North West London Acute Provider Group

NWL APG BOARD IN COMMON - PUBLIC

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28 July 2026

11:15 GMT+1 Europe/London

AGENDA

0. AGENDA

REFERENCES

Only PDFs are attached

00.0 Agenda Board in Common July 2026 Public FINAL.pdf

NHS
North West London
Acute Provider Group

North West London Acute Provider Group
Board in Common - Public
Tuesday 28 July 2026, 11:15-14:00
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 Group website.

A G E N D A

Time	Item No.	Title of Agenda Item	Lead	Enc
11.15	1.0	Welcome and Apologies for Absence	Chair in Common Bob Alexander	Verbal
	1.1	Declarations of Interest	Bob Alexander	Verbal
	1.2	Minutes of the previous NWL Acute Provider Group Board Meeting held on 28 April 2026	Bob Alexander	1.2
	1.3	Matters Arising and Action Log	Bob Alexander	1.3
	1.4	Patient Story: Sickle Cell Pathway	Ralph Brown	Verbal
2. Report from the Chair in Common				
11.40	2.1	Report from the Chair in Common *To note the report*	Bob Alexander	2.1
3. Decision Making and Approvals				
	3.1	Mortuary Board Assurance Statements *To approve the Board Assurance Statements*	Janice Sigworth	3.1
4. Integrated Quality and Performance Report				
-	4.0	Integrated Quality, Workforce, Performance and Finance Report *To note the revised integrated performance report*		4.0
4.1 Quality				
11.50	4.1.1	Quality – Integrated Quality and Performance Report (anything by exception)	Janice Sigworth Roger Chinn	4.1.1
	4.1.2	National Maternity Reviews *To note the report*	Rob Bleasdale	4.1.2
	4.1.3	Learning from Deaths Quarter 4 Report	Roger Chinn	4.1.3

		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*		
	4.1.4	Seven Day Services Annual Report 2025/26 *To note the report*	Alan McGlennan	4.1.4
	4.1.5	Group Quality Committee Chair Report *To note the report*	Patricia Gallan	4.1.5
4.2 People				
12.25	4.2.1	People – Integrated Quality and Performance Report (anything by exception) *To receive the report*	Kevin Croft	4.2.1
	4.2.2	Group People Committee Chair Report *To note the report*	Sim Scavazza	4.2.2
4.3 Finance and Performance				
12.35	4.3.1	Finance and Performance – Integrated Quality and Performance Report (anything by exception) • Emergency • Elective • Cancer • Diagnostics	Lesley Watts	4.3.1
	4.3.2	Financial Performance Report *To receive the financial performance report*	Bimal Patel	4.3.2
	4.3.3	Group Finance and Performance Committee Chair Report *To note the report*	Bob Alexander	4.3.3
5. Data and Digital				
12.55	5.1	Group Data and Digital Committee Report *To note the report*	Bob Alexander	5.1
6. Estates and Sustainability				
13.00	6.1	Group Strategic Estates, Infrastructure and Sustainability Committee Report *To note the report*	Carolyn Downs	6.1
7. Strategy				
13.05	7.1	Group Strategy Committee Report *To note the report*	David Moss	7.1
8. Chief Executive Officers				
13.15	8.1	Report from the Group Chief Executive Officer	Tim Orchard	8.1

		To note the report and APG EMB Business		
	8.2	Reports from the Trust Standing Committees To note the reports • London North West University Healthcare NHS Trust • The Hillingdon Hospitals NHS Foundation Trust • Chelsea and Westminster Hospital NHS Foundation Trust • Imperial College Healthcare NHS Trust	David Moss Mark Titcomb Carolyn Downs Lesley Watts Patricia Gallan Julian Redhead Sim Scavazza	8.2
9. Any Other Business				
	9.1	Nil Advised		
10. Questions from Members of the Public				
13.40	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.	Bob Alexander	Verbal
Close of the Meeting – 14.00				
Date and Time of the Next Meeting				
20 October 2026, timing tbc 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

Standing item | Bob Alexander | 11.15

1.1 DECLARATIONS OF INTEREST

Standing item

Bob Alexander

1.2 MINUTES OF THE PREVIOUS NWL APG BOARD IN COMMON MEETING HELD ON 28 APRIL 2026

Decision Item Bob Alexander

REFERENCES

Only PDFs are attached

01.2 Draft BiC PUBLIC Mins 28 Apr 26 v1.pdf

North West London Acute Provider Collaborative Board in Common

Meeting in Public

Tuesday 28 April 2026, 11:00-13:30

The Oak Suite, W12 Conferences Centre, Hammersmith Hospital

Members Present

Mr Robert Alexander OBE	Interim Chair in Common
Ms Carolyn Downs CB	Vice Chair (THHFT) and Non-Executive Director (LNWH)
Mr David Moss	Vice Chair (LNWH) & Non-Executive Director (THHFT)
Ms Patricia Gallan	Vice Chair (CWFT) & Non-Executive Director (THHFT)
Ms Sim Scavazza	Vice Chair (ICHT) & Non-Executive Director (LNWH)
Ms Vineeta Manchanda	Non-Executive Director (CWFT & THHFT)
Dr Syed Mohinuddin	Non-Executive Director (LNWH & CWFT)
Mr Nick Gash	Non-Executive Director (ICHT & THHFT)
Mr Mike O'Donnell	Non-Executive Director (CWFT & THHFT)
Mr Loy Lobo	Non-Executive Director (LNWH & ICHT)
Ms Catherine Williamson	Non-Executive Director (ICHT & CWFT)
Mr Rupert Bondy	Non-Executive Director (THHFT & ICHT)
Ms Tanaka Chiimba	Non-Executive Director (THHFT & CWFT)
Professor Tim Orchard	Group Chief Executive Officer
Ms Pippa Nightingale MBE	Chief Executive Officer (LNWH)
Ms Lesley Watts CBE	Chief Executive Officer (CWFT & THHFT)
Professor Julian Redhead	Chief Executive Officer (ICHT)
Dr Roger Chinn	Chief Medical Officer (CWFT)
Dr Jon Baker	Chief Medical Officer (LNWH)
Mr Raymond Anakwe	Medical Director (ICHT)
Professor Janice Sigsworth	Chief Nursing Officer (ICHT)
Mr Bimal Patel	Chief Financial Officer (LNWH)
Mr James Walters	Chief Operating Officer (LNWH)

Members present via Teams

Mr Robert Bleasdale	Chief Nursing Officer (CWFT & THHFT)
Dr Alan McGlennan	Managing Director / Chief Medical Officer (THHFT)
Mr Simon Crawford	Deputy Chief Executive (LNWH)
Ms Virginia Massaro	Chief Financial Officer (CWFT & THHFT)
Ms Jazz Thind	Chief Financial Officer (ICHT)
Mr Jason Seez	Chief Infrastructure & Redevelopment Officer (THHFT & CWFT)
Mr Ian Bateman	Chief Operating Officer (ICHT)

In Attendance

Ms Tracey Connage	Chief People Officer (LNWH)
Mr Peter Jenkinson	Director of Corporate Affairs (ICHT, CWFT & THHFT)
Mr Bob Klaber	Director of Strategy, Research & Innovation (ICHT)
Ms Sue Grange	Director of OD, Health and Wellbeing (ICHT, CWFT, THHFT)
Ms Michelle Dixon	Director of Engagement and Experience (ICHT)
Ms Alexia Pipe	Chief of Staff to the Chair (APG)
Mrs Nikki Walcott	Head of Corporate Governance/Assistant Trust Secretary (LNWH)

Present via Teams

Ms Helen Hardy	Deputy Chief Nursing Officer (LNWH)
Mr Mark Titcomb	Managing Director (NWL EOC, CMH, EH & LNWH)
Mr Osian Powell	Executive Director of Transformation (CWFT)
Ms Emer Delaney	Director of Communications (CWFT)
Ms Laura Bewick	Managing Director (CWFT)
Ms Tracey Beck	Director of Communications (LNWH)

Apologies for Absence

Mr Martin Lupton	Non-Executive Director (LNWH & THHFT)
Ms Baljit Ubhey	Non-Executive Director (CWFT & LNWH)
Ms Lisa Knight	Chief Nursing Officer (LNWH)
Mr Kevin Croft	Chief People Officer (ICHT, CWFT & THHFT)
Mrs Dawn Clift	Director of Corporate Affairs (LNWH)

Minute Ref		Action
1.0	**Welcome and Apologies for Absence**	
1.0.1	Bob Alexander (BA) welcomed everyone to the inaugural meeting of the North West London Acute Provider Group (NWL APG) Board held in public.	
1.0.2	The Chair noted the apologies as above.	
1.1	**Acute Provider Group Annual Register of Interests**	
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 will be published on the Group website as a single point of access, rather than on individual Trust websites. Board members were reminded of their personal responsibility to keep declarations up to date.	
1.1.2	It was agreed that following recent changes in Board membership, a further verification exercise would be undertaken to ensure completeness and accuracy before publication on the website. **Action: PJ.**	**PJ**
1.1.3	**The Board in Common noted the register of interests.**	
1.2	**Minutes of the previous meeting**	
1.2.1	The minutes from the meeting held on 20 January 2026 were **approved** as an accurate record subject to corrections to the attendee list and board member titles.	
1.3	**Matters Arising and Action Log**	
1.3.1	The Board reviewed the action log, noting one outstanding action relating to the Clinical Pathways Programme. PJ confirmed that progress had been reported to the Group Quality Committee and the proposals for Phase 2 of the programme and future specialty boards will go through agreed governance routes. The methodology and approach will be returned to the Board for approval once developed.	
2.0	**Report from the Chair in Common**	
2.1	**Report from the Chair in Common**	
2.1.1	BA presented the report and welcomed the new non-executive directors: Tanaka Chiimba and Rupert Bondy. He thanked past-chair Matthew Swindells for his enormous contribution and leadership and also thanked Sarah Burton who has moved into a new role at Surrey and Sussex Healthcare NHS Trust. Congratulations	

2.1.2	were extended to Julian Redhead following his appointment to the Trust-level Chief Executive role for ICHT. BA expressed appreciation to all staff for maintaining services during recent industrial action and recognised the Group's strong performance in the individual Trust's national oversight assessments. **The Board in Common noted the report.**	
2.1.3		
3.0	**Strategy**	
3.1 3.1.1	**Developing our 2026/27 priorities** Tim Orchard (TO) provided an update on the progress with the NWL APG priorities for 2026/27. Consideration was given to what should be done once at Group level, the areas that should be standardised, and the areas that should remain local. This approach has enabled the identification of five priorities for 2026/27 and created a strong base to help co-design a longer term Group strategy. This work will be overseen by the Group Strategy Committee.	
3.1.2	Board members discussed the need for clear, measurable outcomes to define success by year end; alignment of priorities to the Board Assurance Framework, including ownership and accountability; the importance of partnership working, patient voice, and community engagement, and ensuring priorities were overseen through the appropriate committees. **Actions:** • **Develop clear, measurable outcomes and implementation plans for each priority.** • **Align priorities with the Board Assurance Framework, including identification of senior responsible owners.** • **Confirm committee oversight arrangements for each priority area.**	**TO** **TO/PJ** **TO**
3.1.3	The Board gave its support to the five strategic priorities in principle, subject to the development of measurable outcomes and delivery plans.	
3.1.4	**The Board in Common noted the report.**	
3.2 3.2.1	**Staff Story: Group Staff Commitment** Sue Grange (SG) presented the staff story about Carlsen Japsay (Clinical Nurse Specialist, CWFT) and his career progression. The story illustrates the impact of mentorship and access to development opportunities.	
3.2.2	The Board discussed the importance of measuring the impact of staff progression and the need for improved assurance through formal committee oversight. The Board also discussed the opportunities to strengthen academic and clinical career pathways beyond medicine, and to further align and scale initiatives across the Group. **Actions:** • **Strengthen Group-level assurance on staff progression and inclusion through the Group People Committee.** • **Explore opportunities to enhance academic pathways for non-medical professions across the Group**	**KC/TC**
3.2.3	**The Board in Common noted the staff story.**	
3.3 3.3.1	**APG Health Equity Update** Pippa Nightingale (PN) presented an update on the 2025/26 health equity priorities. A task and finish group was established to look at workforce and patient equity, and	

	four metrics were developed and tracked: Did Not Attend rates, waiting times, early maternity booking and sickle cell care. Analysis showed clear links between deprivation, ethnicity and outcomes and improvement work was underway, with metrics embedded into regular performance reporting.	
3.3.2	The Board noted that health equity considerations would be embedded within specialty boards and pathway redesign work, and biannual reporting on the improvement actions would continue through the year.	
3.3.3	**The Board in Common noted the report.**	
3.4 3.4.1	**Variation of the Scheme of Delegated Authority for THHFT** PJ presented a proposal to vary the Scheme of Delegation for THHFT to support timely decision-making for the new Hillingdon Hospital Redevelopment Programme. The Board noted that the variation related specifically to redevelopment activity and appropriate audit and assurance arrangements would remain in place; oversight will be delegated to the local Trust Standing and Audit Committees.	
3.4.2	**The THHFT Board approved the proposed variation to the Scheme of Delegation for THHFT, subject to the addition of an upper cap to the delegated limit for the THHFT Trust Standing Committee.**	
4.0	**Discussion Items**	
4.1 4.1.1	**APG Financial, Operational and Workforce Plans 2026/27** Bimal Patel (BP) presented the Group's financial, operational and workforce plans for 2026/27 to 2028/29, which received approval at the extraordinary Board in Common meeting and submitted to NHS England in February 2026.	
4.1.2	The Board noted that all Trusts plan to break even in 2026/27, and significant efficiency and workforce productivity requirements have been identified equating to £193m across the Group. The operational plan is ambitious but achievable, and delivery will be monitored through Trust Standing Committees, with exception reporting to the Board as required.	
4.1.3	**The Board in Common noted the plans and the associated risks.**	
5.0	**Integrated Quality and Performance Report**	
5.0.1	**Integrated Quality, Workforce, Performance and Finance Report** Lesley Watts (LW) introduced the IQPR, noting that its focus is on the Group's year-end performance position.	
5.1	**Quality**	
5.1.1	**Quality – Integrated Quality and Performance Report (anything by exception)** PN presented the quality section, noting that performance was strong, with no material areas of concern. Key positives include mortality rates, strong patient experience response rates, good compliance with VTE risk assessments and stillbirth rates. Areas of ongoing focus include maternity experience improvements and continued work on healthcare-acquired infections and infection control. **The Board in Common noted the updates and that no new quality risks requiring escalation were identified.**	
5.1.2	**Learning from Deaths Quarter 3 Report** Roger Chinn (RC) presented the Learning from Deaths report and noted that mortality indicators, including SHMI and HSMR, remained at or were better than	

	expected levels across the Group. Robust processes are in place, alongside strong assurance and learning systems. **The Board in Common noted the report.**	
5.1.3	**Group Quality Committee Chair Report** Patricia Gallan (PG) presented the summary report from the Group Quality Committee and noted the discussion around the Group level Quality priorities. **The Board in Common noted the report.**	
5.2	**People**	
5.2.1	**People – Integrated Quality and Performance Report (anything by exception)** PN presented the People section noting that workforce indicators were positive and improving. Vacancy and turnover rates were lower than expected and sickness absence rates were reducing. The Board noted data on the Model Employer Goals where improvement is evident but further work is required, particularly at more senior grades. **The Board in Common noted the update.**	
5.2.2	**Group People Committee Chair Report** The Board noted the summary report from the APG People Committee. Discussions were noted about the workforce risks associated with moving to a Group model. **The Board in Common noted the report.**	
5.3	**Finance and Performance**	
5.3.1	**Finance and Performance – Integrated Quality and Performance Report (anything by exception)** The Board noted the finance and performance section of the report.	
5.3.2	**Financial Performance Report** BP presented the finance report and noted that the Group achieved a break-even position with a small surplus for 2025/26, supported by national performance funding. It was noted that this reflects delivery of a very challenging financial plan. The Board recognised the Executives and their teams for the outstanding performance, especially in view of the targets that were set at the start of the financial year. James Walters (JW) presented the performance report noting that urgent and emergency care has seen a significant improvement with all trusts achieving above 78% by year-end. RTT performance ranged from 64 to 68% achievement, with all organisations meeting expected trajectories. Diagnostics performance is more variable across the Group, with known challenges being addressed. All Trusts achieved the faster diagnostic standard in cancer performance with more the 75% against the national perspective. The 62-day standard remains a challenge, but improvement is expected. The equity indicators are now incorporated into the report, helping guide more accessible and equitable service delivery. **The Board in Common noted the report.**	
5.3.3	**Group Finance and Performance Committee Chair Report** BA presented the summary report from the Group Finance and Performance Committee highlighting the work done to focus on the medium term and on the productivity potential of the Trusts within the Group.	

	The Board in Common noted the report.	
6.	**Data and Digital**	
6.1 6.1.1 6.1.2	**Group Digital and Data Committee Report** Nick Gash (NG) presented the Group Digital and Data Committee report, noting that there is not yet sufficient collective understanding at Board level of digital opportunities and capabilities. It was proposed that a future Board development session should be arranged with a focus on digital and data. **Action: PJ.** **The Board in Common noted the report.**	**PJ**
7.	**Estates and Sustainability**	
7.1 7.1.1	**Group Strategic Estates, Infrastructure and Sustainability Committee Report** The Board noted the Group Strategic Estates, Infrastructure and Sustainability Committee report.	
8.	**Chief Executive Officers**	
8.1 8.1.1 8.1.2	**Report from the Group Chief Executive Officer** TO presented his report, noting that infection prevention and control has been identified as a key priority across all four trusts. A group-wide approach is being developed, drawing on national guidance and a structured improvement plan is being produced to ensure consistency of practice and shared learning. **The Board in Common noted the report.**	
8.2 8.2.1 8.2.2	**Reports from the Trust Standing Committees** **<u>London North West University Healthcare NHS Trust (LNWH)</u>** PN reported that the Trust reported a highly positive end to the year, achieving 'most improved trust in London' and seventh nationally, reflecting strong collective effort across the organisation. Performance targets were exceeded, with 84.2% of patients seen within four hours in ED (against an 80% target) and RTT performance reaching 64.2% (above the 60% target). There was also recognition of staff achievements and organisational culture, including additional funding for the commercial research centre, and national recognition for Idris Mohamed, who won Porter of the Year 2026. David Moss (DM) highlighted discussions on how the Group can better address violence and aggression towards staff. TO confirmed that a sub-group of the Board is being formed to take this forward. **<u>The Hillingdon Hospitals NHS Foundation Trust (THHFT)</u>** LW highlighted that the Trust has demonstrated outstanding performance in urgent and emergency care, consistently leading on ambulance handover times despite challenging conditions. Financially, achieving a breakeven position is particularly notable, reflecting effective resource management. While performance has improved and confidence is growing, further work is needed on cultural change, particularly in relation to staff experience. Staff survey results have improved, but this remains a key development area. Carolyn Downs (CD) congratulated LW and the Executive team for a significant organisational turnaround. Positive progress was also noted in the new hospital programme, which is advancing well. An additional report on the incinerator facility	

	project was highlighted, which has led to strengthened governance, reporting processes, and organisational learning.	
8.2.3	**Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)** LW highlighted a successful clinician-led initiative to reduce unnecessary pathology testing for patients ready for discharge, resulting in significant cost savings and strong clinical engagement. Recognition was given to the mortuary team for achieving gold accreditation, a highly challenging standard, with praise for their professionalism and compassionate care. Wider organisational strengths were noted in performance, research and innovation, and equality and diversity.	
8.2.4	**Imperial College Healthcare NHS Trust (ICHT)** Julian Redhead (JR) outlined three immediate organisational priorities: improving patient flow, outpatient transformation, and strengthening infection control. A significant achievement highlighted was the significant reduction in 52-week waits, falling from a projected 2,511 to just 96 by year-end, with further reductions since, representing a substantial improvement in access to care. Key challenges remain, particularly relating to ongoing estates issues, which continue to require mitigation. SS highlighted the significant senior staff changes, with an emphasis on maintaining organisational performance during this period of transition. Despite pressures, staff survey results show continued improvement.	
9.	**Reports for Information Only**	
9.1 9.1.1	**Use of the Trust Seal** The Board noted the annual report detailing the use of the Trust Seal across the four Trusts in the Acute Provider Group for FY 2025/26, in accordance with standing orders.	
10.	**Any Other Business**	
10.1	No other business noted.	
11.	**Questions from Members of the Public**	
11.1	**Question Summary** **Question from Armelle Thomas:** Armelle Thomas emphasised the importance of listening to patients and working more collaboratively with partners. Drawing on personal experience of end-of-life care, she highlighted concerns about limited patient choice within NHS care, particularly regarding access to alternative or complementary therapies. She urged the APG and wider system to take patient choice more seriously and to better recognise different care preferences. **Response from LW:** The Board expressed sympathy and concern for the Armelle Thomas' situation. It was confirmed that the matter would be followed up outside the meeting, with further discussion involving the ICB and a direct conversation regarding her care and treatment.	
	The Chair drew the meeting to a close and thanked the Board in Common and members of public for joining.	

1.3 MATTERS ARISING AND ACTION LOG

Discussion Item Bob Alexander

REFERENCES

Only PDFs are attached

01.3 BiC - Action Log Public updated 22.7.26.pdf

North West London Acute Provider Collaborative

Board in Common (public) Action Log

Matters Arising and Action Log

Status: For noting

Last Meeting Date: 28 April 2026

Lead Responsibility and Paper Author: Bob Alexander, Chair

Purpose

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

Part 1: Actions from Previous Meetings Remaining Open

	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
1.1.2 (28/04/26)	Acute Provider Group Annual Register of Interests	A further verification exercise to be undertaken to ensure completeness and accuracy before publication of the register on the website.	Peter Jenkinson	Action complete.	April 2026
3.1.2 (28/04/26)	Developing our 2026/27 priorities	Develop clear, measurable outcomes and implementation plans for each priority. Align priorities with the Board Assurance Framework, including identification of senior responsible owners.	Tim Orchard	PIDs developed for each priority programme and executive routines agreed to oversee delivery.	Complete October 2026

	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
		Confirm committee oversight arrangements for each priority area	Tim Orchard/ Peter Jenkinson Tim Orchard	Ongoing work to develop the Trust-level and Group-level BAF, which will include SROs and assurance mechanisms. Each priority is mapped to Group or Trust-level committee, or Board in Common.	Complete
3.2.2 (28/04/26)	Staff Story: Group Staff Commitment	Strengthen Group-level assurance on staff progression and inclusion through the Group People Committee. Explore opportunities to enhance academic pathways for non-medical professions across the Group.	Kevin Croft/ Tracey Connage	People Committee reviewed the current Group project on career progression, which is underway, as well as the actions to improve diversity of leadership. This would be reviewed again in October as part of a deep dive into the annual equality report and proposals for going further faster on equity and inclusion. An initial meeting on Nursing, Midwifery, AHPs and Pharmacy academic careers has been undertaken with Imperial College, initially with the barriers to staff	October 2026

	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
				developing an academic career as well as what can be included in the imminent British Research Council bid in this area. This will then provide a foundation for a wider Group discussion.	
6.1.1 (28/04/26)	Group Digital and Data Committee Report	Future Board development session to be arranged with a focus on digital and data.	Peter Jenkinson	Board development session in May included a focus on digital and data.	Complete

Part 2: Actions previously outstanding but now completed

	Subject Matter	Action	Lead	Progress Updates, Notes	Date of Completion
4.1.3.4 (15/07/25)	Clinical Pathways Programme Update	To present the terms of reference for Phase 2 of the Clinical Pathways Programme to the Board in Common meeting in October 2025 for approval.	Peter Jenkinson	The methodology for Phase 2 of the clinical pathways programme was approved by the APC(G) EMB in March, building on Phase 1 learning to enable larger-scale change while maintaining collaborative working.	May 2026

	Subject Matter	Action	Lead	Progress Updates, Notes	Date of Completion
				A shortlist of pathways has been developed with senior clinical and operational leaders, covering new, cross-cutting, existing and externally led programmes. This phase of the programme will be absorbed into the proposals for the establishment of cross-trust specialty boards, which are being developed and will be agreed by APG EMB.	

1.4 PATIENT STORY: SICKLE CELL PATHWAY

Ralph Brown

2. REPORT FROM THE CHAIR IN COMMON

2.1 REPORT FROM THE CHAIR IN COMMON

Discussion Item | Bob Alexander | 11:40

REFERENCES

Only PDFs are attached

02.1 Chairs Report to the Board in Common 28 July 2026 final.pdf

NWL Acute Provider Group Board in Common (Public)
28/07/2026
Item number: 2.1
This report is: Public

NWL Acute Group Chairs Report

Author: Bob Alexander
Job title: Interim Chair in Common

Accountable director: Bob Alexander
Job title: Interim 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

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

Executive summary and key messages

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

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

The Acute Provider Group (APG)

The formal establishment of the North West London Acute Provider Group continues to progress at pace. Since our last Board meeting, further Group leadership arrangements have been confirmed (as set out in the Group Chief Executive Report), providing greater clarity on the operating model and strengthening the foundations for collective leadership across the four Trusts. The Board will continue to oversee the implementation of these arrangements whilst ensuring that each Trust retains a strong local identity and focus on the needs of its communities.

Pippa Nightingale, Chief Executive at London North West University Healthcare is leaving after four years to take up a new role as Chief Executive of Bedfordshire Hospitals NHS Foundation Trust later this summer. Pippa has driven many improvements across the Trust, including LNWH being ranked the most improved Trust in London and the seventh most improved across the country in 2025/26 NHS England league tables. On behalf of the Board, I want to thank Pippa for the major contribution she has made to LNWH and the wider APG.

I am delighted that Mark Titcomb has been appointed interim Chief Executive of LNWH, he will start in post when Pippa leaves for her new role. Mark is currently the Managing Director of Ealing and Central Middlesex hospitals and the North West London Elective Orthopaedic Centre (EOC).

National Oversight Framework (NOF) – North West London Acutes

The National Oversight Framework (NOF) looks at how NHS organisations are performing across areas such as finances, waiting times and staff experience. The 2025/26 quarter 4 NOF results demonstrate the continued strong performance of the North West London Acute Provider Group (NWL APG). All four Trusts in the APG are now in the top tier.

It is fantastic the organisations have maintained and improved throughout last year. The Hillingdon Hospitals NHS Foundation Trust moved from segment 4 to 1 over the course of 2025/26, which is testimony to the hard work of staff across the Trust.

King's Birthday Honours

I would like to record the Board's congratulations to Professor Tim Orchard on receiving a CBE (Commander of the Order of the British Empire) in the 2026 King's Birthday Honours "for services to the NHS, healthcare research and innovation". This award recognises Tim’s longstanding contribution to the NHS and his leadership within North West London. It is a fitting acknowledgement of his commitment to improving services for patients and supporting collaboration across organisations.

His recognition reflects positively on ICHT and the wider APG and the outstanding work undertaken by colleagues across our organisations.

BMA resident doctors’ accept Government pay and jobs offer

The British Medical Association (BMA) earlier this month announced that resident doctors in England have voted to accept the Government's latest offer on pay and jobs. No further strike action is planned.

The recent agreement reached through these discussions is a positive development and is

welcomed as an important step towards greater workforce stability across the NHS. Thanks to our staff whose continued priority remained the delivery of safe, high-quality care whilst supporting constructive dialogue and long-term workforce sustainability.

The BMA earlier this month announced Consultants had voted in favour of a strike action mandate. The mandate is in place for the next twelve months. No strike action has been announced. The Trusts will review our planning approach to ensure patient safety is maintained if consultant colleagues choose to take strike action.

Annual Members Meetings/Annual General Meetings

All four Trusts this month held their AMMs/AGMs, they provide a valuable opportunity to engage with members, patients, staff and the wider public on the performance and priorities of our Trusts. At each of the events we welcomed patients, carers, families, the public and staff to the event to hear about our work and performance in 2025/26 and our plans for the future.

The feedback and questions raised reflected a strong interest in service quality, access to care, workforce wellbeing and future plans, and will help inform our ongoing discussions and priorities as we continue to develop services across North West London.

3. DECISION MAKING AND APPROVALS

3.1 MORTUARY BOARD ASSURANCE STATEMENTS

Decision Item Janice Sigworth

REFERENCES

Only PDFs are attached

03.1a APG Mortuary Board assurance report - final BiC july 2026.pdf

03.1b PRN02500 System letter on mortuary oversight 26 June 2026.pdf

NWL Acute Provider Group Board in Common (Public)
28/07/2026
Item number: 3.1
This report is: Public

Mortuary Board Assurance Statement Review

Author: Robert Bleasdale
Job title: Chief Nursing Officer – Chelsea and Westminster Hospital NHS FT and The Hillingdon Hospitals NHS FT

Accountable director: Robert Bleasdale , Lisa Knight and Janice Sigsworth
Job title: Chief Nurse CWFT and THH, Chief Nurse LNWUH, Chief Nurse ICHT

Purpose of report (for decision, discussion or noting)

Purpose: Assurance

Report history

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

APG Executive Management Board 20/07/2026 What was the outcome?	Committee name Click or tap to enter a date. What was the outcome?	Committee name Click or tap to enter a date. What was the outcome?

Executive summary and key messages

The NHS England letter issued on 26 June 2026 requires all provider organisations that operate mortuaries, body storage areas or routinely care for deceased patients to undertake a comprehensive review of local arrangements and provide formal Board assurance by 31 July 2026.

The requirement follows publication of the David Fuller Inquiry Phase 2 report together with concerns identified in relation to post-death care during the Nottingham University Hospitals maternity review. NHS England has emphasised that board assurance must extend beyond compliance and should include consideration of culture, leadership, governance, safeguarding, security and dignity following death.

All four Trusts have completed an assessment of their position against the Board Assurance Statement and have confirmed compliance with action plans in place to meet the deadlines for

delivery. This and the assessment against the phase 2 Fuller report recommendations, have been through their internal governance and discussed with the individual Quality NED. This report provides the assurance position for all 4 Trusts in the Acute Provider Group and current compliance against the actions from phase 2 of the Fuller report. Where Trusts are partially compliant against recommendations, clear actions are in place with owners and executive oversight to achieve compliance in line with expectations.

Each Trust has clear governance processes in place for the management and oversight of the mortuary, reporting to executive and board level committees. The safeguarding responsibilities have been reviewed and strengthened inline with the Safeguarding Assurance Framework, with the Chief Nurse holding the responsibility for Safeguarding and the Mortuaries, with updated policies for reporting including safeguarding arrangements.

Individual Trusts are completing the Premises Assurance Model, and will report individual Trust positions to Standing Committees in September, and will ensure submission within the required timescale.

The Board is asked to approve the aligned Board Assurance Statement for each Trust.

Impact assessment

Tick all that apply

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

[Describe the impact HERE.]

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)

Main Report

1. Background

The independent public inquiry into the crimes committed by David Fuller was established following his conviction in 2021 for the murder of two young women and the subsequent discovery that he had abused the bodies of at least 101 deceased women and girls whilst employed within the mortuaries of Maidstone and Tunbridge Wells NHS Trust. The inquiry examined how these offences were able to occur over a prolonged period, why they remained undetected and what actions were required nationally to strengthen the protection, dignity and security of deceased persons.

Following the publication of the Phase 1 Fuller Inquiry recommendations in 2025, all Trusts completed a review of local mortuary arrangements, security controls, staffing, training, governance and performance indicators.

In July 2025, Phase 2 of the Fuller Inquiry led by Sir Jonathan Michael was published. Unlike Phase 1, which focused on the circumstances within Maidstone and Tunbridge Wells NHS Trust, Phase 2 considered the wider national arrangements governing care of the deceased across healthcare settings. The inquiry conducted an extensive review of NHS and independent hospitals, medical schools, hospices, ambulance services, mortuaries, care homes, the funeral sector, and faith-based organisations. The key findings highlighted National safeguards are insufficient, which leaves gaps in regulation and oversight and increased risks.

The inquiry recommends treating protection of the deceased as a core safeguarding duty, establishing consistent national regulation, strengthening leadership and accountability, and improving security across all relevant organisations.

The report made 75 recommendations, with 29 recommendations identified as immediately relevant to the NHS. These recommendations focus upon security, access controls, CCTV, governance, safeguarding, leadership accountability and board oversight arrangements.

All Trusts have completed a review against these recommendations and developed associated plans for full compliance.

The importance of this work was further reinforced by findings arising from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust, which identified serious concerns regarding aspects of post-death care.

In response, NHS England issued a national letter on 26 June 2026 (appendix 1) requiring Boards to undertake a comprehensive review of local mortuary arrangements and provide formal assurance regarding compliance with national expectations by 31st July 2026.

This report presents the outcome of the individual Trust's review against the Fuller Inquiry recommendations relevant to NHS acute hospitals and seeks approval of Board Assurance Statement to NHS England

2. Review of HTA reportable incidents and licensing requirements

Additionally, Trusts must review all incidents between 2015-2026 to ensure that that any incident that meets the criteria for a Human Tissue Authority (HTA) reportable incident, is reported. This must be completed by the 18th September, alongside any outstanding actions associated with the Fuller inquiry.

The HTA issued a regulatory update on the 7th July 2026 (number 004/2026). It states that following a recent Post Mortem sector inspection which identified critical failures in the reporting of HTA reportable incidents (HTARIs) at Nottingham University Hospitals NHS Trust (HTA Licence number 12258), the HTA will be conducting a sector-wide Evidential Compliance Assessment (ECA).

This follows the regulatory update published on 27 April (002/2026) confirming the HTA position on retrospective reporting of incidents relevant to all licensed establishments operating within the Post Mortem sector.

As part of a sector-wide ECA, all licensed Post Mortem establishments must complete a mandatory declaration.

The declaration will be issued on 10 August 2026 and must be completed by 18 September 2026.

The declaration will require Designated Individuals (DIs) to review incident records covering the period 1 April 2015 to 30 June 2026 and confirm in writing whether all HTARIs have been reported to the HTA. Any previously unreported incidents, including near-miss incidents, must be declared and subsequently reported through the HTA portal.

Chelsea and Westminster Hospitals NHS FT and Imperial College Healthcare NHS Trust hold valid HTA licences for the sites where mortuaries are located. The Hillingdon Hospital NHS FT hold a licence for The Hillingdon Hospital only. Whilst Mount Vernon has a mortuary which reports under the governance of The Hillingdon and follows the same principles, it does not require a licence due to the time the deceased patients spend there. London North West University Healthcare NHS Trust, has also had confirmation from the HTA that they do not require a licence, due to any deceased patient needing to be cared for longer than 7 days, is transferred to a collocated public mortuary which holds the licence.

Providers will undertake the required process as stipulated by the HTA, and report through individual executive management boards and standing committees prior to the submission date.

3. Review against Fuller Inquiry recommendations

All providers have completed a self-assessment against the recommendations of the phase 2 Fuller inquiry as part of the Board Assurance process. The assessment and associated action plans have been presented through internal governance systems and discussed with provider Quality link Non-Executive Directors.

- **Chelsea and Westminster Hospital NHS FT**

The Trust are fully compliant with all but one recommendation, where they have assessed themselves as partial compliance. This relates to recommendation 69: "The parties to the contracts or service level agreements should ensure that the contracts or agreements are managed effectively."

The outstanding action relates to arrangements with the Trust's Contracted Site Funeral Directors. Considerable work has been undertaken to establish the contractual position, which confirmed that CWFT does not hold formal contracts with the current providers. Consequently, preparations commenced in early 2025 to undertake a formal procurement and tender process to ensure future arrangements align with the Fuller recommendations and good governance requirements. The Trust is working with NWL Procurement to complete this process by September 2026.

In the meantime, operational oversight and performance monitoring arrangements remain in place, providing assurance that services continue to be delivered safely and effectively while the procurement process is completed.

- **The Hillingdon Hospital NHS FT**

The Trust has assessed themselves as partially compliant with two recommendations, and compliant with all other relevant standards. The two recommendations that are partial complaint are:

Recommendation one: ‘All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur.
The review should include an assessment of:

- The systems in place to identify any unauthorised access to the facility;
- The strength and effectiveness of barriers to prevent unauthorised access to the facilities;
- The systems in place to identify any access to deceased people for unauthorised purposes; and
- How CCTV is used, including its monitoring and any audits undertaken.

Current governance and security review processes are managed through HTA governance, regular security audits, CCTV monitoring and risk assessments, reporting through the division and as part of the mortuary reporting process, with mortuary access is controlled through Security.

In line with the action for recommendation four, a full review of staff access will be completed again for both sites, including support staff such as cleaning staff and estates and facilities. An access control policy will be developed which will also cover clinical site practitioners and NHSBT staff. Staff on the approved list will be mapped to the educational framework for care of the deceased. This will be completed by September 2026.

Recommendation Four: 'The practice of using shared electronic swipe cards for specific staff groups should cease immediately.'

Currently individual swipe card access is issued only to Mortuary and Security staff. Porters do not have individual swipe cards; instead, a single swipe card is attached to an authorised room key. Access is granted when the key and associated swipe card are signed out through Security. Security holds an up-to-date list of authorised mortuary staff, which is regularly reviewed and updated when staffing changes occur.

The Trust is reviewing its processes to establish individual access swipe cards for all staff on the approved list to allow more specific monitoring of the activity within the mortuary. This will be completed by 31 August 2026

- **London North West University Healthcare NHS Trust**

The Trust has assessed themselves as partially compliant with three recommendations, and compliant with all other relevant standards. The three recommendations that are partial complaint are:

Recommendation five: All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons.

The Trust is reviewing the pathway for deceased from all areas to the mortuary, and opportunities to strengthen expectations and safeguards outside the mortuary space.

Recommendation eleven: NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.

The Trust has a clear governance and reporting structure in place to the executive management board. Training requirements for the on call and senior team are being reviewed to ensure they are up to date.

Recommendation fourteen: NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.

A review of the staffing has been completed, and a business case is being developed for additional support. In the interim temporary staffing is being provided. In addition, a review of the equipment provision is taking place.

- **Imperial College Healthcare NHS Trust**

The Trust has assessed themselves as partially compliant in 10 recommendations with a detailed action plan that will provide evidence and so assurance of delivery by 18th September 2026. This plan is being monitored through the weekly executive meeting.

Recommendation One, Two, Three and Eight: all relate to security within the Mortuary setting, whilst the Trust has CCTV and systems in place as part of this assessment, a security expert review will be untaken to provide ongoing assurance.

Recommendation Five: All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons.

The rule is in place with clear signage, this is being updated and a refined SOP has been produced and is going through the Trust Ratification Process.

Recommendation Six: All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.

Whilst the Trust is assured appropriate measures are in place, full compliance cannot be declared until all legacy cases (since 2015) have been reviewed against HTARI standards. This is underway with approximately 1200 incidents to review.

Recommendation Seven: The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority.

Whilst the Trust has an SLA with an external provider to provide full assurance the process is being reviewed.

Recommendation Nine: All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.

Whilst the Trust has processes in place to assure full compliance the SOP is being updated, and security are now providing the DI with access lists monthly.

Recommendation Ten and Fourteen: Both these recommendations relate to the senior leadership in the Mortuary. Currently the DI role and Mortuary role is undertaken by the same individual.

The recruitment for the DI has closed and the interviews are set for the 29th July 2026, this action will be closed on the confirmation of the start date for the new DI.

4. Review of responsibilities

The Board assurance statement requests that the roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.

All four Trusts have completed this review and have clear governance arrangements in place for the operational oversight and reporting of mortuary services.

The Board can assure itself that the roles, responsibilities and accountabilities of teams involved in the care of deceased people are clearly defined through established governance arrangements, policies, standard operating procedures and designated leadership responsibilities. These arrangements include mortuary services, pathology, safeguarding, estates and facilities, patient affairs/bereavement services and corporate governance functions, with clear routes for escalation and executive oversight.

These arrangements are routinely tested through regulatory inspections, internal audits, Mortuary meetings, End of Life Care governance processes, HTA compliance reviews and routine reporting to EMBQ, EMB and the Board. Where opportunities for further clarification or strengthening of responsibilities have been identified, including through the Fuller Inquiry, Ockenden Review and HTA action plans, these have been incorporated into individual Trust plans, with clear ownership, timescales and oversight arrangements.

5. Review of Safeguarding responsibilities

Safeguarding responsibilities, as set out in the NHS England SAAF 2026, explicitly extend to deceased individuals. In response to national learning from the David Fuller Inquiry, the Trust's have strengthened mortuary governance under the executive safeguarding portfolio, through

the Chief Nurse. This ensures robust oversight of security, access, audit, incident reporting and partnership working with key statutory partner agencies, including coronial and police services.

Mortuary risks are monitored through safeguarding governance structures in addition to separate reporting to the EMB, providing assurance that the dignity, safety and protection of deceased people remain integral to our safeguarding responsibilities.

6. Assurance of mortuary oversight and storage areas

The Board can assure itself that appropriate governance arrangements are in place to oversee mortuary services, body storage facilities and the care of deceased people. All providers have established governance structures in place for the regular reporting to the Executive Management Board and Safeguarding functions. This reporting includes the actions associated with any improvement plan to address requirements arising from the HTA, Fuller Inquiry, Ockenden Report, NHS Safeguarding Accountability and Assurance Framework and NHS Premises Assurance Model, with clear executive accountability, named leads, defined timescales and routine reporting EMB.

7. Premises Assurance Model (PAM)

Individual Trust estates teams are in the process of completing the annual PAM assessment. Individual Trust boards will review and approve the self-assessment against the latest version of the NHS Premises Assurance Model via the Trust Standing Committees. This will then be submitted by the 8 September 2026 deadline.

A summary of the submissions at Group level will then be reviewed at the Group Executive Management Board and Group Estates and Sustainability Committee.

7. Recommendation

Each Trust has completed an assessment against the assurance statements as detailed in the NHS England letter in Appendix one, which has been approved through Trust executive arrangements and discussed with Quality NEDs.

Where actions remain outstanding, Trusts have detailed plans in place to complete these and monitor within the existing governance arrangements ahead of the September requirement, with a summary position for the Premises Assurance Model being presented to Trust Standing Committees in September.

The Board is asked to approve the signing and submission of the Board Assurance Statement for each Trust. Table one provides a summary position based on the assurances from each Trust.

Assurance Statement	Confirmed (Yes/No)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	The Board can assure itself that the roles, responsibilities and accountabilities of teams involved in the care of deceased people are clearly defined through established governance arrangements, policies, standard operating procedures and designated leadership responsibilities. These arrangements include mortuary services, pathology, safeguarding, estates and facilities, patient affairs/bereavement services and corporate governance functions, with clear routes for escalation and executive oversight. The Board is assured that these arrangements are routinely tested through regulatory inspections, internal audits, Mortuary meetings, End of Life Care governance processes, HTA compliance reviews (where appropriate) and routine reporting to Executive level committees and the Board. Where opportunities for further clarification or strengthening of responsibilities have been identified, including through the Fuller Inquiry, Ockenden Review and HTA action plans, these have been incorporated into individual Trust improvement plans with clear ownership, timescales and oversight arrangements. The Board is assured that responsibilities across the relevant services are understood and subject to ongoing

		review, testing and assurance, with actions in place to address any areas requiring further development.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	The Board has undertaken a review of progress against the recommendations relevant to NHS organisations arising from the Fuller Inquiry and is assured that where required an improvement programme is in place. The Board recognises that while a significant number of recommendations are already assessed as providing full assurance, a number remain partially complete or in progress. Where full compliance has not yet been achieved, time-limited action plans are in place with identified owners, target completion dates and routine oversight through executive reporting arrangements.
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	The Board is assured that, in line with the April 2026 updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership arrangements have been reviewed and now explicitly include oversight of arrangements for safeguarding the security and dignity of people after they die. It confirms that the Chief Nursing Officer holds executive leadership for safeguarding and mortuary arrangements; that safeguarding policy now recognises deceased patients as being afforded the same rights to safeguarding and dignity as those who are living; and that any safeguarding concerns arising within the mortuary setting must be reported through incident reporting and escalated to the appropriate safeguarding team. Ongoing assurance is provided through mortuary reporting executive and board level meetings, with

		continued oversight of policy, training, incidents, HTA-related actions, security arrangements and delivery of any improvements.
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	The Board can assure itself that appropriate governance arrangements are in place to oversee mortuary services, body storage facilities and the care of deceased people. Improvement plans are in place to address requirements arising from the HTA, Fuller Inquiry, Ockenden Report, NHS Safeguarding Accountability and Assurance Framework and NHS Premises Assurance Model, with clear executive accountability, named leads, defined timescales and routine reporting to executive committees and the Board. The Board recognises that a small number of actions remain in progress. These have been identified through inspection and assurance processes and are being managed through a formal programme of work with defined milestones, executive oversight and regular monitoring. The Board is therefore assured that effective arrangements are in place and that any remaining gaps have been identified, risk assessed and are being addressed as a matter of priority.
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	Our Trust Board will review and approve our self-assessment against the latest version of the NHS Premises Assurance Model via our Trust Standing Committees. This will then be submitted by the 8 September 2026 deadline. A summary of the submissions at Group level will then be reviewed at the Group Executive Management

		Board and Group Estates and Sustainability Committee.

Trust Name	Trust CEO/AO Name	Date	Trust Chair Name	Date

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2026

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (NUH), are shocking. We must

remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, published in July 2025. The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Sarah-Jane Marsh
NHS England Chief Operating Officer

Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. NHS Premises Assurance Model (PAM) (15 April 2026)

The NHS Premises Assurance Model (PAM) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. Insightful provider board guide (November 2024)

Trusts are reminded that the insightful provider board guide is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the Code of governance for NHS provider trusts (March 2026) and Guidance on good governance and collaboration (April 2023).

For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. **Assessing provider capability: guidance for NHS Trust Boards** (August 2025)

Assessing provider capability: guidance for NHS trust boards provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

5. **Advanced Foundation Trust Programme** (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the Advanced Foundation Trust Programme requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

6. **NHS Safeguarding accountability and assurance framework** (April 2026)

The NHS Safeguarding Accountability and Assurance Framework (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about

safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) Codes of Practice provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published good practice guidance for those responsible for the dignity and care of the deceased. This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

Hospice UK have several resources to support clinical and non-clinical staff in a hospice role. Their Care After Death guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit)
The full text of these recommendations can be found in the Phase 2 Report (pp.264-265).
Supporting guidance
NHS Premises Assurance Model (see entry 1 in Annex 1).
Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (see entry 2 in Annex 1).
Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)
The full text of these recommendations can be found in the Phase 2 Report (p.265).
Supporting guidance
Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
The Insightful provider board guide (see entry 3 in Annex 1).
Assessing provider capability: guidance for NHS trust boards and third-party information (see entry 4 in Annex 1).
Advanced Foundation Trust Programme (see entry 5 in Annex 1).

Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the Phase 2 Report (pp.266-267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings)

The full text of these recommendations can be found in the Phase 2 Report (pp.267-268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the Phase 2 Report (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings: Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the Phase 2 Report (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.

In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations.

Annex 3 – **Board Assurance Statement for NHS Provider Trusts.** Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.		
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.		
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.		

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency. For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.		

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date

4. INTEGRATED QUALITY. WORKFORCE, PERFORMANCE AND FINANCE REPORT

REFERENCES

Only PDFs are attached

4. BIC Performance Report - May 2026.pdf

NHS
North West London
Acute Provider Collaborative

Integrated Performance Report

May 2026

(Cancer and Maternity April 2026)

received by EMB July 2026

Performance Summary

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

Link to Slide	Section | KPI	Expected	Actual	Improvement Trend	Assurance
	Section 1a: Performance - Elective Care				
	Referral to treatment waits < 18 weeks	≥65%	66.7%	▲	✓
	Referral to treatment waits > 52 weeks	</=1%	0.7%	▲	✓
	Inequity in Longest Waits for Treatment	95-105	110	○	○
	Access to diagnostics > 6 Weeks	</=5%	19.5%	○	!
	Access to Cancer Care (Faster Diagnosis) < 28 days	≥80%	79.3%	○	✓
	Decision to Cancer Treatment < 31 days	≥96%	96.5%	▲	✓
	Referral to Cancer Treatment Pathways < 62 days	≥85%	79.2%	▲	!
	Section 1b: Performance - Emergency Care				
	Waits in urgent and emergency care < 4 hours	≥80%	78.0%	○	!
	Waits in urgent and emergency care > 12 hours	</=2.0%	4.6%	▼	!
	Good experience reported for emergency depts.	≥74%	77.7%	▼	✓
	ED Patients with Mental Health conditions > 12 hours	<24%	30.4%	○	!
	Section 1c: Performance - Maternity and Neonatal Care				
	Neonatal Crude Deaths (per 1,000 births)	<0.94	2.5	○	○
	Crude still birth rate (per 1,000 births)	<3.3	1.5	○	○
	Pre-Term births (per 1,000 births)	<8	7.9	○	○
	Rate of suspected neonatal intrapartum brain injuries	<1.8	0.99	○	○
	Inequalities in Late Maternity Bookings	<4%	6.1%	○	○
	Good experience reported for maternity services	≥90%	89.6%	○	○
	Section 2a: Finance				
	Financial Performance	-£11.7M	£-19.5M	○	○
	Temporary Staffing Expenditure	<£16.9M	£23.5M	○	○
	Implied Productivity Growth	2.7%	2.6%	○	○

Link to Slide	Section | KPI	Expected	Actual	Improvement Trend	Assurance
	Section 2b: Productivity and Flow				
	Ambulance handover waits < 15 minutes	≥65%	45.6%	○	!
	Emergency Readmission Rate	TBC	TBC	○	○
	Inequity in DNA Rates	95-105	142	○	○
	Patient Initiated Follow Up	≥5%	4.1 %	○	!
	Theatre Utilisation (Hrs)	≥85%	87.3%	▲	○
	Long Length of Stay for Emergency Patients	<78.4%	78.8%	○	○
	Discharge Performance (no Criteria to Reside)	n/a	14.8%	○	○
	Section 3: Workforce				
	Sickness Absence Rate	≤4%	4.7%	▼	!
	Voluntary Turnover Rate	≤12%	7.4%	▲	✓
	Vacancy Rate	≤10%	8.4%	▼	✓
	Non-medical appraisals	≥95%		○	○
	Core skills compliance	≥90%	92.0%	○	✓
	Model Employer Goals	≥61%	42.4%	○	!
	Section 4: Statutory and Safety Reports				
	Healthcare associated c. Diff Infections (per 100,000 bed days)	n/a	15.8	○	○
	Healthcare associated E. coli BSIs (per 100,000 bed days)	n/a	52.3	○	○
	Healthcare associated MRSA BSI	0	5	○	○
	Pressure ulcers (per 1,000 bed days)		0.05	○	○
	Inpatient falls (per 1,000 bed days)		0.04	○	○
	VTE Risk Assessments Completed	≥95%	96.7%	○	✓
	SHMI (as expected or better)	<100	4 / 4	○	○
	Good experience reported by inpatients	≥94%	94.7%	○	○

National Oversight Framework Summary

National Oversight Framework	Direction	Source	NOF Assessment period	Segmentation override	Latest Performance | Assumed Quartile				Inferred improvement needed to next quartile				
					CW	ICH	LNW	THH	CW	ICH	LNW	THH	
Access to Services | Elective Care													
Referral to treatment waits < 18 weeks	Higher is better	Local analysis	Latest month in period		67.20%	70.1%	63.70%	64.0%	1.7%		5.2%	4.9%	*
Variance from 18 week performance plan	Higher is better	Model Hospital	Latest month in period	On plan or better	1.0%	6.4%	4.0%	3.6%	1.5%				*
Referral to treatment waits > 52 weeks	Lower is better	Local analysis	Latest month in period	< 1%	1.3%	0.0%	0.70%	0.4%	0.34%		0.2%		*
Referral to treatment waits > 52 weeks (community)	Lower is better	Model Hospital	Latest month in period		n/a	0.0%	0.2%	n/a					*
Access to Services | Cancer Care													
Access to Cancer Care (Faster Diagnosis) < 28 days	Higher is better	Local analysis	Quarterly aggregate	>80%	79.2%	80.0%	78.8%	79.1%					*
Referral to Cancer Treatment Pathways < 62 days	Higher is better	Local analysis	Quarterly aggregate	>75%	88.4%	68.7%	85.6%	72.8%		1.54%		2.2%	*
Access to Services | Urgent and Emergency Care													
Waits in urgent and emergency care < 4 hours	Higher is better	Local analysis	Quarterly aggregate	>78%	77.6%	78.1%	77.3%	80.4%	0.4%		0.7%		*
Waits in urgent and emergency care > 12 hours	Lower is better	Local analysis	Quarterly aggregate		2.6%	5.1%	6.5%	3.5%			1.0%		*
Effectiveness and experience of care | Patient Experience													
CQC inpatient survey satisfaction rate score	Higher is better	Annual survey	Annual										
SHMI	Lower is better	NHS Digital	Twelve-month rolling		Lower	Lower	Lower	As Expected					*
Effectiveness and experience of care | Effective flow and discharge													
Discharge Performance (average days)	Lower is better	Model Hospital	Latest month in period		0.8	0.92	1.22	0.62	0.3	0.1	0.04	0.07	*
Patient Safety													
NHS Staff survey - raising concerns sub-score	Higher is better	Annual survey	Annual		6.70	6.61	6.42	6.22					
Healthcare associated c. Diff Infections v threshold	Lower is better	Model Hospital	Twelve-month rolling	On plan or better	1.76	1.4	0.71	1.15	0.44	0.08		0.06	*
Healthcare associated E. coli BSIs v threshold	Lower is better	Model Hospital	Twelve-month rolling	On plan or better	0.98	1.14	1.28	1.13		0.08	0.11	0.06	*
Healthcare associated MRSA BSI	Zero tolerance	Model Hospital	Twelve-month rolling		6	8	5	2	3	2	2	1	*
People and workforce | Retention and Culture													
Sickness Absence Rate	Lower is better	Local analysis	Quarterly aggregate		4.2%	4.7%	4.7%	5.5%				0.4%	*
NHS Staff Survey engagement	Higher is better	Annual survey	Annual		7.17	7.11	6.95	6.70					
Finance and productivity | Finance													
Planned surplus/deficit	Higher is better	Model Hospital	Annual plan		0.0%	0.0%	0.0%	0.0%					
Variance to YTD plan	Higher is better	Model Hospital	Year-to-date		0.47	0.25	0.42	0.73					
Finance and productivity | Productivity													
Implied productivity level	Higher is better	Model Hospital	Latest month in period		5.3%	1.4%	0.2%	3.8%					*

Quartile Ranking

Best | | | Worst

This summary includes:

Latest performance: The most recent actual performance figure as per the IPR

National quartile position: Colour-coded boxes indicate the latest performance position within national quartile ranges. The top quartile, shaded dark green, is the best-performing 25% s and the bottom quartile, shaded red, is the worst-performing 25%.

Improvement to next quartile: Shows the improvement score, where needed, to move to the next best performing quartile. The table illustrates the colour of the 'target' quartile.

Segmentation override (provided for information): Some metrics are adjusted in the NOF. Within the Access to Services domain, hitting a national target will place the Trust into the top segment.

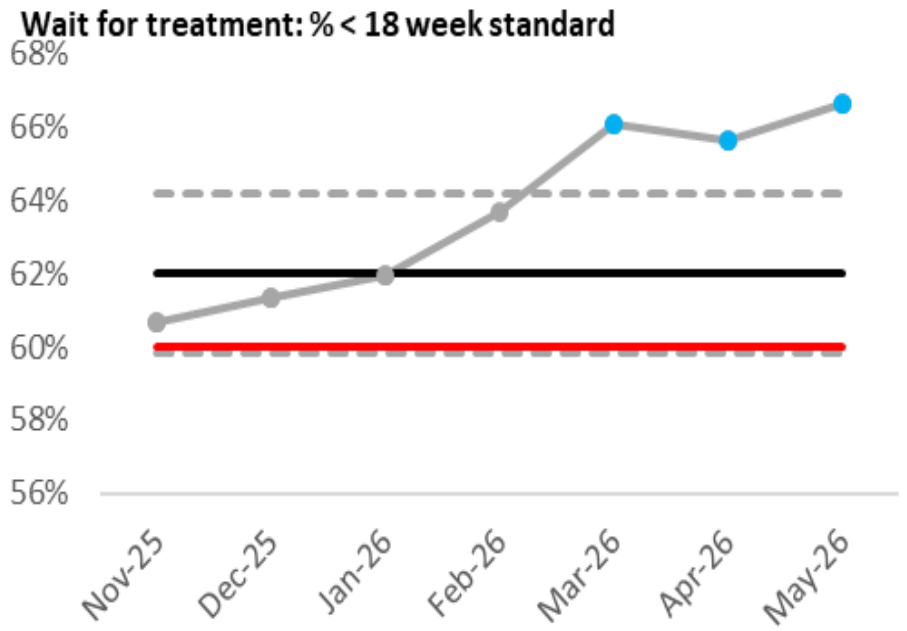
* Updated to M2 2026/27. Scope and thresholds based on current publication 2025/26

Section 1a: Performance Elective Care

May 2026, except Cancer service metrics April 2026

Referral to Treatment Waits

TREND



65%

STANDARD

66.7%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: RTT year-end performance remains strong across the sector. In 2026/27, Trusts are expected to build a minimum 7% improvement into their trajectories for March 2027 to contribute to the national performance target of 70%.

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

Improvements: There has been a gradual improvement in performance.

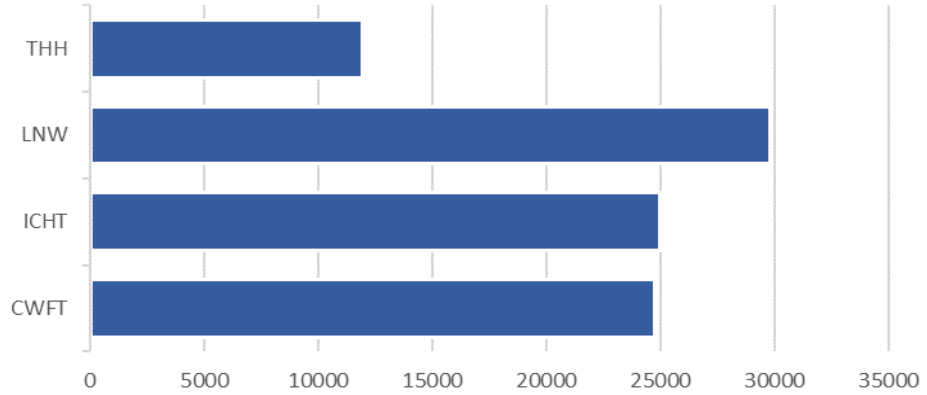
Forecast risks:. Risks to RTT reduction include overall capacity shortfalls, reduction in ERF, reduction in investment of additional activity, industrial action

CURRENT PERFORMANCE

Wait for Treatment: 18 Week standard May-26

	Total Waiting List	Waits < 18 weeks	Difference from target	Waits < 18 weeks	Wait for first Appointments Total	PWFA < 18 weeks
CWFT	75533	67.2%		50794	50915	65.4%
ICHT	83513	70.1%		58508	53635	76.1%
LNW	82280	63.7%		52442	48320	67.1%
THH	33233	64.0%		21284	21026	69.0%
APC	**274559**	**66.7%**		**183028**	**173896**	**69.6%**

STRATIFICATION



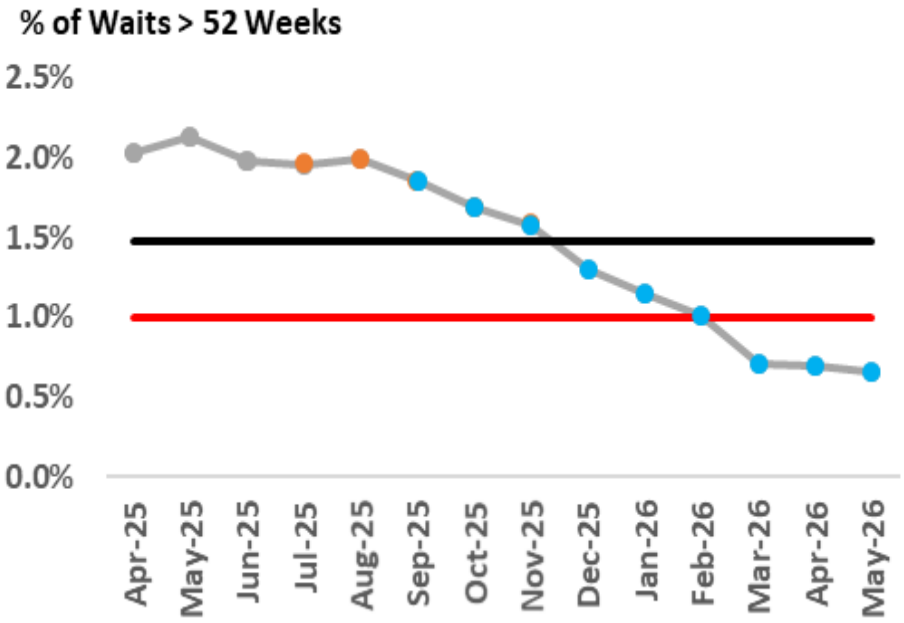
Numbers of patients longer than the 18 Week standard

GOVERNANCE

Senior Responsible Owner: Laura Bewick, Managing Director, Chelsea and Westminster
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Planned Care Board. These figures are validated ahead of a monthly performance return before publication by NHSE.

Referral to Treatment Long Waits

TREND



1.0%

ALLOWANCE

0.7%

PERFORMANCE

TREND

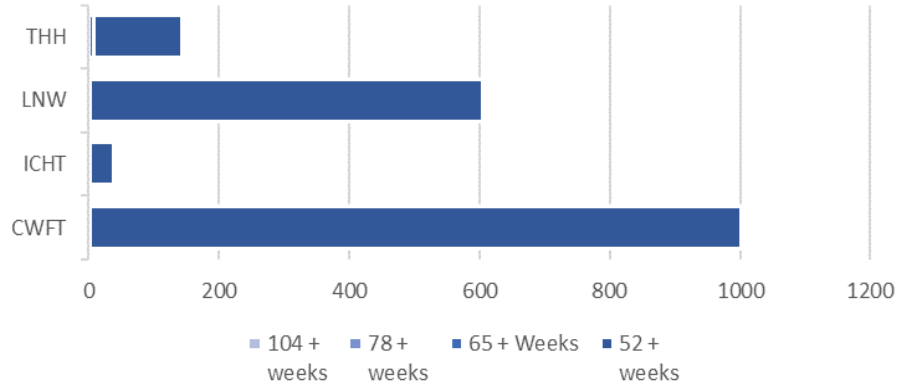
ASSURANCE

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 18-Week Standard May-26

	Total Waiting List	Waits > 52 weeks	Difference from target	52 + weeks	Of which 65 + Weeks	Of which 78 + weeks	Impacted by 104 + weeks	Impacts on OTDCs not booked < 28 days	Impacts on PWFA <18 Weeks
CWFT	75533	1.3%	-0.3%	1002	2	0	0	0	65.4%
ICHT	83513	0.0%		38	1	0	0	12	76.1%
LNW	82280	0.7%		605	1	0	0	0	67.1%
THH	33233	0.4%		143	8	0	0	0	69.0%
APC	**274559**	**0.7%**		**1788**	**12**	**0**	**0**	**12**	**69.6%**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: 52-week performance has been maintained for the sector, with 0.7% of the waiting list waiting over 52 weeks. Only CWFT have more than 1% of their list over 52 weeks.

Recovery: Trusts are focusing on improving productivity and efficiency as most of the 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.

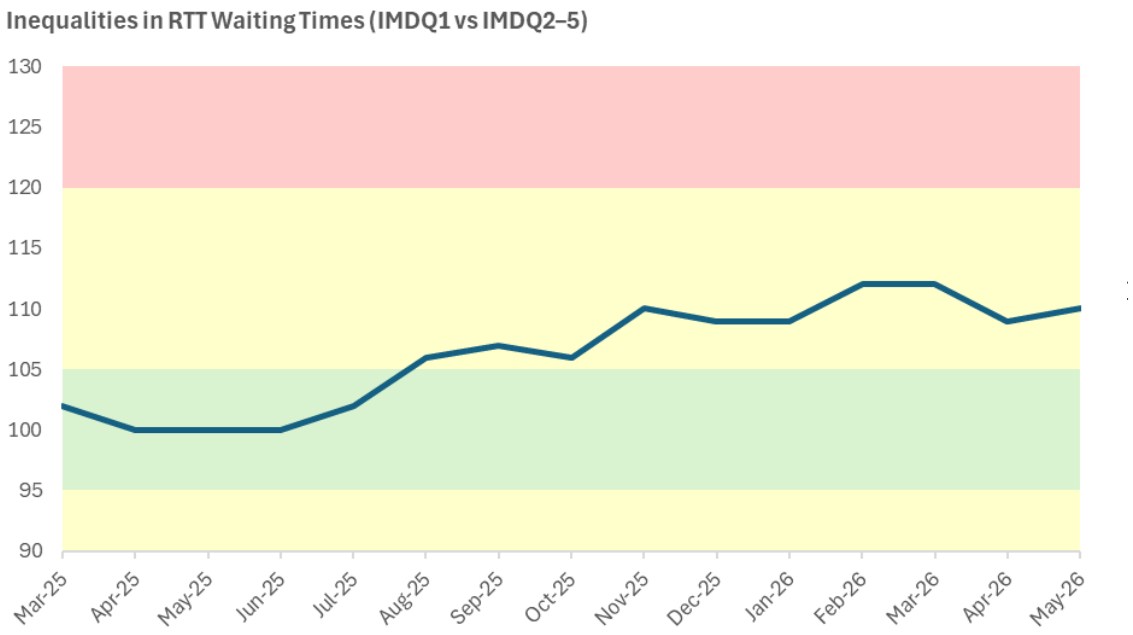
Forecast Risks: Risks to RTT reduction include overall capacity shortfalls, anaesthetic staffing shortages, reduction in ERF, high volumes of trauma and priority 2 patients.

GOVERNANCE

Senior Responsible Owner: Laura Bewick, Managing Director, Chelsea and Westminster
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Planned Care Board. These figures are validated ahead of a monthly performance return before publication by NHSE.

Inequity in Longest Waits for Treatment

TREND



NARRATIVE

Performance: This analysis highlights that at ICH and THH, the most deprived people are more likely to be waiting longer for treatment.

Recovery: Longer-waits in the most deprived quintile are often the result of later referral, poorer baseline health, and faster deterioration while waiting but Trust processes for admin removals and reset 'clocks' (resulting from observed high DNA rates) disproportionally affects the most deprived groups. In addition to the recovery actions needed to reduce inequity in DNAs, Trusts are examining the approach to adopt deprivation-informed waiting list management at specialty level.

Improvements: Improvement plans to be monitored through Trust Outpatient Transformation Boards and the APC Outpatient Group

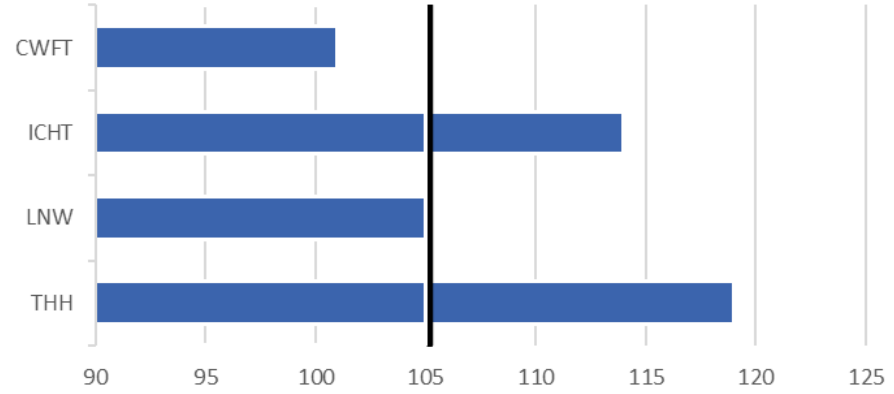
Risks: Failure to introduce risk-stratified interventions alongside digital initiatives will lead to continued levels of potential inequity in access to healthcare in the APC

CURRENT PERFORMANCE

Inequity in Longest Waits for Treatment: May-26

	Total Waiting List	Standardised Performance	% of Longest Waits		Waits > 40 Weeks		Total Waiting	
			IMDQ1	IMDQ2-5	IMDQ1	IMDQ2-5	IMDQ1	IMDQ2-5
CWFT	74,046	101	6.5%	6.5%	553	4,272	8,443	65,603
ICHT	83,072	114	3.8%	3.4%	296	2,534	7,750	75,322
LNW	82,064	105	7.0%	6.6%	719	4,769	10,306	71,758
THH	32,885	119	6.0%	5.0%	122	1,550	2,048	30,837
APC	**272,067**	**110**	**5.9%**	**5.4%**	**1,690**	**13,125**	**28,547**	**243,520**

STRATIFICATION



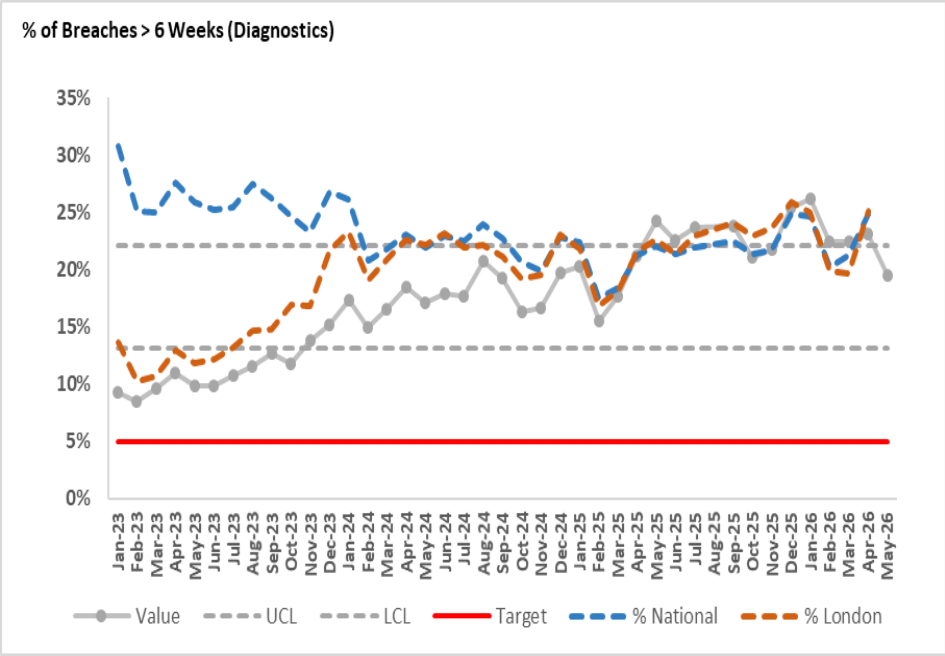
Trust longest waits IMDQ1 cohort against standard

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: This analysis compares the waiting experience of the most deprived 20% of society (IMDQ1) with the experience of the other 80%. A number greater than 100 means they are waiting longer for treatment for the same condition. Analysis displayed for proportion of waiting list with available IMD data.

Access to Diagnostics

TREND



5.0%

ALLOWANCE

19.5%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: Overall delivery is currently below the new improvement trajectory to ensure fewer than 20% of patients are waiting over 6 weeks for a diagnosis test by March 2027. Performance remains in line with both London and National performance.

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

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

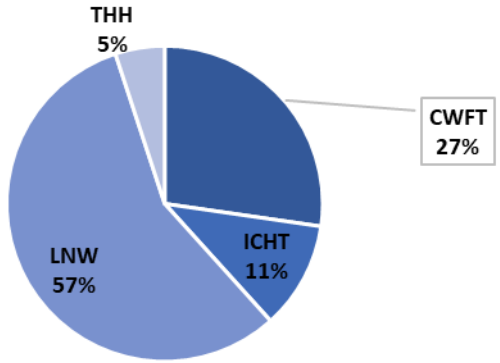
Forecast Risks: MRI capacity continues to be a risk across the sector. Other challenged modalities include Endoscopy, Audiology, Neurophysiology, Echocardiography and Ultrasound which face capacity challenges due to staffing shortages and ageing equipment.

CURRENT PERFORMANCE

Waits for Diagnostic Tests: 6-Week Standard May-26

	Total Waiting List	Waits > 6 weeks	Difference from target	6 + weeks	Of which 13 + weeks
CWFT	17065	20.6%	-15.6%	3521	988
ICHT	17826	8.0%	-3.0%	1421	77
LNW	25613	28.5%	-23.5%	7306	2920
THH	5731	11.4%	-6.4%	652	121
APC	**66235**	**19.5%**	**-14.5%**	**12900**	**4106**

STRATIFICATION



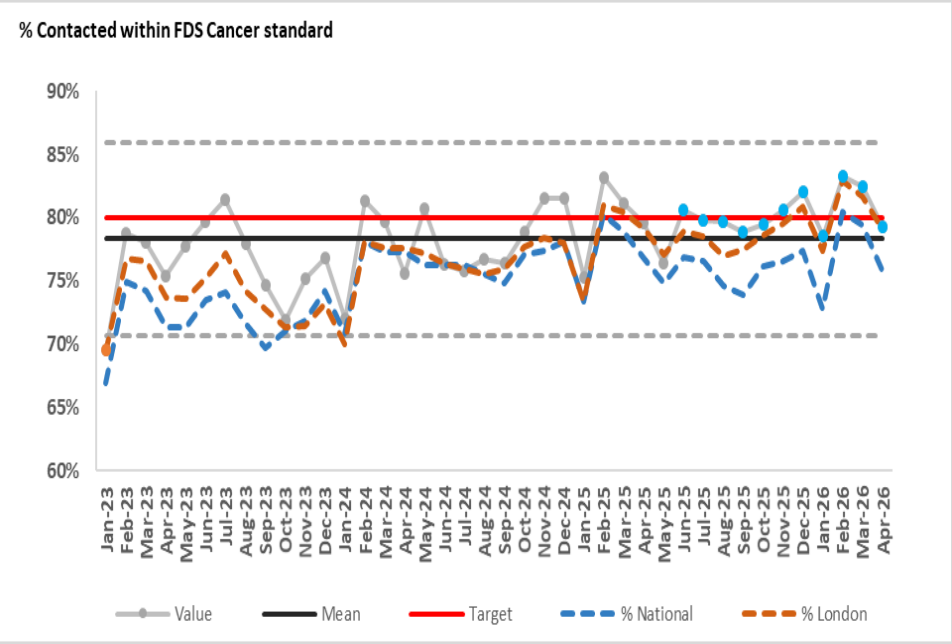
Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Ian Bateman, Chief Operating Officer ICHT
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Planned Care Board. These figures are validated ahead of a monthly performance return before publication by NHSE.

Access to Cancer Care (Faster Diagnosis)

TREND



80%

STANDARD

79.3%

PERFORMANCE

TREND

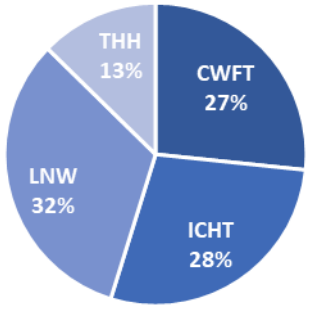
ASSURANCE

CURRENT PERFORMANCE

Access to Cancer Care (Faster Diagnosis) Apr-26

	Total Contacts	Faster Diagnosis performance	Difference from target	28 + days	Of which 62 + days
CWFT	2619	79.2%	-0.8%	546	79
ICHT	2880	80.0%		577	0
LNW	3147	78.8%	-1.2%	666	81
THH	1246	79.1%	-0.9%	260	22
APC	**9892**	**79.3%**	**-0.7%**	**2049**	**182**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: All providers except ICHT were minorly noncompliant with the Faster Diagnosis Standard (FDS) in April 2026 which is linked to Easter holiday, urology and pathology TAT.

Recovery Plan: With aggregate FDS compliance across NWL, focus is on sustaining delivery and addressing challenges in high-impact tumor sites, particularly Urology and Breast, where FDS performance for patients with a confirmed diagnosis remains challenging. Weekly meetings with providers continue to review risks, agree mitigations and identify required alliance support. A Breast pathway redesign away day, hosted by RM Partners, was undertaken in May with outputs aimed at improving the diagnostic pathway.

Improvements: Priority remains maintaining sector-level FDS compliance and improving performance for patients with a cancer diagnosis, particularly in Urology and Breast. Additional breast capacity continues at LNWH, THHT and ICHT and will remain a priority in 2026/27, including delivery of a maximum 10-day wait to first appointment. Front-end Urology pathway improvements remain a key focus – particularly at CWFT.

Forecast Risks: Capacity pinch points, workforce constraints (including ability to run WLIs), and diagnostic delays in radiology and pathology turnaround times remain key risks to delivery.

GOVERNANCE

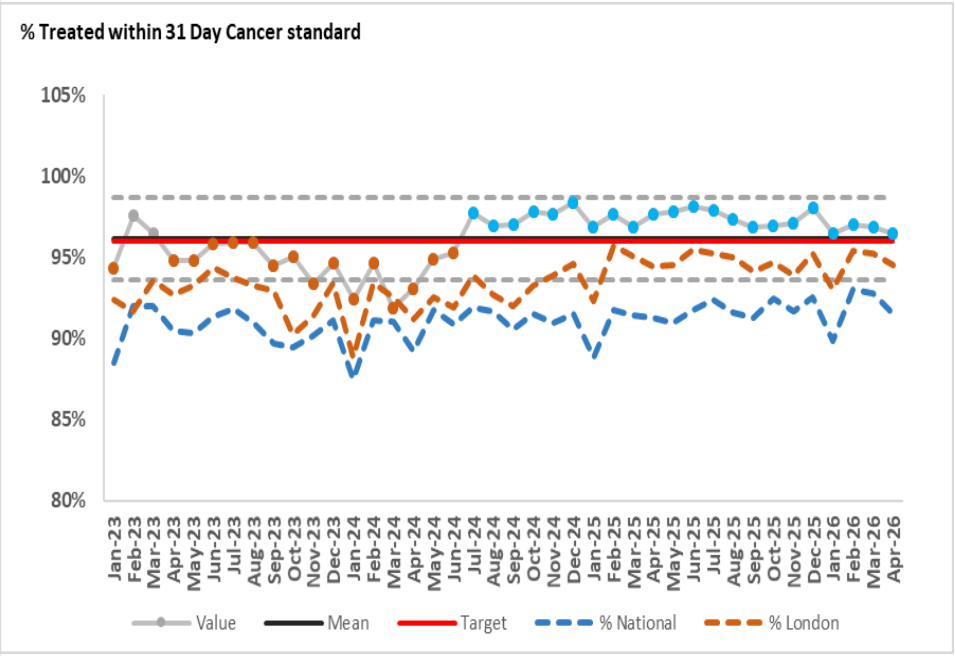
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

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

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

Decision to Cancer Treatment Wait

TREND



96%

STANDARD

96.5%

PERFORMANCE

TREND

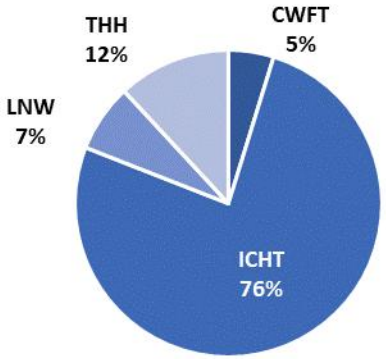
ASSURANCE

CURRENT PERFORMANCE

Cancer 31-day decision to treatment combined standard Apr-26

	Total Treated	31 day performance	Difference from target	31 + days	Of which 62 + days
CWFT	192	99.0%		2	0
ICHT	712	95.5%	-0.5%	32	0
LNW	185	98.4%		3	0
THH	95	94.7%	-1.3%	5	0
APC	**1184**	**96.5%**		**42**	**0**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: 31-day standard performance across NWL and RM Partners remains strong, with NWL continuing to rank among the best performing systems nationally. For April, ICHT and Hillingdon narrowly missed out on compliance.

Recovery Plan: Trusts continue to work closely with RM Partners on audits and targeted, tumor-specific action plans. Engagement with Hillingdon is ongoing to identify further actions to support consistent delivery of the standard. Imperial are continuing to focus on improvements against urology treatments – especially for renal. .

Improvements: Delivery of the 31-day standard has remained broadly consistent across trusts, with limited exceptions.

Forecast Risks: Sustained high referral volumes continue to present a risk of demand outstripping capacity, particularly due to workforce constraints across providers.

GOVERNANCE

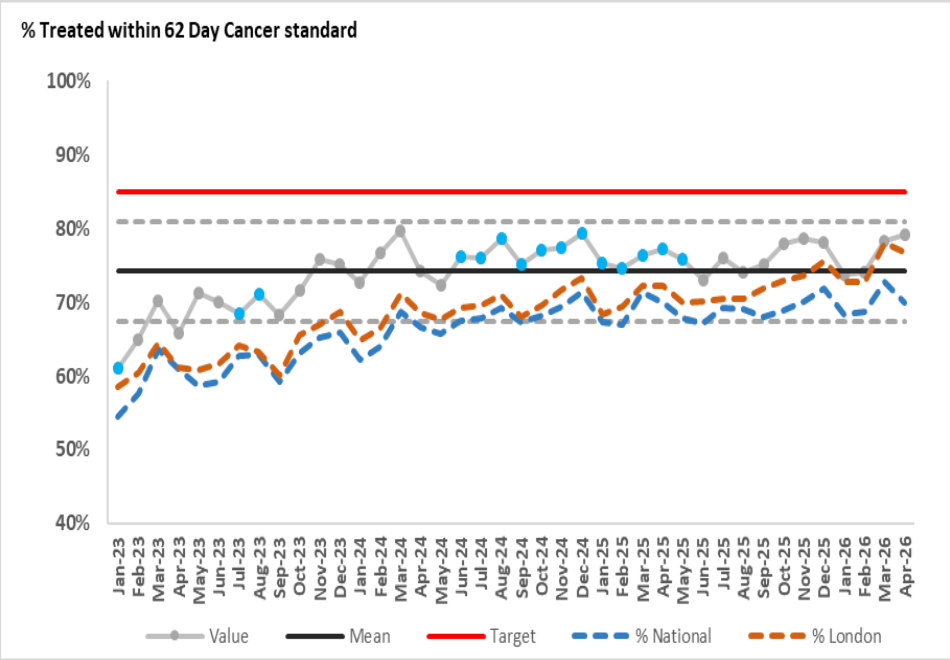
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

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

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

Referral to Cancer Treatment Pathways

TREND



85%

STANDARD

79.2%

PERFORMANCE

H

TREND

F

ASSURANCE

NARRATIVE

Performance: Performance against the 62-day standard remains challenged against the 85% standard. There are system-wide pressures that are contributing to this including delays in inter-Trust transfers. Breast, Urology and Lung are the main challenged tumour sites. However, NWL still remains one of the best performing ICBs nationally.

Recovery Plan: There are plans to address specialist diagnostic capacity for lung (EBUS, RAB & CTGB). Solutions such as navigational bronchoscopy for lung has now gone live via a soft launch at ICHT and improvements in performance will start to be seen in Q2. Front end improvement plans for Urology at CWFT and THHT, and reduced ITR delays are on-going. Additional capacity in place at THHT along with new appointments at ICHT for Breast. Breast will also remain a priority improvement pathway for RM Partners in 26/27 with reintroduction of the 14-day standard to allow more treatment time at the back end of the pathway.

Improvements: Performance slightly improved in Apr-26 but remains below the end of year national ask of 80%. However, this is broadly in line with previous years and expected to recover further in May-26. Focus now on all trusts consistently achieving performance of 80% in 26/27. Urology performance still requires further improvement, but improvements are starting to materialise at CWFT.

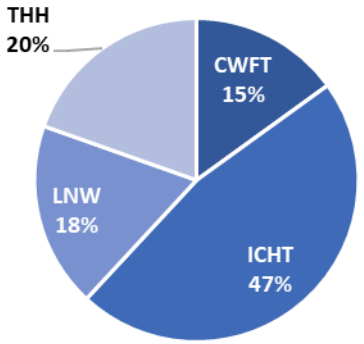
Forecast Risks: Lung diagnostics demand (particularly EBUS and navigational bronchoscopy) remain a risk. However planned mitigations in Q2 of 26/27 should support with addressing these risks. NWL Pathology TATs remain a risk.

CURRENT PERFORMANCE

Unacceptable Waits for the Treatment of Cancer: 62-day Combined Standard Apr-26

	Total Treated	62 day performance	Difference from target	62 + days	Of which 104 + days	Impacts on Backlog 104 + days
CWFT	185	88.4%		21.5	13	0
ICHT	214	68.7%	-16.3%	67	0	63
LNW	184.5	85.6%		26.5	11	47
THH	103	72.8%	-12.2%	28	3	3
APC	**686.5**	**79.2%**	**-5.8%**	**143**	**27**	**113**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

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

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

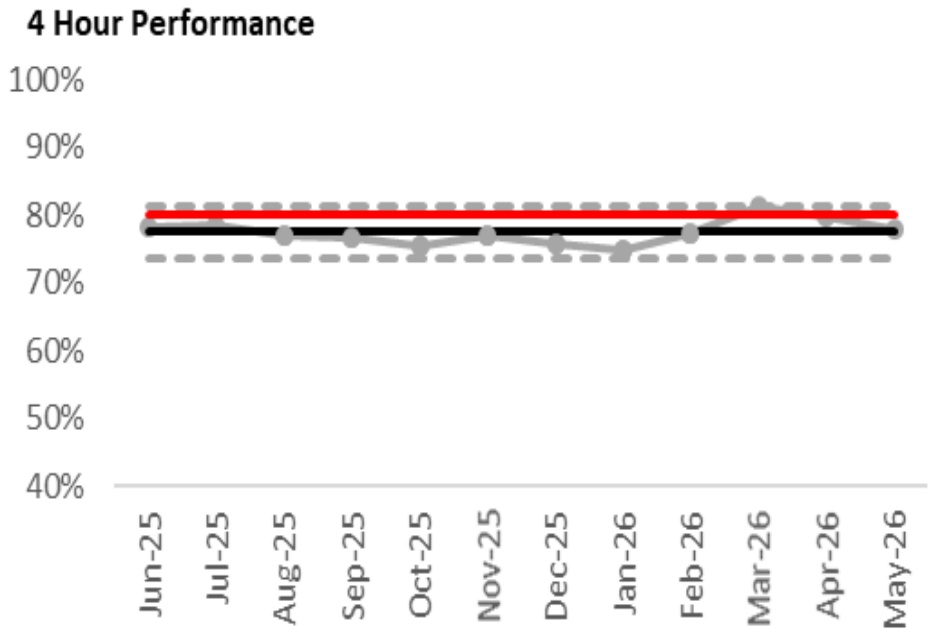
Data Assurance: Delivery through Cancer Clinical Operational Board. These figures are validated ahead of a monthly performance return before publication by NHSE

Section 1b: Performance Emergency Care

May 2026

Urgent & Emergency Department Waits

TREND



78%

STANDARD

78.0%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: Performance is 78.0% of patients were admitted, transferred, or discharged within 4 hours, a reduction month on month (from 79.6%) reported at all four APG sites. Type 1 breaches are the primary driver. Total A&E attendances were 4% higher than the same month last year.

Recovery plan: All four APG trusts have submitted complaint trajectories to meet the 82% by March 2027. Each Trust has a comprehensive action plan to improve four-hour performance and maintain safe levels of care. These plans align with the wider North West London UEC program, which aims to reduce demand and waits across the entire care system.

Improvements: Focused UEC recovery plans have been agreed with NHSE to meet the four-hour performance standard and there is continued collaboration across system to reduce demand and waiting times.

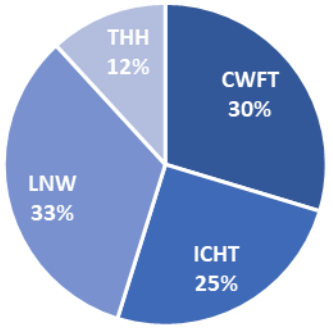
Forecast risks: Further increases in demand and continued delays with discharge for medically optimised patients.

CURRENT PERFORMANCE

Time spend in Emergency Department: 4-Hour Standard May-26

	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	28580	77.56%	-2.4%	6413	6027	72.0%	386	94.6%	1277
ICHT	24779	78.1%	-1.9%	5432	4993	69.9%	439	94.7%	5553
LNW	31775	77.3%	-2.7%	7216	6907	52.1%	309	98.2%	3160
THH	13034	80.4%		2554	2491	57.1%	63	99.1%	4520
APC	**98168**	**78.0%**	-2.0%	**21615**	**20418**	**65.0%**	**1197**	**97.0%**	**14510**

STRATIFICATION



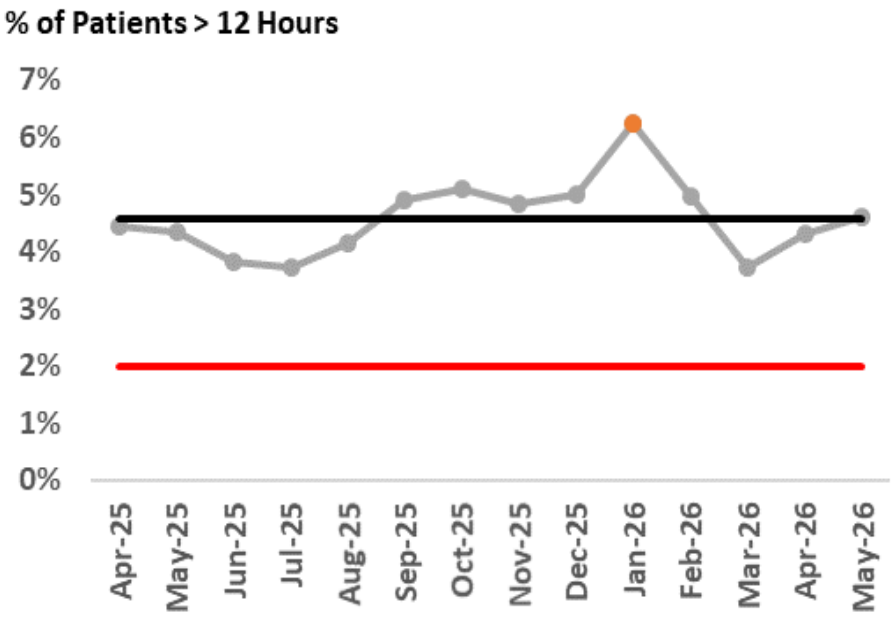
Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Managing Director, Chelsea and Westminster
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Urgent and Emergency Care Board. These figures are validated ahead of a monthly performance return before publication by NHSE.

Urgent & Emergency Department Long Waits

TREND



2.0%

ALLOWANCE

4.6%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: 4.6% of all Types A&E attendances waited over 12 hours from time of arrival (4,508 patients). Mental health delays, which represent a subset of this cohort, remain a challenge for the sector with an overall impact flow and the length of time spent in ED – with potential for significant impacts on patient experience and care quality. Ongoing pressures across community and MH services exacerbate the challenge.

Recovery plan: All Trusts are focused on reducing extended waits in ED and maintaining safe levels of care. Main actions include: improving patient flow from ED to wards and decision-making; strengthening system escalation and discharge coordination; NHSE Model ED standards; and joint work with mental health partners to reduce waits for specialist beds and pathways.

Improvements: Ongoing implementation and enhancement of Trust specific UEC improvement plans and patient flow initiatives.

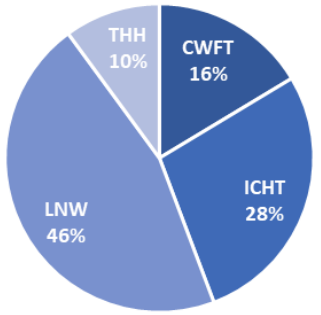
Forecast risks: Increases in demand, continued delays with discharge for medically optimised patients and continued delays for patients waiting for admission to mental health beds.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 12-Hour waits May-26

	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	28580	2.6%	-0.6%	738	738	0	53
ICHT	24779	5.1%	-3.1%	1257	1257	0	618
LNW	31775	6.5%	-4.5%	2059	2059	0	553
THH	13034	3.5%	-1.5%	454	454	0	9
APC	**98168**	**4.6%**	**-2.6%**	**4508**	**4508**	**0**	**1233**

STRATIFICATION



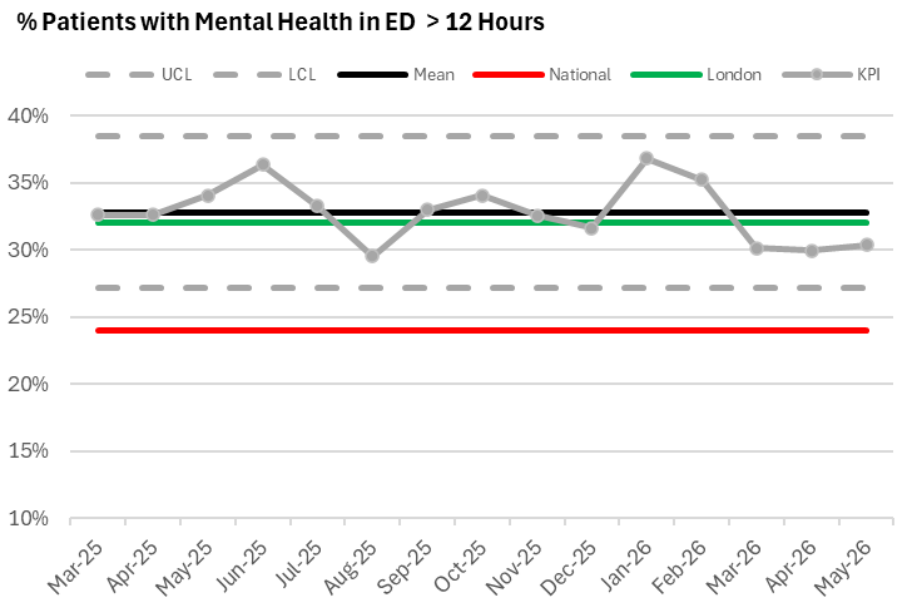
Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Managing Director Chelsea and Westminster.
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Urgent and Emergency Care Board. These figures are validated ahead of a monthly performance return before publication (except 12hr+ waits from arrival) by NHSE.

ED Patients with Mental Health conditions

TREND



24%

ALLOWANCE

30.4%

PERFORMANCE

TREND

F

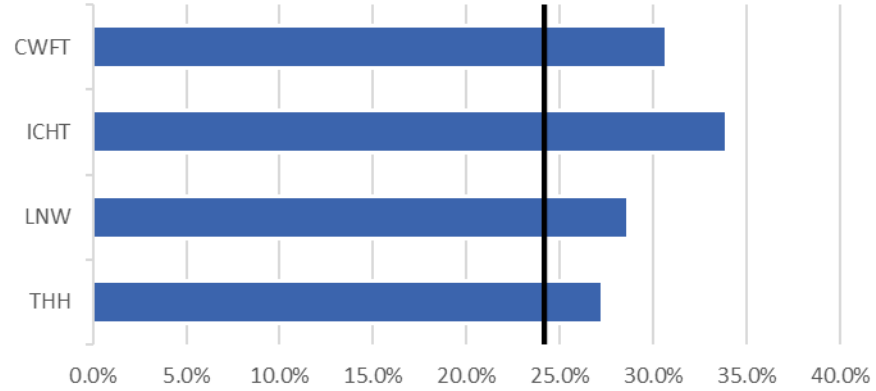
ASSURANCE

CURRENT PERFORMANCE

Unacceptable Waits for Mental Health patients in ED: 12-Hour waits May-26

	ED Type 1 Attendances	Referrals to Pyschiatric Liaison	Demand for Mental Health Care	12 hour Performance	Difference from Provider Median	12 hour + delays
CWFT	21,488	436	2.0%	30.7%	-10.7%	134
ICHT	16,565	504	3.0%	33.9%	-13.9%	171
LNW	14,429	652	4.5%	28.7%	-8.7%	187
THH	5,812	282	4.9%	27.3%	-7.3%	77
APC	**58,294**	**1,874**	3.2%	**30.4%**	-10.4%	**569**

STRATIFICATION



Current Trust waits shown against the national provider median

NARRATIVE

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

Recovery plan: The APC work hand in hand with our Mental Health provider colleagues, and all organisations have both regular operational meetings and the provision of liaison psychiatry in our Emergency Departments. The long waits are raised at the System Urgent & Emergency Care Board and are regularly escalated to the Integrated Care System meeting, which includes the Integrated Care Board (ICB), who are responsible for monitoring demand and commissioning Mental Health capacity.

The APC has done extensive work in ensuring that whilst these patients are waiting for a bed, they are in the best possible environment, and our staff have the correct skills to attend to their needs.

Improvements: The Chief Nurse from LNW is clinically co-ordinating an improvement programme, working jointly with our Mental Health partners.

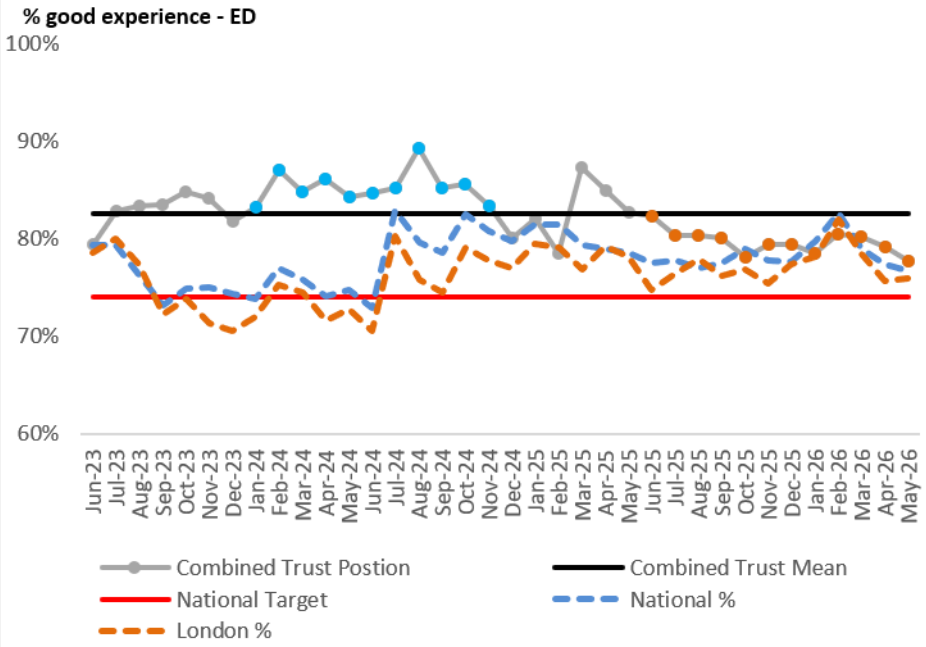
Forecast risks: Continued delays for patients waiting for admission to mental health beds.

GOVERNANCE

Senior Responsible Owner: Laura Bewick, Managing Director, Chelsea and Westminster
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Urgent and Emergency Care Board.

Emergency Dept Friends & Family Test

TREND



74%

STANDARD

77.7%

PERFORMANCE

L

TREND

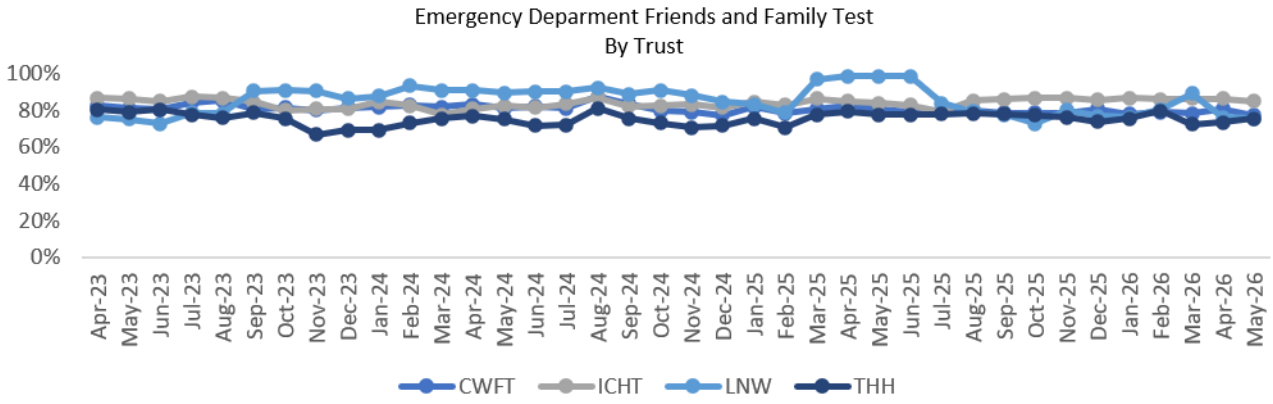
P

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	1,912	77.4%		1,480	79.0%
ICHT	839	84.9%		712	84.7%
LNW	1,687	75.3%		1,271	78.8%
THH	672	75.6%		508	76.3%
APC	**5,110**	**77.7%**		**3,971**	**79.7%**

STRATIFICATION



NARRATIVE

Performance: At APG level, the percentage of patients accessing our emergency departments who report a good experience has been consistently above standard since January 2023, although there has been a downward trend since March 2025. This is being monitored and is likely linked to ongoing operational and capacity issues. All trusts were above the standard in May.

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: Acute provider collaborative executive management board

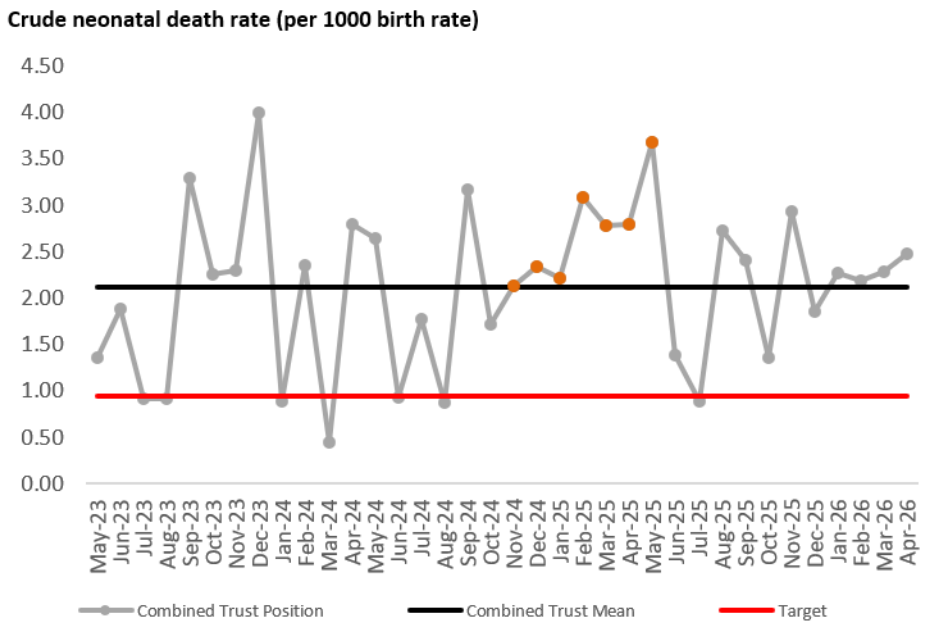
Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Section 1c: Performance
Maternity and Neonatal Care

May 2026

Neonatal Crude Deaths (per 1000 births)

TREND



0.94

STANDARD

2.5

PERFORMANCE

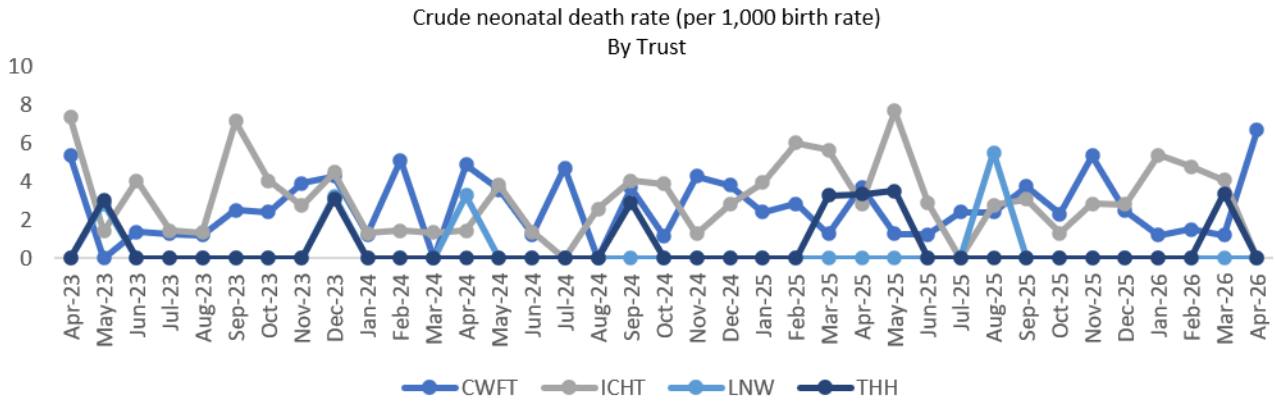
TREND

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	Crude neonatal death rate (per 1000 birth rate) 12 months rolling
CWFT	5	2	3	746	6.7	5.8	2.61
ICHT	0	0	0	724	0.0		3.14
LNW	0	0	0	292	0.0		0.50
THH	0	0	0	253	0.0		0.58
APC	**5**	**2**	**3**	**2015**	**2.5**	**1.5**	2.19

STRATIFICATION



NARRATIVE

Performance: The crude neonatal death rate at APG level is above the standard across the last 12 months. At ICHT the rate has reduced below the national rate following an increase in Q4 – no concerns identified on initial review, many linked to extreme prematurity and congenital abnormalities. There were 5 cases in April at CWFT, primarily attributable to congenital abnormalities. All cases are being reviewed through the PMRT.

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 maternity and neonatal safety group, the following areas of improvement are being prioritised: reducing the number of birthing people who book late; care of birthing people who do not speak or understand English; standardising and improving PRMT practice through creation of a NWL SOP; and a review of bereavement support.

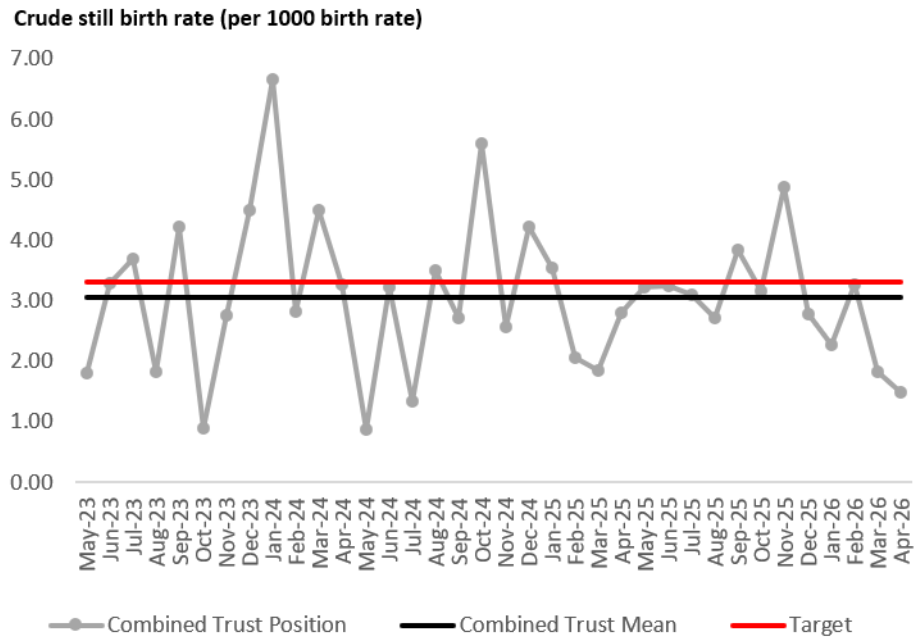
Forecast Risks: None identified.

GOVERNANCE

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

Crude Still Birth Rate (per 1000 births)

TREND



3.3

STANDARD

1.5

PERFORMANCE

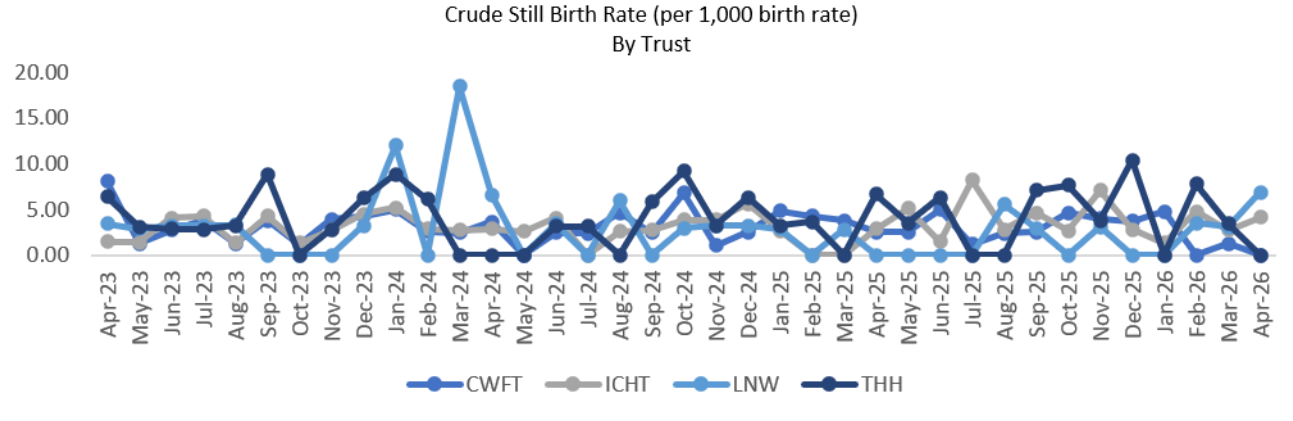
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total Births	Total Still Births & Late Fetal Losses	Total Still Births	Total Late Fetal Losses	Crude Still Birth Rate	12 month rolling rate of Crude Still Birth Rate	Difference from Standard
CWFT	746	4	0	4	0.0	2.7	
ICHT	724	3	1	2	4.1	3.7	0.84
LNW	292	2	2	0	6.8	2.0	3.55
THH	253	0	0	0	0.0	2.9	
APC	**2015**	**9**	**3**	**6**	**1.5**	**2.97**	

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 APG stillbirth rate is below the standard in month and across the last 12 months.

Recovery Plan: The Perinatal Mortality Review Tool (PMRT) is used for all cases to identify local learning & actions. ICHT have noted a small increase in stillbirths in 2025/26 – there have been no signals received via MOSS (maternity outcomes signal system) however an MDT review is underway of recent cases to identify any themes and learning to inform ongoing improvement work. LNW are undertaking a review of all stillbirths across 25-26 which will also include Q1 26-27. No immediate concerns to escalate.

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). CW is a regional pilot site for to implement the Maternal reducing inequalities care bundle (MRICB). All trusts declared full compliance with Saving Babies' Lives Care Bundle v3 for MIS year 7.

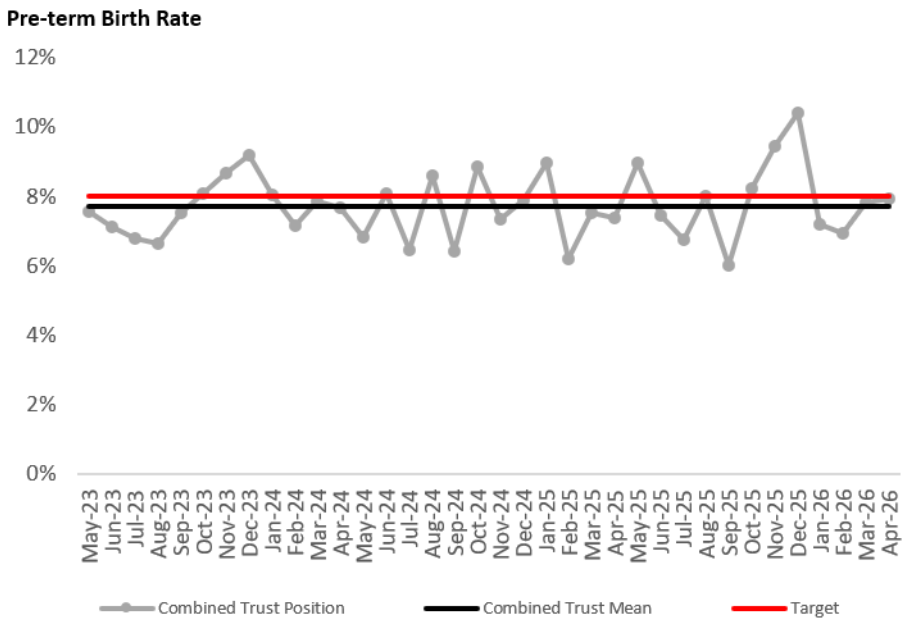
Forecast Risks: No risks identified.

GOVERNANCE

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

Preterm Births (per 1000 births)

TREND



8.0

STANDARD

7.9

PERFORMANCE

TREND

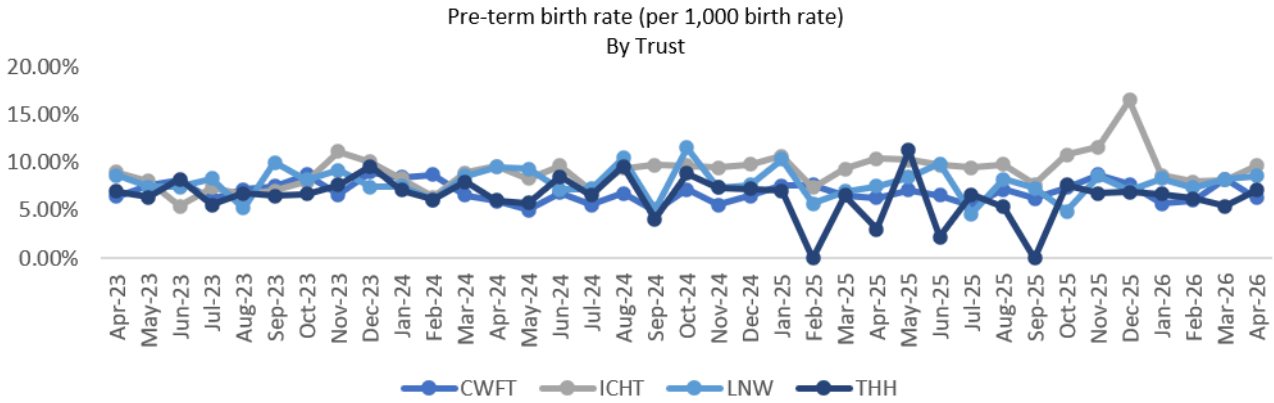
?

ASSURANCE

CURRENT PERFORMANCE

	Number of Pre-Term Births	Early Preterm births	Late Preterm births	Total Births	Pre-term Birth Rate	Difference from Threshold	12 month rolling rate of Pre-Term Births
CWFT	47	6	41	746	6.3%		6.9%
ICHT	70	14	56	724	9.7%	1.67%	10.0%
LNW	25	1	24	292	8.6%	0.56%	7.6%
THH	18	2	16	253	7.1%		6.0%
APC	**160**	**23**	**137**	**2015**	**7.9%**		7.9%

STRATIFICATION



NARRATIVE

Performance: The rate of pre-term births was below the standard at APG level and across the last 12 months. ICHT have the highest rate of the four trusts. They are a net importer of all categories of pre-term In-utero transfers (IUT) and Ex-utero transfers (EUT) due to their status as a medical level 3 NICU.

Recovery Plan: The ICHT rate has reduced following an increase in Q3 – this has been reviewed with no concerns to escalate at this stage. They are focusing on improving MDT involvement in IUT acceptance to ensure effective decision making, particularly during periods of high capacity, prioritising those that require delivery.

Improvements: An education programme has been rolled out at LNW with particular emphasis on personalised assessment to ensure correct maternity care pathway and referrals at booking. They are developing a digital referral to Pre-birth clinic to improve early assessment and intervention rates.

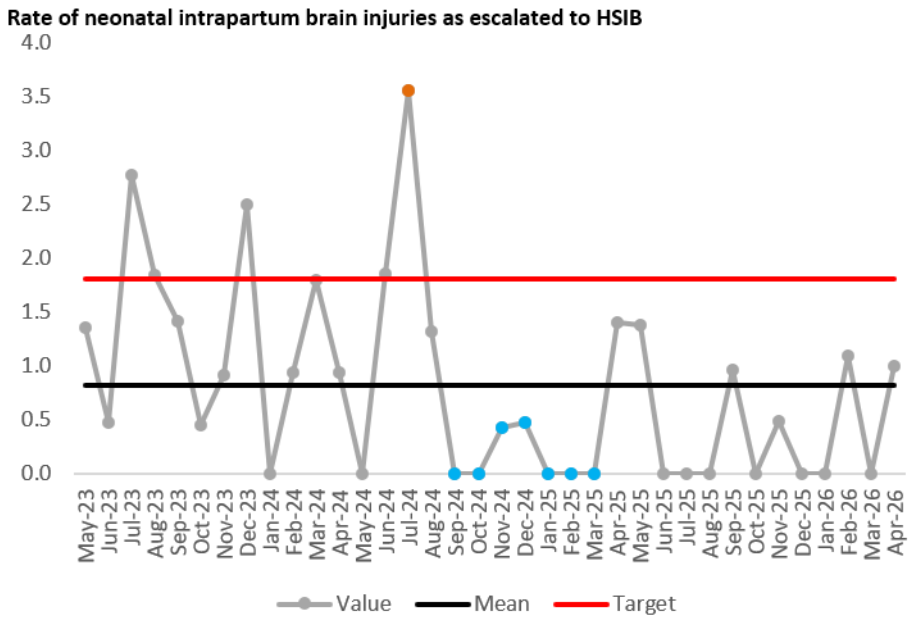
Forecast Risks: No risks identified.

GOVERNANCE

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

Suspected neonatal Intrapartum brain injuries (per 1000 births)

TREND



1.8

STANDARD

0.99

PERFORMANCE

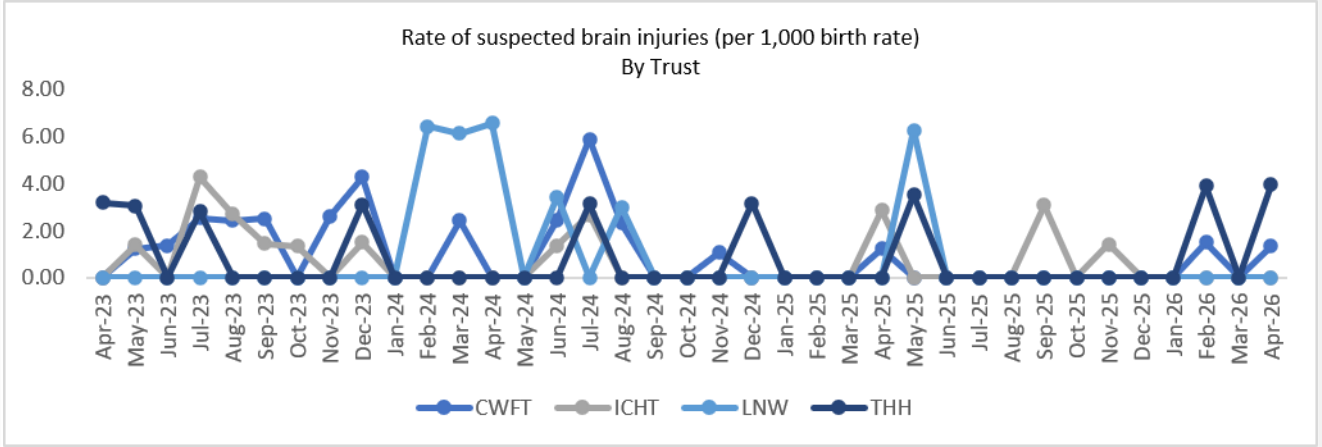
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total Births	Suspected Brain Injuries in Month	Rate of suspected brain injuries	12 month rolling rate of Suspected Brain Injuries
CWFT	746	1	1.34	0.21
ICHT	724	0	0.00	0.35
LNW	292	0	0.00	0.50
THH	253	1	3.95	0.88
APC	**2015**	**2**	**0.99**	0.39

STRATIFICATION



NARRATIVE

Performance: We are below the standard in-month and over the last 12 months. There were 2 cases reported at THH which are under review.

Recovery Plan: N/A

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 APG 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: No risks identified.

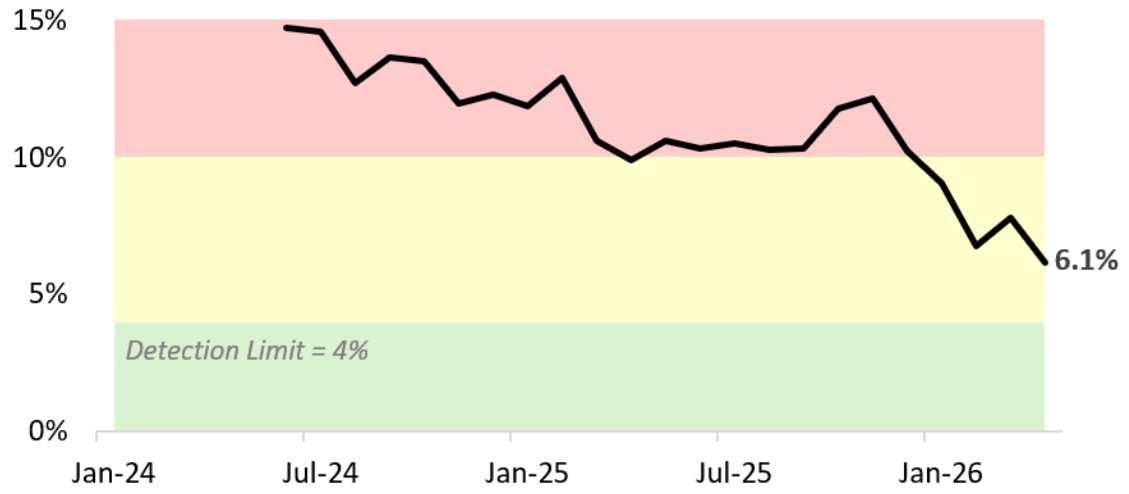
GOVERNANCE

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

Inequalities in Late Maternity Bookings

TREND

% late booking difference Black & Mixed Groups vs. Non-Black 6-month Rolling



CURRENT PERFORMANCE

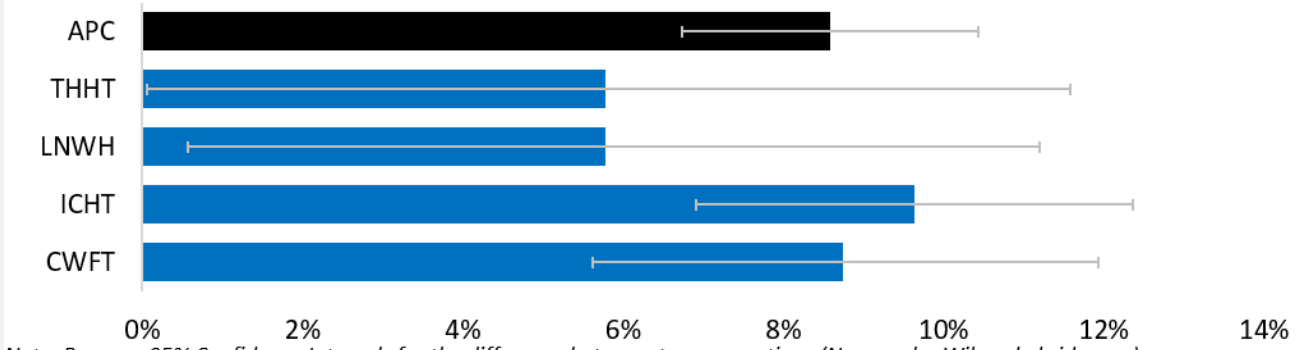
Inequity in Late Bookings, Rolling-6 months to Mar-26

Trusts	Black vs. Non-Black			Black & Black Mixed Groups			Non-Black		
	Difference	Lower 95% CI	Upper 95% CI	All Bookings	Late Bookings	% Late	All Bookings	Late Bookings	% late
APC	6.1%	3.5%	8.8%	1,490	602	40%	12,838	4,400	34%

Note: 95% Confidence intervals for the difference between two proportions (Newcombe-Wilson Hybrid Method)

STRATIFICATION

% late booking difference Black & Mixed Groups vs. Non-Black, 12-month Rolling



Note: Bars are 95% Confidence Intervals for the difference between two proportions (Newcombe-Wilson hybrid score)

NARRATIVE

Performance: The data is provided on a rolling 6-month basis to ensure statistical robustness. Data up to March 2026 demonstrates pregnant people from black and mixed ethnic groups with black heritage are 6.1% more likely to be booked at over 9+6 months gestation than pregnant people from other ethnicities. The percentage has reduced, but remains higher than we would like, in line with national data. Overall, the percentage of late bookers remains high regardless of ethnicity.

Recovery Plan: N/A

Improvements: The directors of midwifery are working to develop an improvement plan in response to this data. This will include working with MNVPs from a community engagement perspective, reviewing accessibility and booking processes and understanding areas of late referral/booking. The plan will be reported to the APG quality meeting once ready. In the meantime, local improvement work continues in all trusts. THH have reduced their booking timeframe from 9+6 to 8+6 to allow additional capacity to book. Work is underway to review the areas where late booking is most common to support targeted improvements (due to commence in September 26).

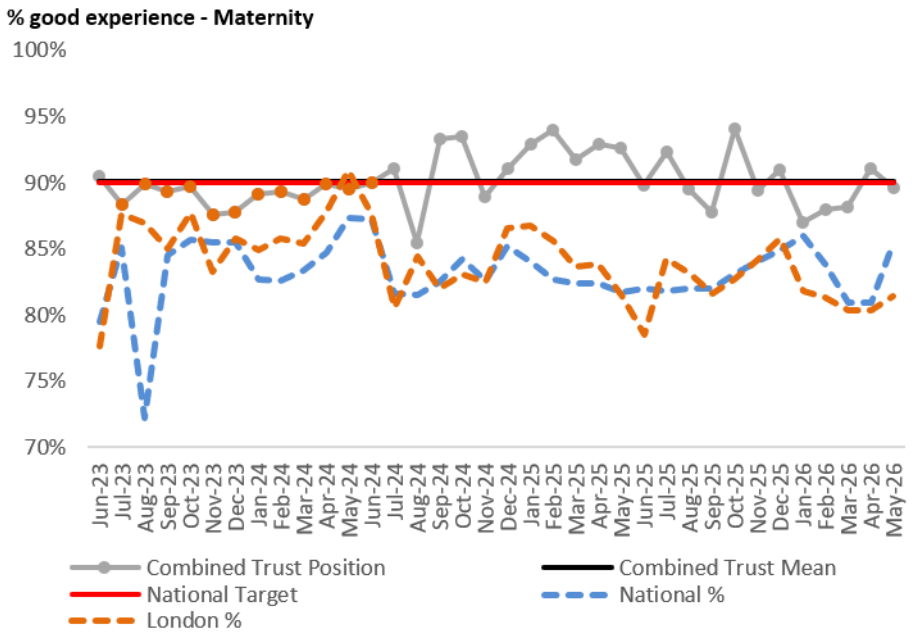
Forecast Risks: N/A

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board
Data assurance: The data is provided on a rolling 6-month basis to ensure statistical robustness. Data is normally supplied by each trust individually and quality assured through teach organisation's internal processes.

Maternity Friends & Family Test

TREND



90%

STANDARD

89.6%

PERFORMANCE

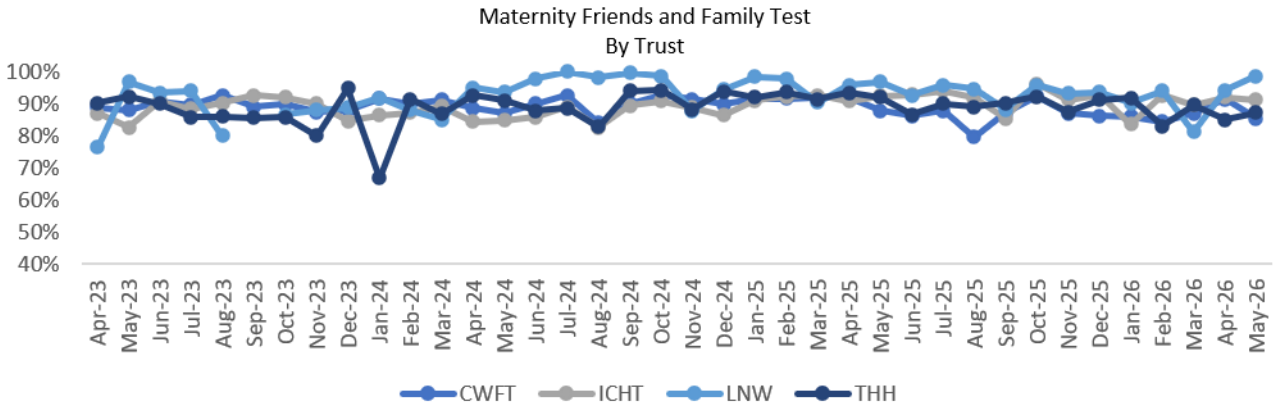
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	211	85.3%	-4.7%	180	87.0%
ICHT	318	91.2%		290	90.8%
LNW	73	98.6%		72	93.5%
THH	109	87.2%	-2.8%	95	88.8%
APC	**711**	**89.6%**	**-0.4%**	**637**	**89.9%**

STRATIFICATION



NARRATIVE

Performance: At APG level, the percentage of maternity patients who report a good experience is variable. We are consistently above national and London averages and are above the 90% standard across the last 12 months of data.

Recovery Plan: Focused work across all trusts to improve response rates and the percentage of service users reporting a good experience. At THH the Maternity and Neonatal Voices Partnership (MNVP) and Director of Midwifery have held a collaborative session on maternity mandatory training during May 2026 on patient experience. LNW reverted to paper collection due to issues with the automated survey which are being resolved, which is impacting performance.

Improvements: The work to improve maternity care and patient experience within each organisation is ongoing. All services have a detailed MNVP workplan in place to co-produce improvements in their services based on the results of the CQC maternity survey.

Forecast Risks: Maternity capacity constraints is 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

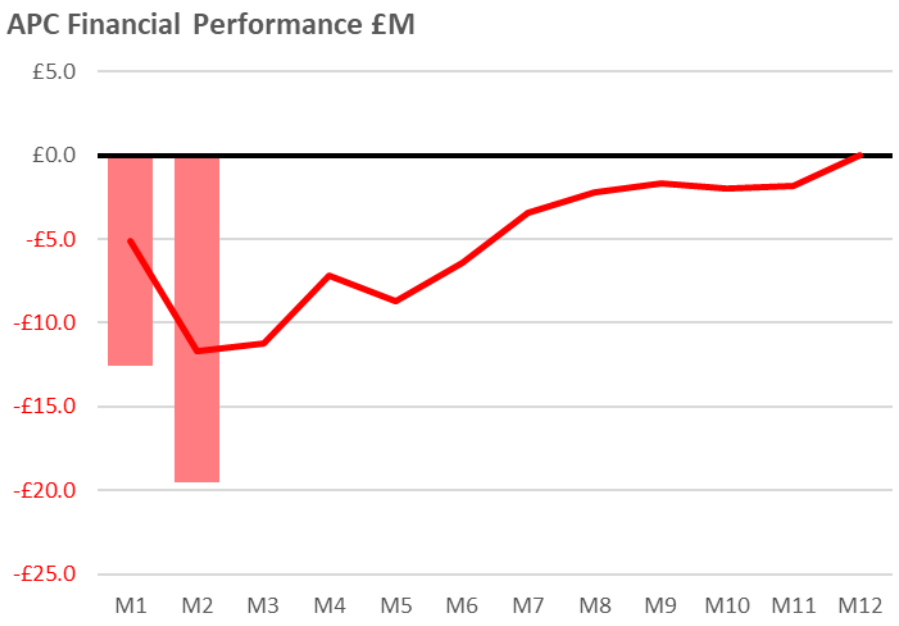
Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Section 2a: Finance

May 2026, except Model Hospital productivity comparisons February 2026

Financial Performance

TREND



-£11.7M

STANDARD

£-19.5M

PERFORMANCE

Plan

Deficit

Surplus

NARRATIVE

Performance: The APG reported a shortall of £7.4M in April against a deficit plan of £12.6M plan. All Trusts reported shortfalls against their month 1 plans.

Recovery Plan / Improvements: A financial performance escalation process has been in place in the previous two financial years.

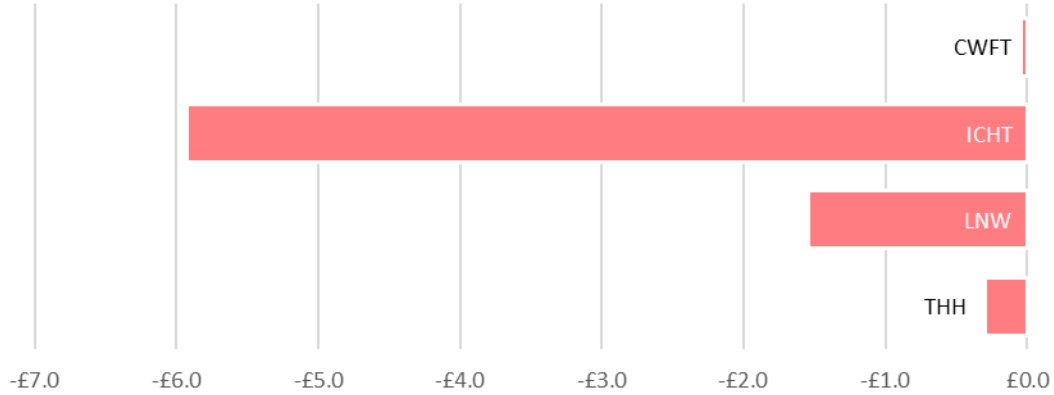
Forecast Risks: Potential under-delivery of efficiency programmes

CURRENT PERFORMANCE

Financial Performance YTD Variance to Plan May-26

	Annual Income Plan £M	I&E YTD Plan £M	I&E YTD Actual £M	Difference from YTD Plan	Forecast Outturn £M
CWFT	1,064	-2.58	-2.62	-0.04	0.0
ICHT	1,923	0.00	-5.92	-5.92	0.0
LNW	1,130	-8.65	-10.19	-1.54	0.0
THH	431	-0.47	-0.77	-0.30	0.0
APC	**4,548**	**-11.70**	**-19.50**	**-7.80**	**0.0**

STRATIFICATION

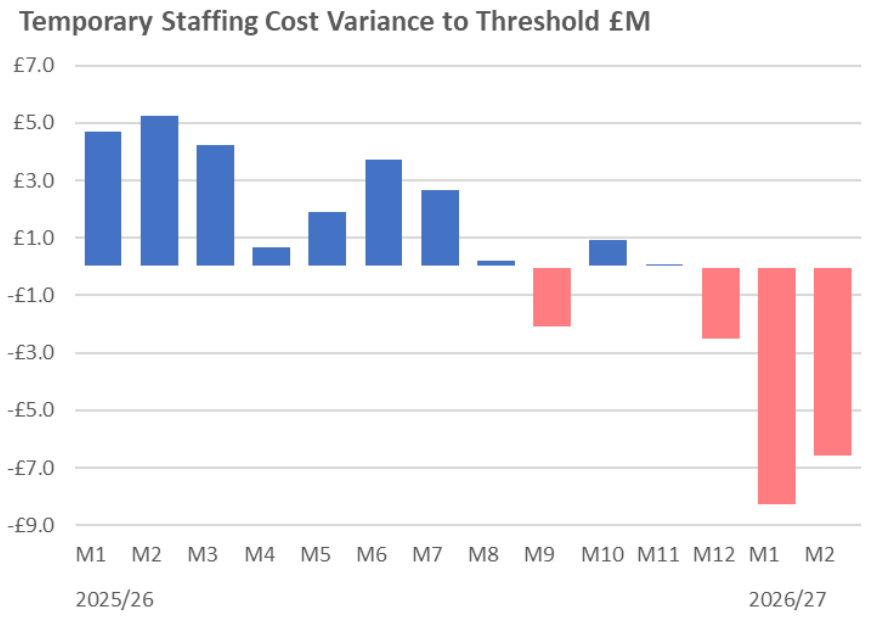


GOVERNANCE

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

Temporary Staffing Expenditure

TREND



£16.9M

ALLOWANCE

£23.5M

PERFORMANCE

n/a

TREND

n/a

ASSURANCE

NARRATIVE

Performance: For 2026/27, agency spend is capped at 0.4% and bank 6.9% for the APG as a proportion of overall pay bill. Spending on temporary staff declined from April but against the new threshold ceiling of £16.9M shows a negative variance in May of £6.6M

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.

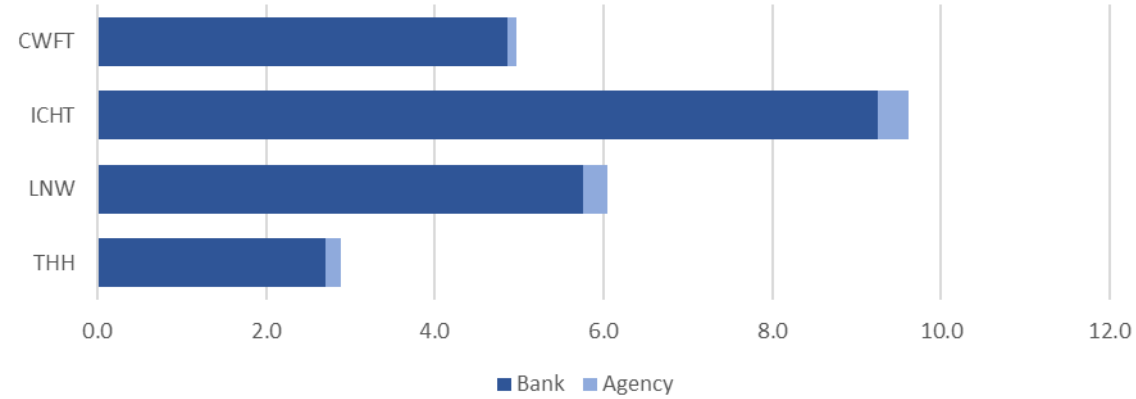
Forecast Risks: Reliance on agency workers is key for the delivery of some services, particularly where there is a national skills shortage such as for sonography, mental health nursing and cardiac physiologists and Trusts are working towards collective solutions in these areas. High levels of vacancies may create additional pressure on temporary staffing demand

CURRENT PERFORMANCE

Cost of Temporary Staffing May-26

	Total Pay Bill £M	Temporary Staffing Threshold	Temporary Staffing Costs	Difference from Threshold	Agency Spend		Bank Spend		Substantive Staff Spend	
					£M	%	£M	%	£M	%
CWFT	52.6	4.0	5.0	-1.0	0.1	0.2%	4.9	9.2%	47.7	90.6%
ICHT	103.7	5.9	9.6	-3.7	0.4	0.4%	9.3	8.9%	94.1	90.7%
LNW	61.0	4.8	6.0	-1.3	0.3	0.5%	5.8	9.4%	55.0	90.1%
THH	24.2	2.2	2.9	-0.7	0.2	0.8%	2.7	11.1%	21.3	88.1%
APC	**241.6**	**16.9**	**23.5**	**-6.6**	**0.9**	**0.4%**	**22.6**	**9.3%**	**218.0**	**90.3%**

STRATIFICATION

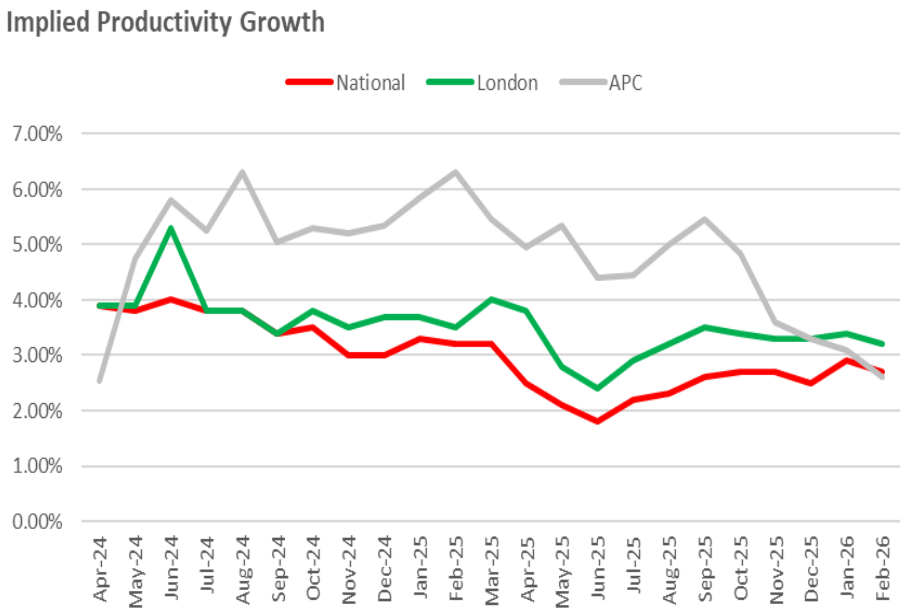


GOVERNANCE

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

Implied Productivity Growth

TREND



2.7%

NATIONAL

2.6%

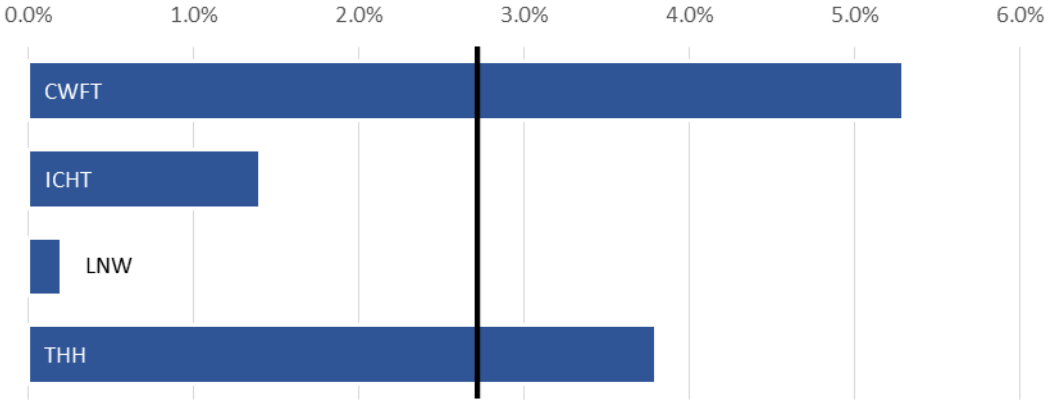
APG MEDIAN

CURRENT PERFORMANCE

Implied Productivity Growth YTD Variance to Previous Year: Feb-26

	YTD Productivity Growth	Variance from National Rate	Cost-weighted Activity Growth YTD	Real-terms Resource Growth YTD Change
CWFT	5.3%	2.6%	2.8%	-3.0%
ICHT	1.4%	-1.3%	1.4%	0.1%
LNW	0.2%	-2.5%	-0.4%	-2.5%
THH	3.8%	1.1%	1.5%	-2.5%
National	2.7%		2.6%	0.1%
London	3.2%		2.2%	-1.0%

STRATIFICATION



NARRATIVE

Performance: The median APC and median London Implied Productivity Growth have been displayed in relation to the national picture.

All NWL APC Trusts are reporting positive productivity growth with CW, and LNW significantly ahead of the national provider median. A key driver are falling Real-term costs across all Trusts.

Recovery Plan / Improvements: See separate *Productivity Reporting Programme Update*

Forecast Risks: Productivity gains may not be maintained due to reduction in the rate of growth in cost weighted activity

GOVERNANCE

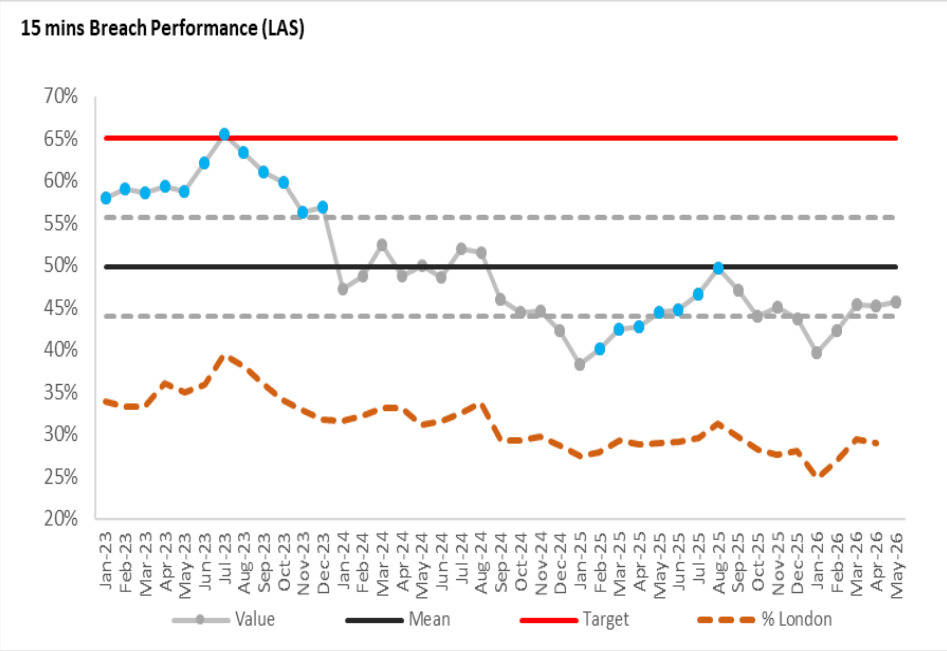
Senior Responsible Owner: Bimal Patel, CFO, LNWH
Committee: APC Finance and Performance
Data Assurance: Implied Productivity Growth is calculated by comparing the YTD growth in cost-weighted activity to growth on operating expenditure against compared to the same period in the previous year. Data is supplied to the Model Hospital System by each trust individually and quality assured through internal processes. There is a greater reporting lag than other metrics presented.

Section 2b: Productivity and Flow

May 2026

Ambulance Handover Waits

TREND



65%

STANDARD

45.6%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: LAS 15-minute handover performance is 45.6% vs 65% standard and is currently tracking just above the lower control limit based on the long-term performance trend. This reflects sustained operational pressure. Total LAS handovers were up 4.4% on the same month last year.

Recovery plan: The priority for 2026/27 is the reduction of the overall average ambulance handover and ensuring all handovers are completed within 45 minutes as a core operational standard. Main actions include: Daily focus on clearing ambulance queues and reducing handover delays; Improved cohorting and offload processes; Strengthening flow through ED; Joint working to maximise the use of alternatives to ED and direct referral; Targeted support to LNW.

Improvements: Local process changes at Hillingdon Hospital have shown positive impact. NWL maintains some of the best Ambulance handover times across London with CWFT, ICHT and THH consistently in the top 5 rankings.

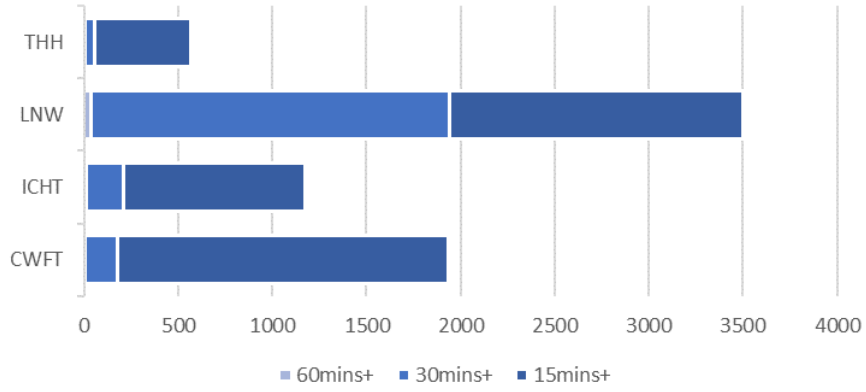
Forecast risks: Continued increases in the number of conveyances.

CURRENT PERFORMANCE

LAS Handover Waits within the fifteen minute standard May-26

	Total Handover	15mins Performance	Difference from target	15 min + delays	Of which		Impacts on
					30min + delays	60 min + delays	LAS time lost (hours)
CWFT	4194	53.9%	-11.1%	1933	175	2	220
ICHT	2553	54.1%	-10.9%	1173	212	10	180
LNW	4419	20.8%	-44.2%	3500	1944	34	2024
THH	2010	71.9%		564	57	1	91
APC	**13176**	**45.6%**	**-19.4%**	**7170**	**2388**	**47**	**2516**

STRATIFICATION



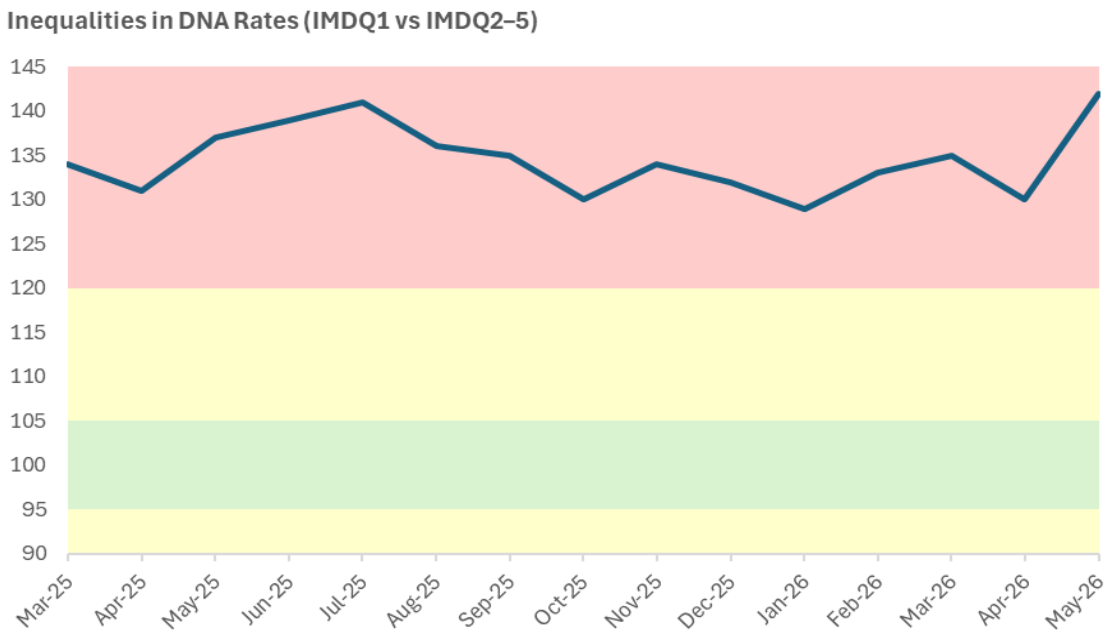
Trust share of APC waits longer than standard

GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Managing Director, Chelsea and Westminster
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Urgent and Emergency Care Board. These figures are provided by LAS

Inequity in DNA Rates

TREND



NARRATIVE

Performance: The long-term trend shows that at all Trusts the most deprived people are more likely to miss their appointment.

Recovery: Socio-economic factors such as unpredictable work patterns, high transport costs, unstable housing, caring responsibilities, and digital exclusion contribute to higher DNA rates in the most deprived quintile. Trusts plan to reducing DNA rates in this group through focusing digital initiatives on the most deprived quintile through two-way appointment reminders, co-produced appointment booking and protecting rescheduling options for this group; and continuing with the digital-first approach, introducing risk-stratified (based on IMD data) outreach via phone.

Improvements: Improvement plans to be monitored through Trust Outpatient Transformation Boards and the APC Outpatient Group

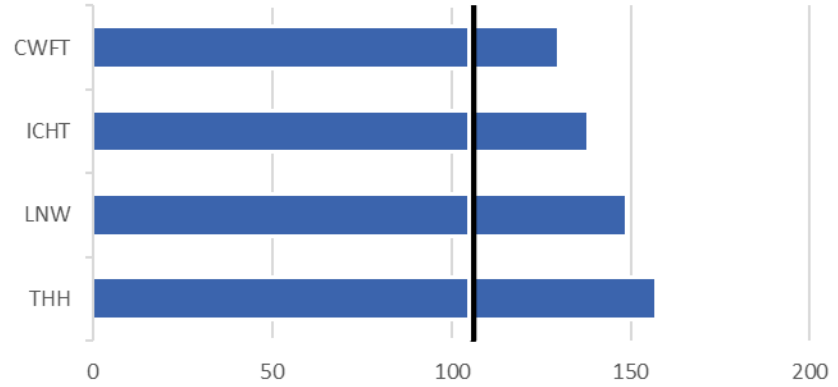
Risks: Failure to introduce risk-stratified interventions alongside digital initiatives will lead to continued levels of potential inequity in access to healthcare in the APC.

CURRENT PERFORMANCE

Inequity in Outpatient DNA Rates: May-26

	Outpatient Bookings	Standardised Performance	DNA Rate		DNAs		Confirmed Appointments	
			IMDQ1	IMDQ2-5	IMDQ1	IMDQ2-5	IMDQ1	IMDQ2-5
CWFT	26,815	130	12.0%	9.3%	367	2,201	3,047	23,768
ICHT	24,052	138	15.9%	11.5%	352	2,505	2,218	21,834
LNW	35,503	149	13.2%	8.9%	481	2,833	3,640	31,863
THH	12,701	157	11.0%	7.0%	79	836	721	11,980
APC	**99,071**	**142**	**13.3%**	**9.4%**	**1,279**	**8,375**	**9,626**	**89,445**

STRATIFICATION



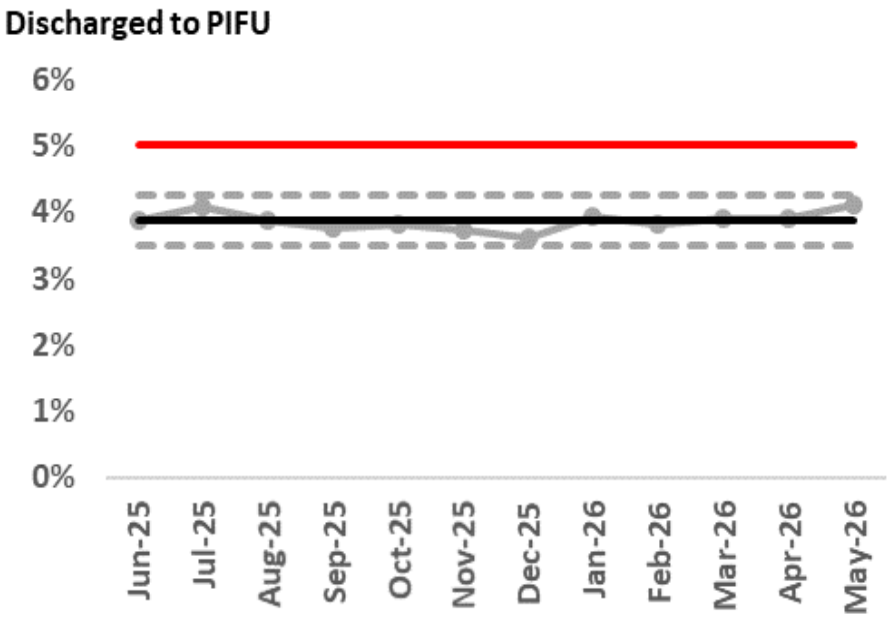
Trust longest waits IMDQ1 cohort against standard

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: This analysis compares the outpatient non-attendance rates of the most deprived 20% of society (IMDQ1) with the rates of the other 80%. A number greater than 100 means they are more likely to miss their booked appointment.

Patient Initiated Follow Up

TREND



5%

STANDARD

4.1%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: Pathways discharged to PIFU remains under the 5% target, but performance remains consistent.

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

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

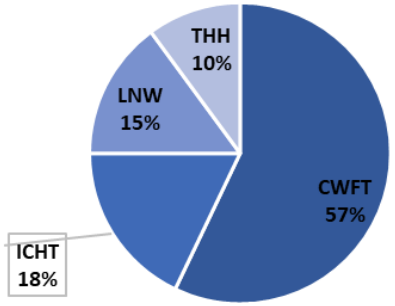
Forecast risks: Stability, usability and interoperability of digital infrastructure.

CURRENT PERFORMANCE

Outpatient Transformation May-26

	Total OP contacts	Discharged to PIFU	Difference from target	Moved / Discharged to PIFU	Impacts on		
					OPFA DNAs	OPFU DNAs	Virtual contacts
CWFT	69469	9.1%		6348	9.9%	7.7%	8394
ICHT	96553	2.1%	-2.9%	1989	11.3%	9.5%	18792
LNW	71182	2.3%	-2.7%	1658	9.9%	10.1%	14386
THH	33495	3.5%	-1.5%	1122	6.9%	7.8%	5053
APC	**270699**	**4.1%**	**-0.9%**	**11117**	**9.9%**	**9.1%**	**46625**

STRATIFICATION



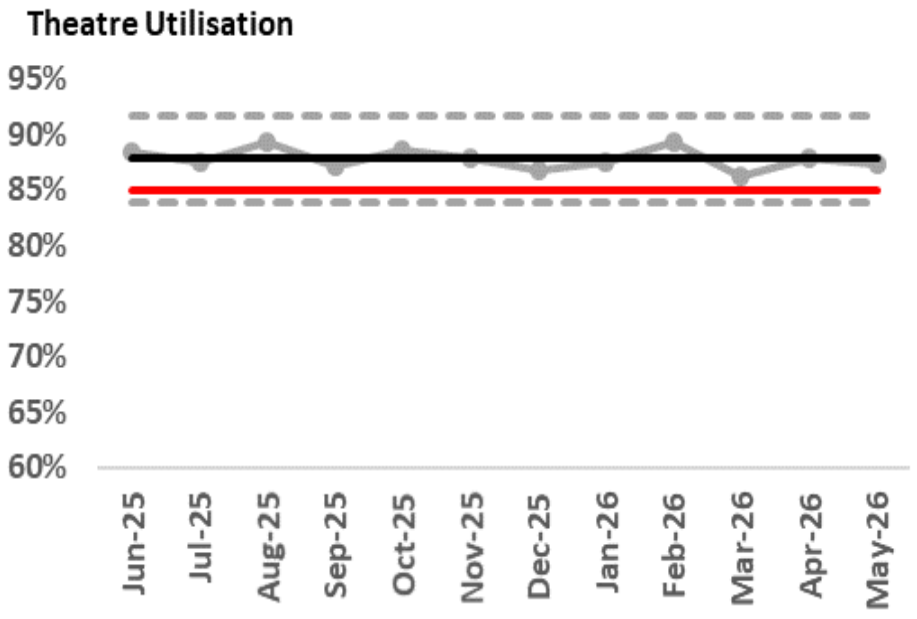
Trust share of APC discharges to PIFU lower than standard

GOVERNANCE

Senior Responsible Owner: Laura Bewick, Managing Director, Chelsea and Westminster
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Planned Care Board. Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Theatre Utilisation *(Uncapped)*

TREND



85%

STANDARD

87.3%

PERFORMANCE

TREND

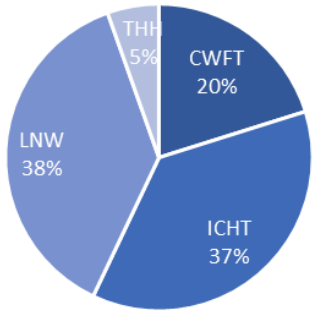
ASSURANCE

CURRENT PERFORMANCE

Theatre Utilisation May-26

	Planned operating time (hours)	Theatre utilisation	Difference from target	Unused time (hours)
CWFT	2786	89.2%		300
ICHT	4840	88.6%		550
LNW	3028	81.6%	-3.4%	559
THH	1090	92.6%		81
APC	**11744**	**87.3%**		**1489**

STRATIFICATION



NARRATIVE

Performance: NWL Theatre utilisation remained stable in M2 and above the 85% benchmark.

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.

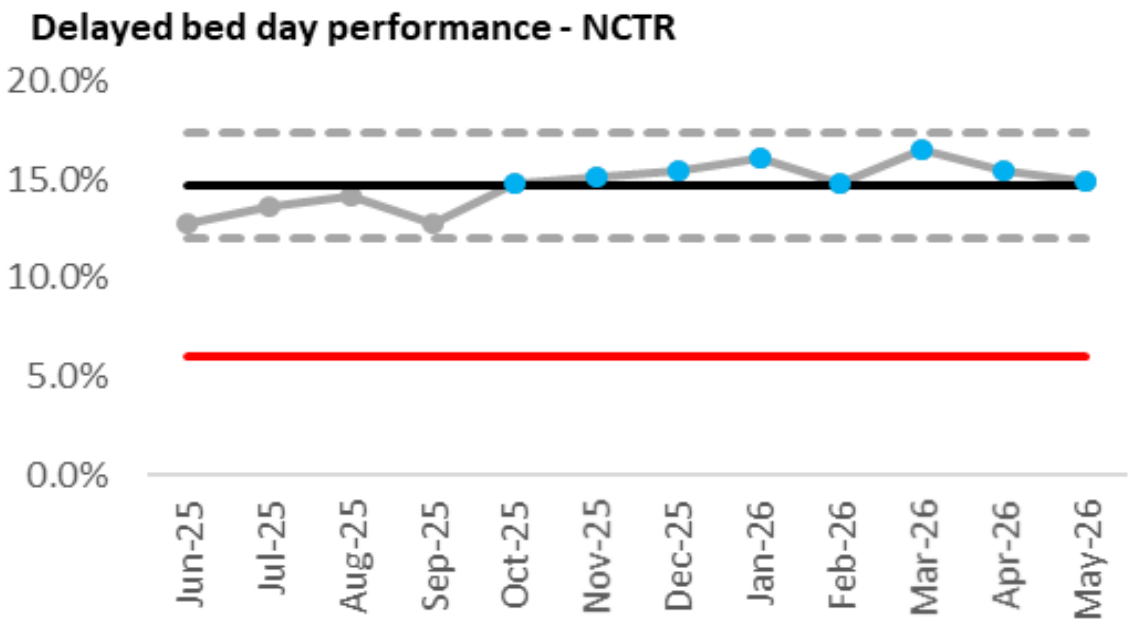
Forecast risks: Shortages in critical staffing groups.

GOVERNANCE

Senior Responsible Owner: Alan McGlennan, Managing Director, THH
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Planned Care Board. Data is supplied by each trust individually and quality assured through each organisation's internal processes

Discharge Performance - no criteria to reside

TREND



NARRATIVE

Performance: System flow remain challenged across the APG.

Recovery: Performance across the trusts shows significant variation in delayed bed days, with delays ranging from 7% to 19.6%. ICHT stands out as the most challenged trust, recording both the highest proportion of delayed bed days (19.6%) and a substantial volume of delayed days overall. In contrast, THH demonstrates strong performance with the lowest delay rate (7%). Continued to focus of long waiters by teams and escalation meetings in place locally for each site. P1 delays seen in some boroughs vary but also being managed through weekly escalation meeting at senior level.

Improvement:. Optica rollout to LAS continues and will help boroughs with achieving targets proposed. Transfer of care hub gaps workshop completed with Hub leads and senior representation from all partner with next steps and actions being drafted.

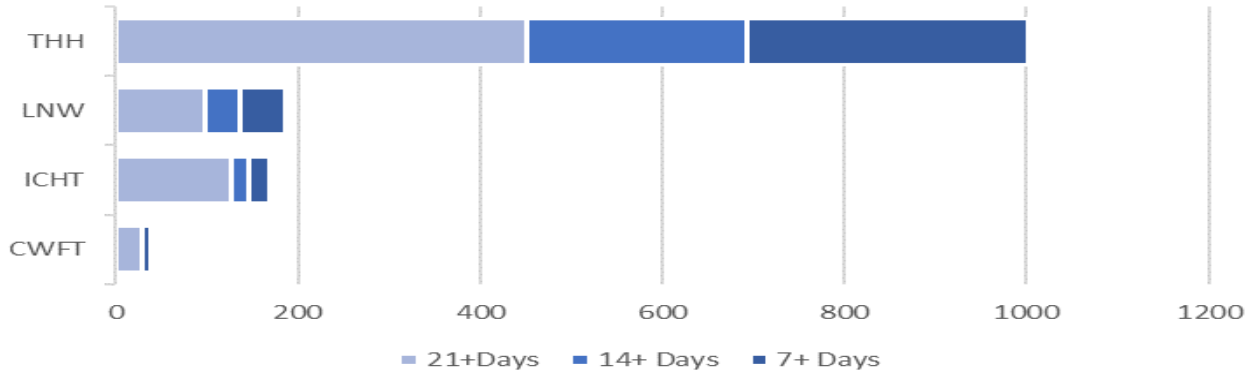
Forecast risks: Continued delays for patients waiting for admission to mental health beds. NCTR occupancy remains challenged and overall attendances remain high.

CURRENT PERFORMANCE

Delayed Bed Days for Patients discharged in month and those that remain in hospital May-26

	Total Bed days	Days Delayed	% Delayed bed days	Number of patients not meeting CTR	Number of patients not meeting the Criteria to Resi			TBC - Average days between DRD and DD
					7+ Days	14+ Days	21+Days	
CWFT	19935	2424	12.2%	258	38	14	29	0.817
ICHT	30912	6046	19.6%	200	170	147	127	1.090
LNW	28602	4177	14.6%	301	186	137	99	1.099
THH	10754	748	7.0%	1364	1002	694	451	0.563
APC	**90203**	**13,395**	**14.8%**	**2123**	**1396**	**992**	**706**	**0.89**

STRATIFICATION

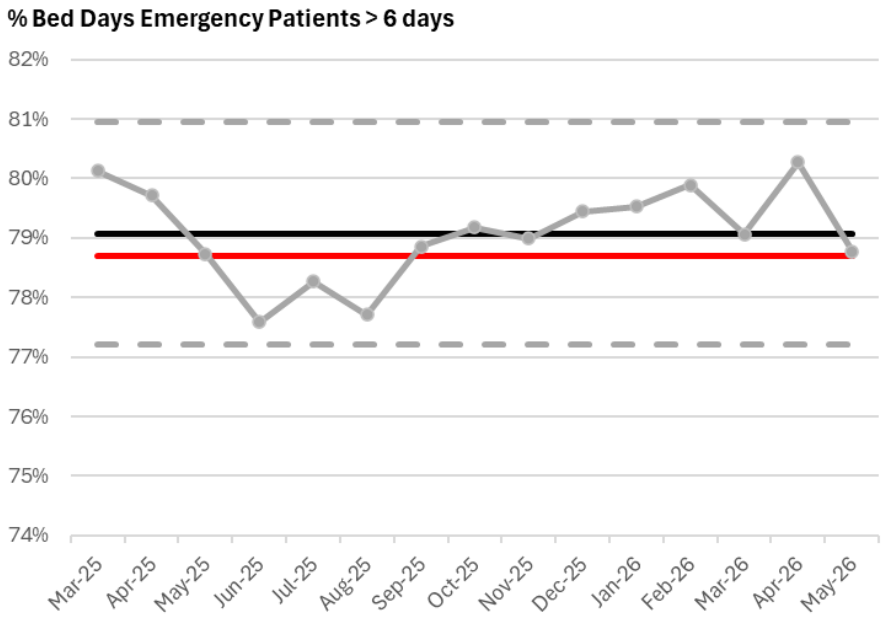


GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Managing Director Chelsea and Westminster.
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: Delivery through Urgent and Emergency Care Board. These figures come for the FDP via the ICB

Long Length of Stay for Emergency Patients

TREND



78.4%

ALLOWANCE

78.8%

PERFORMANCE

TREND

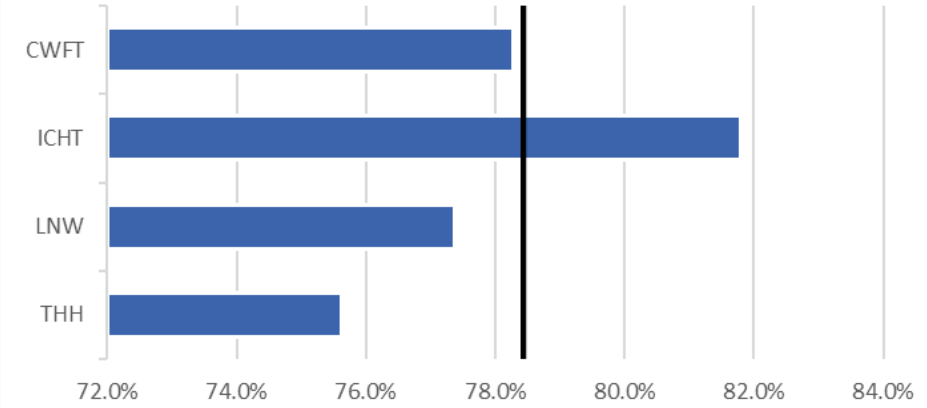
ASSURANCE

CURRENT PERFORMANCE

Bed days attributed to long-stay patients: May-26

	Total Emergency Bed Days	Long LOS Performance	Difference from Provider Median	Long LOS Emegency Bed Days
CWFT	20,842	78.3%		16,313
ICHT	27,193	81.8%	-3.4%	22,242
LNW	27,972	77.4%		21,643
THH	10,322	75.6%		7,807
APC	**86,329**	**78.8%**	-0.4%	**68,005**

STRATIFICATION



Current Trust waits shown against the national provider median

NARRATIVE

Performance: Group performance has been trending over the last few months above the national provider median. However, THH demonstrates better performance than the group position.

Recovery plan / Improvements: Long LOS patients are routinely reviewed at all Trusts. LNW have implemented an improvement programme to improve length of stay and patient flow through the hospital.

Forecast risks: Continued high levels of stranded patients

GOVERNANCE

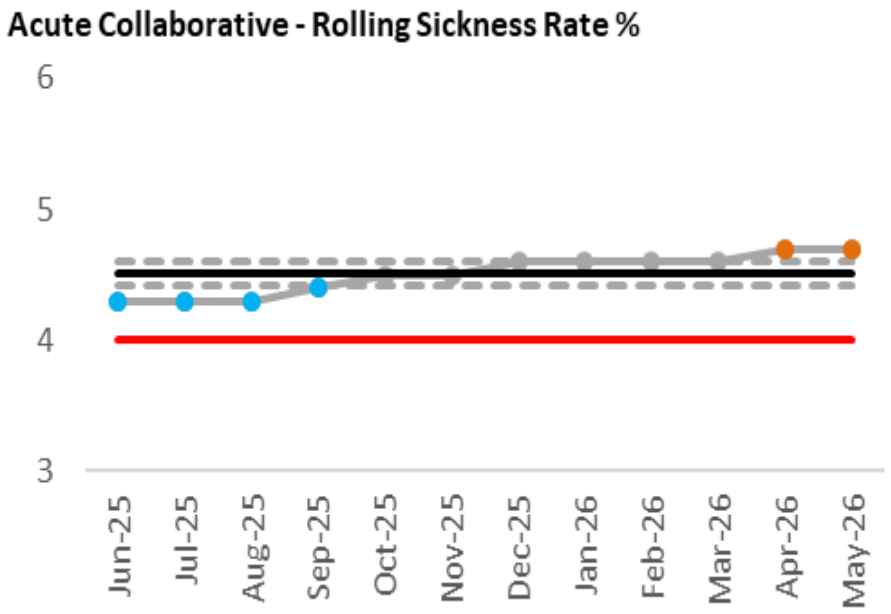
Senior Responsible Owner: Sheena Basnayake, Managing Director Chelsea and Westminster.
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: This metric shows the proportion of bed days for emergency patients that have been attributed to emergency patients staying beyond 6 days. A high rate suggests that an organisation has a problem with stranded patients. Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Section 3: Workforce

May 2026, except Model Employer Goals March 2026 (quarter 4 position)

Sickness Absence

TREND



=/<4%

STANDARD

4.7%

PERFORMANCE

H

TREND

F

ASSURANCE

NARRATIVE

Performance: We have seen an increase in sickness across the Trusts since May 2025 with current 12 month-rolling levels (4.7%) above the collective target of 4.0% and all Trusts are actively monitoring this. This metric is flagging as a special cause for concern and is slightly above the London position of 4.6% but lower than National position of 5.1%. Since COVID, we have seen the proportion of long-term illness increase.

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 and increase reliance on bank cover.

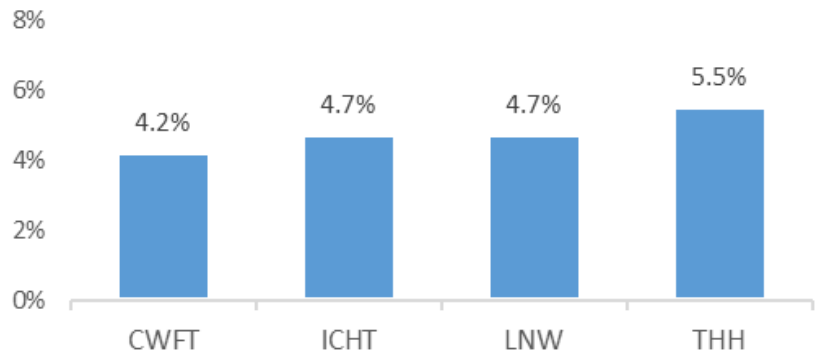
CURRENT PERFORMANCE

Rolling Sickness Absence

	Target %	Month 02 12 Month Rolling Sickness Absence Rate %	Variance to Target %	Month 02 In-Month Sickness Absence Rate %
CWFT	4%	4.2%	-0.2%	4.2%
ICHT	4%	4.7%	-0.7%	4.3%
LNW	4%	4.7%	-0.7%	4.2%
THH	4%	5.5%	-1.5%	5.0%
APG	**4%**	**4.7%**	**-0.7%**	**4.3%**

STRATIFICATION

12 Month Rolling Sickness Absence Rate % across the APC Month 2

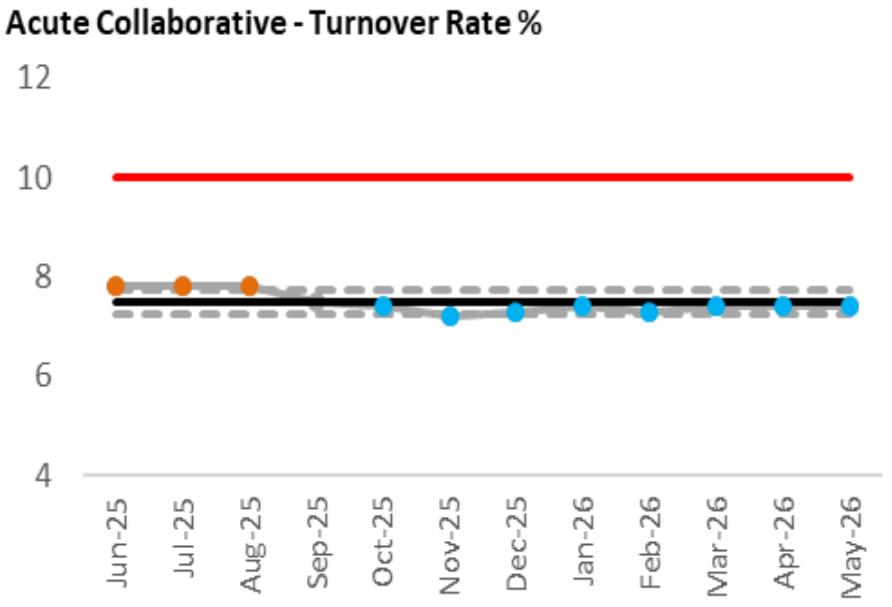


GOVERNANCE

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

Voluntary Turnover

TREND



=/<12%

STANDARD

7.4%

PERFORMANCE

TREND

ASSURANCE

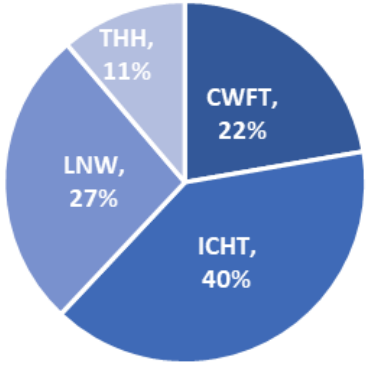
CURRENT PERFORMANCE

Voluntary Turnover

	Target %	Month 02 Turnover Rate %	Variance to Target %	Voluntary Leavers WTE (rolling 12 months)
CWFT	10%	7.6%	4.4%	467
ICHT	10%	7.2%	4.8%	833
LNW	10%	7.1%	4.9%	560
THH	10%	8.5%	3.5%	236
APG	**10%**	**7.4%**	**4.6%**	**2,096**

STRATIFICATION

Trust proportion of voluntary leavers wte (rolling 12 months) across the APC Month 2



NARRATIVE

Performance: Voluntary turnover continues as a special cause improving variation with low voluntary turnover across all four Trusts. As APG voluntary turnover rate is lower than London position (9.1%) and national position of 8.7%.

Recovery Plan / Improvements: Trusts are sharing retention initiatives to inform coordinated local and collaborative action, with continued focus on exit interviews and Stay Conversations in hotspot areas (ICU, midwifery and AHPs). Insight is informing updated retention plans, supported by an established and increasingly aligned wellbeing offer across the Collaborative. Relocation remains a key reason for leaving – with limited opportunity for Trusts to influence. However, data quality issues (notably 'other/unknown' leaver reasons) are limiting analysis, and work is underway to improve data capture to better target interventions.

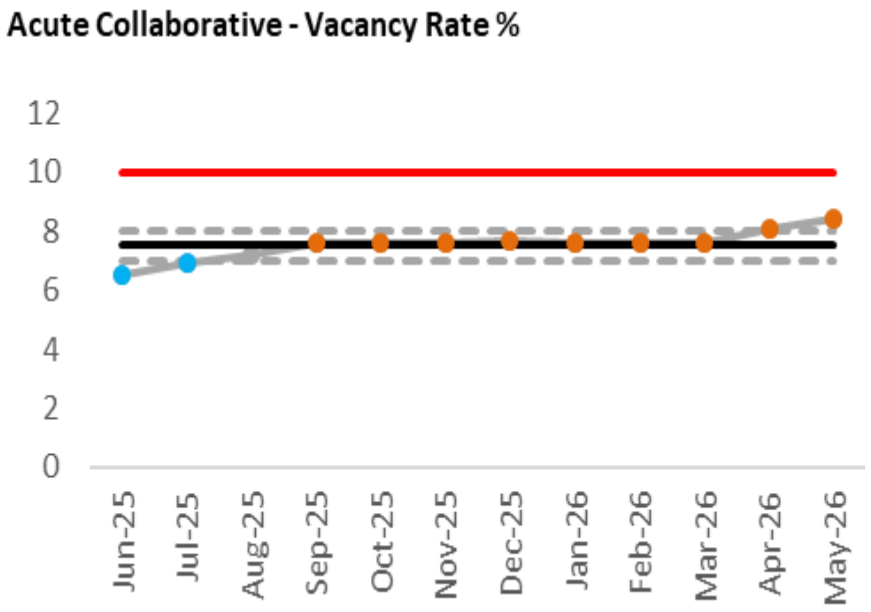
Forecast Risks: The current cost of living issue is one which we are taking seriously, and our CEOs have agreed a common package of measures to support staff.

GOVERNANCE

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

Vacancies

TREND



=/<10%

STANDARD

8.4%

PERFORMANCE

H

TREND

P

ASSURANCE

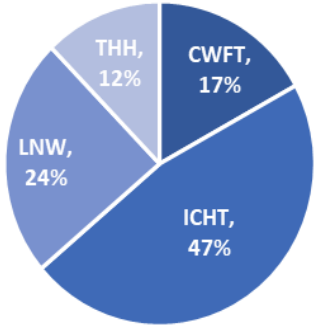
CURRENT PERFORMANCE

Vacancies

	Target %	Month 02 Vacancy Rate %	Variance to Target %	Vacancy WTE
CWFT	10%	6.8%	3.2%	530
ICHT	10%	9.1%	0.9%	1,459
LNW	10%	7.8%	2.2%	744
THH	10%	9.8%	0.2%	383
APG	**10%**	**8.4%**	**1.6%**	**3,115**

STRATIFICATION

Trust proportion of vacant WTE across the APC Month 2



NARRATIVE

Performance: Since January 2024, the collaborative vacancy level has maintained below the agreed target of 10.0% and in May 2026 was 8.4% (London position 6.9% and National position 6.4%).

At collaborative level, we have seen a slow rise in vacancies over the past year which has been influenced by agreed strategies for non-recurrent cost savings as well as enabling newly qualified nurses and midwives to be accommodated with permanent appointments.

Collaborative action remains focussed on hard to fill vacancies with our top areas of concern as: Operating Department Practitioners, Sonographers, Occupational Therapists and Mental Health Nurses.

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

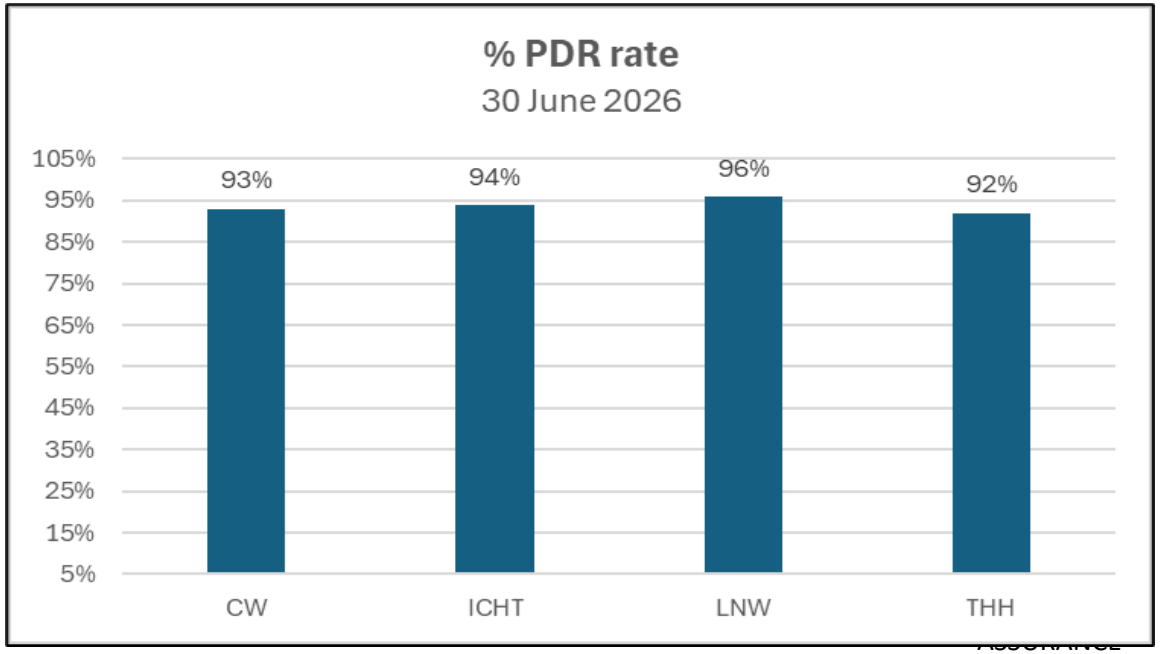
Forecast Risks: High levels of vacancies puts additional pressure on bank staffing demand.

GOVERNANCE

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

Non-Medical PDR

TREND



CURRENT PERFORMANCE

STRATIFICATION

NARRATIVE

All 4 Trusts now operate a PDR window 1 April – 30 June for PDRs for all A4C staff

Data represents the position at each Trust as at Tuesday 30th June. Managers have an additional 7-day window to finish recording PDRs and a final compliance will be reported on 13/14 July. Follow up action is in place with any managers who have not been able to achieve 95% of their PDRs.

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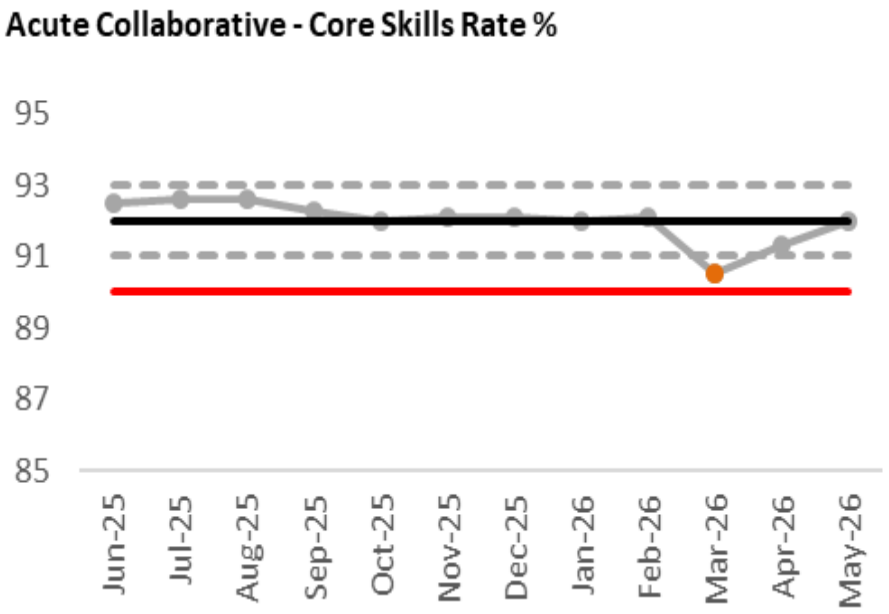
GOVERNANCE

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

Mandatory Training Compliance

TREND



=/<90%

STANDARD

92.0%

PERFORMANCE

TREND

P

ASSURANCE

NARRATIVE

Performance: Mandatory training compliance is essential in the delivery of safe patient care as well as supporting the safety of staff at work and their ability to carry out their roles and responsibilities in an informed, competent and safe way. All Trusts across the APC continue to perform well against the target for Mandatory Training compliance and it is not an area of concern at collaborative level.

Recovery Plan / Improvements: Topic level performance monitoring and reporting is key to driving continual improvement with current areas for focus. The induction programmes for Resident Doctors includes time for them to complete the online elements of their mandatory training, which is essential during high rotation activity including December and April. Where possible, auto-reminders are in place for both employees and their line managers to prompt renewal of core skills training as are individual online compliance reports as well as previous mandatory training accredited for new starters and doctors on rotation to support compliance.

Forecast Risks: None

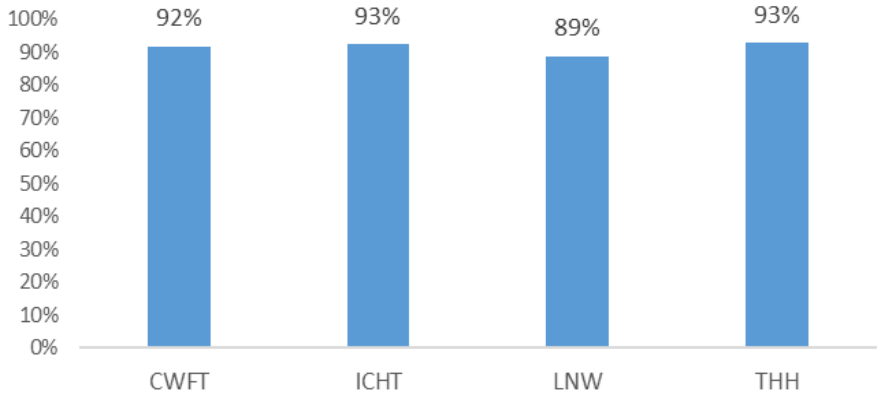
CURRENT PERFORMANCE

Mandatory Training Compliance

	Target %	Month 02 Mandatory Training Compliance Rate %	Variance to Target %
CWFT	90%	91.9%	1.9%
ICHT	90%	93.2%	3.2%
LNW	90%	89.8%	-0.2%
THH	90%	93.3%	3.3%
APG	**90%**	**92.0%**	**2.0%**

STRATIFICATION

Month 2 Mandatory Training Compliance Rate % by Trust across the APC

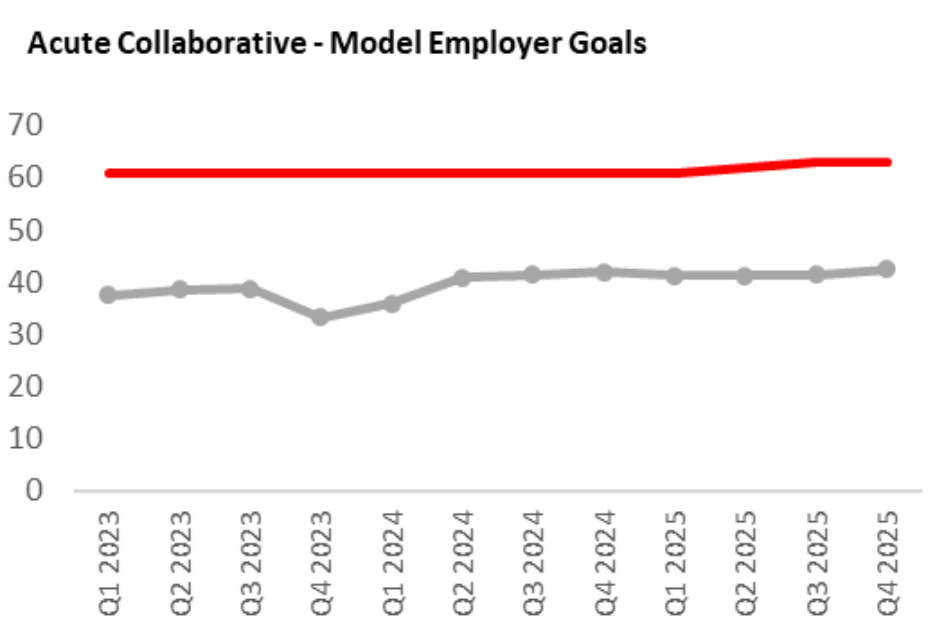


GOVERNANCE

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

Model Employer Goals

TREND



=/<61%

STANDARD

42.4%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: Since April 2023(Q1), the collaborative MEG level has increased by 5 percentage points to 42.4% as at April 2026 (Q4).

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

Forecast Risks: None

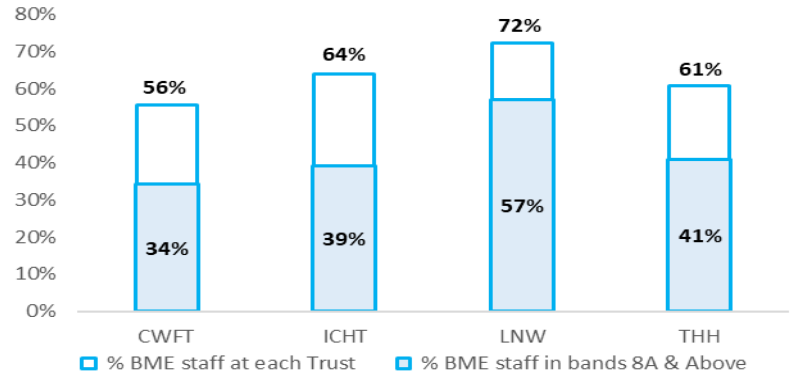
CURRENT PERFORMANCE

Model Employer Goals

	Target %	Month 1 Model Employer Goals %	Variance to Target %
CWFT	56%	34.1%	-21.4%
ICHT	64%	39.1%	-24.9%
LNW	72%	57.1%	-15.2%
THH	61%	40.8%	-20.0%
APG	**63%**	**42.4%**	**-20.7%**

STRATIFICATION

Month 12 Model Employer Goals % by Trust across the APC



GOVERNANCE

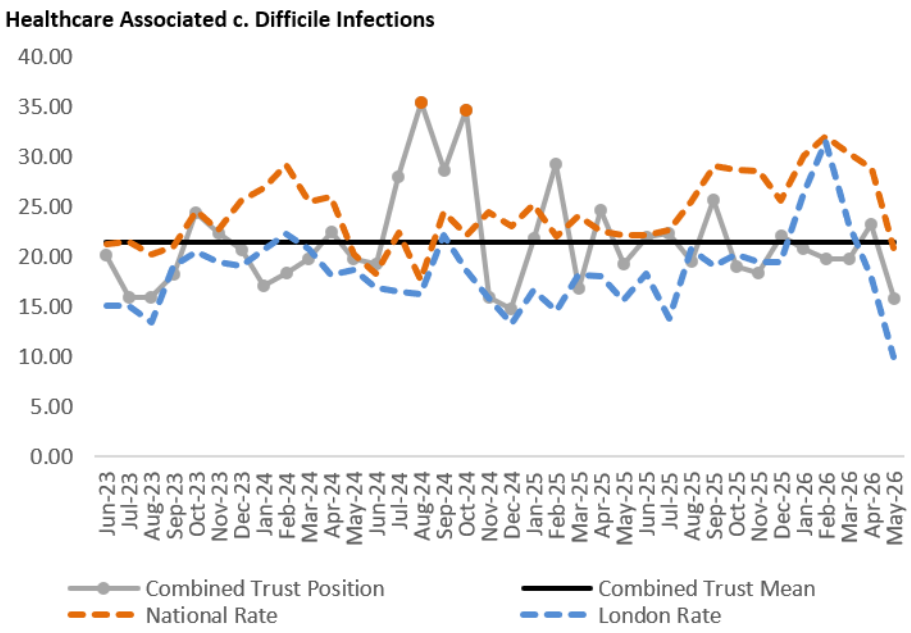
Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC People Committee
Data Assurance: Model Employer Goals (MEG) look at the level of recruitment required to achieve equity and representation of Black, Asian and minority ethnic people within the senior workforce (bands 8a to VSM). MEG uses the difference between the proportion of known ethnicities of an organisation against existing proportion of known ethnicities within each band Data is supplied by each trust individually and quality assured through each organisation's internal processes.

Section 4: Statutory and Safety Reports

May 2026

Healthcare Associated C.Difficile Infections

TREND



Trust Specific

STANDARD

15.78

PERFORMANCE

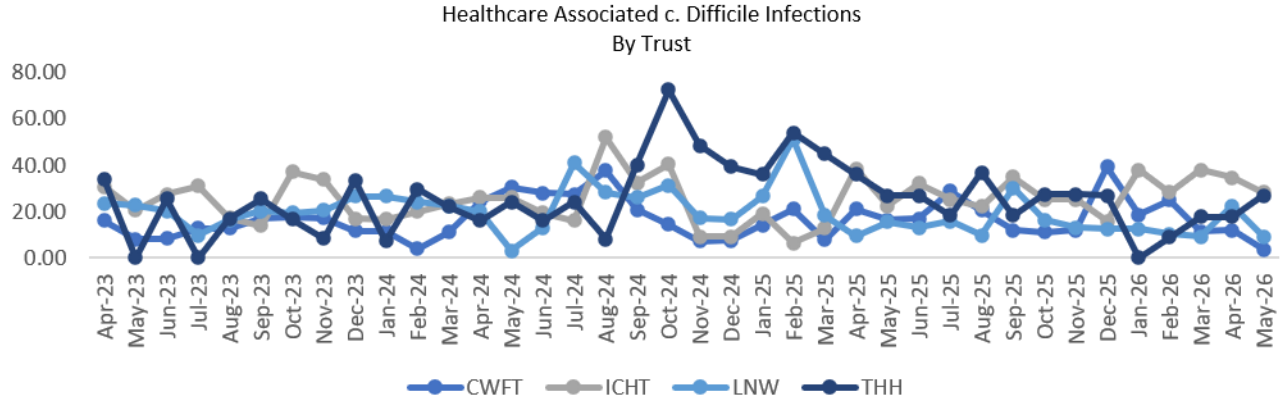
TREND

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 26/27)	Trust Threshold (FY 26/27)	Difference from Threshold
CWFT	25,956	1	3.85	17.57	4		
ICHT	31,694	9	28.40	28.98	20		
LNW	32,581	3	9.21	14.51	10		
THH	11,190	3	26.81	21.14	5		
APC	**101,421**	**16**	**15.78**	**20.66**	**39**		

STRATIFICATION



NARRATIVE

Performance: All trusts except LNW exceeded their annual threshold set by NHSE for 2025-26. Thresholds have not yet been confirmed for 2026-27. There has been a recent decrease at LNW and CWFT, with increases at ICHT and THH.

Recovery plan: Actions at ICHT are focused on reinforcing early recognition and sampling, improving documentation, and strengthening isolation and cohorting practices. Trust-wide commode audits and practice checks continue to support improvements in environmental decontamination. THH has identified learning related to appropriate antimicrobial stewardship with targeted education sessions arranged.

Improvements: To support improvement across the APG IPC practice is a quality priority for 2026-27, a steering group is in place with five workstreams. For Cdiff we are working on standardising reporting and testing processes and a review of MDT input.

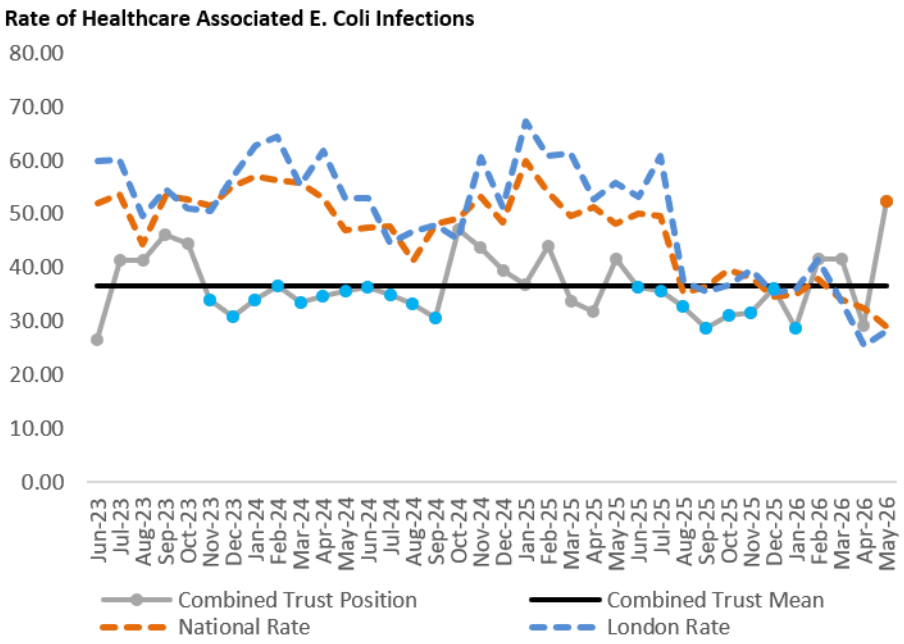
Forecast Risks: National rates are beginning to decrease. Each Trust is set a different threshold not necessarily reflective of the increased admissions or patient complexity of their organisation and are working on reducing numbers.

GOVERNANCE

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

Healthcare Associated E. coli Infections

TREND



Trust Specific

STANDARD

52.3

PERFORMANCE

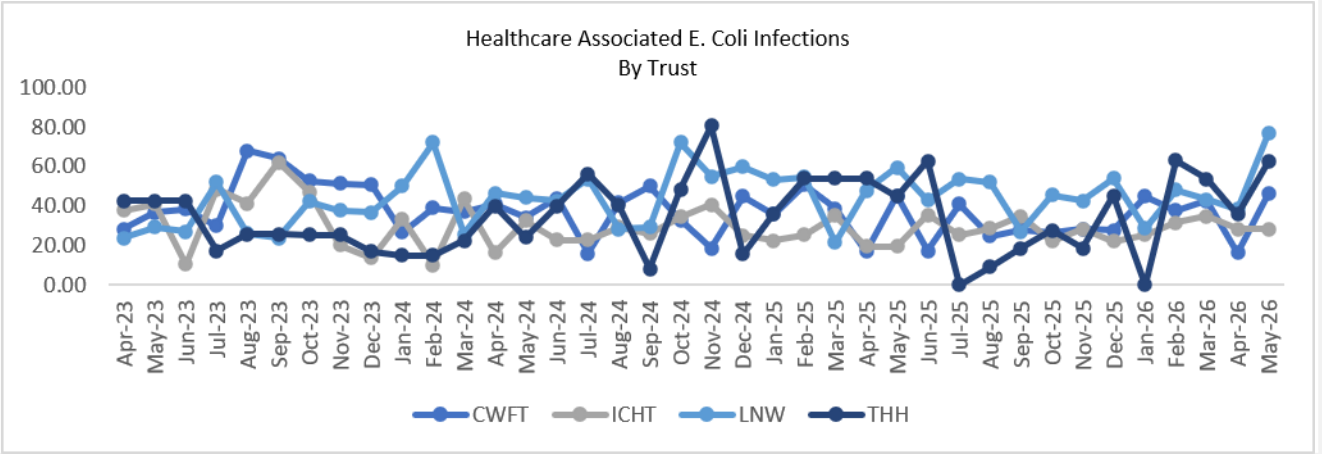
TREND

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 26/27)	Trust Threshold (FY 26/27)	Difference from Threshold
CWFT	25,956	12	46.23	31.83	16		
ICHT	31,694	9	28.40	28.72	18		
LNW	32,581	25	76.73	46.23	37		
THH	11,190	7	62.56	33.22	11		
APC	**101,421**	**53**	**52.26**	**35.51**	**82**		

STRATIFICATION



NARRATIVE

Performance: All trusts except CWFT exceeded their annual threshold for 2025-26. Thresholds have not been set for 2026-27. Following a reduction between June and December 2025, there was a small increase in cases across the APG in Q1, with a significant increase in May 2026.The in-month rise is driven by an increase across most Trusts, but especially within LNW.

Recovery Plan:. Catheter care and device care remain challenges in all organisations, with all trusts focusing on actions around device management, early recognition and timely treatment. At LNW, the primary source continues to be urinary tract infections (UTIs), with a prevention bundle in place, focused on catheter necessity, insertion, and ongoing maintenance.. CWFT have noted a shift towards more GI and hepatobiliary sources for BSI, which they are reviewing.

Improvements: Improving IPC practice is an APG quality priority for 2026-27, a steering group is in place with five workstreams including Gram negative blood stream infections & catheter-associated urinary tract infection reduction, now being developed into a programme of work which will be delivered over the next 24 months. This is being presented separately to APG QC.

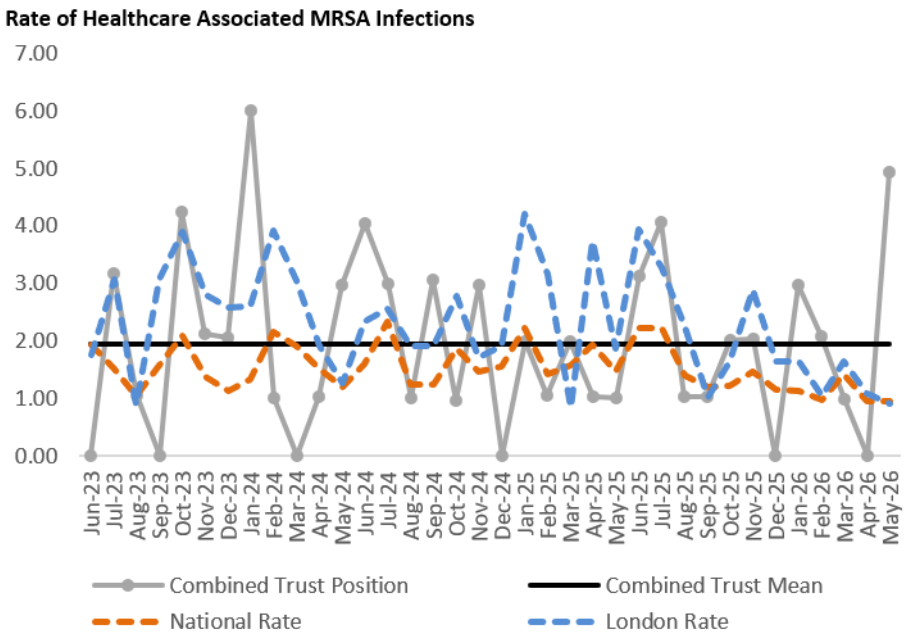
Forecast Risks: National rates are beginning to decline; however, Trust thresholds are set nationally and do not fully reflect rising admissions and patient complexity

GOVERNANCE

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

Healthcare Associated MRSA Infections

TREND



0

STANDARD

5

PERFORMANCE

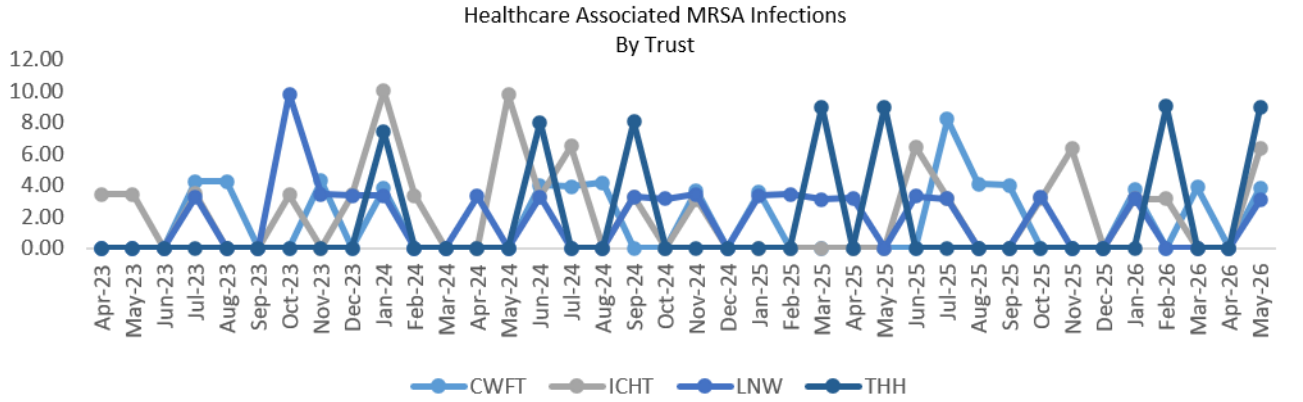
TREND

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 26/27)	Trust Threshold (FY 26/27)	Difference from Threshold
CWFT	25,956	1	3.85	2.32	1		
ICHT	31,694	2	6.31	2.63	2		
LNW	32,581	1	3.07	1.34	1		
THH	11,190	1	8.94	1.51	1		
APC	**101,421**	**5**	**4.93**	**2.02**	**5**		

STRATIFICATION



NARRATIVE

Performance: There were five MRSA BSI reported in month, two of which were at ICHT.

Recovery Plan: At ICHT, a bacteraemia reduction plan is in place with weekly line care and screening data now reported to Exec to increase oversight. The May case and a line related never event identified issues with the use of the insertion LocSSIP, an MDT review is underway with immediate actions in the ITU's. All trusts have an improvement plan in place.

Improvements: Improving clinical standards for infection prevention and control and reducing hospital acquired infection is an APG quality priority for 2026-27. To support this, a new APG IPC Collaborative Improvement Group has been established, with five workstreams, including MRSA and bacteraemia reduction, now being developed into a programme of work which will be delivered over the next 24 months. This is being presented separately to APG QC.

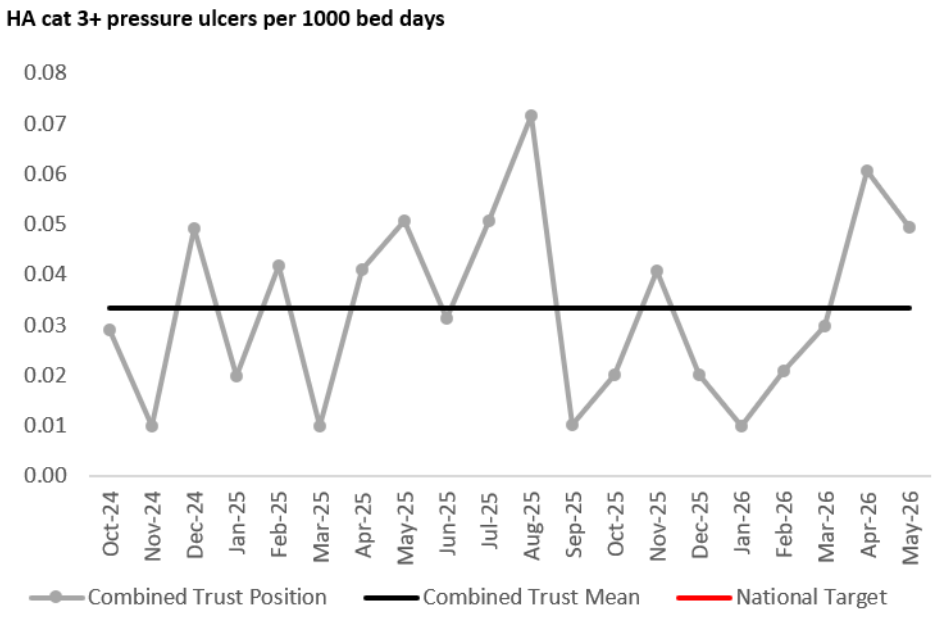
Forecast Risks: The threshold for 2026/27 will remain 0 – all trusts will continue to work on MRSA reduction.

GOVERNANCE

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

Pressure Ulcers (per 1000 bed days)

TREND



-

STANDARD

0.05

PERFORMANCE

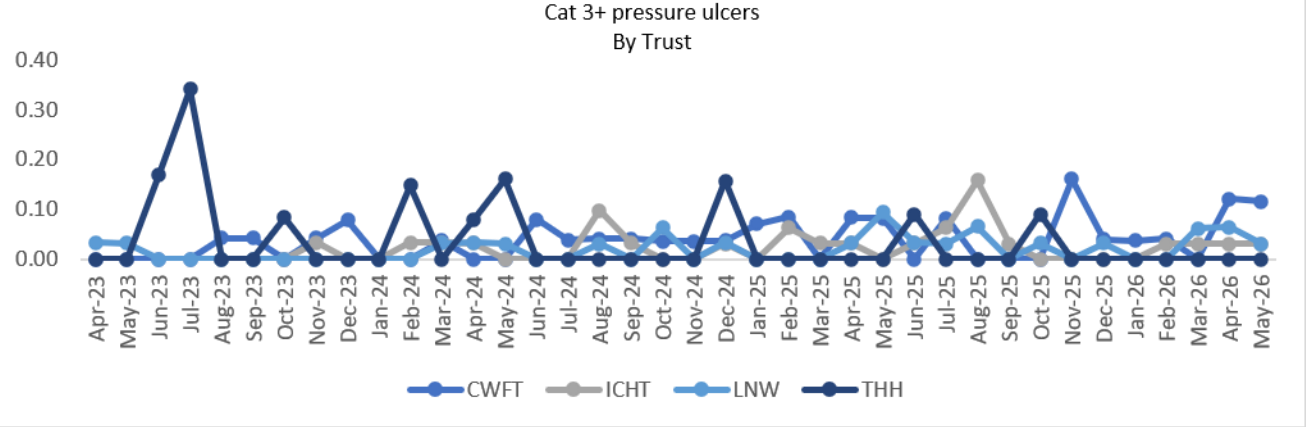
TREND

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	25,956	0.12	3	15	0.05
ICHT	31,694	0.03	1	13	0.03
LNW	32,581	0.03	1	11	0.03
THH	11,190	0.00	0	2	0.02
APC	**101,421**	**0.05**	**5**	**41**	**0.03**

STRATIFICATION



NARRATIVE

Performance: This metric shows the rate of hospital acquired pressure ulcers graded as category 3 and 4. The figures are based on data reported in the Trusts' incident reporting systems and is not risk adjusted.

Recovery Plan: Cases are being reviewed by each organisation to identify learning which will feed into local safety improvement programmes. There has been a small increase over the last 2 months at CWFT. Targeted support and training has been implemented including an increased visibility of the tissue viability team on the wards and delivering of regular bite sized training on the wards. This is being monitored through the pressure ulcer group.

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

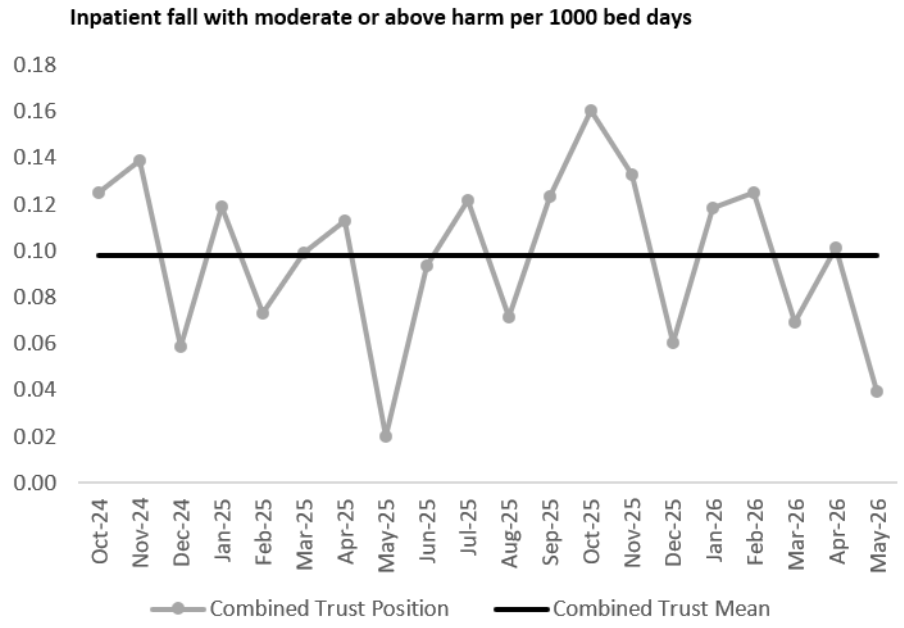
Forecast Risks: No risks identified.

GOVERNANCE

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

Inpatient falls (per 1000 bed days)

TREND



-

STANDARD

0.04

PERFORMANCE

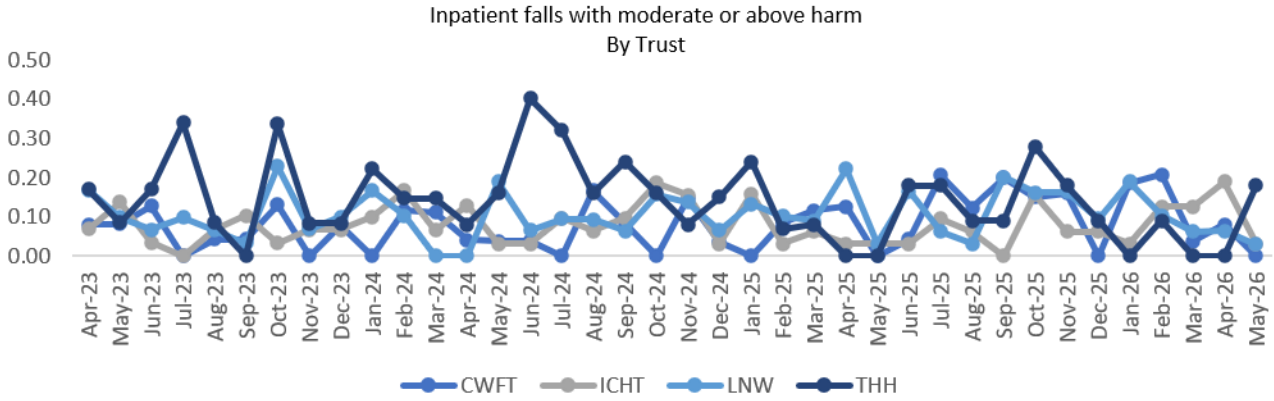
TREND

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	25,956	0.00	0	33	0.11
ICHT	31,694	0.03	1	31	0.08
LNW	32,581	0.03	1	41	0.11
THH	11,190	0.18	2	15	0.11
APC	**101,421**	**0.04**	**4**	**120**	**0.10**

STRATIFICATION



NARRATIVE

Performance:12 month rolling rates show only small variations between trusts.

Recovery Plan: The cases are reviewed via each organisation's PSIRP to identify learning which feeds into local safety improvement programmes. ICHT declared 2 PSIRF MDT reviews in April following small increases in ED and renal. At LNW & CWFT reductions are noted with targeted falls prevention initiatives and a new falls strategy at CWFT. At THH targeted support and quality improvement initiatives are underway in areas with higher numbers. The trust-wide falls action plan has been reviewed to ensure it aligns with actions and learning from PSIRF learning responses.

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

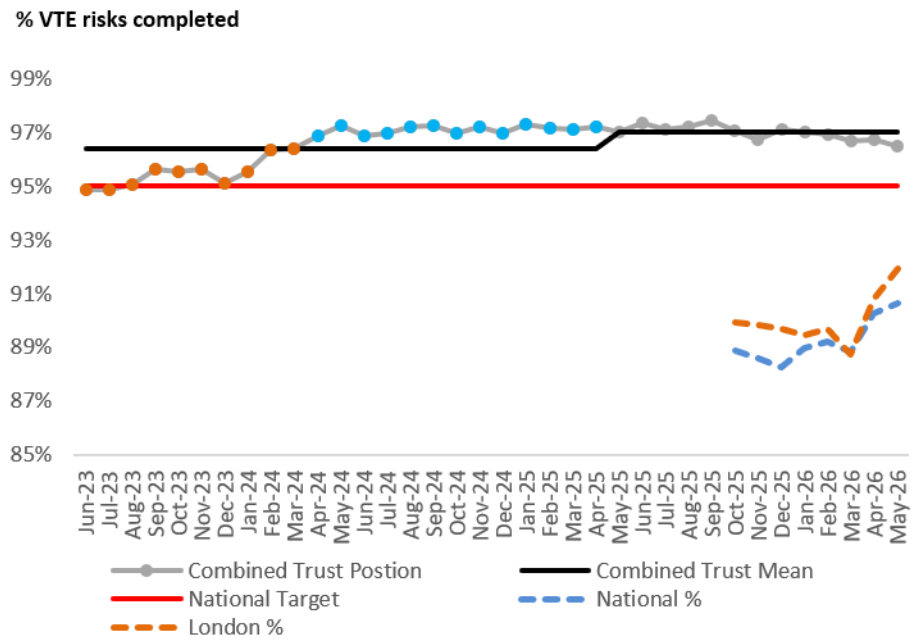
Forecast Risks: No risks identified.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: APC Executive Management Board (Chair: Tim Orchard)
Data Assurance: This metric shows the rate of falls reported as causing moderate or above harm to patients per 1000 bed days. Data is not risk adjusted. Data is supplied by each trust individually and quality assured through each organisation's internal processes.

VTE Risk Assessments

TREND



95%

STANDARD

96.7%

PERFORMANCE

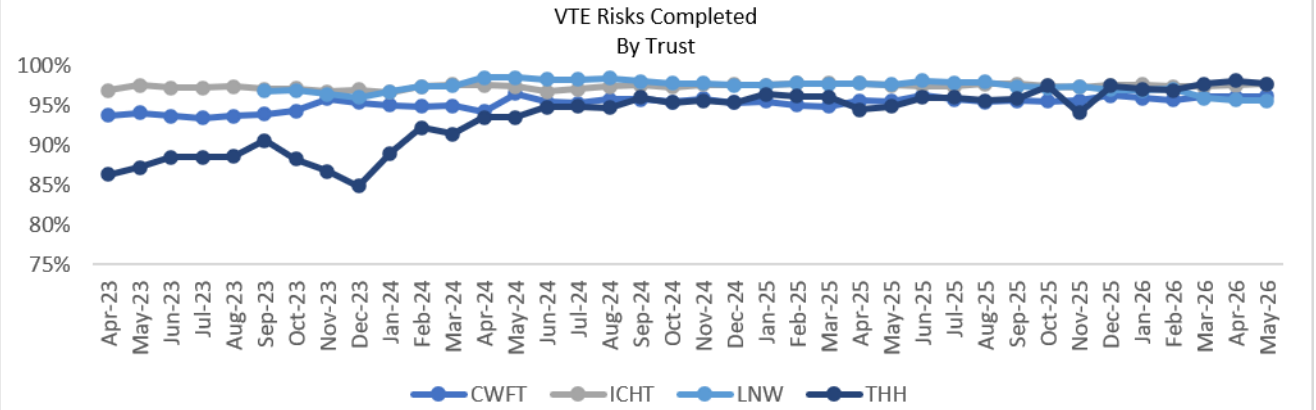
TREND

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	7,320	96.2%		7,042	95.9%
ICHT	16,671	97.7%		16,287	97.5%
LNW	13,502	95.6%		12,906	97.0%
THH	3,965	95.2%		3,773	96.8%
APC	**41,458**	**96.5%**		**40,008**	**97.0%**

STRATIFICATION



NARRATIVE

Performance: We continue to perform considerably better than the London and national rates. We are above the standard in-month and across the last 12 months in all Trusts.

Recovery Plan: Not applicable.

Improvements: Not applicable.

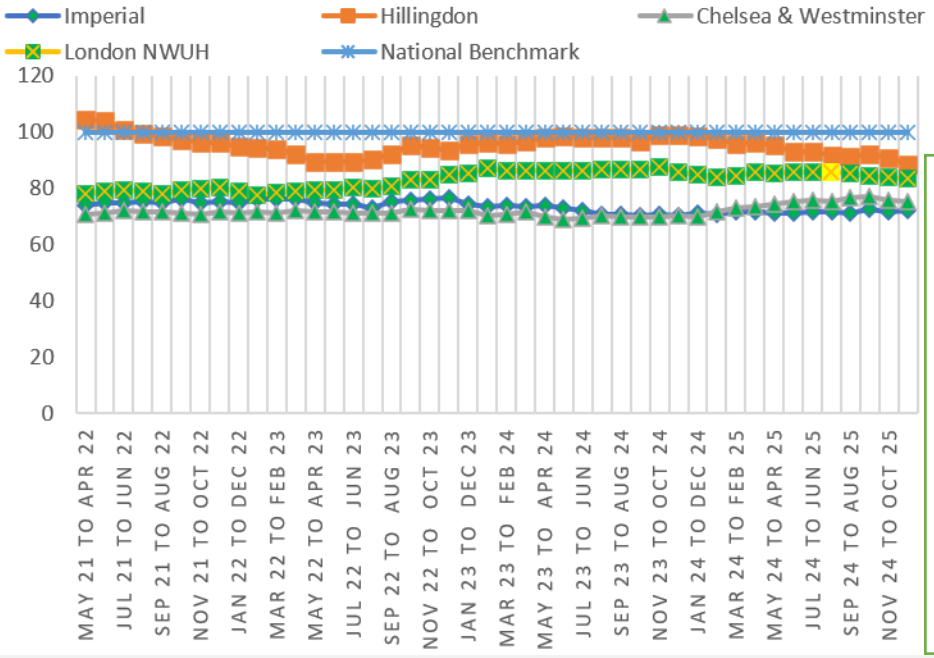
Forecast Risks: No risks identified.

GOVERNANCE

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

Summary Hospital-level Mortality Index

TREND



100
England Average

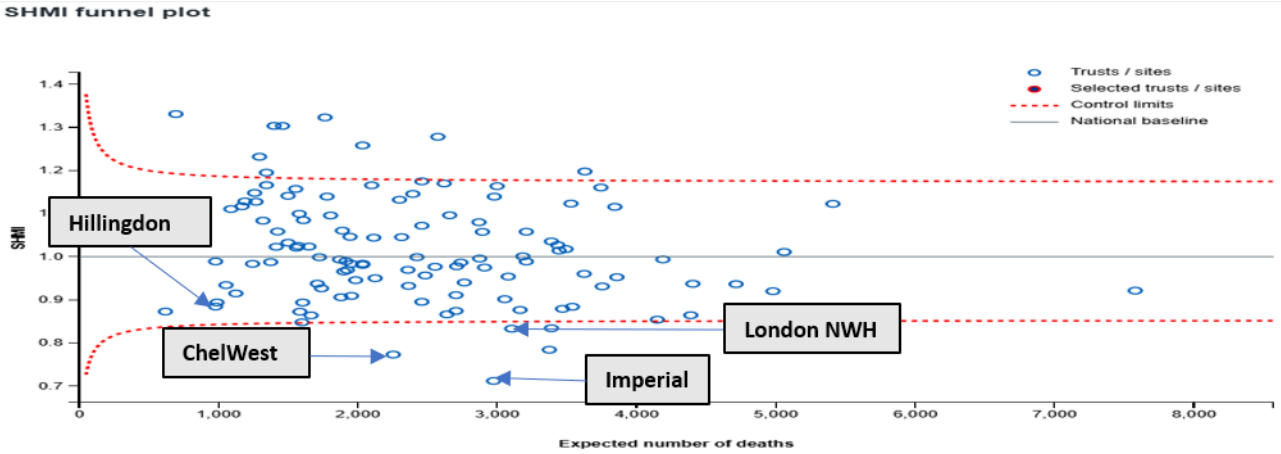
STANDARD

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' SHMI for the data period.
Where data point is red, this represents a high HSMR for the data period.

CURRENT PERFORMANCE

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	84835	75.26	Lower than expected
ICHT	116795	71.94	Lower than expected
LNW	106425	83.54	Lower than expected
THH	45595	88.53	As expected

STRATIFICATION



NARRATIVE

Performance: For three of the four trusts (CWFT, LNW and ICHT), the rolling 12-month SHMI remains lower than expected with the most recent data available (Dec 2024 to Nov 2025). THH's rate is consistently 'as expected'. All trusts remain below the national benchmark of 100.

Recovery Plan: Not applicable.

Improvements: All Trusts investigate variations between observed and expected deaths by diagnostic group. Reviews for quarter four will be summarised in the learning from deaths report presented to APG Quality Committee and the Board in Common.

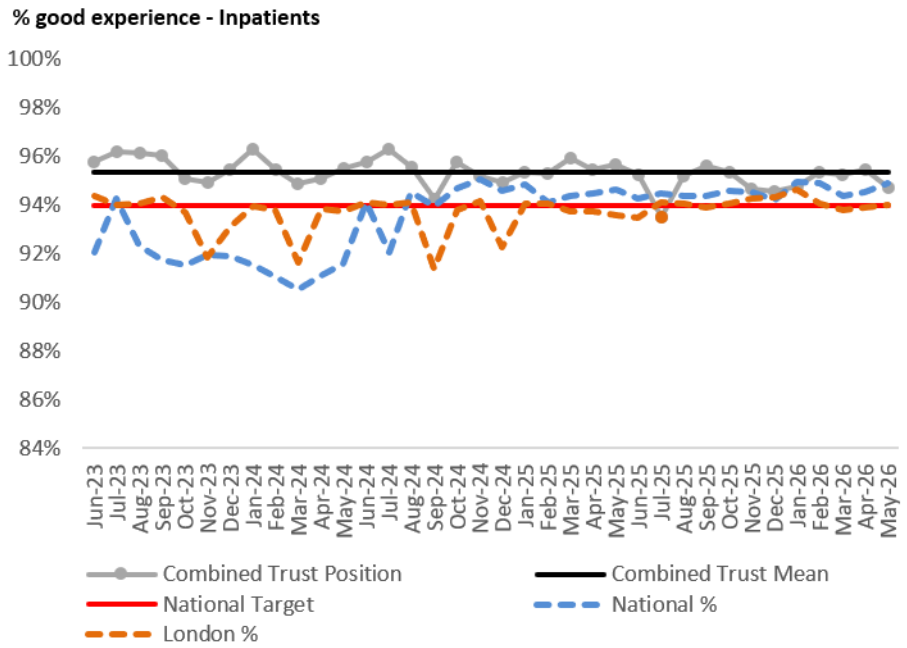
Forecast Risks: No risks identified.

GOVERNANCE

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

Inpatient Friends & Family Test

TREND



94%

STANDARD

94.7%

PERFORMANCE

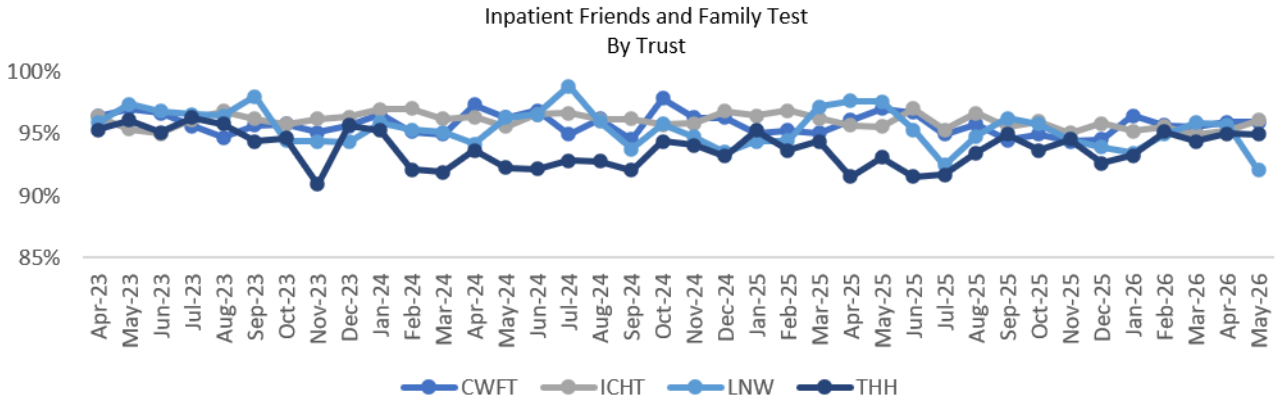
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	1,699	95.9%		1,630	95.4%
ICHT	2,082	96.1%		2,001	95.7%
LNW	1,963	92.1%	-1.95%	1,807	94.6%
THH	1,233	95.0%		1,171	93.7%
APC	**6,977**	**94.7%**		**6,609**	**95.0%**

STRATIFICATION



NARRATIVE

Performance: percentage of inpatients reporting a good experience remains consistently above target at APG level. There was a reduction in LNW in month, driven by lower scores given in Clinical Decisions and Emergency Care Units prior to admission.

Recovery Plan: Not applicable.

Improvements: The 2025 CQC national inpatient survey will be published in August 2026. An analysis of performance will be presented to APGQC once the results have been reviewed locally.

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 Executive Management Board (Chair: Tim Orchard)
Data Assurance: Data is supplied by each trust individually and quality assured through each organisation's internal processes.

4.1 QUALITY

4.1.1 QUALITY - INTEGRATED QUALITY AND PERFORMANCE REPORT (ANYTHING BY EXCEPTION)

Discussion Item | Janice Sigworth/Roger Chinn | 11:50

4.1.2 MATERNITY REVIEWS UPDATE

Discussion Item Rob Bleasdale

REFERENCES

Only PDFs are attached

04.1.2 National Maternity Reviews APG Board in Common July 2026.pdf

NWL Acute Provider Group Board in Common (Public)
28/07/2026
Item number: 4.1.2
This report is: Public

Response to the Amos Investigation, Ockenden Review and Associated National Requirements

Author: Robert Bleasdale
Job title: Chief Nursing Officer (CWFT)

Accountable director: Janice Sigworth
Job title: Lead Chief Nursing Officer (APG)

Purpose of report (for decision, discussion or noting)

Purpose: Information or for noting only

Report history

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

APG Quality Committee 07/07/2026 What was the outcome?	**APG Executive Management Board** 20/07/2026 What was the outcome?	Committee name Click or tap to enter a date. What was the outcome?

Executive summary and key messages

In June 2026, NHS England published the findings of both the Baroness Amos Independent Investigation into Maternity and Neonatal Services in England and the Donna Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust, alongside a national system letter on post-death care and mortuary oversight following the David Fuller Inquiry. These publications collectively identify ongoing national concerns regarding maternity safety, leadership, culture, governance, listening to women and families, workforce pressures, inequalities in outcomes, learning from incidents and organisational accountability.

NHS England National Maternity Panel will consider the findings of these reports and produce a national Action plan. However, in the interim a 10-point plan with immediate actions has been produced. This requires providers to implement a series of immediate actions including the rollout of Martha's Rule, strengthened Board oversight of patient experience and outcomes, dual executive accountability for maternity and neonatal services, workforce reviews, action on

inequalities, maternity triage assurance and improvements in how incidents and complaints are managed. These actions will be supported in the coming weeks with further national guidance, such as the expansion of Martha Rule and national Maternity Triage standards.

The associated NHS England requirements regarding post-death care and mortuary oversight require Trusts to review compliance with relevant recommendations from the Fuller Inquiry, strengthen Board oversight of mortuary services, review safeguarding arrangements for deceased patients and complete a Board Assurance statement by the end of July- 2026.

The Board in Common is asked to note the findings of the national reviews, endorse the proposed programme of assurance activity, to ensure compliance with national requirements and identification of any further improvement actions.

Impact assessment

Tick all that apply

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

Strategic priorities

Tick all that apply

☒ Deliver high quality patient centred care (CWFT)
☒ Be the employer of Choice (CWFT)
☒ Deliver better care at lower cost (CWFT)

☐ 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)

Key risks arising from report

There is a risk that multiple assurance workstreams and improvement workstreams my lead to duplication of reporting, insufficient capacity within teams to respond and in the absence of pending national guidance for some sections may result in multiple changes to practice.

Main Report

1. Introduction

1.1 In June 2026 NHS England published two significant reviews concerning the safety, quality and culture of maternity and neonatal services in England:

- Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England.
- Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (NUH).

1.2 The reviews build upon previous maternity inquiries and highlight persistent concerns regarding safety, culture, governance, leadership, listening to women and families, workforce pressures, inequality and learning from incidents.

1.3 Alongside these publications, NHS England issued a national system letter (appendix 1) regarding post-death care and mortuary oversight, linking the findings of the Ockenden Review with the recommendations arising from the David Fuller Inquiry.

1.4 In response to these publications NHS England issued a letter to providers on 30 June 2026 (appendix 2) setting out a 10-point plan for maternity and neonatal service, taking key elements from the two reports.

1.5 The National Maternity and Neonatal Taskforce will be considering the two reports and producing a national action plan in December 2026. However, in the interim providers are asked to work to implement the 10-point actions.

1.6 This paper provides details of the 10 actions, the current position and approach for the Trusts within the Acute Provider Group.

2. Background

2.1 Baroness Amos Independent Investigation

2.1.1 The Baroness Amos Report refers to the Independent National Maternity and Neonatal Investigation, commissioned by the Government and led by Baroness Valerie Amos to review the safety and quality of maternity and neonatal services across England. The investigation examined:

- The experiences of women, families and babies receiving maternity and neonatal care across England.
- Safety, quality, staffing, leadership, organisational culture and accountability within maternity and neonatal services.
- Evidence from previous maternity reviews and inquiries to determine why similar failings have continued to occur.
- Feedback from over 10,500 responses to a public call for evidence, more than 450 families, and over 9,000 NHS staff.

2.1.2 The investigation undertook detailed reviews of maternity and neonatal services in 12 NHS Trusts that had concerns regarding safety and quality of care. The findings from these reviews were used to identify national themes and recommendations for maternity services across England.

2.1.3 The Amos Investigation concludes that despite significant national efforts to improve maternity and neonatal services, many of the same themes identified in previous reviews remain evident:

- Women and families not always being listened to.
- Inconsistent governance and leadership.

- Variable board oversight.
- Workforce shortages.
- Persistent inequalities in outcomes.
- Poor organisational cultures.
- Failures to act on patient experience, complaints and concerns.

2.1.4 The report has informed the establishment of a National Maternity and Neonatal Taskforce and a forthcoming National Action Plan.

2.1.5 In the immediate term NHS England has issued a national 10 Point Plan requiring all providers and systems to take urgent action, which are detailed in a letter to Trusts 30 June 2026 (appendix 2).

2.2 Ockenden Report into Nottingham University Hospital

2.2.1 The Ockenden Review was commissioned following concerns raised by families about safety and quality of maternity services at Nottingham University Hospitals NHS Trust. The independent review was launched in 2022 and examined maternity and neonatal care provided by Nottingham University Hospitals NHS Trust between 2012 and 2025.

2.2.2 The review became the largest maternity investigation in NHS history, involving:
- More than 2,500 family cases.
- Meetings with over 500 families.
- Engagement from more than 830 current and former staff.
- A review undertaken by a multidisciplinary team of over 160 clinical reviewers.

2.2.3 The review identified repeated themes affecting:
- Leadership and governance
- Failures in Safety and clinical care
- Workforce
- Organisational culture
- Learning from incidents
- Inequalities in care
- Listening to women and families
- Post-death care

2.2.4 The review concluded that many issues were known for years but were not adequately addressed through governance structures, resulting in avoidable harm. A key message of the report is that safe maternity care depends on:
- effective leadership
- robust governance
- compassionate culture
- early escalation
- family involvement
- organisational transparency

2.2.5 The report includes national Immediate and Essential Actions (IEAs) intended for adoption across maternity services in England. These will be considered by the National Maternity Panel, alongside the Amos report in the production of a National Action Plan in December 2026.

2.3 Fuller Inquiry and Post-Death Care

2.3.1 Following the publication of the David Fuller Inquiry and concerns raised within the Ockenden Review regarding post-death care, NHS England has emphasised that all organisations caring for deceased patients must strengthen oversight of:

- dignity after death
- mortuary security
- governance arrangements
- safeguarding responsibilities
- board assurance

2.3.2 The Fuller Inquiry identified significant weaknesses nationally in mortuary governance and concluded that stronger organisational oversight is required to ensure the dignity and security of deceased patients.

2.3.3 NHS England has written to Trusts on 26 June 2026 (appendix 1) asking that the findings detailed within the Ockenden Report be considered alongside the phase two findings and recommendations of the Fuller inquiry. It asks that all mortuaries review HTA reportable incidents (HTARI) between 2015-2026, to ensure that all reportable incidents have been logged appropriately with the HTA, and any missing incidents be reported retrospectively. The HTA will issues a regulatory update in July setting out the parameters, timeframe, process and deadline for the evidential compliance audit.

2.3.4 Additionally, providers are asked to assure themselves that the actions from the Fuller inquiry have been completed and are asked to complete the Board Assurance Statement by 31 July 2026. All four Trusts have completed a detailed assessment against the recommendations and assurance statements. The individual positions have been through Trust governance, and discussed with Quality Non-executive Directors, prior to presentation of the position at the Board in Common on 28 July 2026.

2.3.5 All four Trusts are recommending to Board that the assurance statements are approved, with action plans in place for any area of partial compliance.

3. National Requirements Arising from the Reviews – 10 Point Plan

3.1 NHS England has instructed trusts to prioritise delivery of the following urgent actions:

1. Implement Martha's Rule in Maternity and Neonatal Services

- Rollout across inpatient maternity and neonatal services during 2026/27.
- Covering antenatal, intrapartum and postnatal settings.
- Including maternity triage services.

All four Trusts within the group have already implemented Martha Rule within Maternity services ahead of the national pilot. Work is underway to review and embed the principles across services. This will be supported with the expansion of the national role out, with webinars commencing week beginning 6th July 2026. Neonatal services have not yet formally adopted the process, and there is an opportunity to provide a networked approach across the level 3 units, mirroring the work completed for children's services. This improvement plan for this work will be completed working with the 4 services as part of the Maternity and Neonatal Specialty Board, and the existing deteriorating patients' group who have led on the implementation of Martha's Rule.

2. Strengthen Family Voice and Board Oversight

Monthly board review of:

- patient experience
- outcomes data

- Friends and Family Test
- MNVP intelligence
- clinical audit findings

All four Trusts have embedded processes for the Friend and Family Tests. However, it is recognised this has limited value. CWFT and Imperial ask supplementary questions in keeping with themes from the national survey, which provides greater detail of experience of care. The questions will be shared with Directors of Midwifery, Executive leads for patient experience and a review completed with experience teams to consider standardising this approach, and an options paper discussed in August 2026.

All Trusts have embedded MNVPs who complete quarterly 15 steps visits within services, hold engagement events with women and birthing people and produce quarterly and annual reports.

The service leads in each Trust will review the approach to reporting in line with the Perinatal Quality Framework and findings of these reports. This will be completed as a priority through the establishment of the specialty boards and will include a review of the metrics through to Board in Common. The proposed approach will be completed for approval at the APG Quality Committee in September.

3. Establish Dual Board-Level Accountability

Joint accountability for Maternity and Neonatal services between the Chief Nurse and Chief Medical Officer.

The CNO and CMO have shared executive responsibility for patient safety and quality in all Trusts on the board. As part of these actions Trusts will review reporting and governance.

4. Participate in the National "Amos into Action" Staff Listening Programme

Following publication of the reports each of the Director of Midwifery has supported staff within services, through discussions and listening events. There will be a national approach to engagement with events for staff and leaders within services, which will be collated nationally. Leadership teams will be supported to attend these events once publicised.

5. Address Maternity Inequalities

- Participation in the Perinatal Equity and Anti-Discrimination Programme.
- Board oversight of maternity inequalities data.
- Action plans addressing disparities in outcomes.

The Perinatal Equity and Anti-discrimination programme will be available to all Trusts nationally by the end of 2026, and we will ensure Trusts participate in this. All four Trusts have established maternity cultural safety teams and have achieved bronze award or working towards this of the Capital Midwife Anti-Racism framework. There is a combined APG quality priority for the booking of black and brown women at 9+6, which is monitored through Trusts and APG quality committee. Alongside this and the other recommendations services will review the reporting that is in place to ensure we capture and report outcomes by ethnicity, alongside use of the national equalities dashboard. The implementation of Ideagen across the APG should help improve data accuracy and support with triangulation of data.

6. Implement Maternal Care Bundle

Full implementation of the care bundle is required by March 2027. Each of the four Trusts has an improvement plan in place to support the implementation. The Specialty Board will provide an opportunity to share practice and support implementation. Trusts will provide a report to EMBs in September, and a combined escalation report will be provided to the APG Quality Committee alongside the position for the Maternity Incentive Scheme in September.

7. Review Workforce Resilience

Including:

- 24/7 staffing arrangements
- deployment models
- specialist roles
- skill mix

Trusts complete a bi-annual safe staffing review using professional judgement, acuity and dependency scoring and incident data for maternity and nursing. This is supported daily through the use of red flags to highlight skill mix of quality concerns. Staff are redeployed across pathways as required. The individual Trust Director of Midwifery will undertake a review of specialist posts within the services to align principles of clinical commitments and support the wider development of the workforce. The review will also include members of the obstetric and anaesthetic workforce.

8. Home Birth Review

Board assurance that previous national review requirements have been completed following a letter from the Chief Midwifery Officer in November 2025.

All Trusts completed a review of their homebirth services during quarter 3 2025/26. Directors of Midwifery have been asked to review this assessment and present the updated position, and improvement plans to EMB's in July, and a combined position will be included in the report to the APG Quality Committee in September. This will be reviewed again once national standards are published for homebirth services, which is anticipated later in the year.

9. Improve Complaints and Incident Response

Ensure maternity incidents are managed with:

- candour
- compassion
- trauma-informed approaches

Whilst waiting for the national guidance/blue print from the task force, all four Trusts continue to strengthen the role of the MNVP and support for compassionate engagement. All formal complaints are reviewed and signed by a member of the executive team. The MNVP are active members of the PMRT and PSIRF learning response process to ensure the voice of the women is heard and understood. In addition, an annual audit of complaints is completed with the MNVPs to provide feedback and useful insights into how the complaints have been managed.

10. Maternity Triage Review

New national standards for Triage were published week beginning 6 July 2026. It asks providers to complete a board level audit within three months. To support consistency a national audit tool should be used. This has not yet been published and is anticipated in the coming weeks. The audit and assessment should include a review of the appropriate staffing and skill mix across the 24 hours and the week. Following the audit providers

should have a plan in place to implement the triage standards within 12 months, with regular oversight and reporting of clinical standards.

Currently all Trusts have a maternity triage service, however there is variation in the models and use of standards such as BSOTS and recording and auditing of calls to the telephone line. Following publication of the standards a working group will be established to complete the audit and develop an improvement plan for the individual Trusts, offering an opportunity to share practice.

4. Fuller Inquiry and Mortuary Requirements

4.1 NHS England has requested all providers review compliance with the 29 NHS-relevant Fuller recommendations, in addition to the board assurance statement by 31 July and to the HTA requirement to review and assure completeness of incident records over the past 10 years.

4.2 Trusts have completed a review of their processes having previously reported assurance positions against the Fuller recommendations. Individual positions have been presented through Trust governance committees, with a combined paper presented at the Board in Common on 28 July 2026, prior to submission.

5. Conclusion

5.1 The majority of requirements identified within the Amos Investigation, Ockenden Review and Fuller Inquiry align with existing Trust programmes of work relating to maternity safety, patient experience, Freedom to Speak Up, workforce, quality governance, safeguarding and mortuary oversight.

5.2 The APG will be establishing a Maternity and Neonatal Specialty Board which will provide the forum to bring service clinical and managerial leaders together to implement the standards, providing a space for collaboration and shared learning.

5.3 Whilst the formal National Action Plan in December an initial gap analysis will be completed, which will inform the improvement plan and review of the reporting requirements.

4.1.3 LEARNING FROM DEATHS - QUARTER 4 REPORT

Discussion Item Roger Chinn

REFERENCES

Only PDFs are attached

04.1.3 APG BiC Learning From Deaths Combined Report Q4 25-26 v3.pdf

NWL Acute Provider Group Board in Common
28/07/2026
Item number: 4.1.3
This report is: Public

Acute Provider Group Learning from Deaths Report, Quarter 4 2025/26

Author: Laila Gregory
Job title: Clinical Effectiveness Lead, LNWH

Accountable director: Jon Baker, Alan McGlennan, Roger Chinn, Raymond Anakwe & David O'Callaghan
Job title: Chief Medical Officers

Purpose of report (for decision, discussion or noting)

Purpose: Assurance

Trusts are required to report information to their public board regarding their learning from deaths process. This has been achieved through a detailed quarterly report to individual Trust standing committees with this overarching summary paper drawing out key themes and learning from the four acute provider group (APG) Trusts. This report is presented to the APG quality committee and the Board-in-common with individual reports in the reading room.

Report history

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

Trust Executive Groups and Standing Committees	**APG Quality Committee**	**Committee name**
Various dates	07/07/2026	Click or tap to enter a date.
Individual Trust reports were reviewed at each standing committee and approved for onward submission.	The committee noted the combined report, and the Trust level reports in the reading room with no new issues for escalation.	What was the outcome?

Executive summary and key messages

The Acute Provider Group (APG) Trusts use the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor relative risk of mortality. At the time of reporting (Q4 reports were initially considered by Trusts in June 2026) all organisations continue to operate at lower than, or as expected, relative risk when compared nationally. All Trusts investigate variations between observed and expected deaths at diagnostic group level; no clinical concerns were identified through review this quarter (Q4).

Each Trust has well embedded mortality review processes which ensure in-hospital deaths are systematically reviewed to understand the quality of care provided, identify any potential learning factors, and determine whether there are opportunities for improvement. During this quarter a small number of clinical concerns were identified via this process; 7 cases of sub-optimal care where different care might have made a difference to outcome (CESDI 2). No common themes were identified across these cases and further learning, and improvement opportunities are being sought via the incident management process.

Impact assessment

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

Strategic priorities

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

Key risks arising from report

No key risks for escalation this reporting cycle.

Main Report

1. Introduction

The APG Trusts' mortality surveillance programmes offer assurance to patients, stakeholders, and the Board that high standards of care are being provided and that gaps in service delivery are being effectively identified, escalated, and addressed. This report provides an APG level review of mortality learning for Q4 2025/26.

2. Relative Risk of mortality

The APG Trusts use the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. These tools determine the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths to provides a relative risk of mortality ratio (where 100 is the expected national benchmark).

2.1. Summary Hospital-level Mortality Indicator (SHMI)

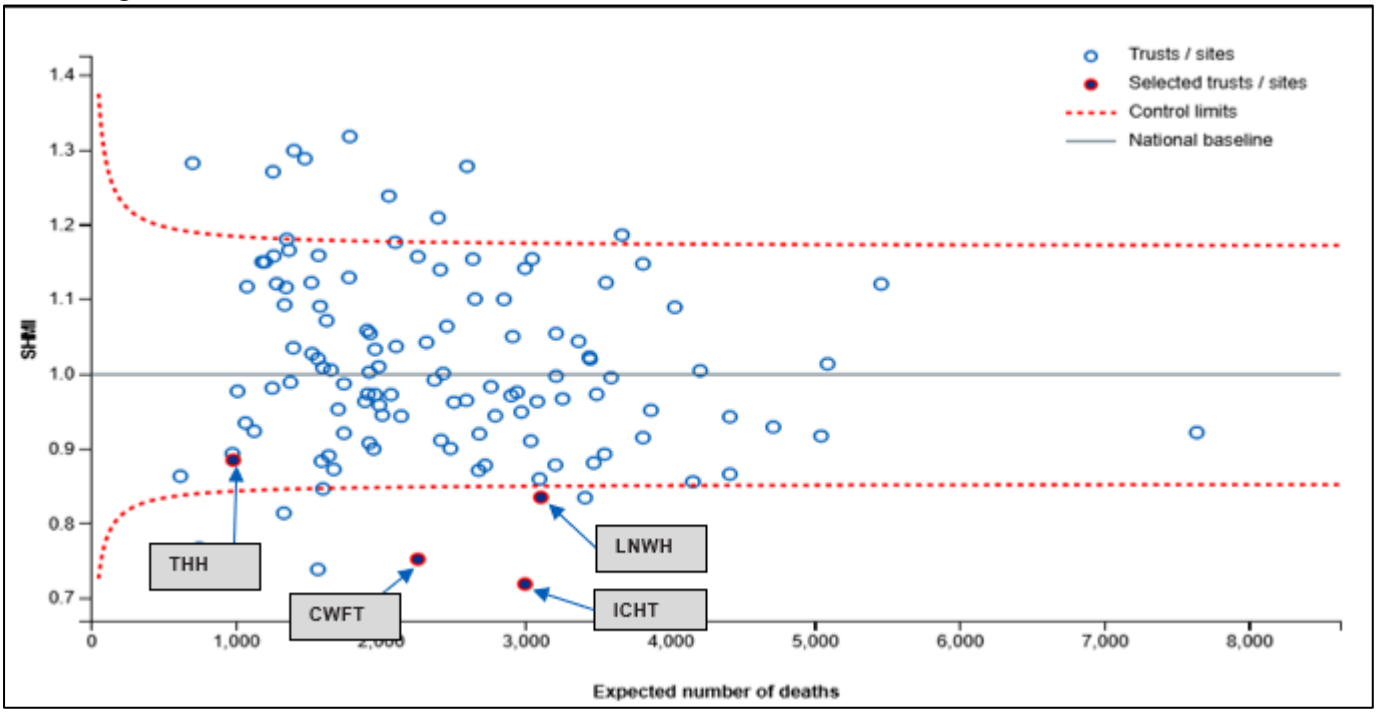
At the time of reporting (April 2026) three Trust's were operating below the expected level, with The Hillingdon Hospital NHS Foundation Trust operating within the expected range for this metric.

North West London Acute Collaborative SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	106,425	2,595	3,105	83.54	85.06	117.56
ICHT	116,795	2,155	2,995	71.94	85.05	117.58
CWFT	84,835	1,695	2,255	75.26	84.94	117.73
THH	45,595	870	980	88.53	84.38	118.51

SHMI by APC provider, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026

NHS England acute Trust's SHMI



SHMI by acute provider, September 2024 to August 2025, Source: NHS Digital, published 9th April 2026

2.2. Hospital Standardised Mortality Ratio (HSMR)

The HSRM demonstrates that each Trust's continues to have a rolling 12-month HSMR below the national benchmark (100) between January 2025 and December 2025.

North West London Acute Collaborative HSMR indicators

Trust	Provider spells	Observed deaths	Expected deaths	HSMR	Lower CI	Upper CI
LNWH	53,600	1,359	1,577	86.2	81.6	90.9
ICHT	49,445	1,200	1,604	74.8	70.6	79.1
CWFT	35,135	970	1,252	77.44	72.6	82.5
THH	18,300	460	511	89.85	81.8	98.4

HSMR (41 diagnostic groups) by Trust, January 2025–December 2025, Source: Telstra, exported 20th April 2026

2.2.1. Relative risk by diagnostic group

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

- **LNWH**: As in the previous report cases linked to 'cardiac arrest and ventricular fibrillation' and 'other psychoses' were previously reviewed following an increase in HSMR above the national benchmark; learning from these clinical reviews did not identify any elements of sub-optimal care. The Trust continues to review cases classified within the HSMR tool as 'Residual codes unclassified'; this classification indicates that the primary diagnostic group has not been identified correctly in the tool. Initial review did not identify any internal coding gaps; further review is taking place to identify factors leading to these HSMR analysis gaps.
- **THH**: During this reporting period a clinical review of diagnostic group 'Other infections' (3 cases observed against 2.1 expected) has been commissioned. A review into diagnostic group 'Biliary tract disease' (10 cases observed against 5.7 expected) is underway to look at the care and coding of these patients.
- **ICHT**: There were no new alerts for Q4 but the trust continues to review alerts from previous quarters, outcomes will be shared once completed.
- **CWFT:** there were no diagnostic groups requiring further review identified during this reporting period.

3. Adult and Child Mortality Review

In-hospital adult and child deaths are screened to identify cases requiring more in-depth (level 2) mortality review. The following level 2 review triggers were implemented across the APC in Q4 2024/25.

- Potential learning identified at Medical Examiner scrutiny.
- Significant concerns raised by the bereaved.
- Deaths of patients with learning disability
- Deaths of patients under a mental health section
- Unexpected deaths
- Maternal deaths
- Deaths of infants, children, young people, and still births
- Deaths within a specialty or diagnosis / treatment group where an 'alarm' has been raised (e.g.

via the
Summary Hospital-level Mortality Indicator or other elevated mortality alert, the CQC or another regulator)

CWFT and LNWH also retain local referral triggers for deaths post elective surgery and deaths accepted by the Coroner for inquest; these additional local trigger result in higher referral rates within these Trust. ICHT uses the incident investigation framework to consider deaths that are accepted by the coroner for inquest rather than the level 2 mortality case note review process. During this quarter the percentage of deaths referred for level 2 review were; ICHT 12%, THH 9%, CWFT 41%, and LNWH 17%.

	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Total
ICHT	54 (12%)	67 (16%)	42 (10%)	50 (12%)	213 (12%)
THH	11 (8%)	18 (13%)	13 (8%)	14 (8%)	56 (9%)
CWFT	128 (43%)	126 (42%)	151 (43%)	130 (36%)	535 (41%)
LNWH	104 (19%)	97 (20%)	117 (20%)	107 (17%)	425 (19%)

Number and percentage of cases referred for level 2 review

Mortality review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements following in-hospital deaths. During this quarter the percentage of triggered level 2 reviews completed were; ICHT 100%, THH 29%, CWFT 100%, and LNWH 88%. Note this position was correct at time of reporting (April 2026).

	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Total
ICHT	54 (100%)	67 (100%)	42 (100%)	50 (100%)	213 (100%)
THH	11 (100%)	18 (100%)	11 (85%)	4 (29%)	44 (79%)
CWFT	128 (100%)	126 (100%)	151 (100%)	130 (100%)	535 (100%)
LNWH	104 (100%)	97 (100%)	105 (90%)	94 (88%)	400 (94%)

Number and percentage of tiggered level 2 reviews completed

3.1. CESDI Grading of Care

Mortality review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements following in-hospital deaths. Outcome and / or suboptimal care provision is defined using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories that have been adopted by the Trust for use when assessing deaths:

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

Seven cases where sub-optimal care would reasonably be expected to (CESDI 3) have or might have (CESDI 2) contributed to the patient's outcome were identified from completed reviews for deaths in this quarter, which is fewer than in the previous quarter.

	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Total
ICHT	6	6	7	6	25 (1.44% of total deaths)

THH	0	1	1	0	2 (0.31% of total deaths)
CWFT	0	1	1	0	2 (0.15% of total deaths)
LNWH	3	5	2	1	11 (0.49% of total deaths)

Number of CESDI grade 2 & 3 cases by Trust and financial quarter

The Patient Safety Incident Response Framework (PSIRF) requires deaths assessed to be, more likely than not, due to problems in care to undergo an enhanced learning response. Therefore level 2 mortality reviews identified as CESDI 2 and 3 are subject to additional scrutiny via the incident investigation framework. These additional learning responses examine each case in more detail, within LNWH, THH and CWFT CESDI grades are amended post investigation to take into account the results of these more in-depth reviews.

ICHT do not retrospectively amend CESDI grading following incident investigation. For the 25 CESDI 2 or 3 cases initially reported within ICHT in the last 12 months the full investigation process has been completed for four; of these completed cases only one was confirmed as CESDI 2 / 3.

A review of the process by which harm levels identified via the incident investigation framework are triangulated with the CESDI grade reported by the mortality review process is being undertaken by the APG mortality surveillance group to further standardise the processes across the APG.

3.2. Learning from adult and child mortality review

Key themes / issues / improvements identified via adult & child mortality review this quarter:

- **ICHT**: learning from review identified area for improvement within a very small number of cases around documentation and effective communication with patients and their families / next of kin.
- **THH**: mortality review highlighted areas for improvement around Treatment Escalation Planning, End-of-Life Care, transfers of care, the recognition of deteriorating patients and use of NEWS, awareness of the role of the Learning Disability Specialist Nurse.
- **CWFT**: highlighted areas for improvement related to; escalation & patient flow, Treatment Escalation Planning & End-of-Life Care, the quality of documentation, communication with patients & families, medication safety, recognition of the deterioration of patients, risk assessment of skin integrity & falls, procedural safety and operational / system factors.
- **LNWH**: review highlighted areas for improvement regarding Advanced Care Planning and Treatment Escalation Planning, the need for timely recognition, review & escalation of clinical deterioration using both ECGs and NEWS Scores and the documentation of communication with patients and families.

4. Other mortality reviews

A number of other national processes are in place for the review of deaths for specific cohorts of patients. These include the Perinatal mortality review tool (PMRT), Learning disability mortality review (LeDeR) and Child death overview panels (CDOP), which are described in the glossary below. Oversight of these processes is considered within Trusts and reported up to the APC Mortality Surveillance Group. There were no LeDeR or CDOP reviews completed in quarter which identified significant concerns regarding the clinical care provided.

5. Prevention of future deaths (PFD)

There was one Prevention of Future Deaths (PFD) notice received during Q4 2025/26 by CWFT,

following an inquest into a neonatal death, where a medication error and failures in the recognition and escalation of deterioration contributed to the outcome. The Trust has implemented a comprehensive improvement programme focused on prescribing safety, multidisciplinary communication, clinical pathways, specialist referral processes and governance oversight. Delivery of these actions continues to be monitored through established governance arrangements to ensure learning is embedded and patient safety strengthened.

6. Conclusion

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.

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.

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

Further standardisation will be led by the APG mortality surveillance group to consider local referral triggers and links between the mortality review process and incident investigation framework.

Appendix A: Glossary

- **LNWH** – London North West University Healthcare NHS Trust
- **THH** – The Hillingdon Hospital NHS Foundation Trust
- **ICHT** – Imperial College Healthcare NHS Trust
- **CWFT** – Chelsea and Westminster NHS Foundation Trust
- **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.
- **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.
- **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.
- **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.
- **Learning Disabilities Mortality Review (LeDeR)** is a review of all deaths of patients with a learning disability. The Trust reports these deaths to 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.

4.1.4 SEVEN DAY SERVICES ANNUAL REPORT 2025/26

Discussion Item Alan McGlennan

REFERENCES

Only PDFs are attached

04.1.4 APG BiC 7 day services summary report v4.pdf

NWL Acute Provider Group Board in Common
28/07/2026
Item number: 4.1.4
This report is: Public

APG Seven day services standards annual summary report

Author: Dr Alan McGlennan
Job title: Chief Medical Officer, THH

Accountable director: Dr Roger Chinn, Professor Raymond Anakwe, Dr David O'Callaghan, Dr Jon Baker, Dr Alan McGlennan
Job title: Chief Medical Officers / Medical Directors

Purpose of report (for decision, discussion or noting)

Purpose: Assurance

[Trusts are required by NHS England to report compliance with the four priority seven day services standards at least once a year to their Board. This is achieved through a detailed annual report to individual Trust standing committees, with this overarching paper providing a summary of compliance across the four acute provider group (APG) trusts. This report is presented to the APG quality committee and the Board-in-common.

Report history

Standing Committee
Various
Individual trust reports were discussed at local standing committees, with compliance confirmed to be reflective of service provision.

APG Executive Team Meeting
29/06/2026
The draft APG level report was noted and agreed for onward submission.

APG Quality Committee
07/07/2026
The committee discussed the report, noting differences in how each trust defines compliance and plans to standardise for the next annual report cycle.

Executive summary and key messages

1.1. The Seven Day Services Clinical Standards (7DS Clinical Standards) were agreed and published by NHS England to achieve the aim that patients should expect a consistent standard of access to treatment, diagnostics and care regardless of the day of admission.

1.2. It sets out 10 standards and identifies four key 'priority' standards. These are:

- consultant-directed assessment (standard 2)
- diagnostics (standard 5)
- interventions (standard 6)
- ongoing review every day of the week (standard 8)

1.3. This report provides a summary of compliance declared with these four standards as per each Trust's annual report, as shown in the table below.

	CWFT	ICHT	LNW	THH
Standard 2	Full compliance	Partial compliance	Partial compliance	Full compliance
Standard 5	Partial compliance	Full compliance	Partial compliance	Partial compliance
Standard 6	Full compliance	Full compliance	Partial compliance	Partial compliance
Standard 8	Full compliance	Partial compliance	Full compliance	Full compliance

1.4. In line with the NHSE guidance, each trust uses a variety of methods to confirm and monitor compliance, however there are differences in methodology and in how 'compliance' is defined. For example, CWFT has declared full compliance with standard 6 although some interventions are provided via networked services rather than on site, with LNW and THH in the same position but declaring partial compliance. The report templates and methodology used will be reviewed and aligned prior to the 2026 reports being submitted so that comparison is more robust.

1.5. There are difficulties recognised in all trusts around providing the same level of care at weekends and out of hours, with all reporting some variation between length of stay and discharge data on weekends compared to weekdays. There are internal and external factors that contribute, including workforce and resource issues. No trusts are reporting a significant impact on patient safety or mortality as a result, however the impact on patient flow is recognised, particularly at LNW who have introduced a new quality priority for 2026/27 focused on addressing variation in weekend clinical activity.

1.6. Although none of the Trusts are reporting full compliance with all four priorities, mitigations are in place and improvements underway in response to each Trust's individual areas of challenge, these are summarised in the main report.

Impact assessment

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

Access to the full range of services and expertise supports the delivery of high-quality patient services and equitable provision of care. Regular and timely consultant review supports high quality care and patient flow including patient safety, multi-disciplinary working and communication. The barriers to full implementation include workforce and resource. Each Trust has processes in place to assess and monitor the gap and any areas of particular risk. These are summarised in this report.

Strategic priorities

☒ Achieve recovery of our elective care, emergency care, and diagnostic capacity (APG)
☒ Support the ICS's mission to address health inequalities (APG)
☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APG)

Key risks arising from report

No key risks to escalate.

Main Report

2. Introduction

2.1. In 2017, NHS England published the Seven Day Services Clinical Standards, setting out 10 standards that NHS providers are required to achieve to promote equity of care and access regardless of geographical location or the day of admission. The document was updated in February 2022 and sets the expected standard while acknowledging that there will be challenges to full compliance.

2.2. The NHS England document identifies 10 standards with four key 'priority' standards. Full details of the standards are available at: https://www.england.nhs.uk/publication/seven-day-services-clinical-standards/.

2.3. Providers have been working to achieve all these standards, with a focus on the four priority standards with the support of the Academy of Medical Royal Colleges. The priority standards are to ensure that patients have access to:

- consultant-directed assessment (Clinical Standard 2)
- diagnostics (Clinical Standard 5)
- interventions (Clinical Standard 6)
- ongoing review (Clinical Standard 8) every day of the week.

2.4. Previously, providers were required to submit data on the four priority standards to NHSE twice a year, this changed in 2022 to an annual report to the Board. A suggested framework was developed, which is used in all four trusts.

2.5. Each trust uses a variety of methods to confirm and monitor compliance including audit, job planning information, policies and guidelines, patient safety incidents, complaints, discharge, length of stay and data related to ward and board rounds.

2.6. The methodology, report format and the period covered has not been standardised and the reporting cycles not yet aligned. Therefore, the individual reports were reported to trust committees at different times, some many months ago.

2.7. A new reporting cycle has been agreed for this current year which is set out in the table below, pending confirmation of meeting dates. A standardised report template will now be confirmed and will cover the calendar year 2026.

Period covered	Local reporting	Standing committee	APG EMB	APG QC	APG BiC
Calendar year 2026	Feb 2027	Mar 2027	Apr 2027	Apr 2027	May 2027

2.8. A summary of compliance with the four priority standards across all trusts based on the information provided in the latest annual reports is provided below.

3. STANDARD 2 Early consultant review and STANDARD 8 Ongoing review

3.1. Standard 2 is that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

3.2. Standard 8 is that all patients with high dependency needs should be seen and reviewed by a consultant twice daily until a clear pathway of care has been established when review can be daily.

3.3. Trusts have declared compliance as follows:

	CWFT	ICHT	LNW	THH
Standard 2	Full compliance	Partial compliance	Partial compliance	Full compliance
Standard 8	Full compliance	Partial compliance	Full compliance	Full compliance

3.4. **LNW** has identified that across divisions, consultant job planning shows strong commitment to emergency and high-dependence services, but variable weekend coverage for routine inpatient care. Several specialties lack scheduled weekend ward rounds, leaving medically active patients without timely consultant review and delaying key decisions until Monday. While services like Stroke, Infectious Diseases, Critical Care and Emergency Medicine demonstrate more consistent seven-day consultant presence, variation elsewhere contributes directly to prolonged length of stay.

3.5. **ICHT** has recognised that although the consultant review standards are the expected standard of care, there are barriers to full compliance due to workforce and resource implications. Improvements have been made since last year's report in areas where issues were identified, including increased cover in paediatrics which now meets the standards, in cardiac and on the ante/postnatal wards, although there remain challenges to achieving full compliance. Work is progressing to improve consultant presence on the neurosurgical ward at CXH; however this continues to be an area of concern with actions to improve being monitored through the neurosurgery quality review meeting (QRM).

3.6. Aside from these areas, compliance levels remain the same as reported and approved last year with acute and high dependency areas prioritised. The divisions have confirmed they are assured of the safety of the current mitigations and do not have plans to change given current resource. No significant risks to patient safety have been identified due to the existing arrangements in these areas however the sustained operational pressures are having an impact on delivery of timely care. Additional actions and mitigations to improve flow are being managed through the integrated patient flow programme (IPFP).

4. STANDARD 5 Access to diagnostic services

4.1 The standard is hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week within 1 hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients.

4.2 Trusts have declared compliance as follows:

	CWFT	ICHT	LNW	THH
Standard 5	Partial compliance	Full compliance	Partial compliance	Partial compliance

4.3 **CWFT:** MRI is only available between 8am-8pm on weekdays, with no on-site provision on weekends. Patients needing urgent MRI require transfer to ICHT (CXH or SMH).

4.4 **ICHT:** there is access to diagnostic services 24/7 if necessary (in some instances this may involve transfer to another ICHT site).

4.5 **LNW:** USS, CT and echocardiography is not available on all sites out of hours, with transfer required to NWP. Patients needing urgent MRI out of hours require transfer to ICHT (CXH or SMH).

4.6 **THH:** Mount Vernon Hospital uses THH diagnostics out of hours with no provision on site. On weekends, echocardiography is available via the network arrangements with Harefield Hospital. Patients needing urgent MRI out of hours require transfer to ICHT (CXH or SMH).

5. STANDARD 6 Access to interventions

5.1 The standard is that hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be critical care, interventional radiology, interventional endoscopy, emergency general surgery, emergency renal replacement therapy, urgent radiotherapy, stroke thrombolysis and thrombectomy, percutaneous coronary intervention (PCI) and cardiac pacing.

5.2 Trusts have declared compliance as follows. To note, there are differences in how 'compliance' is defined, for example, CWFT has declared full compliance with standard 6 although some interventions are provided via networked services rather than on site, with LNW and THH in the same position but declaring partial compliance. The methodology will be standardised for the next reporting period.

	CWFT	ICHT	LNW	THH
Standard 6	Full compliance	Full compliance	Partial compliance	Partial compliance

5.3 **CWFT:** Haemodialysis provision available at both sites but in ITU only, NWL capacity at CXH and HH is limited, plans for inpatient dialysis slots following the opening of DTEC (Diagnostic, Treatment and Education Centre) next year will support cross-site. Some services provided via networked arrangements (e.g. stroke thrombolysis at CXH, PCI and cardiac pacing at HH or Royal Brompton Hospital out of hours and at weekends).

5.4 **ICHT**: Transfer may be required to another ICHT site, for example urgent radiotherapy which is provided at CXH and HH, the regional Hyper-Acute Stroke Unit at CXH and the regional Heart Attack Centre at HH which means patients are transferred for specialist care. These services are supported by 7-day rotas to provide a continuous service.

5.5 **LNW**: Radiotherapy is not available on site at weekends – networked arrangements in place.

5.6 **THH**: Radiotherapy, stroke thrombolysis, PCI and cardiac pacing are not available on site at weekends – networked arrangements in place.

6. Improvements underway/planned

6.1. There are difficulties recognised in all trusts around providing the same level of care at weekends and out of hours, with none reporting full compliance with all four standards, and all identifying some variation between length of stay and discharge data on weekends compared to weekdays. There are internal and external factors that contribute to this, including workforce and resource issues. No trusts are reporting a significant impact on patient safety or mortality as a result, although neurosurgery is an area of concern at ICHT with actions to improve being monitored through the neurosurgery QRM.

6.1 Mitigations are in place and improvements underway within each trust in response to their individual areas of challenge. These include:

- **CWFT:** plans underway to introduce inpatient dialysis slots post-DTEC.
- **ICHT**: improvements in consultant cover as set out in section 3, with further work underway in key areas e.g. neurosurgery. Guides under development setting out what investigations are available and how and when to access this following feedback from staff and evidence from incidents which show that the pathways are not always clear.
- **LNW**: work commenced to strengthen and formalise the existing flow governance arrangements through a refreshed, high-priority LOS and Flow Board, chaired by the Chief Medical Officer and supported by the Deputy Director of Transformation. Improving seven-day services and patient flow, addressing variation in weekend clinical activity that contributes to delays in patient progression and length of stay, has been chosen as a quality priority for the Trust for 2026/27.
- **THH:** improvements seen in key areas including reduced variation in LOS, particularly in maternity, and establishment of weekend working in key areas e.g. pharmacy. Work

ongoing to implement an improvement programme to focus on surgical non-elective length of stay, to embed daily multi-disciplinary board rounds, and a review of SDEC (Same Day Emergency Care) models across all disciplines to standardise opening times and clinical offering across all days of the week.

6.2 At APG level, the focus is on ensuring the safe and timely transfer of patients between our hospital sites, which is a new joint quality priority for 2026/27. Given that several of the key diagnostics and interventions set out in this report currently require transfer to other sites or trusts out of hours and at weekends, the work undertaken should increase the timeliness and safety of access, with an anticipated improvement in patient experience and outcomes. A summary of the programme plan for this priority is being presented separately to this meeting.

7. Conclusion and next steps

6.1 All trusts have good processes in place to assess their compliance with the four priority standards, although there are differences in the methodology. This will be reviewed, alongside work to align reporting cycles, templates and data periods so that comparison is more robust for the 2026 reports.

6.2 Overall, the review demonstrates partial compliance, with no trusts reporting that they fully meet all four standards. Mitigations and improvement work is underway across all Trusts in response to their specific areas of challenge, with an APG-level focus on improving timeliness and safety of patient transfers.

7.1. The impact on flow is recognised, particularly at LNW where a new quality priority has been stood up for 2026/27 focused on addressing variation in weekend clinical activity.

7.2. There are no significant concerns raised about patient safety or mortality in the annual reports, although neurosurgery is an area of concern at ICHT with actions to improve being monitored through the neurosurgery QRM.

4.1.5 GROUP QUALITY COMMITTEE CHAIR REPORT

Discussion Item Patricia Gallan

REFERENCES

Only PDFs are attached

04.1.5 NWL APG Quality Committee Chair's Report - July 2026.pdf

NWL Acute Provider Group Board in Common (Public)
28/07/2026
Item number: 4.1.5
This report is: Public

NWL Acute Provider Group Quality Committee Chair's highlight report to the NWL Board in Common

Author: Amrit Panesar
Job title: Trust Secretariat Officer

Accountable director: Janice Sigsworth & Roger Chinn
Job title: Chief Nursing Officer & Chief Medical Officer

Committee Chair: Patricia Gallan
Job title: Non-Executive Director

Purpose of report

Purpose: Information or for noting only

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

Report history

N/A

Executive summary and key messages

Group Level Quality Priorities

The Committee received the report which set out the priorities for the acute provider group for 2026/27 which were agreed by the chief medical and nursing officers and approved at APG Executive Management Board. The proposed priorities had been previously presented to the Committee in April when further clarity was requested regarding how they were chosen, their alignment with trust level priorities, and the outcome measures.

The group priorities are either to deliver nationally driven pieces of work that we all must do, or in response to issues impacting all Trusts identified through their quality insights including incident investigations.

The priorities agreed are:

- Improve the clinical standards for infection prevention & control and reduce hospital acquired infections
- Complete the implementation of the joint reporting and the risk management system
- Improve the safety and timeliness of inter-hospital transfers

Committee members noted that key workstreams from previous years would continue and would be monitored via the APG quality meeting, with escalation to EMB and this Committee as required:

- deteriorating patients' pathways
- implementation of NatSSIPs2
- maternity improvement
- mental health in acute hospitals

The group-level priorities are aligned with local Trust priorities, with reporting through Trust Standing Committees to support clarity and consistency. The Committee highlighted the need for clear outcome metrics and success measures for each priority and agreed that these would be defined and benchmarked against national progress. Plans were included in more detail in the reports from the individual priorities as separate agenda items.

Committee members endorsed the Group Quality Priorities for 2026/27.

Acute Provider Group Quality Performance Report

The Committee received the Acute Provider Group quality performance report. Performance at group level was similar to previous months with standards being met for most metrics. Committee members noted that improvement actions are in place in individual trusts where there are areas requiring improvement including falls and pressure ulcers, with all trusts having individual priorities to improve infection prevention and control practices as well as this being an overarching APG priority. Committee members noted that patient experience in emergency departments was being reviewed locally, and improvement work underway. There were no new concerns escalated to the committee.

Update on Quality Priorities 2025/26

Improving the clinical standards for IPC and reduce hospital acquired infection

Committee members received the report, which outlined a planned programme of work to improve infection prevention & control and clinical standards for 2026-2028. The purpose of the programme is to achieve sustained reductions in avoidable infection-related harm by improving the reliability of the clinical standards, professional behaviours and everyday practices that determine infection risk.

Committee members noted that the programme would respond to common challenges across the APG including Clostridium difficile infections, MRSA bacteraemia and gram-negative bloodstream infection focusing on shared challenges and opportunities for improvement across the group.

Committee members noted that implementing surveillance tracking systems would strengthen

collective improvement intelligence by enabling real-time monitoring of high-risk patients and supporting more consistent data across Trusts. The programme will use regular metrics and dashboards to monitor progress, with reporting to the Group Quality Committee every three months.

Complete the implementation of the joint reporting and risk management system
Committee members received an update on implementation of the new joint reporting and risk management system across the group, noting the complexity and challenges of standardising processes across four Trusts. Committee members noted that key challenges included system configuration, speed, legacy data integration, and standardisation of incident reporting forms and categories.

Committee members noted that go-live will be phased but must be achieved by the end of August. Awareness and training sessions were underway, alongside ongoing escalation meetings to ensure progress to meet the deadlines.

Committee members noted that the system was expected to provide real-time data visibility, benchmarking and AI-enabled insights across all quality domains, supporting improvement workstreams and linking with Cerner to auto-populate incident information. The project had also supported standardisation of reporting categories and processes across the group, with ongoing evaluation and iterative improvement planned following go live.

Improving the safety and timeliness of inter-hospital transfers
Committee members received the report which set out the plan for the new quality priority to improve safety, quality and timeliness of inter-hospital transfers by establishing a consistent, standardised approach to transfer decision-making, handover, escalation and governance. Six workstreams with key deliverables had been identified which included, learning from Patient Safety Incident Investigations (PSIIs) and incident review; escalation of delays; handover and documentation; alignment of standards and high-risk clinical pathways.

Committee members noted that inter-hospital transfers were necessary to access specialist skills, services and capacity, while recognising the associated risks relating to handover, delays and patient deterioration. Transfers were grouped into three categories: time-critical, clinical and repatriation, each with distinct risks and operational challenges. The Committee also acknowledged incidents and inefficiencies linked to transfer delays and unclear accountability, particularly outside critical care pathways.

Committee members discussed the need for regional and national collaboration, particularly for specialist centres and transfers outside of the catchment areas however, agreed that the immediate focus would be on standardising internal processes. AI was identified as a potential future tool to support the identification of suitable patients for transfer, although this was not currently within scope. Mental health transfers were not included in this workstream however may be considered separately.

Acute Provider Group Clinical Pathways
Committee members received an update on the clinical pathways programme and noted that 28 pathway groups were continuing to progress. Most pathways had either been completed or were in the embedding phase and all are moving into business-as-usual management. Some pathways had been delayed due to data or digital enabler issues, and these will continue to be monitored.

Committee members noted that specialty boards were being established across 30 specialties,

including emergency and acute medicine. These boards will support delivery of constitutional standards, reduce unwarranted variation and enable transformation, including the development of a single point of access for ophthalmology and tracking lists for pain services. Committee members noted that key learnings from phase one included the importance of clinical and operational collaboration, programme management structure, and data alignment. These specialty boards would be monitored through the APG executive management board.

National Maternity Reviews
Committee members received the report which provided an update in response to the Baroness Amos Independent Investigation into Maternity in England and the Donna Ockenden Review of maternity services at Nottingham University Hospitals NHS Trust , alongside a national system letter on post death care and mortuary oversight following the David Fuller inquiry.

Committee members noted that recommendations were pending formal acceptance, and a national action plan was expected later this year. Committee members noted that immediate actions were required as per two national letters which included a 10-point plan and the expansion of Martha's rule to maternity and neonatal services.

Committee members agreed to review national guidance, ensuring compliance with immediate requirements while maintaining focus on local maternity transformation and improvement.

All NHS Provider Trusts that have a mortuary, related storage area for the deceased or routinely care for people after death are required to complete and return a board assurance statement by 31 July 2026. The four board assurance statements will be presented to the board in common for approval ahead of submission to NHS England.

Quality Governance Arrangements
Committee members received the report which outlined the group-level quality governance structure, which included strategic oversight committees, Trust-level statutory responsibilities, and the Group Quality Committee's role in reviewing performance, safety, experience, and risks across the four trusts.

The report detailed the non-executive directors' assurance framework, including touchpoint meetings and complementary sources of assurance, aiming to clarify governance processes and promote shared learning. Committee members noted that the arrangements were maturing, with ongoing development of the non-executive role with the suggestion of non-executive directors reviewing key papers prior to presentation at the board in common.

Combined Risk Escalation Report from Chief Medical & Nursing Directors/Officers
Committee members received the report which highlighted key points to note, or areas of risk identified by each of the four Trust's Standing Committees with a focus on where group-wide interventions would speed up and improve the response.

Chelsea and Westminster Hospital NHS Foundation Trust reported a never event, emergency department pressures and pressure ulcer incidents with improvement plans in place, alongside the need to finalise incident investigations, review risks and improve learning response timeliness in preparation for the new system implementation. The focus on infection prevention and control was highlighted.

The Hillingdon Hospitals NHS Foundation Trust highlighted that maternity services remained an area of focus, with strengthened oversight to support improvement. A head and neck radiology backlog was identified, with harm reviews underway and additional capacity being

added. Overdue patient safety investigations and learning responses were being addressed through enhanced oversight, recruitment, training and governance reviews

Imperial College Healthcare NHS Trust escalated two incidents highlighting concerns regarding invasive line care and insertion (a never event and a MRSA bloodstream infection) with actions underway to reinforce infection prevention and control standards and use of the central line insertion checklist. A review into incidents relating to delayed cancer care was shared with additional actions agreed as part of the on-going cancer transformation programme, and a planned quality review process following a patient-on-patient assault. The Committee noted the significant work underway in response to the ongoing risk related to the estate and environment. They also noted positive progress with the HTA recommendations following their re-inspection of the mortuary and that the hand hygiene and patient safety partner work had been shortlisted for two Health Service Journal (HSJ) patient safety awards.

London North West University Healthcare NHS Trust highlighted an increase in stillbirths which is under review though not expected to be materially significant, infection prevention and control challenges, and a water-associated organism outbreak, with mitigation underway. Complaints remained highest in medicine and emergency care, with improvement focused on communication, outpatient services and access.

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

Acute Provider Group 7-day services annual summary report
Committee members reviewed and noted the 7-day services report incorporating all four Trusts which outlined that all had good processes in place to assess their compliance with the four priority standards, although these differ. The report templates and methodology used will be reviewed and aligned prior to the 2026 reports being submitted so that comparison is more robust.

Overall, the review demonstrated partial compliance, with no Trusts reporting full compliance against all four standards. Mitigations and improvement work is underway across all trusts in response to their specific challenges, with an Acute Provider Group focus on improving timeliness and safety of patient transfers.

1. 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 Standing Committees.

2. Key risks / topics to escalate to the NWL APG BiC

- The continued pressure and clinical risks that exist in caring for mental health patients in an acute setting.

3. Concerns outstanding

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

4. Key actions commissioned

- None noted.

5. Decisions made

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

6. Attendance

Members	September attendance
Patricia Gallan, Vice chair (CWFT), Non-executive director (ICHT) (Chair)	**Y**
Syed Mohinuddin, Non-executive director (LNWH/CWFT)	**Y**
Carolyn Downs, Non-Executive Director (THHT/LNWH)	**Y**
Bob Alexander, Chair in Common	**Y**
Martin Lupton, Non-executive Director (LNWH, THHT)	**Y**
Nick Gash, Non-executive Director, (ICHT, THHT)	**Y**
Raymond Anakwe, Medical director (ICHT)	**Y**
Roger Chinn, Chief medical officer (CWFT)	**Y**
Alan McGlennan, Chief medical officer (THHT)	**Y**
Jon Baker, Chief medical officer (LNWH)	**N**
Robert Bleasdale, Chief nurse (CWFT)	**Y**
Janice Sigsworth, Chief nurse (ICHT)	**Y**
Lisa Knight, Chief nurse (LNWH)	**Y**

4.2 PEOPLE

4.2.1 PEOPLE - INTEGRATED QUALITY AND PERFORMANCE REPORT (ANYTHING BY EXCEPTION)

Discussion Item | Kevin Croft | 12.25

4.2.2 GROUP PEOPLE COMMITTEE CHAIR'S REPORT

Discussion Item Sim Scavazza

REFERENCES

Only PDFs are attached

04.2.2 APG People Committee Chairs Highlight Report July26.pdf

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

9 July 2026

Highlight Report

1. Purpose and Introduction

The role of the NWL APG People Committee is:-

- oversee the development of strategic people change programmes to drive group-wide improvements, inputting into the Group strategy
- oversee and receive assurance relating to the implementation of strategic people priorities for short and medium-term improvements, ensuring effective and efficient use of resources
- oversee and receive assurance regarding Group level people performance and Trust-level contribution towards that collective performance, providing assurance to the Board in Common on performance of each Trust and the Group ensuring that the Group is meeting the people related statutory and regulatory reporting standards and requirements, including constitutional standards.
- identify areas of people performance variation and risk where group-wide interventions would speed and improve the response and agree these as strategic priorities for the Group.

2. Key Highlights

2.1 **Staff Experience**: A staff experience story focused on career progression for colleagues from under-represented Black, Asian and Minority Ethnic (BME) groups into Band 7 and above roles. The discussion highlighted barriers experienced by BME staff, the value of the Healthcare Leaders Fellowship Programme, and the importance of inclusive recruitment, mentorship, supportive line management, stretch opportunities and senior leadership visibility. The Committee noted the need to move from individual examples of good practice to scalable approaches across the Group, including recognising digital capability and digital upskilling as strategic workforce issues.

2.2 **Group People Performance Report:** The Group People Performance Report, including the EDI dashboard, indicated broadly positive performance in areas including vacancies, turnover, agency use, core skills and appraisal compliance. The Committee noted that quality conversations and regular line management engagement remained important alongside appraisal completion. The Committee received assurance and discussed two areas of under-performance requiring more attention, namely sickness absence (being managed locally) and the achievement of the Model Employer Goals on leadership diversity.

2.3 **Group People Related Risks:** The Committee considered Group people-related risks and noted that several risks did not necessarily score highly on immediate risk registers but remained important because they could constrain delivery of the Group people strategy and longer-term objectives.

The financial risk related to workforce costs was raised as a key concern. The Committee sought greater clarity on the extent to which cost pressures were linked to industrial action and whether underlying workforce cost controls were sufficiently robust. The Committee also sought greater assurance on the progress of more medium and longer-term measures to achieve a more financially sustainable workforce model.

2.4 **Group People Priorities and Programmes:** The Committee welcomed the alignment of shared Group people priorities with Trust priorities, the Board Assurance Framework, performance challenges and strategic programmes. Members asked that the priorities be presented in a more integrated way, with clearer sequencing, prioritisation, impact and ownership across the 2026–2029 period.

2.5 The People Priorities update confirmed a set of shared group-level priorities aligned to national people objectives, while recognising variation in delivery at trust level. The discussion highlighted the opportunity to better leverage the scale of the Group, particularly to strengthen career progression, talent development and succession planning, address negative behaviours, and make the benefits of the APG more visible and meaningful for staff, supported by clearer actions and outcomes.

2.6 **The Mann Review:** An update was provided on The Mann Review into tackling racism and antisemitism in the NHS and a letter received from NHS England setting out required actions for Trusts. It was noted that immediate actions related to the adoption of two definitions, with a return required by the end of July 2026, while wider actions would be taken forward through our equality programmes and governance routes.

The Committee supported the approach set out which required engagement of staff networks, an understanding of the legal challenges from the cases currently going through the courts and the preparation of how cases would be handled through Trust policies and procedures, before any decision could be made on adopting the definitions. The Committee also supported the plan to bring back the approach to the Mann Report's full recommendations to the next round of Trust Standing Committees and the Group People Committee as an integral part of all our work on anti-discrimination, equality, diversity and inclusion.

3. Positive Assurances received

- Group people performance was broadly positive in relation to vacancies, turnover, agency use, core skills and appraisal compliance, while recognising that further focus is required on the quality of line management conversations and staff engagement.

- Sickness absence is being managed locally, while also identifying strategic Group-level opportunities for collaboration across psychological support and wellbeing provision.

- The development of the Group people priorities was aligned with Trust priorities, the Board Assurance Framework, performance challenges and strategic programmes, subject to further work to present the priorities as a more integrated assurance framework which quantifies impact.

- The Committee received assurance that the Transforming People Services programme was being considered in the context of Group people services, including the potential benefits of a digital front door, interoperable workforce systems, improved user experience and a clearer target operating model.

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

- Concerns regarding workforce cost pressures, including the need for greater clarity on the impact of industrial action and the robustness of underlying workforce cost controls.

- The Board is asked to note the Committee's view that people-related risks which may not score highly on immediate risk registers could nevertheless constrain delivery of the Group people strategy and longer-term objectives.

- The Board is asked to note the sensitivity and complexity of the response to the Mann Review, including the need for careful legal, engagement and inclusion considerations, and for continued focus on addressing all racism and discrimination.

- The Freedom to Speak Up governance requires further clarity, particularly the distinction between management of the service and independent reporting routes for concerns, including protected disclosures and whistleblowing.

Concerns Outstanding

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

- Need for improved integration and presentation of workforce and EDI data to support decision-making and oversight.

Key Actions Commissioned

- The Committee agreed that the Group Chief People Officer should re-present the Group people priorities and develop a 'glide path' for the 2026–2029 priorities, setting out the main goals, delivery drivers, milestones, assurance sources and areas requiring strategic discussion.

- The Committee supported further discussion with relevant Board leads before any final response was submitted in relation to the Mann Review, with patient and staff safety remaining central to the Group response.

- The Committee agreed that people implications arising from recent national maternity-related reports, including culture, multidisciplinary working and inequalities, should be considered at a future meeting while avoiding duplication with the Quality Committee.

Decisions Made

- The Committee noted the national Transforming People Services programme and agreed that its implications should be integrated into the Group people priorities and capacity planning.

Attendance

Members:	July attendance
Sim Scavazza, Non-Executive Director, ICHT (Chair)	Y
Loy Lobo, Non-Executive Director,	Y
Baljit Ubhey, Non-Executive Director,	N
Tim Orchard, Group Chief Executive Officer (ICHT)	N
Kevin Croft, Group Chief People Officer	Y
Tracey Connage, Chief People Officer, (LNWH)	N
Tanaka Chiimba, Non-Executive Director, (THHFT/CWFT)	Y
Janice Sigworth, Lead Chief Nurse Officer	Y
Roger Chinn, Lead Chief Medical Officer	Y
Attendees:	
Linda Dyson, Deputy Chief People Officer (LNWH)	N
Sue Grange, Director of OD, Health & Wellbeing (ICHT)	Y

Lou Clark, Director of Workforce (ICHT)	N
Peter Jenkinson, Group Director of Corporate Governance	Y
Alexia Pipe, Chief of Staff to Chair in Common	Y
Sharon Balmer, Corporate Governance Manager	Y
Philip Spivey, Director of Workforce (THHFT and CWFT)	Y
Jodian Barrett, Deputy Chief Nursing Information Officer (CNIO) for Northwest London Virtual Hospital Remote Patient Monitoring / Children's CNIO for West London Children's Healthcare – item 3	Y

4.3 FINANCE AND PERFORMANCE

4.3.1 FINANCE AND PERFORMANCE - INTEGRATED QUALITY AND PERFORMANCE REPORT (ANYTHING BY EXCEPTION)

Discussion Item | Lesley Watts | 12.35

4.3.2 FINANCIAL PERFORMANCE REPORT

Discussion Item Bimal Patel

REFERENCES

Only PDFs are attached

04.3.2a M2 APG Finance Update Cover.pdf

04.3.2b NWL APG M2 financial performance final.pdf

NWL Acute Provider Group Board in Common (Public)
28/07/2026
Item number: 4.3.2
This report is: Public

NWL APG Finance Report: Month 2 (May 2026)

Author: Helen Berry
Job title: Associate Director of Finance

Accountable director: Bimal Patel
Job title: Chief Financial Officer, LNWH

Purpose of report (for decision, discussion or noting)

Purpose: Assurance

Report history

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

NWL APG CFO Group 26/06/2026 Approved	**NWL APG Finance & Performance Workstream Board** 26/06/2026 Approved	Committee name Click or tap to enter a date. What was the outcome?

Executive summary and key messages

This report outlines the financial performance of the NWL Acute Provider Group up to the end of May 2026, 2026/27.

Key messages:

- **Income and Expenditure YTD** : a year-to-date deficit of £19.5m, against a year-to-date deficit plan of £11.7m, reporting a £7.8m adverse variance.
- **Income & Expenditure in Month** : a deficit of £7m against an in-month deficit plan of £6.6m, reporting a £0.4m adverse variance

- **Efficiency**: a £7m adverse variance. £22m is delivered to date against a £29.2m plan.
- **Resident Doctors' Industrial Action** occurred in April (Month 1), this is unfunded, and the impact is estimated at £5.5m.
- **ERF** income performance is estimated at an overperformance of £0.2m (LNWH £0.7m underperformance and ICHT overperformance of £0.9m). CWFT & THH have balanced to the YTD plan to Month 2.
- **UEC** income performance (paid at a 20% marginal rate for over/under performance) is estimated at £0.3m underperformance (LNWH £0.2m and ICHT £0.1m). CWFT & THH have balanced to the YTD plan to Month 2.
- **Cash**: the balance across the APG is £355.8m at the end of May, a £9.6m increase in the month, and £27m higher than the cash plan at Month 2.
- **Capital** : spend is £22.1m, against a capital plan £22.5m, a £0.4m underspend to date
- **WTE**: an increase of 0.2% (average month 1 and month 2 compared to the 2025/26 average WTE).
- **Activity against the Operating Plan** : Outpatients above plan (1%); electives and day cases above plan (2%); A&E above plan (3%), NEL (short stay) above plan (5%), Non elective (longer stay) on plan.

Impact assessment

Tick all that apply

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

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

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

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

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)
☐
☐

North West London Acute Provider Group

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

2026/27 Month 2 (May) Finance Report

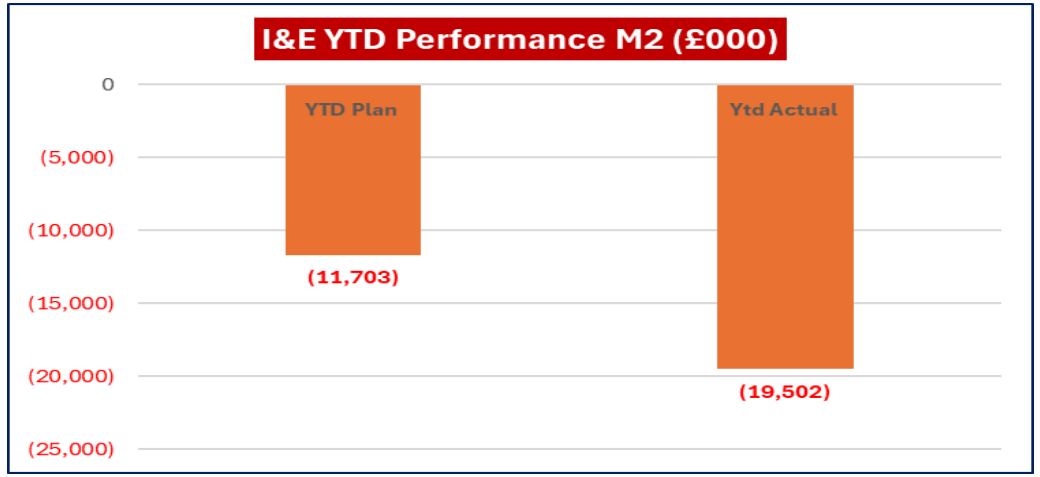
Helen Berry, ADOF, NWL APG

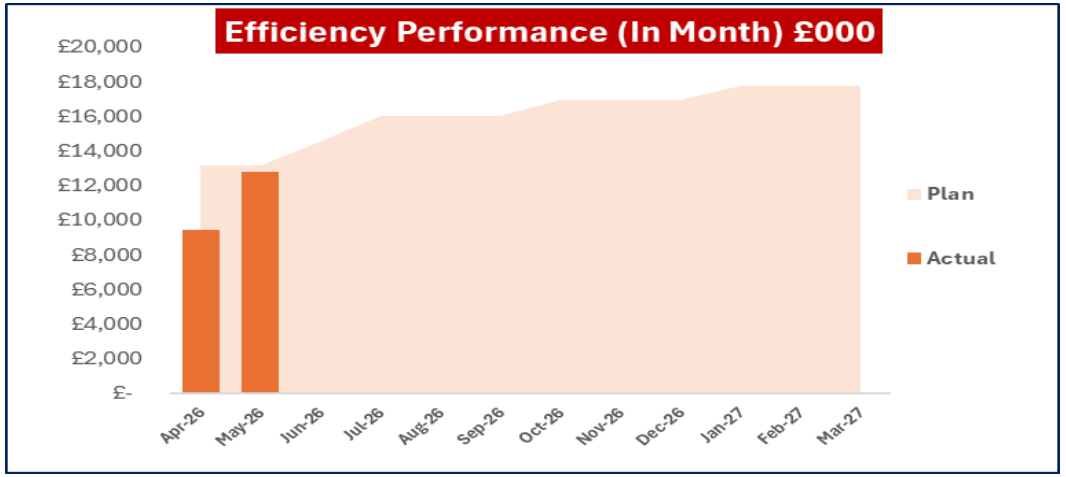
June 2026

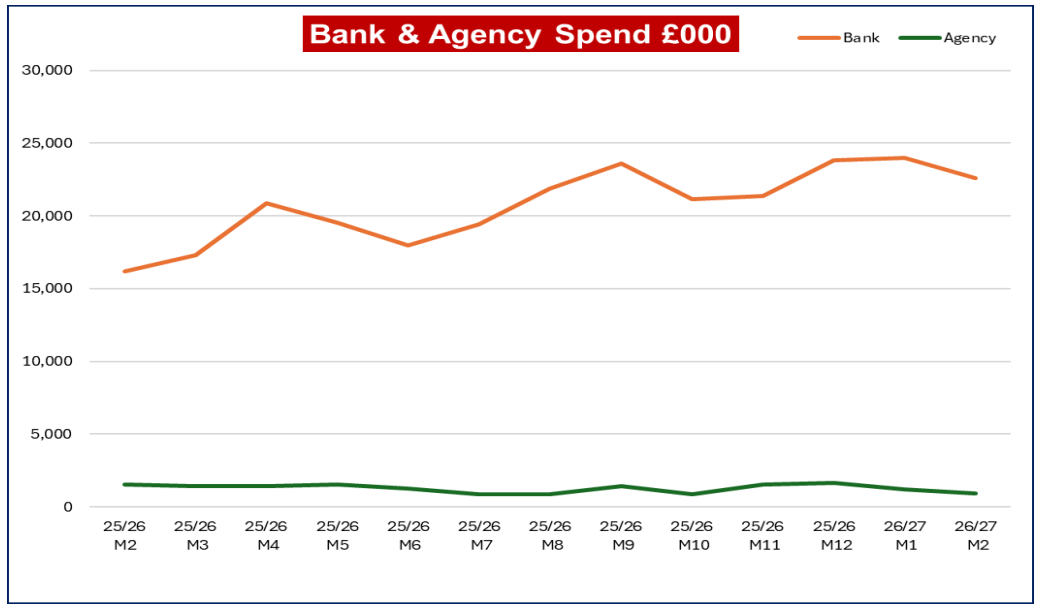
Key Messages

- The NWL APG's financial performance for Month 2 is a year-to-date deficit of £19.5m, against a year-to-date deficit plan of £11.7m, reporting a £7.8m adverse variance. In month, there is a deficit of £7m against an in-month deficit plan of £6.6m, reporting a £0.4m adverse variance.
- All four trusts report year to date adverse variances to plan, although CWFT reports only a marginal adverse variance of £38k.
- The adverse variance is primary driven by the impact of Resident Doctors' Industrial Action during Month 1 (£5.5m) and under delivery against the YTD efficiency plan (£7m).
- Efficiency delivery reports a £7m adverse variance. £22m is delivered to date against a £29.2m plan. £12m to date is delivered via non-recurrent measures. To date 75% of the total efficiency plan (of £193.1m) is identified.
- ERF income is variable for 2026/27. UEC income is paid at a 20% marginal rate for over or underperformance against plan. To month 2, two trusts have assumed income to plan. LNWH & ICHT estimated variances to plan for ERF and UEC and are included in the financial position. From month 3 all trusts will estimate over or underperformance against plan for the ERF and UEC PODs.
- The Agenda For Change pay award is paid from April 2026 and the medical staff pay award has been agreed and due to be paid in June. Tariff in contract income is at the plan value (0.03% uplift), Trusts have therefore accounted for additional income (a further 1.16% uplift to take the total to 1.19%) in the year to date to cover these pay awards. To note W&NL ICB has paid over the additional income for their contracts. For other contracts, teams have accrued the additional income.
- The end of May, cash balance across the APG is £355.8m, a £9.6m increase in the month, and £27m higher than the cash plan at Month 2.
- Capital spend is £22.1m, against a capital plan £22.5m, a £0.4m underspend to date.

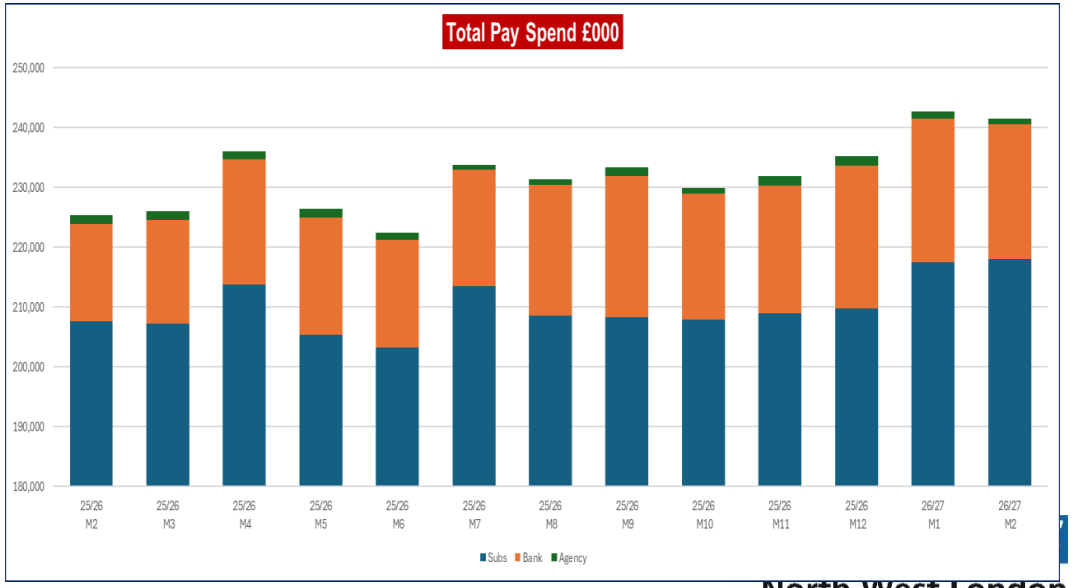
Key I&E Highlights at Month 2







Note: M4, M8 & M9 25/26 and M1 26/27 includes the impact of Resident Doctors' industrial action.



I&E Performance : Month 2

	In-month			YTD			Forecast		
Performance by category	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	372,318	380,904	**8,586**	746,340	753,744	**7,404**	4,511,648	4,511,143	**(505)**
Pay	(233,470)	(241,553)	**(8,083)**	(466,941)	(484,250)	**(17,309)**	(2,782,499)	(2,783,549)	**(1,050)**
Non-Pay	(140,420)	(142,032)	**(1,612)**	(281,099)	(280,134)	**965**	(1,667,402)	(1,667,185)	**217**
Non Operating Items	(4,987)	(4,270)	**717**	(10,003)	(8,862)	**1,140**	(61,747)	(60,409)	**1,338**
Total	**(6,559)**	**(6,951)**	**(392)**	**(11,703)**	**(19,502)**	**(7,799)**	**0**	**0**	**(0)**
Performance by Trust									
CWFT	(1,607)	(343)	**1,264**	(2,584)	(2,622)	**(38)**	0	0	**(0)**
ICHT	0	(1,778)	**(1,778)**	0	(5,924)	**(5,924)**	0	0	**0**
LNWH	(4,719)	(4,710)	**9**	(8,651)	(10,190)	**(1,539)**	0	0	**0**
THH	(233)	(120)	**113**	(468)	(766)	**(298)**	0	0	**0**
Total	**(6,559)**	**(6,951)**	**(392)**	**(11,703)**	**(19,502)**	**(7,799)**	**0**	**0**	**(0)**

Industrial Action

	Apr 26				
IA	**Income loss**	**Pay Saving (Staff Absence)**	**Pay Additional Cost (Backfill)**	**Pay Additional Cost (WLI/In/Out sourcing)**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
CWFT	0	-295	1,549		1,254
ICHT	399	-387	2,188	66	2,267
LNWH	505	-289	1,401		1,617
THH	0	-77	384		307
APG Total	905	-1,048	5,522	66	5,445

The table shows the year-to-date performance by category and by Trust.

Adverse variances on income and pay are due to the impact of industrial action and the year to date under delivery on the efficiency programme.

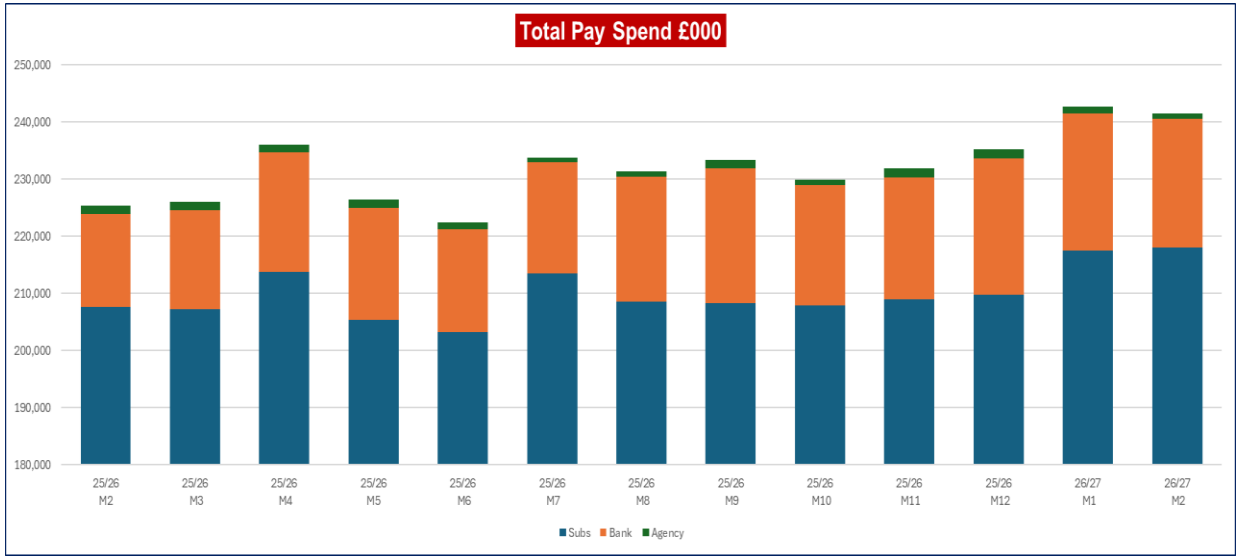
Income has been adjusted for the impact of the Agenda for Change (AfC) pay award which is paid from April, and the medical staff pay award is accrued (due to be paid in June). The income tariff has not yet been inflated to account for the agreed increases (above that funded in tariff) so the relevant income is assumed in the year-to-date position.

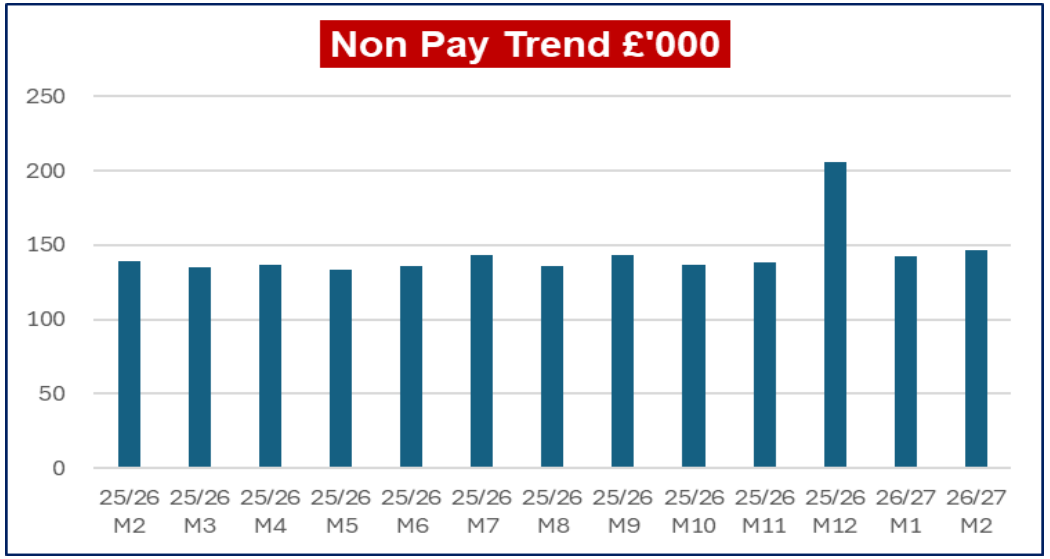
NHS Patient Care Income is accrued to plan to M2 except for LNWH & ICHT which has accounted for over/ underperformance on ERF & UEC PODs.

Residents Doctors' industrial action took place from 7th to 13th April comprising 4 working days and 2 weekend days (6 days).

The estimated financial impact is £5.4m as per the table. £0.9m estimated loss of income, and a £4.5m increase in pay costs.

Expenditure Trend – Month 2





- In Month 2 pay, has increased by 5.7% per WTE in absolute terms compared to the average of 2025/26.
- The 2026/27 AfC pay award (3.3%) is paid from April and medical pay awards (3.5%) are accounted for in the year-to-date position. Thus, there is a real terms increase in average pay spend: per WTE this is estimated at 3.2%.
- In absolute terms, to month 2, agency is 17.5% lower, bank is 18.7% higher, substantive is 4.5% higher than in 2025/26 (average). The higher bank cost is likely driven by industrial action in Month 1. Substantive cost increases are in part due to the 26/27 pay award.
- Agency as a percentage of total pay is 0.4% in 2026/27, this compares to 0.6% for 2025/26.
- Bank as a percentage of total pay is 10% in 2026/27, this compares to 8% for 2025/26.

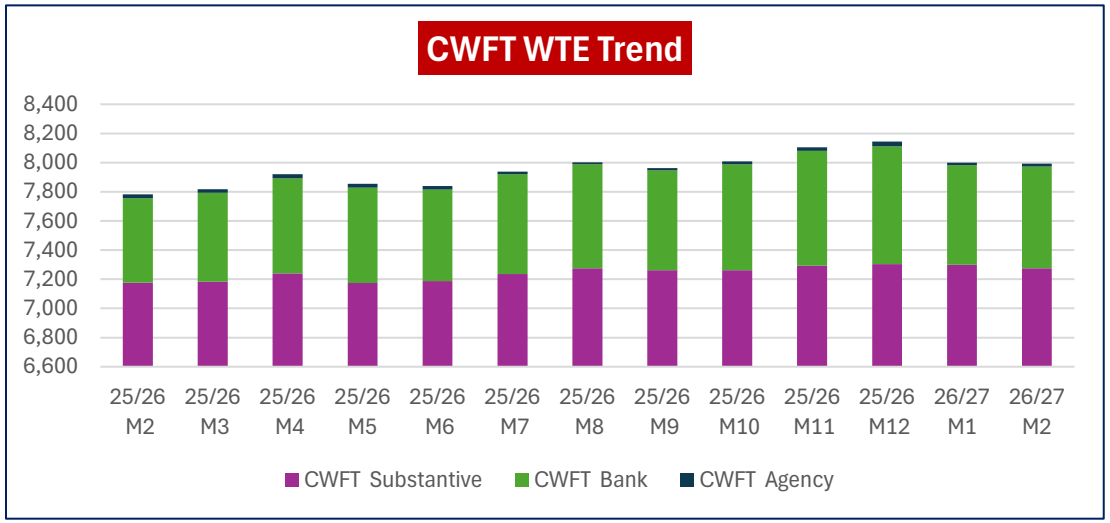
- Non-Pay: compared to the 2025/26 average, non-pay has increased by £1.5m in 2026/27 or 1%, there is a real terms decrease of 3.1% when factoring in the impact of inflation.

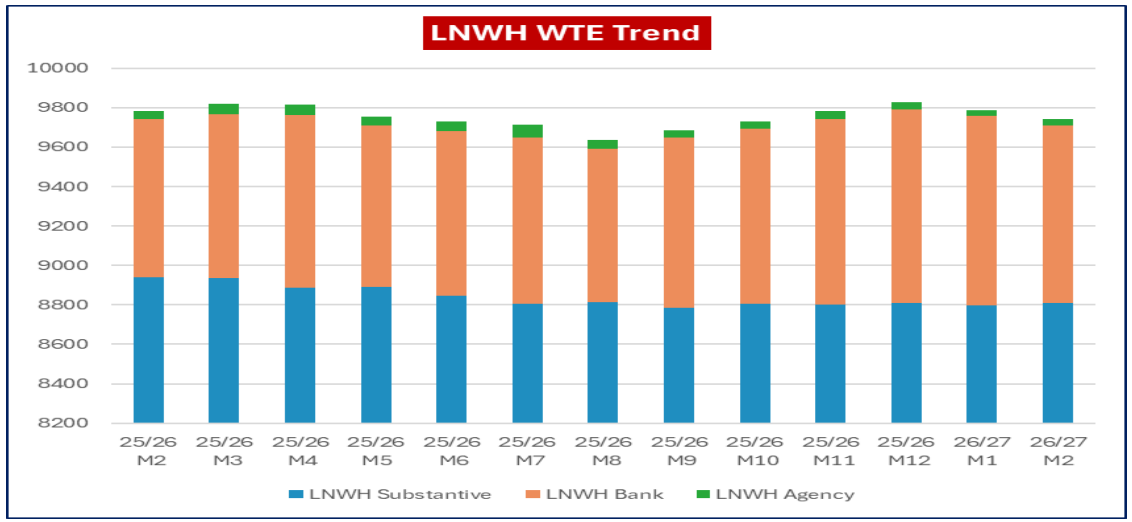
Month 2 WTE Trend

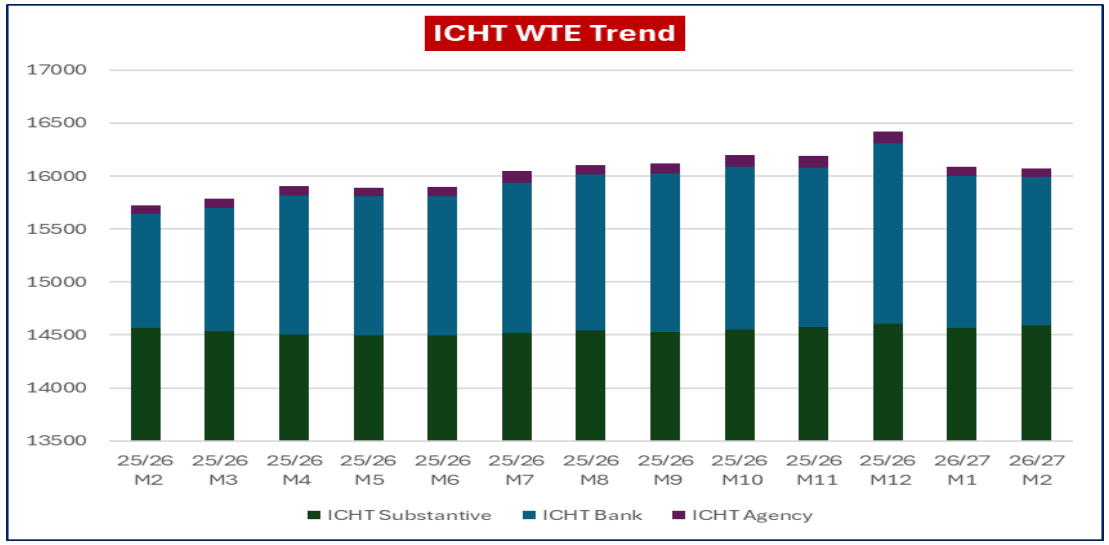
WTE Trend		25/26 M2	25/26 M3	25/26 M4	25/26 M5	25/26 M6	25/26 M7	25/26 M8	25/26 M9	25/26 M10	25/26 M11	25/26 M12	26/27 M1	26/27 M2	% change to 25/26 average	% change M2 25/26 to M2 26/27
APC	Substantive	34,228	34,173	34,154	34,062	34,047	34,097	34,166	34,096	34,149	34,202	34,270	34,157	34,192	0.0%	-0.1%
	Bank	2,789	2,988	3,251	3,136	3,173	3,333	3,293	3,432	3,536	3,658	4,008	3,400	3,377	2.9%	21.1%
	Agency	187	175	217	186	182	219	178	179	187	203	209	160	154	-19.8%	-17.6%
	Total	37,203	37,336	37,622	37,383	37,401	37,650	37,637	37,707	37,872	38,062	38,487	37,717	37,723	0.2%	1.4%
CWFT	Substantive	7,176	7,182	7,240	7,174	7,187	7,237	7,275	7,262	7,262	7,293	7,303	7,299	7,275	0.8%	1.4%
	Bank	580	610	653	654	629	684	713	685	727	787	808	684	697	2.3%	20.2%
	Agency	26	24	28	26	22	17	15	17	19	24	32	17	21	-19.4%	-21.2%
	Total	7,782	7,817	7,920	7,854	7,838	7,938	8,002	7,963	8,008	8,104	8,144	7,999	7,993	0.9%	2.7%
ICHT	Substantive	14,567	14,532	14,506	14,492	14,498	14,522	14,539	14,523	14,550	14,573	14,606	14,566	14,590	0.2%	0.2%
	Bank	1,073	1,171	1,308	1,315	1,314	1,414	1,475	1,498	1,538	1,507	1,706	1,435	1,400	4.0%	30.5%
	Agency	82	83	89	82	86	112	92	97	107	108	106	87	79	-12.9%	-3.3%
	Total	15,722	15,786	15,904	15,889	15,898	16,049	16,106	16,118	16,195	16,187	16,418	16,088	16,069	0.5%	2.2%
LNWH	Substantive	8,940	8,935	8,885	8,891	8,847	8,805	8,813	8,787	8,806	8,801	8,808	8,798	8,808	-0.6%	-1.5%
	Bank	801	833	878	819	834	844	780	860	885	942	985	962	902	8.2%	12.6%
	Agency	42	50	54	44	50	64	43	39	37	40	33	29	32	-32.1%	-25.6%
	Total	9,783	9,818	9,817	9,754	9,730	9,713	9,636	9,686	9,729	9,783	9,826	9,789	9,742	0.0%	-0.4%
THH	Substantive	3,545	3,525	3,523	3,505	3,514	3,533	3,539	3,524	3,531	3,536	3,552	3,494	3,518	-0.7%	-0.8%
	Bank	334	373	411	348	397	391	325	389	385	421	509	320	377	-11.2%	12.8%
	Agency	36	18	47	34	24	26	28	26	25	31	37	27	23	-23.3%	-37.6%
	Total	3,916	3,916	3,981	3,887	3,935	3,950	3,892	3,939	3,942	3,988	4,099	3,841	3,918	-1.9%	0.1%

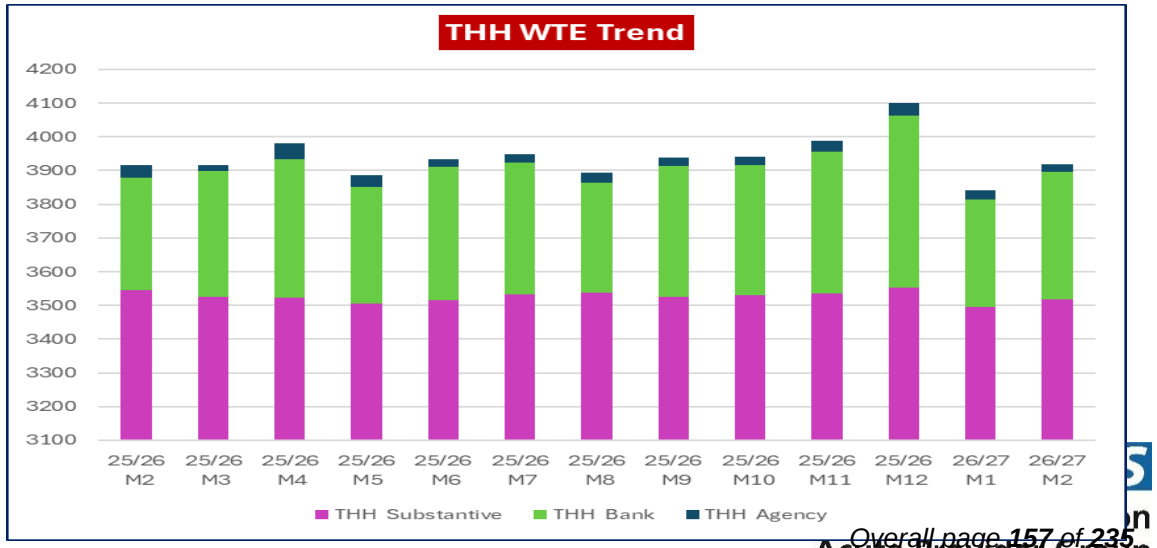
- The table shows the WTE trend from 2025/26: the 2026/27 WTE % change compared to last year (average) and the % change from M2 25/26 to M2 26/27. These are shown in the last two columns.
- An overall increase of 0.2% is driven primarily by bank WTE whereas agency reports a significant decrease. Substantive WTEs are unchanged.
- Comparing month 2 25/26 to month 2 26/27 there is a 1.4% increase, driven by bank.
- There has been a marginal increase in WTE M1 to M2, by 6 WTE, or 0.02% (Substantive +35; Bank -24, Agency -6).

M2 WTE trend graphs







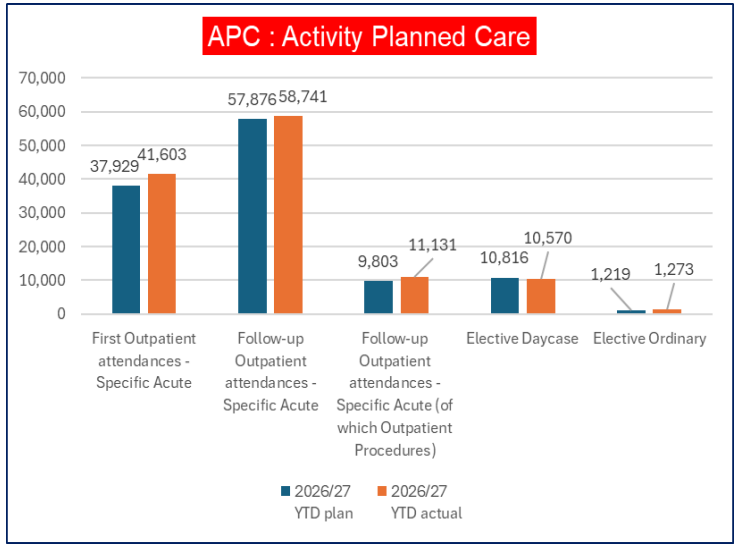


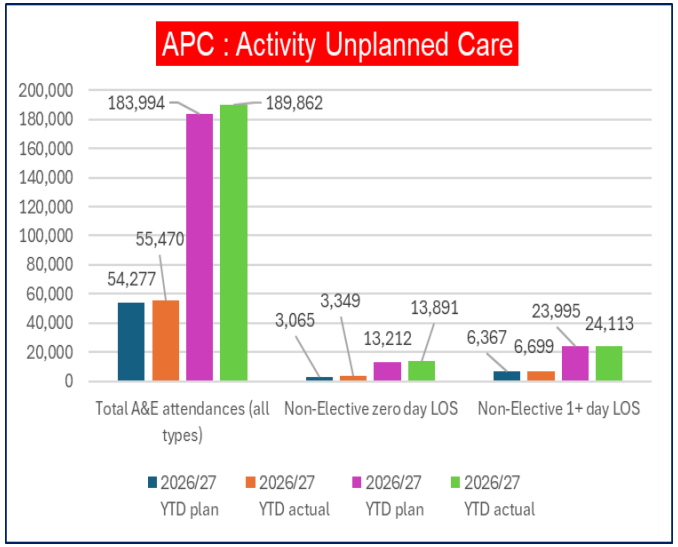
Income : M2

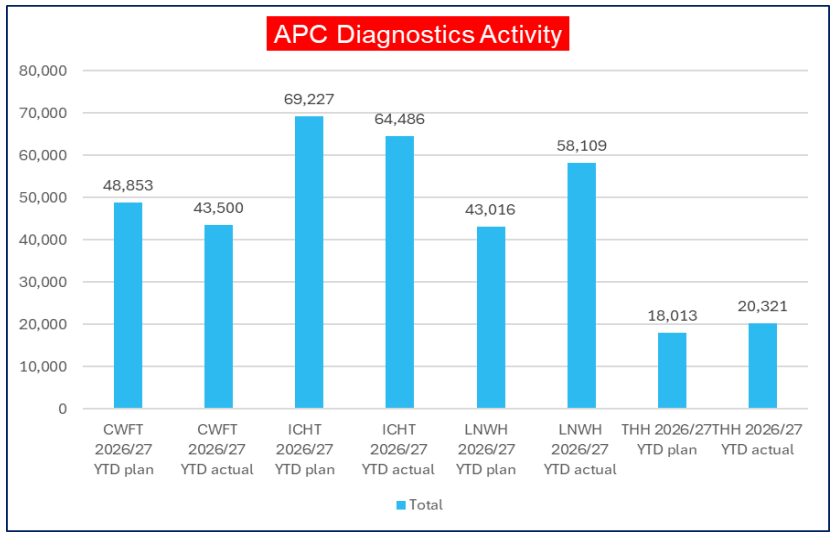
Income Category	YTD APG Plan	YTD APG Actual	YTD APG Var
	£'000	£'000	£'000
Patient Care			
DHSC	28	80	52
ICBs	577,130	585,587	8,457
Injury Cost Recovery Scheme	1,494	2,685	1,191
LA	6,892	6,499	(393)
NHS FTs	10,293	2,191	(8,102)
NHS Other	60	45	(15)
NHS Trusts	1,430	10,164	8,734
NHSE	64,804	66,940	2,136
Non NHS Other	2,382	625	(1,757)
Overseas Patients	3,798	3,611	(187)
Private Patients	14,172	14,937	765
Patient Care Total	**682,483**	**693,364**	**10,881**
Other Operating Income			
Charitable donations	462	137	(325)
Ed & Training	24,228	23,811	(417)
Income : Non Patient Care	8,090	7,780	(310)
Income: staff recharges	4,412	4,596	184
R&D	12,411	11,385	(1,026)
Rental revenue : leases	12,066	10,570	(1,496)
Other	2,188	2,101	(87)
Other Operating Income Total	**63,857**	**60,380**	**(3,477)**
Grand Total	**746,340**	**753,744**	**7,404**

- The table shows the APG's year to date income against plan and the variance.
- The over delivery on patient care income (ICBs) represents recognition of additional tariff income to cover the AfC and medical pay awards.
- For ERF income, the majority of which sits under ICBs : LNWH & ICHT have estimated variances to plan : LNWH £0.7m underperformance and ICHT overperformance of £0.9m.
- For UEC income, the majority of which sits under ICBs, over or under performance is paid at 20% marginal rate. LNWH & ICHT have estimated variances to plan: LNWH £0.2m and ICHT £0.1m underperformance. To note, UEC activity is overperforming to M2 against the operating plan at LNWH , this will be adjusted in Month 3 when activity is updated.
- The variances on NHS FTs and NHS Trusts almost balance each other out – this is a categorisation issue at ICHT and will be amended in month 3.
- The over delivery on NHSE income is primarily due to pass through drugs and devices (at ICHT and there is a compensating over spend under non pay)
- The Appendix notes the breakdown by trust.

Operating Plan : Activity V Plan M2







Appendix 1 notes the performance by trust for Planned and Unplanned Care

The tables note the activity performance against the Operating Plan for at M2 2026/27, for the APG.

Planned Care:
Outpatients
- Firsts : 1% above plan
- FU : 1% above plan
- OP Procedures +6% variance to plan

Elective and day cases are 2% above plan (electives 2% and day cases 5%.

Emergency:
- A&E : 3% above plan
- NEL <1 day 5% above plan.
- NEL > 1 day is on plan

A&E is over plan driven by type 2 and 3 activity which is 7.5% over plan, type 1 activity is on plan. Note the 26/27 UEC plan includes growth of 2.6% (on the 26/27 outturn). There is no SDEC plan submitted in 26/27. Note NEL <1 day coding is being reviewed across the APG.

Diagnostic Tests:
- 43% over plan in total.
- Driven by LNWH and THH over plan
- @LNWH the overperformance is largely for non-obstetric u/s. There were approximately an extra 6000 tests by M2 compared to the run-rate last year. The Trust is currently using an insourcing provider as well as internal WLIs to meet the demand and improve DM01 performance

Efficiency Performance : M2

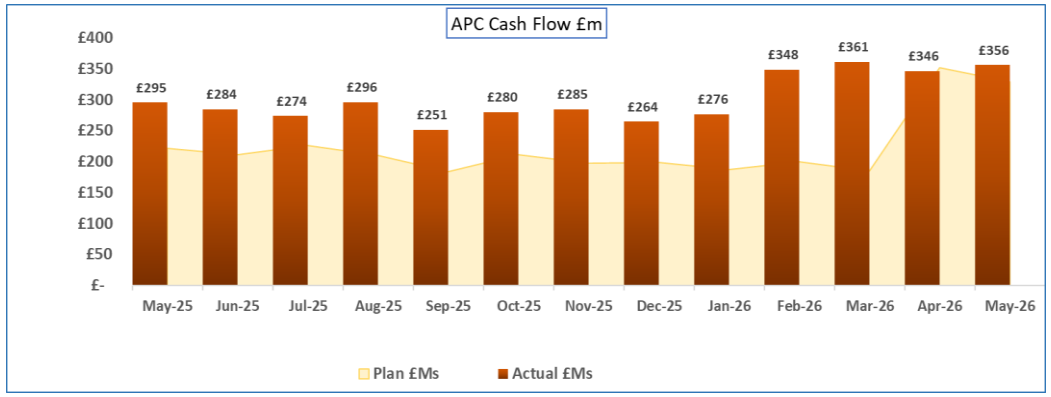
Efficiency Month 2	YTD plan			YTD Actual			YTD Var	YTD R/NR %			In Month Plan	In Month Actuals	In Month Variance	Annual Plan			Annual Forecast			Fcast Variance
	R	NR	Total	R	NR	Total		R	NR	Total	Total	Total	Total	R	NR	Total	R	NR	Total	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	%	%	%	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	3,046	1,414	4,460	1,586	845	2,431	(2,029)	65%	35%	100%	2,230	1,290	(940)	23,871	9,571	33,442	26,017	7,425	33,442	0
ICHT	6,834	8,962	15,796	3,041	8,494	11,536	(4,260)	26%	74%	100%	7,898	7,192	(706)	54,191	40,587	94,778	50,367	44,411	94,778	0
LNWH	3,994	86	4,080	2,483	1,669	4,152	72	60%	40%	100%	2,040	2,110	70	35,000	15,000	50,000	35,000	15,000	50,000	0
THH	542	1,496	2,038	164	1,016	1,180	(858)	14%	86%	100%	1,019	725	(294)	5,928	8,978	14,906	5,928	8,978	14,906	0
Total	**14,416**	**11,958**	**26,374**	**7,275**	**12,024**	**19,299**	**(7,075)**	**38%**	**62%**	**100%**	**13,187**	**11,316**	**(1,870)**	**118,990**	**74,136**	**193,126**	**117,312**	**75,814**	**193,126**	**0**
% delivery of plan				**28%**	**46%**	**73%**								**62%**	**38%**	**100%**	**61%**	**39%**	**100%**	

- The APG's annual efficiency plan is £193.1m, up from £177.8m delivered in 2025/26. An increase of 8%.
- M2 in month delivery is £11.3m, up from £7.9m in month 1. Against the in-month plan of £143.2m there is a £1.9m under delivery.
- To date CIP is under delivered against the plan by £7m, at £19.3m delivered against a plan of £26.4m. 46% of the year-to-date delivery is via non recurrent schemes.
- To date (17.06.26) 75% of the annual plan is identified, of this, 75% is from recurrent schemes.

M2 Cash

NWL APG Cash Balance

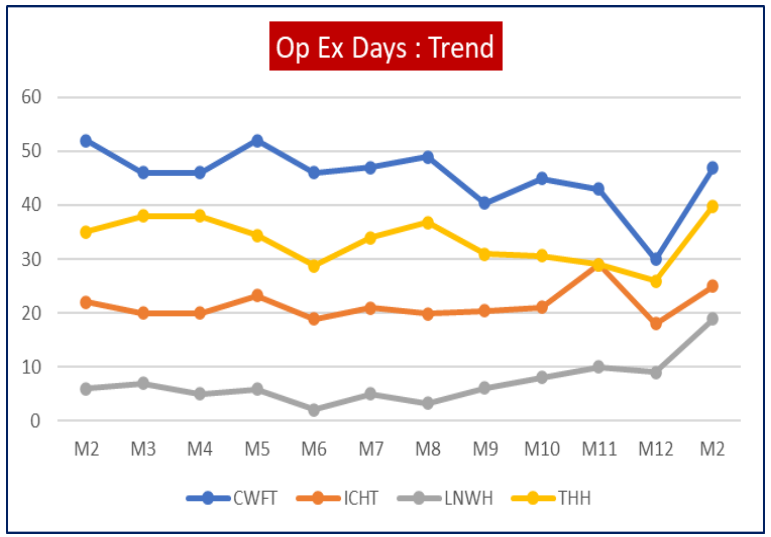
	Mar-26	May-26	Movement to YTD	31 May 26 Cash Plan	Variance from plan
Trust	£m	£m	£m	£m	£m
CWFT	117.6	128.4	10.8	128.0	0.4
ICHT	158.9	127.6	(31.3)	150.7	(23.2)
LNWH	39.4	55.4	16.0	22.9	32.5
THH	44.7	44.5	(0.2)	27.2	17.3
Total	**360.5**	**355.8**	**(4.8)**	**328.8**	**27.0**
			-1%		**8%**

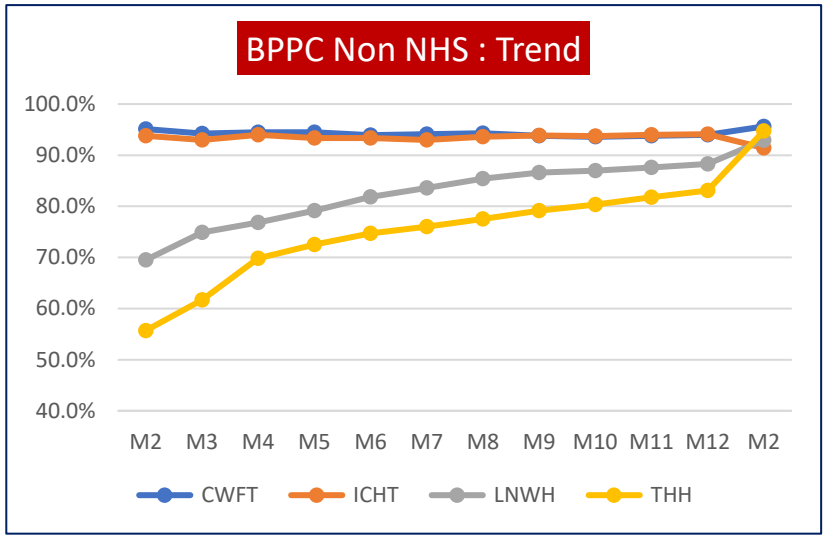


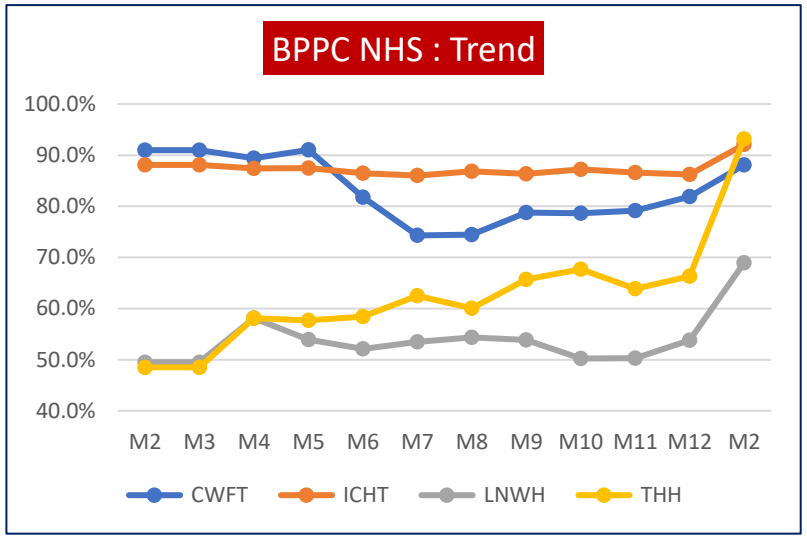
Trust	Op exp days	BPPC (£)Non NHS	BPPC (£) NHS	Debtor Days	Creditor Days
CWFT	47	95.6%	88.1%	20	119
ICHT	25	91.4%	92.1%	33	159
LNWH	19	92.9%	68.9%	17	133
THH	40	94.7%	93.2%	28	154

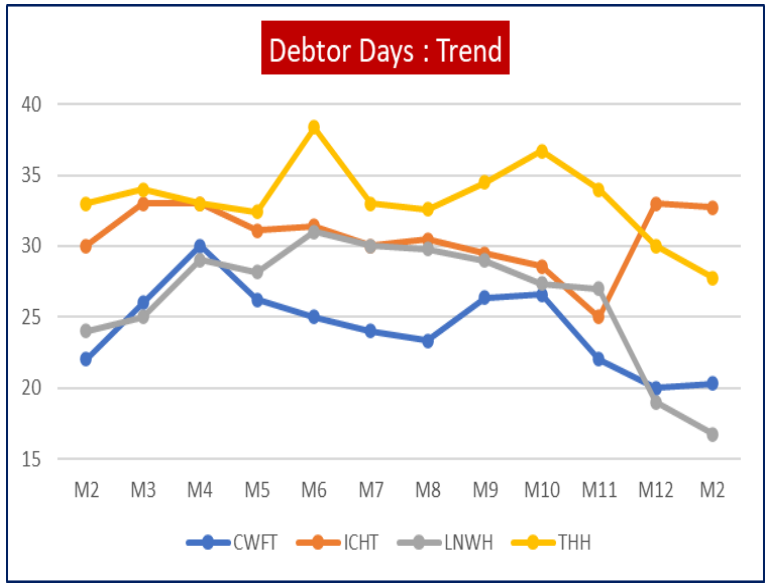
- The APG combined cash balance at the end of April is £355.8m, a £4.8m decrease from the March 26 position. The cash balance is £27m lower than the cash plan at Month 2. The tables and graph above show:
- The end of May cash position against March 26 actual and May cash plan positions (table on the left-hand side).
  - ICHT: the variance against plan is primarily driven by timing differences in working capital movements and capital investment
  - LNWH: the cash balance has increased from last year and is higher than plan primarily due to the quarter 1 Health Education cash receipts from NHS England and lower trade creditor payments and lower capital expenditure than planned for in the first two months.
- Cash flow vs plan trend graph – 13 months.
- Cash Metrics Table on right hand side) :
  - Operating expense days :days of operating expenses that can be serviced by the cash balance at the end of the month.
  - The Better Payment Practice Code (BPPC) performance at the end of March - % of creditor invoices that are paid (by £ value) within 30 days (YTD values).
  - Debtor days: the average no of days for the trust to receive payment of its invoices. A lower no of days signals more efficient Accounts Receivable processes.
  - Creditor days: the average no of days the trust takes to pay its creditor invoices. A higher number of days suggests the trust is taking longer to pay bills which could reflect on supplier relationships.
  - BPPC, debtor and creditor day measures are impacted by the cash position. A lower cash position (Op ex days) creates the impetus to chase debtors (lowering debtor days) and potentially delay the payment of creditors (higher creditor days).

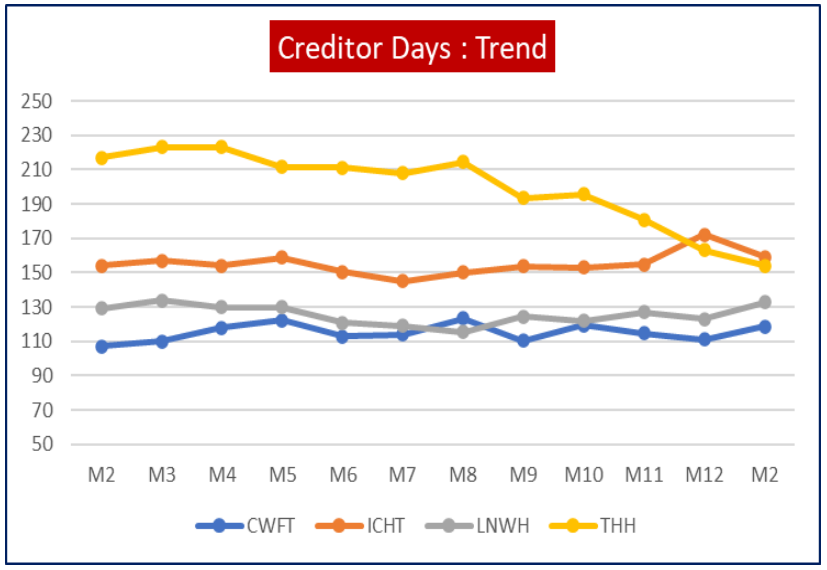
M2 Cash Metrics Graphs











NHS
North West London
Acute Provider Group

M2 Capital

CDEL		2026/27 YTD			Full Year 2026/27		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
CWFT	Core CRL	6,803	5,543	**1,260**	31,125	31,125	**0**
	Nat schemes	1,104	408	**696**	9,531	9,747	**(216)**
	Total	**7,907**	**5,951**	**1,956**	**40,656**	**40,872**	**(216)**
ICHT	Core CRL	3,014	7,243	**(4,229)**	64,099	64,099	**0**
	Nat schemes	2,548	3,400	**(852)**	47,036	48,960	**(1,924)**
	Total	**5,562**	**10,643**	**(5,081)**	**111,135**	**113,059**	**(1,924)**
LNWH	Core CRL	3,696	3,219	**477**	38,120	48,620	**(10,500)**
	Nat schemes	172	1,128	**(956)**	33,796	33,796	**0**
	Total	**3,868**	**4,347**	**(479)**	**71,916**	**82,416**	**(10,500)**
THH	Core CRL	1,476	153	**1,323**	21,810	21,810	**0**
	Nat schemes	3,626	978	**2,648**	43,072	37,106	**5,966**
	Total	**5,102**	**1,131**	**3,971**	**64,882**	**58,916**	**5,966**
APC	Core CRL	14,989	16,158	**(1,169)**	155,154	165,654	**(10,500)**
	Nat schemes	7,450	5,914	**1,536**	133,435	129,609	**3,826**
	Total	**22,439**	**22,072**	**367**	**288,589**	**295,263**	**(6,674)**

National PDC Capital Plan 26/27	CWFT £'000	ICHT £'000	LNWH £'000	THH £'000	APG £'000
Diagnostics	7,250	10,481	2,681	1,500	21,912
UEC		6,600	20,833		27,433
Elective Recovery			2,000		2,000
Estates Safety		5,000	7,250		12,250
New Hospital Programme		21,955		41,571	63,526
RAAC		3,000			3,000
PFI capital charges (e.g. residual interest)	2,281		1,032		3,313
Total	**9,531**	**47,036**	**33,796**	**43,071**	**133,434**

- The total Capital Departmental Expenditure Limit (CDEL) plan for the year is £288.6m.
- The annual capital plan comprises £155.1m internally funded (net of amounts included from other sources such as donations and grants) and £133.4m (35%) represents Nationally Funded PDC Capital Programmes (see breakdown in bottom table on RHS).
- The top table shows the year-to-date capital spend against the plan. The £1.1m overspend on core CRL at ICHT is due to timing of capital spend and is offset by underspends in the other three trusts.
- The forecast overspend is £6.7m:
- £10.5m on core CRL at LNWH represents the allocation of capital reserves at NWL ICB which is agreed but was not included at the time of the plan submission. There is an expectation that additional PDC capital will be granted of the equivalent amount.
- The underspend on national PDC capital is driven by a projected underspend on the NHP at THH due to timing of the project, compensated by overspends at CWFT & ICHT. To note, during the year, additional PDC capital schemes are routinely put forward by NHSE for Trusts to bid for. The forecast position therefore includes these. The plan remains as submitted and does not get adjusted for these.

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

1. Trust's I&E M2
2. Income breakdown by Trust
3. Operating Plan activity M2

NHS North West London Acute Provider Group

1a. Trust M2 Income & Expenditure Performance

CWFT

	In-month				YTD				Forecast			
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %
Income	86,662	88,553	1,891	2%	173,962	175,673	1,711	1%	1,054,604	1,054,604	0	0%
Pay	(51,872)	(52,625)	(753)	-1%	(103,744)	(106,459)	(2,715)	-3%	(620,705)	(620,705)	0	0%
Non-Pay	(35,218)	(35,152)	65	0%	(70,434)	(69,520)	915	1%	(419,063)	(419,520)	(457)	-0%
Non Operating Items	(1,179)	(1,119)	60	5%	(2,368)	(2,317)	51	2%	(14,836)	(14,379)	457	3%
Total	**(1,607)**	**(343)**	1,264		**(2,584)**	**(2,622)**	**(38)**		0	0	(0)	

ICHT

	In-month				YTD				Forecast			
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %
Income	157,397	163,551	6,154	4%	314,794	320,689	5,895	2%	1,888,769	1,888,769	0	0%
Pay	(97,432)	(103,689)	(6,257)	-6%	(194,864)	(207,143)	(12,279)	-6%	(1,170,702)	(1,170,702)	0	0%
Non-Pay	(58,926)	(60,871)	(1,945)	-3%	(117,833)	(117,882)	(49)	-0%	(704,397)	(704,397)	0	0%
Non Operating Items	(1,039)	(769)	270	26%	(2,097)	(1,588)	509	24%	(13,670)	(13,670)	0	0%
Total	0	**(1,778)**	**(1,778)**		0	**(5,924)**	**(5,924)**		0	0	0	

NHS North West London Acute Provider Group

1b. Trust M2 Income & Expenditure Performance

LNWH

	In-month				YTD				Forecast			
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %
Income	92,582	92,220	**(362)**	**-0%**	186,231	184,513	**(1,718)**	**-1%**	1,137,337	1,136,832	(505)	**-0%**
Pay	(60,818)	(61,008)	**(190)**	**-0%**	(121,637)	(122,686)	**(1,049)**	**-1%**	(710,942)	(711,992)	**(1,050)**	**-0%**
Non-Pay	(34,440)	(34,191)	**249**	**1%**	(69,159)	(68,349)	**810**	**1%**	(401,880)	(401,206)	**674**	**0%**
Non Operating Items	(2,043)	(1,731)	**312**	**15%**	(4,086)	(3,668)	**418**	**10%**	(24,515)	(23,634)	**881**	**4%**
Total	**(4,719)**	**(4,710)**	**9**		**(8,651)**	**(10,190)**	**(1,539)**		**0**	**0**	**0**	

THH

	In-month				YTD				Forecast			
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %
Income	35,677	36,580	**903**	**3%**	71,353	72,869	**1,516**	**2%**	430,938	430,938	**0**	**0%**
Pay	(23,348)	(24,231)	**(883)**	**-4%**	(46,696)	(47,962)	(1,266)	**-3%**	(280,150)	(280,150)	**0**	**0%**
Non-Pay	(11,836)	(11,818)	**18**	**0%**	(23,673)	(24,384)	(711)	**-3%**	(142,062)	(142,062)	**0**	**0%**
Non Operating Items	(726)	(651)	**75**	**10%**	(1,452)	(1,289)	163	**11%**	(8,726)	(8,726)	**0**	**0%**
Total	**(233)**	**(120)**	**113**		(468)	(766)	(298)		**0**	**0**	**0**	

NHS North West London Acute Provider Group

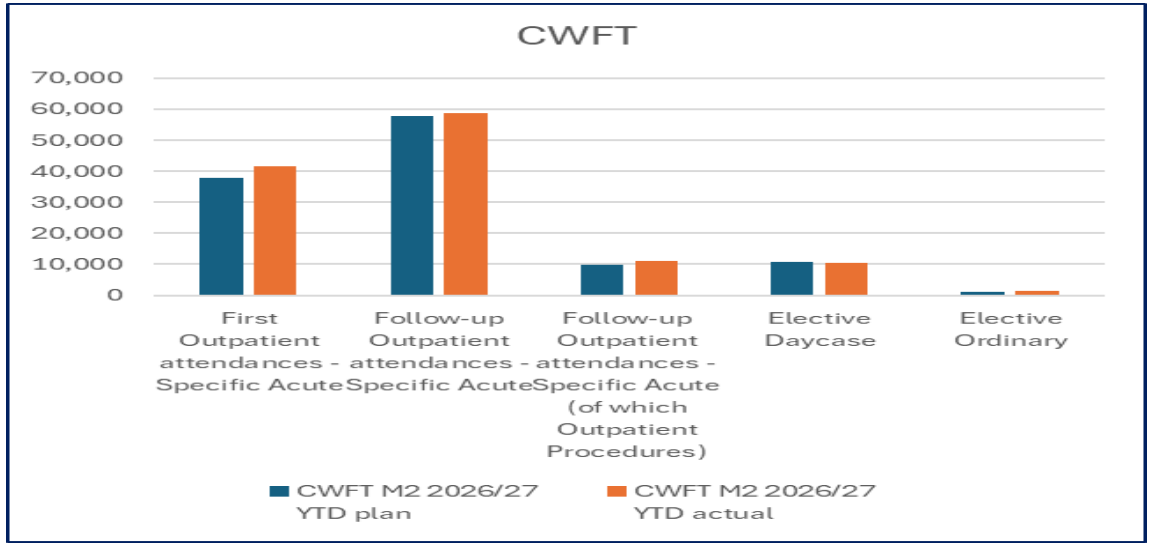
2. Income by Trust

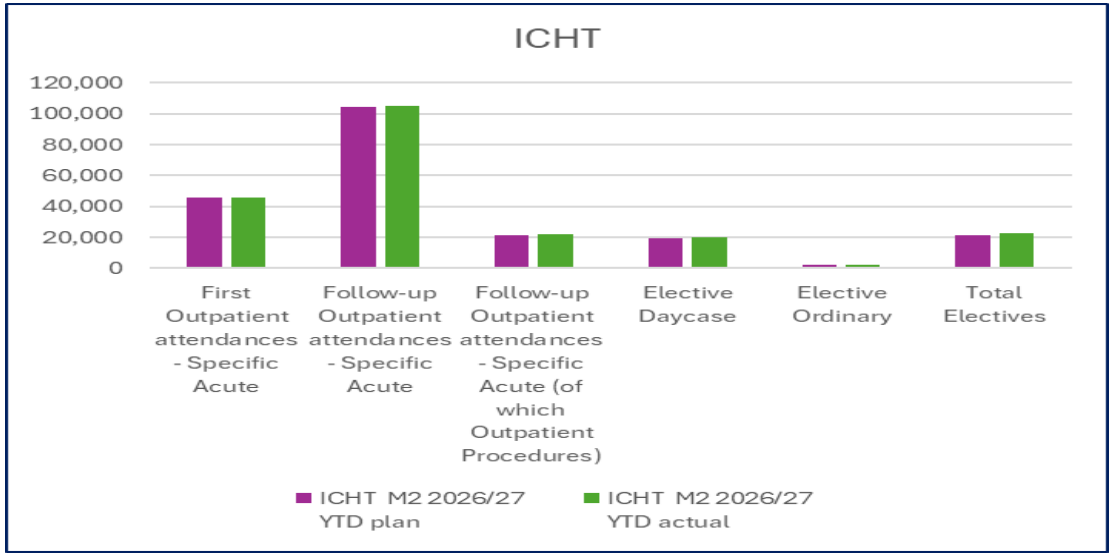
Income Category	YTD CWFT Plan £'000	YTD CWFT Actual £'000	YTD CWFT Var £'000	YTD ICHT Plan £'000	YTD ICHT Actual £'000	YTD ICHT Var £'000	YTD LNWH Plan £'000	YTD LNWH Actual £'000	YTD LNWH Var £'000	YTD THH Plan £'000	YTD THH Actual £'000	YTD THH Var £'000	YTD APG Plan £'000	YTD APG Actual £'000	YTD APG Var £'000
Patient Care															
DHSC	0	0	0	28	80	52	0	0	0	0	0	0	28	80	52
ICBs	129,880	132,036	2,156	226,936	232,512	5,576	156,386	155,747	(639)	63,928	65,292	1,364	577,130	585,587	8,457
Injury Cost Recovery Scheme	218	296	78	710	1,750	1,040	358	379	21	208	260	52	1,494	2,685	1,191
LA	5,222	4,897	(325)	30	26	(4)	1,640	1,576	(64)	0	0	0	6,892	6,499	(393)
NHS FTs	12	0	(12)	10,188	2,007	(8,181)	93	75	(18)	0	109	109	10,293	2,191	(8,102)
NHS Other	52	45	(7)	8	0	(8)	0	0	0	0	0	0	60	45	(15)
NHS Trusts	40	86	46	1,244	10,026	8,782	64	52	(12)	82	0	(82)	1,430	10,164	8,734
NHSE	17,640	16,957	(683)	30,936	34,064	3,128	14,752	14,532	(220)	1,476	1,387	(89)	64,804	66,940	2,136
Non NHS Other	96	127	31	2,196	443	(1,753)	90	55	(35)	0	0	0	2,382	625	(1,757)
Overseas Patients	604	649	45	1,672	1,677	5	1,046	1,111	65	476	174	(302)	3,798	3,611	(187)
Private Patients	3,926	4,382	456	9,688	10,075	387	544	476	(68)	14	4	(10)	14,172	14,937	765
Patient Care Total	**157,690**	**159,475**	**1,785**	**283,636**	**292,660**	**9,024**	**174,973**	**174,003**	**(970)**	**66,184**	**67,226**	**1,042**	**682,483**	**693,364**	**10,881**
Other Operating Income															
Charitable donations	132	117	(15)	330	20	(310)	0	0	0	0	0	0	462	137	(325)
Ed & Training	6,022	5,761	(261)	10,606	10,260	(346)	6,020	5,874	(146)	1,580	1,916	336	24,228	23,811	(417)
Income : Non Patient Care	1,318	1,980	662	4,368	2,924	(1,444)	558	564	6	1,846	2,312	466	8,090	7,780	(310)
Income: staff recharges	2,296	2,441	145	2,052	2,083	31	0	0	0	64	72	8	4,412	4,596	184
R&D	4,804	4,671	(133)	4,154	4,000	(154)	2,300	1,756	(544)	1,153	958	(195)	12,411	11,385	(1,026)
Rental revenue : leases	1,632	1,219	(413)	9,410	8,409	(1,001)	964	869	(95)	60	73	13	12,066	10,570	(1,496)
Other	68	9	(59)	238	333	95	1,416	1,447	31	466	312	(154)	2,188	2,101	(87)
Other Operating Income Total	**16,272**	**16,198**	**(74)**	**31,158**	**28,029**	**(3,129)**	**11,258**	**10,510**	**(748)**	**5,169**	**5,643**	**474**	**63,857**	**60,380**	**(3,477)**
Grand Total	**173,962**	**175,673**	**1,711**	**314,794**	**320,689**	**5,895**	**186,231**	**184,513**	**(1,718)**	**71,353**	**72,869**	**1,516**	**746,340**	**753,744**	**7,404**

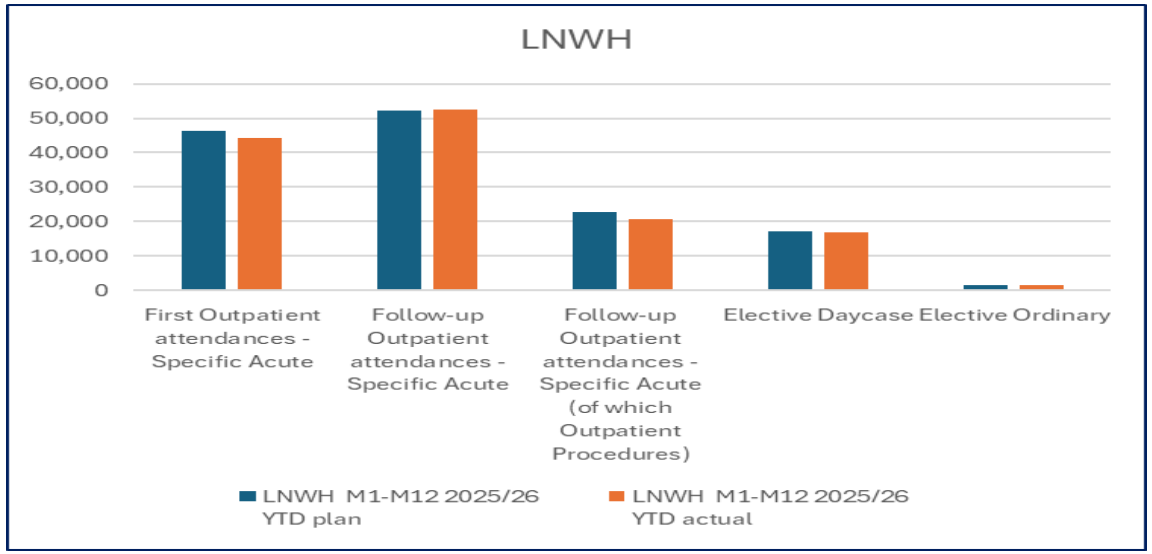
Activity by Trust : Elective and Non-Elective (2026/27 Plan V Actual M2)

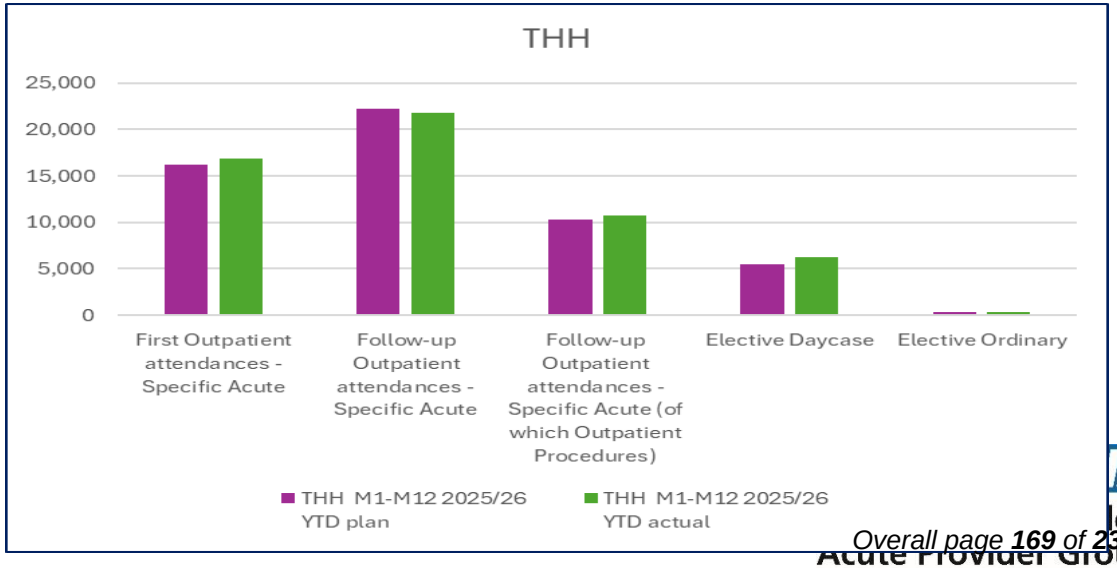
Trust	CWFT				ICHT				LNWH				THH				APG			
	M2				M2				M2				M2				M2			
POD	2026/27 YTD plan	2026/27 YTD actual	Var	% var	2026/27 YTD plan	2026/27 YTD actual	Var	% var	2026/27 YTD plan	2026/27 YTD actual	Var	% var	2026/27 YTD plan	2026/27 YTD actual	Var	% var	2026/27 YTD plan	2026/27 YTD actual	Var	% var
First Outpatient attendances - Specific Acute	37,929	41,603	3,674	9.7%	45,992	45,793	-199	-0.4%	46,190	44,186	-2,004	-4.3%	16,197	16,897	700	4.3%	146,308	148,479	2,171	1%
Follow-up Outpatient attendances - Specific Acute	57,876	58,741	865	1.5%	104,276	105,055	779	0.7%	52,117	52,456	339	0.7%	22,194	21,791	-403	-1.8%	236,463	238,043	1,580	1%
Total Specific Acute Outpatients	**95,805**	**100,344**	**4,539**	**4.7%**	**150,268**	**150,848**	**580**	**0.4%**	**98,307**	**96,642**	**-1,665**	**-1.7%**	**38,391**	**38,688**	**297**	**0.8%**	**382,771**	**386,522**	**3,751**	**1%**
Follow up ratio	1.53	1.41	-0.11	-7.5%	2.27	2.29	0.03	0.01	1.13	1.19	0.06	5.2%	1.37	1.29	-0.08	-5.9%	1.62	1.60	-0.01	-0.8%
*Follow-up Outpatient attendances - Specific Acute (of which **Outpatient Procedures**)*	9,803	*11,131*	*1,328*	*13.5%*	*21,054*	*21,907*	*853*	*4.1%*	*22,709*	*20,760*	*-1,949*	*-8.6%*	*10,270*	*10,702*	*432*	*4.2%*	*63,836*	*64,500*	*664*	*1%*
Elective Daycase	10,816	10,570	-246	-2.3%	19,076	20,169	1,093	5.7%	17,240	16,687	-553	-3.2%	5,462	6,279	817	15.0%	52,594	53,705	1,111	2%
Elective Ordinary	1,219	1,273	54	4.4%	2,368	2,480	112	4.7%	1,404	1,440	36	2.6%	338	379	41	12.1%	5,329	5,572	243	5%
Total Electives	**12,035**	**11,843**	**-192**	**-1.6%**	**21,444**	**22,649**	**1,205**	**5.6%**	**18,644**	**18,127**	**-517**	**-2.8%**	**5,800**	**6,658**	**858**	**14.8%**	**57,923**	**59,277**	**1,354**	**2%**
Total A&E attendances (all types)	54,277	55,470	1,193	2.2%	48,360	47,871	-489	-1.0%	58,940	61,633	2,693	4.6%	22,417	24,888	2,471	11.0%	183,994	189,862	5,868	3%
Non-Elective zero day LOS	3,065	3,349	284	9.3%	3,597	3,217	-380	-10.6%	6,009	6,415	406	6.8%	541	910	369	68.2%	13,212	13,891	679	5%
Non-Elective 1+ day LOS	6,367	6,699	332	5.2%	6,954	6,523	-431	-6.2%	7,737	7,759	22	0.3%	2,937	3,132	195	6.6%	23,995	24,113	118	0%
Total Non-Electives	**9,432**	**10,048**	**616**	**6.5%**	**21,444**	**9,740**	**-11,704**	**-54.6%**	**13,746**	**14,174**	**428**	**3.1%**	**3,478**	**4,042**	**564**	**16.2%**	**37,207**	**38,004**	**797**	**2%**

Activity by Trust : Planned care (2026/2 Plan V Actual M2)

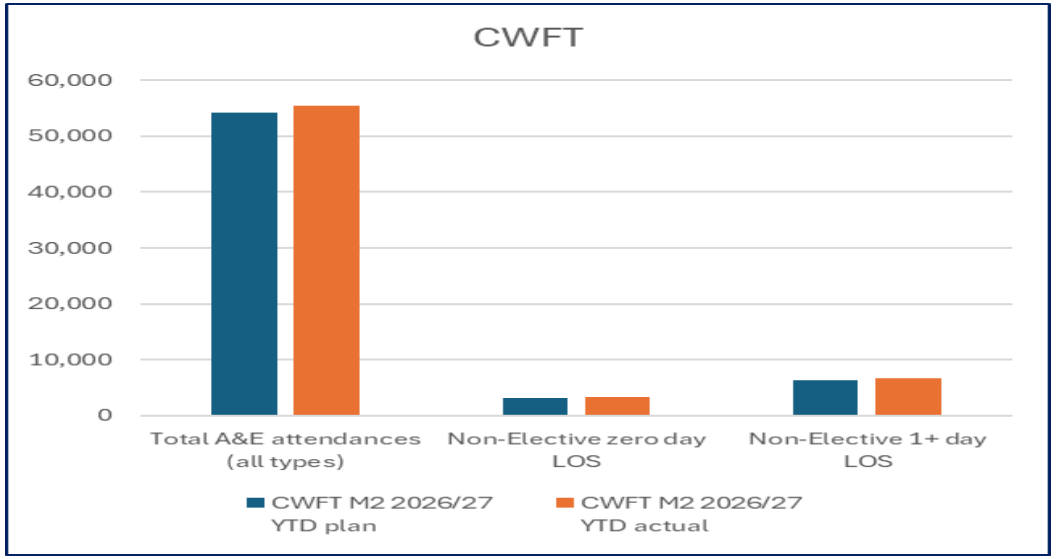


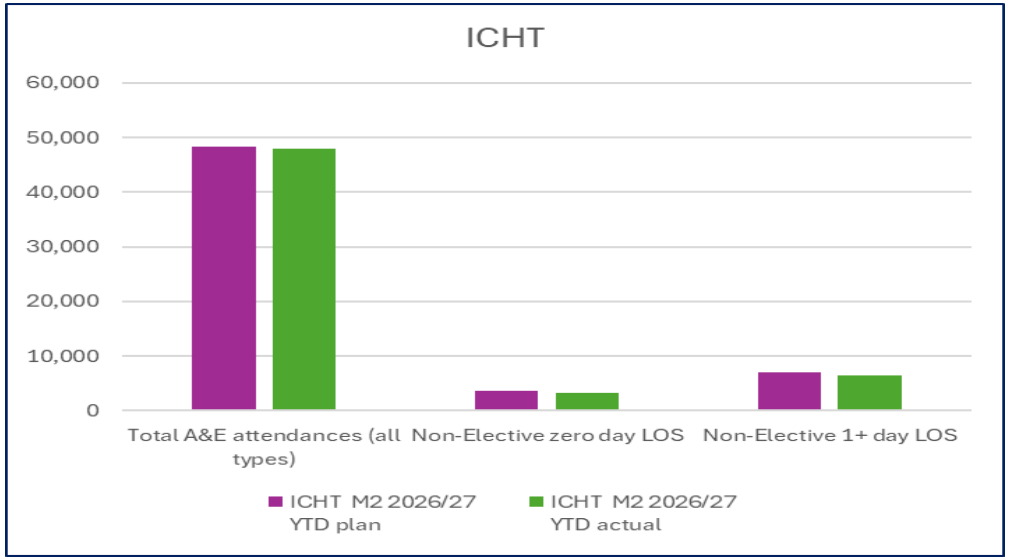


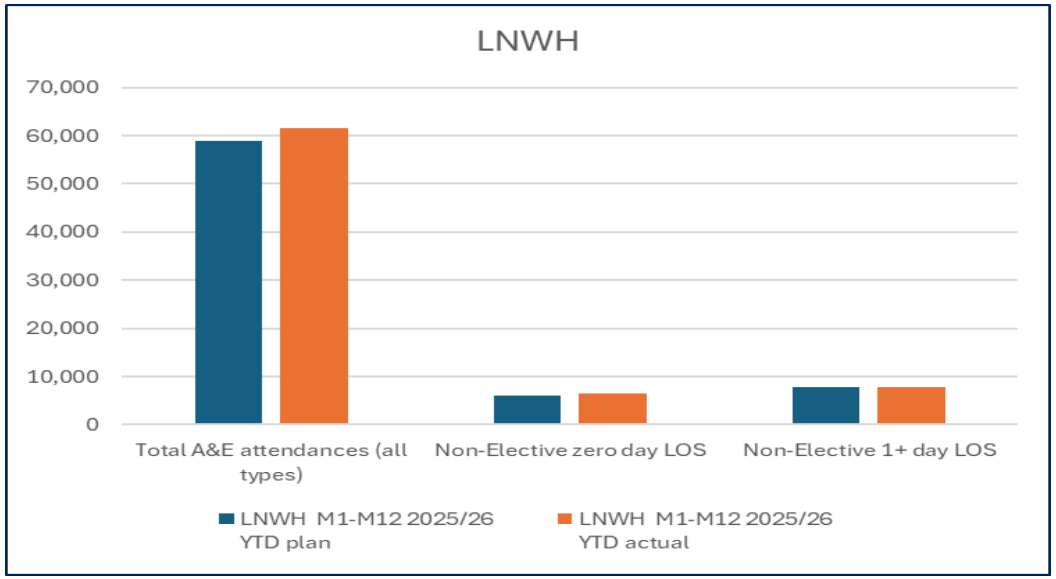


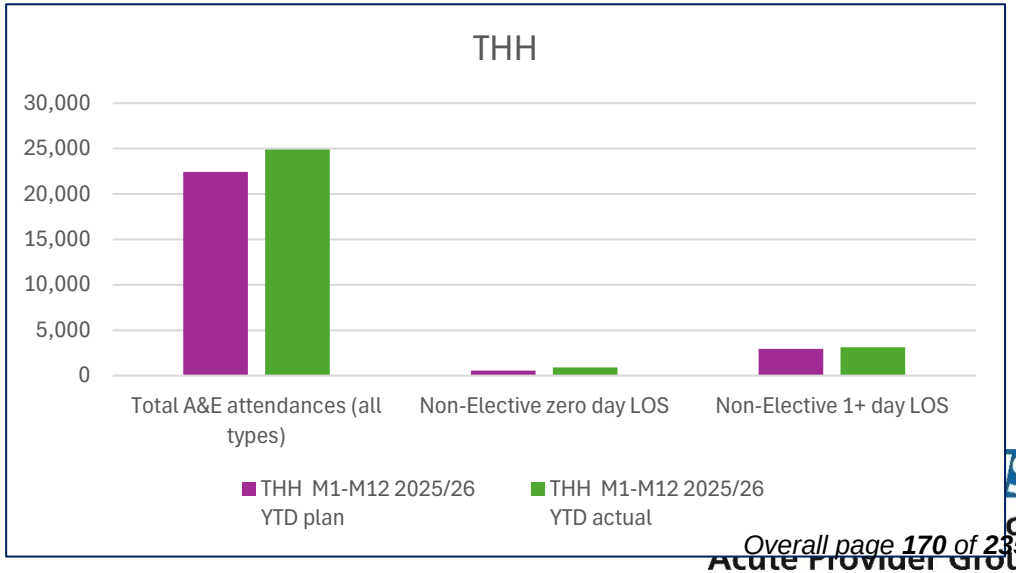


Activity by Trust : Unplanned care (2026/27 Plan V Actual M2)









Activity by Trust : (2026/2 Plan V Actual M2)

Planned Care:

CWFT
- CWFT DQ issues with day case coding both for chemotherapy patients and within our SDEC. This activity is currently showing in RAYDAY and OPFUP – working to correct to day case
- Over performance on outpatient firsts linked to elective recovery

ICHT
- ICHT Outpatient attendances broadly on plan YTD.
- Elective categories and OP Procedures exceeding plan.
- All consistent with an RTT performance that is ahead of trajectory at M2 - 70.1% versus a target of 62.4% for May 2026.
- Whilst the follow-up ratio is broadly on plan, plans are being developed drive a reduction in this metric.

LNWH
- Elective inpatient activity remains on plan year-to-date. Whilst elective day cases and outpatient first attendances are slightly below plan, performance is recovering.
- Outpatient procedure activity remains below plan; however, coding validation has identified a number of services where follow-up activity has been misclassified. Remedial action is in progress and is expected to result in a reallocation of activity to outpatient procedures, improving delivery against plan.

THH
- THH is ahead of plan for both outpatient and elective activity – with a positive under-performance in follow-ups. This reflects the ongoing work to realign clinic templates to deliver more new activity. N:f-up ratio compares favourably.
- Activity levels are being reflected in positive RTT performance.
- ENT remains challenged with increasing long waits.

Unplanned Care

CWFT
- A&E growth is around 5% compared to previous year. Growth assumed in plan = 2.6%. Overperformance driven primarily by type 3.

ICHT
- UEC attendances and Non-Elective categories adverse to plan noting a case-mix change between T1 and T2&T3.
- 4-hour performance for M2 was 78.04% versus a target 78.75%.
- Deep dive in place to understand drivers to the above.
- UEC action plan in place.

LNWH
- A&E growth related to significant increase in Brent and Harrow T3 activity and Ealing T1 activity
- Ambulance demand exceeding operating plan growth
- Carry on from 2526 winter plan to manage increase in attendance growth. Additional CDU (NEL ST beds) remain open and additional SDEC chairs.

THH
- ED attendances are 11% above plan (T1 & T3) and reflects the ongoing pressure felt this financial year.
- 4-hour ALL Type performance has been above 80% in Q1.
- 0-day NEL LOS being investigated – activity being recorded against ED with no plan set.
- Ongoing discussions with Place re high volumes.

4.3.3 GROUP FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT

Discussion Item Bob Alexander

REFERENCES

Only PDFs are attached

- 04.3.3a NWL APG F&P Jul Chair's Report.pdf
- 04.3.3b NWL APG Finance and Performance Committee July 26 - New NOF metrics V2.pdf
- 04.3.3c NWL APG FPC July 26 - New NOF metrics - Appendix 2 Full list.pdf

North West London Acute Provider Group (NWL APG)
Finance and Performance Committee Chair's Highlight Report to the Board in Common

1. Purpose
The Finance and Performance Committee provides oversight of the Group's financial sustainability, operational performance, productivity, efficiency programmes and key financial and performance risks, providing assurance to the Board in Common on matters within its remit.

2. Key Highlights
2.1 Medium Term Financial Plan (MTFP)
The Committee received an update on the development of the Group's Medium Term Financial Plan and noted ongoing work to establish a consistent financial modelling approach across all four organisations. Members were advised that the current focus is on developing a clear understanding of the Group's underlying financial position, identifying the principal drivers of the structural deficit and assessing the actions required to deliver long-term financial sustainability.

The Committee reviewed initial analysis of deficit drivers, productivity assumptions, efficiency opportunities and funding-related challenges, including the impact of unearned income and national tariff arrangements. Members emphasised the importance of linking the MTFP to the emerging Group Strategy and requested future reports provide greater transparency regarding key assumptions, scenario modelling, strategic options and potential Group-wide interventions.

The Committee noted that further development work will continue over the coming months, with a more mature Group-wide position to be presented following the appointment of the incoming Group Chief Finance Officer in September 2026.

2.2 Productivity and Efficiency
The Committee reviewed the quarterly productivity report and noted continued strong performance across the Group, with productivity improvements reported above national benchmarks.
Members reviewed performance across workforce productivity, outpatient services and theatre utilisation and considered further opportunities relating to mental health pathways, reduction in outpatient DNA rates and increased day-case activity. The Committee welcomed the detailed analysis presented and requested future reporting include greater consistency of benchmarking and comparative performance across partner organisations.
The Committee received assurance that productivity improvement activity remains closely aligned to Cost Improvement Programme (CIP) delivery and wider financial sustainability objectives.

2.3 National Oversight Framework (NOF)
The Committee received an update on the revised National Oversight Framework for 2026/27 and noted the introduction of additional metrics and a revised quartile-based assessment methodology.
Whilst current performance remains favourable, Members discussed the potential implications of the revised framework and recognised the uncertainty surrounding several newly introduced measures, particularly workforce, infection prevention and control and financial indicators. The Committee emphasised the importance of ensuring local operational performance management arrangements remain focused on the underlying drivers of improvement rather than solely on external ratings.

The full National Oversight Framework (NOF) report is has been added as an appendix with this report.

2.4 Operational Performance
The Committee reviewed the Integrated Performance Report and noted continued improvement across a range of operational performance indicators.
Key areas of progress included:

Continued improvement in urgent and emergency care performance, including reductions in long waits.
Sustained improvement in referral-to-treatment (RTT) performance and reductions in 52-week waits across the Group.
Ongoing progress against diagnostic recovery plans, supported by strengthened operational focus and improvement programmes.
Cancer performance remaining above London and national averages in several key measures despite continued capacity pressures in some specialties.
Mental health attendances and extended waits for transfer to appropriate mental health beds remain a concern.

Members welcomed the collaborative approach being adopted across the Group to support elective recovery, reduce delays and explore longer-term opportunities for service transformation and pathway redesign.

2.5 Financial Position and Delivery Risks
The Committee reviewed the Group's Month 3 financial position and noted that all four organisations reported delivery in line with plan at Quarter 1.
Members discussed the principal risks to delivery of the financial plan, including achievement of efficiency programmes, activity growth pressures and the ongoing impact of operational demand. The Committee sought assurance regarding the sustainability and recurrent nature of identified savings schemes and requested future reporting provide greater visibility of year-end forecast risks, mitigations and the extent to which balance sheet measures are supporting plan delivery.
The Committee received assurance that Executive-led review processes remain in place and that financial recovery actions continue to be actively monitored.

2.6 North West London Procurement Transformation Programme
The Committee received an update on the Procurement Transformation Programme following completion of an independent review of the shared procurement service.
Members noted that weaknesses had been identified in governance arrangements, workforce stability, operating model design and service delivery processes. In response, a comprehensive transformation programme has been established to strengthen governance, redesign core services and deliver a more effective and sustainable operating model.
The Committee noted that revised governance arrangements are now in place through the Programme Board and Shared Service Board and received assurance that work is progressing on implementation of a new operating model, workforce redesign and revised service level agreements.

3. Positive Assurances Received
The Committee received positive assurance regarding:

- Progress in the development of a Group-wide Medium Term Financial Plan and supporting financial strategy.
- Continued productivity improvement across the Group, with performance comparing favourably against national benchmarks.
- Ongoing improvement in urgent and emergency care, elective recovery, diagnostics and cancer performance.
- Delivery of Quarter 1 financial plans across all four organisations.

- Strengthened governance arrangements supporting the Procurement Transformation Programme.
- Continued alignment between productivity, performance improvement and financial sustainability programmes.

4. Key Risks / Matters for Escalation to the Board in Common

- The development of the Medium Term Financial Plan remains at an early stage and further work is required to establish a shared understanding of the Group's underlying financial position, structural deficit drivers and long-term financial sustainability strategy.
- Delivery of Cost Improvement Programmes remains a key risk across the Group, requiring continued focus on recurrent savings and sustainable financial recovery ctions.
- Ongoing operational demand pressures, particularly within urgent and emergency care services, continue to present risks to delivery of both operational and financial objectives.
- The revised National Oversight Framework introduces additional uncertainty in relation to future segmentation and performance assessment, particularly regarding new workforce, financial and infection prevention and control measures.
- Delivery of the Procurement Transformation Programme will require sustained oversight to ensure implementation of the revised operating model and associated governance improvements.

5. Concerns Outstanding

No additional concerns requiring escalation beyond those identified above.

6. Decisions Made

The Committee:

- Noted the progress and next steps relating to development of the Group Medium Term Financial Plan.
- Noted the quarterly productivity update.
- Noted the revised National Oversight Framework arrangements.
- Noted the Integrated Performance Report.
- Noted the Month 3 financial position and associated financial delivery risks.
- Noted the update on the North West London Procurement Transformation Programme.
- Approved amendments to the Committee Forward Planner.

6. Attendance Matrix

Members:	June attendance
Bob Alexander, Chair in Common, NWL APC Chair in Common	Y
Mike O'Donnell, Non-executive Director	Y
Vineeta Manchanda Non-executive Director	Y
David Moss Vice Chair – LNW	Y
Rupert Bondy - Non-executive Director	Y
Tim Orchard, Group Chief Executive/ Accountable Officer NWL APG	Y
Lesley Watts CBE, Chief Executive Officer	Y
Members:	June attendance
Virginia Massaro, Chief Financial Officer – CW & THH	Y

Bimal Patel, Chief Financial Officer - LNW	Y
Jazz Thind Chief Financial Officer - Imperial	Y
Alan McGlennan, Managing Director – THH	Y
Helen Berry, Associate Director of Finance	Y
Ian Bateman, Chief Operating Officer – Imperial	Y
James Walters, Chief Operating Officer - LNW	Y
Priya Ruda, Associate Director of Finance, NWL	Y
Sheena Basnayake, Managing Director (West Mid - WM)	N
Laura Bewick, Managing Director (Chelsea - CW)	N
Peter Jenkinson, Director of Corporate Governance	N
Attendees:	June attendance
Alexia Pipe, Chief of Staff to NWL APC Chair in Common	Y
Faye McLoughlin, Corporate Governance Officer	Y

NWL Acute Provider Group Finance and Performance Committee
08/07/2026
Item number: 2.3
This report is: Public

New NOF metrics for 2026/27

Author: Enter author name
Job title: Enter author job title

Accountable director: Enter accountable officer
Job title: Enter accountable officer

Purpose of report (for decision, discussion or noting)

Purpose: Information or for noting only

To provide the Acute Provider Group (APG) Finance and Performance Committee with an overview of the NHS Oversight Framework 2026/27, highlighting changes to metrics and scoring methodology, implications and a summary of risks identified through the APG's local assessment.

The Committee is asked to:

1. Note key changes and new metrics within the NOF 2026/27 framework.
2. Consider implications for APG Trusts.
3. Endorse a coordinated monitoring approach across the APG.

Report history

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

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

Executive summary and key messages

- The NHS Oversight Framework (NOF) 2026/27 introduces a number of important changes to how NHS providers are assessed and segmented. While NHS England has

described the framework as an ‘evolutionary’ development of the 2025/26 approach, the revised methodology broadens the range of factors that contribute to organisational segmentation.

- The most significant methodological change is the move from a quartile-based segmentation model towards fixed scoring thresholds. This is intended to provide greater transparency and predictability by allowing organisations to understand more clearly how performance translates into segment outcomes and what improvements are required to achieve higher segments.
- For acute trusts, the framework introduces **11** new scored metrics and **2** new contextual measures (see main report) bringing the total to **36** (see appendix 2 for full list). The largest increase is within the workforce, patient safety, effectiveness and finance, productivity and innovation domains, meaning that organisational segmentation will increasingly be influenced by a broader assessment of performance rather than predominantly by operational access standards.
- Although the metric set has expanded, the financial override remains unchanged and continues to be the most consequential feature of the framework. Organisations deemed to be in financial deficit cannot achieve Segment 1 or Segment 2 regardless of their performance across other domains. As a result, financial delivery remains the single most significant determinant of overall segmentation.
- An APG-wide assessment suggests that the principal areas of risk in 2026/27 are likely to be diagnostic recovery, infection prevention and control performance, workforce indicators and financial delivery. Several newly introduced metrics also remain relatively immature, with further national guidance and benchmarking information still expected during the year.

Impact assessment

Tick all that apply

☒ 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)

Key risks arising from report

Continuation of the financial deficit override, introduction of diagnostic waits over six weeks as a scored metric, Healthcare-associated infection metrics continue to present a significant NOF risk and performance can be challenging to improve quickly due to the use of rolling 12-month measures, the expansion of scored workforce measures, metric maturity – a risk that APG Trusts will be assessed against areas where expectations and comparators are not yet fully developed.

Main Report

1. Background

The NHS Oversight Framework (NOF) 2026/27 is NHS England's main mechanism for assessing the performance and improvement of NHS trusts, foundation trusts and Integrated Care Boards. It forms part of the NHS operating model and uses national metrics and organisational assessments to decide a trust's segment, oversight, support level and autonomy.

> "Its objective is to bring fairness, proportionality, consistency, transparency and predictability to our oversight of NHS trusts and foundation trusts and ICBs."

The 2026/27 framework is described as "intentionally evolutionary" and while the overall approach remains broadly the same as 2025/26, several important changes have been introduced.

- *Better alignment of delivery segmentation across both ICBs and providers.*
- *Greater recognition and lighter oversight for high-performing organisations, including advanced foundation trusts.*
- *Updated oversight metrics to reflect the NHS Medium Term Planning Framework, with enhanced measures for mental health, community, and ambulance services.*
- *A revised segmentation methodology using statistical thresholds rather than quartiles, making performance improvement easier to track.*
- *Stronger links between segmentation, organisational capability, and oversight responses*

Adapted from NHS Oversight Framework 2026/27, published 11 June 2026

2. Key Changes in 2026/27

Segmentation

The main change is the shift from the quartile-based segmentation to fixed thresholds based on the spread of delivery scores in 2025/26 (see methodology manual). Trusts will still receive an average metric score, but this is now mapped to segments 1–4 using nationally defined thresholds:

Segment	Average Metric Score
Segment 1	Below 1.94
Segment 2	1.94 – 2.33
Segment 3	2.34 – 2.77
Segment 4	Above 2.77

The new approach is designed to be easier to understand and to give clarity on what improvements are required. Previously, improvements across other trusts could move an organisation into a lower segment despite no deterioration locally. The new approach is designed to give more emphasis on achievement of absolute performance and allow Trusts to know exactly what is required to reach a segment.

Metric scoring

NHS England has also moved many metrics to fixed targets or bandings for scoring, away from relative ranking. Assessing metric scores against predetermined levels of performance, rather than against performance of peers, is designed to be more transparent, predictable and to align with national priorities and standards (see NOF methodology). NOTE: The national oversight team is still finalising the definitions and scoring methodology for some metrics and final technical guidance has not yet been published.

New NOF metrics for 2026/27

The new NOF metrics for Acute are listed below taken from the draft NOF 2026-27 technical annex on NHS Futures. Scored metrics contribute directly to segmentation using robust, comparable data, while contextual metrics provide supplementary insight (where data quality, comparability, or attribution limit their use).

Domain	New NOF metric - Acute	Status
Population health, prevention and reducing inequality	Percentage of inpatients referred to and seen by an in-house tobacco treatment services who make a supported attempt to stop smoking	Scored
Access to Services	% of diagnostic referrals waiting over 6 weeks	Scored
	% of patients waiting less than 18 weeks for community care and % waiting over 52 weeks for community care	May be applicable where relevant (TBC)
Experience of Care	NHS staff survey advocacy rate - combined staff survey scores	Scored

	Number of patients experiencing corridor care[1]	Contextual
Effectiveness of Care	Delayed inductions rate - The rate of deliveries with a delayed induction (6+ hours) per 1000 deliveries[2]	Scored
	30 day readmission rate band	Contextual
Patient safety	Breadth and depth of clinical audit outliers	Scored
Finance, productivity and innovation	Variance to plan year-to-date	Scored
	Relative cost difference (National Cost Collection Index)	Scored
	% of clinical trials set up within 90 days	Scored
	Overall Data Quality Maturity Index (DQMI)	Scored
People	National Education and Training Survey satisfaction rate	Scored
	NHS staff standards score - compound score based on individual scores covering 6 standards	Scored
	Healthcare Worker Flu Vaccination Rate	Scored
	Temporary staffing cost relative band – combined agency and bank	Scored

In addition to the above new NOF acute metrics, the following changes should be noted:

- **'18 week waits vs target level'** is now a contextual metric (status is TBC)
- **'18 weeks for community care'** is a scored metric for Community trusts but may inform acute where relevant
- **'Discharge Ready Date DRD'** has been moved from a scored metric for Acute to a scored metric for ICBs

Summary of APG Risk Assessment

A provisional APG risk assessment was completed in May 2026 to understand where each of the four APG Trusts may face greatest NOF risk during 2026/27. This included initial assessment of the new NOF metrics.

From a practical APG perspective, several areas have been highlighted that are likely to have a greater impact on NOF assessment during 2026/27.

APG themes

Most constitutional and headline performance metrics are assessed as either low or manageable risk. However, some areas (i) require substantial improvement to achieve targets, (ii) have limited tolerance for underperformance / margins for slippage are low, or (iii) performance may be difficult to improve in the next 3-6 months.

[1] Corridor care: The NOF Technical Annex states that data are not currently published but will be available later in 2026/27 as an experimental statistic as part of phased development

[2] Delayed inductions rate – The NOF Technical Annex states that this data is not currently published by NHSE but will be made available as a supplementary statistic - underlying data can be found in the Daily Maternity and Neonatal Operational Pressures SitreP.

There is also still some uncertainty for some new metrics because there is currently limited technical guidance, definitions or national data to benchmark.

1. **Diagnostics -** The new scored metric for diagnostic waits over six weeks is the most significant access-domain NOF risk. LNWH identified this as a significant risk and THH as a moderate concern.

2. **Infection Prevention and Control (IPC) –** IPC is a consistent concern across the APG for NOF 2026/27. It carries disproportionate risk because MRSA, E. coli bacteraemia and C. difficile metrics contribute significantly to the patient safety domain score. Performance can be difficult to influence in the short term and is assessed on a rolling 12-month basis.

3. **Workforce –** Several workforce indicators are newly scored within NOF 2026/27, and this a common area of concern across APG Trusts.

4. **Finance –** All APG trusts identified financial delivery as a key risk for 2026/27, particularly in relation to delivery of cost improvement programmes and managing inflationary pressures.

Conclusion

While the overall architecture of the framework remains unchanged, the expansion of scored metrics mean that trust segmentation will increasingly reflect performance across a broader range of domains, including workforce, patient safety, productivity, innovation and clinical effectiveness.

For NWL APG Trusts, the most significant implications are the continued importance of financial delivery, diagnostic recovery, growing influence of workforce and patient safety metrics, and the introduction of several new measures where data collection and national benchmarking is still at an early stage.

Given the increasing breadth of NOF metrics, there is value in maintaining a coordinated NWL APG approach to monitoring, benchmarking and sharing data and learning relating to the 2026/27 NOF framework. This will support identification of risks, improve understanding of new and evolving measures, and help mitigate potential impacts on segmentation and league tables.

Recommendations

The Committee is asked to:

1. **Note key changes and new metrics within the NOF 2026/27 framework.**

2. **Consider implications for APG Trusts.**

3. **Endorse a coordinated monitoring approach across the APG.**

Sources

- NHS England. NHS Oversight Framework 2026/27. Published 11 June 2026

- NHS England. NHS Oversight Framework 2026/27 – methodology manual. Published 11 June 2026
- NHS England. NOF 2026-27 technical annex published on NHS Futures (not confirmed and subject to change)
- The NHS Alliance. NHS Oversight Framework 2026/27: what you need to know. Members briefing. Published 11 June 2026.

Appendices

A1. Summary APG risk assessment (completed May 2026) – see below

A2. Full list of NOF Metrics applicable to NHS Acute Trusts – see separate document

A1. Summary APG risk assessment (completed May 2026)

Domain	Metric	New metric for 26/7?	CWFT	THH	LNW	ICHT
Domain 2B - access to services	% of patients waiting less than 18 weeks for care	No	Low risk	Low risk	Moderate risk	Low risk
	% of patients waiting over 52 weeks for care	No	Medium risk	Low risk	Moderate risk	Low risk
	% of diagnostic referrals waiting over 6 weeks	Yes	Low risk	Low/Moderate risk	Significant risk	Low risk
	% of patietns meeting the 28 day faster diagnosis standard	No	Low risk	Low risk	Low risk	Low risk
	% of patients treated within 62 days of referral	No	Low risk	Moderate risk	Low risk	Moderate risk
	% of patients admitted, discharged or transffered within 4 hour	No	Low risk	Low risk	Moderate risk	Moderate risk
	% of patients care for in inappropriate physical spaces	Yes	Low risk	Low risk		Moderate risk
Domain 3 - experience of care	CQC inpatient survey satisfaction rate	No	Low risk	Low risk	High risk	Low risk
	NHS staff survey advocacy rate	Yes	Low risk	Moderate risk	Moderate risk	Low risk
Domain 4 - effectiveness of care	Summary Hospital Mortality Indicator	No	Low risk	Low risk	Low risk	Low risk
	% of pregnant woment with a planned induction that are delaye	Yes	Unquantified	Unquantified	Unquantified	Unquantified
	30 day readmission rate band	Yes	Low risk	Moderate risk	Moderate risk	Low risk
	14 day readmission rate	Yes		Moderate risk	Moderate risk	Low risk
Domain 5 - patient safety	Breadth and depth of clinical audit outliers	Yes	Low risk	Low risk	Significant risk	Low risk
	Number of cases of MRSA in the last 12 months	No	Medium risk	Moderate risk	Significant risk	Moderate risk
	Rate of e-coli	No	Low risk	Moderate risk	Significant risk	Low risk
	Rate of c-difficile	No	Medium risk	Moderate risk	Significant risk	Moderate risk
	NHS staff survey raising concerns sub-score	No	Low risk	Moderate risk	Low risk	Low risk
Domain 6 - finance, productivity and innovation	Planned surplus or defecit	No	ned position set for the year 26/27 a	risk - planned position set for the ye		Low risk
	Variance to plan year-to-date	Yes	Moderate risk	Low risk		Low risk
	Relative cost difference (National Cost Collection Index)	Yes	Low risk	Moderate risk		Low risk
	% of clinical trials set up within 150 days	Yes	Moderate risk	Moderate risk		Moderate risk
	Data Qualtiy Maturity Index	Yes	Low risk	Low risk	Low risk	Low risk
Domain 7 - people	Sickness absence rate	No	Low risk	Significant risk	Low risk	Low risk
	NHS staff survey engagement theme score	No	Low risk	Low risk	Low risk	Low risk
	National Education and Training Survey satisfaction rate	Yes		Low risk	Moderate risk	Moderate risk
	NHS staff standards score	Yes	Data unavailable	Data unavailable	Data unavailable	Data unavailable
	Healthcare Worker Flu Vaccination Rate	Yes	Low risk	Moderate risk	Moderate risk	Moderate risk
	Temporary staffing cost as a % of total pay bill	Yes	Low risk	Moderate risk	Moderate risk	Moderate risk

Delayed inductions rate – in development and risk currently unquantified

A2. Full list of NOF Metrics applicable to NHS Acute Trusts

Spreadsheet available on Futures NHS platform.

Domain area	Subject area	Metric	Primarily applies to	Status	Scoring methodology
Access to services	Cancer care	% of cases meeting the 28 day faster diagnosis standard	Acute trusts	Scoring	Target and spread
Access to services	Cancer care	% of cases treated within 62 days of referral	Acute trusts	Scoring	Target and spread
Access to services	Diagnostics	% of diagnostic referrals waiting over 6 weeks	Acute trusts	Scoring	Even spread
Access to services	Elective care	% of cases waiting over 52 weeks for care	Acute and community trusts	Scoring	Acute - Target and spread Community - Even spread
Access to services	Elective care	% of cases waiting up to 18 weeks for care	Acute trusts	Scoring	Even spread
Access to services	Elective care	% of cases waiting up to 18 weeks for care vs target	Acute trusts	Contextual	N/A
Access to services	Urgent care	% of patients admitted, discharged or transferred within 4 hours	Acute trusts	Scoring	Target and spread
Access to services	Urgent care	% of patients spending over 12 hours in department	Acute trusts	Scoring	Even spread
Effectiveness of care	Effective discharge	30 day readmission rate band	Acute and community trusts	Scoring	Banded score
Effectiveness of care	Outcomes	Rate of pregnant women with a delayed planned induction per 1,000 deliveries	Acute trusts	Scoring	Even spread
Effectiveness of care	Outcomes	Summary Hospital Mortality Indicator	Acute trusts	Scoring	Banded score
Experience of care	Patient flow	Number of patients cared for in corridors	Acute trusts	Contextual	N/A
Experience of care	Experience	CQC inpatient survey satisfaction rate	Acute trusts	Scoring	Banded score
Experience of care	Experience	NHS staff survey advocacy rate	All trusts	Scoring	Even spread
Finance productivity and innovation	Finance	Planned surplus or deficit	All organisations	Scoring	Banded score
Finance productivity and innovation	Finance	Variance to plan year-to-date	All organisations	Scoring	Banded score
Finance productivity and innovation	Finance	Combined finance score	All organisations	Scoring	Banded score
Finance productivity and innovation	Innovation	% of clinical trials set up within 90 days	All organisations	Scoring	Target, floor, and spread

Domain area	Subject area	Metric	Primarily applies to	Status	Scoring methodology
Finance productivity and innovation	Innovation	Data Quality Maturity Index	Acute, mental health and community trusts	Scoring	Even spread
Finance productivity and innovation	Productivity	Implied productivity growth	All organisations	Contextual	N/A
Finance productivity and innovation	Productivity	Relative cost difference (National Cost Collection Index)	All trusts	Scoring	Target and spread
Patient safety	High quality care	Breadth and depth of clinical audit outliers	Acute trusts	Scoring	Banded score
Patient safety	Safe culture	NHS staff survey raising concerns sub-score	All trusts	Scoring	Even spread
Patient safety	Safe outcomes	% of patients to acquire a new grade 3 or 4 pressure ulcer	Acute trusts	Contextual	N/A
Patient safety	Safe outcomes	% of safety incidents resulting in harm	All trusts	Contextual	N/A
Patient safety	Safe outcomes	Number of cases of MRSA in the last 12 months	Acute trusts	Scoring	Target and spread
Patient safety	Safe outcomes	Rate of c-difficile	Acute trusts	Scoring	TBC
Patient safety	Safe outcomes	Rate of e-coli	Acute trusts	Scoring	TBC
Patient safety	Safe outcomes	Rate of inpatient falls that cause harm	Acute trusts	Contextual	N/A
People and workforce	People and culture	Healthcare worker flu vaccination rate	All trusts	Scoring	Even spread
People and workforce	People and culture	National education and training survey satisfaction rate	All trusts	Scoring	Even spread
People and workforce	People and culture	NHS staff standards score	All trusts	Scoring	Even spread
People and workforce	People and culture	NHS staff survey engagement theme score	All organisations	Scoring	Even spread
People and workforce	People and culture	Sickness absence rate	All organisations	Scoring	Even spread
People and workforce	Workforce	Temporary staffing cost relative band	All trusts	Scoring	Banded score
Population health, prevention and reducing inequality	Preventing ill health	% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Acute and community trusts	Scoring	Floor and spread

Standard scoring models (see NHS Oversight Framework 2026/27 – methodology manual)

Each metric receives a score between 1 and 4 (with 1.00 being the highest performance rating), in line with 1 of 4 basic models:

- **target and spread**: a defined target or benchmark is set and every organisation achieving that level scores 1.00. Remaining organisations are evenly scored between 2.00 and 4.00 based on their relative performance

- **banded scores**: specific criteria are defined and converted to a performance band, for example a score of 1.00 would apply to an organisation achieving between 80% and 100%, a score of 2.00 would apply to an organisation achieving between 60% and 79.9%, etc

- **floor and spread**: a defined lower acceptable limit is set and every organisation failing to achieve that limit scores 4.00. Remaining organisations are evenly scored between 1.00 and 3.00 based on their relative performance

- **even spread**: there is no defined performance threshold; organisations are ranked evenly between 1.00 and 4.00 based on their relative performance

The methodology selected for each metric is, to some extent, dictated by the data landscape, that is, narrow distributions lend themselves more towards even spread while wide distributions lend more towards a target and spread model. Wherever possible, we have tried to use target and spread or banded scores as our preferred scoring model as they are most amenable to demonstrating improvement.

5. DATA AND DIGITAL

5.1 GROUP DATA AND DIGITAL COMMITTEE REPORT

Discussion Item | Bob Alexander | 12.55

REFERENCES

Only PDFs are attached

05.1 NWL APG Digital Data Meeting Summary June 2026 (1).pdf

North West London Acute Provider Group (NWL APG)
Digital and Data (D&D) Committee Chair's Highlight Report to the NWL APG Board in Common (BiC) – for discussion
9 June 2026

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 APG Board in Common's attention matters they need to agree or note.

2. Key highlights

2.1 Developing the digital and data plan for 2026/27

The Committee received a report outlining the digital and data plan for 2026/27, structured around five core themes: infrastructure, staff experience, pathway management, business intelligence, and patient and carer experience.

The Committee endorsed the strategic approach of maintaining consistent themes supported by annual project delivery, and requested further assurance on programme sequencing, prioritisation, and alignment with the capital plan. There was also discussion on improving corporate systems, including finance and HR, with a focus on reducing reliance on manual processes and enabling integrated workflows.

2.2 Digital Capital Programme 2026/27

The Committee noted that delivery remained on track, with further detail to be provided at the next meeting to demonstrate alignment between expenditure and agreed strategic priorities.

2.3 Electronic Patient Record (EPR) Ecosystem Programme update

An update was received on EPR delivery across April and May 2026. The Committee noted that the inclusion of baseline KPIs would support improved tracking of progress and benefits realisation.

2.4 EPR project highlight report: Ambient Voice Technology procurement update

The Committee noted that the AVT procurement process had been terminated due to rapid technological evolution since the process began and procurement scoring that

was insufficient to differentiate between suppliers.

Discussion highlighted the need to maintain continuity for existing users; the risks associated with uncontrolled use of non-governed tools; and the need for a more agile procurement approach in emerging digital markets.

The Committee noted that a pragmatic approach to supplier selection, with short-term contractual flexibility, would be required.

2.5 Federated Data Platform (FDP) Programme Update

The Committee noted the progress with APG digital developments, including the demand centre, AI discharge summaries, and system alignment. The demand centre had processed over 120,000 triages, improving response times. The Committee noted the importance of clear adoption metrics and benefits realisation. It highlighted the importance of the common data model, ongoing BI resource pressures, and risks around funding beyond November.

2.6 Infrastructure Programme Update

The Committee received an update on ICT infrastructure delivery and discussed risks associated with system convergence, including the potential for single points of failure. Further assurance on risk mitigation and management will be provided at the next meeting.

2.7 Corporate Systems Programme Update:

2.7.1 Finance Enterprise Resource Planning (ERP) Programme

Procurement has progressed and contract finalisation was nearing completion, with delivery phases planned to begin from summer 2026. The Committee highlighted the need for a comprehensive implementation and change management plan.

2.7.2 Datix Replacement

The Committee noted progress in user acceptance testing, with some performance issues identified and escalated to the supplier. Transition remained planned for July 2026, subject to appropriate executive oversight and go/no-go decisions.

2.7.3 ICT Risk Management

The Committee discussed a key APG-wide risk that fragmented and inconsistent performance reporting limits effective decision-making and assurance across the Group. The proposed Business Intelligence Standardisation Programme was identified as the primary mitigation, supported by a wider Data Governance Alignment Programme. The Committee noted that harmonisation of data definitions may expose differences in performance reporting between Trusts, with potential operational and reputational implications.

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

- There is a risk of uncontrolled use of non-governed ambient voice tools due to the termination of the ambient voice technology procurement. This will be mitigated through learning from the previous procurement and an agile procurement that will follow.

- The lack of harmonisation of data definitions across the APG Trusts has the potential for operational and reputational impacts as the Group moves toward standardisation. This will be mitigated through the proposed Data Governance Alignment and Business Intelligence Standardisation Programmes.

4. Concerns outstanding

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

5. Key actions commissioned

- It was agreed that greater detail and assurance on the timings, prioritisation, and sequencing of the digital projects and workstreams would be brought to the next meeting, along with assurance of alignment with the capital plan.

- It was agreed that the next ICT risk report would include an update on the assurance & detailed mitigation plans for broader infrastructure project risks, including convergence and single points of failure.

- The Committee noted the importance of executive oversight and clinical engagement in the go/no-go decision for go-live, given the imminent expiry of existing Datix contracts. It was agreed that a progress update would be provided at the next meeting.

6. Decisions made

- The Committee endorsed the BI Standardisation Programme and approved in principle the proposed Data Governance Alignment Programme as the assurance framework to support consistent reporting across the Group.

7. Attendance

Members	June 2026 attendance
Bob Alexander, (NWL APG Chair in Common, Acting) – Committee Chair	Y
Nick Gash, Non-Executive Director THHFT/ICHT	Y
Loy Lobo, Non-Executive Director ICHT/LNWH	Y
Tim Orchard, NWL APG Chief Executive Officer	Y
Robbie Cline, Chief Information Officer – LNWH/THHFT/CWFT/ICHT	Y
Attendees	**June 2026 attendance**
Bruno Botelho, NWL APG Programme Director & Deputy COO – Operations Representative	Y
Simon Crawford, Deputy CEO – LNWH	Y
Peter Jenkinson, Director of Corporate Governance	Y
Alexia Pipe, Chief of Staff to the Chair	Y
Mathew Towers, Director of Business Intelligence	Y
Matthew Kybert, Deputy CIO – Systems Solutions ICHT, THHFT, LNWH	Y
Osian Powell, Director of Transformation CWFT	Y
Kobus Retief, Associate Director of Transformation ICHT	Y

6. ESTATES AND SUSTAINABILITY

6.1 GROUP STRATEGIC ESTATES, INFRASTRUCTURE AND SUSTAINABILITY COMMITTEE REPORT

Discussion Item | Carolyn Downs | 13.00

REFERENCES

Only PDFs are attached

06.1 Group Strategic Estates Sustainability Committee - June 2026 final (PJ).pdf

North West London Acute Provider Group (NWL APG) Strategic Estates, Infrastructure and Sustainability Committee Chair's Highlight Report to the NWL APG Board in Common (BiC) – for discussion

June 2026

Highlight Report

This was the first Group Strategic Estates, Infrastructure and Sustainability Committee meeting since the Group Model came into effect on 1st April 2026.

This Committee is a non-statutory standing sub-committee of the North West London Acute Provider Group Board in Common and is established to provide assurance to the Board in Common (BiC) on the development and implementation of estate and sustainability strategies across the North West London Acute Provider Group (the 'Group') within defined and prioritised capital funding resources.

1. Purpose and Introduction of the NWL APG Strategic Estates, Infrastructure and Sustainability Committee

- To consider, advise and govern the overarching estate strategy for the Group, in the context of the ICS estates strategy, ensuring the alignment of estate priorities across the Group and the identification of estate related dependencies arising from changes to service/system operating models.
- To oversee and receive assurance relating to the implementation of group-wide interventions for short and medium-term improvements in estates optimisation and usage, and sustainability.
- Oversee and assure the development of a sustainability strategy for the Group, including the delivery of Net Zero and monitor variation against the Task Force on Climate-related Financial Disclosures (TCFD).
- To receive assurance regarding capital planning and prioritisation across the Group, and to consider the relationship between capital and productivity.
- Overseeing the development of an estates strategy across the Group, 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 Group in relation to soft facilities management contracts.
- To oversee the strategic consideration of investment in major equipment across the Collaborative.
- To consider and contribute to the development of a capital prioritisation framework for the Group.
- Ensuring equity is considered in all strategic estates development.

2. Key highlights

The Strategic Estates, Infrastructure and Sustainability Collaborative Committee met on 8th June 2026. The following papers were discussed.

2.1 Updated Committee Terms of Reference

2.1.1 The updated Terms of Reference had been submitted for approval at the Board in Common meeting that took place in January 2026. Following further amendments,

the revised document was tabled at the NWL APC Strategic Estates, Infrastructure and Sustainability Committee meeting in March. It was agreed that the terms of reference would be discussed with the new Chair of the Committee before they were presented at the June meeting for final sign-off.

2.1.2 There were no further amendments to this document, and it was approved by the Committee.

2.2 Green Plan and Sustainability

2.2.1 Deep Dive: NWL Procurement – Sustainability Update

Sustainability arrangements within the procurement processes were outlined, and key points included confirmation that NHS Net Zero targets remained a core drive; sustainability criteria was incorporated in all eligible tenders; the Procurement Act changes had introduced revised social value priorities; and extensive supplier engagement and SME support activity was underway. The Committee agreed that a future paper that provided examples of social value that had been delivered through small, medium and large contracts was submitted to the Committee, along with an update regarding implementation of post-contract sustainability monitoring arrangements.

2.3 Estates and Infrastructure

2.3.1 APG Board Assurance Framework

The latest Board Assurance Framework was tabled and the key updates included the following:

- Inclusion of the five-year capital plan risk;
- Clarification that capital expenditure monitoring would primarily sit with the Group Finance and Performance Committee;
- Continued oversight by this Committee of infrastructure-related projects; and
- Recognition of poor estate condition as a significant group-wide risk.

Backlog maintenance was also discussed, and the mismatch between annual investment levels and the scale of backlog maintenance was highlighted.
It was noted that several NWL trusts held some of the largest backlog maintenance programmes nationally, and the ongoing work on infrastructure failure contingency planning was also noted. It was clarified that responsibility for capital allocations now sat with NHS England rather than the ICB, and it was confirmed that backlog maintenance was explicitly considered in current capital allocation methodology.

2.3.2 Capital Updates

An update on the Western North London Joint Capital Resource Use Plan and the use of Public Dividend Capital (PDC) was received, and discussion focused on understanding capital funding mechanisms and the constraints that exist regarding transfers of capital and cash between organisations. It was also considered how estate rationalisation and land disposals could contribute towards future capital investment needs, with confirmation that capital receipts from land sales had been successfully used elsewhere in the NHS to support redevelopment activity.

2.3.3 **Group level regulatory compliance dashboards**

A proposal was presented for a Group-wide Estates Safety Compliance Dashboard that covered ten key regulatory and safety risk areas and would monitor compliance critical estate safety requirements. This proposal was strongly supported, and it was viewed as an important mechanism for strengthening Group-wide assurance and establishing consistent reporting across all four Trusts.

It was agreed that the dashboard should first be reviewed through local Standing Committees before returning to the APG Committee with consolidated information. The intention is that dashboard indicators will ultimately align directly with Board Assurance Framework risks.

It was also noted that a project team had already been established, and all Trusts nominated representatives to support the development of the dashboard, which reinforced the collaborative nature of the initiative.

The Committee also discussed the development of a Group-wide health and safety dashboard and agreed that Committee oversight over the estates-related elements of that dashboard would be helpful, while the full health and safety dashboard would be reviewed by the Group People Committee.

2.3.4 **AccessAble Programme**

The Committee was provided with a detailed update on the collaborative accessibility programme operating across all four Trusts.

It was noted that significant progress had been made in standardising contractual arrangements and deliverables across the Group, and accessibility assessments had produced detailed improvement plans. It was also noted that recently approved capital investment was now being used to deliver practical improvements.

As well as promoting physical estate improvements to accessibility, the programme now includes digital accessibility guides that had been designed to improve patient navigation and experience. These guides would be accessible through mobile devices and were intended to support patients before and during visits to hospital sites. Communication campaigns were also being coordinated across organisations to maximise awareness and the uptake of this initiative.

Members welcomed the programme's contribution to equality, diversity and inclusion objectives and requested future evidence demonstrating measurable impact, compliance improvements and user feedback. Quarterly updates would continue.

2.3.5 **Estates Infrastructure Resilience**

The work aimed at developing Group-wide resilience arrangements for major estate and infrastructure failures was reviewed. It was noted that this work emerged directly from growing concerns regarding estate condition and backlog maintenance.

A multi-disciplinary workshop involving estates and emergency preparedness teams identified opportunities to strengthen business continuity planning at Group level had been implemented, and work is focused on infrastructure resilience rather than

digital infrastructure, and it seeks to establish common principles that would support coordinated responses to significant estate failures.

As part of the business continuity planning, a system response was being considered, including how healthcare activity could be provided across the wider North West London system if critical infrastructure failures occurred. The importance of understanding patient flows between organisations and developing operational mechanisms was highlighted, as these would support service continuity during major incidents.

2.3.6 **THHFT Redevelopment Update**

An update on the Hillingdon Hospital redevelopment was presented, and seven key areas of assurance were highlighted: governance; budget and scope; timeline; main works contractor; outline business case development; planning; and enabling and decant work. Other key updates included the following:

- In relation to governance, a formal gateway review had been completed with the New Hospital Programme and partners to move from RIBA Stage 1 to RIBA Stage 2. The alliance agreement and alliance framework would return to Hillingdon's Redevelopment Committee and Standing Committee in July.

- A stocktake meeting had taken place with representatives from the ICB, the Department of Health, the New Hospital Programme, Trust leads and APG leads in attendance. This was a positive meeting, and it was highlighted that the signed-off position may not sit within the current capital envelope. The programme was considering a more accelerated Outline Business Case timetable, with an expectation that this would be completed by Easter 2027.

- The target operating model had been endorsed by the Executive Management Board (EMB), and there had been positive engagement through the planning principals meeting. The Same Day Emergency Care business case would be presented to the Hillingdon Standing Committee.

- Delays had been caused by the New Hospital Programme, who had been advised that no further scope changes could be made going forward.

2.3.7 **ICHT Redevelopment Update**

Key updates regarding the ICHT redevelopment included the following:

- Regarding the St Mary's redevelopment, the design and town planning work was progressing well, with very good engagement from Westminster City Council. The planning of 10 acres of land next to Paddington - which included both the hospital and surplus estate - was complex, and this represented a significant development for the Council, who very supportive of the hospital and broadly supportive of the wider aims of the masterplan.

- A business case had been submitted to secure the second tranche of funding to complete the design and planning work through to around mid-2028. This case had been considered by the New Hospital Programme Investment Committee, and further information in two areas had been requested:

benchmarking the design and planning costs against other schemes, and further information on the master planning ambition. It was noted that three months' funding had been approved in the interim, with the intention of resolving the remaining points by September.

- Phase Two of the public consultation for the town planning public engagement work had been launched, and which took place during June 2026. This consultation including websites, seminars, in-person events and targeted workshops with local groups in Westminster.

- The Committee were advised that KPMG had commenced work on this project, and that an expert panel had been appointed to provide expertise in development funding, government finance, local authority finance, legal and development areas, acting as critical friends and providing assurance, check and challenge to KPMG's work.

- The master planning work was formally a town planning exercise which focused on matters such as height, massing, phasing, landscaping and public spaces. The commercial space had a role in cross-subsidising and partly funding the new hospital, both through capital and potentially by capturing future proceeds of growth through the task force and KPMG work. Discussions with Westminster City Council were taking place in the context of the surplus land contributing to the new hospital.

- With regards to Hospital 2.0 compliance, it was noted that the Trust would work to the principles of Hospital 2.0 but that the Department of Health had accepted that the hospital would not be Hospital 2.0 compliant to the letter, given the nature of the site and the likely height of the development. It was strongly encouraged that written confirmation regarding this was received.

2.3.8 West Middlesex Diagnostic Treatment and Education Centre (DTEC) Update

Key updates on the work regarding DTEC at the West Middlesex site was also provided, including remedial actions being taken with the contractor to address issues with the roof-mounted air handling units. It was noted that the Trust had agreed actions with the contractor and would be monitoring progress.

3 Key risks to escalate

There were no key risks to escalate.

4 Key actions commissioned

4.1 The Committee asked:

- Formal communication to be issued from the Committee to all individual Trusts, confirming that the Committee expected the Compliance Dashboards to be included on the agendas for their Trust Standing Committee meetings in September.
- Continued updates regarding the AccessAble Projects including the impact of the work and compliance across sites.

5. Attendance Matrix

Members:	June Meeting
Carolyn Downs, Vice Chair (THHFT) (Chair)	Y
Bob Alexander, Interim Chair of the NWL Acute Provider Group (ICHT/CWFT)	Y
Tim Orchard, Group CEO	Y
Mike O'Donnell NED (CWFT/THHFT	Y
Sim Scavazza NED (ICHT/LNW)	Y
Bob Klaber, Director of Strategy, Research and Innovation (ICHT)	N
Virginia Massaro, CFO (CWFT/THHFT)	Y
Gary Munn, Interim Director of Estates (LNWH)	Y
Jason Seez, Deputy CEO (THHFT)	Y
In attendance:	
Marie Courtney, Director of Estates and Facilities (CWFT and THHFT)	N
Philippa Healy, Business Manager (minutes)	N
Peter Jenkinson, Director of Corporate Governance (ICHT, CWFT and THHFT)	Y
Andrew Murray, Deputy Director of Estates and Facilities (ICHT)	Y
Eric Munro, Director of Estates and Facilities (ICHT)	Y
Alexia Pipe, Chief of Staff – Chair's office	Y
Jazz Thind, CFO (ICHT)	Y
Mark Titcomb, Managing Director of NWL EOC, CMH and Ealing Hospital, Executive Director for Estates and Facilities (COO representative) (LNWH)	Y
Matt Tulley, Redevelopment Director – ICHT	Y
Rachel Kline, Interim Director Procurement Excellence - Central London Community Health Trust	Y
Mahroof Anwar, Head of Sustainability and Social Value - Central London Community Health Trust	Y
Graham Chalkley, Corporate Governance Officer (minutes)	Y

7. STRATEGY

7.1 GROUP STRATEGY COMMITTEE REPORT

Discussion Item | David Moss | 13.05

REFERENCES

Only PDFs are attached

07.1 Group Strategy Chairs Report APPROVED 2026.05.13 (1).pdf

North West London Acute Provider Group (NWL APG)
Strategy Committee Chair's Highlight Report to the NWL APG Board in Common (BiC) – for discussion
28 July 2026

Highlight Report

1 Purpose and Introduction

The Strategy Committee met on 13 May 2026 to commence oversight of the development of a five-year strategy for the NWL Acute Provider Group. The Committee's role is to support, scrutinise and provide assurance to the Board in Common on the development of the strategy, with a particular focus on the medium- to long-term strategic horizon.

2 Key highlights

2.1 External Context and Existing Priorities

The Committee considered the national and system context, including the NHS Ten-Year Plan and key strategic shifts towards community-based care, digital transformation and prevention. Defining the Group's future role within evolving system structures and contractual models was identified as a key strategic priority.

Year 1 priorities were noted, including strengthening clinical delivery, corporate services, patient engagement, business intelligence and workforce planning.

2.2 Strategy Development Framework and Approach

A structured framework for strategy development (diagnosis, guiding policy and coherent actions) was approved. Members emphasised the importance of a robust analytical baseline, scenario modelling and clearly defined design principles and evaluation criteria.

The Committee agreed an initial phase of broad strategic exploration, including understanding the external context and establishing a shared baseline across partner Trusts. Priorities were identified as defining scope, agreeing the stakeholder engagement approach, and building a consistent system-wide understanding.

2.3 Terms of Reference

The Committee approved its Terms of Reference in principle, subject to amendments to strengthen alignment with other committees and avoid duplication. It was noted that approval of the strategy and oversight of delivery remains the responsibility of the Board in Common.

3 Positive assurances received

- A clear and agreed framework for strategy development, providing a structured and transparent approach to decision-making.
- Existing Year 1 priorities provide a strong operational foundation for longer-term strategic development.

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

- Ongoing uncertainty regarding future commissioning and funding arrangements may impact strategy development and implementation.
- The need to clearly define the Group's future role within evolving system architecture and integrated neighbourhood models.

- Balancing the pace of strategy development with the need for meaningful stakeholder engagement.

5 Concerns outstanding

- Clarity required on the Group's position in relation to system changes, including commissioning and contractual arrangements.
- Potential constraints in capacity and resources to support analytical work and engagement at the required scale.
- Need to ensure alignment and coordination with other committees, particularly in relation to financial strategy.

6 Key actions commissioned

The Committee agreed a number of actions for the Executive to take forward before the next meeting, to:

- Establish a reporting framework for assurance on delivery of Year 1 priorities.
- Develop a strategy workplan, including resourcing and the approach for stakeholder engagement.
- Commence development of the analytical baseline (demand, capacity, finance and workforce).
- Develop design principles and evaluation criteria to guide specialty boards.

7 Decisions made

The Committee:

- Approved the Committee Terms of Reference in principle, subject to amendment and onward submission to the Board in Common.
- Approved the strategy development framework as the basis for progressing work.
- Agreed that the Committee will retain oversight of Year 1 priorities for assurance purposes.

8 Attendance

Members	Attendance (Y/N)
David Moss, Chair of Committee, Vice Chair (LNWH) and Non-Executive Director (ICHT)	**Y**
Bob Alexander, Interim Chair in Common	**Y**
Tanaka Chiimba, Non-Executive Director (THHFT and CWFT)	**Y**
Carolyn Downs, Vice Chair (THHFT) and Non-Executive Director (LNWH)	**N**
Patricia Gallan, Vice Chair (CWFT) and Non-Executive Director (ICHT)	**N**
Martin Lupton, Non-Executive Director - Academic (LNWH and THHFT)	**Y**
Vineeta Manchanda, Non-Executive Director (ICHT and CWFT)	**Y**
Sim Scavazza, Vice Chair (ICHT) and Non-Executive Director (LNWH)	**Y**
Tim Orchard, NWL APG Chief Executive Officer	**Y**

8. CHIEF EXECUTIVE OFFICERS

8.1 REPORT FROM THE GROUP CHIEF EXECUTIVE OFFICER

Discussion Item | Tim Orchard | 13.15

REFERENCES

Only PDFs are attached

08.1 Group CEO report July 26.pdf

North West London Acute Provider Group (NWL APG)
Chief Executive Officer's report to the Board in Common

July 2026

1. Introduction and key messages

1.1 I'm delighted that all four trusts remain in NHS Oversight Framework (NOF) segment 1, giving confidence that we continue to perform well. Chelsea and Westminster Hospital NHS Foundation Trust was ranked 8th, Imperial College Healthcare NHS Trust was ranked 11th, London North West University Healthcare NHS Trust was 15th and The Hillingdon Hospitals NHS Foundation Trust is ranked 17th.

1.2 Alongside this positive work, however, we continue to face significant financial challenge, with all four trusts reporting a shortfall against their month two plans. The APG as a whole reported a shortfall of £19.5m against a deficit plan of £11.7m in May (a £7.8m adverse variance). This is largely due to the impact of industrial action and under-delivery of efficiencies. We have an escalation process in place and are closely monitoring the financial plans including a weekly report on the cost improvement plans identified across the group and how we are working together to close the financial gap.

Development of the group

1.3 **Governance** – We have established the executive routines for the group, with weekly executive team meetings and monthly APG Executive Management Board (EMB). I have summarised the discussions of the EMB meetings below. These are working well and allowing a group-wide view of performance and key group priorities. We have also established subgroups of the APG EMB to progress key priorities. These subgroups include: violence and aggression, research, innovation & education, digital innovation, cancer board, flow board, estates and sustainability, IPC taskforce and Specialty Boards.

1.4 We continue to establish and appoint to group executive roles. Currently confirmed executive roles are:

- Chief Financial Officer: Stephen Bloomer, from September 2026
- Chief Delivery Officer: Edmund King, from November 2026
- Chief People Officer: Kevin Croft
- Director of Corporate Governance: Peter Jenkinson
- Chief Information Officer: Robbie Cline
- Lead Chief Medical Officer: Dr Roger Chinn
- Lead Chief Nurse: Dame Janice Sigsworth
- Director of Communication and Engagement: Michelle Dixon (interim)

1.5 We are currently in the process of recruiting for Director of Strategic Partnerships and Chief Strategy and Transformation Officer.

1.6 **Strategy and strategic priorities –** We are working to develop the diagnostic data to underpin an APG strategy and in the meantime progressing the APG

priorities agreed by the Board in Common. For example, we have launched the Specialty Boards to progress alignment of 30 specialties across the group. Each is led by an executive and brings together clinical and operational colleagues across the group to improve clinical pathways. The corporate transformation board is also progressing its work to define approaches to convergence across trusts and support greater alignment of our corporate functions.

1.7 We are also delivering some of the agreed shorter term ('quicker win') group priorities we promised at the launch of the group. This includes a joint recruitment hub across the APG. From 6 July 2026, our recruitment service is now physically based across two locations – Charing Cross Hospital (in the south of the Group footprint) and Northwick Park Hospital (in the north of the Group footprint).

1.8 We are also introducing a new group-wide incident reporting system, Ideagen, to support a more consistent, system-wide approach to incident reporting, risk management and safety assurance.

1.9 Our next phase of staff and stakeholder engagement on the group will begin soon to further shape strategy. The first phase showed there was positivity about the group, though concerns about maintaining local identify and existing strong trust relationships and performance. We will continue to engage staff across the trusts and work up our staff offer. We are also planning to begin an external engagement programme with patients and local communities about the group.

Successes

1.10 In terms of other successes, the North West London Integrated Care Board, including our acute provider group, won the Driving Virtual Wards and Hospital at Home Through Digital award at the 2026 HSJ Digital Awards. The award was in recognition for the sector's virtual wards programme which has helped to reduce hospital admissions, shorten lengths of stay, and improve patient experience.

1.11 Dr. Robert Hywel Thomas, consultant in interventional and diagnostic radiology at Imperial College Healthcare NHS Trust and clinical radiologist to King Charles, was appointed a Lieutenant of the Victorian Order (LVO) in the 2026 King's Birthday Honours for his distinguished service to the Crown.

1.12 Professor Stephen Brett, consultant in intensive care medicine at Imperial College Healthcare NHS Trust, has been awarded an MBE in the 2026 King's Birthday Honours for services to critical illness and intensive care medicine.

1.13 Finally, I was delighted to receive a CBE for services to the NHS, healthcare research and innovation in the 2026 King's Birthday Honours. I would like to thank all the staff across the group who have contributed to the excellent care that this award recognises.

1. Key highlights from the four individual trusts include:

2.1 Chelsea & Westminster NHS Foundation Trust

- Remains in Segment 1 of the NHS Oversight Framework and ranked 8th nationally. Continued performance on emergency care, cancer standards and elective care.
- The West Middlesex Elective Hub has been successfully accredited under NHS England's Getting It Right First Time (GIRFT) programme, recognising delivery of high standards in both clinical and operational practice.
- Partnered with La Roche-Posay and CW+, the Trust's official charity, to help improve access and outcomes in skin cancer care. The 3-year partnership and £250k donation will support research, education and awareness, building on established teledermatology services.

2.2 The Hillingdon Hospitals NHS Foundation Trust

- Moved into Segment 1 of the NHS Oversight Framework, 17th nationally, rising from 27th in the previous quarter.
- Second nationally for elective theatre utilisation, above 90% in March.
- Progress continued on redevelopment of Hillingdon hospital with Laing O'Rourke appointed as the builder.

2.3 Imperial College Healthcare NHS Trust

- Operational performance remains strong, with excellent ambulance handovers and improving elective and diagnostic waits, though extended ED waits remain a key challenge.
- Imperial College Healthcare is one of 16 trusts in the second wave of the Advanced Foundation Trust Programme, due to begin assessment in 2026/27. Currently awaiting further detail on what this will involve.
- Hammersmith Hospital has been awarded Pathway to Excellence designation with distinction.

2.4 London North West University Hospitals NHS Trust

- Continued to be in Segment 1 of the NHS Oversight Framework recognising continued strong performance. Continued progress in cancer services, steady improvement in diagnostics and ongoing recovery in UEC and elective pathways despite sustained system pressures.
- Priorities for 2026/27 focus on: stopping corridor care; increasing timeliness of diagnostics and planned care; tackling violence, aggression and discrimination; and living within our means.
- Congratulations to Mark Titcomb on his appointment as interim chief executive of LNWH following a competitive process. He will begin once Pippa Nightingale leaves at the end of July. I would like to thank Pippa for all her outstanding work for LNWH and we all wish her the best in her new role.

2. Key highlights from the APG EMB

The APG EMB met on 5 May, 3 June and 20 July 2026. Key discussion items are summarised below.

3.1 Performance reporting

At each meeting, the APG EMB reviewed quality, workforce, operational and financial performance across the Trusts, receiving assurance on outliers and activity ongoing to address variation. The EMB noted continued progress in elective recovery, emergency department performance, and overall financial delivery with further work required to address challenges including ambulance handover delays, diagnostic performance (DM01), and variation in NOF metrics.

The EMB noted the need to focus on infection prevention and control with an implementation plan due to be discussed.

3.2 Finance reporting and medium-term planning

The APG EMB reviewed financial performance and noted that the year-end outturn was £18.1m surplus, with £18.1m bonus deficit support funding received in month 12 driving this. All four Trusts achieved their planned breakeven position, excluding this additional funding.

However, all trusts are reporting adverse variances at month 2 due to industrial action and under-delivery of efficiency plans. We review a cost improvement programme (CIP) tracker weekly to ensure sufficient identification of CIPs to meet financial plans.

3.3 Strategic priorities

The APG EMB received an update on the group priority programmes which set out coordinated, system-wide approach to improving clinical outcomes, operational performance, workforce experience and financial sustainability across the Trusts. The EMB noted the importance of reducing variation, standardising approaches, and strengthening data-driven decision-making across the Group. Senior Responsible Owners agreed to progress delivery plans, with further detail on timelines, resources, and deliverability to be reviewed through the weekly Executive Team Meeting.

The APG EMB also received terms of reference for subgroups that are doing important group-level work that will feed into the EMB. These include violence and aggression, research, innovation & education, digital innovation, cancer board, flow board and estates and sustainability.

The APG EMB also discussed the approach to quality priorities and discussed the quality metrics which included, infection prevention & control, MRSA, e coli, pressure ulcers, falls and family & friends' questionnaires.

3.4 APG clinical pathways and specialty boards

APG EMB received an update on the closure of phase one of the clinical pathways programme. The EMB also received the terms of reference for the establishment of specialty boards, agreeing that these will be clinically led with executive directors as senior responsible officers.

APG EMB received an update on the progress in setting up these specialty boards, with all 30 due to meet in July.

3.5 Elective Orthopaedic Centre (EOC)
The APG EMB receive regular updates on the EOC and have noted strong operational progress with a total of 3,278 patients treated in year two, while noting variations in activity across the four trusts, with only one trust performing above plan. We will be reviewing referral flows and developing a revised delivery plan.

3.6 Federated data platform
APG EMB receive monthly updates on digital, data and the Federated Data Platform. The EMB noted that good progress, for example the Demand Centre went live in March 2026, supporting over 1,300 staff and delivering an anticipated recurrent financial benefit of approximately £1m per annum. The EMB noted the importance of maintaining focus on adoption and consistency, including development of a single patient tracking list and regular performance monitoring across all Trusts.

3.7 Staff survey action plan
The EMB received the staff survey results action plan which included actions for NWL APG programmes, common people priorities and local divisional/ward level actions.

3.8 Corporate transformation
APG EMB receives monthly updates on the corporate transformation programme. Work so far has included defining approaches to convergence across corporate functions and use of a scoring framework to assess progress. A 'clearing the path' workstream has been established to address pain points and blockers to effective working across the Group that are common across corporate areas.

3.9 Violence and aggression
APG EMB received an update on the work to reduce violence and aggression against our staff (as part of our priority to tackle 'negative behaviours' experienced by our staff). This included collating data on violence and aggression across trusts and setting out priorities for 2026/27 in tackling these issues.

3.10 Workforce sharing agreement
APG EMB approved a workforce sharing agreement between the Group trusts to enable smoother sharing and deployment of staff across Trusts.

3.11 Group policy approach
APG EMB approved an approach to harmonising policies across the Group, including developing a group policy catalogue and establishing a policy review group to approve group-level policies.

3.12 Lord Mann Review
APG EMB received an update on the actions the Group is taking in response to the Lord Mann report on Antisemitism and Other Forms of Racism in the NHS.

3.13 EDI dashboard

The APG EMB also received an update on the EDI dashboard, which updated on key metrics relating to race equality (under-representation of BME staff in AfC bands 7 and above, career progression, disciplinary action and training and development) and our agreed priorities and actions to address under-performance.

8.2 REPORTS FROM THE TRUST STANDING COMMITTEES

- London North West University Healthcare NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust

REFERENCES

Only PDFs are attached

08.2a LNWH TSC Report FINAL 2026.06.24.pdf

08.2b THHFT Trust Standing Ctee June 2026 Chairs Report.pdf

08.2c CWFT Standing Committee Chair's Report - PUBLIC Jun 2026.pdf

08.2d ICHT TSC Assurance Report to BiC June 2026 jh.pdf

North West London Acute Provider Group (NWL APG)

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

June 2026

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 24 June 2026. The following papers were discussed.

2.2 Board Training Session: Corporate Manslaughter and the proposed Public Authority (Accountability) Bill, (Hillsborough Law)

2.2.1 The Committee received a training session on corporate manslaughter legislation and the proposed Hillsborough Law, including its implications for governance, transparency, and accountability.

2.2.2 The Committee discussed the implications for the Trust, including the need to enhance record management systems, particularly relating to informal communication channels; the importance of clear accountability structures and role clarity across the Trust; and ensuring robust subcontractor governance, particularly where outsourced services are involved.

2.2.3 The Committee reflected that there is a need for consistent Group-wide understanding and application of the requirements and there would be benefit in a further Board development session.

2.3 Trust Strategy Review

2.3.1 The Committee received an update on the Trust's Our Way Forward strategy and Year 3 performance. It was reported that progress had been mixed, with notable improvements in some operational areas, alongside continued challenges in staff and patient experience.

2.3.2 Four strategic priorities for the forthcoming year were confirmed as the elimination of corridor care, delivery of elective care standards, including the 18-week target, improvement in staff experience, particularly relating to violence and aggression, and financial sustainability.

2.3.3 The Committee discussed the importance of measuring staff experience more regularly and agreed that enhanced monitoring arrangements should be introduced for key staff

experience indicators. It was also recommended that partnership metrics should be further developed.

2.4 Integrated Quality Performance Report

2.4.1 The Committee received the Month 2 Integrated Quality Performance Report and noted strong performance in cancer services and diagnostics, alongside improving referral-to-treatment performance, although the 18-week standard remained below target.

2.4.2 Members discussed the continuing operational pressures arising from emergency demand exceeding planned levels, which was impacting urgent and emergency care performance despite reductions in long waits. Particular attention was given to the ongoing challenges associated with corridor care and high DNA rates, with the Committee seeking further analysis to support improvement planning.

2.4.3 Assurance was received that initiatives to improve patient flow and reduce corridor care were beginning to have a positive impact, although members emphasised the need to maintain focus on demand management, improve data integration, and better understand variations in demand across localities to support sustainable operational improvements. The Committee requested a more detailed analysis of corridor care and DNA rates in future reports.

2.5 Finance and Performance

2.5.1 The Committee reviewed the Month 2 Finance and Performance Assurance Report and noted a year-to-date deficit of £10.2m, £1.5m adverse to plan, largely driven by the impact of industrial action. Members received assurance that mitigating actions were in place, including elective activity recovery, workforce controls, contract settlement benefits and improved clinical coding income, to support recovery of the financial position.

2.5.2 The Committee noted that savings delivery remained on track, with £4.2m achieved against a £4.1m target and 81% of the full-year CIP identified, although concerns were raised regarding the need to accelerate scheme identification and delivery.

2.5.3 Operationally, non-elective activity remained above plan while elective performance had been affected by industrial action but was showing improvement.

2.5.4 The Committee also reviewed workforce expenditure, noting continued pressure from bank staffing costs despite agency spend remaining within target, and welcomed management actions to strengthen workforce controls. Cash balances remained stable and additional capital funding had been secured to support emergency care and elective recovery initiatives.

2.6 Quality and Safety

2.6.1 The Committee received the assurance report and reviewed a number of emerging quality risks and improvement initiatives. Members noted an increase in stillbirths, with all cases under investigation, and received assurance that national maternity recommendations were being reviewed and that further updates would be provided.

2.6.2 The Committee welcomed reductions in Clostridioides difficile and MRSA infections but discussed increases in E. coli and Pseudomonas infections, together with an outbreak of water-associated organisms at Ealing Hospital, for which mitigation measures and ongoing surveillance were in place.

2.6.3 The Committee also considered the continued rise in complaints, particularly relating to corridor care, delays, communication and outpatient services, and emphasised the importance of improving patient communication as a key driver of patient experience.

2.6.4 Members reviewed the Adult Inpatient Survey results, noting improvements in some areas but a decline in overall recommendation scores.

2.6.5 The Committee reviewed the draft Annual Quality Account for 2025/26 and noted that three of the four quality priorities had been achieved, with further work required to reduce controlled drug discrepancies despite the successful implementation of a digital controlled drug register. Members welcomed significant improvements in maternity services, and in the Patient-Led Assessment of the Care Environment (PLACE) results, particularly in dementia care, and welcomed the positive impact of enhanced interpretation services on patient experience and value for money.

2.6.6 The Committee reviewed and supported the proposed quality priorities for 2026/27, and approved the draft Quality Account for submission.

2.7 People

2.7.1 The Committee received the assurance report and noted that workforce indicators remained broadly positive, with sickness absence continuing to compare favourably against national averages and appraisal compliance exceeding 75%, placing the Trust on track to achieve its 90% target.

2.7.2 Members reviewed progress against the staff survey action plan and discussed concerns regarding the significantly poorer experience reported by medical staff, particularly in relation to race and gender discrimination, noting that a dedicated task and finish group had been established to develop targeted interventions.

2.7.3 The Committee welcomed strong progress in apprenticeship development, including a substantial increase in apprenticeship levy utilisation and collaborative workforce initiatives across the Group.

2.7.4 Members also discussed the NHS England Resident Doctor 10-Point Plan, leadership development and career progression, emphasising the need to strengthen medical leadership, improve staff engagement and accelerate progress towards model employer ambitions and greater equality of opportunity.

2.8 Board Committee Reports

2.8.1 The Committee received escalation reports from the Audit and Risk, and the Charitable Funds Committees, noting assurance that robust financial and audit controls remain in place.

2.9 Chief Executive's Report

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

3. Positive assurances received

3.1 Cancer and diagnostic services continue to perform strongly, with improvement evident in elective recovery and reductions in long waits.

3.2 Assurance on quality and safety, including exceptionally strong mortality performance, strong maternity outcomes, and progress in maternity quality and interpretation services.

3.3 Financial controls remain robust, with delivery of savings plans broadly on track and management actions in place to recover the in-year financial position.

3.4 Audit and governance arrangements remain effective, supported by an unqualified external audit opinion and positive internal audit outcomes.

3.5 Workforce indicators remain generally positive, with appraisal compliance improving and sickness absence comparing favourably with national benchmarks.

3.6 The Committee Effectiveness Review concluded that the Trust Standing Committee had operated effectively during 2025/26 and continued to provide appropriate oversight and assurance to the Board.

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

4.1 Continued emergency demand above planned levels and high DNA rates remain significant operational risks, impacting patient flow and performance.

4.2 Continued risks of caring for patients in corridors, including the risks to patient experience, fire safety and infection risks in the emergency departments, especially during winter pressures.

4.3 Violence and aggression towards staff remains a significant concern requiring Trust-wide and group-level action.

4.4 Complaints remain significantly elevated, particularly within medicine and emergency care, driven by corridor care, delays, communication issues and outpatient services.

4.5 Increasing operational, safety and financial risk arising from acute trusts absorbing care for mental health patients, with unresolved issues around commissioning responsibility and regulatory expectations.

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

5. Concerns outstanding

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

6. Key actions commissioned

6.1 For the Group People Committee to consider a Group-wide Board development programme on Corporate Manslaughter legislation and the proposed Public Authority (Accountability) Bill, and develop of a Group-wide ethical code of conduct aligned to emerging statutory expectations and organisational accountability requirements.

7. Decisions made

7.1 The Committee:

7.1.1 Agreed actions to strengthen organisational preparedness for proposed Corporate Manslaughter and Hillsborough legislation, including consideration of governance reviews, organisational readiness planning and development of an ethical code of conduct.

7.1.2 Approved the draft Quality Account 2025/26.

7.1.3 Approved the Terms of Reference for the Charitable Funds Committee

8. Attendance Matrix

Members:	June 2026 Meeting
David Moss	Y
Bob Alexander	Y
Carolyn Downs	Y
Loy Lobo	Y
Martin Lupton	Apologies
Syed Mohinuddin	Y
Sim Scavazza	Y
Baljit Ubhey	Y
Tim Orchard	Apologies
Pippa Nightingale	Y
Simon Crawford	Y
Bimal Patel	Y
James Walters	Apologies
Jon Baker	Y
Lisa Knight	Y
In attendance:	
Mark Titcomb	Y
Peter Jenkinson	Y
Tracey Connage	Y
Kevin Croft	Y
Jason Antrobus	Y
Tracey Beck	Y
Lisa Henschen	Y
Hannah Taylor	Y
Stuart Marchant	Y
Alexia Pipe	Y
Nikki Walcott	Y

The Hillingdon Hospitals NHS Foundation Trust (THHFT)

Trust Standing Committee Chair's Report to the North West London Acute Provider Collaborative Board in Common (BiC) – July 2026

Purpose and Introduction

1. The role of The Hillingdon Hospitals NHS Foundation Trust Standing Committee is:

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 22 June 2026

2.1 Staff Story – Violence and Aggression in the Emergency Department

- The Committee members received a staff story following a serious violent incident in the Emergency Department, during which a member of staff was stabbed by a patient. Members recognised the professionalism and resilience demonstrated by staff, security teams and emergency services in responding to the incident.
- The Committee welcomed the immediate actions taken to strengthen security arrangements, provide psychological support for staff and review environmental controls. Members emphasised the importance of embedding learning across the Group through the cross-trust Violence and Aggression Programme and ensuring staff safety remains a strategic priority.

2.2 People and Organisational Development

- The Committee received the People and Organisational Development Assurance Report together with the findings of a People Deep Dive. Progress was noted in reducing agency expenditure, improving appraisal compliance and developing staff survey action plans. However, long-term sickness absence, leadership capability, workforce culture and equality remain key areas requiring sustained improvement.
- Members supported a strengthened focus on management capability, leadership development, workforce equality and succession planning. The Committee also emphasised the need to demonstrate measurable improvements arising from staff survey feedback and requested regular updates on workforce priorities.

2.3 Freedom to Speak Up Annual Report

- The Committee reviewed the Freedom to Speak Up Annual Report and noted that most concerns related to workforce culture and staff experience rather than direct patient safety issues.
- Members emphasised the importance of strengthening organisational learning through improved triangulation of Freedom to Speak Up data with other workforce intelligence to identify trends, hotspots and opportunities for earlier intervention.

2.4 Hillingdon Health and Care Partnership (HHCP) Place Transformation

- The Committee received an update on the HHCP Place Transformation Programme, recognising continued progress in developing neighbourhood-based care, reducing admissions from key settings and strengthening collaboration across health and care partners. Members acknowledged increasing urgent care demand and system pressures, emphasising the need to accelerate delivery of initiatives that reduce acute demand, improve patient flow and support the future operating model for the new hospital.

2.5 Chief Executive's Report

- The Committee noted the Chief Executive's report, recognising continued strong operational performance and sustained improvements across quality and service delivery despite ongoing system pressures.
- Members acknowledged the evolving national performance framework and supported the continued focus on maintaining organisational resilience, financial sustainability and effective communication with staff and stakeholders.

2.6 Hillingdon Hospital Redevelopment

- The Committee received an update on the Trust's redevelopment programme, including progress following the national New Hospital Programme stocktake and preparations to support an accelerated delivery timetable.
- Members welcomed the continued progress of enabling work and recognised that future programme timelines remain dependent upon national approval. The Committee also supported progression of the Same Day Emergency Care (SDEC) Business Case as a key enabling project for the wider redevelopment programme.

2.7 Quality and Safety

- The Committee noted continued improvements across operational performance, patient safety and quality indicators. Improvements were reported in urgent and emergency care performance, ambulance handover delays, elective recovery and complaint response times.
- Members considered annual reports covering safeguarding, learning from deaths, patient experience, infection prevention and control, health and safety and resident doctor experience. Assurance was received that robust governance arrangements are in place, while recognising ongoing priorities including maternity improvement, complaint handling, violence and aggression, and embedding organisational learning across quality systems.
- Members noted a radiology reporting backlog affecting patients on the Head and Neck pathway. Assurance was received regarding mitigating actions, including additional reporting capacity, mutual aid arrangements and completion of harm reviews, with ongoing oversight through established governance processes.
- The Committee also reviewed performance against patient safety investigation timescales and noted a backlog of overdue learning responses. Members received assurance regarding additional patient safety training and strengthened governance arrangements to support recovery.

2.8 Finance and Cost Improvement Programme

- The Committee noted the Month 2 financial position, recognising that the reported deficit primarily reflected the impact of recent industrial action and associated operational pressures. The Trust remains forecast to achieve its planned breakeven position by year end.
- Members reviewed progress against the Cost Improvement Programme, noting that approximately 72% of the annual savings target has been identified. The Committee recognised that delivery remains a key organisational risk and emphasised the importance of identifying additional recurrent schemes and maintaining robust oversight of programme delivery.

2.9 Board Assurance Framework

- The Committee reviewed updates to the Board Assurance Framework, noting improved alignment with the revised governance structure and closure of the Electronic Patient Record strategic risk.
- Members supported continued refinement of the Framework to strengthen alignment between strategic risks, committee work programmes and assurance reporting.

3. Positive assurances received

The Committee received positive assurance in relation to:

- Continued improvement in operational performance, urgent and emergency care and elective recovery.
- Strong governance arrangements supporting quality improvement, safeguarding, learning from deaths and infection prevention and control.
- Progress in workforce initiatives, including reduced agency expenditure, improved appraisal compliance and strengthened leadership development.
- Continued progress in redevelopment planning and enabling projects supporting the New Hospital Programme.
- Financial performance remaining on trajectory to deliver the planned year-end position despite the impact of industrial action.

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

- Workforce sustainability, particularly long-term sickness absence, leadership capability and organisational culture.
- Violence and aggression affecting frontline staff, requiring continued system-wide collaboration and learning.
- Financial sustainability and delivery of recurrent Cost Improvement Programme savings.
- Continued dependency on national decisions regarding the New Hospital Programme and accelerated redevelopment timetable.

5. Concerns outstanding

• No significant additional concerns requiring escalation to the Board in Common at this time.

7. Decisions made

- Approval of the Same Day Emergency Care (SDEC) Business Case to progress through the formal approval process.
- Approval for participation in the North West London collaborative procurement arrangement for bulk intravenous fluids.
- Approval of the twelve-month extension to the Pharmacy Wholesaler Call-Off Contract pending implementation of the national replacement framework.

Attendance 22 June 2026

Members	22 June 2026 Attendance
Carolyn Downs, Non-Executive Director (Chair)	**Y**
Bob Alexander, Group Interim Chair	**Y**
Nick Gash, Non-Executive Director	**Y**
Tanaka Chiimba, Non-Executive Director (Online)	**Y**
Rupert Bondy, Non-Executive Director	**Y**
Mike O'Donnell, Non-Executive Director (Online)	**Y**
Martin Lupton, Non-Executive Director	**Y**
David Moss, Non-Executive Director	**Y**
Lesley Watts, Chief Executive	**Y**
Alan McGlennan, Chief Medical Officer	**Y**
Rob Bleasdale, Chief Nurse	**Y**
Virginia Massaro, Chief Finance Officer	**Y**
Jason Seez, Chief Infrastructure and Redevelopment Officer	**Y**
Peter Jenkinson, Director of Corporate Governance	**Y**
Kevin Croft, Chief People Officer	**Y**
Emer Delaney, Director of Communications	**Y**
In Attendance	
Keith Spencer, Managing Director, Hillingdon Health and Care Partners	**Y**
Lirije Morina-Dermaku, Executive Business Manager	**Y**
Vikas Sharma, Trust Secretary	**Y**
Phil Spivey, Director of Workforce	**Y**
Alexia Pipe, Chief of Staff to the Chair in Common	**Y**
Kim Prendergast, Staff Nurse	**Y**
Basaam Aweid, Consultant for Stroke	**Y**
Paul Ukpai, Service Manager for Stroke	**Y**
Naomi Ike, Clinical Lead Stroke Nurse	**Y**
Apologies	
Tim Orchard, Group Chief Executive Officer	**N**

Chelsea and Westminster NHS Foundation Trust (CWFT)

Standing Committee Chair's Highlight Report to the North West London Acute Provider Group (NWL APG) Board in Common (BiC) – for discussion July 2026

1. Purpose and Introduction

The role of the Chelsea and Westminster NHS Foundation Trust Standing Committee is

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

2. Key Highlights from the Trust Standing Committee Meeting on 30 June 2026

2.1 Quality, Safety and Patient Experience

The Committee reviewed quality and safety performance and noted continued operational pressures impacting patient flow, discharge arrangements and diagnostic access. Members received assurance regarding the management of a Never Event relating to a cataract procedure, noting that a full investigation had been completed, learning identified, and actions implemented to reduce the risk of recurrence.

The Committee also reviewed learning arising from incidents, complaints and mortality reviews, noting recurring themes relating to communication, escalation and care coordination together with ongoing work to strengthen organisational learning and timely completion of improvement actions.

Members received assurance regarding actions to manage increasing demand and workforce pressures within maternity services.

The Committee reviewed infection prevention and control performance, noting continuing challenges in relation to Clostridium difficile infections whilst receiving assurance regarding targeted improvement actions, antimicrobial stewardship and strengthened governance oversight arrangements.

2.2 Operational Performance

The Committee noted that Emergency Department performance remains below operating plan trajectory and continues to be a key organisational focus. Members reviewed ongoing pressures arising from increasing demand, high bed occupancy and delayed discharges and received assurance regarding actions to improve patient flow and discharge processes across the Trust.

Diagnostic performance remains below national standards, particularly at West Middlesex Hospital where workforce and equipment constraints continue to impact delivery. Recovery plans remain in place and performance improvements were noted during May and June. Elective and cancer performance continued to improve, with RTT and cancer standards remaining ahead of trajectory in key areas. Reducing long waits remains a priority and additional elective capacity is expected to support further progress.

2.3 Finance and Improvement

The Committee reviewed the Month 2 financial position and noted a year-to-date deficit of £2.62 million, broadly in line with plan. Delivery of the Cost Improvement Programme (CIP) remains a key financial risk, with 75% of the annual savings target identified but delivery currently behind trajectory. Significant focus continues on identifying additional recurrent schemes and improving delivery performance.

Members reviewed progress across a range of improvement initiatives including outpatient DNA reduction, theatre utilisation, pathway optimisation and procurement savings. Private patient income remains below plan and recovery actions continue. Members also noted the financial impact of recent industrial action and the ongoing uncertainty regarding national industrial relations arrangements.

2.4 People and Workforce

The Committee reviewed workforce performance and noted that sickness absence remains above target. Members received assurance regarding ongoing work to strengthen attendance management, occupational health support and staff wellbeing initiatives.

The Committee also noted increasing incidents of violence and aggression towards staff across the Acute Provider Group and emphasised the importance of continuing preventative measures, staff support arrangements and system-wide learning.

Progress was noted in relation to flexible working and self-rostering arrangements, alongside ongoing work to improve compliance with mandatory and statutory training requirements.

2.5 Governance and Risk

The Committee reviewed the Board Assurance Framework and received assurance that principal strategic risks continue to be appropriately monitored and managed. Members noted ongoing work to strengthen alignment between Trust, Acute Provider Group and system governance arrangements and emphasised the importance of ensuring risks remain appropriately reflected across organisational assurance processes.

2.6 Strategic Development

The Committee noted ongoing progress with delivery of the Clinical Services Strategy and considered the emerging Group Strategy, including increased emphasis on neighbourhood-based models of care. Members requested that future updates include clear outcome measures and implementation milestones to support delivery and oversight.

3. Positive Assurances Received

The Committee received positive assurance in relation to:

- Appropriate investigation, learning and action arising from a reported Never Event relating to cataract surgery.
- Continued improvement in elective recovery and cancer performance.
- Progress with diagnostic recovery plans despite ongoing capacity challenges.
- Ongoing actions to strengthen organisational learning from incidents, complaints and mortality reviews.
- Continued progress against the Clinical Services Strategy.
- Continued progress in embedding the Patient Safety Incident Response Framework (PSIRF), strong Duty of Candour compliance and ongoing development of enhanced organisational learning and risk management arrangements.

4. Key Risks / Topics to Escalate to the NWL APG Board in Common

- Continued operational pressures affecting patient flow, discharge performance, Emergency Department performance and patient experience.
- Clostridium difficile performance and wider infection prevention and control challenges.
- Workforce pressures, including sickness absence and increasing incidents of violence and aggression towards staff.
- Delivery of the Cost Improvement Programme and achievement of the Trust's financial plan.
- Diagnostic capacity constraints, particularly at West Middlesex Hospital.

5. Concerns Outstanding

No significant additional concerns requiring escalation to the Board in Common beyond those identified above.

6. Decisions Made

The Committee approved:

- Replacement MRI scanner business case at Chelsea and Westminster Hospital.
- Critical infrastructure works business case at West Middlesex Hospital.
- Maternity UPS installation works.
- Extension of pharmacy wholesaler contracts.
- Participation in the North West London collaborative procurement arrangement for bulk intravenous fluids, which will be considered separately by the Board in Common due to its cross-organisational impact.

3. Attendance Matrix

Members:	June attendance
Patricia Gallan, Vice Chair and Senior Independent Director (SID) - Chair	Y
Bob Alexander, Chair in Common, NWL APC Chair in Common	Y
Mike O'Donnell, Non-executive Director	Y
Vineeta Manchanda Non-executive Director	N
Baljit Ubhey Non-executive Director	N
Dr Syed Mohinuddin Non-executive Director	Y
Tanaka Chiimba Non-executive Director	Y
Catherine Williamson, Non-Executive Director	N
Members:	June attendance
Tim Orchard, Group Chief Executive/ Accountable Officer NWL APG	N
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
Jason Seez, Chief Infrastructure & Redevelopment Officer	Y
Osian Powell, Director of Transformation	Y
Natasha Singh, Board Adviser, Equality Diversity & Inclusion (EDI)	Y
Emer Delaney, Director of Communications	Y
Peter Jenkinson, Director of Corporate Governance	N
Chris Chaney, Chief Executive Officer, CW+	Y
Attendees:	June attendance
Alexia Pipe, Chief of Staff to NWL APC Chair in Common	Y

Vikas Sharma, Trust Secretary	Y
Faye McLoughlin, Corporate Governance Officer	Y

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) – June 2026

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. Staff Story – Emergency Department and Managing Violence and Aggression

Committee members received a staff story from Shauna Pitchford, Emergency Department Matron, describing an incident of violence and aggression from a patient and the support provided to the affected staff member, including clinical care, ongoing support and accompaniment through the legal process, which resulted in a successful prosecution.

The Committee noted historical under-reporting and received assurance that strengthened reporting and support arrangements, including welfare checks and body-worn cameras, had increased reporting and supported a cultural shift. Members discussed the continuing challenge in the department and agreed that the consistency of digital patient record notes and treatment plans for violent or aggressive patients would be reviewed offline, including pan-London flagging and possible digital tools to reduce incidents.

2.2. Investment Proposals Requiring Board Approval

The Committee reviewed and **approved** the Soliton Radiology Information System Picture Archiving Communication System (RIS PACS) business case.

The Committee recommended for onwards submission to the Board in Common (BIC) the following cases: CXH Same Day Emergency Care (SDEC) Redesign; Robotic-Assisted Surgery Expansion Phase 1 – HH; Cancer Nurse Specialist Workforce; and Specialist Paediatric Asthma Service.

The Committee requested clearer articulation of medium-term revenue implications and how ongoing costs would be managed through financial planning.

2.3. Fleming Centre Supply Chain Partner Replacement

The Committee recommended for onward submission to the BIC the appointment of the Principal Supply Chain Partner for the Fleming Centre.

2.4. 5 Year Capital Plan 2026/27–2030/31

The Committee approved the revised five-year capital plan and noted a total programme value of £612.1m. Discussion included RAAC-related estate issues, decant arrangements and the importance of stronger alignment between capital investments, strategic objectives and Board Assurance Framework risks.

2.5. Chief Executive Report

The Committee received the Chief Executive Report, noting continued strong performance in the NHS Oversight Framework and ongoing focus on 62-day cancer performance, corridor care, patient flow, infection prevention and control, financial recovery and recurrent cost improvement plans.

Members were pleased to note the positive impact of the cancer contact centre and discussed the need to strengthen tracking of survival rates, patient outcomes, national benchmarking and joined-up reporting.

2.6. Quality Assurance Report

The Committee received assurance that mortality, incident reporting and harm indicators remained strong compared with national benchmarks, while noting continued focus on cancer pathways, infection prevention and control, and estates-related impacts on patient safety and flow. Members noted the May 2026 never event involving an unintentionally retained guidewire following insertion of a central venous catheter during an emergency procedure at Charing Cross Hospital, with a safety alert circulated and MDT review commenced. The Committee also noted that, following the planned Human Tissue Authority mortuary re-inspection on 8 June 2026, 15 of 18 actions had been closed, with the remaining three progressing to revised timelines until December 2026.

2.7. Learning from Deaths Quarterly Report

The Committee noted that mortality rates remained statistically low, all deaths were reviewed by Medical Examiners, relevant cases were escalated for Structured Judgement Review, and no new recurring themes had been identified.

Although more deaths were investigated through the Patient Safety Incident Response Framework route at ICHT than elsewhere in the Acute Provider Group, members received assurance from lower-than-average harm levels, a low Hospital Standardised Mortality Ratio and the limited number of issues identified as affecting outcomes.

2.8. Complaints and PALS Annual Report

Members noted an increase in the number of complaints during the year compared with pre-pandemic levels, reflecting a national trend. The Committee received assurance that improved triage arrangements and stronger collaboration with clinical teams had improved identification and management of concerns, particularly in relation to cancer pathways.

2.9. Safeguarding Annual Report

The Committee received the Safeguarding Annual Report 2025/26, noting increasing complexity and referral volumes, particularly in adult services. Members received assurance that governance and oversight had strengthened, external review recommendations were being addressed, workflows were being digitised and mandatory training compliance had improved, while Mental Capacity Act training was temporarily paused pending national guidance.

2.10. Operational Performance M12-M1

The Committee received the Operational Performance Report for Month 12 to Month 1, noting that all national operational targets had been met in 2024/25, except the 31-day cancer treatment standard, which was missed by 0.01%. Performance remained strong into 2025/26, maintaining some of the best

ambulance handover times in London. Members discussed challenges in 62-day cancer performance, particularly in breast and urological tumour groups, and noted actions to improve waiting times and theatre capacity. Corridor care usage matched the London average, with ongoing plans in place to mitigate risks.

2.11. Integrated Activity and Finance Report M12–M1

The Committee received the Integrated Activity and Finance Report for Month 12 to Month 1, noting that the Trust had delivered a £4.924m income and expenditure surplus for 2025/26, including a cash-backed national bonus for achieving break-even; this could not be invested and was required to improve the bottom line. Members noted that although break-even had been achieved, a significant proportion of savings was non-recurrent. The year-end position remained subject to external audit, with no significant risks or issues identified at the time of reporting and a positive value for money assessment expected. At Month 1 2026/27, the Trust reported a £4.1m deficit against a breakeven plan, driven by industrial action and under-delivery of efficiencies.

2.12. Month 2 Operational and Finance Update Including Recovery Actions

The Committee went on to discuss the Month 2 position for operational and financial performance noting that operational performance had broadly been maintained with elective recovery remaining on track and strong diagnostic waiting times. Members noted that four-hour performance had dropped slightly and that challenges remained in 12-hour waits and 62-day cancer performance.

The Committee noted that the Trust had an income and expenditure deficit of £5.9m against a breakeven plan, with £2.3m attributed to industrial action and £3.6m to under-delivered efficiencies. Cash remained resilient and capital spend was ahead of plan. Members discussed targeted actions underway to stabilise the position for the remainder of the year, including workforce and non-pay controls, and noted the commitment to deliver an in-month break-even position in June 2026.

2.13. People Assurance Report

The Committee received assurance on key workforce indicators, including vacancy and turnover rates, whilst noting areas requiring further focus such as sickness absence, bank spend and senior BME representation. Members also noted achievements including the APG recruitment hub and Pathway to Excellence designation.

2.14. Freedom to Speak Up Annual Report 2025/26

The Committee received the Freedom to Speak Up Annual Report 2025/26, noting a significant increase(22%) in the number of cases from the previous year which demonstrated a continuing improvement in the awareness of the service. . Worker safety and wellbeing, and inappropriate attitudes and behaviours, were the highest reported categories of concern. Bullying and harassment cases had continued the downward trend observed in 2024/25, now accounting for approximately 10% of cases (compared to 36% in 2024/25). This could reflect the impact of the Trust's ongoing anti-bullying and culture improvement work. Members discussed the benefits of the triangulation processes in place which had continued to be a positive mechanism for ensuring that concerns escalated through the various routes of raising concerns and whistleblowing are identified, shared, and addressed quickly and appropriately

The Committee noted key priorities going into 2026/27 included continuing to grow awareness across all staff groups, collating a broader set of data relating to staff that use the service to ensure there is equitable access to the service and ensuring the continued sustainability of the service both at Trust and Group level.. Members expressed appreciation for the Guardians' work and the support provided by the service's lead non-executive directors.

2.15. Strategic Deep Dive – Fleming Project

The Committee received an update from Lord Darzi regarding progress with the Fleming Initiative and Centre development, including international partnerships, funding progress and alignment with the Trust's wider life sciences strategy.

2.16. Board Committee Report – Redevelopment and Estates Committee

The Committee received the summary report from the Redevelopment and Estates Committee held on 21 May 2026. Members noted two issues escalated: progress with the propping works for the Mint Wing and progress with the actions arising from the London Fire Brigade enforcement notice

2.17. Board Assurance Framework and Corporate Risk Register

The Committee received the most recent iteration of the Board Assurance Framework and Corporate Risk Register. Members noted that three strategic risks had been amended: partnership working, regulatory compliance and data quality, reflecting improved assurance and ongoing mitigation efforts. The Committee discussed the importance of ensuring robust assurance mechanisms in the absence of Board subcommittees and noted the planned session with audit chairs to further review risk management policies and the Board Assurance Framework at Group level.

2.18. Board Committee Report – Audit, Risk and Governance Committee

The Committee received the summary report from the Audit, Risk and Governance Committee held on 14 May 2026. Members noted that an extraordinary Audit Committee was scheduled for 25 June 2026 for sign-off of the final annual accounts, with no significant issues anticipated.

3. Positive Assurances Received

The Committee received positive assurance on mortality and harm indicators, with mortality rates remaining statistically low, all deaths reviewed by Medical Examiners, and relevant cases escalated for Structured Judgement Review. The Committee also received assurance from the Trust's lower-than-average harm levels and low Hospital Standardised Mortality Ratio.

The Committee received assurance that all national operational targets had been met in 2024/25, with the exception of the 31-day cancer treatment standard, which had been missed by 0.01%, and that performance remained strong into the new financial year, including ambulance handover performance.

The Committee received assurance that the Trust had delivered an income and expenditure surplus of £4.924m for 2025/26, although the Committee noted the need for continued focus on recurrent efficiency delivery in 2026/27.

The Committee received assurance on workforce performance, including low vacancy and turnover rates and agency spend, while noting areas requiring further focus including pay control, bank spend, sickness absence and BME representation at Band 7 and above.

These assurances were reflected in the sustained position of the Trust in segment 1 of the National Oversight Framework.

4. Key Risks and Topics to Escalate to the Board in Common

There are no key risks which require escalation to the Board.

5. Concerns Outstanding

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

6. Decisions Made

The Committee **approved** the Soliton RIS PACS business case.

The Committee **approved** for onward submission to the Board in Common the CXH Same Day Emergency Care SDEC Redesign, Robotic-Assisted Surgery Expansion Phase 1 at Hammersmith Hospital, Cancer Nurse Specialist Workforce, and Specialist Paediatric Asthma Service investment proposals.

The Committee **approved** for onward submission to the Board in Common the appointment of the Principal Supply Chain Partner for the Fleming Centre.

The Committee **approved** the 5 Year Capital Plan 2026/27–2030/31.

7. Summary Agenda

Item No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
6.	Staff Story – End of Life Care	To note	15.	Operational performance report	To note
7.	Investment Proposals requiring Board approval	To approve	16.	Integrated Activity and Finance Report	To note
8.	Fleming Centre Supply Chain Partner Replacement FLEM2501	To approve	17.	M2 Operational and Finance Update Including Recovery Actions	To note
9.	5 Year Capital Plan 2026/27 – 2030/31	To approve	18.	People Assurance report	To note
10.	Chief Executive's report	To note	19.	Freedom to Speak Up Annual Report	To note
11.	Quality Assurance Report	To note	20.	Update on the Fleming Project from Lord Darzi	To note
12.	Learning from deaths quarterly report	To note	21.	Board Committee Report – Redevelopment and Estates Committee	To note
13.	Complaints & PALS Annual Report	To note	22.	Board Assurance Framework and Corporate Risk Register	To note
14.	Safeguarding Annual Report	To note	23.	Board committee report – Audit, Risk and Governance	To note

8. Attendance

Members	June attendance
Sim Scavazza, Vice-Chair and Committee Chair	Y
Bob Alexander, Interim Joint Chair, Acute Provider Group	Y
Nick Gash, Non-Executive Director	Y
Vineeta Manchanda, Non-Executive Director	Y
Patricia Gallan, Non-Executive Director	Y
Catherine Williamson, Non-Executive Director	Y
Rupert Bondy, Non-Executive Director	Y
Loy Lobo, Non-Executive Director	Y
Kevin Croft, Chief People Officer	Y
Ian Bateman, Chief Operating Officer	Y
Julian Redhead, Chief Executive Officer	Y
Janice Sigsworth, Chief Nurse Officer	Y
Jazz Thind, Chief Financial Officer	Y
Raymond Anakwe, Medical Director	Y
David O'Callaghan, Medical Director	N
Tim Orchard, NWL APG Chief Executive Officer	N

9. ANY OTHER BUSINESS

10. QUESTIONS FROM MEMBERS OF THE PUBLIC

13:40

DATE AND TIME OF THE NEXT MEETING: 20 OCTOBER 2026, TIMING TBC,

W12, HAMMERSMITH HOSPITAL