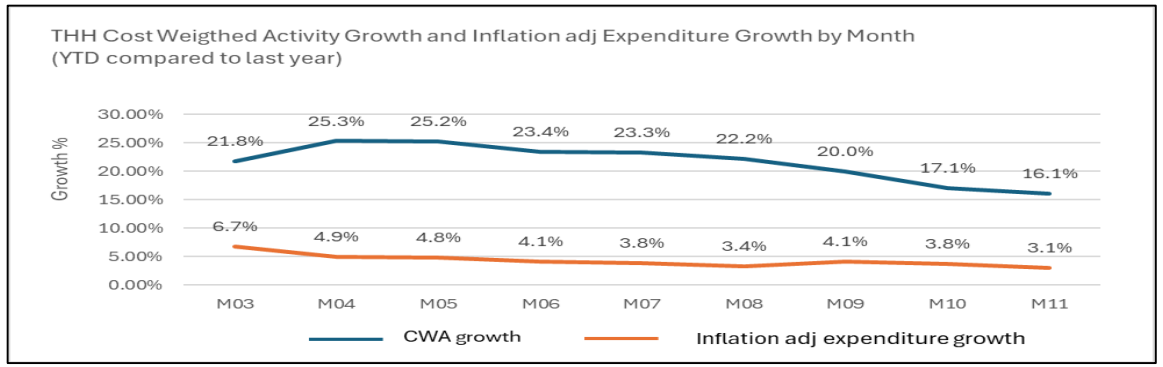
- Implied Productivity position ytd M11 (24-25 v 19-20) deteriorated by -6.8% (compared to national provider average of -11.1%).
- Inflation adjusted growth of 27.3% outstripped the cost weighted activity growth of 16.6%, hence a fall in implied productivity.

Source – NHSE Efficiency team
Note - The first 2 months are made to equal to M3 in MHS due to data quality.
*National averages to M10.

THH: Implied Productivity, Cost Weighted Activity and Inflation adjusted expenditure growth trends

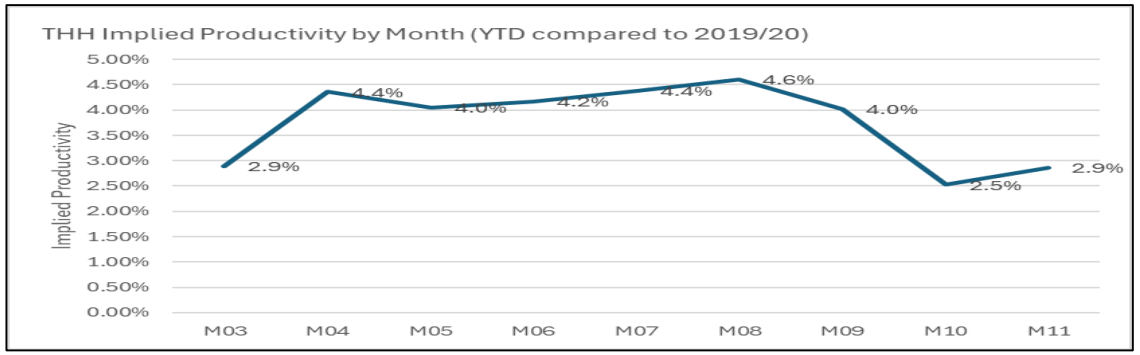
2024-25 vs 2023-24

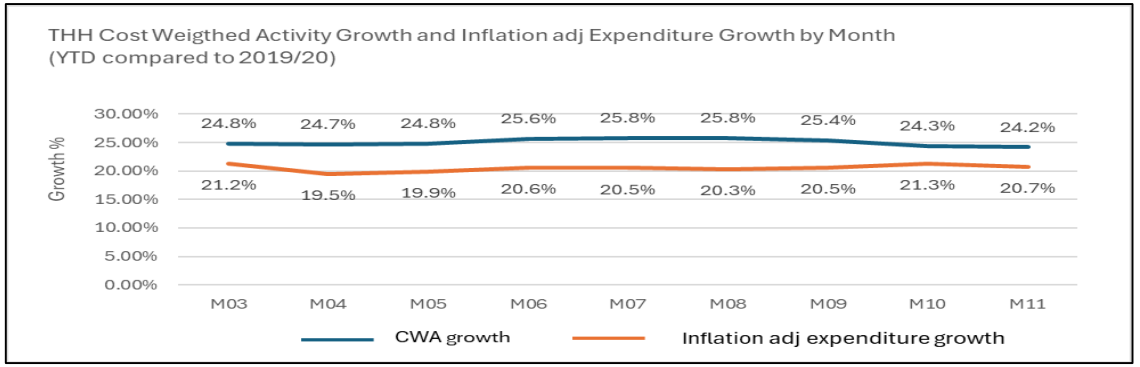




- Implied Productivity position ytd M11 (24-25 v 23-24) improved by 12.6% (compared to national provider average of +2.5%).
- Cost weighted activity growth of 16.1% outstripped inflation adjusted expenditure growth of 3.1%, hence an improvement in implied productivity.

2024-25 vs 2019-20





- Implied Productivity position ytd M11 (24-25 v 19-20) improved by 2.9% (compared to national provider average of -11.1%).
- Cost weighted activity growth of 24.2% outstripped inflation adjusted expenditure growth of 20.7%, hence an improvement in implied productivity.

Source – NHSE Efficiency team
Note - The first 2 months are made to equal to M3 in MHS due to data quality.
*National averages to M10.

Appendix B – 23-24 Cost per WAU update

23-24 MHS Cost per WAU Updates :

- In Feb 25, the new Weighted Activity Units (WAU) were published in the Model Health System (MHS) using a full year of data from 2023/24. This data already adjusts via a Market Forces Factor (MFF) for the high cost of service delivery in London.
  - **CWFT's** overall WAU (£3,264) has remained at the top Quartile 1 compared to the prior year and is lower than the National Median (£3,538) and lower than the Recommended Peer Median (£3,420).
  - **ICHT'**s overall WAU has not been updated on MHS (clarify why this is with National team).
  - **LNWH's** overall WAU (£3,722) has deteriorated to Quartile 3 from Quartile 2 (22/23 position) and is higher than the National Median (£3,538) and the Recommended Peer Median (£3,434).
  - **THH's** overall WAU (£3,410) has improved to quartile 2 from quartile 4 (22/23 position) ; lower than the National Median (£3,538) and the Recommended Peer Median (£3,447).
- Specialty WAU's
  - **CWFT has 2 specialties (Dentistry and oncology**) that have WAUs in Quartile 4, suggesting there is opportunity to look at efficiency and cost in these areas.
  - **ICHT has 5 specialties (General Surgery, Geriatric Medicine, Gynaecology, Oncology and Orthopaedic Surgery)** that have WAUs in Quartile 4, suggesting there is opportunity to look at efficiency and cost in these areas.
  - **LNWH has 7 specialties (Gastroenterology, General Surgery, Oncology, Neurology, Ophthalmology, Orthopaedic Surgery and Vascular Surgery)** that have WAUs in Quartile 4, suggesting there is opportunity to look at efficiency and cost in these areas.
  - **THH has 10 specialties (Breast Surgery, ENT, Emergency Medicine, Oncology, Neurology, Ophthalmology, Orthopaedic Surgery, Respiratory Medicine, Rheumatology and Urology)** that have WAUs in Quartile 4, suggesting there is opportunity to look at efficiency and cost in these areas.

CWFT 23-24 Specialty Cost per WAU

CWFT has 2 specialties (Dentistry and oncology) that have WAUs in Quartile 4, suggesting there is opportunity to look at efficiency and cost in these areas.
In 22-23, there were 4 specialties that had WAUs in Quartile 4 (Dentistry, Dermatology, Oncology, Paediatrics). Paediatrics and Dermatology has improved to quartile 3.

Cost per WAU by Specialty	Data period	Provider value	Peer average	National value	National value method	Chart
Breast Surgery - Cost per WAU (MFF adjusted)	2023/24	£2,917	£3,456	£3,477	Provider median	
Cardiology - Cost per WAU (MFF adjusted)	2023/24	£3,382	£3,664	£3,581	Provider median	
Dentistry - Cost per WAU (MFF adjusted)	2023/24	£4,449	£3,505	£3,529	Provider median	
Dermatology - Cost per WAU (MFF adjusted)	2023/24	£3,958	£3,683	£3,490	Provider median	
Diabetes and Endocrinology - Cost per WAU (MFF adjusted)	2023/24	£2,865	£3,423	£3,633	Provider median	
Ear, Nose and Throat - Cost per WAU (MFF adjusted)	2023/24	£2,557	£3,588	£3,537	Provider median	
Emergency Medicine - Cost per WAU (MFF adjusted)	2023/24	£3,076	£3,564	£3,522	Provider median	
Gastroenterology - Cost per WAU (MFF adjusted)	2023/24	£2,629	£3,435	£3,636	Provider median	
General & Acute Medicine - Cost per WAU (MFF adjusted)	2023/24	£2,750	£3,313	£3,611	Provider median	
General Surgery - Cost per WAU (MFF adjusted)	2023/24	£3,662	£3,610	£3,583	Provider median	
Geriatric Medicine - Cost per WAU (MFF adjusted)	2023/24	£3,722	£3,480	£3,741	Provider median	
Gynaecology - Cost per WAU (MFF adjusted)	2023/24	£3,301	£3,538	£3,459	Provider median	
Oncology - Cost per WAU (MFF adjusted)	2023/24	£4,279	£3,946	£3,439	Provider median	
Neurology - Cost per WAU (MFF adjusted)	2023/24	£2,916	£3,507	£3,412	Provider median	
Neurosurgery - Cost per WAU (MFF adjusted)	No data available					
Obstetrics - Cost per WAU (MFF adjusted)	2023/24	£3,492	£3,694	£3,543	Provider median	
Ophthalmology - Cost per WAU (MFF adjusted)	2023/24	£3,976	£3,463	£3,507	Provider median	
Oral and Maxillofacial - Cost per WAU (MFF adjusted)	2023/24	£2,242	£3,414	£3,458	Provider median	
Orthopaedic Surgery - Cost per WAU (MFF adjusted)	2023/24	£3,227	£3,247	£3,525	Provider median	
Paediatrics - Cost per WAU (MFF adjusted)	2023/24	£3,553	£3,581	£3,405	Provider median	
Plastic Surgery and Burns - Cost per WAU (MFF adjusted)	2023/24	£3,602	£3,424	£3,269	Provider median	
Respiratory Medicine - Cost per WAU (MFF adjusted)	2023/24	£2,944	£3,111	£3,562	Provider median	
Rheumatology - Cost per WAU (MFF adjusted)	2023/24	£3,631	£3,338	£3,412	Provider median	
Spinal Surgery - Cost per WAU (MFF adjusted)	2023/24	£2,937	£3,469	£3,436	Provider median	
Stroke- Cost per WAU (MFF adjusted)	2023/24	£4,663	£3,792	£3,688	Provider median	
Urology - Cost per WAU (MFF adjusted)	2023/24	£3,020	£3,554	£3,513	Provider median	
Vascular Surgery - Cost per WAU (MFF adjusted)	2023/24	£1,058	£3,157	£3,455	Provider median	

ICHT 23-24 Specialty Cost per WAU

ICHT has 5 specialties (General Surgery, Geriatric Medicine, Gynaecology, Oncology and Orthopaedic Surgery) that have WAUs in Quartile 4, suggesting there is opportunity to look at efficiency and cost in these areas. In 22-23 these 5 specialties were also in Quartile 4.

Cost per WAU by Specialty	Data period	Provider value	Peer average	National value	National value method	Chart
Breast Surgery - Cost per WAU (MFF adjusted)	2022/23	£3,046	£3,419	£3,415	Provider median	
Cardiology - Cost per WAU (MFF adjusted)	2022/23	£3,237	£3,592	£3,455	Provider median	
Dentistry - Cost per WAU (MFF adjusted)			No data available			
Dermatology - Cost per WAU (MFF adjusted)	2022/23	£3,652	£3,119	£3,423	Provider median	
Diabetes and Endocrinology - Cost per WAU (MFF adjusted)	2022/23	£2,916	£3,369	£3,622	Provider median	
Ear, Nose and Throat - Cost per WAU (MFF adjusted)	2022/23	£3,254	£3,505	£3,500	Provider median	
Emergency Medicine - Cost per WAU (MFF adjusted)	2022/23	£3,644	£3,627	£3,605	Provider median	
Gastroenterology - Cost per WAU (MFF adjusted)	2022/23	£3,443	£3,914	£3,534	Provider median	
General & Acute Medicine - Cost per WAU (MFF adjusted)	2022/23	£2,065	£3,346	£3,647	Provider median	
General Surgery - Cost per WAU (MFF adjusted)	2022/23	£3,815	£3,727	£3,487	Provider median	
Geriatric Medicine - Cost per WAU (MFF adjusted)	2022/23	£4,458	£4,326	£3,750	Provider median	
Gynaecology - Cost per WAU (MFF adjusted)	2022/23	£3,941	£3,518	£3,505	Provider median	
Oncology - Cost per WAU (MFF adjusted)	2022/23	£4,179	£3,883	£3,573	Provider median	
Neurology - Cost per WAU (MFF adjusted)	2022/23	£3,135	£3,558	£3,465	Provider median	
Neurosurgery - Cost per WAU (MFF adjusted)	2022/23	£3,048	£3,813	£3,781	Provider median	
Obstetrics - Cost per WAU (MFF adjusted)	2022/23	£2,768	£3,365	£3,581	Provider median	
Ophthalmology - Cost per WAU (MFF adjusted)	2022/23	£3,795	£3,702	£3,558	Provider median	
Oral and Maxillofacial - Cost per WAU (MFF adjusted)	2022/23	£1,769	£3,343	£3,494	Provider median	
Orthopaedic Surgery - Cost per WAU (MFF adjusted)	2022/23	£4,160	£3,729	£3,503	Provider median	
Paediatrics - Cost per WAU (MFF adjusted)	2022/23	£3,084	£3,719	£3,486	Provider median	
Plastic Surgery and Burns - Cost per WAU (MFF adjusted)	2022/23	£3,329	£3,481	£3,576	Provider median	
Respiratory Medicine - Cost per WAU (MFF adjusted)	2022/23	£3,291	£3,377	£3,548	Provider median	
Rheumatology - Cost per WAU (MFF adjusted)	2022/23	£3,352	£3,414	£3,470	Provider median	
Spinal Surgery - Cost per WAU (MFF adjusted)	2022/23	£3,615	£3,594	£3,476	Provider median	
Stroke- Cost per WAU (MFF adjusted)	2022/23	£2,889	£3,572	£3,745	Provider median	
Urology - Cost per WAU (MFF adjusted)	2022/23	£3,313	£3,624	£3,570	Provider median	
Vascular Surgery - Cost per WAU (MFF adjusted)	2022/23	£2,825	£3,981	£3,327	Provider median	

LNWH 23-24 Specialty Cost per WAU

LNWH has 7 specialties (Gastroenterology, General Surgery, Oncology, Neurology, Ophthalmology, Orthopaedic Surgery and Vascular Surgery) that have WAUs in Quartile 4, suggesting there is opportunity to look at efficiency and cost in these areas. In 22-23, LNWH had 5 specialties (Gastroenterology, Oncology, Neurology, Ophthalmology, Orthopaedic Surgery) that had WAUs in Quartile 4.

Cost per WAU by Specialty	Data period	Provider value	Peer average	National value	National value method	Chart
Breast Surgery - Cost per WAU (MFF adjusted)	2023/24	£3,508	£2,917	£3,477	Provider median	
Cardiology - Cost per WAU (MFF adjusted)	2023/24	£2,869	£3,759	£3,581	Provider median	
Dentistry - Cost per WAU (MFF adjusted)	2023/24	£3,497	£3,146	£3,529	Provider median	
Dermatology - Cost per WAU (MFF adjusted)	2023/24	£3,434	£3,566	£3,490	Provider median	
Diabetes and Endocrinology - Cost per WAU (MFF adjusted)	2023/24	£3,484	£3,577	£3,633	Provider median	
Ear, Nose and Throat - Cost per WAU (MFF adjusted)	2023/24	£3,399	£3,724	£3,537	Provider median	
Emergency Medicine - Cost per WAU (MFF adjusted)	2023/24	£3,801	£3,528	£3,522	Provider median	
Gastroenterology - Cost per WAU (MFF adjusted)	2023/24	£4,864	£3,649	£3,636	Provider median	
General & Acute Medicine - Cost per WAU (MFF adjusted)	2023/24	£3,252	£3,477	£3,611	Provider median	
General Surgery - Cost per WAU (MFF adjusted)	2023/24	£3,985	£4,090	£3,583	Provider median	
Geriatric Medicine - Cost per WAU (MFF adjusted)	2023/24	£3,841	£3,602	£3,741	Provider median	
Gynaecology - Cost per WAU (MFF adjusted)	2023/24	£3,599	£3,589	£3,459	Provider median	
Oncology - Cost per WAU (MFF adjusted)	2023/24	£4,268	£3,269	£3,439	Provider median	
Neurology - Cost per WAU (MFF adjusted)	2023/24	£4,144	£3,458	£3,412	Provider median	
Neurosurgery - Cost per WAU (MFF adjusted)			⊘ No data available			
Obstetrics - Cost per WAU (MFF adjusted)	2023/24	£3,809	£3,719	£3,543	Provider median	
Ophthalmology - Cost per WAU (MFF adjusted)	2023/24	£4,709	£3,841	£3,507	Provider median	
Oral and Maxillofacial - Cost per WAU (MFF adjusted)	2023/24	£3,484	£3,471	£3,458	Provider median	
Orthopaedic Surgery - Cost per WAU (MFF adjusted)	2023/24	£4,860	£3,283	£3,525	Provider median	
Paediatrics - Cost per WAU (MFF adjusted)	2023/24	£3,733	£3,553	£3,405	Provider median	
Plastic Surgery and Burns - Cost per WAU (MFF adjusted)	2017/18	£3,641	£3,491	£3,444	Provider median	
Respiratory Medicine - Cost per WAU (MFF adjusted)	2023/24	£2,906	£3,199	£3,562	Provider median	
Rheumatology - Cost per WAU (MFF adjusted)	2023/24	£3,872	£3,467	£3,412	Provider median	
Spinal Surgery - Cost per WAU (MFF adjusted)	2023/24	£3,679	£3,658	£3,436	Provider median	
Stroke- Cost per WAU (MFF adjusted)	2023/24	£3,230	£4,663	£3,688	Provider median	
Urology - Cost per WAU (MFF adjusted)	2023/24	£3,836	£3,579	£3,513	Provider median	
Vascular Surgery - Cost per WAU (MFF adjusted)	2023/24	£3,945	£4,073	£3,455	Provider median	

THH 23-24 Specialty Cost per WAU

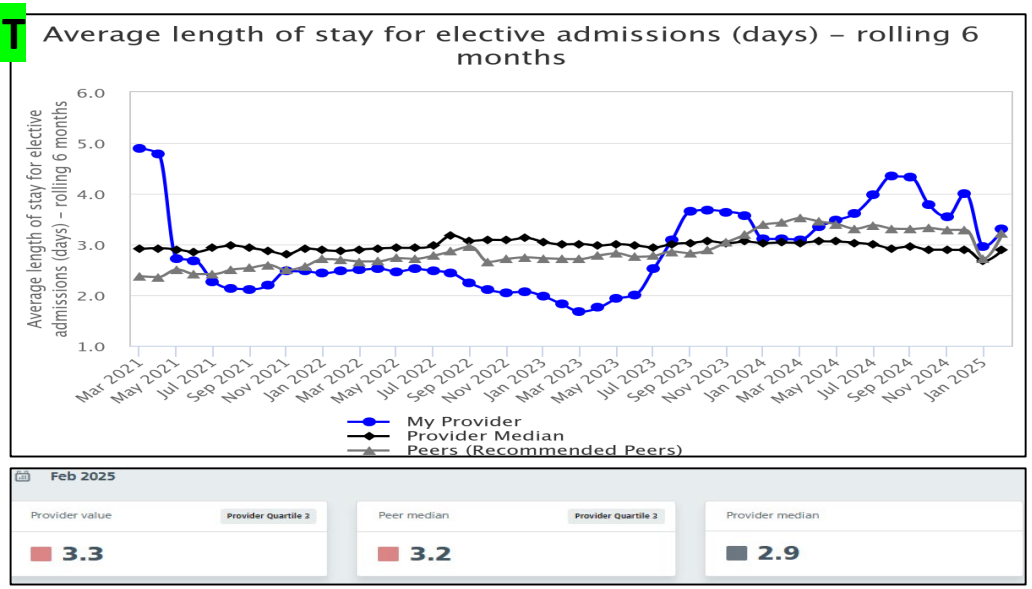
THH has 10 specialties (Breast Surgery, ENT, Emergency Medicine, Oncology, Neurology, Ophthalmology, Orthopaedic Surgery, Respiratory Medicine, Rheumatology and Urology) that have WAUs in Quartile 4, suggesting there is opportunity to look at efficiency and cost in these areas. In 22-24, THH has 13 specialties (Breast, Cardiology, ENT, Emergency Medicine, Gynaecology, Oncology, Neurology, Ophthalmology, Orthopaedic Surgery, Respiratory Medicine, Rheumatology, Stroke, Urology) that had WAUs in Quartile 4.

Cost per WAU by Specialty	Data period	Provider value	Peer average	National value	National value method	Chart
Breast Surgery - Cost per WAU (MFF adjusted)	2023/24	£5,152	£3,005	£3,477	Provider median	
Cardiology - Cost per WAU (MFF adjusted)	2023/24	£3,700	£3,514	£3,581	Provider median	
Dentistry - Cost per WAU (MFF adjusted)			No data available			
Dermatology - Cost per WAU (MFF adjusted)	2023/24	£3,753	£3,582	£3,490	Provider median	
Diabetes and Endocrinology - Cost per WAU (MFF adjusted)	2023/24	£3,362	£3,712	£3,633	Provider median	
Ear, Nose and Throat - Cost per WAU (MFF adjusted)	2023/24	£4,171	£3,461	£3,537	Provider median	
Emergency Medicine - Cost per WAU (MFF adjusted)	2023/24	£4,260	£3,201	£3,522	Provider median	
Gastroenterology - Cost per WAU (MFF adjusted)	2023/24	£2,608	£3,229	£3,636	Provider median	
General & Acute Medicine - Cost per WAU (MFF adjusted)	2023/24	£2,902	£3,675	£3,611	Provider median	
General Surgery - Cost per WAU (MFF adjusted)	2023/24	£3,556	£3,488	£3,583	Provider median	
Geriatric Medicine - Cost per WAU (MFF adjusted)	2023/24	£3,263	£4,004	£3,741	Provider median	
Gynaecology - Cost per WAU (MFF adjusted)	2023/24	£3,487	£3,221	£3,459	Provider median	
Oncology - Cost per WAU (MFF adjusted)	2020/21	£9,807	£3,783	£3,493	Provider median	
Neurology - Cost per WAU (MFF adjusted)	2023/24	£4,753	£2,411	£3,412	Provider median	
Neurosurgery - Cost per WAU (MFF adjusted)			No data available			
Obstetrics - Cost per WAU (MFF adjusted)	2023/24	£2,420	£3,365	£3,543	Provider median	
Ophthalmology - Cost per WAU (MFF adjusted)	2023/24	£4,506	£3,647	£3,507	Provider median	
Oral and Maxillofacial - Cost per WAU (MFF adjusted)	2023/24	£2,886	£2,952	£3,458	Provider median	
Orthopaedic Surgery - Cost per WAU (MFF adjusted)	2023/24	£3,858	£3,603	£3,525	Provider median	
Paediatrics - Cost per WAU (MFF adjusted)	2023/24	£3,562	£3,570	£3,405	Provider median	
Plastic Surgery and Burns - Cost per WAU (MFF adjusted)	2017/18	£2,961	£3,507	£3,444	Provider median	
Respiratory Medicine - Cost per WAU (MFF adjusted)	2023/24	£5,604	£3,622	£3,562	Provider median	
Rheumatology - Cost per WAU (MFF adjusted)	2023/24	£4,434	£3,493	£3,412	Provider median	
Spinal Surgery - Cost per WAU (MFF adjusted)	2023/24	£3,260	£3,618	£3,436	Provider median	
Stroke- Cost per WAU (MFF adjusted)	2023/24	£4,260	£4,747	£3,688	Provider median	
Urology - Cost per WAU (MFF adjusted)	2023/24	£4,083	£3,344	£3,513	Provider median	
Vascular Surgery - Cost per WAU (MFF adjusted)	2023/24	£2,099	£2,774	£3,455	Provider median	

Appendix C – Operational Driver Metric Trend Analysis

Average length of stay for elective admissions (days) - rolling 6 months – By Organisation

CWFT



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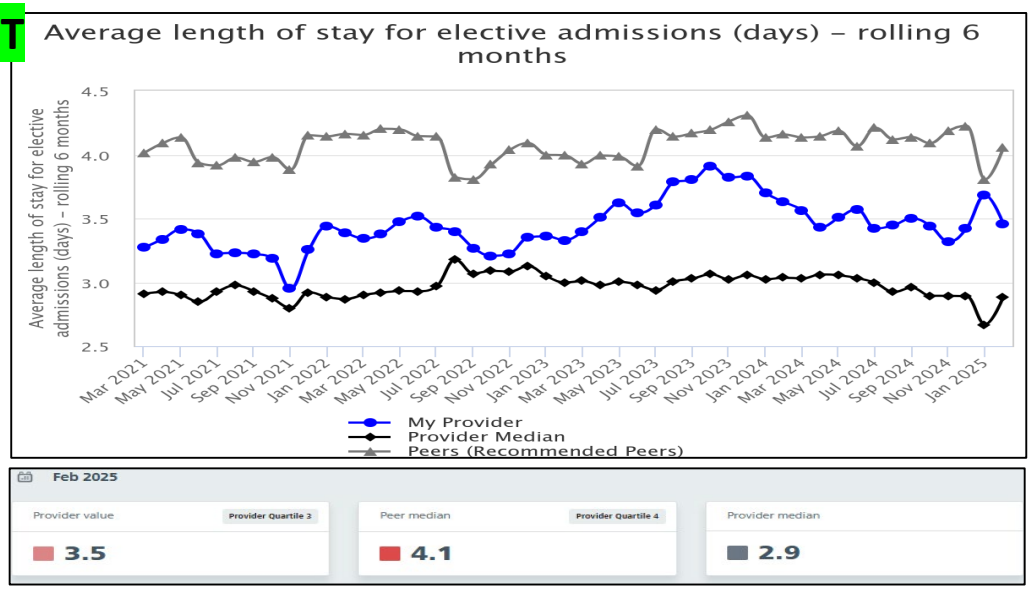

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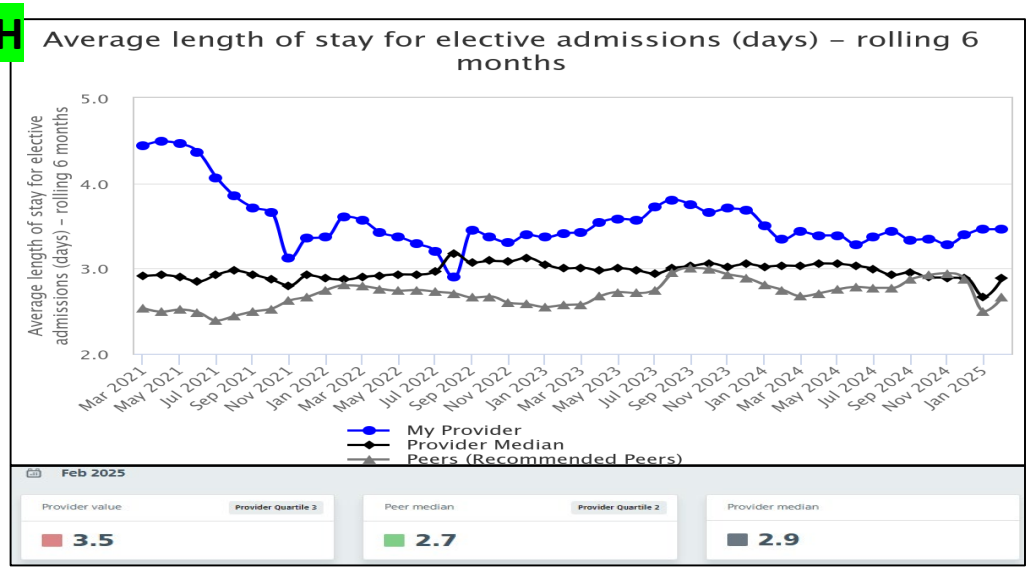

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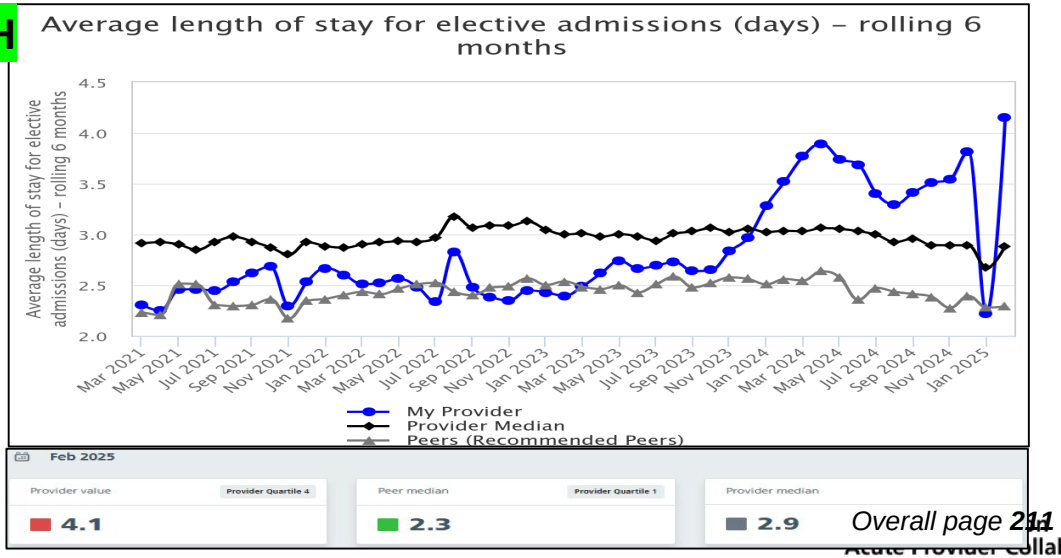

Average length of stay for emergency admissions (days) - rolling 6 months – By Organisation

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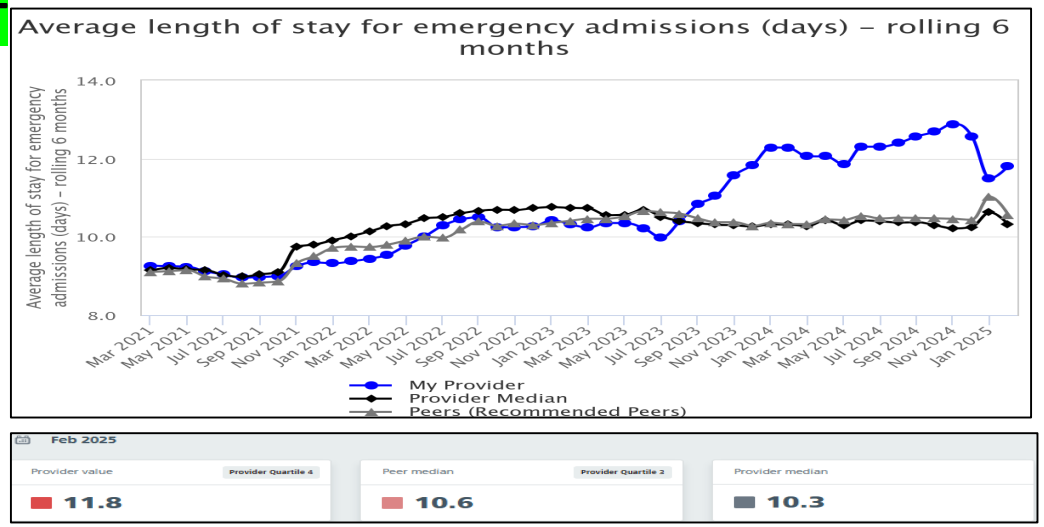

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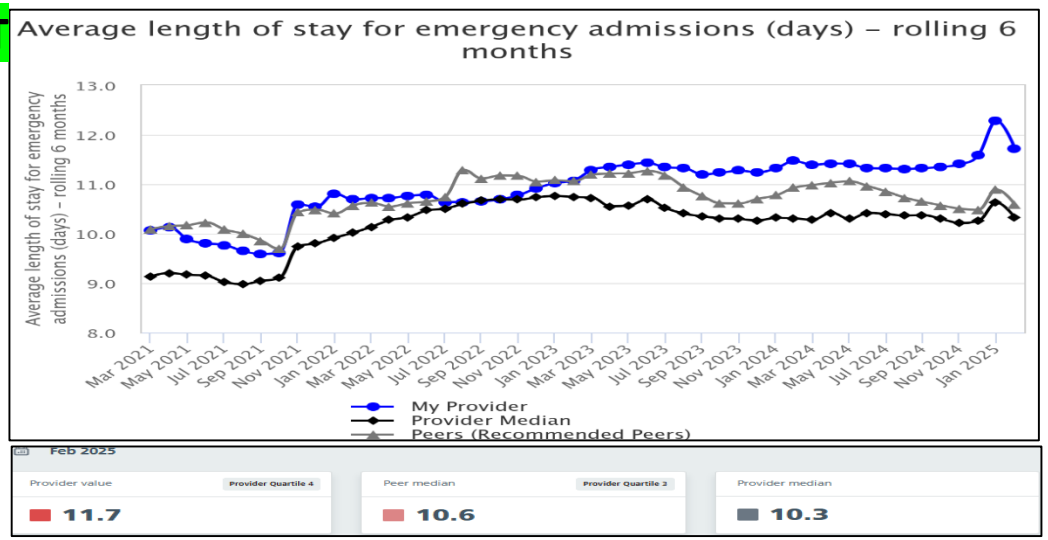

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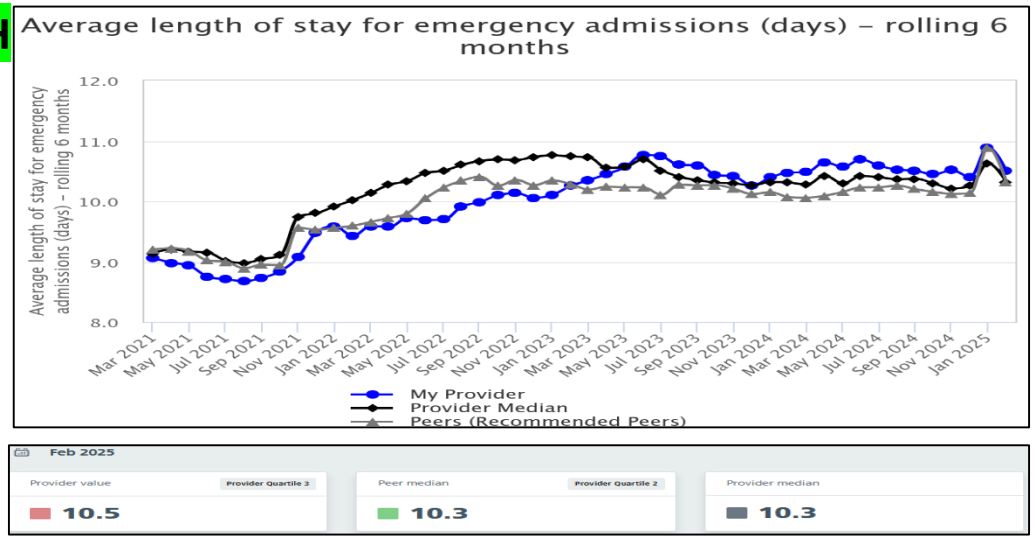

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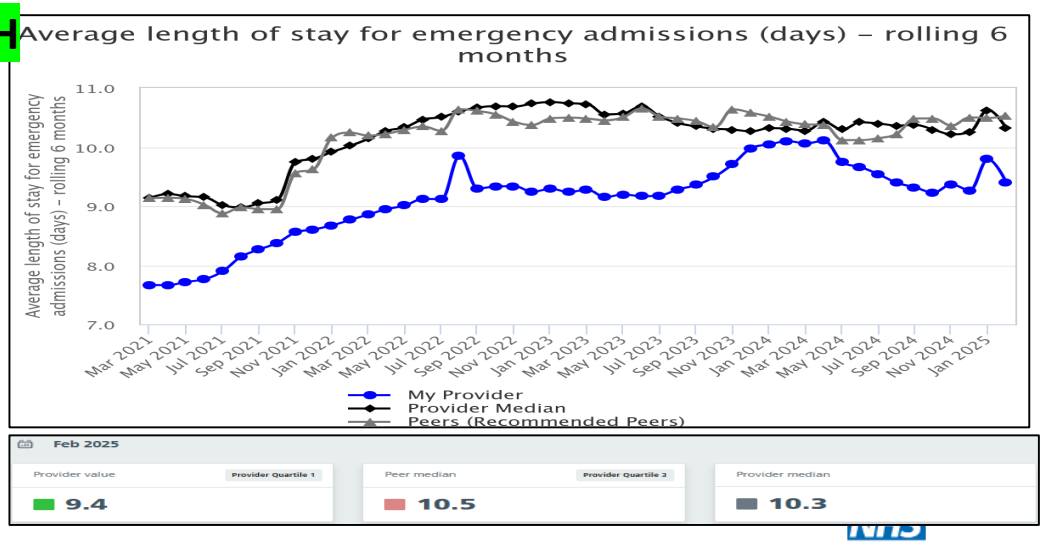
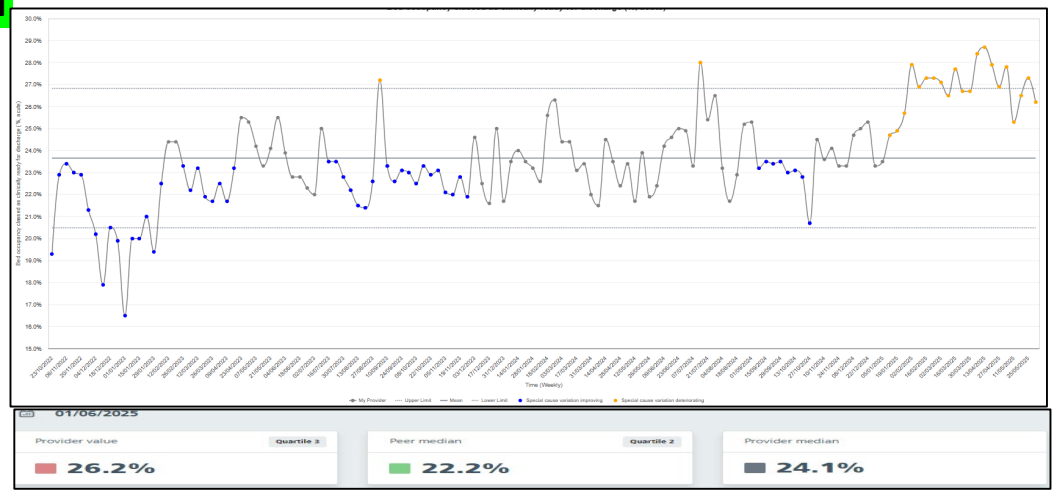


North West Regional Acute Provider Collaborative

Bed occupancy classed as clinically ready for discharge (%, acute) – By Organisation

CWFT



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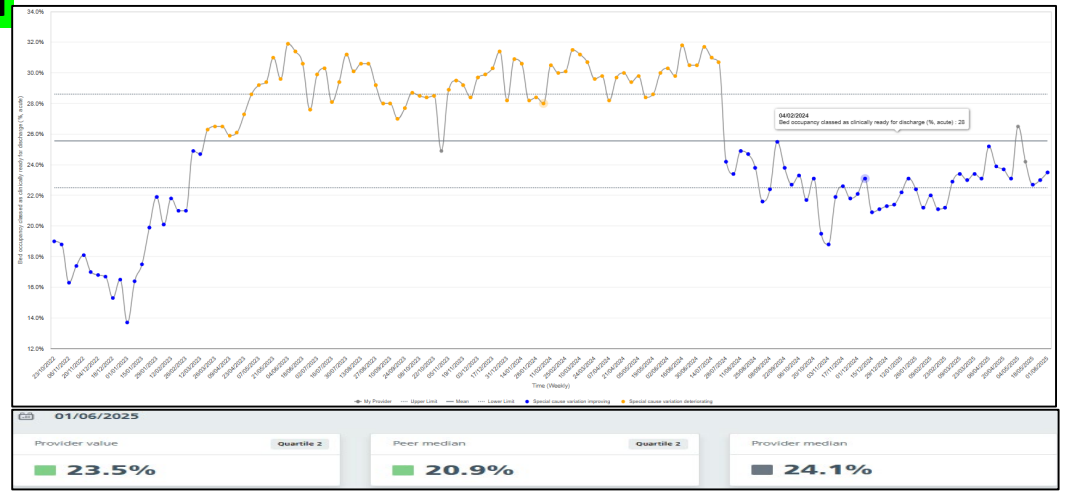

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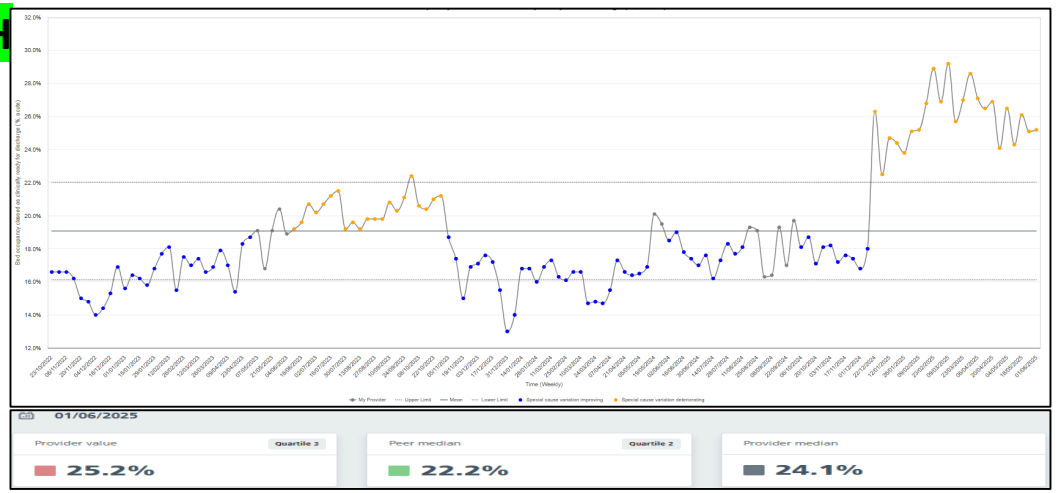

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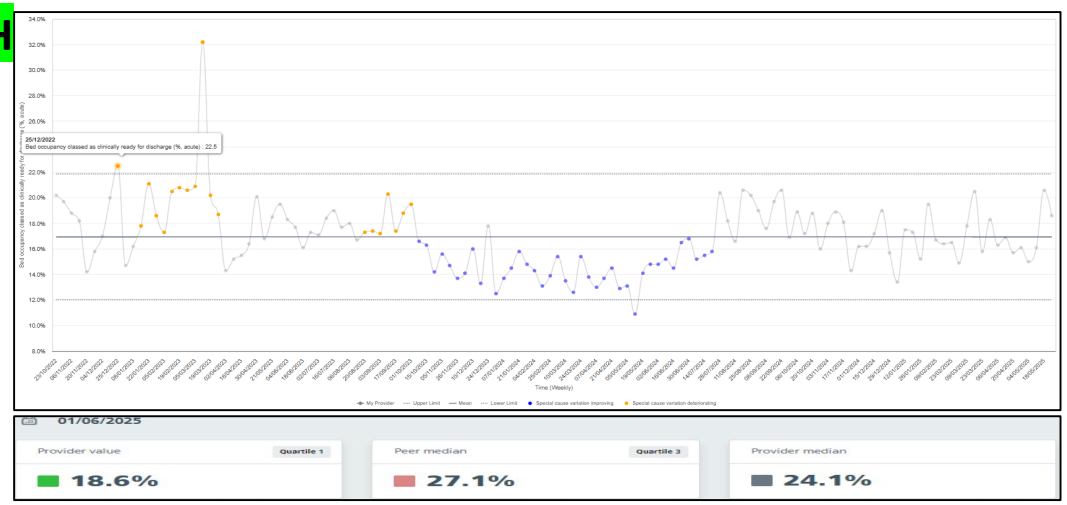
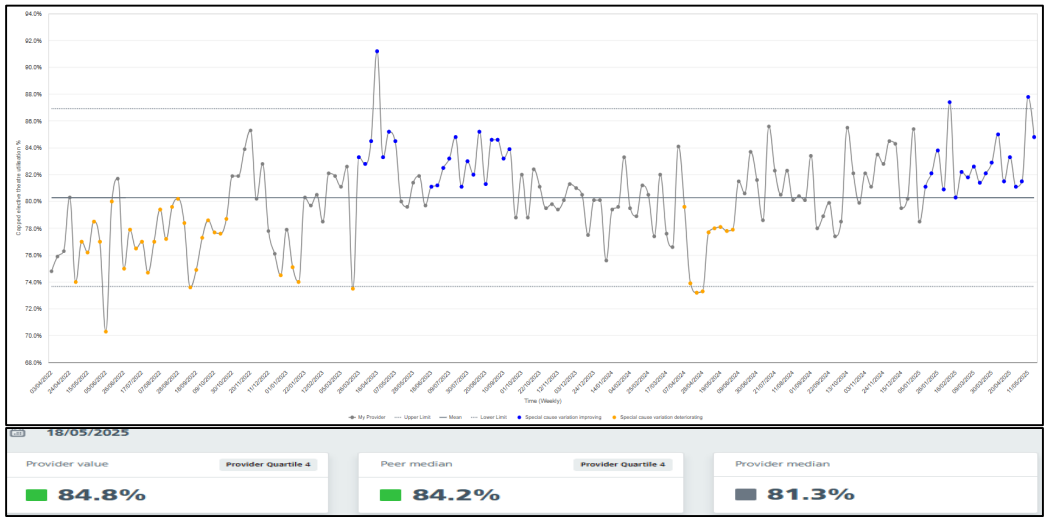


Capped elective theatre utilisation % – By Organisation

CWFT



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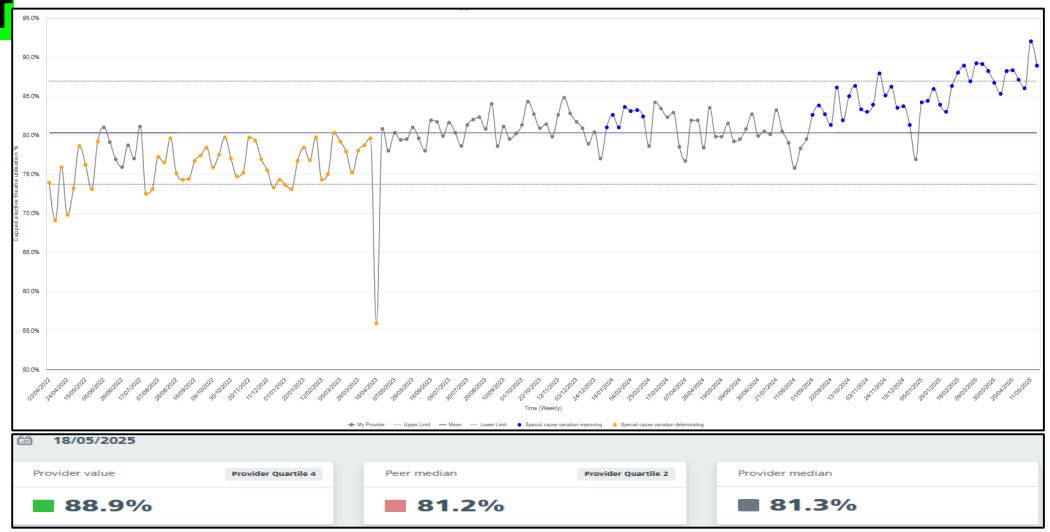

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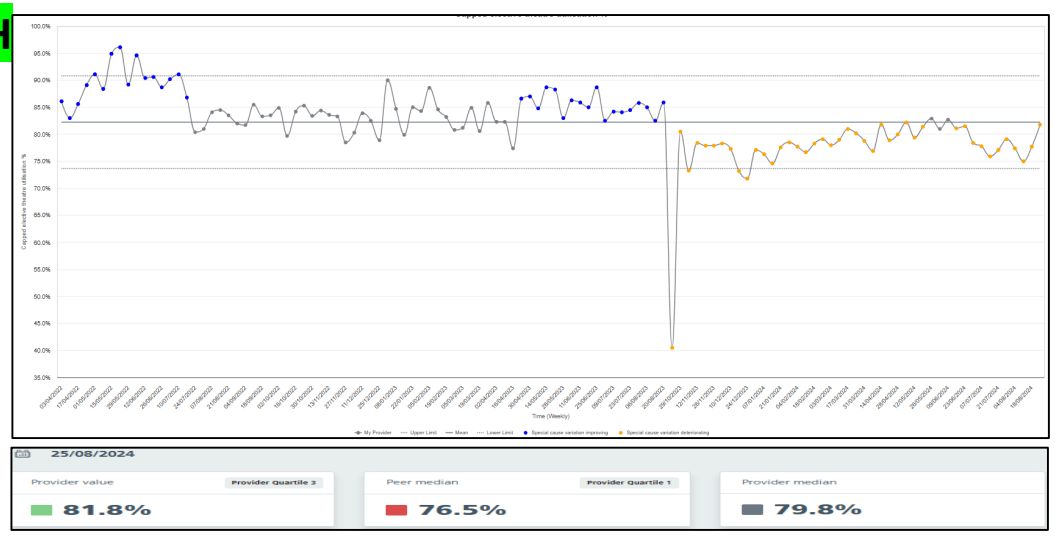

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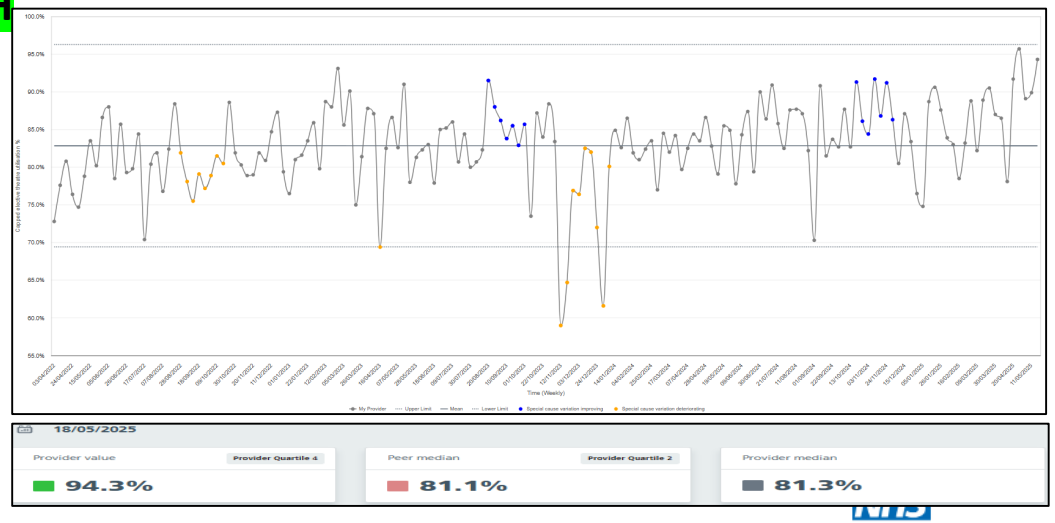
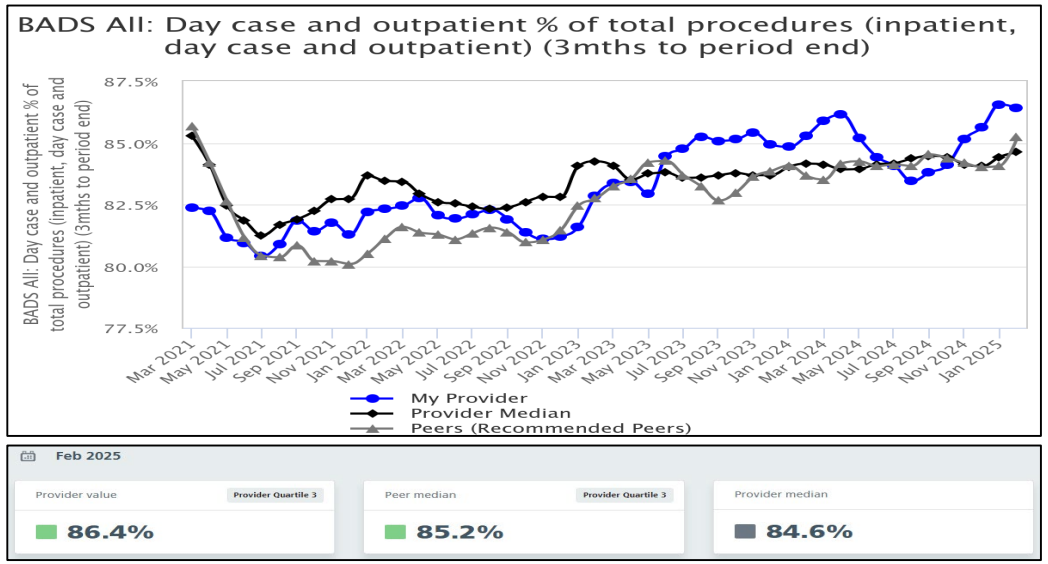


BADS All: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period end) – By Organisation

CWFT



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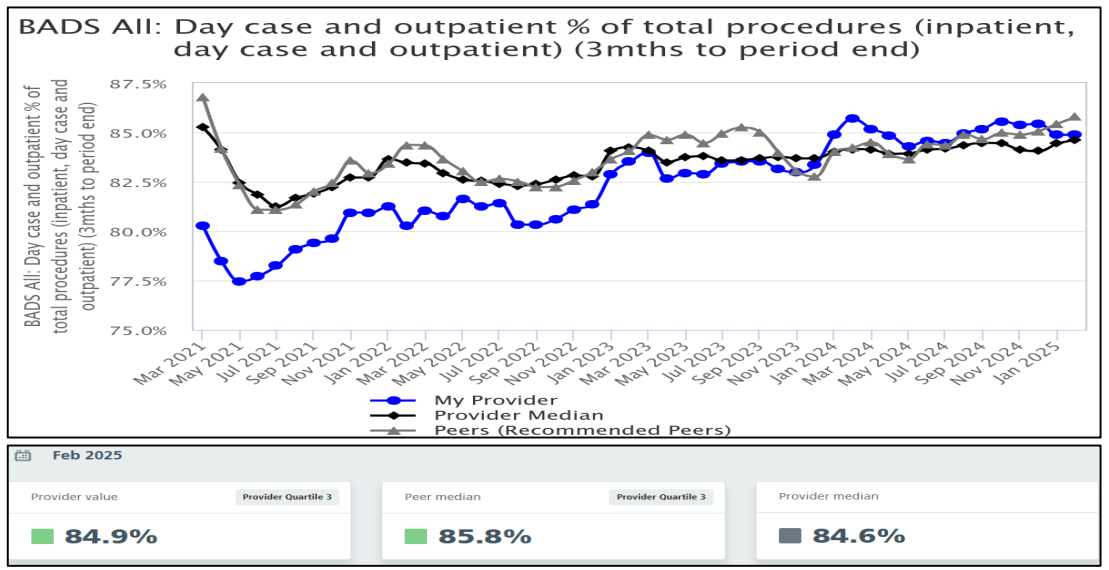

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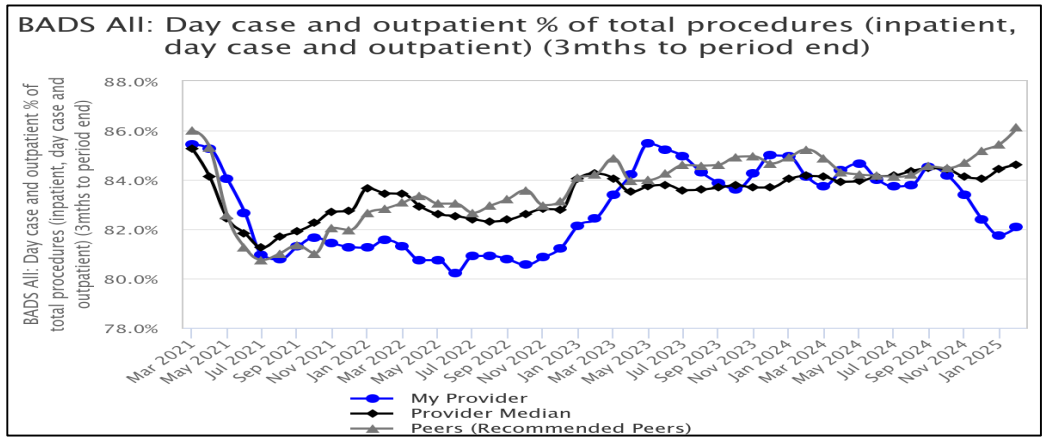

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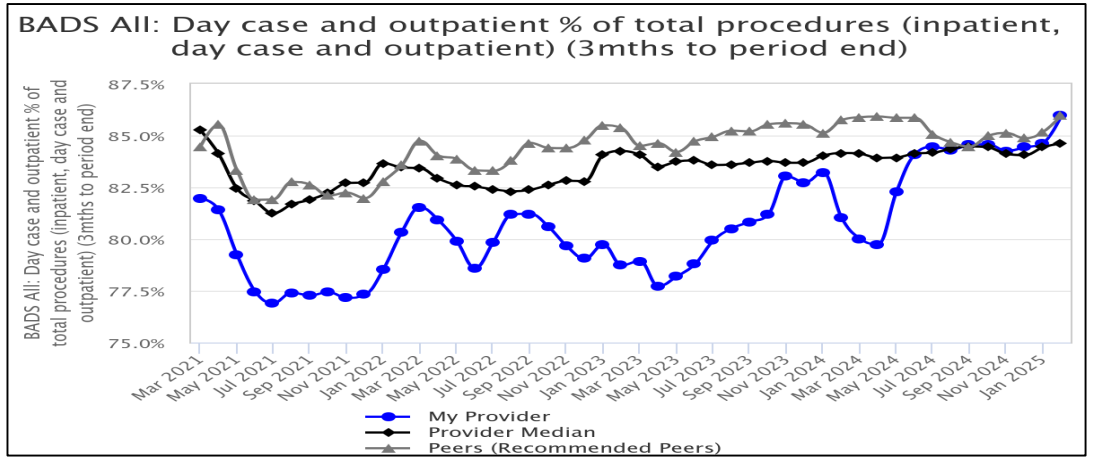
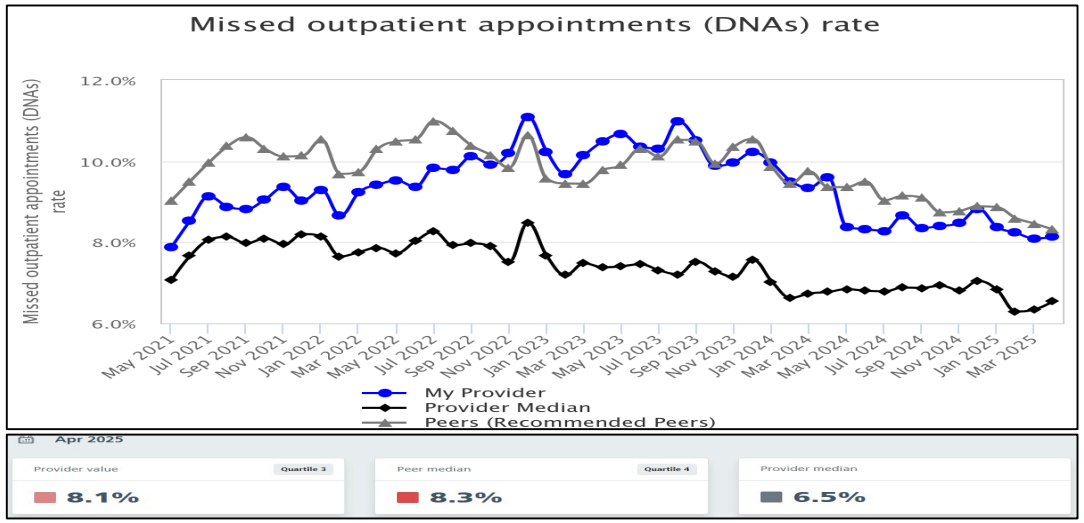


Missed outpatient appointments (DNAs) rate – by organisation

CWFT



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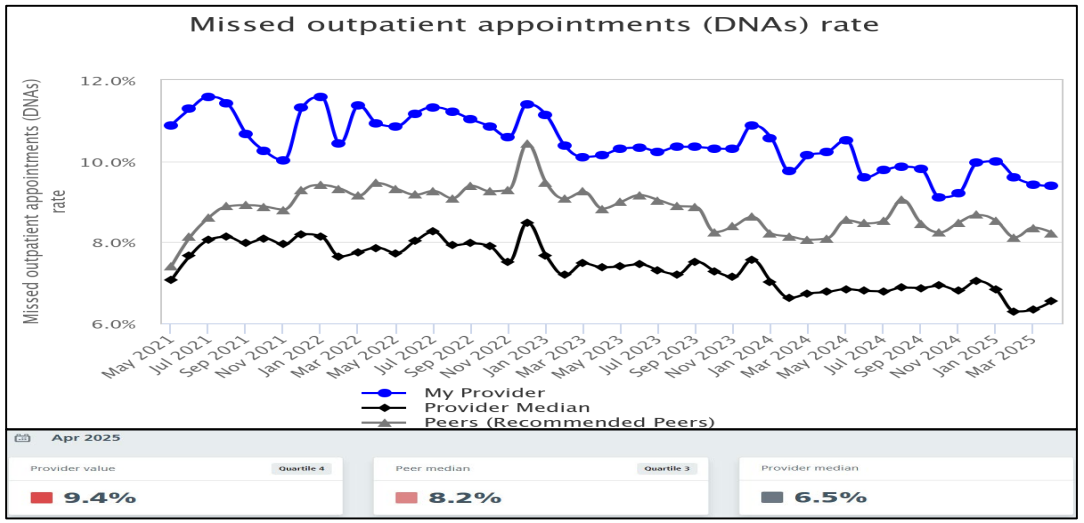

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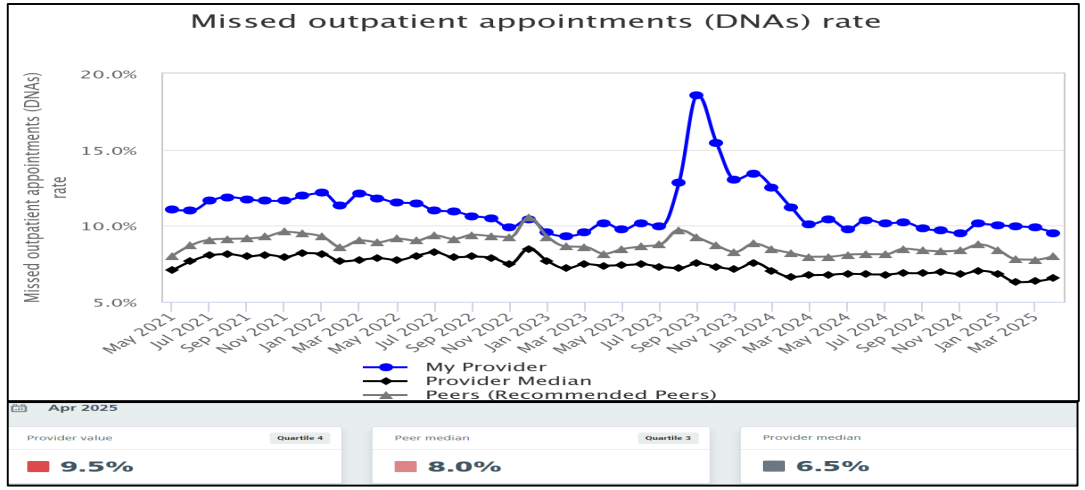

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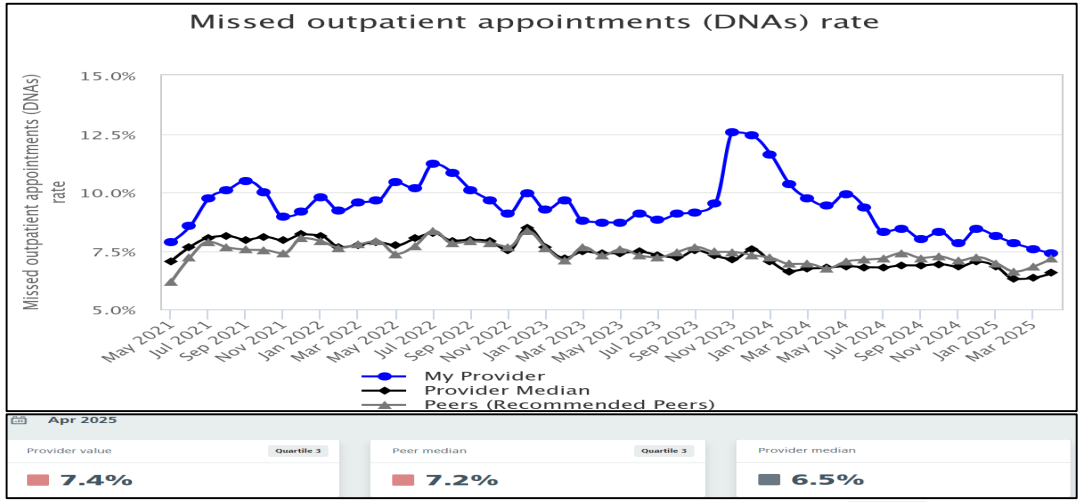
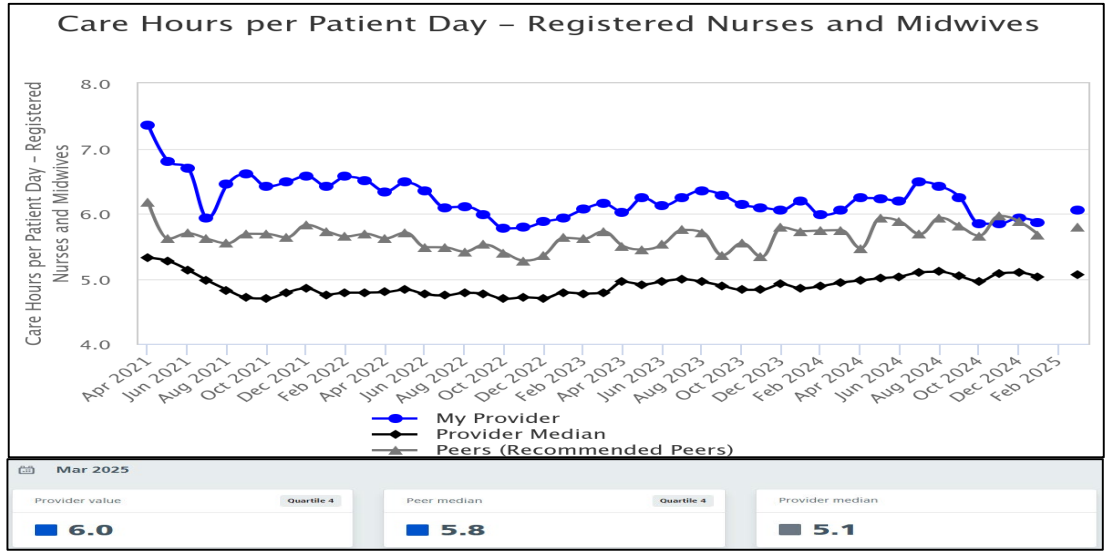


Appendix D – Workforce Productivity and Driver metric trends

Care Hours per Patient Day - Registered Nurses and Midwives – by organisation

CWFT



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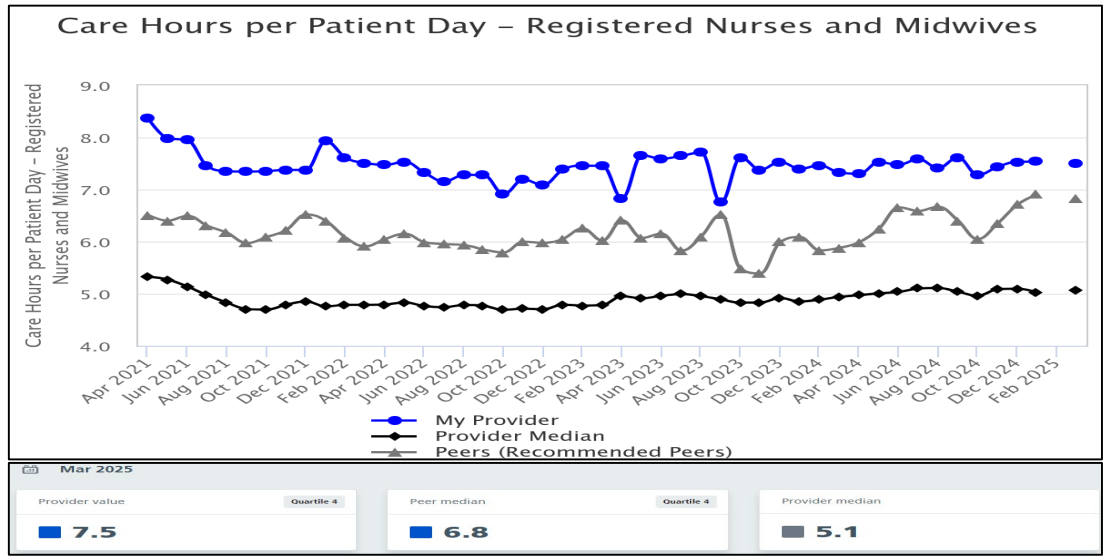

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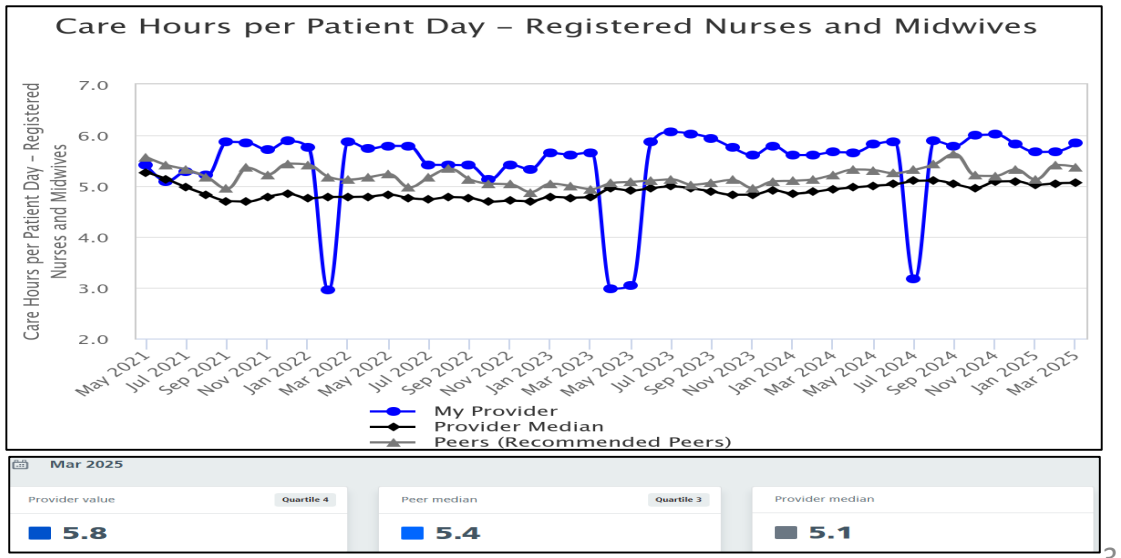

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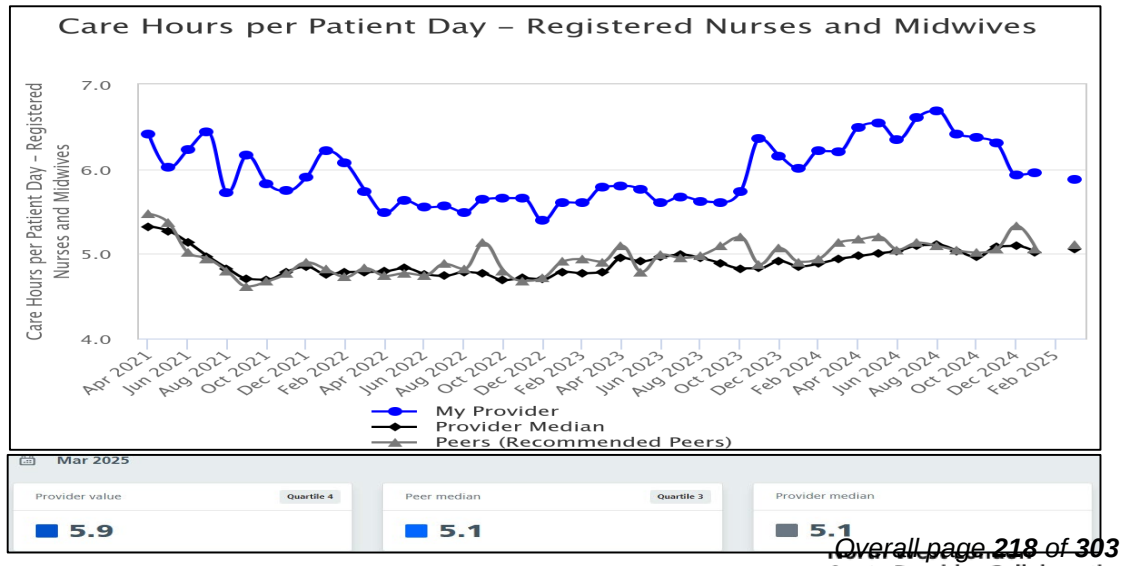

Appendix E – APC Implied Productivity Model Development – Project Summary

APC Implied Productivity Model Development – Project Summary

Section	Summary
Purpose	Develop a standardised, locally-informed productivity model to support benchmarking, planning, and specialty-level analytics across APC.
Scope	Implied Productivity Metric – Cost Weighted Activity Growth in relation to Inflation Adjusted Expenditure Growth (Model has potential to include workforce productivity and other P&E metric benchmarking analysis – all in one dashboard).
Context	Increased scrutiny on NHS productivity. National metrics for implied productivity lack transparency and local relevance. Limitations include time lags; underpinning activity data is based on SUS which isn't useful for reconciliations with financial datasets; drilldown capability limited to POD level.
Governance	APC Productivity analytics group includes following membership – ADoF NWL APC (Chair), ICB BI leads, ICB and Trust Productivity, Efficiency, Costing, Finance leads. Group is reporting into NWL ICB PIG.
Progress So Far	- National Implied Productivity model review (methodology and assumptions) - ICB BI team has built a local model for cost weighted activity growth using Trust SLAM datasets - The other parts of model consistent with national model (e.g 22-23 NCC National average unit costs used for cost weighting activity; Cost growth model as per NHSE calculations) - Initial model shared back with Trust for validation and further review
Key Challenges	Limited Trust finance team capacity to validate models in May/June 25 due to 24–25 NCC costing submission deadlines Project management resource is a constraint.
Next Steps	- Identify project management resource - Post costing submission, validate the model - Update model for year-end view - Establish a periodic refresh and validation cycle
Strategic Value	- Locally driven, system-wide dataset for implied productivity - Reduces duplication (developed once for 4 trusts) - Project builds internal capability for productivity analytics - Setting foundations for future automation and integration opportunities via an APC wide data warehouse

Appendix F – Understanding the data

Dashboard Notes -

Metric	Understanding the data
New implied productivity	The methodology for the Implied Productivity Growth metrics has recently been updated and are included in the 'Headline Productivity (New Methodology)' section. The values produced using the old methodology will continue to be calculated for the remainder of 2024/25 and are included in a new section at the bottom of the metrics list: 'Headline Productivity (Old Methodology)' Implied Productivity of acute and specialist trusts is calculated by comparing output growth (cost-weighted activity) to input growth (based on expenditure costs) against a baseline period. The measure examines the current year's YTD activity and costs to the same period in the previous financial year. A negative value implies decreased productivity whilst positive implies productivity growth. The target is to see positive year on year change in this value and reduce / eliminate any negative distance from the same value calculated for same period last year.
Cost per WAU (MFF adjusted)	The cost per WAU metric is the headline productivity measure used within the Model Hospital. It shows how a organisation's costs compare to the amount of output (i.e. the number of WAUs) the organisation produced. The national average cost per WAU is £3,500 for non-specialist acute organisations. organisations with an overall cost per WAU above £3,500 appear to spend more per unit of output than the average organisation, whereas organisations with a cost per WAU below £3,500 appear to spend less than the average organisation. It is possible to break the cost per WAU down into the various cost components (e.g. doctors, nurses, or drugs cost per WAU) to provide a more detailed indication of where a organisation appears to be more or less productive than its peers. A higher than average cost per WAU suggests that the organisation spends more per unit of activity than a typical organisation. A lower than average cost per WAU suggests that the organisation spends less per unit of activity than a typical organisation. The cost per WAU indicators should be used to benchmark relative efficiency - i.e. to make comparisons between similar organisations within one financial year. For simplicity, the national average (for non-specialist acute providers) cost per WAU is fixed at £3,500.

Dashboard Notes -

Metric	Understanding the data
National Cost Collection Index	The National Cost Collection Index (NCCI) is a measure of the relative cost difference/efficiency between NHS providers. – It measures the relative efficiency of NHS organisations from an index centred around 100 - for example, an NCCI of 110 suggests a provider's costs are 10% above average; a score of 90 suggests they are 10% below average. This metric is not part of the MHS P&E benchmarking; Included on APC P&E dashboard for completeness.
Ave LOS of elective admissions (excluding day cases) - rolling 6mths	On the P&E MHS benchmarking dashboard, the actual metric used is the total average length of stay for the current week (week ending Sunday) for all ages. However due to an anomaly with the data for the month of March, the dashboard on slide 2 is using the data under the Inpatient compartment of Model Health System (MHS) for Average length of stay (days) of elective admissions, excluding day cases – rolling 6 months.
Ave LOS of emergency admissions(excluding short stays) - rolling 6mths	This metric is not included within the MHS P&E Benchmarking dashboard. Included on APC dashboard on slide 2 for completeness (sourced under the inpatients compartment on MHS).
Bed occupancy classed as clinically ready for discharge (%, acute)	This metric allows the tracking of the proportion of patients who do not meet the criteria to reside and therefore are clinically ready for discharge but are inhibited by other contributing factors. A decrease in this proportion can be seen to release much-needed capacity in acute hospital settings. This metric value is mean aggregated from daily values to a daily average for the week showing. The total value is derived from the sum of the count of patients who meet the criteria to reside in hospital (Question 1), patients who do not meet the criteria to reside (Question 2) and the count of patients discharged by 23:59 each day (sum of Question 3a and 3b). The question(s) mentioned above are collected daily, by 11:00 the day following the reported date.

Dashboard Notes -

Metric	Understanding the data
Capped theatre Utilisation	Capped elective theatre utilisation % is one of the key operating theatre efficiency metrics. This indicator helps understand the effectiveness of the operation scheduling processes within planned valid elective sessions in comparison to other organisations. Please note, all metric values prior to 26/8/2024 are calculated using an older methodology and may not be comparable. NHSE planning guidance for 24/25 includes a target rate of 85% for Capped Theatre Utilisation. Specialty, casemix and average cases per session should be factored into any benchmarking on this metric.
Day case rates for BADS procedures (3mths to month end)	This metric allows organisations to understand variation in their combined day case and outpatient procedure rate in the BADS (British Association of Day Surgery) basket of procedures. A low rate can indicate an opportunity to release inpatient bed days and cost savings. This rate includes day cases (planned as a day case, with no overnight stay) and outpatient procedures. Note: this metric only includes activity reported in NHS secondary care, where data is submitted to Admitted Patient Care and Outpatient Commissioning Data Sets (CDS), so GP practice procedure activity is not included. Local context is needed to interpret this metric. Please note at NHS trust site level, we show data where the NHS trust site carried out at least the following number of BADS procedures in 12 months 2023/24: - elective surgical hubs: no BADS minimum threshold; - endocrine surgery: 25 BADS endocrine procedures; - spinal surgery: 25 BADS spinal procedures; - vascular surgery: 50 BADS vascular procedures; - remaining BADS specialties: 100 BADS procedures per specialty These thresholds show at least 95% of BADS procedure activity per specialty

Dashboard Notes -

Metric	Understanding the data
New Implied Workforce Productivity Growth YTD	The methodology for the Implied Workforce Productivity Growth metrics has recently been updated and are included in the 'Headline Productivity (New Methodology)' section. The values produced using the old methodology will continue to be calculated for the remainder of 2024/25 and are included in a new section at the bottom of the metrics list: 'Headline Productivity (Old Methodology)' Implied Workforce Productivity Growth of acute and specialist trusts is calculated by comparing output growth (cost-weighted activity) to input growth (workforce) against a baseline period. The measure examines the current year's YTD activity and costs to the same period in the previous financial year. A negative value implies decreased productivity whilst positive implies productivity growth. The target is to see positive year on year change in this value and reduce / eliminate any negative distance from the same value calculated for same period last year.
Non-elective admissions per clinical WTE	Non-elective admissions per clinical WTE is calculated by dividing the number of non-elective admissions in month by the number of clinical WTEs (nursing plus consultants). The Provider Workforce Return (PWR) data used includes substantive, bank and agency staff. The metric allows users to benchmark against other organisations and identify possible improvements. The non-elective admissions per clinical WTE calculation uses the monthly Provider Workforce Return (PWR) data for clinical WTEs and activity using SUS data, adjusted for data quality issues.
Elective admissions per clinical WTE	Elective admissions per clinical WTE is calculated by dividing the number of elective admissions (day case and ordinary elective inpatients) in month by the number of clinical WTEs (nursing and consultants). The Provider Workforce Return (PWR) data used includes substantive, bank and agency staff. The metric allows users to benchmark against other organisations and identify possible improvements. The elective admissions per clinical WTE calculation uses the monthly Provider Workforce Return (PWR) data for clinical WTEs and activity using SUS data, adjusted for data quality issues.

Dashboard Notes -

Metric	Understanding the data
Out-patient Attendances per consultant WTE	Outpatient attendances and procedures per consultant WTE is calculated by dividing the number of outpatient attendances (new and follow-up and outpatients with a procedure) in month by the number of consultants. The Provider Workforce Return (PWR) data used includes substantive, bank and agency staff. The metric allows users to benchmark against other organisations and identify possible improvements. The outpatient attendances per consultant WTE calculation uses the monthly Provider Workforce Return (PWR) data for consultant WTEs and activity using SUS data, adjusted for data quality issues.
A&E attendances (Type 1 and 2) per Emergency Medicine consultant	A&E attendances (Type 1 and 2) per Emergency Medicine consultant is calculated by dividing the number of A&E attendances (Type 1 & 2) in month by the number of Emergency Medicine Consultants (Whole Time Equivalents (WTEs) are used). The Provider Workforce Return (PWR) data used includes substantive, bank and agency staff. For workforce, the sum of all staff whole time equivalents (WTEs) (including substantive, bank and agency) is used. The metric allows users to benchmark against other organisations and identify possible improvements. The A&E attendances (Type 1 & 2) per Emergency Medicine consultant calculation uses the monthly Provider Workforce Return (PWR) data for Emergency Medicine consultants and activity using SUS data, adjusted for data quality issues.
Overall Temporary Staff Spend as a % of Total Spend	This metric is intended to highlight to organisations where they may be spending more on temporary staffing than others and should consider reducing the usage of temporary staffing as a whole, if possible. Temporary staffing costs ideally should be kept to a minimum and the benchmark figures are set at the following values: Green: 0 – 8.5% Amber: 8.5 – 12% Red: More than 12%
Overall Agency Spend as a % of Total Spend	This metric is intended to highlight to organisations where they may be spending more on agency staff than others and should consider reducing the usage of temporary staffing as a whole, if possible. Agency staff costs ideally should be kept to a minimum and the benchmark figures are set at the following values: Green: 0 – 5.5% Amber: 5.5 – 8% Red: More than 8%

Dashboard Notes -

Metric	Understanding the data
Bank as a proportion of pay costs %	This metric is intended to highlight to organisations where they may be spending more on bank staff than others and should consider reducing the usage of temporary staffing as a whole, if possible. Bank staff costs ideally should be kept to a minimum and the benchmark figures are set at the following values: Green: 0 – 5.5% Amber: 5.5 – 8% Red: More than 8%
Registered Nurses: Sickness absence rate	Reducing rates of sickness absence reduces costs and has a positive impact on the efficiency of an organisation and patient care. In a report published in November 2009 an Independent review team, led by Dr Steven Boorman found that by improving the sickness absence by a third the NHS could save £155million pounds to re-invest in patient care. Sickness absence costs can be substantial and are easily identifiable. Evidence shows that poor health can be caused by a number of work-related factors, including lack of management support, heavy workload, job insecurity, lack of organisational justice or control and work-home conflict. Health and well-being can be enhanced by providing a healthy work-life balance and family-friendly practices, such as flexible working and childcare assistance. Job enrichment and enlargement can help reduce stress and job dissatisfaction. The lower the value, the lesser sickness absence.
Turnover rate %	A percentage of All staff that left an organisation to join another NHS organisation, or left NHS over the previous 12 months. A high turnover rate may indicate a number of opportunities to identify reasons for staff leaving and allow management the chance to introduce staff retention schemes to lessen the impact of staff leaving. The turnover rate includes a certain amount of expected turnover for normal transition of staff, including career advancement, promotions and voluntary reasons for leaving. This is also can be affected by region and geographical dependencies.

Dashboard Notes -

Metric	Understanding the data
Bank as a proportion of pay costs %	This metric is intended to highlight to organisations where they may be spending more on bank staff than others and should consider reducing the usage of temporary staffing as a whole, if possible. Bank staff costs ideally should be kept to a minimum and the benchmark figures are set at the following values: Green: 0 – 5.5% Amber: 5.5 – 8% Red: More than 8%
Registered Nurses: Sickness absence rate	Reducing rates of sickness absence reduces costs and has a positive impact on the efficiency of an organisation and patient care. In a report published in November 2009 an Independent review team, led by Dr Steven Boorman found that by improving the sickness absence by a third the NHS could save £155million pounds to re-invest in patient care. Sickness absence costs can be substantial and are easily identifiable. Evidence shows that poor health can be caused by a number of work-related factors, including lack of management support, heavy workload, job insecurity, lack of organisational justice or control and work-home conflict. Health and well-being can be enhanced by providing a healthy work-life balance and family-friendly practices, such as flexible working and childcare assistance. Job enrichment and enlargement can help reduce stress and job dissatisfaction. The lower the value, the lesser sickness absence.
Turnover rate %	A percentage of All staff that left an organisation to join another NHS organisation, or left NHS over the previous 12 months. A high turnover rate may indicate a number of opportunities to identify reasons for staff leaving and allow management the chance to introduce staff retention schemes to lessen the impact of staff leaving. The turnover rate includes a certain amount of expected turnover for normal transition of staff, including career advancement, promotions and voluntary reasons for leaving. This is also can be affected by region and geographical dependencies.

Dashboard Notes -

Metric	Understanding the data
Care Hours per Patient Day - Registered Nurses and Midwives	A measure of ward level productivity and transparency on variation in staff to patient ratios across wards, specialties and organisations. Very low rates may indicate a potential patient safety risk. Very high rates may suggest the organisation has several unproductive wards or inefficient staff rostering processes. Lord Carter's report "Operational productivity and performance in English NHS acute hospitals: Unwarranted variations" provides background evidence on the development of the Model Hospital and the development of CHpPD (Care Hours per Patient Day).
Top 10 Medicines – Savings Delivered	This metric allows provider organisations to identify the total monthly value of the delivered savings for the combined Top Medicines (as detailed in the Top Medicines sub-compartment) in the current financial year as well as the value of any potential additional savings that have not been delivered. This metric when viewed at a system level, will display aggregated data for acute organisations in an ICB/Region.
Estates and facilities costs per square metre	The total estates and facilities running cost is the cost of running an NHS estate, including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, are included. Many services related to the NHS estates and facilities may be fully or partly related to the size of the estate. However, this relationship is frequently affected by other factors. For example, cleaning costs are relative to the floor area being cleaned, but are also affected by how often the cleaning occurs and the type of cleaning. Clinical areas will be cleaned more thoroughly than office areas. The total running costs consist of four parts: Hard FM, Soft FM, Management (Hard and Soft FM) costs and and Financing costs. Changes to this metric can be the result of movements in either of these elements year-on-year.

5. DATA AND DIGITAL

11:10

5.1 COLLABORATIVE DIGITAL AND DATA COMMITTEE REPORT

Matthew Swindells

REFERENCES

Only PDFs are attached

05.1 APC Data and Digital Committee Chair Report.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

June 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

The Committee received the report which provided the Committee with an update on the project to move from a transcription service to Dragon, a voice recognition service for clinical documents. Committee members noted that the technology had been implemented across all of the Trusts across the Acute Provider Collaborative. Committee members noted the benefits of the transition which included improving efficiency, reducing costs and enhancing the speed of clinical documentation.

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

Committee members received an update on the Federated Data Platform (FDP) delivery plan which highlighted the progress made in various areas though a roadmap, including data architecture, patient care and operational efficiency. The Committee were keen to understand adoption of each of the modules at all four Trusts. It was noted there were still latency issues at LNWH and THHFT, which is being worked on by the Trusts and suppliers. The FDP roadmap was agreed at the APC EMB in June, the next stage needed is to embed the modules and scale adoption.

2.1.3 ICT Infrastructure 2025/26 delivery plan

Committee members received the report which highlighted the plans in place on joining ICT infrastructures across the Acute Provider Collaborative, which included data centres, networks, and computers, to ensure seamless access to data and applications. Committee members noted the plan to address technical challenges, improving adoption, and ensuring that ICT infrastructure projects will be effectively integrated into clinical workflows.

2.1.4 Patient Communications system update

Committee members received the report noting the recommended approach for managing the risk in relation to sustained funding for North West London personal health record – The Care Information Exchange. Committee members were supportive of the approach to continue with the existing system for 24 months whilst exploring an alternative provider. This would ensure a continued service was provided. The Committee discussed the need for national products to be able to fill in the gaps, such as with the NHS App.

2.1.5 Update on Rego (advice and guidance)

The Committee received the report which highlighted that the contract for the current advice and guidance system was due to end in March 2026. A steering group had been established, including both primary and secondary care representatives, to evaluate the current system and review funding opportunities to build integrate our clinical systems with the national products such as ERS.

2.2 Finance and clinical systems integration

Committee members discussed the potential benefits of integrating finance and clinical systems. Committee members agreed that further evaluations were required to determine the best approach for integration, ensuring that the chosen finance solution would align with strategic goals and provide a cost-effective, integration.

2.3 Oracle Health Global Partnership Programme update – Ambient Scribe Pilot

Committee members received an update on the Oracle Health Partnership and the Ambient Scribe Pilot. Committee members noted that the pilot aimed to evaluate ambient scribe technologies that use voice recognition and Artificial Intelligence to interpret clinical conversations and integrate the summaries into clinical systems.

2.4 Update on APC ICT department convergence

Committee members received an update on the convergence which aimed to integrate the ICT departments across the four acute Trusts within the Acute Provider Collaborative to streamline operations and improve efficiency. Committee members noted that once the consultation had been completed, the new roles will be implemented. The teams would continue to address the challenges related to joint positions and other integration issues.

2.5 Update on ICB digital and data changes

Committee members received an update on the status of the digital and data functions of the Integrated Care Board noting that the Acute Provider Collaborative were ensuring that they were prepared to integrate any transferred functions effectively.

2.6 ICT Risk Register

Committee members received an update on the risk register, highlighting key digital and data risks, including cyber security, EPR Ecosystem benefits realisation, and effective reporting systems. Committee members agreed that the risk register would be updated to reflect the risk of achieving productivity benefits from new and existing systems.

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

- The success of the Patient Communications and Federated Data Platform rollout
- **Oracle Health Global Partnership Programme update – Ambient Scribe Pilot:** There is an ambient voice pilot taking place to evaluate available tools. NHS England has issued guidance to only adopt tools that are approved by the HMRA, which we need to be mindful of.
- **Federated Data Platform (FDP):** The FDP roll-out is being delayed by latency issues (how long it takes for an update in Oracle/Cerner to be displayed in the FDP). There is a solution but Oracle are working through problems at their end.
- **Patient Communications**: It was agreed that whilst we may have to make some short-term investment in our existing technology, the ambition is to align with the national NHS App solution.
- **Advice and Guidance**: It was agreed that whilst we may have to make some short-term investment in our existing technology, the ambition is to align with the national solutions.

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. Summary Agenda

No.	Agenda Item	Purpose
1.	Digital and data strategy 1. EPR ecosystem - Deep dive into one project's benefits 2. FDP 2025/26 delivery plan 3. ICT Infrastructure 2025/26 delivery plan 4. Patient communication systems update 5. Update on Rego (advice and guidance)	For discussion
2.	Finance and clinical systems integration	For Discussion
3.	Oracle Health Global Partnership Programme update - Ambient Scribe Pilot	For Discussion
4.	Update on APC ICT department convergence	For Discussion
5.	Update on ICB digital and data changes	For Discussion
6.	ICT Risk Register	For Discussion

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)	N
Robbie Cline (Joint Chief Information Officer – LNWH/THHT/ICHT/C&WFT)	Y
Sanjay Gautama (Consultant anaesthetist & Chief Clinical Information Officer (CCIO) Representative)	N
Bruno Botelho (NWL APC Programme Director & Operations Representative)	Y
Mathew Towers (Business Intelligence (BI) Representative)	Y
Nick Gash (NED – ICHT/THHT)	Y
Janet Campbell (NED THHT)	Y
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)	Y

6. ESTATES AND SUSTAINABILITY

11:15

6.1 COLLABORATIVE STRATEGIC ESTATES, INFRASTRUCTURE AND SUSTAINABILITY COMMITTEE REPORT

Discussion Item Bob Alexander

REFERENCES

Only PDFs are attached

06.1 APC Estates and Sustainability Committee Chair Report.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
June 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 18 June 2025. The following papers were discussed.

2.2 **Update on green plan and sustainability plans**

2.2.1 The paper provided an update on the implementation of the Green Plans of the four Trusts within the North West London Acute Provider Collaborative (APC), and included an update on the latest APC-wide NHS Carbon Footprint for all greenhouse gas emissions (GHGE), excluding fleet and business travel between 2019/20 and 2023/24. Between 2019/20 and 2023/24, GHGE reduced by 9.9% across the APC.

2.2.2 In terms of progress against the interim net zero target for NHS Carbon Footprint, as of 2023/24, the APC was 6.8% behind a linear trajectory to achieve this target by 2031/32. The Committee discussed the variation in energy savings across the APC and noted, given the age of the estate and without significant funding, Trusts were unlikely to be able to hit the net zero target.

2.2.3 Reflecting new NHSE guidance, work remained in progress to refresh Trust Green Plans. These were due to be completed by 31 July 2025. Refreshed plans will be brought to the September meeting for sign-off.

2.2.4 The Committee received an update on an Insights Innovation pilot to reduce the use of

single use plastic in theatres.

2.2.5 The Committee commended work undertaken on green / sustainability, particularly around benchmarking, however noted further work is needed around data validation / variance analysis.

2.3 North West London Procurement – Sustainability Update

2.3.1 The Committee received a report from North West London Procurement Service about embedding sustainability and social value outcomes in future procurement processes. The Committee discussed weighting of social value and sustainability in future procurement tenders.

2.3.2 The Committee noted the report.

2.4 Deep Dive: EDI Benchmarking – Accessibility and Cost Benefit

2.4.1 All four of the APC Trusts have individual contracts with Disabled Enabled Limited (also known as AccessAble), a specialist company providing advice and accessibility information. AccessAble have also proposed a programme of five collaborative accessibility initiatives across the APC.

2.4.2 The Committee welcomed the work and agreed with the principle of each Trust setting aside £20k of capital to deliver the programme. However, members queried whether the funds would be enough to tackle prioritisation areas in 12 hospitals across the APC and noted it would be helpful to see prioritisation areas and scale / scope. It was agreed this would be discussed further through the APC Executive Management Board.

2.5 The Hillingdon Hospitals NHS Foundation Trust Strategy for Redevelopment Engagement

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

2.6 Imperial College Healthcare NHS Foundation Trust Redevelopment Update

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

2.7 High-level contingency planning in the Acute Provider Collaborative

2.7.1 The Committee received a verbal update on high-level contingency planning work to be undertaken across the APC, including mapping out, in the event of a catastrophic estates failure in any of the hospital sites, which services would be affected and understand the impact / response required at Trust, APC and London region level. It was agreed that the APC would engage with key stakeholders, including ICB and Region, as part of this work to enable sector and London-wide understanding of potential impact.

2.8 Benchmarking the APC Estate and Workplan

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

2.8.2 The Committee noted the report and looked forward to receiving further PIDs and agreed that ‘deep dive’ reviews of the projects would form part of the committee’s forward plan.

2.9 Register of forward business cases

2.9.1 The Committee noted two national capital schemes; estates safety and returning to constitutional standards. As an APC, £9m had been allocated for electives; £3m for

diagnostics; £16.9m for UEC capacity. Both the estate safety and return to constitutional standards bids would need to be included in the register of forward business cases. An update would be included in the next report to the committee.

2.10 APC-level Capital Plan

2.10.1 The paper noted the APC Capital Plans for 2025/26, showing the source of funding: system capital (internal) and national public dividend capita (PDC). The four Trust capital plans included the detail of capital planned spend across schemes at each Trust.

2.10.2 The Committee noted £189.9m would be internally funded, with £93.7m supported by nationally funded PDC capital programmes.

2.10.3 Members noted bids for the ICS capital reserve were not cash backed. It was agreed bids submitted, which were not cash backed, would be discussed further at the APC Executive Management Board.

2.11 APC Board Assurance Framework

2.11.1 The APC Board Assurance Framework remained work in progress. Risks described at the committee would be refined and there was an emerging risk around the 10-year plan.

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 March 2025.

3 Positive assurances received

3.1 The Committee noted the positive work on the green / sustainability plans and welcomed the future refreshed green plans aligned to the new NHSE guidance.

4 Key risks to escalate

4.1 The condition of the estate across the Collaborative and cost of backlog maintenance remains a significant risk. Contingency plans for estates needed to be refreshed and considered by individual trust Redevelopment Committees, with each Trust Standing Committee receiving assurance regarding the robustness of contingency planning.

5 Key actions commissioned

5.1 The Committee asked for a register of land be compiled, including land owned across the APC but not occupied by buildings and what the current use is.

6 Decisions made

6.1 N/A

7 Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Update on green plan and sustainability plans	To note	7.	Benchmarking the APC Estate and Collaboration Workplan	To note
2.	NWL Procurement Sustainability update	To note	8.	Register of forward business cases	Verbal
3.	Deep Dive: EDI Benchmarking – Accessibility and cost benefit	To note	9.	APC-level Capital Plan	To note

4.	THHFT strategy for redevelopment engagement	To note	**10.**	APC BAF	To note
5.	ICHT Redevelopment update	To note	**11.**	Summary report from the Estates and Sustainability Executive Group	To note
6.	High-level Contingency Planning in the APC	Verbal			

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)	Apologies
Janice Sigsworth, Chief Nurse (ICHT)	Y
Steve Wedgwood, Director of Estates (THHFT)	Apologies
James Walters, Chief Operating Officer (LNWH)	Apologies
Jason Seez, Deputy CEO (THHFT)	Y
In attendance:	
Huda As'ad, Associate NED (LNWH)	Y
Philippa Healy, Business Manager (minutes)	Y
Peter Jenkinson, Director of Corporate Governance (ICHT and CWFT)	Y
Eric Munro, Director of Estates and Facilities (ICHT)	Y
Mark Titcomb, Managing Director of NWL EOC, CMH and Ealing Hospital, Executive Director for Estates and Facilities (LNWH)	Y
Alexia Pipe, Chief of Staff – Chair's office	Y
Iona Twaddell, Senior Advisor to the CEO	Y
Emma Chryssikos, Managing Director (Interim) North West London Procurement Services	Y
Mahroof Anwar, Head of Sustainability and Social Value, North West London Procurement Services	Y
Lucinda Thomson, Sustainability Manager (CWFT	Y

7. CHIEF EXECUTIVE OFFICERS

11:20

7.1 ACUTE PROVIDER COLLABORATIVE EXECUTIVE MANAGEMENT BOARD (EMB) SUMMARY

Discussion Item Tim Orchard

REFERENCES

Only PDFs are attached

07.1 EMB Chair's Report.pdf

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

July 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 10 June 2025 and 7 July 2025. Key discussion items are summarised below.

2.1. Performance reporting

2.1.1. 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.

2.1.2. APC EMB reviewed and discussed the new performance report template which had 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 remained relevant and focused. The proposed report had been streamlined and re-structured and targets for existing indicators had also been updated where required.

2.1.3. APC EMB had a discussion about metrics across the APC and commissioned further work to develop shared operational, workforce and financial data across the collaborative.

2.2. Finance reporting and recovery

2.2.1. The APC EMB discussed the financial performance and forecast in detail. The APC EMB received an update on the APC medium-term financial plan as well as a summary of the 2025/26 Productivity & Efficiency (P&E) opportunities as identified by NHS England (NHSE) and assessed by each of the four NWL acute Trusts. The objective is to support planning and delivery of the 2025/26 cost improvement programmes (CIPs) and inform system-level collaboration.

2.3. Business planning

2.3.1. The APC EMB received monthly updates on the 12 priority projects across the five workstreams that support one or more of the system productivity, corporate consolidation and savings, and APC pathways. It was noted in the June meeting that support was required for five of the priority projects including local trust leads to support a single APC reporting system, digital support to workstream the deteriorating patients project, improved cross-trust BI processes to analyse and track outcomes of the APC speciality pathways, programme support for outpatients and HR, finance and transformation expertise for the digital programme improvements.

2.4. APC clinical pathways

2.4.1. The APC EMB received regular updates on the APC clinical pathways programme.

2.4.2. APC EMB agreed that over the next few months, pathways teams would work to ensure the first phase of pathways were fully implemented with subsequent pathways being chosen for the next phase of the project expected to commence over the summer.

2.4.3. APC EMB noted the progress in the pathways projects meeting their milestones and the positive relationships that had been built from this project. The APC EMB noted the development of a more programmatic approach to the pathways projects, with reporting on the projects' progress against their milestones as well as the metrics projects are using to measure progress.

2.4.4. APC EMB noted that an event on 15 July would be held to bring together the operational and clinical leads from the pathways project to share learning on phase 1 and to discuss what would be useful for the next phase of the programme.

2.5. Governance

2.5.1. The APC EMB received updates on the collaborative Board Assurance Framework (BAF), which the risks were now aligned to the APC EMB executive representative. The BAF would be reviewed by relevant Collaborative Committees in June and September before presentation to the Board in Common in October.

2.6. Collaborative projects

2.6.1. 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 workstreams.

2.6.2. The APC EMB received updates on sector programmes including the APC Robotics Strategy. The APC EMB also received an update on the model of care for ophthalmology services in NWL and supported the recommendations to implement a NWL eye care single point of access, enhanced digital infrastructure and system wide interoperability for NWL NHS ophthalmology

services and collecting a data and activity baseline for NWL NHS ophthalmology landscape.

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

- **NWL HR Digital Transformation Strategic Positioning**: APC EMB supported the proposal to test the market for a development partner to support the digital transformation of HR enabling services within the North-West London Acute Provider Collaborative (NWL APC).

- **Federated Data Platform:** APC EMB noted the Federated Data Platform (FDP) update noting how the platform would support the collaborative objectives for 2025/26 and beyond. The governance and key risks and mitigations of the programme were noted and key decisions needed to deliver the FDP vision and broader digital priorities were discussed and supported.

- **Elective orthopaedic centre (EOC)**: The APC EMB received an update on the EOC noting that the operational performance during year 1 had been strong and positive feedback received about the care delivered. APC EMB noted that financial sustainability was a key concern and discussed the proposed mitigations. APC EMB noted the strategic priorities for 2025/26.

- **Corporate transformation:** APC EMB discussed the corporate transformation programme noting programme updates on finance, digital and people services improvement programme. APC EMB noted that each trust would be going through a thorough review of corporate growth and it was acknowledged that only through successful consolidation of corporate services would it be possible to drive out savings.

- **Joint learning and reporting system**: APC EMB received an update on the implementation of the joint learning and reporting system across the collaborative, noting the work ongoing to align processes and the expectation that the system will go live no later than January 2026.

3. Attendance of members

The APC EMB is attended by all trust CEOs and a representative of each 'functional group' of executive roles.

The current membership as of June 2025 is:

- **CEOs** – Tim Orchard, ICHT (Chair), Lesley Watts, CWFT & THHFT, 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

7.2 REPORTS FROM THE CHIEF EXECUTIVES OFFICERS AND TRUST STANDING COMMITTEES

7.2A LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST

Information Item

Pippa Nightingale / David Moss

REFERENCES

Only PDFs are attached

07.2a LNWH CEO Report.pdf

07.2a LNWH TSC Report.pdf

Chief Executive Officer's Report

Accountable director: Pippa Nightingale
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

1.1 Sir Jim Mackey, Transitional Chief Executive for NHS England, wrote to chairs and chief executives in April. This correspondence elaborated on discussions from a meeting with Chief Executives I attended in March, including the mandate to reduce corporate services' budgets to pre-pandemic levels – a savings target of £8.3m for LNWH. However, there has been no further update from the national team regarding redundancy schemes (beyond recent press announcements concerning NHSE staff), and we do not anticipate a large-scale national voluntary redundancy scheme.

Our Cost Improvement Programme (CIP) must achieve £48.5m in savings this year (see section 4), and we are collaborating closely with teams and divisions to meet this target through initiatives focused on pay, non-pay, and procurement. Efforts are underway to significantly reduce our reliance on bank and agency shifts, and we are encouraging regular bank staff to apply for permanent positions. There will be some consultation as part of our CIP work. We recognise that consultations can be stressful due to uncertainty, and we will strive to manage these processes efficiently and effectively to mitigate stress.

1.2 In March, the Trust achieved the 78% target for A&E waiting times, marking a substantial improvement from the 73% recorded in February. Additionally, the urgent treatment centre team at Central Middlesex Hospital attained a four-hour performance rate of 100%, successfully treating 3,600 patients. These accomplishments contributed to a significant decrease in the number of patients managed in escalation spaces within our emergency departments, thereby enhancing overall performance, patient safety, and experience.

1.3 Over the Easter weekend (19-20 April), the Trust escalated to OPEL Level 4, the highest level in the framework. Our executive and divisional leadership teams collaborated closely with NHS and social care partners to implement additional support measures for our staff.

1.4 We note the recent letter to all NHS maternity providers from Sir Jim Mackey, appended to this report, which highlights the need for a refreshed focus on maternity care while a new national review is ongoing.

2. Quality and safety

2.1 The Trust is implementing a new support programme to help expedite discharge processes, patient flow, and reduce the need for escalation spaces. The programme will start on ward 6 North at Ealing Hospital and Fletcher ward at Northwick Park hospital, before moving to other wards. Multidisciplinary teams will work together with dedicated improvement leads from our transformation team to look at all aspects of our flow processes. Swifter discharge is better for patients and essential for our ward teams in offering the right care in the right place.

3. Operational performance

3.1 Emergency department performance: 4 hr performance reported 75.7% for May 2025 against the 77.6% operating plan trajectory for the month. This is the 10th highest performance in London for the 17 acute Trusts reporting. 93.2% of attendances across departments were treated within 12 hours (all types)

Through spring and summer 2025, we are assessing and redesigning same day emergency care pathways to support flow and 4 hr A&E performance:

- To increase productivity within the ED
- To increase productivity across ward discharge processes
- To review ward configuration across sites ready for winter demand
- To review the usage of Temporary Escalation Spaces across EDs and wards
- System working with partners for increased admission avoidance and discharges

Ambulances: There were 5,237 arrivals by ambulance in May 2025 compared to 5,097 in April 2025. The average handover time (HH:MM:SS) was 00:26:41 against the 00:23:18 May 2025 trajectory.

3.2 Referral to treatment: As per the national focus the Trust continues to reduce the number of long waiting patients over 65 weeks. We reported 47 65-week breaches at the end of May, predominantly due to unexpected capacity challenges in paediatric ENT, which has expanded its capacity for June to address the issue.

The focus on reducing patients over 52 weeks continues, and RTT performance has continued to improve to this month, exceeding the trajectory set for both April May and continuing with an upwards trend.

The Trust continues to progress sustainable solutions looking at productivity opportunities, training as well as digital solutions such as the Rova model.

3.3 Cancer pathways: The Trust continues to prioritise improvement in cancer diagnostic and treatment pathways, using real-time data to drive action and accountability.

We are working to maintain FDS compliance by continuing to implement pathway enhancements, ensuring diagnostic results are delivered promptly and consistently exceed the 75% threshold. We are accelerating improvement in 2 week wait performance through focused interventions in high-volume specialties and urgent action to close the breast pathway reporting gap. We are tackling the 62-day backlog, prioritising patients waiting over 104 days through robust tracking, clinical prioritisation, and clear escalation protocols.

4. Finance and estates

4.1 Finance: As previously discussed at the Standing Committee, the Trust along with other APC partners had set out a challenging breakeven plan for the 2025/26 financial year. The plan includes delivery of £48.5m efficiencies (CIP). We acknowledged that achieving this target will be particularly difficult due to pressures from emergency demand and RTT performance, which must be managed within a financial framework that caps funding for emergency and elective care. Nonetheless, as a system we remain committed to delivering against this plan.

We have reported a deficit of £6.5 at M2 which is £2.7m off plan. Overall pay costs have stabilised and both vacancy freeze, and temporary staffing controls remain in place. The main reason for the variance relates to CIP where the target is profiled evenly across the year at c£4m/month. Our actual delivery profile ramps up in the last two quarters of the year.

We identified £1.6m CIP for April and delivered £1.5m. For the year we have identified £40m at June and expect to identify the full £48.5m by July. This includes the savings in corporate services.

The capital programme is progressing as planned and remains within the allocated target, with ongoing oversight from the Capital Review Group to ensure 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 finance & performance committee.

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 & monitored and we are working very closely with our system partners.

4.2 Estates and facilities: Despite there being fewer major capital build programmes than during the past two years, the LNWH estate and facilities team are focussed on delivering multiple improvement projects and programmes across all three main hospital sites; these cover NPH and Ealing emergency departments, better theatre recovery facilities and ward refurbishments linked to transformation and an important cost improvement programme to ensure clinical delivery is maximised, while buildings remain fit for purpose. Additionally, the team are rebalancing resources towards the more routine, but critically important, back log, lifecycle and minor works adjustments; such as lifts repairs, leaks, roof maintenance and, where possible, improving the ventilation of clinical spaces that are most heavily used.

Work is now underway on the Ealing hospital decarbonisation programme that runs from 2025 – 2027 and follows the successful SALIX public decarbonisation grant bid approval for £5.8m. This money will support improving heating efficiency, provide better electrical infrastructure and support solar panel and lighting resilience at the site.

The major procurement of our Soft FM facilities management contract continues to progress as scheduled. This contract provides the cleaning, portering, catering and other support facilities for patients and staff across all three hospital sites and some off-site facilities. The tender process is currently at the ITT (Invitation to tender) point and will run through until the Autumn 2025. It is following the standard procurement and cabinet office cost control processes. As the bid phase moves to evaluation and then moderation, both staff and patients continue to provide specialist service knowledge and expertise. The procurement process is due to conclude with a contract award in October 2025 and ahead of a three-month mobilisation period.

Work has also progressed to update our sustainability policies and is on track to deliver a refreshed and approved LNWH Green Plan by July 2025 following Trust Standing Committee approval. The plan covers eleven workstreams ranging from digital to transport and also links closely to future clinical planning for climate change, as well as contributing to the wider NHS plan to achieve net-zero by 2040. An increasing amount of this planning is being done in collaboration with APC colleagues to reduce duplication, share best practise and deliver the patient and staff benefits in the most efficient manner. The finalised LNWH Green Plan 2025 – 2028 contains the actions need to deliver a range of direct and indirect carbon emission reductions.

5. People

5.1 Former patient Manawar Saeed has been appointed Chair of the Patient Panel for Inflammatory Bowel Disease (IBD) at St. Mark's Hospital. The panel provides non-clinical advice to individuals living with IBD and collaborates closely with St. Mark's to ensure that the patient perspective is considered. Additionally, Manawar serves as co-chair of the Race and Ethnicity Network at the Financial Conduct Authority.

5.2 Dr Ayesha Akbar, Medical Director and Gastroenterologist, has been appointed as the National Gastroenterology Clinical Advisor for the Getting It Right First Time (GIRFT)

programme following a competitive interview process. Dr Akbar has also served in various capacities within the British Society of Gastroenterology.

6. Equity, diversity and inclusion

6.1 The Trust's Equity Index, the first of its kind in the UK, has been nominated in the Reducing Health Inequalities Through Digital category of the Health Service Journal Digital Awards. Developed by LNWH, the index aggregates variations in care quality across 30 indicators, including safety, effectiveness, patient experience, timeliness, and access. This helps ensure consistent quality of care irrespective of factors such as gender, ethnicity, disability, and socio-economic status.

7. LNWH updates

7.1 New NHS uniforms have been distributed, making identification of specialisms easier with use of different colours. This also marks the first occasion that pharmacists have been required to wear clinical uniforms. Over 5,000 uniforms have been distributed across our three hospital sites, with each staff member receiving three sets of uniforms.

7.2 St Mark's Hospital Endoscopy Unit and Bowel Cancer Screening Centre at Northwick Park Hospital has reopened after a multi-million pound refurbishment. The new facilities include two additional clinic rooms, a dedicated colonoscopy room, and a recovery area. The Endoscopy Unit now provides private ensuite facilities for patients and improved air flow, ensuring compliance with modern standards and equipment requirements. The unit also maintains Joint Advisory Group accreditation, indicating the high standard of services provided. The unit remained open throughout the refurbishment.

7.3 A wayfinding pilot initiative is underway at Ealing Hospital. This exercise is evaluating new zoning and renaming strategies, in addition to addressing other practical considerations of our long-term wayfinding strategy. The pilot's focus is outpatients, the Community Diagnostic Centre, Moorfields, Meadow House Hospice, and the acute care unit.

The trial involves engaging with patients, visitors and staff to gather feedback on the effectiveness of these strategies, with a view to developing a comprehensive, diverse, and inclusive wayfinding system that meets the needs of all our stakeholders. We are also working with Transport for London to improve the information on the bus stops around our three hospital sites, in addition to updating online mapping references such as Google Maps, to improve the accuracy of service locations.

7.4 The Staff Experience and Wellbeing Festival returned this June, with events held across all three sites. Fitness challenges and free massages were some of the offers available amongst the many stall holders, which included staff networks who took the opportunity to speak to colleagues from across the Trust, and sign-up new recruits.

8. Research and innovation

8.1 The Trust's Research and Innovation team held their annual conference in June. The keynote speaker was Dr Alex Churchill, Deputy Director of Clinical Trial Policy at the DHSC and Head of Commercial Clinical Trials. The conference, which was live streamed on MS Teams, provided colleagues from across the Trust an opportunity to showcase their work and emphasise how research, innovation, and service evaluation improve patient care.

8.2 New headsets have been introduced to assist patients with hearing loss. The reusable devices amplify sound during interactions with clinical staff and are being utilised in A&E, Same Day Emergency Care, and elderly care wards. Of approximately 200 elderly patients seen each month, around 10% have hearing aids or undiagnosed hearing loss. Initial findings are being submitted to the British Geriatrics Society, emphasising how unaddressed hearing loss can compromise quality of care, delay diagnoses, and affect patient experience. The devices were funded by the League of Friends.

8.3 Decaffeinated drinks are being trialled on five wards across Ealing and Northwick Park hospitals to see if they can help reduce falls. Caffeine negatively affects balance and stability and can worsen symptoms for those with an overactive bladder. Teams are analysing falls data to determine the impact of this change.

9. **Stakeholder engagement**

9.1 Stephen Timms MP, Minister of State for the Department of Work and Pensions, visited Northwick Park Hospital in June to learn about our involvement with Project SEARCH. This initiative supports students with learning disabilities and autism in gaining practical workplace experience within the NHS. The minister met with interns and graduates from across the Trust. Since welcoming its first interns in 2017, the Trust has supported approximately 90 young people. A further 12 are due to commence in September.

9.2 Dr Vin Diwaker, NHSE National Director of Transformation, visited Northwick Park Hospital in May. He was joined by other senior staff from the National Transformation Directorate to learn of our successes and challenges in adopting the NHS Federated Data Platform. The platform brings together operational data that is currently stored in separate systems into one safe and secure environment and reduces the need for multiple logins into separate IT systems to access information.

9.3 Karen Bonner, Regional Chief Nurse visited Northwick Park Hospital in May, meeting Chief Nurse Lisa Knight, and staff across several departments.

9.4 NHSE London visited the Ealing Community Diagnostic Centre in June. Norma O'Leary Implementation Lead, Suzette Fernandes Senior Programme Manager, and Eleanor Long Senior Diagnostic Manager, were given a tour of the entire facility, including the new CYP asthma and adult breathlessness pathways.

9.5 In June, Cllr Polly Knewstub, Ealing Council's Cabinet Member for Healthy Equal Lives**,** met with CEO Pippa CEO Nightingale, staff from Cardiology, and representatives from

Heartlink, a local charity providing advice and support to people living with heart conditions. This visit served as an opportunity to discuss how the Trust and Ealing Council can collaborate with Heartlink to support work both within the hospital and in the local community.

10. Recognition and celebrating success.

10.1 Ealing Hospital's Paediatric Diabetes team has won Paediatric Nurse of the Year at the 2025 Diabetes Nursing Awards. The award was given for their exemplary support of children with diabetes. The team's collaborative and tailored approach was shown to have significantly improved diabetes outcomes in Ealing, with an emphasis on innovation, shared learning and holistic care.

10.2 Samantha Tross, orthopaedic surgeon at Ealing Hospital, has been elected to the Council of the Royal College of Surgeons of England. The role enables Samantha to contribute to policy which influences surgeons nationwide on issues including training, safe surgical practice, and examinations.

10.3 Nurses Mia Small and Jo Gent have been awarded the silver medal for Nutrition Nurse of the Year, at the British Journal of Nursing Awards. Mia was also awarded the bronze medal for her work on the National Home Parenteral Nutrition Stakeholders Group.

10.4 An LNWH in-house education program has beaten more than 600 applicants to win the Nurse Education Provider of the Year (Post-Registration) category at the Nursing Times Awards. The Postgraduate Certificate in Critical Care bridges classroom learning with clinical practice without the burden of university fees. More than 65 nurses have completed the programme since its launch three years ago.

10.5 Our professional nurse advocates and restorative clinical supervision supervisors at Northwick Park Hospital's ED have won first place at the Regional Professional Nurse Advocate conference. Their winning entry was for a quality improvement project supporting the health and wellbeing of ED nurses.

10.6 All five speakers in the second session of the National Diabetic Eye Screening conference were from LNWH. Dhannie Ramcharan, Sharita Jhummun, Davinia Austin, Russell Gwebu, and Gemma Doku delivered presentations on topics including communication strategies with multilingual individuals living with diabetes, and advanced data collection methods for patient feedback. There were also keynote addresses from LNWH consultant ophthalmologists Christiana Dinah and Rabia Bourkiza.

10.7 LNWH has been shortlisted in five categories for the HSJ patient safety awards. The categories are: improving health outcomes for minority ethnic communities, improving medicines safety, mental health safety, nursing-led patient safety, and safety improvement through technology. The winners will be announced in September.

To: • Trust CEOs and Chairs

cc. • ICB CEOs
Regional Directors

NHS England
Wellington House
135-155 Waterloo Road
London
SE1 8UG

23 June 2025

Dear colleague

Maternity and neonatal care

Today, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

This announcement comes on the back of significant failings in maternity services in parts of the NHS and we need – with real urgency – to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

It is clear that we are too frequently failing to consistently listen to women and their families when they raise concerns and too many families are being let down by the NHS. There remain really stark inequalities faced by Black and Asian women and women in deprived areas. In addition, we continue to have significant issues around safety and culture within our maternity workforce.

These have been persistent issues over recent years, so we now need to act with urgency to address these. The vast majority of births in England are safe and we have teams providing good and outstanding maternity and neonatal care every day. However, the variation in quality and performance across the NHS underscores why we can't accept the status quo.

So, between now and December, the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. We'll meet with relevant leaders of several organisations over the next month and while there will be some challenging conversations, we are really keen to hear what more we can be doing to support you to go further and faster in improving maternity and neonatal care.

In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay

- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.

- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.

- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.

- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This is really challenging for all of us and the most important step we have to take to rebuild maternity and neonatal care is to recognise the scale of the problem we have and work together to fix it.

This will require us all to work together and this includes teams where care is outstanding where you will have a role to play in sharing best practice and supporting others to return their services to where their communities and staff want and need them to be. We hope you understand the importance of this and, as always, please get in touch if you want to discuss this ahead of the CEO call later in the week.

Sir Jim Mackey
Chief Executive

Duncan Burton
Chief Nursing Officer for England

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
July 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 2 July 2025. The following papers were discussed.

2.2 Research and Development Presentation

2.2.1 The Committee received a presentation on progress with the Research and Innovation Strategy and the London North West Commercial Research Delivery Centre (CDRC). The CDRC is one of only three in London and 21 in the UK, and plays an important role in workforce development, digital advancement, community engagement, and revenue generation. The Committee discussed health inequalities across North West London in terms of access to clinical trials and welcomed the focus on research inclusion and designing research around the needs of the community.

2.3 Trust Strategy Review: Our Way Forward – Year 2

2.3.1 An update was provided on progress with the Trust's Strategy (Our Way Forward) at Year 2. The Committee received assurance from the notable improvements in strategic Key Performance Indicators (KPIs), including staff recommending the Trust as a place to work and receive care. The most significant risk identified was patient experience in the emergency departments and associated safety concerns, and the need to address the flow of patients and reduce the number of patients in temporary escalation spaces. The Committee recognised the ongoing operational and financial performance challenges, but also the progress made in these areas.

2.4 LNWH Green Plan 2025-2028

2.4.1 The Committee approved the refreshed LNWH Green Plan 2025-2028 which focuses on reducing the Trust's carbon footprint, with specific targets and milestones. A communications campaign will be launched to engage staff and other stakeholders in sustainability initiatives.

2.5 Board Committee Reports

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

2.5.2 The Trust Standing Committee noted the following papers as approved by the relevant

sub-committees:

- Quality Account 2024/25
- M2 Finance Report
- M2 Integrated Quality and Performance Report
- Annual People Report
- Staff Survey Report
- WRES / WDES Annual Report
- Freedom to Speak Up Annual Report
- Annual Report and Accounts 2024/25

2.6 Chief Executive's Report

2.6.1 The Committed noted highlights from the Chief Executive's Report including that the Trust had identified £40m of the required £48.5m CIPs which consisted of predominantly recurrent schemes, and that Accident & Emergency (A&E) performance was improving at 75.7% for May 2025. The Trust had also received positive assurance from being rated as National Oversight Framework Level 2. The Committee heard that LNWH has been shortlisted in five categories for Health Service Journal (HSJ) patient safety awards, and also that successful Staff Experience and Wellbeing events had been held across the three hospital sites in June 2025.

2.7 Board Assurance Framework

2.7.1 The Committee reviewed and approved the Board Assurance Framework for Quarter 1, which included a new risk relating to the delivery of the Referral to Treatment time standard.

2.8 Committee Effectiveness, Terms of Reference and Forward Plan

2.8.1 The Committee received generally good feedback as part of its effectiveness review, with a recommendation around the provision of concise and relevant information.

2.8.2 The Committee approved its terms of reference and forward plan for 2025/26.

3. Positive assurances received

3.1 The Committee noted that:

3.1.1 The Trust received an unqualified opinion from external audit for its Annual Report and Accounts 2024/25 and a moderate rating with improvements in operational effectiveness from its internal auditors.

3.1.2 LNWH has been rated as National Oversight Framework Level 2, which is positive and indicates a stable position.

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

4.1 LNWH's cash position remains challenging, with only 5.6 working days of cash available at the end of May 2025. A collaborative approach to cash would reduce this risk.

4.2 CIP delivery is a key financial risk, with £3.5m delivered to date against the c£8m target.

4.3 The experience in the emergency departments and associated safety concerns remain a significant risk.

4.4 Ambulance handover continues to be a challenge, particularly at Northwick Park Hospital.

5. Concerns outstanding

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

6. Key actions commissioned

6.1 None.

7. Decisions made

7.1 The Committee:

7.1.1 Made a recommendation to the NWL APC Board-in-Common to approve the proposals set out in the paper 'Developing the Governance Arrangements for NWL APC', subject to the amendments noted in section 2.3.1 of this report.

7.1.2 Approved the LNWH Green Plan 2025-2028.

7.1.3 Approved the Charitable Funds Governance Manual as Trustees of the Charity.

7.1.4 Approved the Board Assurance Framework for Quarter 1.

7.1.5 Approved its Terms of Reference and Forward Workplan for 2025/26.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Research and Development Presentation	Discussion	6.	Chief Executive's Report	Information / Assurance
2.	Developing the Governance Arrangements for NWL APC	Approval	7.	Board Assurance Framework	Assurance
3.	Trust Strategy Review: Our Way Forward – Year 2	Assurance	8.	Committee Effectiveness Review	Assurance
4.	LNWH Green Plan 2025-2028	Approval	9.	Committee Effectiveness Review	Assurance
5.	Board Committee Reports	Assurance	10.	TSC Terms of Reference / Forward Plan	Approval

8. Attendance Matrix

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

David Jones	Y
Alexia Pipe	Y
Mark Titcomb	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

7.2B IMPERIAL COLLEGE HEALTHCARE NHS TRUST

Information Item

Tim Orchard / Bob Alexander

REFERENCES

Only PDFs are attached

07.2c ICHT CEO Report.pdf

07.2c ICHT TSC Report.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 For the 2024/25 financial year, the Trust has reported a draft income and expenditure position of breakeven (on plan), thank you to everyone who helped achieve this. We know 2025/26 will be more challenging and have implemented robust financial controls including scrutiny on recruitment and temporary bookings. At the end of month 2 (May 2025) the Trust reported a deficit of £1.3m against a breakeven plan.

1.2 We made good progress in April and May towards our operational performance targets, including meeting expectations for the 18-week referral to treatment and 28-day cancer referral to diagnosis standards. We did not meet the key urgent and emergency care targets but had some of the best performance in London, particularly for ambulance handovers. Our biggest challenge is in achieving the target to have no more than five per cent of patients waiting over six weeks for a diagnostic test or procedure, with continuing issues with our older MRI machines.

1.3 We will be investing £115m across our hospitals this year to reduce estate risks and improve experience in response to redevelopment delays, up from £70m last year. The funding is a mix of our own capital budget plus support from Imperial Health Charity and additional government allocations, including a new £25.5m award from the Government's new Estates Safety Fund – one of the largest awards nationally.

1.4 There was a fire in the linen storage at St Mary's on Thursday 1 May which resulted in evacuation of inpatient areas and a critical incident was declared. Staff evacuated the affected areas promptly and the London fire brigade was called. Wards were re-occupied within 24 hours and the main affected area was isolated for further investigation and necessary repair works are in progress. A structured debrief has been completed and detailed investigations are being carried out in relation to fire safety and in response to a report from London Fire Brigade is awaited. An update on fire safety is provided to the Committee later in the agenda.

1.5 We have shared early architect designs for The Fleming Centre and gathering feedback from staff, patients, the public and the local community. The Centre will be a new research and public engagement hub at St Mary's Hospital, and is part of the wider Fleming Initiative, a collaboration with Imperial College London to tackle antimicrobial resistance. As well as sharing the designs online and running a webinar, we ran an exhibition in The Bays (the location of the new Centre) to showcase the designs from 26-28 June.

2. Quality and safety

2.1 We continue to maintain good performance against key quality measures. Mortality rates are consistently amongst the lowest in the NHS and incident reporting rates remain high. Our harm levels remain below national averages, with a small recent increase which we are

monitoring and addressing. The biggest increase is in procedural complication incidents, this is linked to ongoing work to improve morbidity and mortality review meeting processes and ensure accuracy of reporting and review. A recent increase in ophthalmology issues is being closely monitored and addressed with issues identified with appointment booking processes and diagnostic errors.

2.2 As we manage the increasing financial pressures with additional scrutiny of recruitment decisions and temporary staffing spend, we have enhanced measurement of potential quality impact, with weekly reporting to the executive. This is in addition to the standard quality impact assessment processes. There has been no significant impact on patient safety identified as a result of these measures so far.

2.3 We made positive progress with our quality priorities during 2024/25 including:

- a 38 per cent reduction in "failure to rescue" incidents causing harm through a focus on improving how we recognise and respond to patients when their condition is deteriorating
- improvements to our Call for Concern service and rollout to over 70 wards, alongside work to implement the other elements of Martha's Rule as one of the 143 pilot sites chosen to help develop and agree an NHS-wide approach to this important patient safety initiative
- improved hand hygiene with compliance reaching our ambitious 75 per cent target in April 2025
- introduced a new clinic to support patients discharged with anticoagulation treatments, which has been shortlisted for a national award

2.4 As well as building on these priorities for 2025/26, we have identified four new areas for improvement: endorsement and management of diagnostic results; medication safety during discharge and time critical medications; pain management for inpatients; and patient fasting times before procedures.

2.5 Since the last report, two never events have been declared both of which involve items left inside patients during procedures, although the incidents are distinct and involved different services. Immediate actions have been taken while the incidents are investigated fully.

2.6 We are continuing to provide significant support and enhanced governance to our neurosurgery specialties to maintain patient safety and in response to multiple complex issues, including managing and mitigating a high number of long waiting patients for elective care, reviewing and improving the experience of resident doctors, ongoing surveillance and management of surgical site infections (SSIs) in the cranial service and the response and actions to the royal college invited service review of the Neuro-oncology MDT. We are seeing some progress, including a reduction in SSI rates and reductions in the numbers of patients waiting a long time for surgery. NHS England visited on 5 June to review progress with the resident doctor improvement plan; they were positive about the improvements made and confirmed closure of some of the outstanding actions. Following a temporary pause in response to the external review, Neuro-oncology operating resumed at the end of March, with external support for the MDT and strict governance in place to monitor appropriate metrics. A clinical harm review process is underway with no significant harm identified so far.

3. Operational performance

3.1 A new approach to booking our outpatient appointments has seen hospital-initiated cancellations fall by over 11 percentage points, patient-initiated cancellations drop almost four percentage points and the proportion of patients who do not attend their appointment

also fall by over four percentage points. The ‘choice booking’ approach involves offering patients a choice of dates and times, only six to eight weeks in advance of their appointment. Giving patients a choice of slots, relatively close to their appointment time, means they are less likely to have clashes or forget to attend. And for clinical teams, it means that holidays and other scheduling factors are considered before appointments are offered. The approach has so far been piloted for over 2,000 ‘follow-up’ appointments in clinics across five services since January.

3.2 We continue to have some of the fastest ambulance handover times in London. Our May 2025 performance against the 30-minute handover standard was 93.6 per cent, and we achieved 98.6 per cent against the 45-minute handover standard. In May, 75.5 per cent of patients were admitted, transferred or discharged from the emergency department within four hours. Our performance was below our improvement target, but it was consistent with the England average of 75.4 per cent. We are working towards meeting the national NHS operating standard for this financial year, which requires reaching a minimum of 78 per cent of patients being seen within four hours by March 2026.

3.3 The number of patients waiting for elective treatment on our referral to treatment waiting list has been steadily reducing and 60.3 per cent of our patients were waiting 18 weeks or less in May. Our trajectory for 2025/26 is to reach a minimum performance of 62.7 per cent by March 2026. We are currently taking part in a national RTT validation sprint, which aims to aid elective recovery through ensuring waiting lists are accurate. We are also continuing to make progress in reducing the overall long waiter backlog. At the end of May, 1,729 of our patients had been waiting over one year for treatment, 57 per cent lower than its peak in September 2023.

3.4 In May 2025, 17.1 per cent of patients were waiting over six weeks for their diagnostic tests or procedures, an increase from 14.5 per cent the previous month. One of the main contributors to overall performance is within Imaging, which is facing ongoing issues with older MRI machines, as well as some loss of MRI capacity at the Community Diagnostic Centre due to repairs. The operating plan target for March 2026 is to reduce the overall level of waits to no more than 5 per cent.

3.5 In terms of cancer performance, we continue to meet the faster diagnostic operating standard, updated for 2025/26 to at least 80 per cent of patients given a positive or negative cancer diagnosis within 28 days of referral. Our performance for April 2025 reached 81.1 per cent. We consistently meet the constitutional standard of ensuring that 96 per cent of patients receive first treatment within 31 days of the decision to treat (97.1 per cent in April 2025). We are working to improve waits against the core 62-day referral to first treatment standard, as currently the level falls below the NHS operating plan target of 75 per cent for 2025/26 and our more ambitious local target. Our performance for April 2025 was 73.4 per cent of patients treated within 62 days of referral.

4. Financial performance

4.1 For the 2024/25 financial year, the Trust has reported a draft income and expenditure position of breakeven (on plan), subject to audit. This is a remarkable achievement and I would like to thank everyone for their hard work in achieving this. However, a one percent real term reduction in funding, a requirement to demonstrate a four percent improvement in productivity and live within a constrained resource envelope, means the 2025/26 financial year will be even more challenging. In response to this and to ensure the Trust is best placed to manage its finances well, we have implemented robust cost control measures including a vacancy pause and daily executive-level scrutiny of all bank and agency bookings.

4.2 At the end of month 2 (May 2025) the Trust reported a deficit of £1.3m against a breakeven plan. The key drivers of the year-to-date deficit include slippage in the achievement of an equally phased, higher efficiency target and the cost pressures associated with medical staffing, both of which were materially offset by the pay controls enacted since the beginning of the financial year. Our annual budget requires us to deliver £80.1m of cost improvements and at the time of writing, plans for delivering 84 per cent of this target have been identified

4.3 Year to date, the Trust has incurred £13.0m of total capital spend against a £22.0m budget, £9.0m behind plan. This is due to the phasing of the plan and we expect to deliver the plan by the end of the year. At 31st May 2025, the Trust had a cash balance of £106.7m, which is higher than plan and due to timing differences.

5. Workforce update

5.1 We will be moving all our band 2 health care support workers to band 3, backdated to 1 August 2021 or start date if more recent. This follows a detailed review of our roles, in collaboration with our trade union partners, to align with NHS England's view that healthcare support worker roles have changed over time and those that include delegated clinical duties should be assessed as band 3.

5.2 **People performance metrics** - the vacancy rate is 7.3 per cent in April 2025, reduced from 10.2 per cent in April 2024, and our turnover rate at 7.6 per cent reduced from 10.1 per cent in April 2024 - both exceeding their target and are special cause improvement variation following a sustained improvement. Total staffing (bank, agency and substantive) for April 25 was 15,725 against a plan of 15,876 WTE and within the funded establishment of 15,754 WTE.

5.3 **EDI update** - We have launched 12 new training programmes on EDI and have held sessions on EDI at Work, Data and EDI and Accessible Design. Our Workforce Race Equality Standard (WRES) showed improvement in 7 of 9 indicators and the Workforce Disability Standard (WDES) submissions showed improvement in 8 of 11 metrics. We are continuing to undertake our EDI audits and formal reporting for our Gender, Ethnicity and Disability Pay Gaps as well as EDI annual report.

Senior leadership changes

5.4 Claire Hook, chief operating officer and deputy chief executive, left the Trust in June 2025 to take up a role as chief operating officer at the Francis Crick Institute. She is greatly missed but I am delighted that Ian Bateman has taken on the chief operating officer role on an interim basis. Following Ian's appointment, Matt Ayes has been appointed hospital director of Hammersmith and Queen Charlotte's & Chelsea Hospital on an interim basis in addition to his current role as hospital director of Charing Cross Hospital.

5.5 Imperial Health Charity has appointed Gail Scott-Spicer as its new chief executive. Gail has more than 25 years of experience in the charity and not-for-profit sectors and is currently chief executive of King's College Hospital Charity. She will start in September, taking over from Ian Lush, who is retiring in July. We wish him all the best for his retirement.

6. Regulatory update

6.1 Key external regulatory visits have included:

6.1.1 The Wolfson IVF clinic at Hammersmith Hospital had a successful inspection by the Human Embryology and Fertilisation Authority (HFEA) on 7 May 2025.

6.1.2 A Getting It Right First Time (GIRFT) Breast Surgery Gateway Review was carried out on 20 June 2025.

6.1.3 A routine inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER) took place on 25 June 2025. IRMER inspections are carried out by a specialist team within the CQC, however, this was not a CQC inspection of nuclear medicine or of the wider imaging service.

7. Research and innovation

7.1 We recruited 41,184 participants into NIHR Portfolio studies in 2024/25, from 391 individual studies (101 of these commercially sponsored) across 33 different specialties.

7.2 In May, the NIHR Imperial Biomedical Research Centre (BRC) conducted a major mid-term review to inform our BRC funding re-application in 2027. An eminent panel of external independent scientists spent a full day listening to and challenging BRC leadership.

7.3 Recent BRC-funded projects making the news include:

7.3.1 A BRC-supported study published in May revealed that the progesterone-only contraceptive pill may increase the risk of asthma attacks in some women[1].

7.3.2 A new study from the BRC Surgery & Cancer Theme has provided crucial insights into who needs ongoing monitoring for bowel cancer by colonoscopy after initial polyp removal (known as 'post-polypectomy surveillance') to potentially refine global bowel cancer surveillance practices[2].

7.3.3 A new study has analysed routinely collected data from the Trust's inclusive recruitment programme using artificial intelligence and found that the requirement for hiring managers to write a letter to the chief executive explaining recruitment decisions raised the odds of a BME candidate being offered a role by 1.7 times compared to white candidates.[3]

7.4 We continue to grow Paddington Life Sciences partners, with new industry members joining and a strengthened social value workstream linked into Westminster City Council's North Paddington Programme. In July, in partnership with Imperial College Health Partners, we are launching a series of networking events designed to bring together people working in academic, industry and the NHS, with a particular focus on supporting people earlier in their careers. We are also working with Imperial's Helix Centre to use their expertise in user-centred design in transforming the experience our staff have of our innovation pathways.

8. Redevelopment update

8.1 The New Hospital Programme (NHP) has confirmed a £16.8 million allocation for the St Mary's Hospital (SMH) redevelopment for the 2025/26 financial year, with funding beyond this period still to be confirmed. This represents a shift from the previously held position that the scheme would be supported to progress through to full planning consent. The Trust is actively working to confirm the SMH funding position and is developing a revised delivery strategy that reflects the reduced budget. NHP has also advised that there is currently no funding available to advance the Charing Cross and Hammersmith Hospitals redevelopment. Concurrently, the Trust is engaging with Westminster City Council and Hammersmith and Fulham Council to explore alternative

[1] https://publications.ersnet.org/content/erjor/early/2025/04/17/2312054101278-2024
[2] https://gut.bmj.com/content/early/2025/04/05/gutjnl-2024-334242
[3] https://imperialbrc.nihr.ac.uk/2025/06/10/inclusive-recruitment-initiative-could-enhance-the-ethnic-diversity-in-senior-roles/

funding mechanisms to support and accelerate the delivery of its wider hospital redevelopment ambitions.

9. Estates update

9.1 The estates-related incidents in the last quarter include the fire at St Mary's on 1 May 2025, which is detailed in the key messages.

9.2 We have won a bid to the NHS National Energy Efficiency Fund for £12.9 million to replace our lighting and gas and electricity controls. This will brighten our spaces, reduce our energy use and, ultimately, help us achieve net zero carbon emissions. Works began in April and continue until December.

9.3 A new, state-of-the-art MRI scanner was installed at Charing Cross Hospital in April. The new scanner will improve our diagnostic capability and ultimately help us reduce waiting times.

10. Stakeholder engagement and visits

10.1 Below is a summary of significant meetings I have had with stakeholders.

- Cllr Sheth, JHOSC Chair, 16 April, 9 June 2025
- Lord Bailey of Paddington, 15 May 2025
- Cllr Butler-Thalassis and Cllr Albert (Westminster), 12 June 2025
- Cllr Perez and Cllr Sanderson (Hammersmith & Fulham), 19 June 2025

10.2 We welcomed Sir Jim Mackey, CEO of NHS England to St Mary's on 23 June 2025, to hear about our plans for redevelopment.

11. Recognition and celebrating success

11.1 I would like to congratulate the Imperial people awarded honours in the King's Birthday Honours List – Bob Alexander, Vice Chair, awarded an OBE for services to leadership in the NHS; Professor Pankaj Sharma, consultant neurologist, awarded an OBE for services to Research in Strokes in South Asian People; and Professor Daffyd Thomas, previously a consultant neurologist and Chairman of St Mary's Development Trust, awarded an OBE for services to clinical neuroscience.

11.2 After over 25 years of research, a woman has given birth following a womb transplant. New mother Grace and baby Amy are both doing well following the birth at Queen Charlotte's & Chelsea Hospital in February. Congratulations to everyone involved in this huge achievement, including Professor Richard Smith, one of our consultant gynaecological surgeons who has led this work from the start, as well consultant obstetrician Bryony Jones, obstetric physician Charlotte Frise and the whole of the maternity team at Queen Charlotte's & Chelsea Hospital who did such a brilliant job looking after Grace and Amy.

11.3 Congratulations to the team who were shortlisted for 'Student Placement of the Year' in the Student Nursing Times Awards 2025 in recognition of the supportive, hands-on environment our teams create for student nurses.

11.4 Congratulations to our teams shortlisted for this year's prestigious HSJ Patient Safety Awards. We're in the running for the Maternity and midwifery services led initiative of the year award, the Nursing led patient safety initiative of the year award, and Safety improvement through technology award (with West London Children's Healthcare). Winners will be announced on 15 September 2025.

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

July 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. Chief Executive's report

The Committee received and noted the updates within the Chief Executive's report. The key points were:

- For 2024/25 financial year, the Trust had reported a draft income and expenditure position of breakeven (on plan).
- At the end of month 2, the Trust reported a deficit of £1.3m against a breakeven plan.
- Year to date, the Trust had incurred £13.0m of total capital spend against a £22.0m budget, £9.0m behind plan.
- The Trust had made good progress in April and May towards its operational performance targets, including meeting expectations for the 18-week referral to treatment and 28-day caner referral to diagnosis standards.
- A fire incident occurred in May 2025 in the linen storage at St Mary's Hospital which resulted in evacuation of inpatient areas and a critical incident was declared. A more comprehensive report on the issue is for discussion later in the agenda.
- The Trust continued to maintain good performance against key quality measures. Mortality rates were consistently amongst the lowest in the NHS. Incident reporting remained high and, harm levels remained below the national average.
- The Trust had made positive progress with its quality priorities during 2024/25.
- The Trust declared two never events since the last report.
- The Trust would be moving all band 2 healthcare support works to band 3 backdated to August 2021.
- Claire Hook, Chief Operating office & Deputy Chief Executive, left the Trust in June. The Trust was delighted that Ian Bateman has taken on the Chief Operating Officer role on an interim basis.
- The New Hospital Programme had confirmed a £16.4m allocation for the St Marys Hospital Redevelopment for the 2025/26 financial year, with no commitment of funding beyond this period.

- Imperial Health Charity had appointed Gail Scott-Spicer as its new Chief Executive.
- The Trust's vacancy rate was 7.3% in April 2025, reduced from 10.2% in April 2024.
- A new MRI scanner was installed at Charing Cross Hospital in April.
- The Trust won a bid to the NHS National Energy Efficiency Fund for £12.9m o replace the lighting and gas and electricity controls.

2.2. Board Assurance Framework and Risk Appetite

The Committee received a report on the Board Assurance Framework (BAF) which contained the Trust's strategic risks and assurances to ensure such risks were managed. The Committee were reminded that the Trust Executive Management Board (EMB), via the EMB Risk Group, reviewed the BAF on a monthly basis to ensure risks to the objectives were correctly identified and to oversee the development of robust controls to manage the risks. The Committee noted the updated BAF and were assured that appropriate mechanisms were in place and overseen by the sub-board Committees.

Committee members noted that the current risk appetite was being reviewed in the context of the operational plan and, that the risk appetite remained unchanged for patient safety, culture, financial management, with a relaxed approach to redevelopment to encourage innovation.

2.3. Trust Standing Committee annual report including Committee Effectiveness

Committee members received the Committee annual report including the Committee effectiveness summary noting that the report summarised the Committee's activities and its role in overseeing the governance and strategic objectives.

Committee members noted that the Committee effectiveness review highlighted areas for improvement, including the timeliness and quality of information provided to the Committee however, it was noted that the Committee was still maturing having been established in July 2024.

2.4. 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 with a small recent increase which was being monitored to ensure shared learning and to ensure actions were in place to mitigate recurrence. Committee members were pleased to note that the Trust had held a positive patient safety improvement event, recognising initiatives and achievements in patient safety.

Committee members noted that changes would be made to how deteriorating patients and sepsis were reported, aligning with national guidance and Acute Provider Collaborative Standards.

Committee members noted the continuing support and enhanced governance required in response to multiple complex issues within the neurosurgery specialties, with fortnightly oversight meetings being held by the medical director; regular updates were provided to

the Executive Management Board and Quality Committee.

Committee members received and noted the quarterly learning from deaths report noting that the Trust's morality rates remained statistically significantly low. When considered with the Trust's harm profile and the outcomes of the Trusts Structured Judgement Reviews (SJRs), assurance was provided that the Trust was providing safe care for most of its patients.

2.5. Fire Safety update

Committee members received the report which provided the Committee with an update on the Trust's fire safety following a fire that occurred in May 2025, in the Mary Stanford Building, originating from a spontaneous combustion of linen. The fire led to the evacuation of three wards. Immediate actions focused on the affected clinical areas and the Mary Stanford Building. The London Fire Brigade provided a debrief, and most immediate actions had been concentrated on these areas.

Non-Executive Committee members acknowledged and were concerned that the London Fire Brigade had issued the Trust with an enforcement notice, which the Trust was addressing with a detailed action plan. Whilst the Committee understood that the Executive Team would be reviewing and managing the action plan closely, further updates on the implementation of the action plan were requested to come to future TSCs. The Trust was also preparing for a potential inspection at the other Trust sites.

Committee members noted that the fire had highlighted issues with building compartmentalization, which had allowed smoke to spread. Efforts were underway to improve fire compartmentalisation and to ensure fire doors were effective.

Committee members discussed the shortfalls in matters of risk management, governance and oversight that the incident had shown, including the Trust's fire risk assessment compliance noting that the Trust had fallen behind on fire risk assessments, with the current compliance at 59% and deficiencies in the level of face-to-face operational fire training. The Trust had commenced a plan to ensure assessments were completed by the end of the year, starting with the high-risk areas. A comprehensive training programme had been developed to ensure staff are prepared for fire emergencies. An internal audit review of related system processes and governance arrangements was to be scheduled for later in this year and ARG will ensure its terms of reference cover these matters and ensure appropriate oversight of such recommendations as may be made. As the committee with Health & Safety responsibility, People Committee will review the reporting arrangements, particularly with respect to training compliance.

Committee members noted that issues such as storage of chemicals in the basement and the adequacy of fire alarm testing were identified. These were being assessed as part of the overall fire safety improvement plan.

However, the Committee recognised that the staff had responded effectively and thanked them all for ensuring no harm came to patients and other staff.

2.6. Operational performance report

The Committee received and noted the operational performance report for month 2.

2.7. Finance update

The Committee received and noted the forecast outturn position at month 2 including the current cash position and forecast.

2.8. 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. The Committee noted an update on health and safety including the continuing work to address violence and aggression on staff and received the Freedom to Speak up Annual Report 2024/25 which had been reviewed and scrutinised at the People Committee in May 2025.

2.9. NWL Acute Provider Collaborative (APC) Executive Management Board (EMB)

The Committee received an update of the key discussions held at the APC EMB on 9th April and 10th June 2025. Discussions included performance, finance and recovery, business planning, APC clinical pathways and collaborative projects.

2.10. **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 May 2025. The Committee received assurance that key risks overseen by each Board Committee were being managed appropriately.

3. Positive assurances received

The Committee acknowledged the swift and effective actions of Trust staff during the fire incident on 1st May 2025, noting that three wards were safely evacuated without any harm to patients or staff.

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

There are no key risks which require escalation to the Board. However, on subsequent reflection in respect of the issues highlighted by the fire incident, the Collaborative Estates and Sustainability Committee will request assurance reports from each of the Trusts in respect of Fire Risk Assessments, mandatory fire training and the status of any improvement actions required by the London Fire Brigade as a result of attendance or inspection.

5. Concerns outstanding

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

6. Decisions made

No decisions were made that require reporting to the Board in Common.

7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Proposed changes to APC Governance	For approval	8.	Board Committee report – Quality	To note
2.	CEO eport	To note	9.	Operational performance report	To note
3.	Board Assurance Framework and Risk Appetite	To discuss	10.	Finance report	To note
4.	Trust Standing Committee annual report including Committee effectiveness	To note	11.	Board committee report – Finance, Investment and Operations	To note
5.	Board Committee report – Audit, Risk and Governance	To note	12.	People Assurance report	To note
6.	Quality assurance report	To note	13.	Board committee report – People	To note
7.	Fire Safety update	To note	14.	Redevelopment & Estates Committee report	To note
			15.	Report from APC Executive management Board	To note

8. 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	**Y**
Catherine Williamson, Non-Executive Director	**N**
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**

7.2C THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST

Information Item

Lesley Watts / Carolyn Downs

REFERENCES

Only PDFs are attached

07.2b THHFT CEO Report.pdf

07.2b THHFT TSC Report.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 Improved CQC rating represents significant progress

The Care Quality Commission (CQC) has recognised the progress across a number of key areas and services at The Hillingdon Hospitals NHS Foundation Trust with improvements seen across urgent and emergency care, and surgery services at Mount Vernon Hospital. Our urgent and emergency and surgery services have improved and reported urgent and emergency, and surgical services on the Hillingdon site have also improved.

1.2 Maintaining ED performance

Improvement in our ED performance has maintained for a number of weeks despite high footfall over the last month. It is essential that we continue to maintain our focus and efforts to ensure sustained progress.

1.3 Minister of State for Health backs our plans for new hospital

Minister of State for Health, Karin Smyth visited Hillingdon Hospital to emphasise the government's support to our redevelopment. She was accompanied by Uxbridge and South Ruislip Labour MP, Danny Beales. The visit was featured on BBC London and local London media with interviews with the Minister of State for Health reinstating her support for the redevelopment of Hillingdon Hospital, the broadcast also featured an interview with Chief Medical Officer and Managing Director, Dr McGlennan.

Construction works on The Furze building are progressing, with completion expected in October 2025.

1.4 Voted best acute Trust in the country for food

Our Trust was again voted the best acute trust for food, as judged by patients and staff. NHS England published the annual results of patient-led assessment of the care environment (PLACE) for 2024. The Hillingdon Hospitals NHS Foundation Trust again received full marks, and no other Trust got this high a rating.

1.5 Pharmacy First pilot exceeds expectations

We have completed a pilot, the first of its kind in London, measuring the feasibility and effectiveness of implementing a Pharmacy First referral pathway from a UTC setting. Urgent Care staff were training in the new pathway, resulting in successful re-direction of patients with minor illness from urgent and emergency care services to community pharmacists.

The pilot exceeded expectations, demonstrating the potential to release UTC capacity, reduce pressure and waiting times, and improve access to timely care. The positive outcomes prompted the formation of a Pan-North London working group to share learnings, best practices and resources to encourage wider adoption across other London ICBs.

2. Quality and Safety

2.1 There was a slight increase in falls in May, but an overall decrease of falls per bed day. The IPC Team are leading a Trust-wide training programme on ANTT to improve practice and reduce infection rates.

2.2. The Trust number of complaints remained stable (39 received in May compared to 40 in April) and performance improved from 85% to 91.4%. There were no reopened complaints.

2.3 There was a slight increase in 52 weeks waits and one patient waiting over 65 weeks – but the Trust remains on track to deliver the operational target for 25/26. Diagnsotic performance dropped, but recovery plans are in place and imrpovements are visible in June 2025.

2.4 The Emergency Department and the wards greatly enhanced their sepsis screening. This indicator hit its peak value since January in May 2025. The improvement has come gradually. It still falls short of our target compliance rate of 90%.

3. Operational performance

3.1 UEC performance has improved significantly, delivering 77.18% in June against the 78% standard. Type 1 performance also improved by 5.6%.

3.2 Overall activity has recently remained stable with an average 422 attends per day. The UTC had the highest attends for the last year.

3.3 12-hour length of stay in our Emergency Department (for all T1 patients) reduced below the national target of 10% to 8.52%.

4. Financial performance

4.1. The Trust is currently £1.1m behind its financial plan due to slippage in savings/cost improvement and overspends. There have been reductions in pay through the pay controls and agency spend.

4.2 The fill rates for both medical and non-medical has remained positive. Medical and Dental fill rate for May 2025 was 96.1% which is a 2.5% increase from April 2025. Non-medical the fill rate for May 2025 was 99.6% which is a slight increase from April 2025 of 0.1%. In Medical, the agency usage for May 2025 was 14.5% which is a 3.3% decrease from April 2025. This decline has been consistent over the last 2 months.

5. People

5.1 Recognising the role of our volunteers

Our volunteers play an important role, helping our staff make the hospital experience better for patients. In recognition of the commitment of our incredible 176 volunteers, we held a Volunteers' Week Coffee Morning during Volunteers' Week 2025 in June.

5.2 Temporary staffing service back in-house

The Trust has brought our temporary service back in house and it is now managed by the temporary staffing manager at Chelsea and Westminster NHS Foundation Trust, working with our Head of Resourcing and Head of Medical Staffing throughout the transition. Benefits of the change are greater efficiencies through scale, resilience, improved performance; more balanced team structure; and the ability to maintain and develop team knowledge of the organisation and good relationships with service managers.

6. Equity, diversity and inclusion (EDI) update

6.1 PRIDE month and London Parade

During PRIDE month, staff have signed up to join in the London PRIDE Parade with our LGBTQ+ Network, in partnership with our colleagues from the Acute Provider Collaborative.

6.2 New LGBTQ+ chairs

Our Trust LGBTQ+ Network has appointed two new chairs to run the network and encourage participation.

6.3 New network meetings for LGBTQ+

The LGBTQ+ staff network held the first of a series of monthly meetings with the new LGBTQ+ Network Chairs. This was a chance for staff to ask questions, share ideas, and find out how you can get involved in the network, as well as to meet other network participants.

6.4 Staff Networks Day highlights profile of our networks

We highlighted our staff networks with a profile of each network chair and the network on Staff Networks Day, encouraging the profile of each group and encouraging participation.

7. Trust highlights

7.1 New early warning score in paediatrics

Our paediatric services have gone live with the new national paediatric early warning score (NPEWS). This measurement includes additional parameters and changes to the scoring for escalation, designed to improve detection of the deteriorating patient and escalation processes. New parameters include suspicion of sepsis, clinical intuition, carer escalation and blood pressure.

7.2 Digital consent is live - a benefit for our patients and clinicians

Concentric is now live - the digital consent for procedures in our hospitals. Paula Galea, consultant obstetrician and clinical project leads discusses this new clinically-led application. It seamlessly integrates with other digital systems to provide the patient and the Trust with an online record of consent. By using Concentric, patients can take as long as they need to read all the information about their test, treatment, or procedure before giving consent, completing the form at home or at the hospital.

7.3 The healthcare language app

A new communication tool has been implemented for conversations between healthcare staff and patients. CardMedic provides clinically interpreted interactions in more than 50 languages, as well as videos in British Sign Language, AI video interpretation. It also enables 1-click chat and interpreter access, easy read and read aloud tools. The app is available to all clinical staff to assist them in communicating with patients about their care.

7.4 Alertive

We have gone live with Alertive, a replacement tool for bleeps and emergency messaging in the Trust. It provides real-time alerts, secure messaging, role-based handovers, clinical system integration, and full compliance and auditability. It also offers a secure alternative to WhatsApp for discussions about patient care. The app enables real-time messaging with individuals, groups, and role-based assignments. Staff can take on and relinquish roles as needed during shifts, ensuring seamless communication handovers.

8. Updates from the Council of Governors (COG)

8.1 The Council of Governors (CoG) formally met in public on 29 June 2025. In advance of this, the CoG received a briefing in May 2025 on the future of Minor Injuries Provision across the Trust.

CoG elections will be held over the summer, with 10 seats up for election in 2025: 2 each for the North, South, and Central constituencies, and 4 within the staff constituencies. We aim to conclude the process and announce the results on 30 September 2025.

Our Annual Members Meeting will take place on 16 July 2025, from 5:00 PM to 6:00 PM. You can join us online via the following link: [Click here to join].

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 International Nurses Day and International Day of the Midwife

We hosted our own Nursing and Midwifery Awards to recognise the role and contribution of our colleagues. The awards brought together the nursing and midwifery community to shine a light on the talent within the professions and recognise those who have made incredible contributions, and honour both individuals and teams who stand out as truly exceptional and who have gone above and beyond what is expected of their day-to-day role.

9.2 Volunteers' Week

During Volunteers’ Week, we celebrated our 176 volunteers with a celebration breakfast, to thank them for their continued time, compassion and energy to support our patients, visitors and staff.

9.3 Estates and Facilities Day

Colleagues from across the Trust gathered to celebrate our Estates and Facilities Teams, with awards and presentations. The winners of the annual awards for improvement areas ranged from innovation to digitisation, and from personal to people development.

9.4 Paediatric Epilepsy Service named as positive outlier

The Paediatric Epilepsy Service was named as a positive outlier for epilepsy nurse input or one or more of the Epilepsy12 clinical audit measures. Epilepsy12 is a national audit in the UK focused on improving the quality of care for children and young people with epilepsy.

9.5 Achieved Gold Standard Award from National Joint Registry

Our Trust has achieved Gold Standard Award for the Trust from NJR (National Joint Registry). The National Joint Registry (NJR) awards a Gold Quality Data Provider Award to hospitals that demonstrate exceptional commitment to data quality and patient safety in joint replacement procedures.

9.6 Jeanette wins Healthcare Support Worker Award

Jeanette Curtin has been honoured for her contribution in Theatres at Hillingdon Hospital, winning a prestigious Healthcare Support Worker Award in the Chief Nursing Officer and Chief Midwifery Officer Awards.

9.7 Two NHS England awards for cyber security

Our cyber security manager, Nasser Arif, picked up two national awards for his work in cyber security. He won the 'Diversity in Cyber' and the 'Pete Rose Outstanding Achievement Award' during the NHS England Cyber Associates Network (CAN) awards ceremony.

The Hillingdon Hospitals NHS Foundation Trust

Trust Standing Committee report to the North West London Acute Provider Collaborative Board in Common (BiC) – for discussion 15 July 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 3 July 2025

2.1 Hillingdon Health and Care Partnership (HHCP) Transformation Update

The Committee received an update from Keith Spencer (Managing Director HHCP) providing a strategic overview of integrated care developments and system pressures across Hillingdon, with alignment to the new NHS 10-Year Plan. The Committee noted the progress being made, ongoing challenges, and the mitigations in place.

Integrated Neighbourhood Teams and Reactive Care

- Development of three integrated neighbourhood teams is underway to strengthen preventative care and reduce avoidable crises.
- A new approach to reactive care aims to improve crisis response and reduce non-elective hospital use.
- Key risks include high levels of demand, insufficient urgent community response capacity, and reduced discharge rates at weekends.

Alignment with the NHS 10-Year Plan

- Hillingdon's strategic direction closely aligns with NHS England's long-term objectives.
- Focus areas include place-based care, crisis prevention, and improved population outcomes.

Urgent Care Transformation

- Two urgent care hubs are now fully operational, averaging 180 attendances per day.

- Progress on the third hub is delayed due to estate constraints.
- Efforts are underway to reduce pressure on Urgent Treatment Centres (UTCs) and Emergency Departments (EDs) through new service models.

Enhanced Case Management for Frailty

- Currently, 50% of the severe frailty cohort is supported through enhanced case management.
- The ambition is full cohort coverage by April next year to reduce non-elective admissions and improve continuity of care.

Population Health: Hypertension Programme

- A borough-wide programme is being implemented to improve hypertension detection and control—the leading health issue locally.
- Targets include a 24% prevalence rate and 85% blood pressure control to reduce demand on acute care.

Key Risks and Mitigating Actions

- System pressures including urgent response capacity, demand surges, and weekend discharge bottlenecks remain challenges.
- The Committee noted the introduction of new services and pathways aimed at risk reduction and system resilience.

Joint Plan for No Criteria to Reside: The Committee requested a collaborative plan with the local authority to address delays in discharge for patients with no medical reason to remain in hospital.

Delivery Plan for Initiatives: A comprehensive delivery plan was requested for the next meeting, outlining timelines and the anticipated impact of key initiatives across community and acute services.

2.2 CEO 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 Maternity Culture Update

The Committee received an update on the maternity department's cultural development, reflecting ongoing efforts and measurable progress following previous reviews.

- **Improvement Initiatives:** A range of targeted interventions—workshops, seminars, and focused organisational development—have supported cultural change in key areas.
- **Positive Trends in Survey Results:** Quarterly staff surveys indicate a steady upward trend in positive cultural indicators across the service.
- **Improved Staff Retention and Wellbeing:** Staff turnover and sickness rates have decreased significantly, suggesting better morale and workplace satisfaction.
- **Incorporation of Patient Voice:** The Maternity Voices Partnership (MVP) continues to provide valuable feedback, working directly with staff and ensuring patient perspectives are embedded in assessing culture change.
- **Ongoing Work and Challenges:** The Committee noted that while improvements are evident, further cultural development is needed as teams adjust to new ways

of working.

2.4 Deep Dive examples

The Committee received an overview of the executive deep dive process, which is used to assess service lines holistically across performance, quality, workforce, and financial dimensions.

- **Purpose and Scope:** Deep dives serve as structured reviews of departments or services, offering insight beyond standard reporting metrics.
- **Examples Reviewed:** Pharmacy and Respiratory Services were examined in detail:
    - ***Pharmacy:*** Addressed issues flagged by the Care Quality Commission, with a focus on areas needing targeted improvement.
    - ***Respiratory Services:*** Brought attention to long-term care pressures that are less visible in routine data but critical to patient outcomes.
- **Accountability and Monitoring**: Each review leads to clearly defined actions, with progress monitored and re-evaluated to ensure sustained improvement.
- **Future Reporting Approach:** The Committee discussed the benefit of regular summaries of deep dive findings to enhance Board visibility of emerging risks and responsive actions.

These deep dives are proving essential to identifying service challenges early and driving continuous quality improvement.

2.5 Annual Plan Reporting 2025/26

The Committee received the Trust's annual plan delivery and governance report, outlining how progress will be monitored and reported over the coming year.

- **Oversight Structures:** The plan includes defined governance mechanisms and committee oversight arrangements, providing robust assurance across all workstreams.
- **Digital Oversight Gap:** The Committee noted that digital initiatives are not currently reported through standing Board structures. An update on this area will be scheduled at a future meeting.
- **Report Approval:** The Committee acknowledged the report as comprehensive and self-evident, formally noting its acceptance.

This framework ensures the Trust maintains structured accountability and Board visibility over delivery of the annual priorities.

2.6 Integrated Quality and Performance Report (IQPR)

The Committee received the month 2 IQPR, providing a comprehensive view of the Trust's operational performance across key metrics.

- **Elective Care:** Referral-to-treatment (RTT) performance continues to improve, rising from under 50% to over 60%. This progress reflects strengthened RTT management, better validation processes, and refinements to consultant job plans and templates.
- **Urgent and Emergency Care (UEC):** UEC performance has reached

78%, sustaining two consecutive months close to the 77% national standard. Improvements are attributed to changes in ED clinical leadership and a positive shift in divisional team culture.

- **Ongoing Challenges:** While progress is evident, the Committee noted that some performance areas remain under pressure. Targeted actions are in place to continue driving improvement.

2.7 Finance Report and Cost Improvement Programme (CIP) - M2

The Committee received the M2 finance and CIP report, providing an update on the Trust's in-year financial and cost improvement position, and associated risks and controls.

- **Deficit Position:** The Trust is currently reporting a £1.5 million deficit, primarily driven by operational spending pressures, including agency staffing costs.
- **Cost Improvement Plan (CIP):** A significant gap remains in CIP delivery. The Committee noted the continued focus on applying financial controls and the need to make difficult decisions to bridge the gap.
  - **Cost Reductions Achieved:** Significant reductions in pay and agency spend have been realised, including targeted savings on mental health nurse staffing. Agency spend is now at its lowest level in two years.
  - **Future Planning and Transformation:** The Committee acknowledged the need for more radical change and agreed that a medium-term strategy is essential. Discussions are focusing on transformative approaches, including potential service consolidation, to secure further savings over the next 3–5 years.
- **Cash Flow:** The cash position is strong, bolstered by a £30 million funding receipt related to the incinerator revaluation.

The Committee acknowledged the Trust's progress in financial control while recognising the ongoing challenges to delivering in-year savings.

2.8 Mount Vernon – Urgent Care Nurse Practitioner Service

The Committee reviewed and approved a proposal to consolidate all urgent care services at Hillingdon Hospital, moving the MIU from Mount Vernon Hospital.

- **Rationale for Change:** Centralisation is intended to:
  - Improve clinical safety and quality
  - Enhance access, particularly for underserved populations
  - Strengthen workforce resilience
  - Deliver recurring savings of over £1 million annually
- **Engagement and Feedback:** The proposal was supported by system partners including the Integrated Care Board (ICB) and the Confederation. The Committee acknowledged concerns raised by local politicians and residents regarding accessibility, which will continue to be addressed through engagement.
- **Committee Decision:** The Committee:

- Approved the proposal to consolidate services
- Endorsed the implementation plans and communications approach
- Supported the commencement of a staff consultation to facilitate safe redeployment

Recommendation to Board: The Committee recommends the proposal to the Board for final ratification, given its strategic alignment with quality, access, and financial sustainability goals.

2.9 Green Plan Refresh

The Committee received the refreshed Green Plan, reflecting the Trust's continued commitment to environmental sustainability.

- **Progress Recognised:** The Trust has made measurable strides in implementing green initiatives, which were positively acknowledged in recent Care Quality Commission (CQC) assessments.
- **Standardisation and Collaboration:** The Committee identified the need for greater standardisation in how progress is measured across sustainability initiatives. Strengthening cross-organisational collaboration was also highlighted as key to improving impact.
- **Committee Decision:** The refreshed Green Plan was approved by the Committee as recommended by the Audit and Risk Committee, with a shared emphasis on ongoing development and alignment.

2.10 Board Committee Reports

The Committee noted the following updates from Board subcommittees:

- **Quality and Safety Committee:** The report was noted.
- **People Committee:** The report was noted.
- **Finance and Performance Committee:** The report was noted. The Committee discussed the current financial position, including the reported £1.5 million deficit and the range of measures in place to address it.
- **Audit and Risk Committee:**
  - ***Internal Audit:*** Several reports were reviewed, including one on maternity data quality and another on procurement—both receiving limited assurance due to identified weaknesses.
  - ***External Audit:*** The external audit concluded on time. While the overall opinion was moderate assurance, it was at the lower end of the scale. Management has accepted the recommendations outlined.
  - ***Annual Report and Accounts 2024/25:*** The Committee noted the timely submission of the Annual Report and Accounts for 2024/25 by the 30 June deadline, and extended thanks to the teams involved in achieving this milestone**.**

2.11 Items for noting

- **Annual Reporting:** The Committee formally noted the Annual Report, Annual Accounts, and Auditor's Annual Report for 2024/25.
- **Care Quality Commission (CQC) Reports:** The Committee noted the latest CQC reports, recognising the positive feedback received and acknowledging the commitment and efforts of staff.

2.12 Departures and appreciation

The Committee noted the departure of Janet Campbell and expressed sincere thanks for her valued contributions during her tenure as an Associate Non-Executive Director.

3. Positive assurances received

Referral-to-Treatment (RTT) and Urgent & Emergency Care (UEC):

- RTT performance has shown marked improvement, now exceeding 60%, supported by better pathway management and planning.
- UEC performance reached 78%, maintaining progress above the 77% standard over recent months.

Care Quality Commission (CQC) Reports:

- Feedback from CQC inspections was positive, reflecting the sustained efforts and improvements delivered by Trust staff.

Maternity Culture:

- Cultural indicators continue to improve, evidenced by enhanced staff survey results and reduced sickness and turnover rates.

Financial Management:

- Pay and agency expenditure has declined, with agency costs now at a two-year low.
- Specific control over Registered Mental Nurse (RMN) spending has contributed to financial stability.

New Hospitals Programme:

- The Trust is making constructive progress in aligning the hospital redevelopment with NHS Hospital 2.0 standards, supporting long-term adaptability and transformation.

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

The Trusts challenging financial position, procurement and contract management concerns - triangulated with Internal Audit recommendations.

5. Concerns outstanding

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

6. Key actions commissioned

- **Financial Management**:
  Continue to implement and maintain strict pay and agency spend controls to ensure financial stability.
  Procurement and Contract Management:
- Conduct a thorough review and audit of the procurement processes and contract management aligned to the recent Internal Audit of Procurement.
  New Hospitals Program:
- Align the new hospital design with NHS Hospital 2.0 standards and ensure flexibility for future transformations.

7. Decisions made

The Committee Approved:

- Green Plan Refresh
- Fire and Electrical Infrastructure Works - Approved for this year's fire and electrical infrastructure works.

The Committee supported and recommended approval to the BiC:

- Governance arrangements – NWL APC
- Consolidation of MIU services

The Committee agreed to delegate authority for finalising the New Hospital Schedule of Accommodation (SoA) to the Chair of the Redevelopment Committee, the Senior Responsible Officer for Redevelopment, and the Trust's Managing Director.

8. Summary Agenda 3 July 2025

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Chief Executive's report	To note	12.	Developing the governance arrangements for the NWL APC	Approval
2.	HHCP Transformation Update	Assurance	13.	Mount Vernon – Urgent Care Nurse Practitioner Service	Approval
3	Maternity Culture Update	Assurance	14.	New Hospitals Programme – Schedule of Accommodation	Approval
4.	Deep Dive Examples	Assurance	15.	Green Plan Refresh	Approval
5.	Integrated Quality and Performance Report	Assurance	16.	Business Cases (Fire and Electrical)	Approval
6.	Finance Report – M2	Assurance	17.	Annual Report 2024/25	Noting
7.	Cost Improvement Programme – M2	Assurance	18.	Annual Accounts 2024/25	Noting
8.	Board Committee report – Quality & Safety	Assurance	19.	Auditor's Annual Report 2024/25	Noting
9.	Board Committee report – People	Assurance	20.	CQC Final Reports (published 4 June 2025)	Noting
10.	Board Committee report – Finance & Performance	Assurance			
11.	Board Committee report – Audit and Risk	Assurance			

9. Attendance 3 July 2025

Members	3 July 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	**Y**
Mike O'Donnell, Non-Executive Director	**Y**
Vineeta Manchanda, Non-Executive Director	**Y**
Lesley Watts, Chief Executive Officer	**Y**
Managing Director/Chief Medical Officer	**Y**
Virginia Massaro, Chief Finance Officer	**Y**
Sarah Burton, Chief Nursing Officer	**Y**
Jason Seez, Chief Infrastructure and Redevelopment Officer	**Y**
In attendance	
Janet Campbell, Associate Non-Executive Director	**N**
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**

7.2D CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

Information Item

Lesley Watts / Patricia Gallan

REFERENCES

Only PDFs are attached

07.2d CWFT CEO Report.pdf

07.2d CWFT TSC Report.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 Our Trust made national headlines in The Sunday Times, The Mail, The Independent, The Guardian, LBC, ITV and Sky for piloting an innovative digital tool that helps speed up cancer diagnosis and treatment, reducing delays and improving patient outcomes. Developed as part of the NHS Federated Data Platform, the NHS app, Cancer 360 brings patient information into one place—cutting admin time and allowing clinical teams to focus on care. Since its launch, more than 52,000 patients have been managed through the system, with diagnosis within 28 days rising from 71.5% to 84.7%. This is now being piloted at other NHS sites and continues to drive real improvements for patients nationally.

1.2 At London Tech Week, the Prime Minister Keir Starmer, recognised an Artificial Intelligence (AI) project being led by our Trust: the development of AI-assisted software designed to streamline the time required to draft discharge summaries. We discharge more than 600 patients each week, and this software is expected to bring significant benefits to both patients and staff by reducing the administrative demand on clinicians. This will enable us to dedicate more time towards patient care and professional development. The project is a collaboration between the Trust and the NHS Federated Data Platform programme.

1.3 A national film led by the Nursing and Midwifery Council (NMC) features a number of our staff, to celebrate International Nurses Day. This year's theme, Caring for Nurses Strengthens Economies, reflects the essential contribution nurses make not only to healthcare, but also to the strength and wellbeing of our wider society. The film is a tribute to all our nurses, sharing some of the inspiring journeys and achievements of our colleagues, and highlighting the incredible impact they make every single day.

1.4 Day Surgery Unit at Chelsea opens: The Unit—formerly The Treatment Centre will help us treat more patients, more quickly, while maintaining high standards of care. It will house two new state-of-the-art operating theatres, enabling a wider range of procedures to be carried out in the Day Surgery Unit and freeing up capacity in Main Theatres for more complex surgeries, including increased use of surgical robots. We hosted an event as a thank you to all the staff involved with the opening.

2. Quality and Safety

2.1 Infection Prevention and Control (IPC): In April 2025, five cases of Clostridioides difficile (C. diff) were reported – three at Chelsea and Westminster (CW) and two at West Middlesex (WM) – which is one fewer than the same period last year. The threshold for 2025/26 is yet to be confirmed, and a new reduction plan is in development. No cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia were reported, and hand hygiene compliance has improved given the focus across the Trust and within teams.

2.2 Safety: The Trust continues to demonstrate a strong safety culture, with robust incident reporting and no never events recorded in April 2025. The Patient Safety Incident Response Framework (PSIRF) is now fully embedded. The Summary Hospital-level Mortality Indicator (SHMI) remains favourable, and there were no category 3 or 4 hospital-acquired pressure ulcers. Despite changes in national operational planning guidance and increased scrutiny on temporary staffing, safe staffing levels have been maintained.

2.3 Patient Experience: Friends and Family Test (FFT) results remain positive across inpatient and maternity services. Notably, Chelsea's Emergency Department (ED) saw a reduction in negative feedback, as did West Middlesex (WM) ED which remains slightly above target. National benchmarking shows the Trust compares favourably to other acute Emergency Departments.

2.4 Effectiveness: Venous thromboembolism (VTE) risk assessment compliance remains above 95% Trust-wide. The CW site is slightly below at 94.8%, but targeted improvement actions are in place. Dementia screening rates continue to exceed targets. Sepsis pathway reviews are ongoing across the Acute Provider Collaborative (APC), with local improvement programmes in place to enhance screening and review timeliness.

3.0 Operational performance

3.1 Emergency Care: In April 2025, the Trust achieved 81.81% compliance with the four-hour A&E standard. WM reported 81.04% (13,364 attendances) and CW 82.66% (12,368 attendances). There were 49 twelve-hour trolley waits, all related to mental health bed delays.

3.2 Referral to Treatment (RTT): RTT performance declined to 59.02% in April, primarily due to reduced elective activity. The total Patient Treatment List (PTL) rose to 67,299. There were 474 patients waiting over 52 weeks and nine over 65 weeks (due to patient choice and capacity). No patients were waiting over 78 weeks. Focus remains on reducing long waits, particularly in high-risk specialties such as Vascular Surgery, Urology, ENT, Paediatric ear, nose and throat (ENT), Trauma and Orthopaedics, Colorectal, Plastic, and General Surgery.

3.3 Cancer Standards:

- 31-Day Standard: Achieved 96.69% in March (validated) and 98.64% in April (unvalidated).
- 62-Day Standard: Remains challenged at 81.82% in March and 70.18% in April (unvalidated), impacted by diagnostic delays, annual leave, and patient choice.
- 28-Day Faster Diagnosis Standard (FDS): Maintained strong performance with 80% compliance in March and 80.79% in April (unvalidated), exceeding the national 77% target.

3.4 Diagnostics: April saw a 6.7% drop in diagnostic performance due to reduced activity and reliance on temporary staffing, particularly in ultrasound and endoscopy. Despite this, the overall diagnostic PTL remains stable.

4. Financial performance

4.1 In Month 2 (May 2025) the Trust reported an in-month deficit of £1.4 million, which is £1.1 million worse than planned. Year-to-date (YTD) performance shows a cumulative deficit of £2.4 million, representing a £1.7 million adverse variance against plan.

4.2 The main drivers of this position are:
- Slippage in the delivery of planned cost improvement programmes (CIPs), including unidentified savings targets.
- Pressures on medical staffing costs.
- Higher-than-expected non-pay expenditure.

4.3 There are positive signs of improvement regarding whole-time equivalent (WTE) staffing levels and total pay spend, both have continued to reduce in Month 2, reflecting tighter workforce controls.

Elective Recovery Fund (ERF) activity and unbundled radiology services are currently over-performing against their capped levels.

4.4 Finance leads across the APC are working together on the medium term financial plan to support future sustainability of each Trust and the collaborative as a whole.

5. People

5.1 We celebrated our latest PROUD Award winners and Long Service colleagues at a special ceremony on Tuesday 13 May. Certificates and badges were presented by members of the senior leadership team in recognition of colleagues' outstanding contributions to our patients and services. The event also saw two Long Service Awards presented, honouring colleagues' dedication and continued impact over the years.

5.2 We recognised the contribution of our 372 volunteers during Volunteers' Week with celebrations across the Trust, including decorated offices and a thank-you party at West Mid. From welcoming patients and supporting discharge to offering comfort at the end of life, our volunteers make an incredible difference

every day. The week was a chance to thank each and every volunteer for their time, kindness and energy – and to celebrate the vital role they play in our hospitals.

5.3. We marked International Day of the Midwife, International Nurses Day and National ODP Day throughout May 2025 with a week-long celebration of our Midwives, Nurses and Operating Department Practitioners. Activities included a special staff bulletin, thank-you messages, a CEO-led webinar with guest speakers, a staff quiz, a Parkrun at Osterley Park, and ward deliveries of treats and cards. The celebrations were a vibrant and heartfelt recognition of the compassion, skill and commitment of colleagues working across maternity, nursing and theatres.

6. Research and innovation

6.1 Now in its tenth year, the Research, Innovation and Quality Improvement (RIQI) Event marks a decade of progress, learning, and transformation across our Trust. It is an opportunity to reflect on the innovations that have shaped our journey so far, and to look ahead to the next ten years—guided by our people, our values, and the evolving needs of our patients. This year's theme, aligned with the NHS' 'Three Big Shifts'—prevention, community, and digital—echoes the ambitions of the NHS 10-Year Plan and sets the framework for the future we are already building. The event will be held on 8 and 9 July 2025.

7. Equity, diversity and inclusion

7.1 Our Heart Failure Team launched an exciting new pilot in partnership with the Healthy Hounslow team which brings heart failure screening directly into the community using roaming clinics, focusing on reaching high-risk and harder-to-reach patients. By identifying heart failure earlier, we can start treatment sooner and help prevent avoidable hospital admissions. This service will target high-risk patients and those in more deprived areas of the borough, often the most vulnerable in our community. We know approximately 80% of patients diagnosed with heart failure receive their diagnosis when admitted to hospital. If we can identify these patients earlier we plan to start therapies and reduce the risk of a health decline.

7.2 On International Day of Action for Women's Health (IDAWH); a day which aims to encourage people to advocate for women's sexual and reproductive health rights. We hosted an event in collaboration with CW+, ARC, NHS Hiyos, Hounslow Council and local organisations, where numerous health experts and lived experience speakers gathered to discuss the topics facing women living in West London. Attendees also took part in workshops, covering a range of topics from HIV Prevention in ethnic minority women to mental health care and gender inequalities in healthcare.

Healthcare professionals from the Trust also collaborated with Hiyos, an NHS GP practice aiming to tackle health inequalities through events and online initiatives, to create a number of insightful and educational podcasts, discussing a variety of women's health topics.

8. Recognition and celebrating success

8.1 Congratulations to the Pre-hospital Ambulance Support Team (PhAST) team for being shortlisted for the *Improving Care for Older People Initiative of the Year* category at the 2025 Patient Safety Awards. The PhAST system-wide approach aims to improve care for frailty patients in nursing and care homes. Through close collaboration between our Trust, the London Ambulance Service, West London NHS Trust, Hounslow Primary Care Network, and local care homes, the team successfully reduced unnecessary hospital admissions, improved patient outcomes, and delivered care closer to home.

8.2 I am really proud to announce that our Trust has been recognised across several different categories at this year's *Royal College of Physicians Awards*.

- Pioneering Cardiac Digital Care Through Virtual Wards project shortlisted for an *'Excellence in Patient Care Award'*.
- Improving wellbeing for Internal Medicine Trainees across London shortlisted for *'Developing Workforce – Empowering and Supporting Teams' award*.
- Welcoming, Developing, and Helping to Flourish shortlisted for the *'Excellence in Patient Care Award'.*

8.3 Our cross-site anticoagulation and thrombosis team recently received a Highly Commended award at the Thrombosis UK VTE Awards, held at the House of Commons. The team was recognised for an outstanding quality improvement programme in thrombosis prevention and management. Highlights included sustained compliance with national VTE metrics, regular audits and feedback on risk assessments and thromboprophylaxis, and the use of dashboards to support learning and action.

8.4 Congratulations to Paoline Funtila, Apprenticeship Programme Delivery Manager, who recently won an *Apprentice Guide Award* for Apprentice Mentor of the Year. This award honours an individual who has provided exemplary mentorship and guidance to apprentices, contributing significantly to their development. Paoline was recognised for her involvement in the whole journey of the Trust’s apprentices, from recruitment process to orientation and induction, to the delivery of the program, and End Point Assessment completion.

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
July 2025

Highlight Report

1. Purpose and Introduction

1.1 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.

1.2 The Committee will meet on a quarterly basis in advance of the BiC. 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 risks and issues relating to this are being managed. The last meeting took place on 30 June 2025.

2. Key highlights

2.1 Chief Executive's Report

2.1.1 DSU Official Opening
The new Day Surgery Unit (DSU) is now officially open and operational. This marks a significant milestone in our surgical service transformation, expected to improve patient flow and elective care efficiency.

2.1.2 Winter Preparedness – Infection Control
Targeted infection prevention measures have been intensified in anticipation of increased seasonal pressures. Focus areas include enhanced cleaning protocols, staff vaccination drives, and infection, prevention and control (IPC) staff visibility across high-risk zones.

2.1.3 Proud Awards 2025
The annual Proud Awards were held with strong attendance and engagement. This event continues to serve as an important cultural cornerstone, recognising staff excellence and boosting morale.

2.1.4 Research, Innovation and Quality Improvement (RIQI) Event
An upcoming RIQI event is expected to catalyse a wave of system-wide transformation through knowledge exchange, best practice sharing, and cross-organisational collaboration.

2.1.5 Ambulatory Diagnostic Centre (ADC)
The ADC project team was commended for exemplary project management, delivering the unit within budget and timeline. This facility is pivotal to our outpatient diagnostic strategy.

2.1.6 Heart Failure Pilot

Initial outcomes from the Heart Failure Team Pilot are promising, demonstrating improved patient outcomes and reduced readmissions. Plans are underway to explore a phased regional rollout.

2.2 APC Governance

2.2.1 Group Governance Model Proposal

The Committee reviewed and approved in principle the proposed model, aiming to streamline executive functions and board operations across organisations. This will be further discussed at the Board in Common (BiC) July session. A board development session is planned to explore the proposals further, ahead of a report to the BiC in October.

2.3. Items for Assurance

2.3.1 Integrated Quality and Performance Report (IQPR)

- Emergency Department (ED) performance stood at 79.9% in May, showing improvement.
- Elective activity exceeded planned levels.
- Cancer pathways and RTT remain under target, with 18-week RTT performance at 59.8%.
- Diagnostic wait times continue to be pressured, particularly in endoscopy and echocardiography.
- Mental health service delays are of concern, highlighting the need for system-level reform.
- Focus remains on managing long waits and ensuring clinical prioritisation. A detailed review will be presented to the Finance and Performance Committee.

2.3.2 Quality Report

- The HSEEG report (Health, Safety and Environmental Risk Report) and associated governance structures were reviewed by the Quality Committee.
- The Quality Account highlights growing emphasis on patient feedback and data triangulation.
- Infection control performance remains strong.
- Active management of maternity service demand and ongoing legal inquest reviews are underway.
- Continuous improvement through the InPhase system is progressing.

2.3.3 Finance Report

- Month 2 reported a £2.4m deficit, £1.7m worse than plan, primarily due to cost improvement plan (CIP) underperformance.
- Capital spend to date is £5.7m.
- Elective performance exceeded plan targets, contributing positively to income generation.
- Concerns were raised over financial sustainability and the reliance on CIP delivery.
- The re-procurement of Sexual and Reproductive Health Services was approved, with the Chelsea and Westminster NHS FT (CWFT) designated as the lead provider.

2.3.4 People and Workforce

- PDR completion rates have declined, prompting a refocus on compliance and leadership engagement.
- Vacancy rates remain optimal; workforce strategy is aligned to financial plans.
- Ongoing challenges include:
    - Increased reports of violence and bullying.
    - Complex employee relations cases.
    - Engagement and retention issues.
- A Tri-Trust collaboration is being explored to optimise shared workforce services.

2.3.5 Audit and Risk Committee

- External Audit (Deloitte) findings were favourable: Eight - Green, One - Amber.
- Internal Audit raised moderate concerns in Estates compliance.
- Standing Financial Instructions (SFIs) reviewed without escalation.
- Annual Report and Accounts were endorsed, pending final submission.

2.3.6 Board Assurance Framework

- Framework updated to incorporate recent committee reviews and strategic risks.
- Workforce risks to be more clearly defined in the next iteration.
- Development of a standardised reporting format is ongoing.

2.4. Other Items for Noting

2.4.1 Annual Report and Accounts

- The update on these was noted, with some final amendments due, with an impact on the timeline due to delays on the auditor side.

2.4.2 Neonatal Intensive Care Unit (ICU) Inquest

- A high-profile inquest relating to a NICU case is ongoing.
- Non-Executive Directors (NEDs) will receive a detailed briefing post-resolution.

2.4.3 NED Training

- Discussion held on the relevance and scope of mandated NED training content. Further clarity on alignment with Board responsibilities will be provided.

3. Attendance

Members and attendees:	June attendance
Patricia Gallan, Vice Chair and Senior Independent Director (SID) - Chair	Y
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	N
Dr Syed Mohinuddin, Non-executive Director	N
Carolyn Downs, Non-executive Director	Y
Catherine Williamson, Non-executive Director	N

Members:	June attendance
Aman Dalvi, Non-executive Director	Y
Dame Helen Stephenson, Non-executive Director	Y
Lesley Watts CBE, Chief Executive Officer	Y
Roger Chinn, Chief Medical Officer	Y
Robert Bleasdale, Chief Nursing Officer	Y
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
Osian Powell, Director of Transformation	Y
Natasha Singh, Board Adviser, Equality Diversity and Inclusion (EDI)	N
Emer Delaney, Director of Communications	Y
Peter Jenkinson, Director of Corporate Governance	Y
Chris Chaney, Chief Executive Officer, CW+	Y
Faye McLoughlin, Corporate Governance Officer	Y
Peter Jenkinson, Director of Corporate Governance	Y
Alexia Pipe, Chief of Staff to NWL APC Chair in Common	Y

8. REPORTS FOR INFORMATION ONLY

None.

9. ANY OTHER BUSINESS

Information Item 11:40

Nil Advised.

10 QUESTIONS FROM MEMBERS OF THE PUBLIC

Discussion Item | Matthew Swindells | 11:45

11. DATE OF THE NEXT MEETING: 21 OCTOBER 2025