Fola Irikefe, Principal
Scrutiny Officer

fola.irikefe@haringey.gov.uk

28 January 2026

To: All Members of the North Central London Joint Health Overview and Scrutiny Committee

Dear Member,

North Central London Joint Health Overview and Scrutiny Committee - Friday, 30th January, 2026

I attach a copy of the following reports for the above-mentioned meeting which were not available at the time of collation of the agenda:

8. PAEDIATRIC SERVICES REVIEW UPDATE (PAGES 1 - 12)

9. NORTH MIDDLESEX & ROYAL FREE HOSPITAL MERGER UPDATE (PAGES 13 - 22)

Yours sincerely

Fola Irikefe, Principal Scrutiny Officer

This page is intentionally left blank

North Central London
Health and Care
Integrated Care System

NHS

Start Well
Paediatric Surgery
Update for the NCL JHOSC

January 2026

Overview of the Start Well Paediatric Surgery Programme

North Central London Health and Care
Integrated Care System

Since November 2021, NHS North Central London Integrated Care Board (NCL ICB), has been leading a programme of work on behalf of the local health and care system in North Central London called the Start Well Programme to review and improve maternity, neonatal and children's surgical services in North Central London – Barnet, Camden, Enfield, Haringey, and Islington.

The Start Well programme has involved several years of partnership working and significant engagement with patients, staff and partners to review and improve the quality and outcomes of services. Our collective ambition as a health and care system is to give babies and children the best start in life and improve outcomes for pregnant women and people.

This update only pertains to the changes to paediatric surgical pathways.

In 2024, we undertook an extensive public consultation in partnership with NHS England Specialised Commissioning under the North Central London Start Well Programme, on proposals to change the way some surgical services for young children are delivered. This set out opportunities to improve the quality of children's surgical services, for both planned and emergency care, to improve outcomes, as well as to provide a better experience for young children, their families, carers, and our staff too. The ambition was to ensure that young children get the surgery and care they need as quickly as possible, in age-appropriate and child friendly environments.

Having considered the feedback from the consultation and the suggested alternative options, further engagement activity took place during June and July 2025 specifically focused on updated proposal for emergency surgery for young children.

Under our updated proposal, very young children who need emergency surgery would be transferred to a specialist centre, to either hospitals in West London Children's Healthcare (primarily Chelsea and Westminster Hospital and St Mary's Hospital) or to The Royal London Hospital (with the exception of ENT which would be managed by GOSH/UCLH). These hospitals already provide specialist care for very young children in North London who need emergency surgery and have the skills and expertise to meet their needs. The hospital site young children would be transferred to would depend on which local hospital they initially go to for their emergency care. Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) would continue to treat children who are medically and surgically complex and/or very high risk for anaesthesia, or who are already under the care of GOSH.

The NCL ICB Board approved the revised care model on 30 September 2025, and we are now working with the North Thames Paediatric Network to take forward the implementation of the proposals.

Start Well is a collaborative programme involving a wide range of patients, carers, community representatives, clinical leaders and ICS partners

North Central London Health and Care
Integrated Care System

Start of review
November 21

Trust Boards agree to commence the Start Well programme (covering both maternity/neonates and paediatric surgery).

Case for change
Nov 21 – Sept 22

- New care model developed with over 100 clinicians
- Significant engagement through workshops and interviews to co-develop a case for change
- Engagement with patients and the public on the case for change through meetings, questionnaires and youth summit

Over **75% of respondents agreed or strongly agreed with opportunities identified**

Pre-Consultation Business Case
Nov 22 – Nov 23

- Evaluation of options with clinical and patient/public groups
- Drafting of pre-consultation business case
- Engagement of service users with the development of the Integrated Impact Assessment
- Review of proposals by clinical senate and NHSE

Public consultation
Dec 23 – Feb 25

- 14 week Consultation on proposals with community, NHS organisations and other stakeholders
- Independent report published
- Development of Maternity Decision-Making Business Case (DMBC) based on feedback

Maternity and Neonates DMBC Approved
March 25

- ICB approved the Maternity and Neonates Decision Making Business Case (DMBC)
- Paediatric Surgery de-coupled from this decision so it could be developed further

Paediatric Surgery Engagement
Apr – Sept 25

- Further development of Paediatric Surgery proposals
- 4 week engagement on revised proposals
- Independent report published
- Development of Paediatrci Surgery Decision-Making Business Case (DMBC) based on feedback

Paediatric Surgery DMBC Approved
Sept 25 – Jan 26

- ICB approved the Paediatric Surgery Decision Making Business Case (DMBC) 30 Sept 25
- Implementation planning begins

This update is only on Paediatric Surgery

Our case for change identified opportunities for improvement for children and young people

North Central London Health and Care
Integrated Care System

- The Start Well case for change identified opportunities for improvement for paediatric surgical services in NCL
- We have developed a new model of care for paediatric surgical services that addresses these opportunities for improvement

Children and young people's opportunities for improvement

Reducing long waits for elective care
- In NCL, 4,750 children and young people are currently waiting for a planned operation with over 464 children and young people waiting over a year for surgery

Improving transition to adult services
- Across NCL there is a challenge in providing consistent care across transition into adult services
- There is no consistent definition across NCL around the age cut off for children's and young people's services

Recruitment and retention of the paediatric workforce
- Vacancy rates are particularly high in paediatric nursing, ranging from 13%-36% across NCL sites
- Often our own staff are having to work to provide cover for shifts

Meet national recommendations for the environment for paediatric surgical care
- Currently not all sites provide dedicated paediatric theatres or child-friendly environments
- The impact of the current estate and organisation means that some sites are struggling to manage their activity

Increasing demand for emergency care
- NCL sites are providing emergency care to an additional 73 children and young people a day compared to 2016/17
- A higher number of low acuity cases are being treated in ED

Improving long-term conditions management
- Some children and young people do not get enough support to manage their health and wellbeing, and this can lead to unplanned time in hospital
- Children and young people with long term conditions who live in the most deprived areas are more likely to be admitted to hospital

Organisation of paediatric surgical care
- There is variation between and within hospitals on whether a child can be treated on site, depending on the confidence and skills of adult surgeons and anaesthetists covering the emergency rota
- Children with lower complexity emergency cases are being transferred to specialist hospitals, causing treatment delays for some children.

*Information gathered from the NCL Start Well Case for Change - NCL_Start-Well-Case-for-Change-FINAL.pdf with an update on planned operation waits based on May 2025 waiting list data across NCL.

Consultation and Engagement

North Central London Health and Care
Integrated Care System

CONSULTATION - 14-weeks (from 11 December 2023 to 17 March 2024).

This included extensive outreach to the local community, NHS organisations and wider stakeholders using a variety of consultation activities was guided by the IIA to target those most affected.

(Link for full report: Start Well: Consultation feedback on proposed changes to children's surgical services in North Central London)

3,112 responses to the questionnaire
- 2,031 from members of the public
- 1,060 from NHS staff
- 21 from organisations

79 written submissions
- 32 from members of the public
- 47 from NHS staff and other organisations

ENGAGEMENT – 4-weeks (from 23 June 2025 to 21 July 2025).

Due to changes in some aspects of our proposals following consultation, we undertook further engagement, resulting in:

(Link for full report: NCL-Start-Well-Paediatric-Surgery-Engagement-vFINAL.pdf)

154 responses to the questionnaire
- From staff and members of the public

160 parents/carers reached
- 9 focus groups
- 10 hospital drop ins

140+ staff engaged
- 12 dedicated staff engagement sessions

Approved Care Model

Paediatric Surgery Decision Making Business Case (DMBC) approved by the NCL ICB Board on 30 September 2025
(See full DMBC via link: NCL-Paeds-Surgery-DMBC_vFINAL.pdf)

North Central London Health and Care
Integrated Care System

VISION

To ensure that any child or young person requiring planned or emergency surgery is treated by the right team, at the right place and in a timely way. We want paediatric surgical care to be delivered as locally as possible and by specialist staff who regularly deliver this type of care. If an operation is needed, children and young people, their families and carers, should all be confident that they are receiving the best possible care. We want to ensure that all children and young people have access to the same experience and quality of care wherever they may access it.

Emergency Specialist Centre

- Have **paediatric ED or direct access inpatient beds**
- Have **24/7 paediatric surgeons and anaesthetists**
- Delivers majority of **emergency surgery** for children under 3 and for some age 4 - 5 (general surgery/urology)
- **Dedicated specialist paediatric** workforce
- Supported by **NCL paediatric surgery referral hub** (next slide)

WLCH (St Mary's; Chelsea & Westminster) and Royal London (ENT by exception at GOSH and UCLH)

Planned Inpatient Specialist Centre

- Provides **inpatient planned surgery** for children age 1 year and over for low volume specialties
- **Dedicated specialist paediatric** workforce

Great Ormond Street Hospital and UCLH

Day Case Specialist Centre

- Delivers **all day case surgery and single overnight stay for children age 1-2**
- Provides **low-volume day case surgery and single overnight stay** for children age 3+
- Provides **dedicated staff and spaces** for children
- **Dedicated specialist paediatric workforce**

UCLH

Local unit

- Delivers **emergency surgery for most children age 3+ or 5+** (specialty dependent)
- Provides **day case and planned overnight stay surgery** in ENT, max fax and dentistry for age 3+
- Children under 3 or 5 may be **transferred to the specialist centre** for emergency and planned inpatient

No Change

Specialist unit

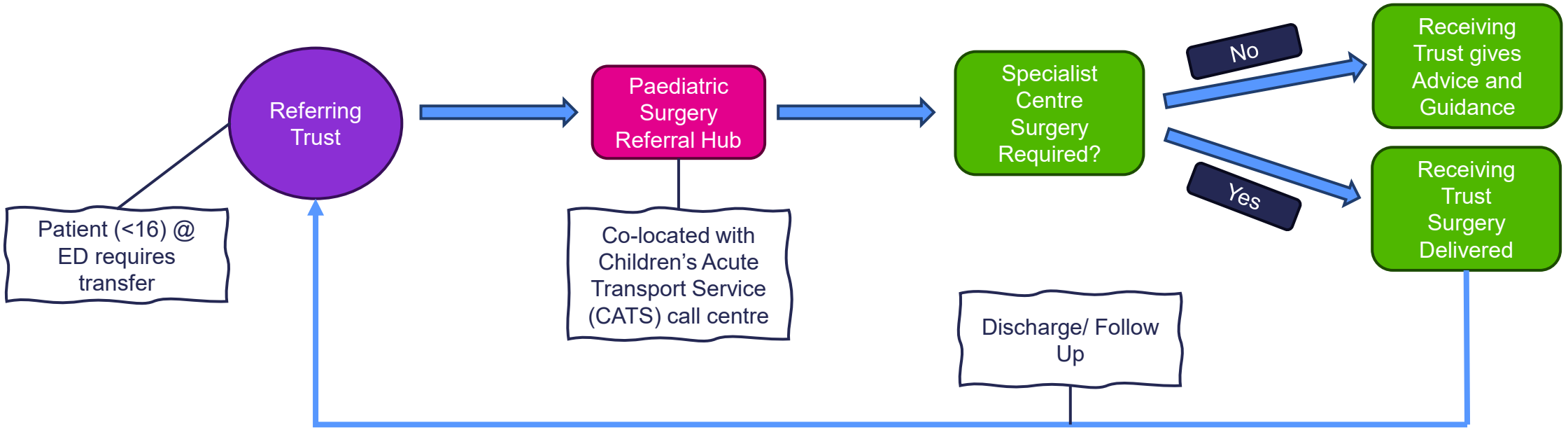
- Provides **highly specialist emergency and planned surgery** including for neonates
- Delivers **across age groups**
- Supported by **highly specialist workforce**

No Change

Model for NCL Paediatric Surgery Referral Hub

North Central London Health and Care
Integrated Care System

For paediatric emergency surgery, a paediatric surgery referral hub would be set up to support referrals for emergency paediatric surgery across North Central London, for all children aged 16 and under, including a bed-finding service, if required. Children would access care initially at their local site, as they do now. If they needed more specialist care, the referral hub would act as a single point of referral for clinicians in local hospitals in NCL and would ensure smooth and timely support from specialist centres, and transfer (if required). In addition, for emergency surgery for the small number of under 3s or under 5s (general surgery and urology) that are currently operated on locally, local units would transfer children from local EDs to a specialist centre. Specialist centres already have access to a 24/7 specialist paediatric surgical and paediatric anaesthetic workforce as well as the wider clinical staff who regularly look after young children. These centres also have a paediatric ED, which can assess children who may need a surgical procedure, or can take children directly into inpatient beds.



Benefits and Implementation
(Taken from the Paediatric Surgery DMBC, September 2025)

North Central London Health and Care
Integrated Care System

Do Nothing

- × Does not deliver the **best practice** and achieve the **clinical standards** as set out by professional bodies such as Getting It Right First Time (GIRFT).
- × Surgical services would remain **fragmented.**
- × **Paediatric expertise** required to deliver the best quality care is not readily available at local units.
- × Difficult to maintain and develop the **skills and capabilities** to deliver this service at local units.
- × Staff at local units would continue to spend time trying to find a **suitable bed** for young children requiring surgical assessment and treatment.
- × **Access to care** would remain the same with no changes in the travel or driving times but with more children and young people having to sometimes travel outside of NCL to access care.

New Care Model

- ✓ Implementing the care model would ensure that surgical care is delivered in the **right setting**
- ✓ Delivers **clear emergency surgical pathways**
- ✓ Reduces the amount of time spent by senior clinicians in local hospitals trying to get **specialist advice and organising transfers**
- ✓ Makes best use of the scarce **specialist paediatric surgical workforce**
- ✓ Enables **sustainable volumes of surgical activity**
- ✓ Delivers surgical activity in **child friendly environment**
- ✓ **Reduces waiting times**

Enablers

- **Referral hub**: the smooth set-up and operation of the NCL referral hub would underpin the transfer of children in an emergency. Cases would be directed via an algorithm to the provider with a suitable bed rather than on a purely geographical basis, allowing systemwide pathways and best use of available capacity.
- **Workforce**: training and skills development of local unit adult surgical workforce to ensure there are the skills and capabilities in place to provide surgical and anaesthetic care for children aged 5 years and older.
- **Finance**: delivering the required capacity and estate requirements at UCLH. The capital investment would be managed within UCLH's business as usual capital resources. The revenue cost of the referral hub would be funded partly by NCL ICB and partly by the North Thames Paediatric Network.
- **Communication and engagement**: to communicate the changes and engage with the local population and providers on these and the new pathways.

Integrated Impact Assessment (IIA)

(See full IIA report via link: **NCL Start Well Programme**)

North Central London Health and Care
Integrated Care System

A thorough Integrated Impact Assessment (IIA) was carried out and was published alongside the decision-making business case in September 2025 which includes looking at population groups with protected characteristics.

- For people travelling to **GOSH for planned inpatient surgery**, an average increase in travel times for car/taxi (peak) by 29 minutes, by 20 minutes (off-peak) and public transport by 19 minutes and an average increase in taxi costs of £29 per journey.
- For people travelling to **UCLH for planned day case surgery or planned inpatient surgery**, an average increase travel times for car/taxi (peak) by 26 minutes, by 18 minutes (off-peak), public transport by 11 minutes and an average increase in taxi costs of £26 per journey.
- Children and young people would continue to access the **emergency department (ED)** at their local hospital for emergency paediatric surgery, and the majority would continue to be treated locally. This means there would be no change to where children and young people access emergency paediatric surgical care, and people would continue to access care at their nearest local ED, being transferred from their local ED to a specialist centre, if required. However, there may be an impact for families and carers visiting children and young people who have been transferred to a specialist centre at St Mary's, GOSH, Chelsea & Westminster, UCLH or Royal London from a local site. Children would be transferred to the specialist centre most able to meet their needs, which may not be the closest, although there is an intention to treat children as close to home as possible.
- There would be a similar impact on travel times for vulnerable populations. People further away from the specialist centres may need to pay up to an additional maximum of £54 per taxi journey. Specific consideration would also need to be given to other access needs for vulnerable populations including digital access, access to cars, physical on-site access and cultural and language barriers.

Mitigations have been developed to support children and their families to access surgical care that they need given this increase in journey time and cost, including:

- Providing **support with the costs of travel** to hospital by raising awareness of schemes to support patients with travel costs and providing information on trust-level arrangements.
- Supporting people who may be more vulnerable to the impacts of our proposals by **communicating the changes**, working with local hospitals to support families, communicating relevant arrangements for the reimbursement of travel expenses and continuing engagement with potentially impacted families and communities.
- Communicating and engaging about implementation should changes be agreed by making sure **information is accessible** and widely shared and co-designing emergency redirection messaging with staff and parents.
- Ensuring families **understand the pathways** of care by giving information to families and disseminating information through community groups.
- Mitigations for those who may need **extra support** to access an unfamiliar hospital by providing information, offering opportunities to visit the site, ensuring appointments are at appropriate times and working with the Learning Disability Liaison Nurse and primary care colleagues.
- Supporting families to **travel to the hospital** by providing clear, accessible information and linking to live journey planners.
- Providing as much **care locally as possible**, especially for planned care, by having appointments locally where possible, offering virtual appointments and implementing hospital appointments at home, where possible.

The recommendation is that the benefits of implementing the proposals, as described in the DMBC, mean that it should be implemented, despite the identified disadvantages.

Paediatric Surgery Implementation

North Central London Health and Care
Integrated Care System

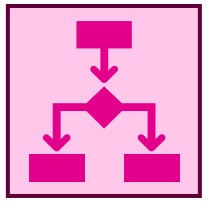
Emergency	Planned (day case / inpatient)	Cross-cutting enablers
• **Governance and partnership** – formalise collaboration with North Thames Paediatric Network (NTPN) as delivery partner and establish joint governance between ICS/ICB/NTPN • **Clinical leadership** – define system-level surgical leadership • **Service model implementation** – NTPN will lead development of paediatric surgery referral hub for NCL (agree implementation to go live in first half of 2026), as well as defining and communicating protocols across sites • **Digital enablement** – to review interoperability requirements • **Finance** – ICB to work through contractual implications and funding flows in line with DMBC assumptions including funding for Children's Acute Transport Service (CATS) to host Paediatric Surgery Referral Hub • **Acute airway management** – work with NTPN and Trusts to review local protocols and training for acute airway management	• **Clinical leadership** – to define NCL-level surgical clinical input with NTPN, as well as developing clear patient pathways (including discharge and follow up) • **Service model implementation** – to define and communicate protocols and clinical pathways, and monitor/audit activity • **Finance** – as part of 2026/27 planning round, ICB ensuring appropriate funding flows in line with DMBC assumptions	• **Workforce training and development** – NTPN to work with Trusts to develop comprehensive training package for local units (including upskilling staff and maintaining CPD for anaesthetic staff on emergency intubation), explore expansion of rotational posts with innovative training models • **Organisational Development and staff engagement** – continue coordinated staff briefings, and implement OD initiatives to maintain morale and collaboration • **Recruitment and retention** – to align with NCL people strategy and NHS Long Term Workforce Plan, and strengthen recruitment pipelines and retention strategies (e.g., Capital Nurse programme) • **Stakeholder engagement** – maintain inclusive engagement with patients, public, providers, clinicians and NHS staff • **Holistic care standards** – ensure age-appropriate environments, play specialists etc during implementation

Next Steps

North Central London Health and Care
Integrated Care System

Continue to work with partners and stakeholders to communicate the outcome of the process

Continue to engage and involve stakeholders in the development of implementation plans.



Establish the programme governance and capacity to manage the operational implementation working closely with the North Thames Paediatric Network

This page is intentionally left blank

Paper for 30 January 2026

Update on merger of Royal Free London NHS Foundation Trust and North Middlesex University Hospital NHS Trust

1. Introduction

1.1 On 1 January 2025, Royal Free London NHS Foundation Trust (RFL) and North Middlesex University Hospital NHS Trust and community services (North Mid) came together, forming an enlarged organisation, with North Mid becoming a health unit in the RFL group.

1.2 This followed several years of close working between the two organisations and means the RFL group is one of the largest NHS trusts in the country. It now has more than 17,000 staff and provides care for a population of more than two million across over 70 sites.

1.3 This paper is written a year after the merger took place, and provides an update on structure, service changes and performance during 2025.

2. Improvements in the first six months post-merger

2.1 From improvements in emergency department performance and cancer pathways, to increasing virtual ward capacity and expanding access to clinical trials, the merger is strengthening RFL's collective ability to deliver outstanding care, now and into the future.

2.2 Despite the merger taking place during winter, a time of typically high demand on services, no adverse performance changes were seen with the below improvements formally identified by NHS England (NHSE) in their six-month post-merger review:

- Cancer performance has significantly improved. Since the merger, the total cancer backlog at North Mid has decreased by 147 patients (from 231 to 84 as of 22 July 2025). North Mid's Faster Diagnosis Standard (FDS) performance has increased by 16% since the merger. The 31-day radiotherapy performance has continued to improve, reaching a high of 94.5%. In October, North Mid hit the NHSE interim target of 75% for 62-day referral to treatment having achieved 82.5% placing it as one of the highest performing in the country. At the same time the overall RFL position had similar levels of improvement.

- RFL prioritised £7.4m of capital funding to redevelop the urgent treatment centre (UTC) at North Mid, which will support four-hour, twelve-hour and ambulance handover performance. Part of this was enabled by the receipt of a £1m of additional capital funding bonus received from NHSE as part of the national urgent and emergency care (UEC) capital incentive scheme and as a result of the RFL's (Royal Free Hospital, Barnet Hospital, Chase Farm

Hospital and North Mid) four-hour performance improvement in March 2025.

- In the last year, we have seen a more integrated approach to the development of our virtual hospital and hospital home model enabling access to Enfield virtual ward pathways with expansions in capacity, improvements in productivity, and enabling collective access to both North Mid and Barnet patients.

- Maternity services at North Mid received an improved rating following a Care Quality Commission re-inspection, with highlights including more equipment in the department, a new handover tool to improve communication between midwives and doctors and a dedicated breastfeeding midwife.

- The scale of the RFL enabled the deployment of UEC improvement resource to work alongside operational and clinical leaders and emergency care improvement support team (ECIST) at North Mid, resulting in a step-change improvement in four-hour performance. In June 2025 performance reached 73.6%, which is 5.6% above North Mid's agreed operating plan trajectory for 2025-26 and compares to 68.4% achieved in June 2024. This performance has been maintained in the second half of the year.

- Working across the RFL, and leveraging the scale of the group, secured senior clinical support and capacity to enable the establishment of the NCL Integrated Care Co-ordination Hub, which had a significant positive impact on ambulance conveyances demand and ambulance category two response performance over winter.

- Clinical Practice Group (CPG) pathways have been expanded across North Mid; maternity triage pathway across all health units and preoperative assessment have been successfully built into Care Flow so that we can have comparative key metrics across all health units.

- The North Mid Research & Development (R&D) function was successfully integrated into the RFL R&D function on 1 January 2025 and early benefits have already materialised.

3. Performance Indicators

3.1 Taking a view over a longer period (12 months), the table below shows performance against key standards pre- and post-merger (12 months apart). The pre-merger position shows a calculated merged performance position for ease of comparison.

3.2 For most metrics, performance has improved under a merged organisation, with only small impacts to Long Length of Stay (LOS) exceeding 21 days (noting that LOS exceeding seven days has improved), and Diagnostic Waiting Time and Activity (DM01) performance with a small downturn.

		Pre-Merger *(December 2024)*						**Post-Merger** *(November 2024)*		
		-- Royal Free Group -		-- North Middlesex --		-- Merged Performance --		-- Merged Performance --		
Cohort	**KPI**	*Target*	*Royal Free*	*Target*	*NMUH*	Target	Merged Performance	Target	Merged Performance	Variation
ED Access	4hr Performance - *All Types*	*76%*	*78.0%*	*76%*	*63.6%*	78%	72.6%	78%	76.8%	↑
	4hr Performance - *Type 1*	*76%*	*67.8%*	*76%*	*41.6%*	78%	59.3%	78%	66.1%	↑
	4hr Performance - *UTC*	-	*97.8%*	*0.76*	*86.5%*	-	92.7%	-	94.6%	↑
	12hr Breaches	-	*9.1%*	-	*9.3%*	-	9.2%	-	8.8%	↓
	Ambulance Handover Performance <30mins	*80%*	*48.0%*	*67%*	*47.9%*	80%	48.0%	80%	48.7%	↑
	Mean Handover Time	-	*34.3 mins*	-	*42.1 mins*	-	37.5 mins	-	36.8 mins	↓
Bed Mgment	Bed Occupancy Rate (G&A)	*92%*	*94.8%*	*92%*	*99.9%*	92%	96.4%	92%	95.8%	↓
	Long LOS >7 Days (% of discharges)	-	*54.6%*		*61.2%*	-	56.7%	-	54.2%	↓
	Long LOS >21 Days (% of discharges)	-	*22.8%*		*28.3%*	-	22.9%	-	24.2%	↑
Elective Access	RTT Incomplete Performance *(% <18 weeks)*	*92%*	*56.3%*	*92%*	*65.3%*	92%	58.2%	92%	58.7%	↑
	RTT Total Waiting List Size	-	*111812*	-	*29766*	-	141578	-	136902	↓
	RTT - *104 Week Breaches*	*0*	*2*	*0*	*0*	0	2	0	0	↓
	RTT - *78 Week Breaches*	*0*	*44*	*0*	*1*	0	45	0	8	↓
	RTT - *65 Week Breaches*	-	*235*	-	*5*	-	240	-	60	↓
	RTT - *52 Week Breaches*	-	*3048*	-	*244*	-	3292	-	2380	↓
	DM01 Performance	*95%*	*83.8%*	*95%*	*95.7%*	95%	87.8%	95%	87.2%	↓
Cancer	62 Day Merged performance	*70%*	*58.9%*	*70%*	*73.9%*	70%	62.1%	70%	78.5%	↑
	31 Day Merged performance	*93%*	*88.2%*	*93%*	*81.9%*	93%	86.6%	93%	91.8%	↑
	28 Day FDS Performance	*77%*	*73.4%*	*77%*	*60.4%*	77%	70.9%	77%	76.5%	↑
	62 Day Backlog	-	*416*	-	*189*	-	605	-	262	↓
Workforce	Vacancy Rate - All Staff	*10%*	*7.7%*	*8%*	*9.9%*	10%	8.3%	10%	5.6%	↓
	Sickness Rate - All Staff	*3.5%*	*4.8%*	*4.0%*	*4.9%*	3.5%	4.9%	3.5%	5.0%	-
	Statutory Training Rate - All Staff	*90%*	*76.5%*	*85%*	*91.3%*	90%	79.1%	90%	83.3%	↑
	Appraisal Rate - All Staff	*90%*	*84.7%*	*90%*	*72.0%*	90%	81.7%	90%	82.1%	↑
	Voluntary Turnover Rate - All Staff	*13%*	*10.2%*	*12%*	*9.8%*	13%	10.1%	13%	8.2%	↓

4. Front-line service changes

4.1 As planned, there have been changes seen by patients at our hospitals, with patient benefit cases detailed in the merger business case describing where early integration work would take place. Benefits include:

4.2 Surgical hubs

- Accreditation of Edgware Community Hospital as a surgical hub achieved in November 2025.

- A 7% improvement in capped theatre utilisation at Chase Farm Hospital (CFH) between May 2025 and August 2025, with sustained performance throughout the autumn period – equating to 40-50 additional patients per month.

- Increased productivity across lists during this period, leading to an additional 40 patients through CFH per month.

- Chase Farm capacity expanded to offer access to North Mid services, build on existing shared work, and with plans to expand further to the next specialties as per the integration plans.

- Pre-assessment pathway improvements with the CPG team to standardise the pathway across the group and triage more patients to virtual preoperative assessment, releasing face-to-face capacity. Work is ongoing to roll the pathway out to all specialities and develop a digital triage tool.

4.3 Colorectal

- Complex colorectal work has been consolidated at the Royal Free Hospital (RFH) site (from BH and North Mid).

- All three North Mid colorectal surgeons are operating at the RFH, which increases the resilience of the service and enables more cross-cover to reduce the number of lists that are handed back late.

- Slight improvement in length of stay for North Mid complex colorectal patients.

- Between April and July 2025, an additional 23 North Mid complex colorectal patients have had their operations at the RFH; the number of North Mid complex colorectal patients being operated on at the RFH per month has doubled from an average of circa four to circa eight post-merger.

- Work is ongoing to train additional surgeons, including North Mid surgeons, on the surgical robot to increase equity of access to these new techniques.

4.4 Oncology

- Two joint RFH-North Mid medical oncology posts have been recruited to and are now in post. This has significantly increased medical oncology capacity, particularly at North Mid in an area that had previously been hard to recruit to.

- Established group-wide cancer of unknown primary (CUP) multidisciplinary team – North Mid CUP patients now have faster access to this specialist advice.

- Joint RFH-North Mid radiotherapy workforce business case approved with recruitment complete for year one posts. This will reduce radiotherapy agency and bank costs and increase the resilience of both services.

- Work is ongoing to substantiate locum posts across North Mid and the RFH. This will increase both services' resilience:

    - CFH/North Mid clinical oncology breast / lung approved
    - North Mid breast medical oncology substantiated
    - RFL medical oncology breast substantiated
    - RFL medical oncology gastrointestinal substantiated

- Proactively collaborating and sharing learning ahead of formal integration, for example sharing Financial Improvement Plan (FIP) ideas around reducing drug spend.

- Workplan generated with timeframes to harmonise clinical guidelines across both sites.

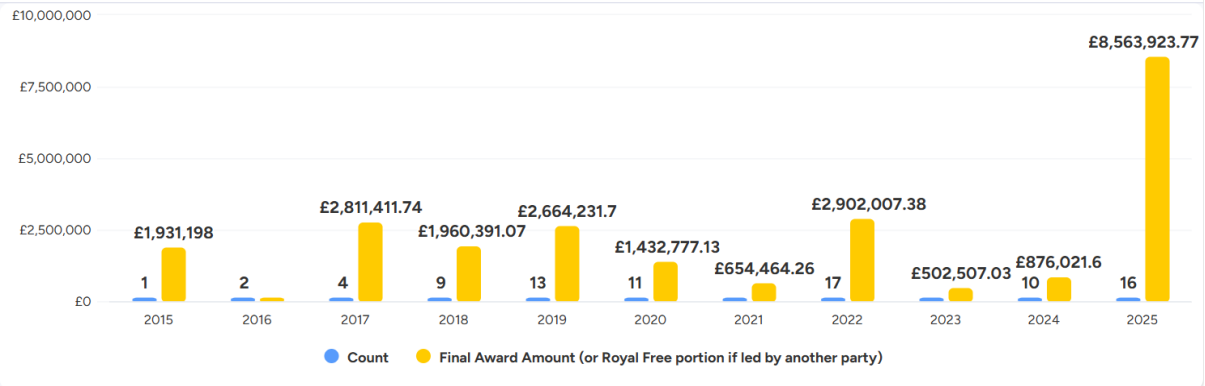
4.5 Research and development

- Financial sustainability of North Mid R&D has improved through using the RFL's research grants manager for accurate costing models, access to a patient and public involvement and engagement manager (which increases competitiveness with funders), work to grow the current portfolio and attract commercial studies, and identifying studies open at other RFL sites that are potentially suitable for North Mid.

- Enhanced income tracking from previously unclaimed activities has been established through improved finance training.

- More efficient study set-up at North Mid has been achieved, with at least six new North Mid studies opened since the merger with an average set-up time of 188 days (median 148.5 days), representing an improvement from the North Mid baseline.

- Across the group, the median set-up time has improved from 186.5 days in 2024 to 148.5 days in 2025.
- North Mid patients now have potential access to RFL's extensive study portfolio, including phase one trials through the clinical research facility, providing more equitable access to trials.
- Recruitment across all studies at North Mid increased from 465 patients in 2024 to 820 in 2025, while the number of studies opening remained stable at 11 in both years.
- The annual target for increasing the number of studies opening per site per year has been exceeded.
- The R&D KPI for studies to be set up within 92 days for new studies is being met.
- North Mid patients are now included in the research tissue bank project trials.
- Streamlined governance has been achieved by integrating North Mid R&D as Theme 6 in the RFL's delivery structure, which eliminated duplicate processes.
- Centralised support is now available, with North Mid having access to the RFL's dedicated research grants manager and costing support team.
- Four allied health professional staff members are acting as research champions, expanding non-medical research advocacy.
- Regional Research Development Network has funded one whole time equivalent band six post for HIV research portfolio development.
- North Mid R&D team now has access to comprehensive training programmes including workshops, standard operating procedures, shadowing opportunities, and clearer career progression pathways.
- The graph below shows a summary of grants over the past 10 years, showing a substantial uplift in value in 2025.



4.6 Emergency care and UTC at North Mid

- Four-hour performance improvement has been sustained at North Mid. The latest month, December 2025, was 73.61% compared to 63.60% in December 2024.

- Improvement in UEC performance, pathways, leadership and clinical engagement at North Mid recognised by NHSE ECIST tier one support team and de-escalation from tier one to tier two for UEC (notified in October 2025).

- New UTC capital development at North Mid is progressing well and is on track for opening in the spring of 2026, which will enable improved access for minor injury and minor illness patients at North Mid as well as providing additional clinical space to manage ambulance handover and reduce delays.

- Increased capacity of integrated virtual ward pathways with utilisation improving to over 80%. The North Mid virtual ward pathway has increased from 32 to 49 beds this year and utilisation in November was 93% against national benchmark of 80%.

- New initiatives supported with investment of circa £4m into North Mid:
    - investment and recruitment of additional permanent emergency department and acute medicine workforce
    - operational improvement and transformation support resource (ongoing)
    - opening of a new discharge lounge (February 2025)
    - opening of a new emergency ambulatory care unit (May 2025)
    - opening of the same-day acute frailty service (January 2026)

4.7 Mental health A&E services – CFH and North Mid

- Work continues with NCL ICB and North London Partnership Foundation Trust (NLPFT) to establish a mental health crisis assessment service based at CFH to serve patients, particularly those with mental health needs, who currently attend North Mid and Barnet Emergency Departments, with the capital enabling works currently underway by NLPFT at CFH.

5. Staff Benefits of Merger

5.1 In Q3 2025/26, 485 clinical leaders were consulted on the new clinical operating model (COM). This new structure goes live in April 2026 and will bring further benefits for our staff which include:

- Increased investment in our clinical leadership structures which ensures we attract the best individuals to the roles to allow us to deliver on our ambitions for our patients and populations.

- The structure has been benchmarked with other trusts and supports retention of our valued staff and allows us to attract high-calibre people from outside

the group.

- Greater parity between operational, nursing and clinical leadership at all levels.

- Greater scope for rotational opportunities as well as opportunities for progression across the health units within the group.

6. Financial Position

6.1 Both legacy trusts delivered their agreed financial plans across recent years. However, both had significant underlying deficits with challenging recovery plans. To support plan delivery, both trusts historically relied heavily on non-recurrent means and flexibilities.

6.2 Taking historical financial positions into account, alongside the significant shift in the national financial landscape within the NHS, the merged organisation set an £88.5m underlying deficit plan for 2025/26, £30m of this was the legacy North Mid underlying position.

6.3 Incorporated into this plan was an assumed delivery of a total £121.5m of financial efficiencies, including a blend of recurrent and non-recurrent expectations. Within this, the opportunity to make savings achieved as a result of corporate and back-office integration through the merger has been taken. The delivery of those savings targets has reflected the efficiency expectations of the merger as stated within the original business case:

Transaction benefits	2024/25 Year 1	2025/26 Year 2	2026/27 Year 3	2027/28 Year 4	2028/29 Year 5	2029/30 Year 6
CSI	-	5,265	10,529	10,529	10,529	10,529
CNST	-	-	422	422	422	422
Operational Cost	-	1,342	1,342	1,342	1,342	1,342
EPR	-	-	316	631	631	631
	-	**6,607**	**12,609**	**12,924**	**12,924**	**12,924**

6.4 The merger savings were achieved via:

- Corporate Savings Integration (CSI) benefits - £5.3m in 2025/26 with a £10.5m full year effect

- Clinical Negligence Scheme for Trusts (CNST) premium reduction of £0.4m from 2026/27 to reflect adoption of best practice across the enlarged group

- £1.3m of clinical consumables savings from increased purchaser power and the rationalisation of contracts

- £0.3m savings in 2026/27 from reducing North Mid Electronic Patient Record (EPR) licence fees as a consequence of implementing a new EPR, with a £0.6m full year effect

6.5 Strong progress has been made on the delivery of the noted efficiencies, with the full CSI benefit expected to be delivered. Similarly, efficiencies allied to improved value associated with clinical consumables have been delivered as a part of the group's non-pay programme.

6.6 Initial work is underway to assess opportunities to deliver the CNST and EPR benefit in future years. There is a risk associated with both schemes, which is being managed via trust governance.

6.7 Alongside the above, the group continues to progress additional opportunities offered by the integration of the legacy organisations. Work is underway to optimise the use of CFH as a surgical hub, which offers a significant opportunity to increase elective productivity with existing resources. The group's new COM has also been finalised, with implementation due in April 2026. This offers scope for further improved care by ensuring optimal services and pathways are established, thereby eliminating unwarranted variation.

6.8 Delivery of benefits will continue to be tracked as a part of the wider group's FIP and reported via appropriate governance.

7. Conclusion

7.1 There is obviously ongoing work to continue to move forward and deliver the benefits that working together as a single organisation gives, as well as developing the new organisational culture, plans, and continuously exploring new areas to improve. Whilst not everything has gone smoothly, the areas of integration where there have been delays have largely been logistical and impacted staff, not patients, and have been quickly identified and resolved.

7.2 But one year into the merger of the Royal Free London and North Middlesex Trusts, there has been good progress made against both the delivery and realisation of the merger integration plans, and resulting benefits. Overall, there has been progress and improvement in all areas of delivery including key NHS and patient metrics. The NHSE formal review of progress noted the improvements and the successful delivery of the merger plans.

This page is intentionally left blank