North West London
Acute Provider Collaborative

ACUTE PROVIDER COLLABORATIVE BOARD IN COMMON PUBLIC MEETING

ACUTE PROVIDER COLLABORATIVE BOARD IN COMMON PUBLIC MEETING

16 April 2024

14:15 GMT+1 Europe/London

The Legends, Brentford Football Club, Entrance Gate C, South Stand, Gtech Community Stadium, Lionel Road South, Brentford, TW8 0RU & MS TEAMS

AGENDA

0. AGENDA

REFERENCES

Only PDFs are attached

0. BIC Agenda NWL APC BiC Public Board 16 April 24 final.pdf

Chelsea and Westminster Hospital NHS Foundation Trust | The Hillingdon Hospitals NHS Foundation Trust | Imperial College Healthcare NHS Trust | London North West University Healthcare NHS Trust

North West London Acute Provider Collaborative
Board in Common - Public
Tuesday 16 April 2024, 14.15 – 17:15
Venue – The Legends, Brentford Football Club, Entrance Gate C, South Stand, Gtech Community Stadium, Lionel Road South, Brentford TW8 0RU

Members of the public are welcome to join this meeting in person or by Microsoft Teams, via the following link: **Microsoft Teams** **Join the meeting now** *(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 thh.corporatemanagement@nhs.net but this is not a requirement, you can ask new questions on the day. Any questions that are submitted in writing but due to time are not addressed in the meeting will be answered in writing on the Acute Provider Collaborative website.

A G E N D A

Time	Item No.	Title of Agenda Item	Lead	Enc
14.15	1.0	Welcome and Apologies for Absence	Chair in Common Matthew Swindells	Verbal
	1.1	Declarations of Interest	Matthew Swindells	1.1
	1.2	Minutes of the previous NWL Acute Provider Collaborative Board Meeting held on 16 January 2024	Matthew Swindells	1.2
	1.3	Matters Arising and Action Log	Matthew Swindells	1.3
14:20	1.4	Patient Story – on ENT pathway across The Hillingdon Hospitals and Central Middlesex Hospital. *To note the patient story*	Patricia Wright	1.4
2. Report from the Chair in Common				
14.35	2.1	Report from the Chair in Common *To note the report*	Matthew Swindells	2.1
	2.2	Board in Common Cabinet Summary *To note any items discussed at the Board in Common Cabinet meetings*	Matthew Swindells	2.2
3. Integrated Quality and Performance Report				
14:45	3.1	Integrated Quality, Workforce, Performance and Finance Report *To receive the integrated performance report*	Patricia Wright Pippa Nightingale Lesley Watts	3.1
4. Quality				
15.15	4.1	Collaborative Quality Committee Chair Report *To note the report*	Steve Gill	4.1
	4.2	Learning from deaths report *To note the report*	Jon Baker	4.2
5. Workforce				

15.30	5.1	Collaborative People Committee Chair Report *To note the report*	David Moss	5.1
	5.2	APC Improvement Plan – EDI Action plan *To note the report and approve Board objectives*	Pippa Nightingale Sim Scavazza Ajay Mehta	5.2
6. Data and Digital				
15.40	6.1	Collaborative Data and Digital Committee Report *To note the report*	Steve Gill	6.1
7. Estates and Sustainability				
15.50	7.1	Collaborative Estates and Sustainability Committee Report *To note the report*	Bob Alexander	7.1
8. Finance and Performance				
16.00	8.1	Collaborative Finance and Performance Committee Chair Report *To note the report*	Catherine Jervis	8.1
	8.2	Financial performance report *To receive the financial performance report*	Jonathan Reid	8.2
	8.3	Acute Provider Collaborative Business Plans – Priorities, Operating and Financial *To note the update*	Lesley Watts	8.3
9. Audit				
16.20	9.1	Reports from Trust Audit Committees *To note the reports* • The Hillingdon Hospitals NHS Foundation Trust • Chelsea and Westminster Hospital NHS Foundation Trust • Imperial College Healthcare NHS Trust • London North West University Healthcare NHS Trust	 Neville Manuel Aman Dalvi Nick Gash Baljit Ubhey	9.1 9.1a 9.1b 9.1c 9.1d
	9.2	Revising the Acute Provider Collaborative Governance Arrangements *To approve the delegated authority to establish Standing Committees of the Trust Board*	Peter Jenkinson	9.2
	9.3	Delegated Authorities to Provider Trust Committees 2023/24 To approve the recommended delegated authorities to provider Trust committees for the financial year ending 2023/24. • Annual Report and Accounts • Quality Account • Self-certifications for Non Foundation Trusts	Peter Jenkinson	9.3

		• Self-certifications for Foundation Trusts • Modern Slavery Act Statement		
10. Chief Executive Officers				
16.35	10.1	Executive Management Board (EMB) Summary *To note any items discussed at the EMB meetings*	Tim Orchard	10.1
	10.2	Reports from the Chief Executive Officers *To note the reports* • London North West University Healthcare NHS Trust • Chelsea and Westminster Hospital NHS Foundation Trust • Imperial College Healthcare NHS Trust • The Hillingdon Hospitals NHS Foundation Trust	 Pippa Nightingale Lesley Watts Tim Orchard Patricia Wright	10.2 10.2a 10.2b 10.2c 10.2d
11. Reports for Information Only				
16.50	11.1	Use of the Trust Seal *To note the report*	Peter Jenkinson	11.1
	11.2	Health and Safety Annual Report 2022-23 *To note for assurance*	Jonathan Reid	11.2
12. Any Other Business				
16.55	12.1	Nil Advised		
13. Questions from Members of the Public				
17:00	13.1	The Chair will initially take one question per person and come back to people who have more than one question when everyone has had a chance, if time allows.	Matthew Swindells	Verbal
Close of the Meeting				
Date and Time of the Next Meeting				
16 July 2024 Venue to be confirmed				
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)				

1.0 WELCOME AND APOLOGIES FOR ABSENCE - CHAIR IN COMMON, MATTHEW SWINDELLS

1.1 DECLARATIONS OF INTEREST - MATTHEW SWINDELLS

REFERENCES

Only PDFs are attached

1.1 BIC NWL APC Register of Interest cover.pdf

1.1a BIC Board in Common Register of Interests.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 1.1
This report is: Public

NWL Acute Provider Collaborative Board in Common Register of Interests

Author: Peter Jenkinson
Job title: Director of Corporate Governance

Accountable director: Peter Jenkinson
Job title: Director of Corporate Governance

Purpose of report

Purpose: Information or for noting only

The NWL Acute Provider Collaborative Board in Common Register of Interests is presented for noting.

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

Following presentation to the NWL Acute Provider Collaborative Board in Common, the Register of Interests will be published on the microsite and individual Board Register of Interests will be published on respective Trust websites.

At the commencement of each Board in Common, Collaborative and local Committee, members are also required to declare any revisions to their declared interests and any interests relating to agenda items.

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

NORTH WEST LONDON ACUTE PROVIDER COLLABORATIVE
BOARD IN COMMON - REGISTER OF INTERESTS 2023-24

Date last updated: 9 April 2024 (PH)

NAME	ROLE	TYPE OF INTEREST				DESCRIPTION OF INTEREST	DATE INTEREST OPENED	DATE INTEREST CLOSED	ACTIONS TO BE TAKEN TO MITIGATE RISK	BOARD MEMBER			
		Financial	Non-Financial Professional	Non-Financial Personal	Indirect					CWFT	ICHT	LNWH	THHFT
Non-Executive Directors													
Matthew Swindells	Chair in Common	x				Founder / Owner: MJS Healthcare Consulting	Aug-19	Ongoing		x	x	x	x
				x		Chair: Citizens Advice	Mar-24	Ongoing					
		x				Non-Executive Director: Prism Improvement Limited (Prism Improvement owns 25% stake in another NHS consulting firm Four Eyes Consulting)	Apr-22	Ongoing					
		x				Senior Advisor: Global Council	Sep-19	Ongoing					
		x				Internal Advisor: Carnall-Farrar Consulting	Feb-22	Ongoing					
		x				Advisor: Akeso	Oct-23	Ongoing					
			x			President: Health Care Supply Association (HCSA)	Jan-23	Ongoing					
						Advisor - Five Arrows (private equity)	Jul-23	Oct-23					
Bob Alexander	Vice Chair - Imperial College Healthcare NHS Trust	x				Non-Executive Director: London Ambulance Service NHS Trust	Aug-21	Ongoing			x	x	
		x				Non-Executive Director: Community Health Partnership Ltd	Apr-19	Ongoing					
		x				Advisor: Chartered Institute of Public Finance & Accountancy (CIPFA)	Apr-18	Dec-23					
		x				Advisor: CHKS Ltd	Nov-18	Ongoing					
			x			Trustee: Demelza Children's Hospice	Aug-19	Mar-24					
Linda Burke	Non-Executive Director	x				Non-Executive Director: Frimley Health	Apr-22	Apr-25			x		x
				x		Medical Justice Charity	May-20	May-27					
Aman Dalvi	Non-Executive Director	x				Owner: Aman Dalvi Limited - owner	2017	Ongoing		x	x (designate NED)		
		x				Non-Executive Chair: Goram Homes (Bristol)	2019	Ongoing					
		x				Non-Executive Chair: Kensington & Chelsea TMO Residuary Body	2019	Ongoing					
		x				Non-Executive Chair: Aspire Housing (Staffordshire)	Jan-21	Ongoing					
		x				Non-Executive Chair: Newlon HT	Jan-21	Ongoing					
		x				Board member: Old Oak Development Corporation	Mar-22	Ongoing					
Carolyn Downs	Non-Executive Director	x				Senior Advisor: Newton Europe	Sep-23	Ongoing		x	x		
		x				Non-Executive Director: States of Jersey Health and Care Advisory Board	Sep-23	Ongoing					
		x				Non-Executive Advisor / Member: London Policing Board	Sep-23	Ongoing					
Patricia Gallan	Non-Executive Director	x				Non-Executive Director: HMRC	Jul-19	Ongoing	Permanent Secretary HMRC has given formal approval to Patricia's appointment	x			x
		x				Non-Executive Director: Trade Remedies Authority	Jun-21	Ongoing					
				x		Chair of Governors: Drapers' Brookside Infant and Junior School. Member of Drapers Academy Trust (Trustee)	Aug-21	Ongoing					

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		Financial	Non-Financial Professional	Non-Financial Personal	Indirect					CWFT	ICHT	LNWH	THHFT
				x		Council of Queen Mary University of London	Jan-23	Ongoing					
Nick Gash	Non-Executive Director	x				Self-employed: Public Affairs Consultant	2004	Ongoing			x		x
		x				Associate: Westbrook Strategy Ltd	Feb-20	Ongoing					
			x			Trustee: CW+ Charity	2017	Ongoing					
		x				Chair: London North West Advisory Committee for Clinical Impact Awards (ACCIA)	Nov-18	Ongoing					
			x			Chair Audit and Risk Committee: Royal Society of Medicine	Nov-21	Ongoing					
		x				Independent member: Risk and Audit Committee of Office for Students	Feb-24	Ongoing					
					x	Spouse: Member of Parliament for Brent and Isleworth	2015	Ongoing					
Steve Gill	Vice Chair - Chelsea and Westminster NHS FT	x				Owner: S&PG Consulting	May-14	Ongoing		x			x
			x			Chair of Trustees: Age Concern Windsor	Jan-18	Ongoing					
		x				Shareholder: HP Inc	Apr-02	Ongoing					
				x		Member of the Finance and Audit Committee (FAC), Phyllis Court Members Club	Aug-19	Ongoing					
Catherine Jervis	Vice Chair - The Hillingdon Hospitals NHS FT		x			Non-Executive Director: Independent Office for Police Conduct	Jan-15	May-24		x			x
			x			Member of Audit Committee: Camden and Islington Foundation Trust	Jul-21	Ongoing					
		x				Non-Executive Director: Surrey and Sussex Healthcare Trust	Mar-24	Ongoing					
Loy Lobo	Non-Executive Director	x				Owner: Wegyanik Ltd	Apr-14	Ongoing			x	x	
		x				Co-founder and shareholder: Sana Health Solutions Ltd	Apr-14	Ongoing					
		x				Co-founder and shareholder: Healthme.AI	Jul-22	Ongoing					
		x				Non-Executive Director: Essex Partnership University Trust (EPUT)	Mar-21	Ongoing					
		x				Visiting Lecturer: Imperial College Business School	Sep-14	Ongoing					
		x				Member of the Digital Health Council and Past President of the Council: Royal Society of Medicine	Aug-14	Ongoing					
		x				Advisor: No Suffering Ltd	Apr-23	Ongoing					
		x				Advisor: Dama Health Ltd	Apr-23	Ongoing					
		x				Advisor: Juul Labs Inc	Nov-23	Ongoing					
Martin Lupton	Non-Executive Director					Nothing to declare						x	x
Neville Manuel	Non-Executive Director					Nothing to declare				x			x
Ajay Mehta	Non-Executive Director	x				Director and Co-founder: EM4 Ltd	2019	Ongoing		x		x	
Professor Neena Modi	Non-Executive Director (Academic)	x				Employed by Imperial College London	Nov-87	Ongoing		x	x		
			x			Trustee: Academy of Medical Sciences	Dec-20	Dec-23	Approved by Imperial College London				
			x			Trustee - TheirWorld	2019	Ongoing	Approved by Imperial College London				
			x			Trustee - Action Cerebral Palsy	2019	Ongoing	Approved by Imperial College London				
			x			Trustee - David Harvey Trust	2015	Ongoing	Approved by Imperial College London				
			x			Trustee: Keep Our NHS Public	2019	Ongoing	Approved by Imperial College London				

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		Financial	Non-Financial Professional	Non-Financial Personal	Indirect					CWFT	ICHT	LNWH	THHFT
			x			Trial Committee member - Australian National Medical Research Council	2018	Ongoing	Approved by Imperial College London				
		x				Academic Advisory Board - Ministry of Health, Singapore	2022	Due to close in 2025	Approved by Imperial College London				
		x				External Examiner - University of Cambridge Medical School	2021	2023	Approved by Imperial College London				
			x			Academic Advisory Board - Sophia Children's Hospital Foundation, The Netherlands	2021	Ongoing	Approved by Imperial College London				
			x			Governing Board - LKC Medical School, Singapore	Apr-23	Ongoing					
			x			Trustee: Health Prom	2017	Ongoing	Approved by Imperial College London				
Dr Syed Mohinuddin	Non-Executive Director	x				Director: NeoMate Ltd	Jan-23	Ongoing		x		x	
		x				Director: Evolve Coaching Solutions Ltd	Jan-23	Ongoing					
Simon Morris	Non-Executive Director	x				Chair-elect: North London Hospice	Jun-11	Ongoing				x (designate NED)	x
		x				Director: Crisis Homes Ltd	Oct-23						
David Moss	Non-Executive Director (became Vice Chair of London North West University Healthcare NHS Truston 15 February 2024)					Nothing to declare					x (desginate NED)	x	
Sim Scavazza	Non-Executive Director	x				Acting Chair: Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	Apr-23	Ongoing			x	x (designate NED)	
		x				Special Advisor on Race: NHS Providers	Jun-21	31-Mar-24					
			x			Chair: The Seacole Group; BAME NHS Chairs and NEDs	Apr-24	Ongoing					
			x			Member: The Seacole Group; BAME NHS Chairs and NEDs	2021	Mar-24					
				x		Fellow: Royal Society for Arts, Manufacturers and Commerce	2018	Ongoing					
				x		Trustee: Smartworks	May-22	Ongoing					
				x		Trustee: National Saturday Club	Sep-22	Ongoing					
		x				Chair: Office of the Independent Adjudicator	Oct-23	Ongoing					
					x	Spouse: CTO Newcross Healthcare	Aug-21	Ongoing					
Baljit Ubhey	Non-Executive Director					Nothing to declare						x	x
Executive Directors													
Lesley Watts	Chief Executive - Chelsea and Westminster Hospital NHS FT		x			Trustee: CW+ Charity	Apr-18	Ongoing		x			
			x			Director: Imperial College Health Partners	Sep-15	Ongoing					
					x	Daughter: member of staff at Chelsea and Westminster NHS FT	Apr-18	Ongoing					
					x	Son: Director of Travill construction	Apr-18	Ongoing					
				x		Honorary member: Chelsea Arts Club	Aug-23	Ongoing					
Robert Bleasdale	Chief Nursing Officer - Chelsea and Westminster Hospital NHS FT		x			Trustee: CW+ Charity	Apr-22	Ongoing		x			

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Dr Roger Chinn	Chief Medical Officer - Chelsea and Westminster Hospital NHS FT	x				Private consultant radiology practice is conducted in partnership with spouse. Diagnostic Radiology service provided to CWFT and independent sector hospitals in London (HCA, The London Clinic, BUPA Cromwell)	1996	Ongoing		x			
			x			Provide support to The Hillingdon Hospitals NHS FT Executive Team	Aug-20	Ongoing	Current and ongoing as part of NWL Integrated Care System mutual aid				
			x			Trustee of CW+ Charity	Mar-21	Ongoing	4 year term with option to stand for re-election for further 4 years				
Virginia Massaro	Chief Financial Officer - Chelsea and Westminster Hospital NHS FT			x		Director: Cafton Lodge Limited	Mar-14	Ongoing		x			
			x			Member: Healthcare Financial Management Association London Branch Committee	Jun-18	Ongoing					
			x			Finance Director of CW Medicines Limited	Sep-21	Ongoing	CW Medicines Ltd is a wholly owned subsidiary outpatient pharmacy which has been operational from 1 April 2022				
Professor Tim Orchard	Chief Executive - Imperial College Healthcare NHS Trust		x			Professor: Imperial College London	N/A	Ongoing			x		
			x			Member of the Board of the Office for Strategic Co-ordination of Health Research Representing NHS Trusts	Jan-24	Jan-27					
			x			Director: Imperial College Health Partners	Nov-18	Ongoing					
Mr Raymond Anakwe	Joint Medical Director - Imperial College Healthcare NHS Trust	x				Non-Executive Director: East Kent Hospital University NHS FT	May-21	Ongoing. Due to close in June 2024			x		
		x				Self Employed: Imperial Private Healthcare	Jan-13	Ongoing					
		x				Self Employed: Hospital of St John and St Elizabeth Hospital	Jan-13	Ongoing					
		x				Self Employed: Cromwell Hospital	Jan-13	Ongoing					
Claire Hook	Deputy Chief Executive / Chief Operating Officer - Imperial College Healthcare NHS Trust	x				Chartered Director: Hook Medico Legal Ltd	Apr-20	Ongoing			x		
Professor Julian Redhead	Joint Medical Director - Imperial College Healthcare NHS Trust	x				Club Doctor: Chelsea Football Club	2000	Ongoing			x		
		x				Medical Director: Fortius Clinic	2005	Ongoing					
			x			Private Clinic: Imperial College Private Healthcare	2004	Ongoing					
			x			Non-Executive Director: Royal Society Prevention of Accidents	2014	Ongoing					
			x			Secretary: British Association Immediate care (London)	2003	Ongoing					
			x			National Clinical Director: Urgent and Emergency Care	2020	Ongoing					
Professor Janice Sigsworth CBE	Director of Nursing - Imperial College Healthcare NHS Trust		x			Honorary Professional Appointment: King's College London	Jan-13	Ongoing			x		
			x			Honorary Professional Appointment: Bucks New University	Jan-13	Ongoing					
			x			Honorary Professional Appointment: Middlesex University	Jan-00	Ongoing					
			x			Trustee: General Nursing Council Trust	Dec-15	Dec-23					
			x			Clinical Adviser: NMC of Pre-Registration Midwifery Standards	Mar-20	Ongoing					

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		Financial	Non-Financial Professional	Non-Financial Personal	Indirect					CWFT	ICHT	LNWH	THHFT
			x			Chair: Shelford Safer Care Nursing Tool (SNCT) Committee	Sep-18	Nov-23					
			x			Member: Shelford Safer Care Nursing Toot (SNCT) Committee	Nov-23	Ongoing					
			x			Chair: NHSI Safe staffing Faculty Group	Jun-18	Oct-23					
			x			National Professional Lead: Nursing and Midwifery Genomics	Jan-19	Ongoing					
Jazz Thind	Chief Financial Officer - Imperial College Healthcare NHS Trust		x			Non-Trustee Member: Cancer Research UK Audit Committee	Jan-23	Ongoing			x		
Pippa Nightingale	Chief Executive Officer - London North West University Healthcare NHS Trust		x			Trustee: Rennie Grove Hospice Board	Apr-19	Ongoing				x	
		x				Non-Executive Director: Birth Rate+ Midwifery safe staffing	Jun-21	Ongoing					
Jon Baker	Chief Medical Officer - London North West University Healthcare NHS Trust	x				Freelance screenwriter	2019	Ongoing				x	
Simon Crawford	Deputy Chief Executive - London North West University Healthcare NHS Trust		x			Director: Imperial College Health Partners	2018	Ongoing				x	
Lisa Knight	Chief Nursing Officer - London North West University Healthcare NHS Trust					Nothing to declare						x	
Jonathan Reid	Chief Financial Officer - London North West University Healthcare NHS Trust					Nothing to declare						x	
James Walters	Chief Operating Officer - London North West University Healthcare NHS Trust					Nothing to declare						x	
Patricia Wright	Chief Executive - The Hillingdon Hospitals NHS FT				x	Partner works with IMERA.AI	Nov-21	Ongoing					x
Jon Bell	Chief Finance Officer - The Hillingdon Hospitals NHS FT		x			Trustee: Association of Coloproctology of Great Britain and Ireland	Sep-16	Ongoing					x
Tina Benson	Chief Operating Officer - The Hillingdon Hospitals NHS FT				x	Daughter: works as a Paediatric Nurse at The Hillingdon Hospitals NHS FT	Aug-23	Ongoing					x
Sarah Burton	Chief Nurse - The Hillingdon Hospitals NHS FT					Nothing to declare							x
Alan McGlennan	Chief Medical Officer - The Hillingdon Hospitals NHS FT					Nothing to declare							x
Jason Seez	Deputy Chief Executive and Director of Strategy - The Hillingdon Hospitals NHS FT				x	Spouse: Works in NHSE	Feb-19	Ongoing					x
Phil Spivey	Chief People Officer, The Hillingdon Hospitals NHS FT					Nothing to declare							x
Steve Wedgwood	Director of Operational Estates and Facilities - The Hillingdon Hospitals NHS FT					Nothing to declare							x

1.2 MINUTES OF THE PREVIOUS NWL ACUTE PROVIDER COLLABORATIVE BOARD MEETING HELD ON 16 JANUARY 2024 - MATTHEW SWINDELLS

REFERENCES

Only PDFs are attached

1.2 BIC Draft BiC public minutes January 2024 v3.pdf

Chelsea and Westminster Hospital NHS Foundation Trust | The Hillingdon Hospitals NHS Foundation Trust | Imperial College Healthcare NHS Trust | London North West University Healthcare NHS Trust

North West London Acute Provider Collaborative Board in Common
Meeting in Public
Tuesday 16 January 2024, 9.00am – 12noon
The Storey Club, 4 Kingdom Street, London W2 6BD

Members Present

Mr Matthew Swindells	Chair in Common
Mr Robert Alexander	Vice Chair (ICHT) & Non-Executive Director (LNWH)
Mr Stephen Gill	Vice Chair (CWFT) & Non-Executive Director (THHFT)
Ms Catherine Jervis	Vice Chair (THHFT) & Non-Executive Director (CWFT)
Ms Janet Rubin	Vice Chair (LNWH) & Non-Executive Director (ICHT)
Ms Linda Burke	Non-Executive Director (THHFT & ICHT)
Mr Aman Dalvi	Non-Executive Director (CWFT & ICHT)
Mrs Carolyn Downs	Non-Executive Director (ICHT & CWFT)
Ms Patricia Gallan	Non- Executive Director (CWFT & THHFT)
Mr Nick Gash	Non-Executive Director (ICHT & THHFT)
Mr Martin Lupton	Non-Executive Director (LNWH & THHFT)
Mr Neville Manuel	Non-Executive Director (THHFT & CWFT)
Dr Syed Mohinuddin	Non-Executive Director (LNWH & CWFT)
Mr Simon Morris	Non-Executive Director (THHFT & LNWH)
Mr David Moss	Non-Executive Director (LNWH & ICHT)
Ms Baljit Ubhey	Non-Executive Director (LNWH & THHFT)
Ms Pippa Nightingale	Chief Executive Officer (LNWH)
Professor Tim Orchard	Chief Executive Officer (ICHT)
Ms Lesley Watts	Chief Executive Officer (CWFT)
Ms Patricia Wright	Chief Executive Officer (THHFT)
Mr Simon Crawford	Deputy Chief Executive (LNWH)
Mr Jason Seez	Deputy Chief Executive Officer/Director of Strategy (THHFT)
Ms Claire Hook	Chief Operating Officer (ICHT)
Mr James Walters	Chief Operating Officer (LNWH)
Mr Jon Bell	Chief Financial Officer (THHFT)
Ms Virginia Massaro	Chief Financial Officer (CWFT)
Mr Jonathan Reid	Chief Financial Officer (LNWH)
Ms Jazz Thind	Chief Financial Officer (ICHT)
Dr Jon Baker	Chief Medical Officer (LNWH)
Dr Roger Chinn	Chief Medical Officer (CWFT)
Dr Alan McGlennan	Chief Medical Officer (THHFT)
Professor Julian Redhead	Chief Medical Officer (ICHT)
Mr Robert Bleasdale	Chief Nursing Officer (CWFT)
Ms Sarah Burton	Chief Nursing Officer (THHFT)
Ms Lisa Knight	Chief Nursing Officer (LNWH)
Professor Janice Sigsworth	Chief Nursing Officer (ICHT)

In Attendance

Ms Tracey Beck	Head of Communication (LNWH)

Ms Dawn Clift	Director of Corporate Affairs (LNWH)
Mr Kevin Croft	Chief People Officer (ICHT)
Ms Jo Fanning	Interim Chief People Office (THHFT)
Mr Peter Jenkinson	Director of Corporate Governance (ICHT & CWFT)
Mr Raymond Anakwe	
Emer Delaney	Chief Medical Officer (ICHT)
Michelle Dixon	Director of Communications (CWFT) Director of Communications (ICHT)

Apologies for Absence

Ms Sim Scavazza	Non-Executive Director (ICHT & LNWH)
Ms Neena Modi	N Interim Chief People Officer (CWFT)
Ms Lindsey Stafford-Scott	on-Executive Director (ICHT & CWFT)
Mr Ajay Metha	Non-Executive Director (CWFT & LNWH)

Minute Ref		Action
1.0	**Welcome and Apologies for Absence**	
1.0.1	Mr Swindells (MS), the Chair, welcomed everyone to the public Board in Common.	
1.0.2	Apologies were noted from Sim Scavazza, Neena Modi, Ajay Metha and Lindsey Stafford-Scott	
1.1	**Declarations of Interest**	
1.1.1	There were no new declarations of interest raised at the meeting in relation to the agenda items being discussed.	
1.2	**Minutes of the Meeting held on 17 October 2023**	
1.2.1	The Board in Common **approved** the minutes of the Board in Common meeting held on 17 October 2023.	
1.3	**Matters Arising and Action Log**	
1.3.1	The Board noted no outstanding actions from previous meetings	
1.4	**Patient Story**	
1.4.1	The Board welcomed Ian Sinha (IS), Consultant Orthopaedic Surgeon (ICHT) and his patient Mr David Wootton to the meeting. Mr Sinha introduced Mr Wootton as the first patient to be treated at the North West London Elective Orthopaedic Centre (EOC) at Central Middlesex Hospital. Mr Wootton reflected on his experience as a patient going through the EOC for a knee replacement and highlighted that he was offered a date for his surgery very quickly, had felt supported by the anaesthetic team, surgical team and physio as well as noting that the follow up care by the GP practice nurse had been very positive. Mr Wooton noted that whilst he hadn't needed to use it, he was pleased to note the transport service offer to EOC patients. One area that he felt could be improved was the Patients Know Best portal being simplified if possible as he reported that it seemed quite difficult to navigate and a lot of messages had been sent on the portal.	

	Overall, he felt it had been an amazing experience and felt that he had been included and well communicated with throughout the pathway. **The Board in Common thanked Mr Wootton for sharing his experience and were pleased to note his story and feedback.**	
2.1	**Report from the Chair in Common** MS presented his report to the Board in Common highlighting the findings and recommendations arising from the internal audit of the collaborative governance arrangements, noting that there were no significant issues and several areas of work were in progress to develop an Acute Provider Collaborative (APC) strategy, strengthen governance at local trust board level, and improve interaction of committees. MS was pleased to note recent nominations of people, projects and initiatives from within the Collaborative at the recent Health Service Journal (HSJ) annual awards ceremony. MS noted that this was Janet Rubin's last board meeting as Vice Chair of London North West University Healthcare NHS Trust (LNWH), and extended a warm thanks to her for her contributions over the years and wished her the very best for the future. **The Board in Common noted the report.**	
2.2	**Board in Common Cabinet summary** MS presented the report from the meetings of the Board in Common Cabinet since the last Board in Common meeting, highlighting that the Cabinet had approved an urgent amendment to the scheme of delegated authorities to allow the Audit Committees of LNWH and The Hillingdon Hospitals NHS Foundation Trust (THHFT) to sign off their respective charitable annual reports and accounts. The Cabinet also approved the Strategic Outline Case (SOC) for the additional bed capacity project at St Mary's Hospital (ICHT). **The Board in Common noted the report.**	
3.1	**Integrated Quality, Workforce, Performance and Finance report** The Board in Common received and noted the integrated quality, workforce, performance and finance report. Lesley Watts (LW) highlighted that it continued to be a challenging time for the trusts with prolonged industrial action and a challenging winter with increasing demand on the emergency departments. A key focus across the APC remained on urgent and emergency care (UEC) performance and elective recovery. Other key areas of focus included a review into maternity data including the still birth rate at THHFT (the output of the review would be received and discussed at the next Collaborative Quality Committee), PSIRF implementation, diagnostic performance and the impact of industrial action.	

	Board members were pleased to note the improving position of venous thromboembolism (VTE) compliance, with all four trusts meeting the required standard with further improvement expected as a result of the Cerner implementation. **The Board in Common noted the report.**	
4.1	**Collaborative Quality Committee Chair's report** Steve Gill (SG) presented the Chair's report from the Collaborative Quality Committee, highlighting that key areas of focus of the Committee had been the stillbirth rate at THHFT and mitigating actions in place, recent never events at LNWH and CWFT and the Never Events review taking place across the APC to determine whether there were any themes. The Committee had also focused on the Patient Safety Investigation Review Framework (PSIRF) implementation, maternity incentive scheme self-assessments and the impact of industrial action. **The Board in Common noted the report.**	
4.2	**Safeguarding annual report** Pippa Nightingale (PN) presented the annual safeguarding summary report and assured Board members that each Trust had scrutinised their individual safeguarding annual reports at local Quality Committees and each report had been published on the relative Trust websites. All four Trusts were compliant with the national statutory duties and mandatory requirements required to safeguard adults and children. It was noted that there were two new pieces of work taking place nationally which included the implementation of the mandated Oliver Gowen training as well as updated guidance relating to mental capacity and deprivation of liberty (DoLs) which had been delayed in being published but would be implemented by Trusts once received. **The Board in Common noted the report.**	
4.3	**Infection Prevention & Control annual report** Robert Bleasdale (RB) presented a summary of the four Trusts' annual infection prevention and control reports, noting that the annual reports had been reviewed at local Quality Committees and were published on each Trust's website. Board members were assured that all four Trusts were compliant with mandatory requirements in terms of reporting and metrics and improvement work was ongoing. Responding to a query from Carolyn Downs regarding the process that takes place when patients acquire serious harm infections whilst in hospital, RB confirmed that each case is reviewed with a root cause analysis being completed for all healthcare associated infections and agreed to include this information in future reports to the local Quality Committees.	

	The Board in Common noted the report.	
4.4	**Learning from deaths report** Alan McGlennan (AM) presented the report highlighting that each Trusts' quarterly report had been reviewed at local Quality Committees and summarising key themes across the four trusts. Board members were pleased to note the standardised reporting template and noted that work was underway to include data for outstanding metrics in the quarter 3 report. Board members were pleased to note that the mortality rates continued to be lower than, or as expected, when compared nationally, with regular review of these occurring both internally and through the Collaborative Quality Committee. There continued to be low numbers of cases where clinical concerns were identified through level 2 reviews; this aligned with consistently good mortality rates and small numbers of incidents reported overall where the harm to patients was confirmed as severe of extreme/death. It was noted that work to improve care at the end of life, a consistent theme across most quarters, continued with local actions in place and joint work through the APC quality priority work stream. **The Board in Common noted the report.**	
4.5	**Maternity incentive scheme plan for submission** RB presented the report noting that each Trust was required to submit its compliance against the safety actions for year 5 of the Maternity Incentive Scheme (MIS) to NHS Resolution on 1 February 2024. All Trusts were compliant or on track to be compliant by year end apart from(THHFT), who were reporting non-compliance against safety action 8 relating to evidencing that the maternity unit staff groups have attended as a half day 'in house' multi-professional maternity emergencies training session. Patricia Wright (PW) confirmed that the service was reviewing the December position and evidence of training completed by staff at other Trusts prior to starting at THHFT. Board members noted that submission sign off had been delegated from the Board in Common to Trust Quality Committees. **The Board in Common noted the report.**	
5.1	**Collaborative People Committee Chair's report** Janet Rubin (JRu) presented the report and was pleased to highlight that the vacancy rate across the APC was below the target of 10% and had been steadily reducing over the year; this had been a result of targeted recruitment campaigns both at home and abroad with a continuing focus to drive further improvement particularly in hard to fill vacancies. Board members noted the 'Scaling Up' programme work being led by the Chief People Officers which aimed to reduce variation and enable a sustainable run rate going into the new financial year.	

	Flu and Covid vaccination uptake remained a challenge for the Trusts within the APC (though it was noted that this was an issue nationally) and was a particular area of focus for the Committee. **The Board in Common noted the report.**	
6.1	**Collaborative Data and Digital Committee Chair's report** SG presented the report highlighting that the Committee had focused on the potential risk relating to the ICT capital programme and insufficient investment on infrastructure. The Committee also focused on reviewing the data and digital priorities including a focus on EDI priorities. An update on the digital and data related risks across the APC had also been requested to ensure that there was granularity to fully understand the common risks and those that arise as a result of the collaborative across North West London APC. Further work to refine and clarify controls, mitigations, target scores and risk appetite, would be undertaken. **The Board in Common noted the report.**	
6.2	**Cerner 'go live' update** Simon Crawford (SC) presented the update highlighting that the implementation of Cerner at LNWH and THHFT had broadly been successful and Board members noted the anticipated significant benefit for patients across all four Trusts now that there was a single Electronic Patient Record (EPR). The two Trusts were going through a stabilisation period between now and 31 March 2024 with the aim of returning to steady state in terms of activity and then formally closing the programme and transitioning to business as usual. Board members noted the post go-live challenges following the deployment included training support, workflow issues and medical device integration but were assured that work to mitigate the risk of these issues was in hand. The Board congratulated the team for the implementation phase and noted that benefits to patients across the APC. **The Board in Common noted the report.**	
7.1	**Collaborative Estates and Sustainability Committee Chair's report** Bob Alexander (BA) presented the report highlighting that the Committee had received an update on the green plans and sustainability plans including key achievements as well as an update on the APC estates strategy work. The Committee had also reviewed the first iteration of a working document to be regularly considered by the Executive Strategic Capital and Estates Group for onward submission to the Committee, to give insight into the key elements of the current capital programme. The Committee had commissioned some work to develop a pipeline of capital projects and to confirm the approval process for business cases, to allow the Committee to have input into APC business cases. **The Board in Common noted the report.**	

7.2	**Elective Orthopaedic Centre (EOC) update** Board members were pleased to note the successful initial implementation of the EOC and opening of the first three theatres on 4 December 2023. The current period from December 2023 to February 2024 was being used to gain partner confidence, resolve any teething issues and complete all activities required for the shift to full capability (five theatres) by the end of March 2024. A key focus was on theatre scheduling to ensure that the theatres are fully utilised; this was being monitored through the APC Executive Management Board. Board members were particularly pleased to note the transport provision provided to patients and responding to a query from Catherine Jervis (CJ) regarding whether the transport provision was adequate to meet the demand when the centre was at full capacity, Mark Titcomb (MT) confirmed that he was confident with the service provision, which was frequently reviewed including patient feedback. The Board in Common congratulated the team on the successful opening of the EOC and extended thanks to the members of the public that had been involved in the stakeholder engagement and design of the service. **The Board in Common noted the report.**	
8.1	**Collaborative finance and performance committee Chair's report** CJ presented the report highlighting the focus on operational performance particularly around diagnostics, urgent and emergency care, cancer and elective recovery. In terms of finance, the Committee had focused on financial recovery and the deterioration in the overall position given the plans submitted in November 2023. The Committee commissioned an extraordinary meeting to take place at the end of January 2024, to look at the forecast end of year position plus the underlying position and impact for 2024/25. Board members discussed the North West London Procurement update noting that there was increasing concern around the performance of the service and its challenges in meeting its Cost Improvement Plan (CIP) delivery plan for 2023/24; a report would be reviewed by the Committee at the next meeting with a focus on actions being taken to improve performance. **The Board in Common noted the report.**	
8.2	**Financial performance report** Jonathan Reid (JRe) presented the finance report noting that at the end of month 8 the APC was reporting a deficit of £52.3m against a year to date deficit plan of £16.3m, thus reporting a £36.m adverse variance to plan. Board members noted the work commissioned by the Collaborative Finance and Performance Committee regarding CIP delivery. Tim Orchard (TO) highlighted that all four trusts would be using TrakIt, a platform to log and track CIPs and this would deliver greater consistency across the APC.	

	The Board in Common noted the report.	
9.1	**Reports from Trust Audit Committees** The Board in Common received the reports from the most recent Trust Audit Committees. Neville Manuel (NM) noted that the THHFT Audit Committee had received an update on progress against the external audit recommendations following the 2022/23 audit. **The Board in Common noted the reports.**	
9.2	**Proposed response to the review of APC governance arrangements** Peter Jenkinson (PJ) noted that the APC had commissioned the two internal audit providers across the four trusts to conduct a review of the collaborative governance arrangements a year after the formation of the APC. Board members agreed that the review had been a helpful reflection of the arrangements in place, noting that the governance model would continue to evolve and agreeing with the recommendations for improvement (the development of a APC strategy, the strengthening of local trust board level governance, and the establishment of a APC risk management approach). Nick Gash (NG) reflected that as part of the work to develop an APC risk management approach, the introduction of an APC level risk committee should be considered. It was noted that next steps would be to focus on the areas of improvement at upcoming board development sessions with a formal response coming back to the Board in Common in July 2024. **The Board in Common noted the report.**	
10.1	**Executive Management Board summary report** Tim Orchard presented the first summary report from the Acute Provider Collaborative Executive Management Board (APC EMB) meeting held in December, highlighting that the meeting had been established in July 2023. Key areas of focus for the EMB included performance reporting, updates and assurance on APC projects such as the Elective Orthopaedic Centre, Ophthalmology services and the Cerner implementation as well as business planning, staffing and the development of the APC strategy. **The Board in Common noted the report.**	
10.2	**Reports from the Chief Executive Officers** <u>London North West University Healthcare NHS Trust</u> PN extended thanks to all staff for their contribution and support during times of industrial action and was pleased to note the recent EDI festival which highlighted work around the EDI agenda at the Trust, particularly the launch of the staff inclusion network. PN highlighted that the North West London Urology Centre had opened at the Northwick Park Hospital site in November and initial feedback had been extremely positive.	

	PN thanked Janet Rubin for her contribution as Vice Chair and to David Moss for taking on the Vice Chair role following Janet's departure. <u>Chelsea and Westminster Hospital NHS Foundation Trust</u> LW highlighted the recent staff awards that had been held to recognise the tremendous efforts of staff over the year particularly during times of industrial action and increasing demand going into winter. LW also highlighted recent achievements in research and innovation and individual staff achievements and awards. <u>Imperial College Healthcare NHS Trust</u> TO reflected that it had been a particularly challenging winter and was pleased to note that elective performance for month 9 had reached 107% which was largely reflective of improved theatre efficiency; TO thanked theatre staff for their support in achieving this. Key staff changes included a new Director of Estates and Facilities, Eric Munro, and Claire Hook had been appointed as Deputy Chief Executive alongside her role as Chief Operating Officer. TO highlighted exciting achievements in research and innovation and was pleased to note that work to obtain planning for the redevelopment of the St Mary's Hospital site was now in progress. TO extended thanks to Janet Rubin for her contribution as a non-executive director on the ICHT board. <u>The Hillingdon Hospitals NHS Foundation Trust</u> PW extended thanks to trust staff for their support during a challenging year and was pleased to note that the Trust had moved from NOF 4 to NOF 3. PW thanked Jo Fanning who had recently left the Trust and noted that an interim chief people officer would be in place for 12 months from 5 February 2024. **The Board in Common noted the reports.**	
11.0	**Questions from members of the Public**	
11.1	The Board in Common noted that questions were received in advance of the meeting. MS summarised the questions and asked members of the Board to provide answers, noting that written responses would be provided on the NWL Acute Provider Collaborative website.	
11.2	The Chair drew the meeting to a close and thanked the Board and members of public for joining the meeting.	

1.3 MATTERS ARISING AND ACTION LOG - MATTHEW SWINDELLS

1.4 PATIENT STORY - ENT PATHWAY - PATRICIA WRIGHT

2.1 REPORT FROM THE CHAIR IN COMMON - MATTHEW SWINDELLS

REFERENCES

Only PDFs are attached

2.1 BIC Chairs Report to the Board in Common 16 April 2024 final.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 2.1
This report is: Public

NWL Acute Collaborative Chairs Report

Author: Matthew Swindells
Job title: Chair in Common

Accountable director: Matthew Swindells
Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

The Board in Common is asked to note the report.

Report history

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

N/A

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

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

Strategic priorities

Tick all that apply

☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity
☒ Support the ICS's mission to address health inequalities
☒ Attract, retain, develop the best staff in the NHS

☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
☒ Achieve a more rapid spread of innovation, research, and transformation

Click to describe impact

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

1. Appointments and Recruitment

1.1 I would like to begin on behalf of the Board by thanking Neville Manuel who is stepping down this month at the end of his term. Neville has been a Board member at The Hillingdon Hospitals NHS Foundation Trust (THHFT) for the last three year and at Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) since September 2022. He has contributed hugely to those two trusts and to the Acute Provider Collaborative (APC), in particular bringing valuable insight as Chair of audit at THHFT and across the wider APC.

1.2 I am delighted to welcome Loy Lobo officially on to the Board in Common, who has joined as NED at LNWH and ICHT in February; this will be his first Board meeting with us. I am also very pleased to announce Vineeta Manchanda will be joining the North West London Acute Provider Collaborative from 1 May 2024. Vineeta will be a Board member for THHFT, where she will chair the Audit Committee, and a Board member for CWFT, where she will be a member of the Quality and Safety Committee and the Finance and Performance Committee. Loy and Vineeta bring an enormous range of NHS and industry experience to the APC. David Moss has started his new role as Vice Chair at LNWH.

2. The Acute Provider Collaborative

2.1 The NHS planning guidance was published by NHS England at the end of last month, 3 months later than usual, which means the deadline to submit our Business Plans is in May this year. In the papers for today's Board meeting you can see the latest iterations of the plans which show the work and preparation the teams across the four Trusts have been diligently doing so we can actively start 2024/25 in the best position to deliver our operational, financial and business plans from the start of the year.

2.2 It is an important time in the year, where we take stock and look back at what we have collectively achieved in the past twelve months. We have made great strides not just in our individual Trusts but across the Acute Provider Collaborative (APC) where we have improved in many areas in often challenging circumstances. Which is thanks to the hard work and dedication of all our staff and volunteers across the APC.

2.3 Following on from last year, we have again delivered more elective activity compared to pre-COVID levels; despite a challenging winter and an increase in demand we have improved our A&E performance across the board and in some Trusts delivered amongst the best performance in London; and we continue to provide one of the safest acute hospital care, as measured by the Summary Hospital-level Mortality Indicator, of any ICS in England. The Trusts continue to support each other to optimise acute care across North West London (NWL), to reduce the waiting list for patients on our long waiting pathways. A new patient safety incident response framework (PSIRF) is being implemented across the four Trusts with a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and delivering improvement.

2.4 Over the last year two Community Diagnostic Centres (CDC) have opened across the APC in Willesden and Wembley, with a third CDC due to open at Ealing in June. These centres will increase diagnostic test capacity across NWL. There has been plenty of capital activity over 2023/24 and going forward across our 12 sites, examples of these are, the major refurbishment of the Western Eye was completed last summer; the Modular Unit for an A&E ward at Northwick Park Hospital is nearing completion. The Treatment Centre refurbishment at Chelsea Hospital and the Ambulatory Diagnostic Centre (ADC) at West Middlesex Hospital are both now underway.

2.5 The governance model for the APC has been a good mechanism for encouraging and strengthening collaborative working between the Trusts, in particular allowing Trusts to focus on standardising and improving working practices for the benefit of patient outcomes. The internal audit review of the collaborative governance arrangements, completed in November 2022, concluded that the governance model for the Collaborative is operating appropriately overall to enable the individual Trust Boards to fulfil their required duties, but highlighted some areas for improvement to the existing model.

2.6 These included ensuring individual Trust issues are discussed adequately and improving reporting and risk management. A proposal is coming to today's BiC for each Trust Board to delegate authority for the establishment of a Standing Committee of the Trust Board. The standing committee will provide an opportunity for each Trust Board to consider Trust performance, issues and risks, and receive assurance from executive directors, across all domains, and to provide assurance to the Trust Board, meeting in public as the Board in Common, that local issues and risks are being managed**.**

2.7 The review also identified the need for the APC to formally set its strategic direction, which we had already given some thought to and have now started this work to look at areas where we can work more effectively at scale together. We are engaging with staff and patients across NWL to develop a shared strategy, which as an APC will focus our partnership over the next three years, setting out clear goals for what we would like to achieve together. The aim is for the APC strategy to come to July BiC.

3. Elective Orthopaedic centre (EOC)

3.1 NWL EOC activities have continued at pace to prepare for the shift to full capability from mid-April 24 as planned. This will provide two additional operating theatres (making a total of 5 theatres), a new 10 bedded recovery area and expanded ward and staff facilities; these new spaces were handed over from the contractor as scheduled on 28 March 2024.

3.2 Patient experience and feedback has been very positive with patients commenting specifically on the high quality of service with specific positive feedback on the flow of care during their admission, being kept well informed throughout the pathway, staff being attentive and helpful, and with overall satisfaction with the facilities. Over 110 patients have responded to the Friends and Family Test (FFT) survey with the overall positive rating being 95.8%. Additionally, no transport issues have been reported and the EOC patient pathway team are checking to ensure every patient is offered support in accordance with the designed transport plan.

3.3 The EOC focus is now on a safe transition to full delivery, ironing out the remaining teething issues of patient scheduling to improve overall productivity and welcoming the first partner surgeons from THHFT, who will use the centre for the first time, from early April. The official opening of the centre at Central Middlesex Hospital is scheduled for 13 May 2024.

4. Staff Survey Results

4.1 On the 7 March 2023 NHS staff survey results were published, they provide excellent insight into where our people think we are doing well and where we need to do better. There are plenty of learnings to take out of the staff survey and much more work to do, but there has been significant improvements in all areas across the four Trusts. Congratulations all round. The Chief Executive reports go into more detail on the individual trusts results.

5. Redevelopment

5.1 THHFT were delighted to welcome the Secretary of State for Health and Social Care, Victoria Atkins, and local MP Steve Tuckwell to Hillingdon Hospital on 22 February 2024 for a presentation on the case for change and the new hospital plans as well as a tour of Hillingdon Hospital, which included meeting with staff and patients on Kennedy Ward. The visit provided our guests with a first-hand view of why a new, state-of-the-art hospital that is fit for the future is so critical.

5.2 THHFT are now in year four of a comprehensive five year enabling and decant plan to clear the site for the onward construction of the new Hillingdon Hospital. The appointed Principal Supply Chain Partner, GRAHAM, is continuing to oversee the remaining projects in the enabling and decant programme, which remain on track to deliver a cleared site for the new facility by the end of 2025. Alongside this, civil engineering works for the incoming power supply for the new hospital are progressing well and are expected to conclude in May 2024.

5.3 The THHFT Redevelopment Communications and Engagement team have produced a new video featuring staff, patients and local people talking about how important it is to build a new Hillingdon Hospital. The video is the first of a series of short videos that we will be publishing of people across the community in Hillingdon talking about why a new hospital is needed and how they are looking forward to the plans. The video can be viewed here: Hillingdon Voices - What a new Hillingdon Hospital means to you - YouTube. The team will continue to work closely with our local communities as plans for the new Hillingdon Hospital progress.

5.4 THHFT are continuing to work closely with the New Hospital Programme (NHP) team to agree the next steps for the business case for the new hospital. This will be informed by the latest version of NHP's Programme Business Case, which is due to be considered by the Treasury at the end of April 2024.

5.5 ICHT are continuing to progress their redevelopment plans, with the support of NHP are now waiting for a decision on funding to progress to full design and planning stages for the new St Mary's hospital. Also in the New Hospital Programme are the Charing Cross Hospital and Hammersmith Hospital major refurbishment and expansion schemes which are on track to submit first-stage business cases shortly.

6. THHFT Maternity

6.1 CQC inspected Hillingdon Maternity Services in August 2023 as part of a nationwide maternal services inspection programme. The inspection report was published on 14th February 2024. The service received a rating of 'Requires Improvement' for maternity services with both 'Safe' and 'Well Led' domains rated as 'Requires Improvement'. We have been reviewing our Maternity Improvement Plan in light of this and further details can be found in the THHFT Chief Executive's report.

7. Patient-Led Assessments of the Care Environment (PLACE)

7.1 Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. PLACE assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability.

7.2 THHFT scored really well in the latest assessments, it was the top Acute Trust in the country with the best (patient) food score and ranked fourth in the Acute Trusts for best cleanliness score. ICHT also came fifth in the Acute Trusts for best cleanliness score. Excellent work by the teams in achieving this recognition.

8. Fit and Proper Person Test (FPPT) requirements

8.1 NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

8.2 The framework introduces a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC

8.3 As Chair of each Trust, I am responsible for ensuring that each organisation conducts and keeps under review a FPPT to ensure board members are, and remain, suitable for their role. The Governance and HR teams have been working on assessing all Board members of the BiC to ensure we have the proper checks and information on file ahead of the NHSE submission later this year.

2.2 BOARD IN COMMON CABINET SUMMARY - MATTHEW SWINDELLS

REFERENCES

Only PDFs are attached

2.2 BiC Cabinet Committee Summary 13 Feb and 19 March 2024 v1.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 2.2
This report is: Public

Board in Common Cabinet – Committee Summary

Author and Job Title: Philippa Healy, Business Manager

Accountable director: Matthew Swindells
Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

This paper provides an update on items discussed at the Board in Common Cabinet held on 13 February and 19 March 2024.

Report history

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

Board in Common Cabinet 13/02/2024 What was the outcome?	**Board in Common Cabinet** 19/03/2024 What was the outcome?	Committee name Click or tap to enter a date. What was the outcome?

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

The Board in Common are asked to note the following decisions made by the Board in Common Cabinet.

1. Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) – Ambulatory Diagnostics Centre Equipping – Outline Business Case

1.1 Members of the CWFT Board approved the outline business case for capital investment to equip the new Ambulatory Diagnostic Centre (ADC). The case was submitted to the BiC Cabinet in order to meet the programme timeframes for concluding the major medical equipment procurement. The paper was previously presented and approved by CWFT's Capital Planning Board and Finance and Performance Committee.

2. Imperial College Healthcare NHS Trust (ICHT) – Food supply contract award

2.1 Members of the ICHT Board approved the direct award to the incumbent supplier for the supply of food consumables. The paper was previously presented and approved at ICHT's Finance, Improvement and Operations Committee.

3. The Hillingdon Hospitals NHS Foundation Trust – Energy Generation Centre (incinerator) Lease and Operating Contract

3.1 Members of the THHFT Board approved the signing of the lease agreement and operating contract for the energy generation centre. The paper was previously presented and approved at THHFT's Finance and Performance Committee.

Executive summary and key messages

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

The key items to note from the Board in Common Cabinet meeting held on 13 February and 19 March 2024 were:

4. CEO Update on significant issues including the performance report by exception

4.1 Chief Executives gave an update on significant areas/issues within their respective Trusts. This included:

CWFT

- The Treatment Centre contract had been circulated to CWFT Board members for approval, via e-governance. Following legal advice on the change of contractors, members of the CWFT Board approved the contract award and the Trust were preparing to sign the contract. Feedback had been provided to NHS England (NHSE).

ICHT

- The short-form business case for St Mary's Hospital redevelopment was under consideration at the National Hospitals Programme. Feedback was awaited.
- Two never events had been reported with no harm to patients on either occasion and lessons learned considered.
- Two overseas hospitals had recently joined Imperial College Healthcare's International Affiliate Network.

THHFT

- The BiC Cabinet received an update, following a meeting immediately prior with Board members of THHFT, around maternity services. Assistance was being provided from within the Collaborative to provide additional expertise and draw on the improvement work undertaken by LNWH.

LNWH

- The Trust received notification from the national team, in recognition of the sustained improvement around maternity, that it had been stepped off the Maternity Safety Improvement Programme. Internal tracking would continue.

5. Acute Provider Collaborative Executive Management Board

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

6. Acute Provider Development / Board in Common Development Session

6.1 The draft agenda and focus of the Board in Common development session in February 2024 was discussed. The focus of the session would be around the development of the Acute Provider Collaborative strategy and business planning.

7. Business Planning

7.1 Business planning guidance was awaited from NHSE, however Trusts continued to undertake business planning for 2024/25.

8. APC Governance arrangements

8.1 Following the internal audit review, commissioned by the Acute Provider Collaborative around its governance structure, a number of options had been considered to strengthen local oversight and engagement while maintaining the core principle of the APC. The Board in Common Cabinet discussed the preferred option ahead of further socialisation with all Board members, noting that any change to the governance arrangements would be approved by all four Trust Boards.

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

3.1 INTEGRATED QUALITY, WORKFORCE, PERFORMANCE AND FINANCE REPORT - PATRICIA WRIGHT, PIPPA NIGHTINGALE, LESLEY WATTS

REFERENCES

Only PDFs are attached

- 3.1 BIC IQPR cover sheet.pdf
- 3.1a BIC Performance Report - February_Final(8.4.24).pdf

Chelsea and Westminster Hospital NHS Foundation Trust
The Hillingdon Hospitals NHS Foundation Trust
Imperial College Healthcare NHS Trust
London North West University Healthcare NHS Trust

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 3.1
This report is: Public

Integrated Performance Report

Author: Pippa Nightingale, Tim Orchard, Lesley Watts, Patricia Wright
Job title: Chief Executive Officers

Accountable director: Pippa Nightingale, Tim Orchard, Lesley Watts, Patricia Wright
Job title: Chief Executive Officers

Purpose of report

Purpose: To provide assurance that performance across the quality, workforce, core operational standards and financial metrics are being monitored and that appropriate action is being taken to assess variance from agreed standards.

The Board in Common is asked to note the report.

Executive summary and key messages

This report provides the Board in Common with an overview of the performance of all four Trusts against key quality, workforce, core operational standard and financial metrics.

The aim is to produce a consolidated integrated performance report for the acute collaborative that provides assurance that the individual trusts and the acute collaborative are providing high quality, safe and effective care, and that in doing so due consideration has been given to the experience of its workforce and population served and to the use of resources.

The information in this report brings together the information covering a range of indicators that have been drawn from the Trust integrated performance reports and agreed by the lead Chief Executive for each area of performance and highlights areas of good practice and areas of concern. Financial performance is also now included in the pack as well as in separate reports.

This report reflects performance data at Collaborative level for month 11 (month 10 for some metrics). Trust level performance data is available on each of the four trust's website:

ICHT: https://www.nwl-acute-provider-collaborative.nhs.uk/publications
LNWH: London North West University Healthcare NHS Trust | Quality and performance
CWFT: Chelsea and Westminster Hospital NHS Foundation Trust | Quality and performance
THH: https://thh.nhs.uk/performance

Strategic priorities

Tick all that apply

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

Impact assessment

Tick all that apply

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

Reason for private submission

Tick all that apply

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

N/A

NHS
North West London
Acute Provider Collaborative

Integrated Performance Report

February 2024 data

(Cancer, Maternity & Op Plan Performance = January 2024)

received by EMB and BIC April 2024

Integrated Performance Report - Summary

Introduction:

This report provides an overview of performance across the APC for month 11 with some lag indicators reporting at month 10. Over the months, the SMEs have refined the indicators, to provide assurance to the Executive and Board in the four areas of quality, workforce, performance and finance and further refinement will occur in Q4 to determine the shape and content of the report in 2024-25.

Performance:

Overall, performance is stable or improving across the majority of the ‘scorecard’ at APC level, although there is still some variation at individual trust level. Plans are in place to improve trajectories and work is underway, where relevant, to explore further what is driving variability.

All trusts have maintained performance despite industrial action, winter pressures and the introduction of Cerner at LNW and THH and there has been continued focus on improving financial performance. Urgent and emergency care has had increasing focus at a national level and performance across the APC is on an upward trajectory, exceeding the 76% in February 2024.

Escalation:

No specific areas to escalate this month other than the ongoing winter pressures.

Layout of the KPI slides

TREND

This quadrant shows time series data for an agreed sentinel indicator with the data amalgamated at **collaborative level**

Where there is a clear national or local performance target, run charts are used and, where possible, comparative performance at London and National level will be included on the chart

NARRATIVE

The narrative includes commentary on Performance; the Recovery Plan to tackle any shortfall; Improvements made since the last report and a forecast view on risk to delivery

CURRENT PERFORMANCE

This quadrant shows the **current month data by trust** for a range of related metrics, presented as a table with 'off track' performance highlighted

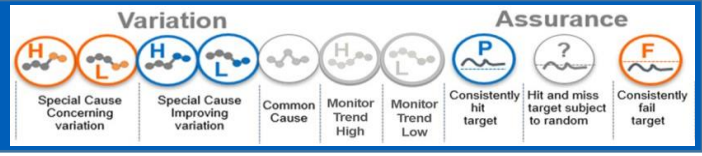
STRATIFICATION

This section provides more granular detail under the specific metric/metrics. This section is under development.

GOVERNANCE

The governance section notes the Senior Responsible Owner for performance, the committee responsible for managing delivery and the data assurance processes in place to confirm the reported performance is accurate

Balanced Scorecard (NOTE: Maternity metrics are reported separately currently)



Quality	Expected	Actual	Trend	Assurance
Reporting rate of patient safety incidents per 1000 bed days	≥54.9	55.44		
Serious Incidents	n/a	0.14		
Patient safety incidents with severe/major harm	<0.26%	0.23%		
Patient safety incidents with extreme harm/death	<0.14%	0.06%		
Healthcare Associated c. Difficile Infections	n/a	18		
Healthcare Associated E. coli blood stream Infections	n/a	36		
Healthcare Associated MRSA blood stream Infections	0	1		
Formal complaints received per 1000 WTE	n/a	7.23		
Good experience reported by inpatients	≥94%	95.5%		
Good experience reported for maternity services	≥90%	89.3%		
Good experience reported for emergency depts.	≥74%	87.1%		
VTE Risk Assessments Completed	≥95%	95.8%		

Performance	Expected	Actual	Trend	Assurance
Ambulance handover waits	≥90%	85.4%		
Waits in urgent and emergency care > 4 hours	≥76%	77.9%		
Waits in urgent and emergency care > 12 hours	≤2%	4.1%		
Referral to treatment waits > 52 weeks	≤2%	3.5%		
Access to diagnostics > 6 Weeks	≤5.0%	15.0%		
Access to cancer specialist < 14 days	≥93%	80.4%		
Access to Cancer Care (Faster Diagnosis) < 28 days	≥75%	72.0%		
Cancer First Treatment from Diagnosis < 31 days	≥96%	92.4%		
Referral to Cancer Treatment Pathways < 62 days	>85%	72.7%		
Theatre Utilisations (Hrs)	>85%	83.5%		
Outpatient Transformation - PIFU	>5%	3.5%		
Critical Care – Unoccupied Beds	≤85%	95.4%		

Workforce	Expected	Actual	Trend	Assurance
Vacancy Rate	≤10%	8.4%		
Voluntary Turnover Rate	≤12%	10.4%		
Sickness Absence Rate	≤4%	4.1%		
Agency spend	≤2%	2.2%		
Non-medical appraisals	≥95%	90.2%		
Core skills compliance	≥90%	91.9%		

Finance	Expected YTD £m	Actual YTD £m	Variance YTD £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m		
Financial Delivery (I&E)	(13.8)	(35.2)	(21.3)	0	0	(0.5)		
Financial Delivery (CIP)	109.0	79.6	(29.5)	119.5	119.5	0		
YTD Capital Spend - £m	214.6	185.7	29.0	262.4	260.4	2.0		
Elective Over/Under Performance £m YTD	0	37.0	37.0	0	n/a	n/a		
CWA (Cost weighted Activity) YTD	100%	98%	-2%	100%	n/a	n/a		

Quality/Clinical Performance

Safety Summary

Introduction: The quality metrics and reporting methodology were agreed following review of the trust board scorecards, national guidance and CQC insight reports. This data pack contains charts showing the trend over time at acute provider collaborative (APC) level for each metric, with in-month and rolling 12-month data for each trust. National and regional benchmarks have been added, where available, to aid comparison.

Performance:

- Performance at APC level is similar to previous months. In February, standards (where they exist) were met for the majority of metrics. Mortality rates and harm levels remain low, and the incident reporting rate is increasing which is positive. Our patient experience 'FFT' results are consistently above national and London averages.
- Trusts are transitioning from reporting SIs to the PSIRF (patient safety incident response framework) which is differentially impacting on the number of Sis being reported. The processes are being piloted within each trust at different scale and pace as per their local implementation plans. As we move forward, we will develop different metrics which are more outcomes focused, including patient/family involvement and engagement in the process which will be a better marker of how successfully we are embedding the framework.
- There were two never events in month, one at ICHT and one at LNW. Across the APC we have reported 11 never events since January 2022. The majority of these (n=7) were related to invasive procedures. Implementation of the new national safety standards for invasive procedures (NatSSIPs2) has been confirmed as an APC quality priority for 2024/25, which will support collaborative improvement in this area.

<u>Areas where we are consistently adverse to target include</u>:

- IPC: all trusts are above the annual thresholds for the three mandatorily reportable healthcare associated infections included in this dashboard. Increases are being seen nationally. Bed day rates will be included from next month to allow additional comparisons and benchmarking. All cases are reviewed locally with action taken where there are specific increases and learning feeding into on-going improvement plans. The APC priority work stream is considering challenges and opportunities for learning within the acute setting, with the current focus on C. difficile. A review of all MRSA BSI cases will feed into the workstream to support identification of collective action in response to the recent increase. Data shows that three quarters of E.Coli BSIs occur before people are admitted to hospital; improvement is therefore being undertaken at ICS level with a focus on reducing catheter associated urinary tract infections.

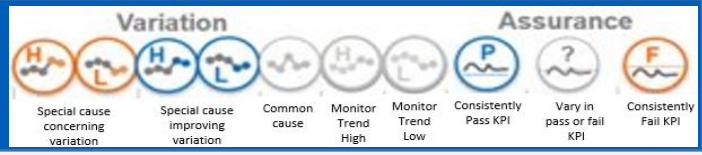
Key Actions: All areas of variance in the data are being managed with action plans in place to support improvement. There are examples where areas of variance align to the agreed quality priority work streams and where the actions planned will drive further improvement across the APC. Current actions include:

- Continued focus on the implementation of 'Learn from patient safety events' (LFPSE), which replaces the NRLS and will provide opportunity for improvements in incident reporting rates, including training and communications. The required Datix upgrades are progressing with 2 trusts transitioning in April and the remaining 2 as soon as possible. Implementation of the new incident management system, once the procurement process has been completed (expected January 2025), will support standardisation of processes and ensure the system is as user-friendly as possible. Staff regularly feedback that current systems are barriers to reporting.
- Monthly workshop sessions are in place with complaints leads to review and harmonise metrics and identify areas for joint work. Work is underway to jointly re-tender for patient survey platforms which will include wider thinking on capturing patient feedback. Linked to this, work is continuing to explore the potential for rolling out Imperial College natural language analysis tool for FFT which will provide greater granularity of feedback and enable better targeting of improvements.
- All Trusts are investigating variations between observed and expected deaths by diagnostic group. Reviews undertaken in quarter three were presented to the APC mortality surveillance group in March and are summarised in the quarterly learning from deaths reports to APCQC and BiC. No new risks or themes were identified.
- A review of SIs declared between January –December 2023 across the APC, encompassing incidents reported with a harm level of severe or extreme and never events, was presented to APC EMB in March. The review confirmed that themes are consistent with the trusts' Patient Safety Incident Response Plans (PSIRPs), which align in most cases to the APC quality priorities and have been used to inform each trust's local quality and safety priorities for 2024/25. As outlined above, the implementation of NatSSIPs2 has been confirmed as a new APC quality priority. The project initiation document for this new workstream will be presented to the June APCQC.
- A review of the APC quality priorities has commenced in line with annual governance processes. The focus of many of the existing priorities are to standardise data collection and reporting to allow focus and comparison to support improvement within each trust and then at APC level where appropriate. Progress has been variable with some now able to transition to business-as-usual reporting and others with more work required. Rather than remaining as standalone priority workstreams we are aiming that those which are ready will now have their key metrics and improvements tracked through this dashboard. Metrics are being finalised for inclusion to allow this.

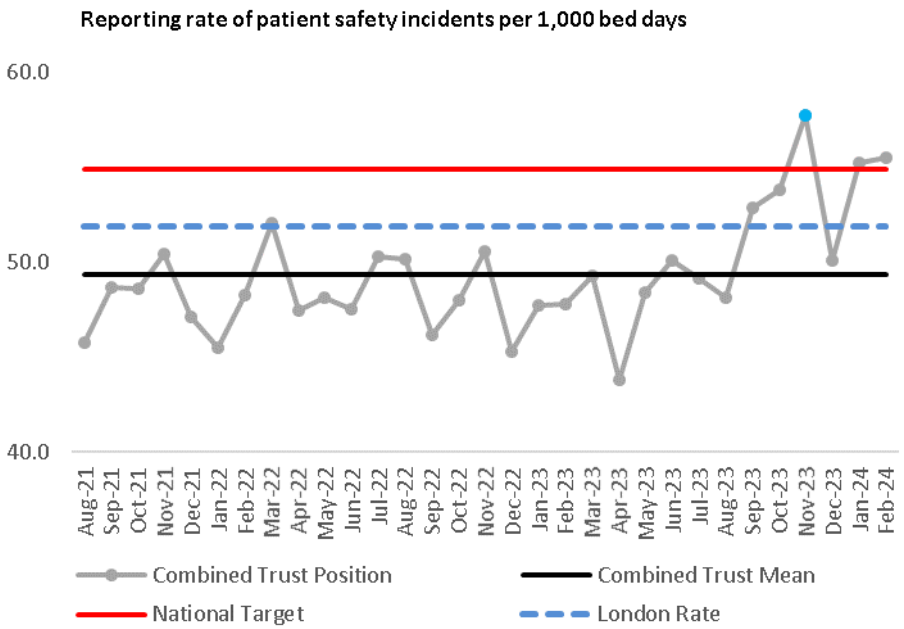
Escalations by Theme: Continued workforce and operational pressures, including industrial action, may result in an increase in incidents causing harm to patients, including those waiting for treatment, and have a negative impact on patient experience. Trusts have robust plans in place to manage the pressures.

Patient Focus

(Patient) Patient Safety Incidents



TREND



≥54.9

STANDARD

55.44

PERFORMANCE

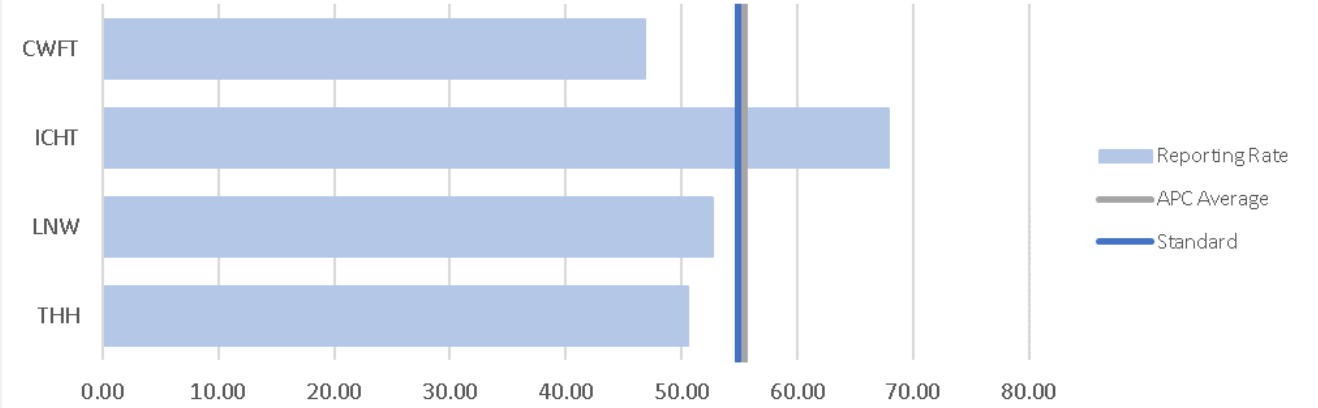
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total bed days	Reporting Rate	Difference from Standard	Patient Safety Incidents	12 Month Rolling Reporting Rate
CWFT	25,717	46.86	-8.04	1,205	43.81
ICHT	28,986	67.89		1,968	64.52
LNW	29,134	52.65	-2.25	1,534	46.16
THH	11,899	50.51	-4.39	601	45.97
APC	**95,736**	**55.44**		**5,308**	**51.14**

STRATIFICATION



NARRATIVE

Performance: In February, the patient safety incident reporting rate per 1,000 bed days was above the standard at APC level (a positive measure of safety culture). This is primarily due to the high reporting rate at ICHT, although both THH and LNW have seen increases over the last two months which is positive. Each trust reviews incidents in detail through their quality governance framework with no risks or new issues to escalate to the board.

Recovery Plan: Trusts are currently focused on the implementation of LFPSE, which replaces the National Reporting and Learning System (NRLS), which is providing opportunity for training and communications to encourage reporting. The Datix upgrades to allow transition are now progressing. Two trusts are launching in April and the other 2 will follow as soon as possible.

Improvements: The tender process for the new incident reporting management scheme launched on 4th March 2024. As well as supporting standardisation of processes and allowing us to meet the requirements of LFPSE together, this should also ensure the system is as user-friendly as possible (staff regularly feedback that current systems are barriers to reporting). The new system is now expected to be in place by January 2025. Once this is procured and in use incidents will be able to pull directly from Cerner; however this is a longer-term action. ICHT are planning a pilot of direct Cerner incident pulls, starting with falls. If successful, this will be considered across the APC in advance of the new system.

Forecast Risks: N/A.

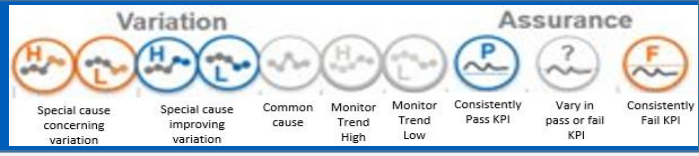
GOVERNANCE

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 their internal processes.

(Patient) Serious Incidents



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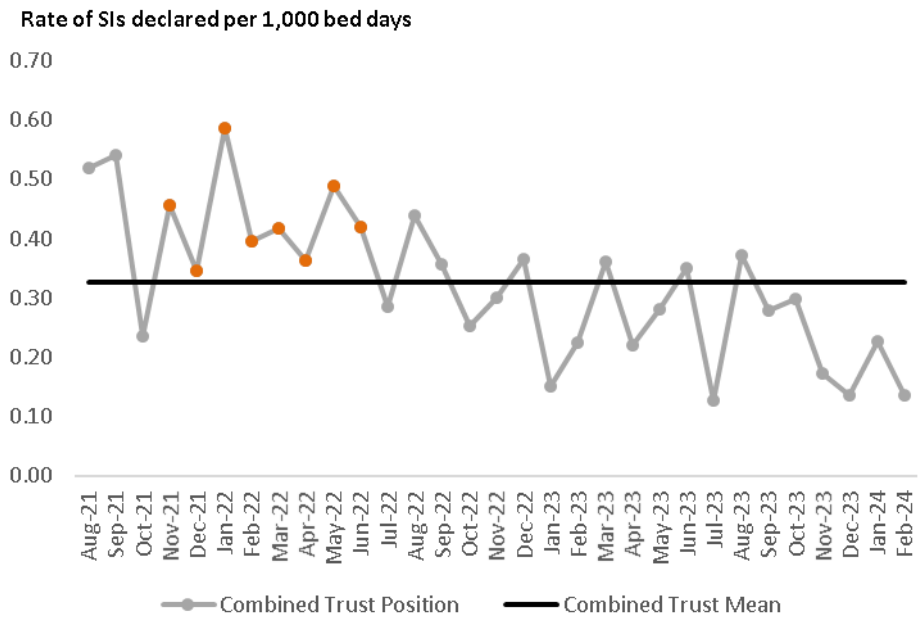


n/a

STANDARD

0.14

PERFORMANCE

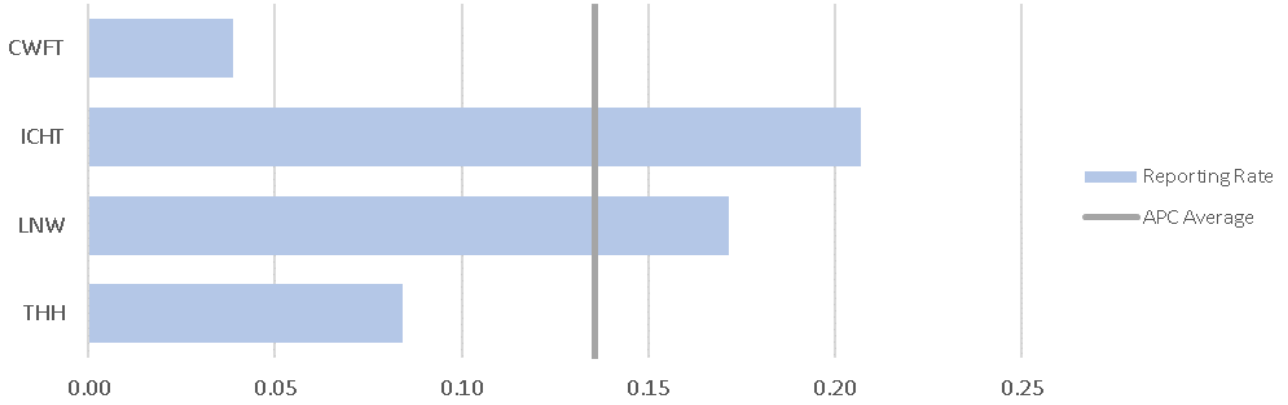
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total bed days	In Month Serious Incidents	Reporting Rate	12 Month Rolling Serious Incidents	12 Month Rolling Reporting Rate
CWFT	25,717	1	0.04	38	0.13
ICHT	28,986	6	0.21	130	0.37
LNW	29,134	5	0.17	54	0.15
THH	11,899	1	0.08	60	0.42
APC	**95,736**	**13**	**0.14**	**282**	**0.25**

STRATIFICATION



NARRATIVE

Performance: There is no standard for this metric. A reporting rate per 1,000 bed days has been calculated, and a rolling 12-month rate included, to allow more meaningful comparison. At APC level, the trend shows common cause variation with a reduction since August 2022. This data includes PSIIs which have been declared under the new PSIRF framework and reported externally on STEIS.

Two never events are included in the numbers:

- ICHT: O-negative blood was transfused to the wrong patient. Positive patient identification (PPID) was not carried out. An immediate safety alert was released and the PPID policy reviewed to improve clarity. A new safety improvement priority has been agreed to focus on PPID into 2024/25. The patient did not come to harm.
- LNW: a flexible sigmoidoscopy was performed on a patient who required an Oesophago-gastro duodenoscopy,. Both procedures were carried out successfully on separate days, with no complications.
- **Recovery Plan:** N/A
- **Improvements:** A review of all never events across the APC has been completed. The majority related to invasive procedures. Implementation of NatSSIPs2 (new national safety standards for invasive procedures) has been confirmed as a new APC quality priority to support improvement in a standardised way. The project initiation document will be presented to APCQC in June.

Forecast Risks: There is a risk that not all investigations opened under the existing SI framework will be completed before transition to PSIRF in April. Dates for these cases are being tracked and plans agreed with the ICB.

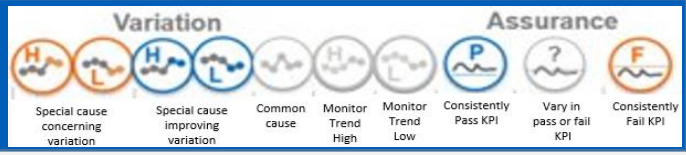
GOVERNANCE

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 their internal processes.

(Patient) Patient Safety Incidents with Severe/Major Harms



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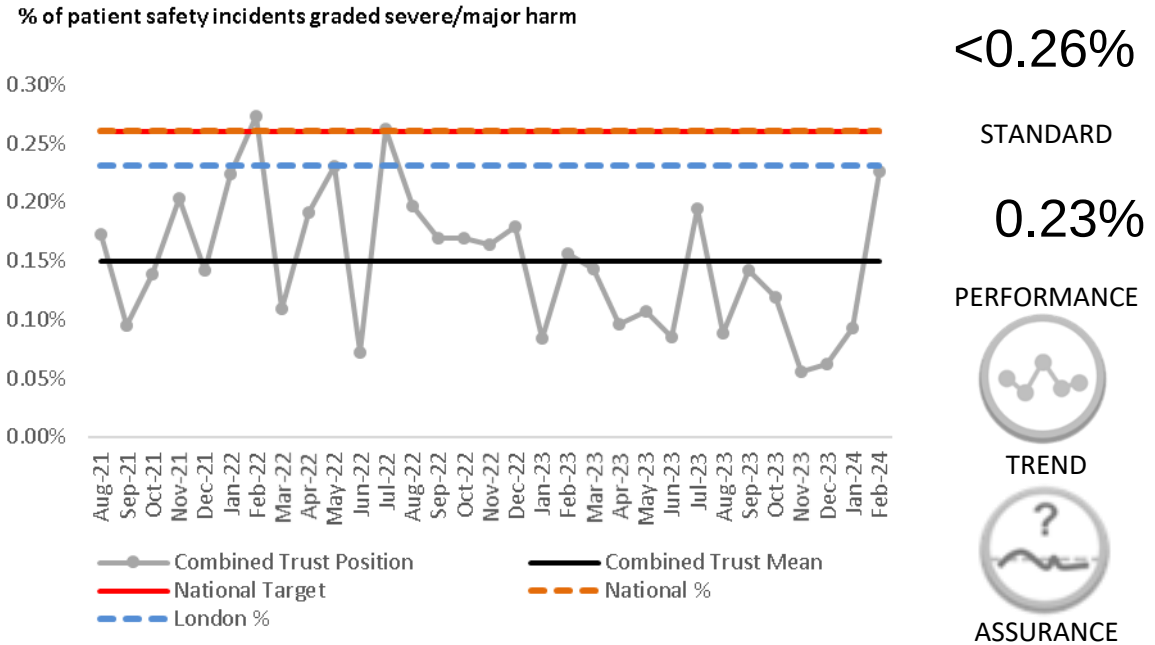
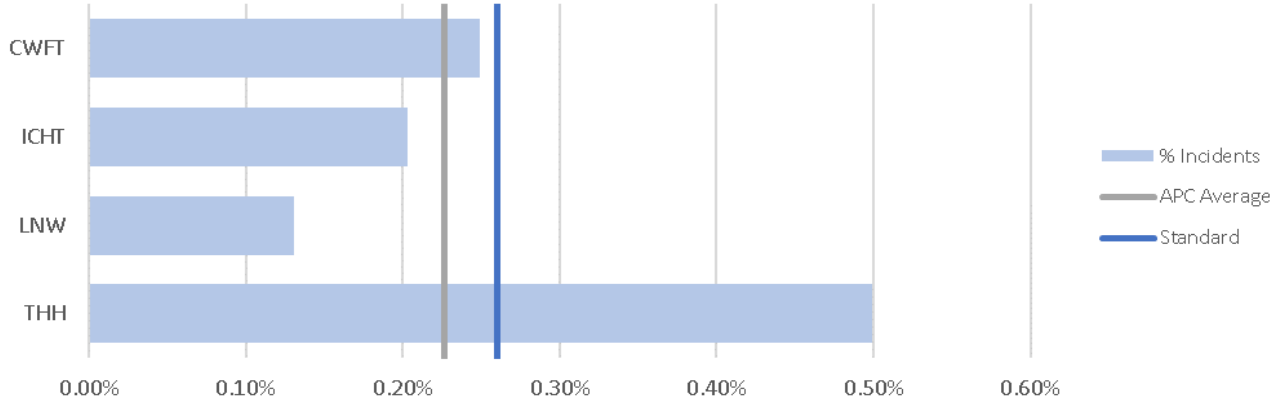


CURRENT PERFORMANCE

	Patient Safety Incidents	% Incidents	Difference from Standard	Severe/ Major Harm	12 Month Rolling % Incidents
CWFT	1205	0.25%		3	0.12%
ICHT	1968	0.20%		4	0.12%
LNW	1534	0.13%		2	0.06%
THH	601	0.50%	0.24%	3	0.26%
APC	**5,308**	**0.23%**		**12**	**0.12%**

STRATIFICATION



NARRATIVE

Performance: At APC level and within most trusts we remain below national average on rolling 12-month and in-month data (THH are marginally above). Cases reported in Feb are under investigation and include:

- CWFT: n=3. Case 1: patient fall resulting in an inoperable subdural haematoma; Case 2: Potential delay in surgical treatment ; Case 3: failure to escalate/treat a patient with sepsis.
- ICHT: n= 4 . In-patient falls resulting in hip fractures. Trust wide improvement work already in place.
- LNW: n = 2. Case 1: delayed out-patient follow-up; Case 2: small bowel perforation during a surgical procedure.
- THH: n = 3 – Case 1: catheter insertion damage to the urethra, Case 2: fall with hip fracture in ED , Case 3: Missed 3rd degree tear following forceps delivery and episiotomy.

Recovery Plan: Robust processes are in place to identify and investigate incidents and implement actions in response with no new risks or issues to escalate to the board.

Improvements: Local quality and safety priorities for 2024/25 are being approved through trust governance processes. Themes and areas for improvement will be included. Work continues through APC steering groups for themes previously identified, including care of the deteriorating patient.

Forecast Risks: We do not anticipate any risks, the numbers are low and continuously monitored.

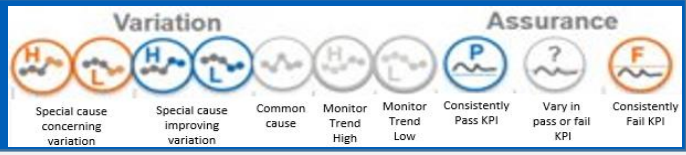
GOVERNANCE

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 their internal processes.

(Patient) Patient Safety Incidents with Extreme Harms/Death



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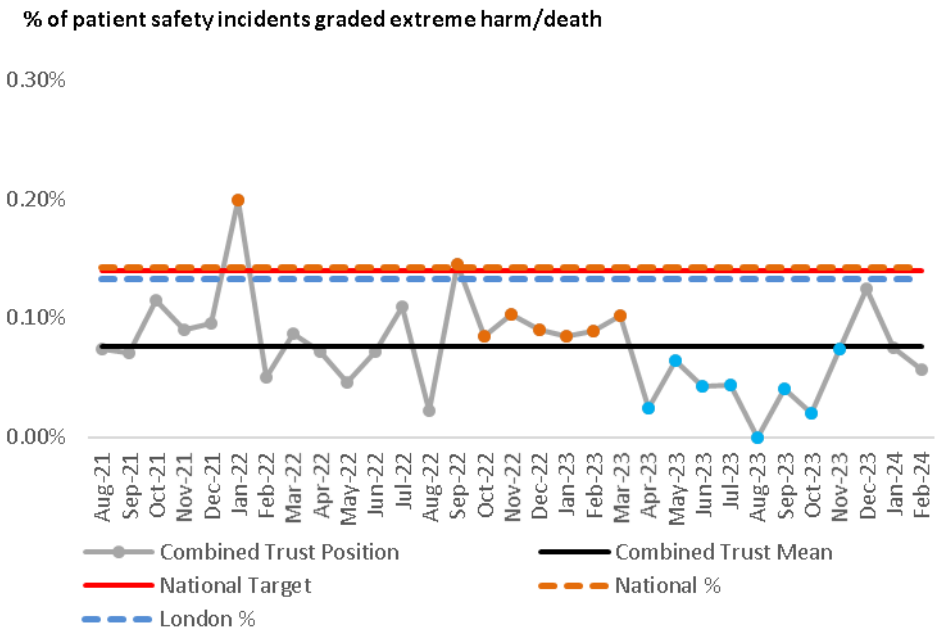


Below 0.14%

STANDARD

0.06%

PERFORMANCE

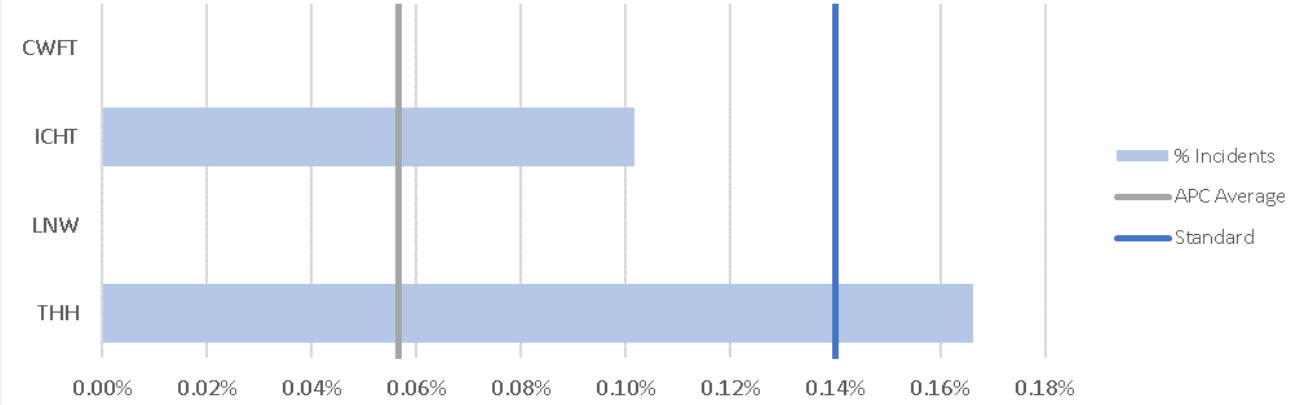
TREND

ASSURANCE

CURRENT PERFORMANCE

	Patient Safety Incidents	% Incidents	Difference from Standard	Extreme Harm/ Death	12 Month Rolling % Incidents
CWFT	1205	0.00%		0	0.05%
ICHT	1968	0.10%		2	0.06%
LNW	1534	0.00%		0	0.04%
THH	601	0.17%	0.03%	1	0.08%
APC	**5,308**	**0.06%**		**3**	**0.06%**

STRATIFICATION



NARRATIVE

Performance: At APC level and within most trusts we remain below national average on rolling 12-month data and in month. THH are marginally above the standard in month.
The cases reported in February are under investigation and include:

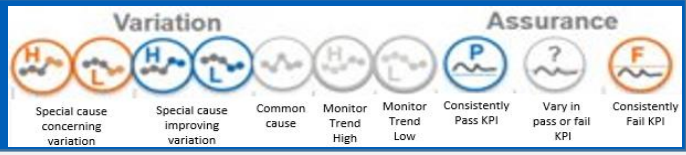
- ICHT: n=2 . Case 1: patient found unresponsive following transfer after a CT scan –trust wide transfer improvement programme in place and this case will be included in this. Case 2: death on the waiting list identified through the clinical harm process. Quality review process in place for the specialty and a focus on supporting improvement in demand/capacity management for priority patients.
- THH: n = 1. Reported following receipt of a claim. A patient died after admission with abdominal issues. Incident will focus on identifying any concerns around the care and management of the patient.

Recovery Plan: N/A
Improvements: Individual cases which are identified through the learning from deaths process as sub-optimal care that might have made a difference to the patient's outcome are reported in the quarterly LFD reports to APCQC and Board-in-common, alongside any themes identified. Cross-cutting themes previously across the APC are end of life care and care of the deteriorating patient both of which are APC quality priority workstreams with action plans in place. No new risks or issues to escalate to the board.
Forecast Risks: We do not anticipate any risks as the numbers are consistently low; however this is continuously monitored.

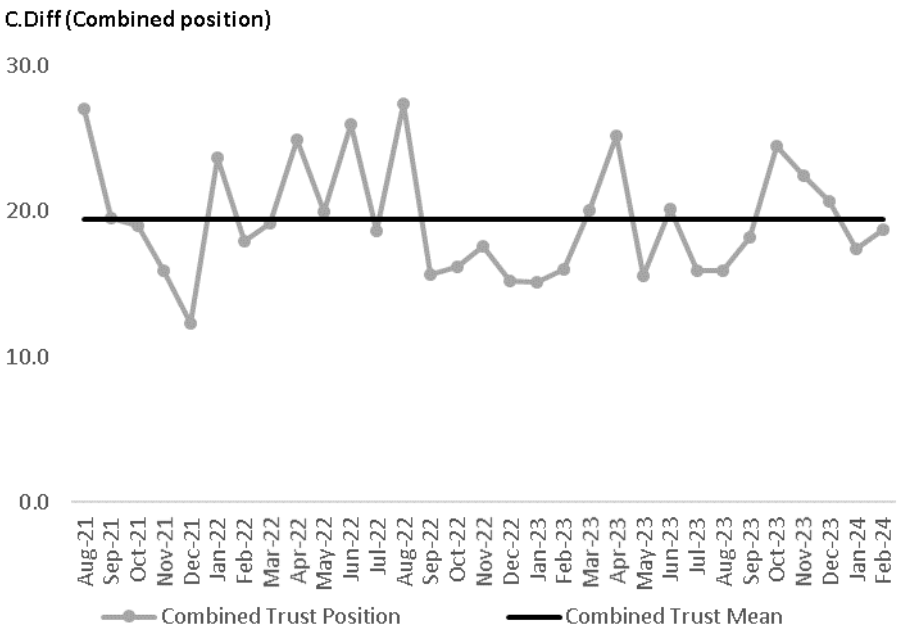
GOVERNANCE

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 internal processes.

(Patient) Healthcare Associated C.Difficile Infections



TREND



Trust Specific

STANDARD

18

PERFORMANCE

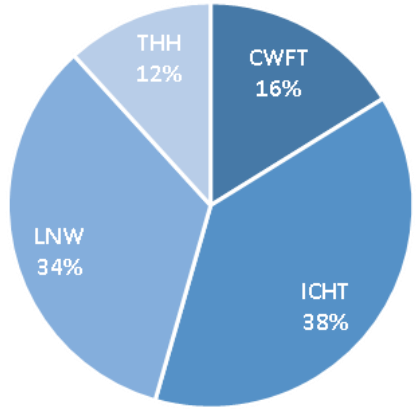
TREND

ASSURANCE

CURRENT PERFORMANCE

	Count of c.Diff cases in month	Count of c.Diff cases in year (FY 23/24)	Trust Threshold (FY 23/24)	Difference from Threshold
CWFT	1	33	25	-8.0
ICHT	6	78	65	-13.0
LNW	7	69	63	-6.0
THH	4	24	23	-1.0
APC	**18**	**204**	**176**	**-28.0**

STRATIFICATION



Trust share of APC count of infections in year

NARRATIVE

Performance: Healthcare associated cases of C. difficile across the APC remain above threshold with 18 cases reported in month. Increases are being seen nationally. From next month, we will include rates based on bed days to allow for more meaningful comparison between Trusts and nationally.

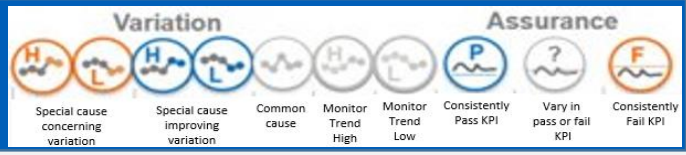
Recovery Plan: Each Trust has robust processes for managing and investigating cases, with on-going improvement work in place, with a focus on improving routine IPC practice. A review of the challenges, themes and learning from C. Diff cases has been undertaken through the APC priority workstream. This has identified two main issues – delayed or inappropriate sampling and delays in isolating unwell patients, primarily due to capacity issues. Time to testing and time to isolation will now be monitored and a review of laxative prescribing and documentation is underway. A review is underway across the NWL ICB of patients aged ≥ 65 years on oral Proton Pump Inhibitors for more than a year.

Improvements: An APC priority work stream is now in place to consider challenges and opportunities for learning. The initial focus is on C. diff as outlined above.
Forecast Risks: N/A

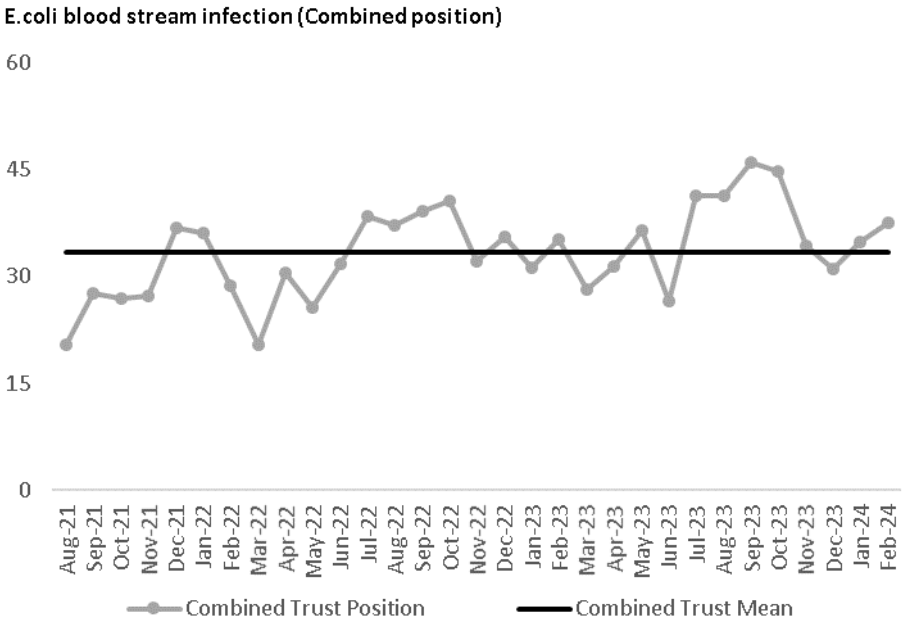
GOVERNANCE

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 their internal processes.

(Patient) Healthcare Associated E. coli Infections



TREND



Trust Specific

STANDARD

36

PERFORMANCE

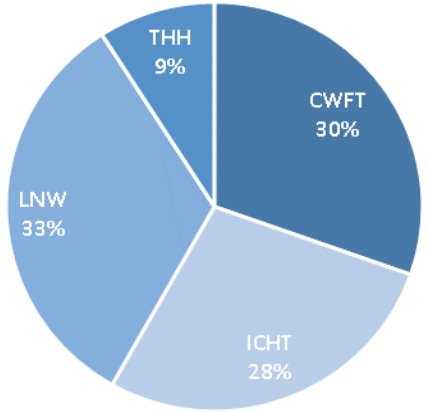
TREND

ASSURANCE

CURRENT PERFORMANCE

	Count of E.Coli BSIs in month	Count of E.Coli BSIs in year (FY 23/24)	Trust Threshold (FY 23/24)	Difference from Threshold
CWFT	10	117	70	-47.0
ICHT	3	107	90	-17.0
LNW	21	126	87	-39.0
THH	2	35	27	-8.0
APC	**36**	**385**	**274**	**-111.0**

STRATIFICATION



Trust share of APC count of infections in year

NARRATIVE

Performance: There was a slight increase in E. Coli blood stream infections (BSIs) reported across the APC in February. All trusts have exceeded their annual thresholds. From next month, we will include rates based on bed days to allow for more meaningful comparison between Trusts and nationally.

Recovery Plan: The ICB is focused on reduction of E.coli blood stream infections in line with the NHS Long Term Plan (50% reduction by 2024/25). A regular ICS-led meeting is in place to drive improvement as approximately three-quarters of these BSIs occur before people are admitted to hospital and half are caused by urinary tract infections. Reduction, therefore, requires a whole health economy approach. The main action undertaken has been implementation of an updated catheter passport to help prevent catheter associated urinary tract infections, with Trust teams involved in the development.

Robust processes for managing and investigating cases, and on-going improvement work is in place in all four Trusts, with a focus on improving routine IPC practice.

Improvements: Impact of actions taken through ICS reduction plan are monitored in each trust.

Forecast Risks: N/A

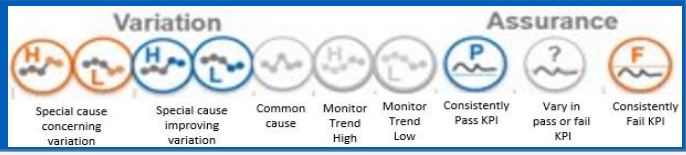
GOVERNANCE

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 their internal processes.

(Patient) Healthcare Associated MRSA Infections



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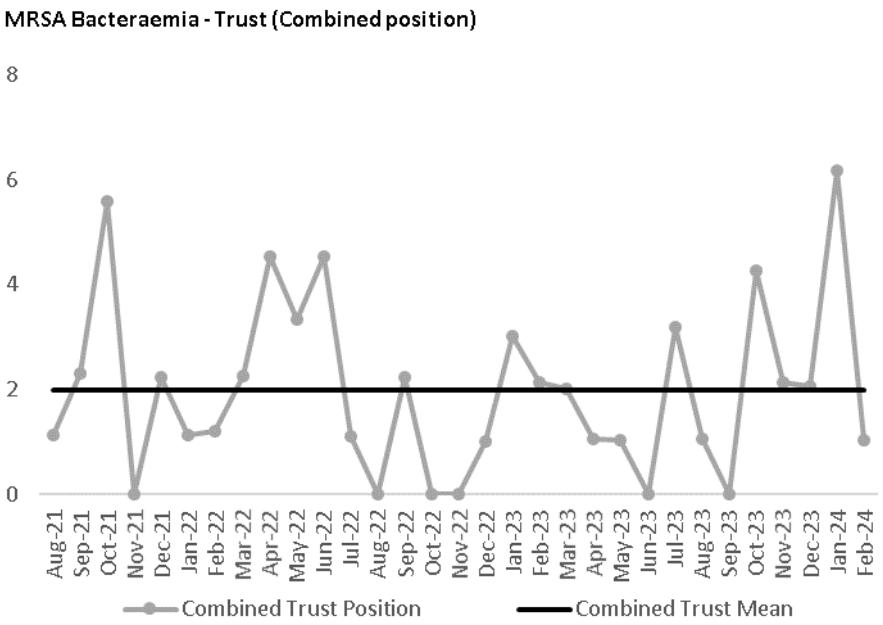


0

STANDARD

1

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: There was one MRSA BSI reported in month, at ICHT. A total of 21 cases have been reported this financial year: 4 at CWFT, 9 at ICHT, 7 at LNW and 1 at THH. From next month, we will include rates based on bed days to allow for more meaningful comparison between Trusts and nationally.

Recovery Plan: Robust processes for managing and investigating cases, and on-going improvement work is in place, with a focus on improving routine IPC practice. All cases are reviewed to identify any lapses in care or learning opportunities. At ICHT intensive support is being provided to an area with repeat cases with a focus on invasive line care, ANTT, environmental cleanliness and hand hygiene.

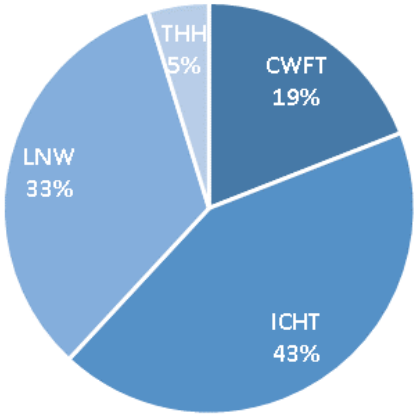
Improvements: A review of these cases will feed into the APC priority workstream to support identification of collective action or learning. Each trust has improvement work in place in response to these infections, the outcomes of which will report into the APC work stream and any shared learning planned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

Forecast Risks: N/A

CURRENT PERFORMANCE

	Count of MRSA BSIs in month	Count of MRSA BSIs in year (FY 23/24)	Trust Threshold (FY 23/24)	Difference from Threshold
CWFT	0	4	0	-4.0
ICHT	1	9	0	-9.0
LNW	0	7	0	-7.0
THH	0	1	0	-1.0
APC	**1**	**21**	**0**	**-21.0**

STRATIFICATION



Trust share of APC count of infections in year

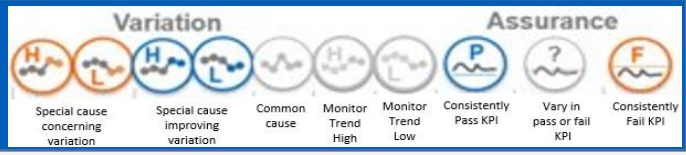
GOVERNANCE

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 their internal processes.

(Patient) Formal Complaints



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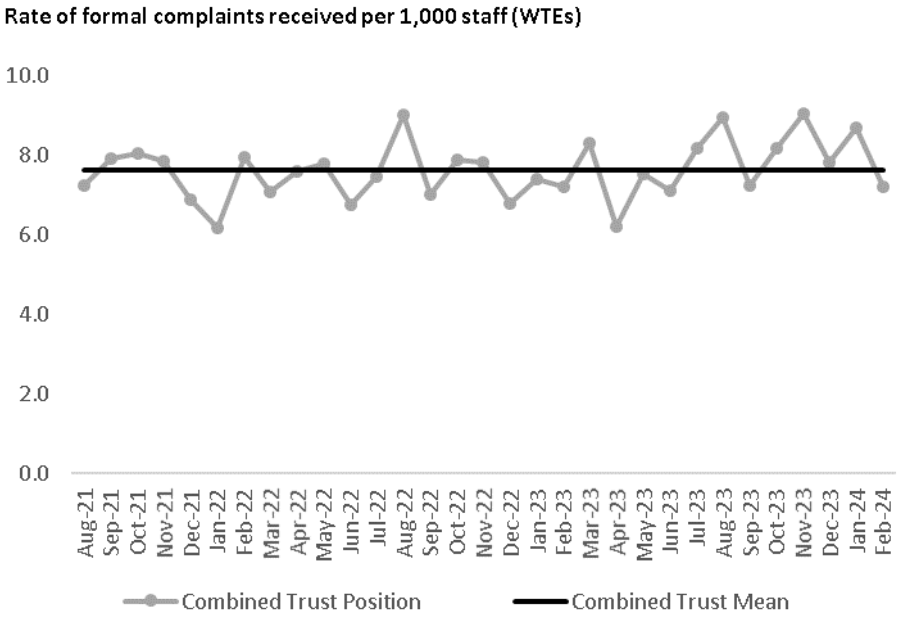


n/a

STANDARD

7.23

per 1,000 WTE

PERFORMANCE

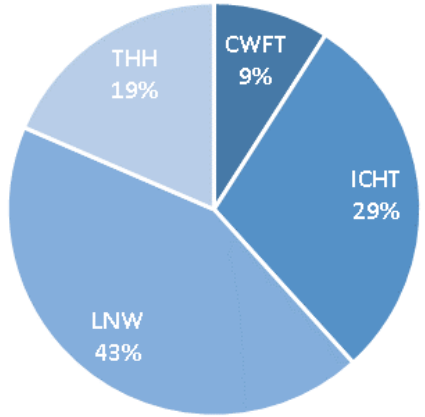
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total WTE Staff	Rate per 1,000 WTE	Count of Patient Complaints	12 Month Rolling Rate per 1,000 WTE
CWFT	6,951	3.17	22	5.77
ICHT	13,523	5.25	71	6.76
LNW	9,518	11.03	105	10.58
THH	3,616	12.44	45	9.28
APC	**33,608**	**7.23**	**243**	**7.89**

STRATIFICATION



NARRATIVE

Performance: There is currently no agreed standard for the rate of formal complaints per 1,000 WTE, and no benchmarking data available. The trend graph shows small amounts of variation across the last 18 months, with a reduction in-month. The rate in February was 7.23, below the mean. Rates vary at trust level, with THH having the highest rate in month and LNW across the last 12 months. The recent increase at THH does not appear to be focused on one service or theme and the Trust is continuing to monitor complaint performance and activity. LNW have confirmed there are no themes requiring escalation.

Recovery Plan: N/A

Improvements: The 'User insight and focus' improvement workstream is identifying and prioritising opportunities for shared learning and common approaches to understanding, measuring and improving responsiveness to the needs and views of our patients and local communities across the APC. Monthly workshop sessions are in place with complaints leads to review and harmonise metrics and identify potential areas for joint work. The patient experience metrics in this dashboard will be updated to reflect this work once complete.

Forecast Risks: None.

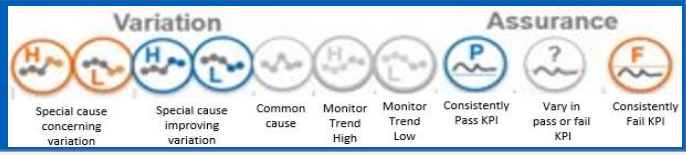
GOVERNANCE

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 their internal processes.

(Patient) Inpatient Friends & Family Test



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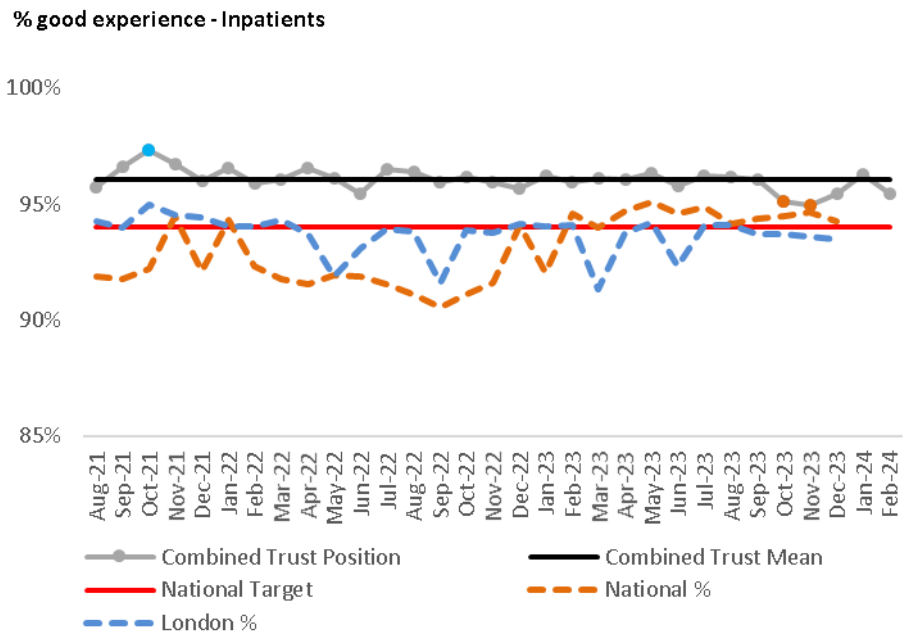


94%

STANDARD

95.5%

PERFORMANCE

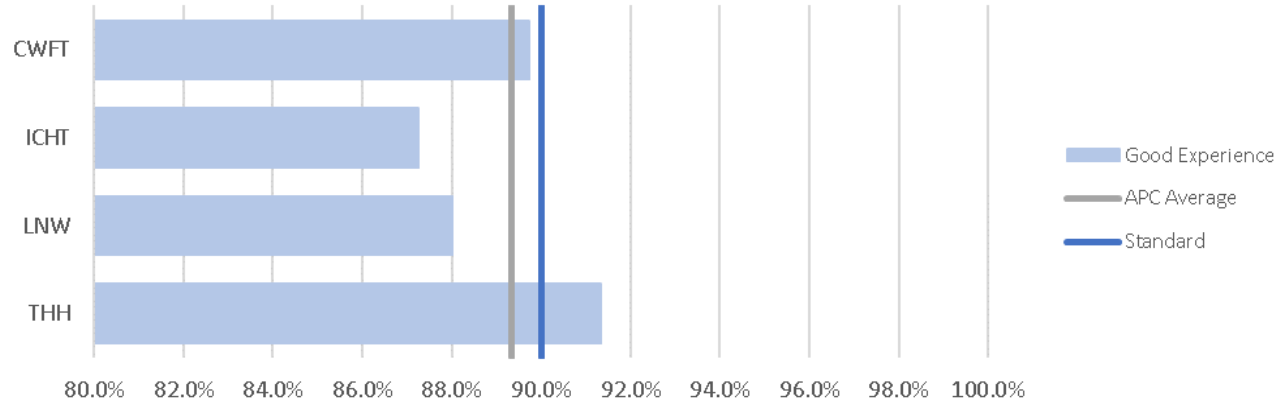
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target Recommended Care		12 Month Rolling Good Experience
CWFT	808	95.2%		769	95.9%
ICHT	2,856	97.0%		2,771	96.3%
LNW	2,476	95.3%		2,360	95.7%
THH	1,671	93.1%	-0.9%	1,556	95.0%
APC	**7,811**	**95.5%**		**7,456**	**95.8%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of inpatients reporting a good experience is consistently above target and above national and London average (N.B. national data from December 2023 onwards is not currently available). All trusts met the target in month, except for THH which was slightly below.

Recovery Plan: N/A

Improvements: A working group has been established to take forward the re-tendering process for joint procurement of a patient survey platform, which will support better identification of areas for collaborative improvement once implemented.

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

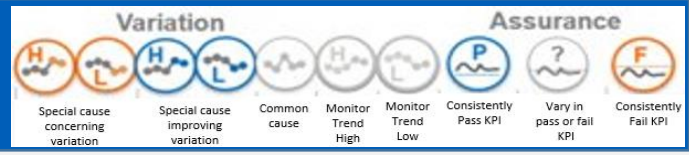
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

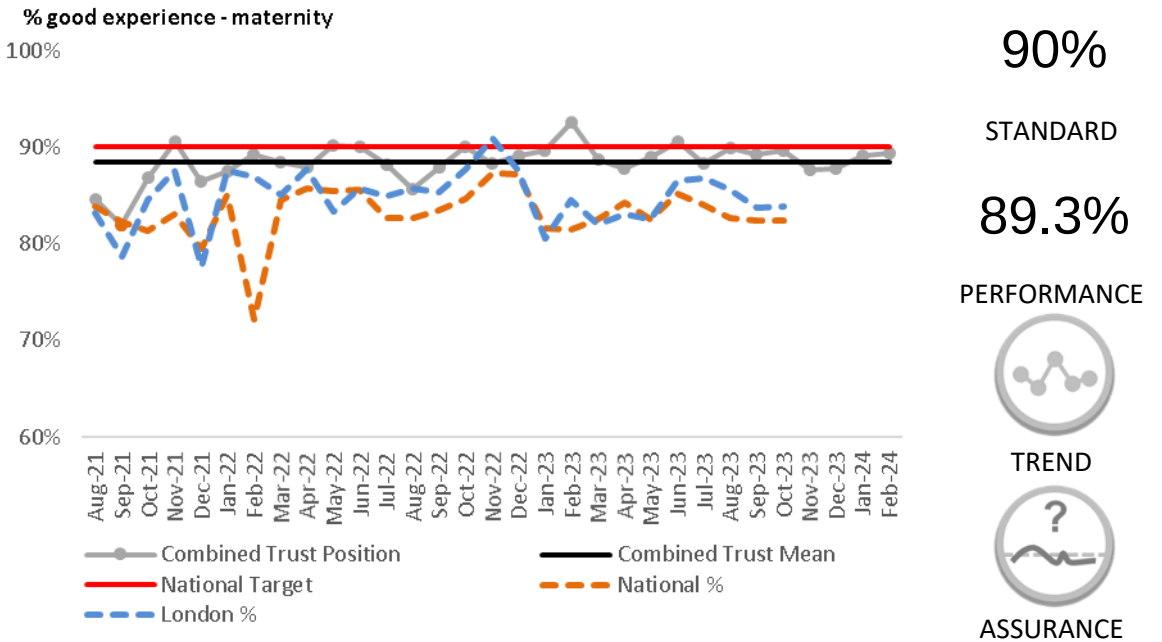
Committee: Acute provider collaborative executive management board

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

(Patient) Maternity Friends & Family Test



TREND



90%

STANDARD

89.3%

PERFORMANCE

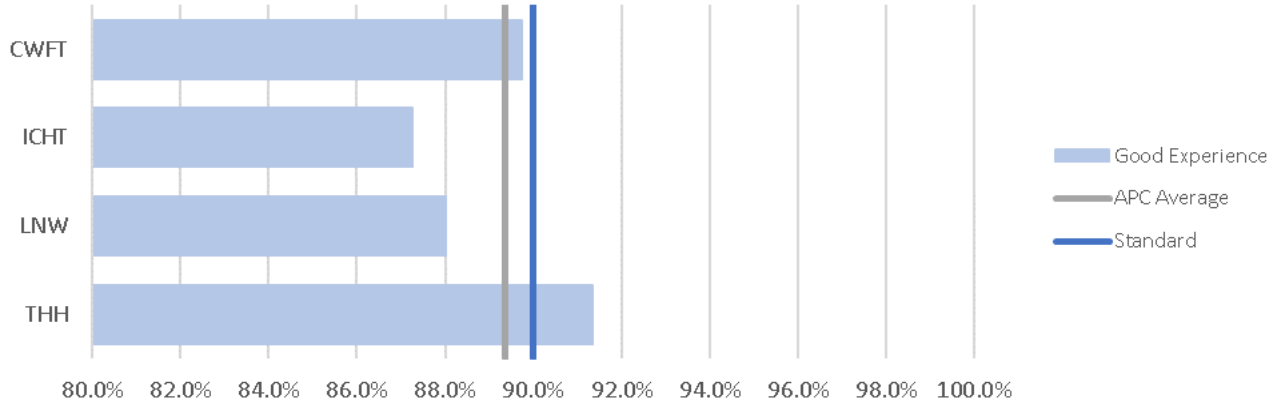
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	263	89.7%	-0.3%	236	89.9%
ICHT	196	87.2%	-2.8%	171	88.7%
LNW	25	88.0%	-2.0%	22	87.6%
THH	173	91.3%		158	88.3%
APC	**657**	**89.3%**	**-0.7%**	**587**	**89.0%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the monthly percentage of patients who report a good experience varies, although there has been a noted improvement since September 2021. Performance at APC level is just below the standard on a rolling 12-month basis and in-month. In January CWFT, ICHT and LNW are below the target (with CWFT just marginally below at 89.7%). ICHT's rate fluctuates with no specific issues to escalate. LNW's response rate is low because automated collection has not recommenced following Cerner implementation. The patient experience and BI teams are working to develop the inclusion and exclusion criteria required.

Recovery Plan: There is a significant amount of work being undertaken within each trust and across the APC to improve maternity care in response to national reviews and statutory requirements.

Improvements: A summary of the CQC's survey of maternity patients was reported to APCQC in March. There is an opportunity for collaborative improvement regarding information provision to patients and families which will now be taken forward by the maternity APC workstream and through the LMNS.

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

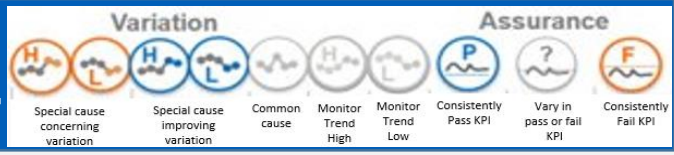
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

(Patient) Emergency Dept Friends & Family Test



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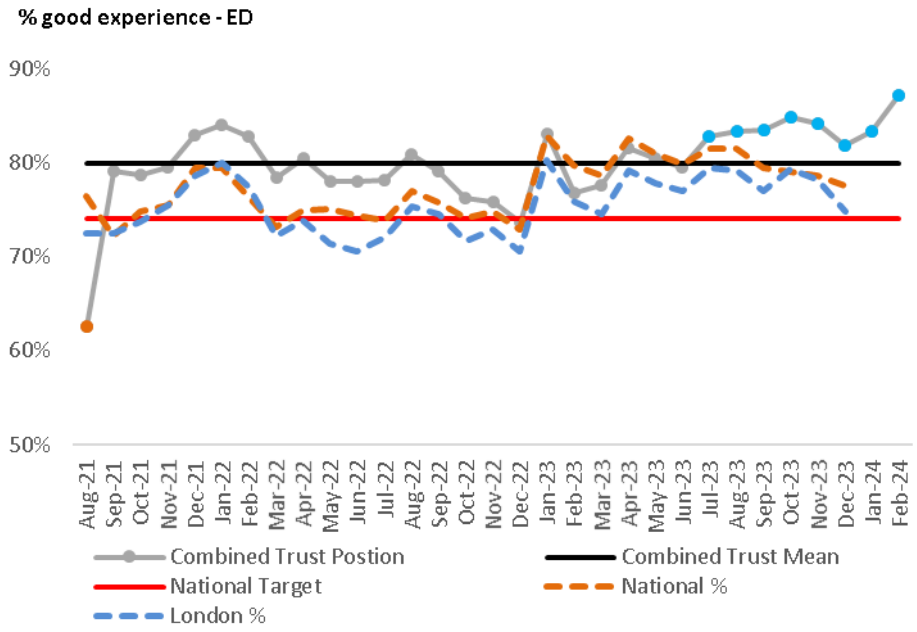


74%

STANDARD

87.1%

PERFORMANCE

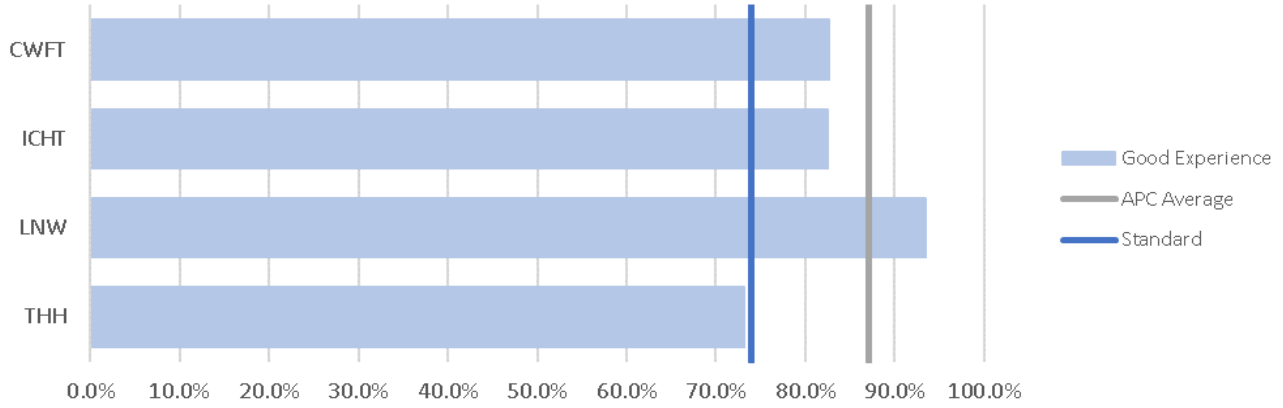
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	4,937	82.7%		4,082	81.7%
ICHT	1,123	82.5%		927	84.2%
LNW	6,228	93.4%		5,819	86.4%
THH	870	73.1%	-0.9%	636	74.9%
APC	**13,158**	**87.1%**		**11,464**	**82.9%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of patients accessing our emergency departments who report a good experience has been consistently above standard since January 2023, with a period of special cause improving variation since July 2023. All trusts except THH met the standard in February. Their performance continues to be challenged by operational and staffing issues and focused work is being undertaken to improve the response rate within the Emergency Department, including using volunteers to collect responses. The 12-month rolling figure shows that we are above the 74% standard at APC level, and in all Trusts.

Recovery Plan: Not applicable.

Improvements: The ICB team has collated a composite action list from the peer reviews undertaken in ED which are being monitored through the NWL urgent and emergency care board. These actions should improve experience and outcomes for patients once implemented.

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

GOVERNANCE

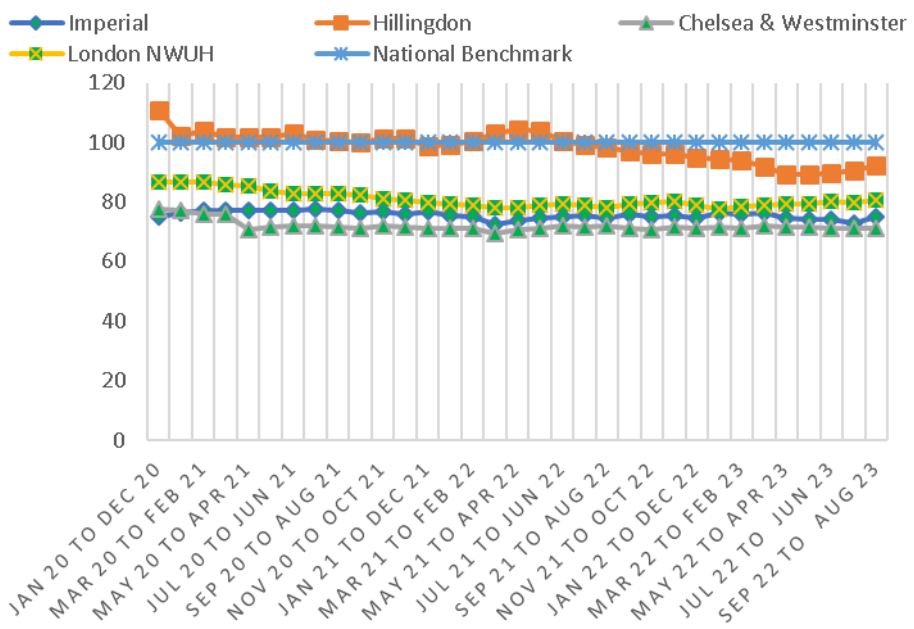
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

(Patient) Summary Hospital-level Mortality Index

TREND



100
England Average

STANDARD

n/a

PERFORMANCE

n/a

TREND

n/a

ASSURANCE

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 (September 2022– August 2023) demonstrating similar figures to previous reporting periods. THH's rate is consistently 'as expected'.

Recovery Plan: None

Improvements: All Trusts are investigating variations between observed and expected deaths by diagnostic group. Reviews undertaken in quarter three were presented to the APC mortality surveillance group in March and are summarised in the quarterly learning from deaths reports to APCQC and BiC. No new risks or themes were identified.

Forecast Risks: N/A

CURRENT PERFORMANCE

Summary Hospital-level Mortality Index (SHMI) Year to Aug 2023

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	92765	71.26	Lower than expected
ICHT	98880	75.13	Lower than expected
LNW	102655	80.81	Lower than expected
THH	37045	92.21	as expected

STRATIFICATION

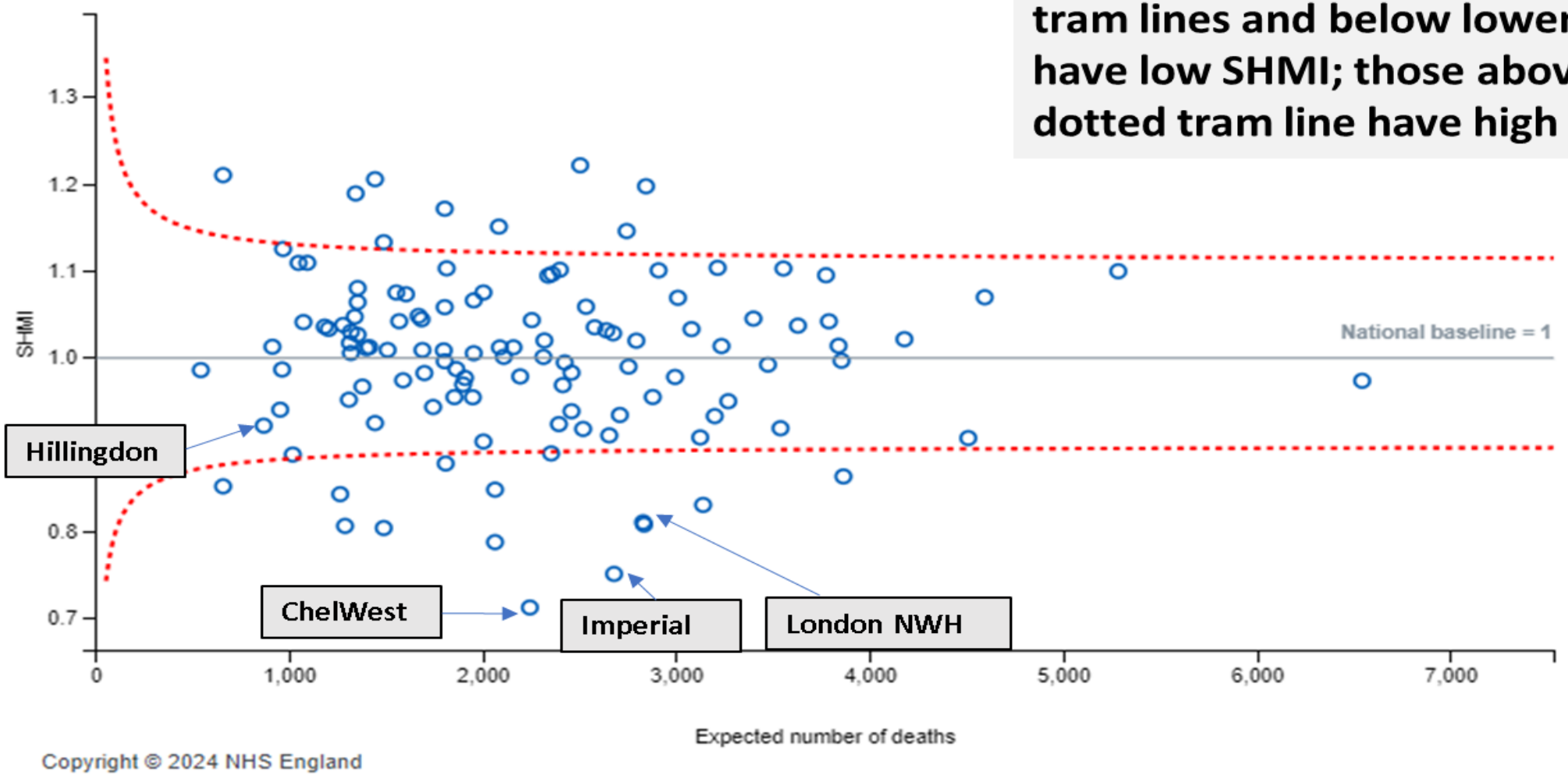
- The value and banding of the Summary Hospital-level Mortality Indicator ('SHMI') for the trust for the reporting period.
- The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
- It covers patients admitted to non-specialist acute trusts in England who died either while in hospital or within 30 days of discharge.
- SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'.

GOVERNANCE

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

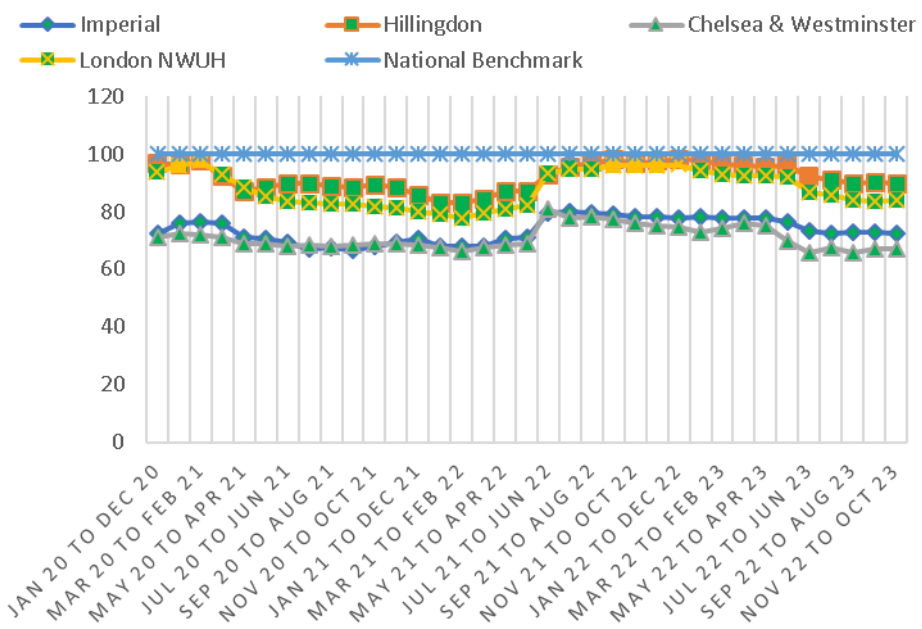
(Patient) Summary Hospital-level Mortality Index

Those providers outside dotted tram lines and below lower line have low SHMI; those above dotted tram line have high SHMI



(Patient) Hospital Standardised Mortality Ratio

TREND



100

England Average

STANDARD

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

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

CURRENT PERFORMANCE

Hospital Standardised Mortality Ratio (HSMR): Year to Oct 2023

	Provider Superspells	HSMR	HSMR - relative risk ranking
CWFT	47180	67.2	Lower than expected
ICHT	68535	72.6	Lower than expected
LNW	58803	83.9	Lower than expected
THH	15949	90.0	Lower than expected

STRATIFICATION

- HSMR is a summary mortality indicator. It is based on a subset of 56 diagnosis groups that give rise to approximately 85% of in hospital deaths.
- It is adjusted for case mix, taking into account factors such as age, gender, comorbidities, palliative care coding, deprivation, month of admission, method of admission, admission source, number of previous emergency admissions, discharge year.
- Each patient has a 'risk' of death based on these factors. Risks are aggregated to give an expected number of deaths.
- The HSMR is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures and taking into account the adjustments outlined above.

NARRATIVE

Performance:. The most recent data (for the year November 2022 – October 2023) shows that each trust has a rolling 12-month ratio below the national benchmark. THH's rate has been steadily reducing and has been lower than expected for the last four months.

Recovery Plan: N/A

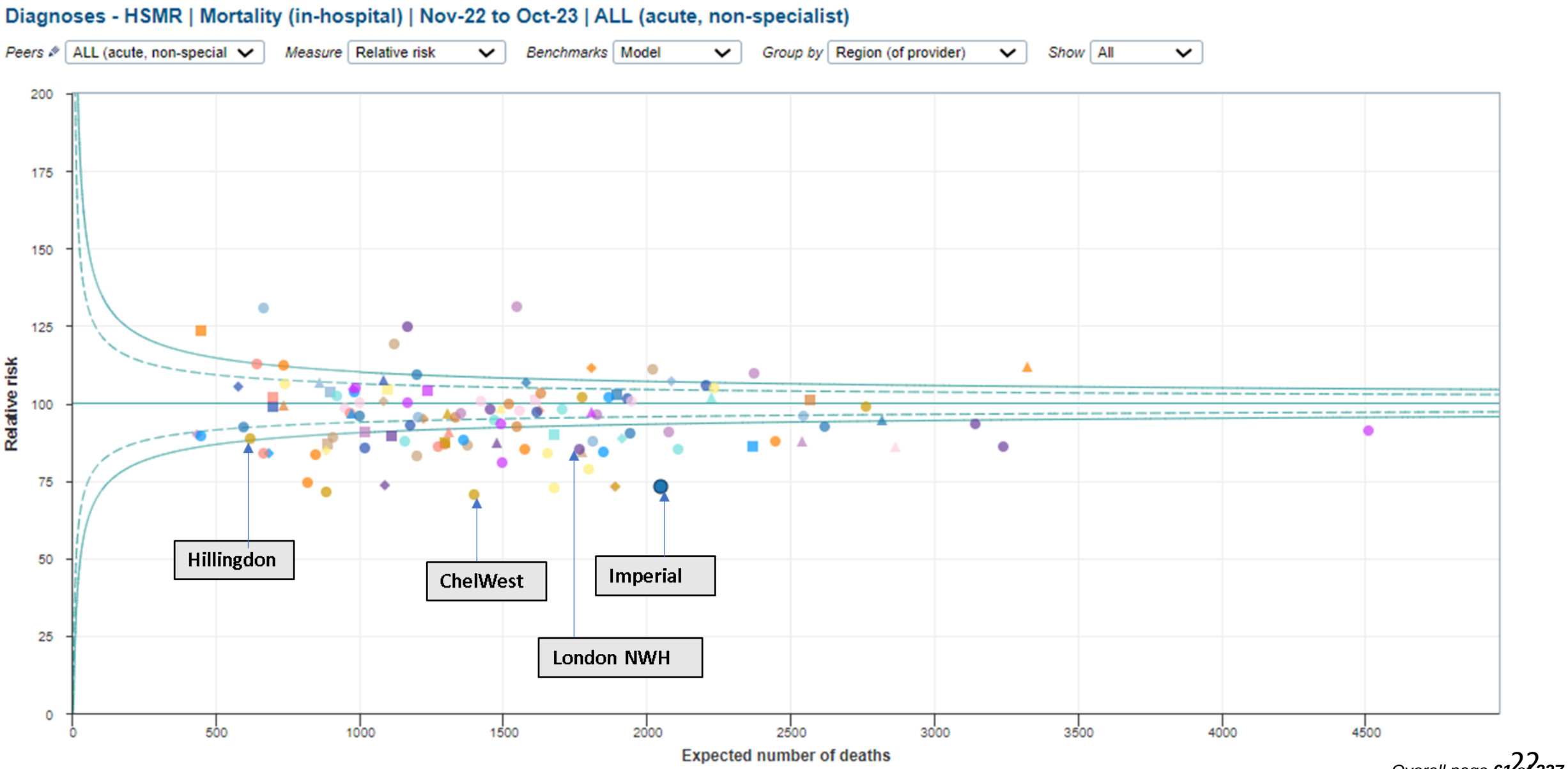
Improvements: All Trusts are investigating variations between observed and expected deaths by diagnostic group. Reviews undertaken in quarter three were presented to the APC mortality surveillance group in March and are summarised in the quarterly learning from deaths reports to APCQC and BiC. No new risks or themes were identified.

Forecast Risks: N/A

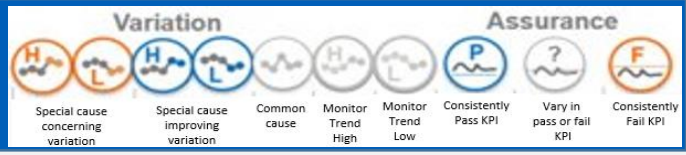
GOVERNANCE

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

(Patient) Hospital Standardised Mortality Ratio



(Patient) VTE Risk Assessments Completed



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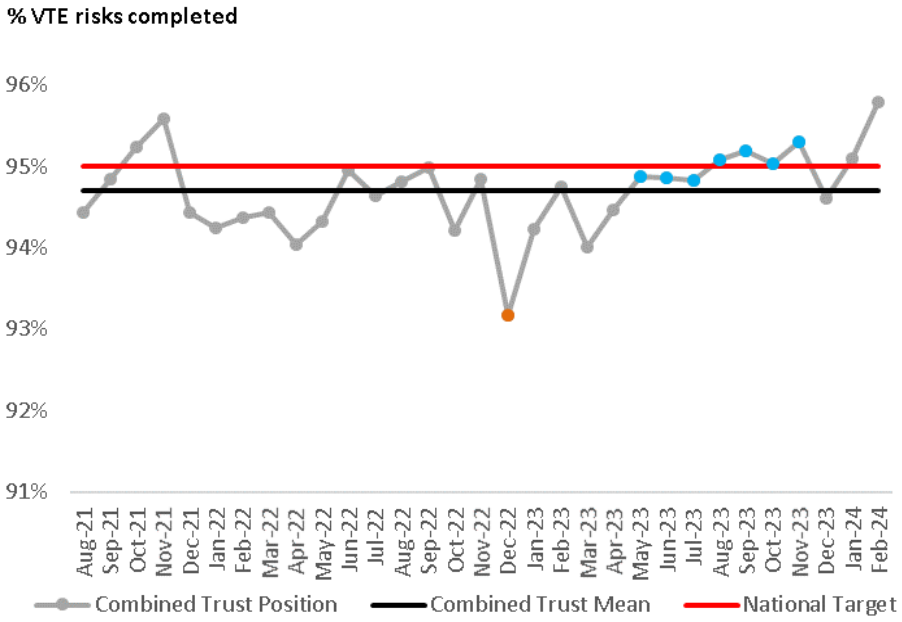


95%

STANDARD

95.8%

PERFORMANCE

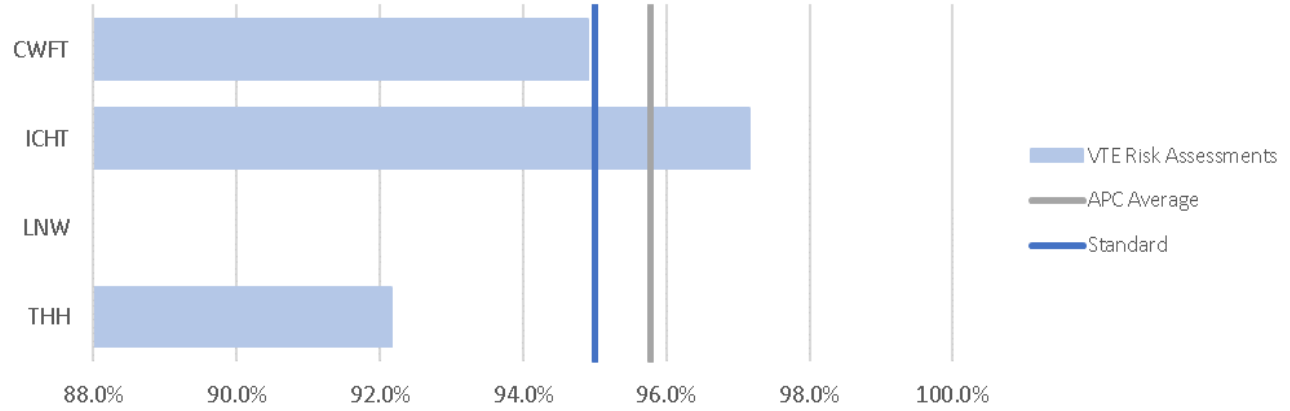
TREND

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	7,351	94.9%	-0.1%	6,977	94.2%
ICHT	15,578	97.2%		15,135	97.0%
LNW					
THH	4,164	92.2%	-2.8%	3,838	88.3%
APC	**27,093**	**95.8%**		**25,950**	**94.9%**

STRATIFICATION



NARRATIVE

Performance: Benchmarking data is not available for this metric as national reporting was paused in response to the pandemic in 2020 and has not restarted. The trend chart shows an increase in February and we are just above the standard at APC level, with ICHT consistently meeting the target and CWFT just below.

Recovery Plan: THH has identified some issues with the data available via Cerner which are currently being addressed. It is expected that compliance will increase as these changes come into effect.

LNW will begin to report data from Cerner by the end of Q4 once data validation has occurred.

Improvements: LNW has established a VTE Task and finish group which reviews systems and oversight for data, coding and practice. Local VTE audits are continuing until Cerner reporting is in place. THH has mandatory training for clinical staff in place and education is on-going to ensure the message on importance of risk assessment is disseminated.

Once full reporting from Cerner is in place for both trusts, improvements in compliance are expected to be seen.

Forecast Risks: None.

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 their internal processes.

Neonatal and Maternity Report

Scorecard January 2024

Maternity	Expected	Actual	Trend	Assurance
Crude still birth rate (per 1000 birth rate)	3.3	6.2		
Number of neonatal intrapartum brain injuries as escalated to HSIB	Downward Trend	1		
% of babies delivered in appropriate care setting for gestation (in a care setting within an NICU for singletons <27+0 weeks or <800gms, or all multiples <28+0 weeks)	>85%	71.4%		
Term Admissions in Neonates; proportion of babies >=37 weeks GA admitted to neonatal care for 24 hours or more	<6%	3.1%		
Pre-Term Births	<8%	8.0%		
Neonatal Crude Deaths (per 1000 birth rate)	0.94	0.89		
Maternal Deaths	0	0		

Introduction

Introduction:

The four acute hospital Trusts deliver maternity and neonatal services in NW London, located across the system with provision of a total of six maternity units. The number of births at each unit varies between 3,000 and 5,700 per year. All units provide pregnant women and birthing people with the options of obstetric or midwifery led birth. There are two level three neonatal units, providing neonatal intensive care for all gestations of newborns. Three level two neonatal units providing critical and intensive care to babies >28 weeks gestation and one special care baby unit providing care to babies born >32 weeks gestation.

Acute provider trust	Maternity unit	Annual number of live births (2022/23)	Neonatal care provision
Chelsea & Westminster Hospital Foundation Trust (CWFT)	Chelsea and Westminster Hospital	5,287	Level 3
	West Middlesex Hospital	4,444	Special care baby unit
Imperial College Healthcare NHS Trust (ICHT)	Queen Charlotte's and Chelsea Hospital	5,388	Level 3
	St Mary's Hospital	2,997	Level 2
London North West Hospitals NHS Trust (LNW)	Northwick Park Hospital	3,832	Level 2
The Hillingdon Hospitals NHS Foundation Trust (THH)	Hillingdon Hospital	4,026	Level 2
Total live births		**25,974**	

Metric definition

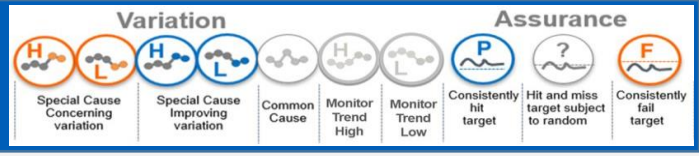
Metric definitions:

1. Crude still birth rate (per 1000 birth rate) - babies born showing no signs of life at 24 weeks or more gestation
2. Number of suspected neonatal intrapartum brain injuries as escalated to HSIB - Number of births reported to NHS resolution as meeting Each Baby Counts criteria. Potential severe brain injury diagnosed in the first seven days of life, when the baby:
    - Was diagnosed with moderate or severe (grade III) hypoxic ischaemic encephalopathy (HIE). This is brain injury caused by the baby's brain not getting enough oxygen.
    - Was therapeutically cooled (active cooling only). This is where the baby's body temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.
    - Had decreased central tone (was floppy) and was comatose and had seizures of any kind.
3. % of babies born in an appropriate care setting for gestation –An appropriate care setting for singletons <27+0 weeks or <800gms, or all multiples <28+0 weeks is one that has NICU provision. Chelsea and Westminster Hospital and Queen Charlotte's and Chelsea Hospital both have level 3 neonatal units and would therefore be an appropriate care setting.
4. Term Admissions in Neonates - proportion of babies >=37 weeks Gestational Age admitted to neonatal care within first 28 days of life, for 24 hours or more. The ATTAIN programme focuses on four key areas relating to term admissions − hypoglycaemia, jaundice, respiratory conditions and asphyxia (hypoxic–ischaemic encephalopathy) − and the factors leading to these admissions. These represent some of the most frequently recorded reasons for admission according to neonatal hospital admissions data.
5. Pre-term births – Total Number of live Births before 37 weeks
6. Crude neonatal death rate - Neonatal mortality rate p/1000 live births - adjusted to remove <24wks and those not born in NWL
7. Maternal deaths – Number of maternal deaths

The data in this dashboard is for month 10 (January 2024). Work is underway to improve the timeliness of the data for these metrics.

When reviewing the reported increasing cases of neonatal deaths, suspected cases of intrapartum brain injury and neonatal intensive care admissions at ICHT discrepancies have been identified in the data when compared to local data. No obvious additional clinical risk has been identified at ICHT. A full review of the patient level details, data definitions and data feeds across the APC is being undertaken, led by the Chief Nurse from CWFT, the SRO for the APC maternity work stream with trust leads, the ICB and LMNS. The outcome of this is now being reviewed by the executive leads for all trusts and once agreed, confirmed data will be reported (expected for the month 11 dashboard).

(Maternity) Crude still birth rate (per 1000 birth rate)



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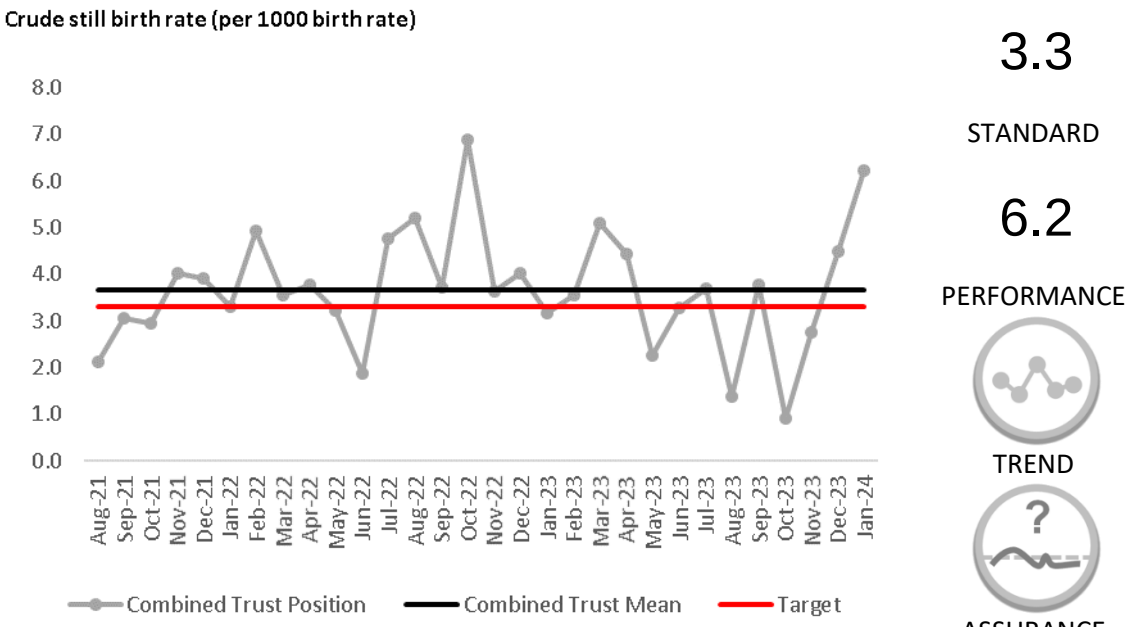


3.3

STANDARD

6.2

PERFORMANCE

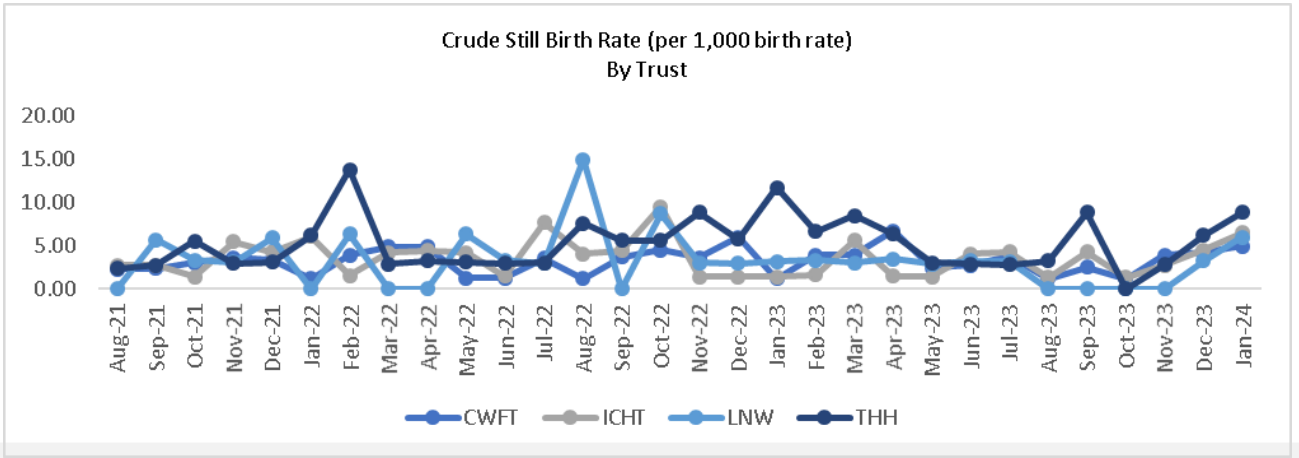
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total Births	Total Still Births	Crude Still Birth Rate	Crude Still Birth Rate YTD	Difference from Standard
CWFT	806	4	5.0	3.33	1.66
ICHT	771	5	6.5	3.20	3.19
LNW	334	2	6.0	2.23	2.69
THH	339	3	8.8	4.46	5.55
APC	**2250**	**14**	**6.2**	**3.30**	**2.92**

STRATIFICATION



NARRATIVE

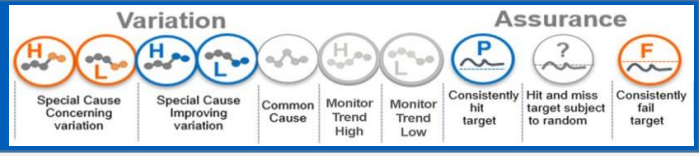
Performance: The APC stillbirth rate is on target year to date, but above target in month. All trusts saw an increase in cases in January with THH above target year to date.

CWFT – 4 cases of growth restriction and/or reduced fetal movements. Initial MDT review undertaken, no immediate actions identified.
ICHT – 5 cases - 1 late fetal loss rather than stillbirth (will be re-classified), 4 cases of reduced fetal movements or growth restriction. Initial MDT review and appropriate incident investigations progressing, no issues to escalate.
LNW – 2 cases – 1 severe anomaly identified on scan prior to still birth and 1 identified when presented to the birth centre. No issues to escalate.
THH – 3 cases - 1 placental abruption, 1 baby born before arrival to hospital and 1 reduced fetal movements.
Recovery Plan: All cases will be investigated via PMRT to identify learning and actions.
Improvements: Local improvements are being implemented at each trust for example at CWFT the length of appointments in community settings have been extended and a working group in place to review translation services. At ICHT counselling services for patients transferred for level 3 neonatal care are being reviewed with a focus on the risk assessments and documentation of personalised care plans.
Forecast Risks: THH is currently undertaking an internal review of all stillbirths and related processes that have taken place during 2023. This is expected to be completed in March 2024 and a final report prepared with recommendations and learning.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board

(Maternity) Neonatal intrapartum brain injuries (suspected)



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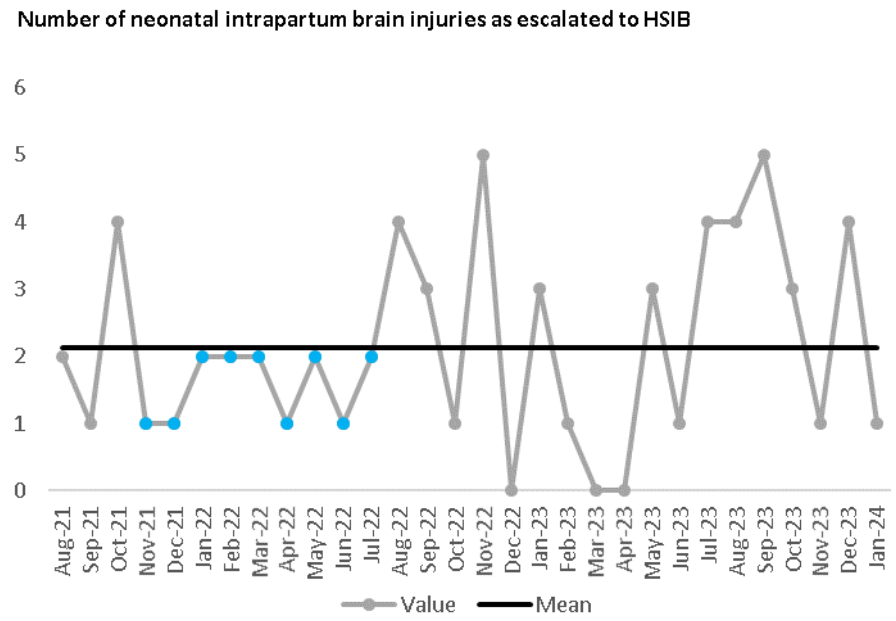


Downward Trend

STANDARD

1

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: One case of suspected intrapartum brain injury in NWL in January, for a baby born at THH. This was a term baby transferred to Queen Charlotte's & Chelsea Hospital for cooling after birth with shoulder dystocia. The MRI was confirmed as normal.

We have noted discrepancies in the data when compared to internal reports at ICHT. A full review of the patient level details, data definitions and data feeds across the APC is being undertaken. The outcome of this will be reviewed by the executive leads and once agreed, confirmed data will be reported (expected for the month 11 dashboard).

Each case is referred to the Maternity and Newborn Safety Investigations (MNSI which has replaced HSIB) for investigation with learning and themes shared in each Trust and across the LMNS.

Recovery Plan: A full review of all cases has commenced as part of the data review described above. This will confirm data definitions, move to align these across the ICB, LMNS, APC and all internal trust reports. The birthplace for babies will be mapped as part of this and reporting to identify this will be considered. THH have noted an increase in cases, a thematic review is underway.

Improvements: Improvements will be confirmed as part of this report in March 2024 where required.

Forecast Risks: Data discrepancies require review to ensure consistent reporting and allow identification of trends and themes.

CURRENT PERFORMANCE

	Total Births	Brain Injuries in Month	Brain Injuries YTD	Early Notifications of Concern YTD
CWFT	806	0	8	
ICHT	771	0	9	
LNW	334	0	1	
THH	339	1	8	
APC	**2250**	**1**	**26**	

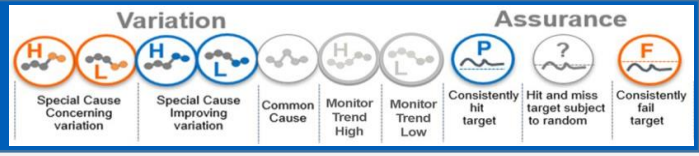
STRATIFICATION

This section is deliberately left blank

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board

(Maternity) % of babies delivered in an appropriate care setting for gestation



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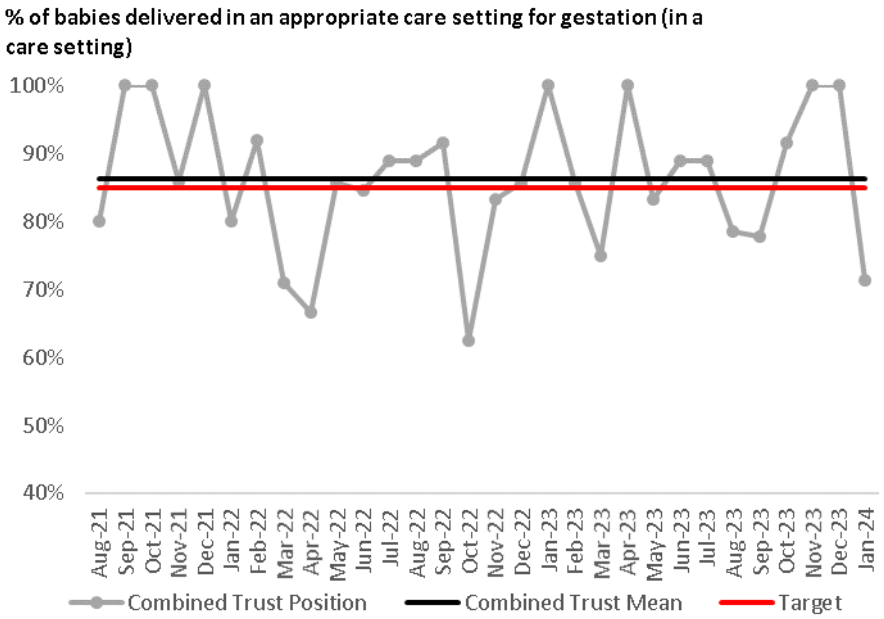


>85%

STANDARD

71.4%

PERFORMANCE

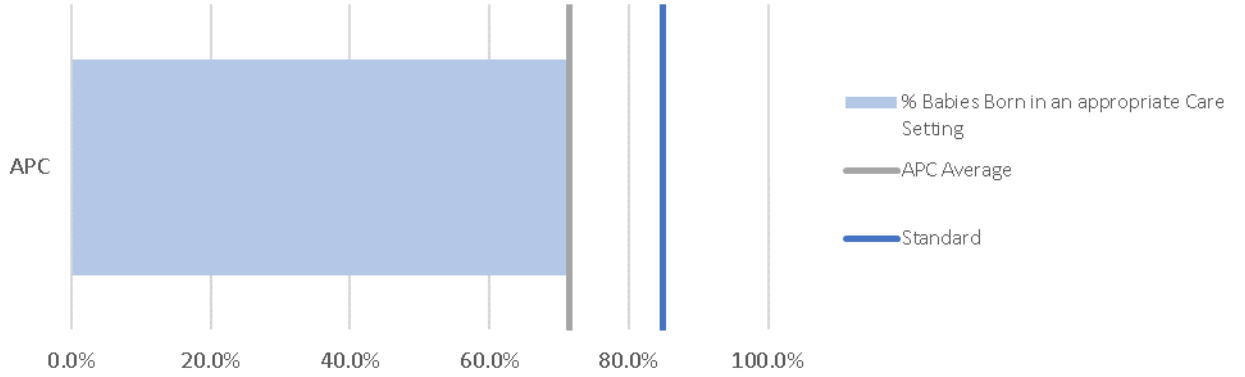
TREND

ASSURANCE

CURRENT PERFORMANCE

	% Babies Born in an appropriate Care Setting	Number of Babies Born in an Inappropriate Care Setting / Number of Babies of that Gestation In Month	Babies Born in an Inappropriate Care Setting / Number of Babies of that Gestation YTD
CWFT	80%	1 / 5	4 / 29
ICHT	100%	0 / 1	1 / 62
LNW	-	0 / 0	2 / 2
THH	0%	1 / 1	5 / 5
APC	71.4%	**2 / 7**	**12 / 98**

STRATIFICATION



NARRATIVE

Performance: The APC was below the standard for this metric in January. There were two babies born in an inappropriate care setting, one at CWFT and one at THH.

CWFT: 26+5, woman with a history of recurrent antepartum haemorrhage admitted in spontaneous labour following suspected pre-term rupture of membranes at home and the baby was born within 1 hour of the woman attending.

THH: Baby delivered at 23+1 gestation. No risk factors for preterm birth. Mother unsuitable for transfer due to clinical condition. Currently under investigation with an ‘after action' review.

Recovery Plan: N/A

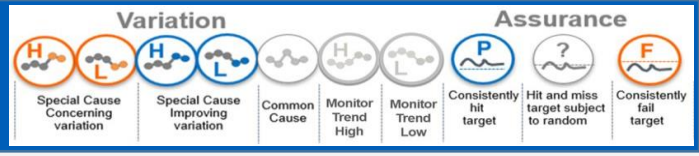
Improvements: Pan London IUT guidelines launched in October 2023. There are challenges in ensuring all aspects are being implemented and this is being worked through in each unit and across the APC.

Forecast Risks: Vacancy rates are dropping however workforce across maternity and neonatal services continues to be of concern in regards to being able to meet this target.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board

(Maternity) Term Admissions in Neonates



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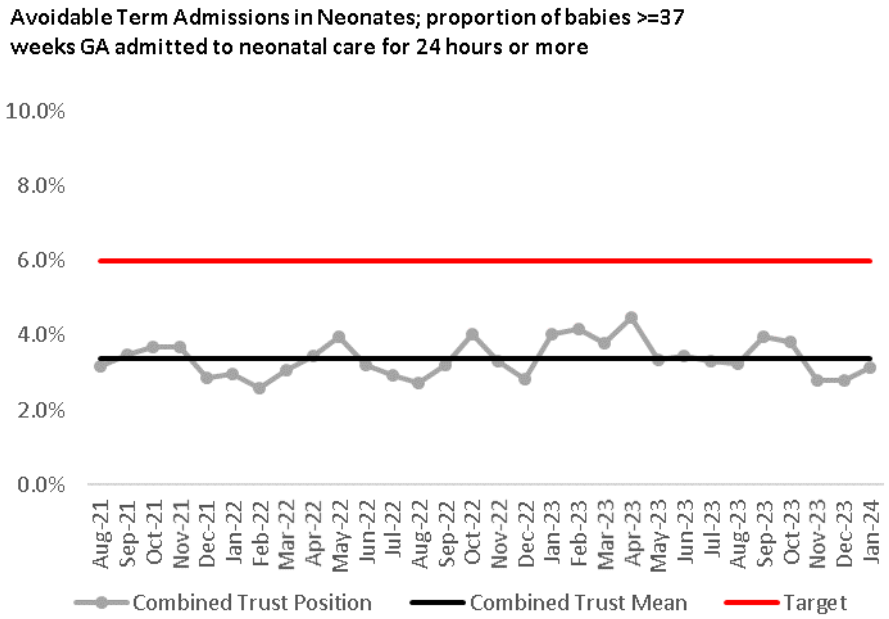


<6%

STANDARD

3.1%

PERFORMANCE

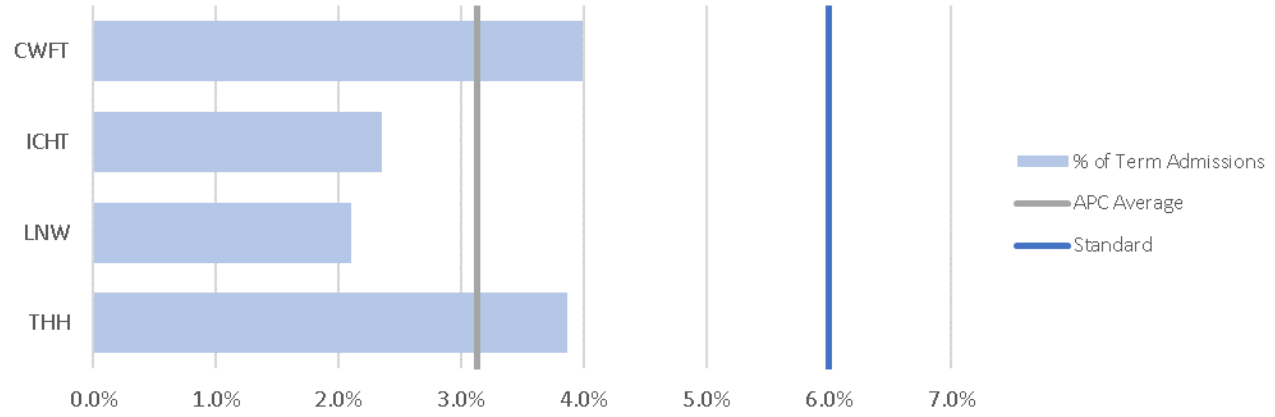
TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Term Admissions	Number of Term Admissions YTD	% of Term Admissions	Difference from Threshold
CWFT	32	278	4.0%	
ICHT	18	196	2.3%	
LNW	7	110	2.1%	
THH	13	158	3.9%	
APC	**70**	**742**	**3.1%**	

STRATIFICATION



NARRATIVE

Performance: In January, NWL had 3.1% term admissions to neonatal units (ATAIN), below the 6% national target. All maternity units have transitional care units and ongoing quality improvement projects to maintain best practice.

Each term admission is reviewed for learning and to determine if it was 'avoidable'. Data on avoidable admissions is reported quarterly and in arrears in this report to allow for the review process to be completed. The data below is for Q3 2023/24 (Oct-Dec 2023):

- CWFT: 16 avoidable admissions (6 at WM, 0 at CW). There are action plans in place for both sites.
- ICHT: 3 avoidable admissions (1 at QCCH and 2 at SMH)
- LNW: 3 avoidable admissions
- THH: 1 avoidable admission

Recovery Plan: N/A

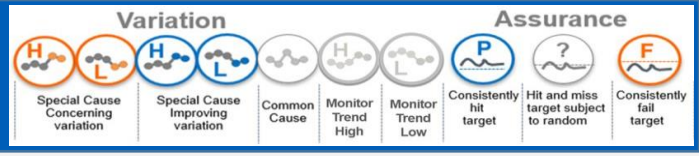
Improvements: Neonatal units co-producing standardised ATAIN and Transitional care audits to facilitate benchmarking and trend analysis across the sector to reduce separation of mother and baby. Findings reported to and discussed in LMNS board quarterly.

Forecast Risks:. None identified

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board

(Maternity) Preterm Births



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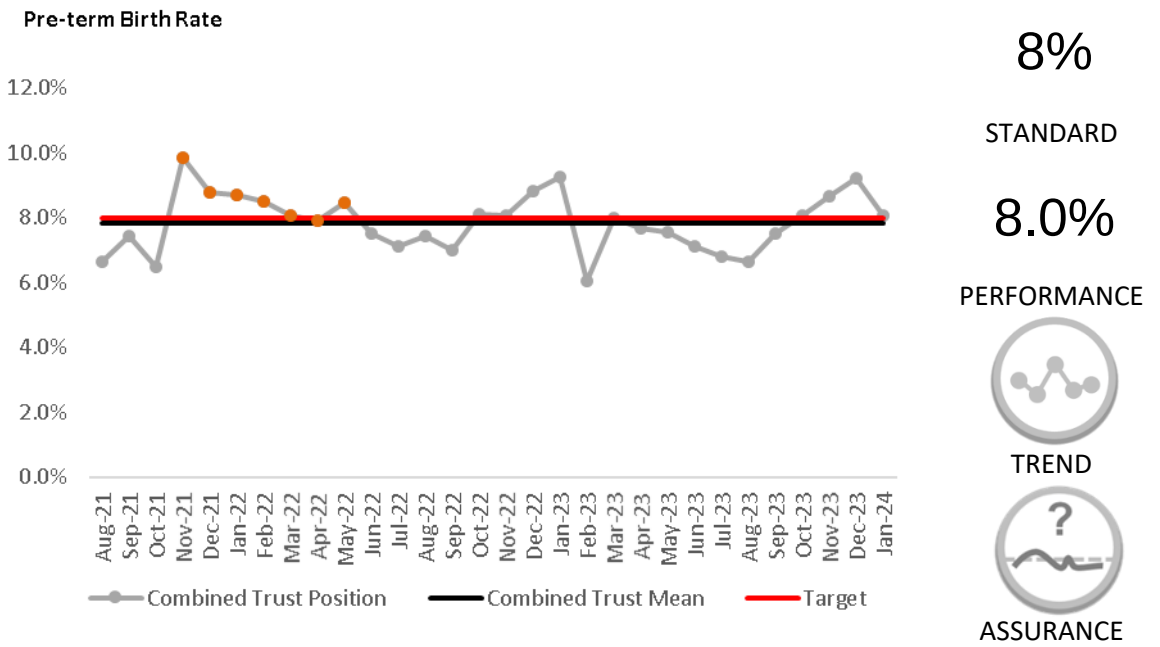


8%

STANDARD

8.0%

PERFORMANCE

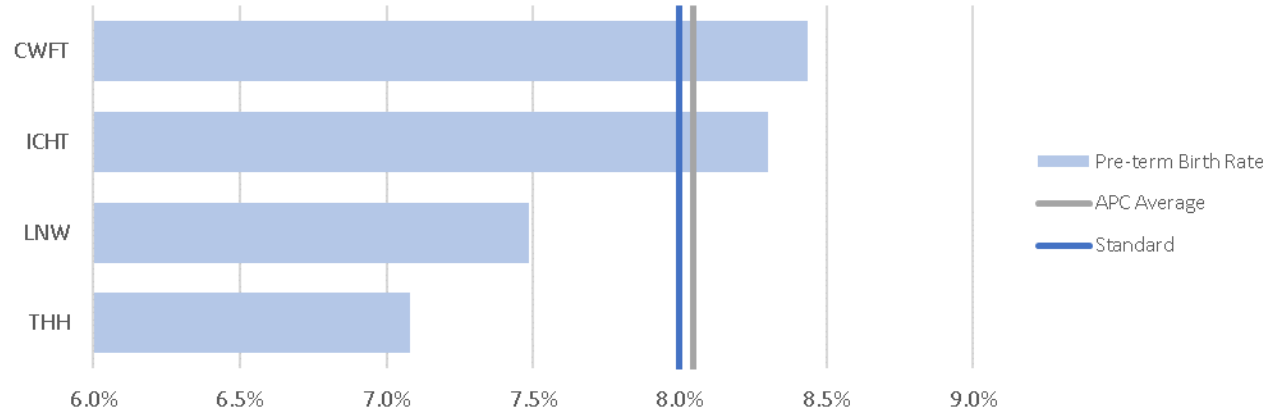
TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Pre-Term Births	Total Births	Pre-term Birth Rate	Difference from Threshold
CWFT	68	806	8.4%	0.44%
ICHT	64	771	8.3%	0.30%
LNW	25	334	7.5%	
THH	24	339	7.1%	
APC	**181**	**2250**	**8.0%**	**0.04%**

STRATIFICATION



NARRATIVE

Performance: In month, NWL had a pre-term birth rate of 8% which is just on the target. ICHT and CWFT are just above target.

Recovery Plan: A review of the data is being undertaken at ICHT to identify any trends or issues. CWFT has seen a sustained increase in pre-term births this is mostly driven by iatrogenic preterm birth (this is mainly due to pre-eclampsia, growth restriction/abnormal USS, abnormally invasive placenta), this is being monitored closely by the leads

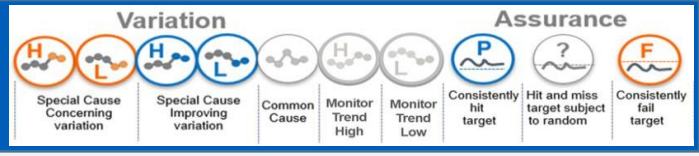
Improvements: LNW is setting up a preterm birth working group with the aim of focusing on their local data/audit/guidelines and some wider QI initiatives to review rates. The APC is undertaking a review of all preterm births and IUT across both sites at CWFT as part of the business case development to support service redesign of the level 2 NICU as well as the preterm birth antenatal service at WM site.

Forecast Risks: No risks identified.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board

(Maternity) Neonatal Crude Deaths



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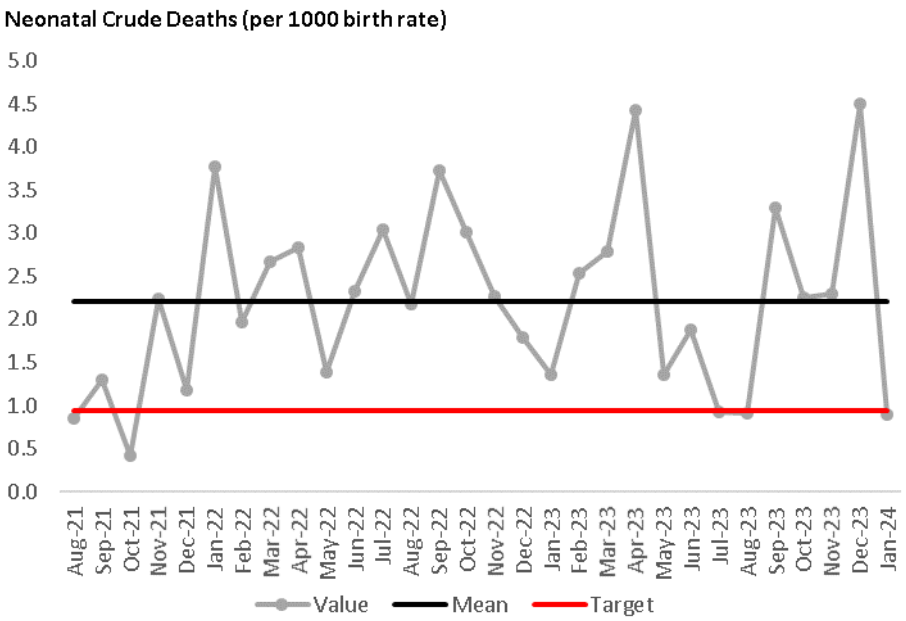


0.94

STANDARD

0.89

PERFORMANCE

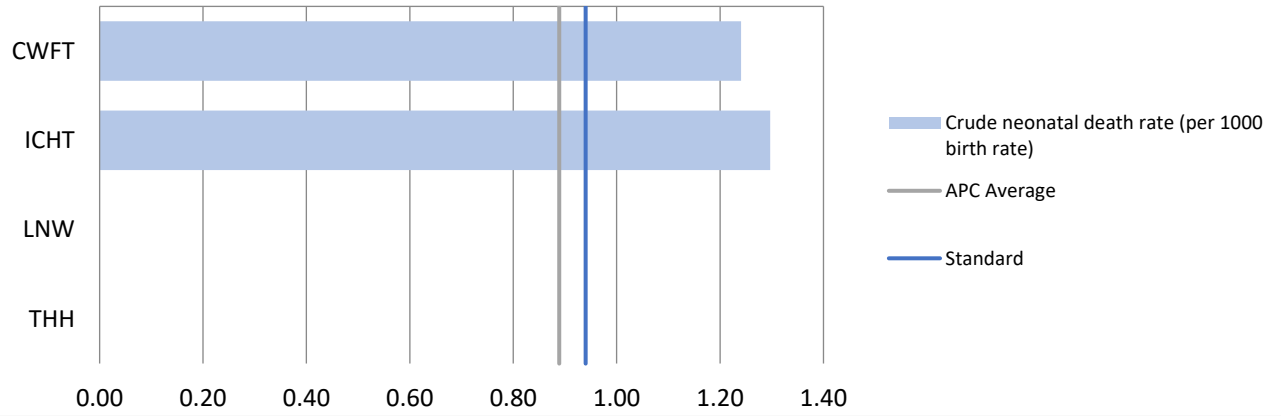
TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Neonatal Deaths	Total Births	Crude neonatal death rate (per 1000 birth rate)	Difference from Threshold
CWFT	1	806	1.24	0.30
ICHT	1	771	1.30	0.36
LNW	0	334	0.00	
THH	0	339	0.00	
APC	**2**	**2250**	**0.89**	

STRATIFICATION



NARRATIVE

Performance: The crude neonatal death rate at APC level was below target in January. There were two neonatal deaths reported in-month (1 at CWFT and 1 at ICHT).

CWFT: 25+3, admitted with bleeding & premature rupture of membranes, maternal complex medical history. Baby severely growth restricted at birth despite maximal support sadly care was redirected.

ICHT: Pre-term pre-labour rupture of membranes at 21+2 weeks gestation.

All cases are being appropriately investigated.

Recovery Plan: Discrepancies have been noted when comparing the internal data at ICHT. A review of the data definitions and patient level information is being undertaken, led by the Chief Nurse from CWFT, the SRO for the APC maternity work stream with trust leads, the ICB and LMNS.

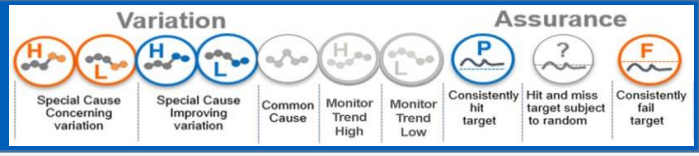
Improvements: The Neonatal CRG and the Trust teams will continue to monitor any new cases.

Forecast Risks: None identified.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board

(Maternity) Maternal Deaths



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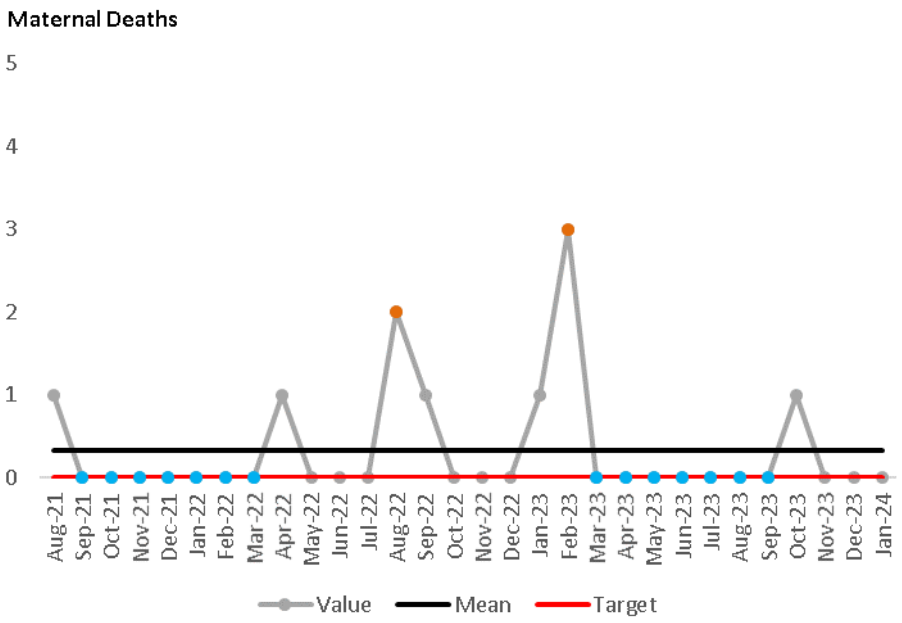

0

STANDARD

0

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Maternal Deaths	Total Births	Difference from Threshold
CWFT	0	806	
ICHT	0	771	
LNW	0	334	
THH	0	339	
APC	**0**	**2250**	

STRATIFICATION

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NARRATIVE

Performance: There were no maternal deaths in January 2024. The death which occurred in October remains under investigation by MNSI.

Recovery Plan: N/A

Improvements: N/A

Forecast Risks: No current risks.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board

Operational Performance

Operations Summary

Introduction:
A range of operational performance indicators are monitored to ensure that the APC is on target to deliver the level of performance set out in the Operating Plan 2023-24 and that locally agreed targets are met. All Trusts continued with areas of improved performance.

Performance:
The UEC pathways have seen improvements across all metrics with an increase in overall performance and decrease in long waiting patients in ED. The ICB with the APC are looking at additional transformation work with LAS to reduce conveyancing and increase response times. Pathway 1 patients in the acute Trusts not meeting the criteria to reside remains a significant challenge to the acute bed base.

Long-waiting patients have decreased again with consistent high activity and LNW recovering post Cerner go-live . NWL remains a high performer both within London and nationally. The long-waiting patient cohort has been impacted by strike action, and more recently patient choice, meaning that there will be a small number of 78ww at the end of the financial year.

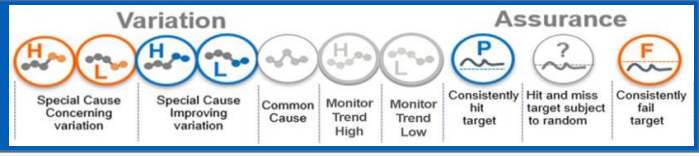
Cancer performance was challenged in January for all targets due to two period of strike action and seasonality. This is recovering post January.

Diagnostics has deteriorated and all Trusts have recovery plans to meet DM01. Mutual aid, where appropriate, will be utilised.
Some data errors are still being corrected post Cerner implementation.

Key Actions:
Continued focused work on the last month to meet the 76% UEC target.
Continued drive to meet the Faster Diagnosis Standard for our cancer patients.

Escalations:
DM01 unlikely to be consistently achieved until Quarter 2 of 2024-25.
Ongoing strike action is a risk to most standards.

Operations Ambulance Handover Waits



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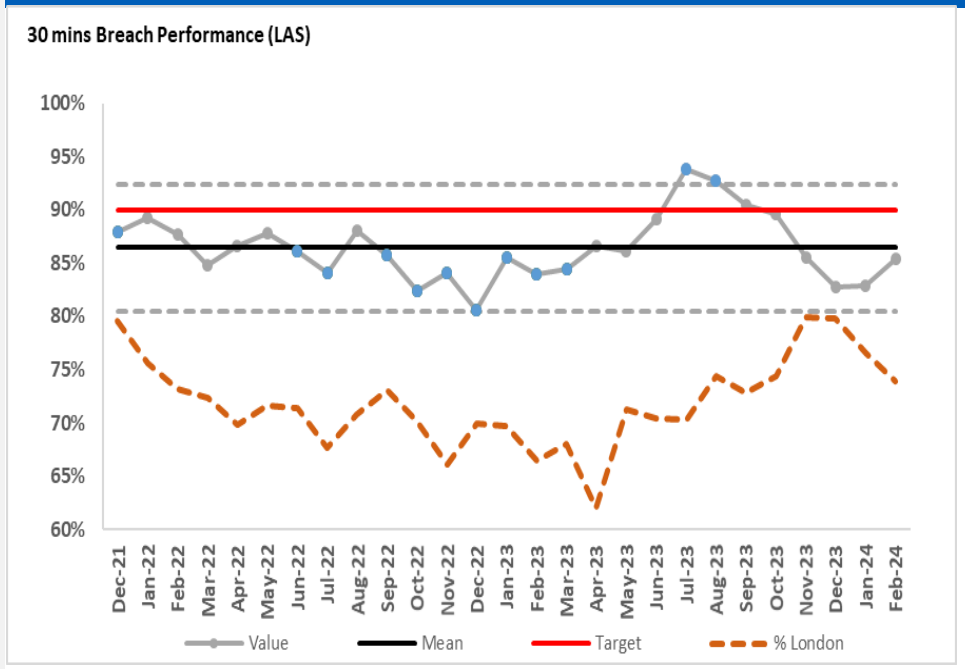


90%

STANDARD

85.4%

PERFORMANCE

TREND

F

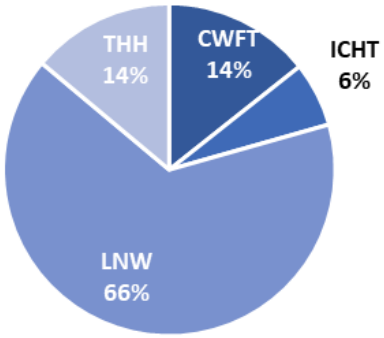
ASSURANCE

CURRENT PERFORMANCE

LAS Handover Waits within the thirty minute standard Feb-24

	Total Handover	30 mins Performance	Difference from target	30 min + delays	Of which	Impacts on	
					60 min + delays	15 min + delays	LAS time lost (hours)
CWFT	3147	92.4%		238	4	1693	241
ICHT	2694	96.1%		104	1	922	100
LNW	3816	71.5%	-18.5%	1086	43	2300	1333
THH	1681	86.3%	-3.7%	231	6	904	157
APC	**11338**	**85.4%**	**-4.6%**	**1659**	**54**	**5819**	**1831**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: NWL continues to have the best handover performance across London, with the lowest average overrun per breach.

Recovery plan: All sites have a focus on minimising handover delays. Collectively we are participating in transformation work with LAS and the ICB to maximise the use of alternatives to ED and to expand the use of direct referral routes and direct booking.

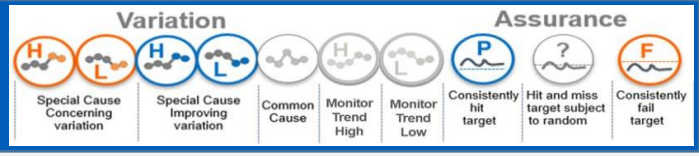
Improvements: At LNW, the process for managing ambulance volumes between Northwick Park and Ealing has been reviewed and improved. THH reported in-month improvement in 30-minute performance of 9 percentage points. The acute collaborative was the first in London to pilot and implement the new LAS standard operating procedure for immediate handover at 45 minutes. The process is now embedded in business as usual.

Forecast risks: Continued increases in the number of conveyances.

GOVERNANCE

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

Operations Urgent & Emergency Department Waits



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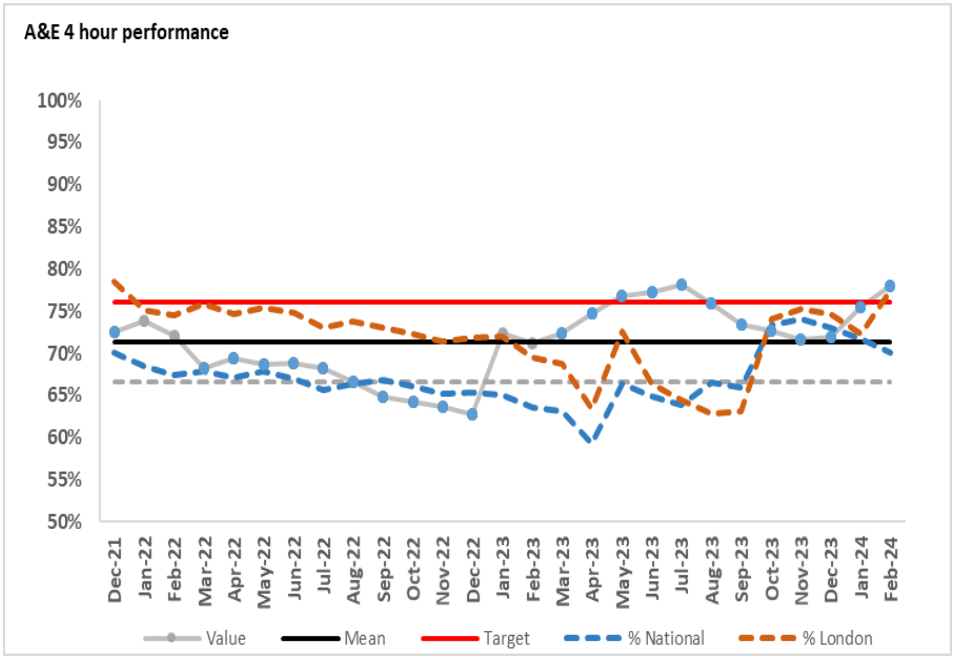


76%

STANDARD

77.9%

PERFORMANCE

TREND

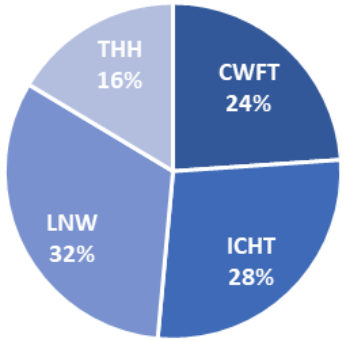
ASSURANCE

CURRENT PERFORMANCE

Time spend in Emergency Department: 4-Hour Standard Feb-24

	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	24663	81.8%		4494	4359	77.2%	135	97.6%	1567
ICHT	22133	76.6%		5170	4684	69.1%	486	93.1%	4882
LNW	26748	77.4%		6039	5808	54.9%	231	98.3%	1008
THH	11557	73.4%	-2.6%	3078	2962	45.3%	116	98.1%	1904
APC	**85101**	**77.9%**	**1.9%**	**18781**	**17813**	**66.1%**	**968**	**97.0%**	**9361**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: Performance against the 4-hour standard improved across all four APC sites, meeting the 76% target overall.

Recovery plan: A range of measures are in place at each site to improve and sustain performance and maintain safe levels of care.

Each Trust met with the APC UEC Lead and the UEC National Clinical Director to review their recovery plans during March 2024.

Improvements: The improvement plans are built on the recommended actions arising from the patient first and FOCUSED self-assessments, missed opportunity audits, peer reviews for adult ED, paediatric ED and discharge, and maturity assessments against the NHSE ten recommended high impact interventions. THH introduced a new clinical decision unit to improve flow.

Forecast risks: Increases in demand, continued delays with discharge for medically optimised patients.

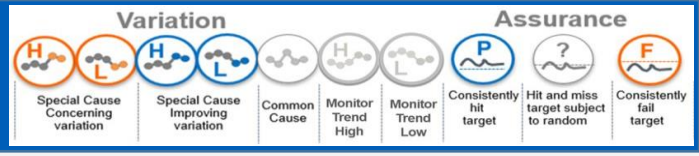
GOVERNANCE

Senior Responsible Owner: Claire Hook, Chief Operating Officer, ICHT

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

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

Operations Urgent & Emergency Department Long Waits



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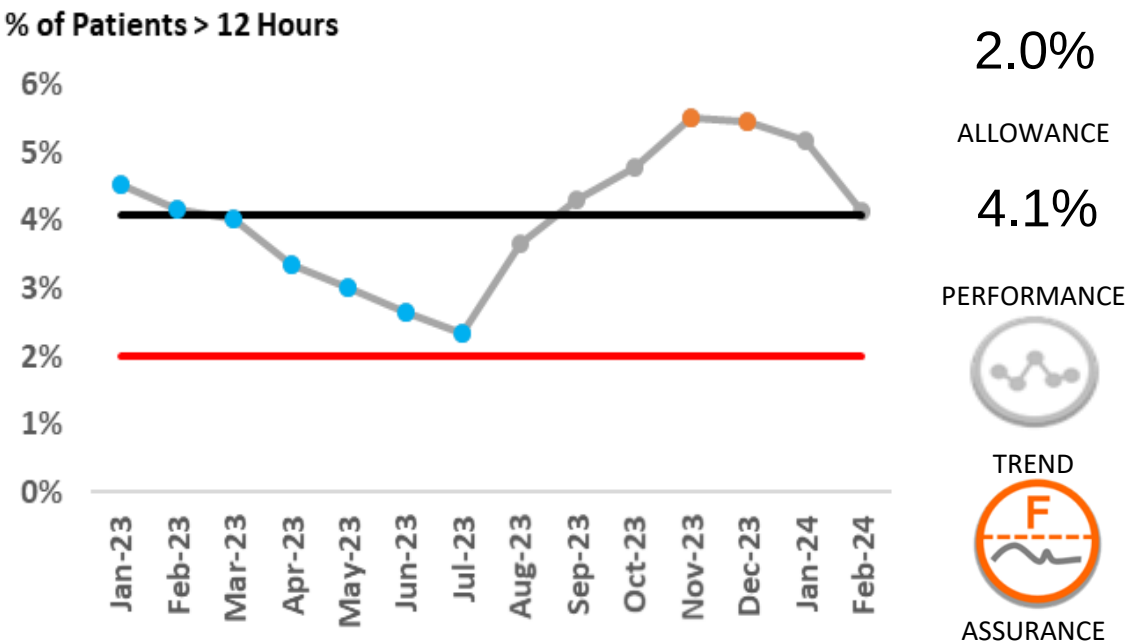


2.0%

ALLOWANCE

4.1%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: Performance improved across all four APC sites to the lowest level since September 2023.

Recovery plan: Long waits in the ED are linked to flow through the hospital as well as those waiting for beds outside the hospital. Winter capacity is being utilised at all sites to support flow. As with 4-hour performance, each site has identified a range of actions to recover performance and maintain safe levels of care.

Improvements: Work continues to deliver the NWL UEC work programme, which comprises 12 work streams with the aim of reducing demand for emergency services where appropriate, reducing the number of admissions and reducing waits at every point in the pathway.

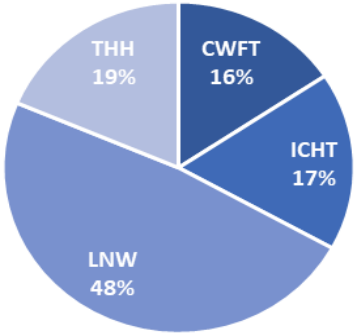
Forecast risks: Increases in demand, continued delays with discharge for medically optimised patients, continued delays for patients waiting for admission to mental health beds.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 12-Hour waits Feb-24

	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	25836	2.1%	-0.1%	551	551	0	51
ICHT	22133	2.8%	-0.8%	611	611	0	77
LNW	26748	6.4%	-4.4%	1699	1699	0	556
THH	11557	5.7%	-3.7%	654	654	0	20
APC	**86274**	**4.1%**	**-2.1%**	**3515**	**3515**	**0**	**704**

STRATIFICATION



Trust share of APC waits longer than standard

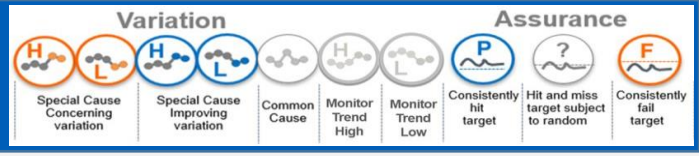
GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Deputy Chief Operating Officer,

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

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

Discharge – patients not meeting the criteria to reside



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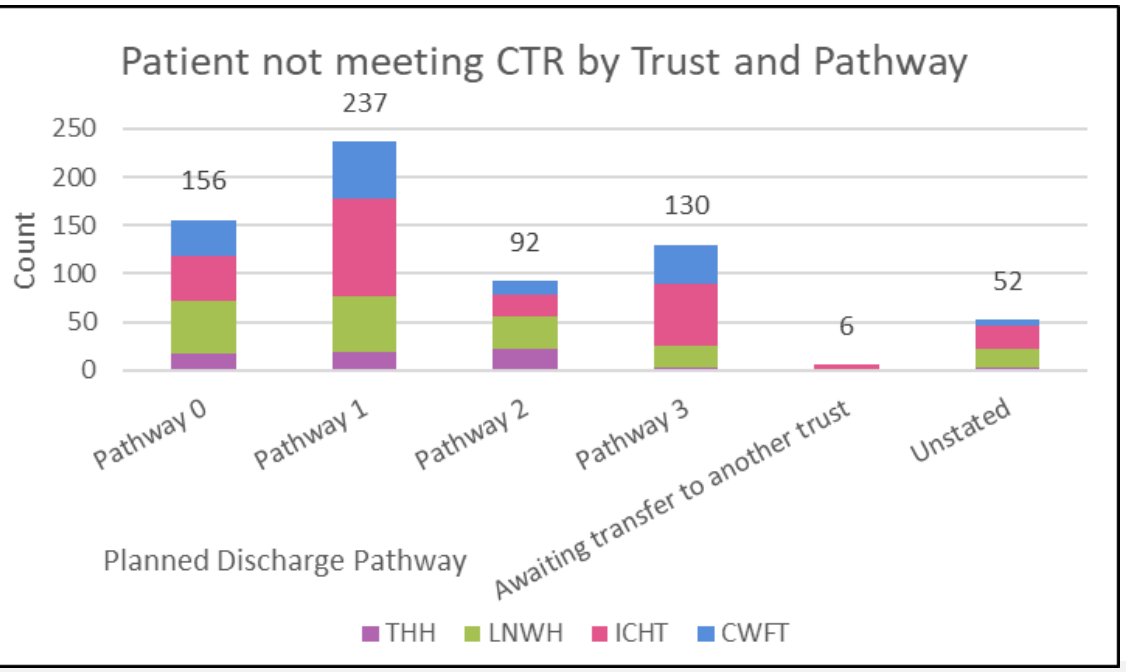

NARRATIVE

Performance: In January significant improvement was seen in the P1 pathway across most boroughs. This has deteriorated since then and P1 patients make up the largest volume or delays. P0 numbers appear high as all patients are input into the Optica system, not just pathway 1-3. This number will likely be the largest, but a majority of these patients are discharged on the same day. ICHT is the Trust most impacted by the high number of P1's.

Recovery: Improvement: On going work with each local authority to improve P1 discharges.

Forecast risks: Ongoing pressure on G&A bed occupancy.

Simplified pathway definitions: P0 –no care needs once discharged/ P1 –minimum care needs such as therapy of package of care/ P2 – rehabilitation needs not at home/ P3 – placement in a different place of residence

CURRENT PERFORMANCE

Local Authority	CWFT	ICHT	LNW	THH	Total	List Size	Rater per 10,000
Brent		37	54		91	438,574	2.07
Ealing	10	33	60	6	109	425,331	2.56
H&F	16	66	2		84	300,686	2.79
Harrow	1	1	46	3	51	258,617	1.97
Hillingdon	1	10	9	49	69	319,816	2.16
Hounslow	49	21	2	1	73	335,954	2.17
Kensington & Chelsea	27	19			46	268,535	1.71
Westminster	1	47			48	255,610	1.88
Out of area	52	30	14	6	102		
Total	157	264	187	65	673		

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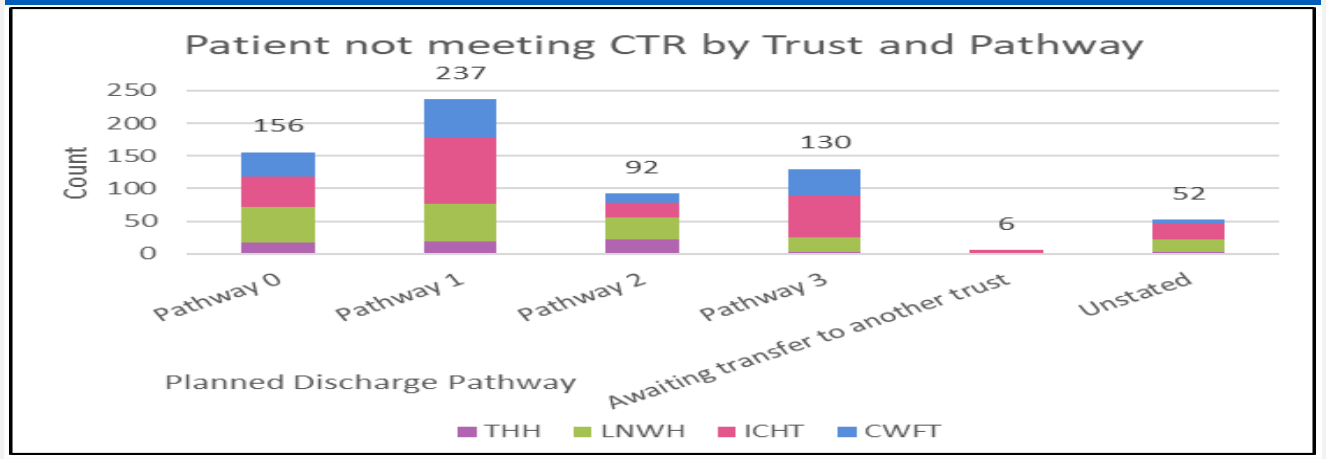
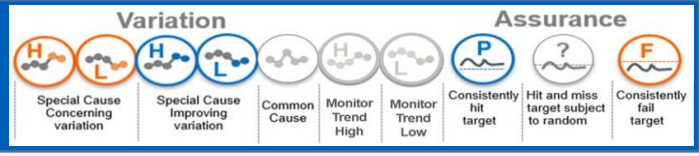


GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Deputy Chief Operating Officer
Committee: APC EMB (Chair: Tim Orchard); NWL UEC Board (Chair: Rob Hurd)
Data Assurance: These figures come for the FDP via the ICB

Operations Referral to Treatment Waits



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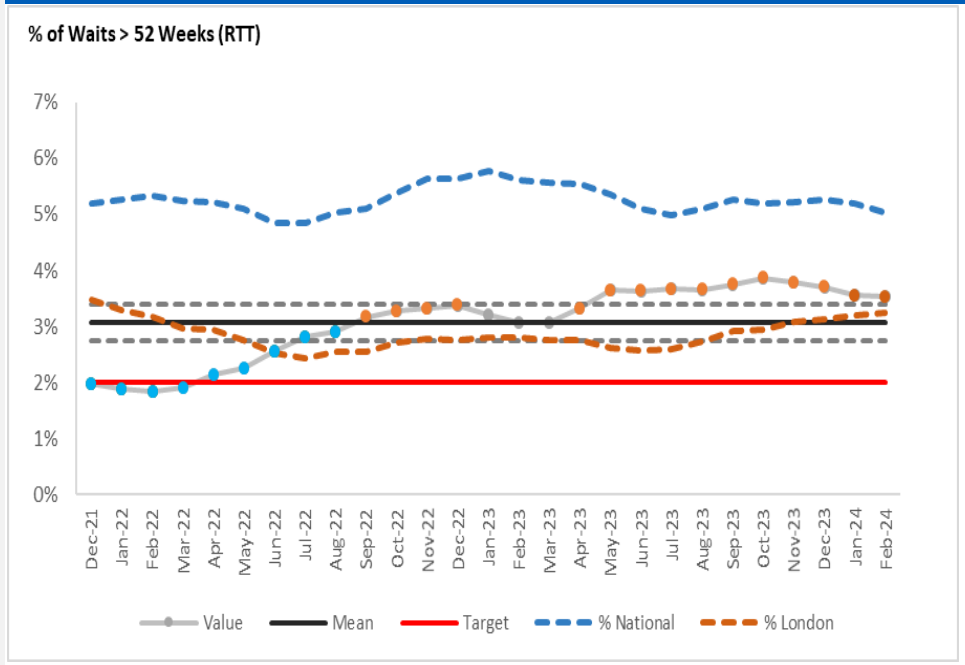


2.0%

ALLOWANCE

3.5%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: The total RTT waitlist increased post Cerner implementation at LNW and THH. These lists have now stabilised and both Trusts are taking action to increase the level of validation to remove duplicate pathways. Long waiting patients continue to reduce. The Trusts with breaches of 78ww are LNW, ICHT and CWFT. ICHT have two 104ww which were discovered as part of a routine audit. One has been seen and discharged, the second will be treated in April at their choice.

Recovery: Trusts are looking at additional insourcing to supplement some of the lost activity in recent months. NWL's most challenged specialities remain Trauma & Orthopaedics (CWFT), ENT (ICHT), ENT (THH) and Gynaecology (LNW).

Improvement: On going reduction of long waiting patients.

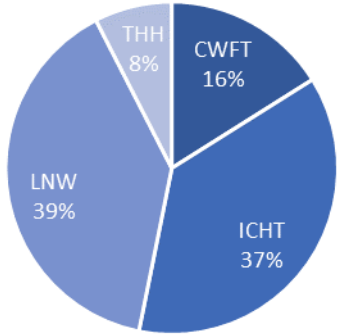
Forecast risks: There will be 78ww at the end of the year.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 18-Week Standard Feb-24

	Total Waiting List	Waits > 52 weeks	Difference from target	52 + weeks	Of which		Impacted by	Impacts on	Average wait (weeks)
					65 + Weeks	78 + weeks	104 + weeks	OTDCs not booked < 28 days	
CWFT	61358	2.7%	-0.7%	1665	425	114	0	4	17.47
ICHT	100270	3.8%	-1.8%	3845	1020	110	2	15	19.73
LNW	99994	4.1%	-2.1%	4068	1154	155	0	0	20.67
THH	32292	2.4%	-0.4%	782	90	0	0	0	19.47
APC	**293914**	**3.5%**	**-1.5%**	**10360**	**2689**	**379**	**2**	**19**	**19.55**

STRATIFICATION



Trust share of APC waits longer than standard

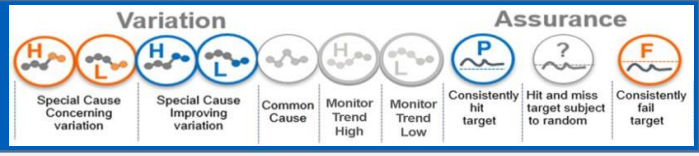
GOVERNANCE

Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

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

Operations Access to Diagnostics



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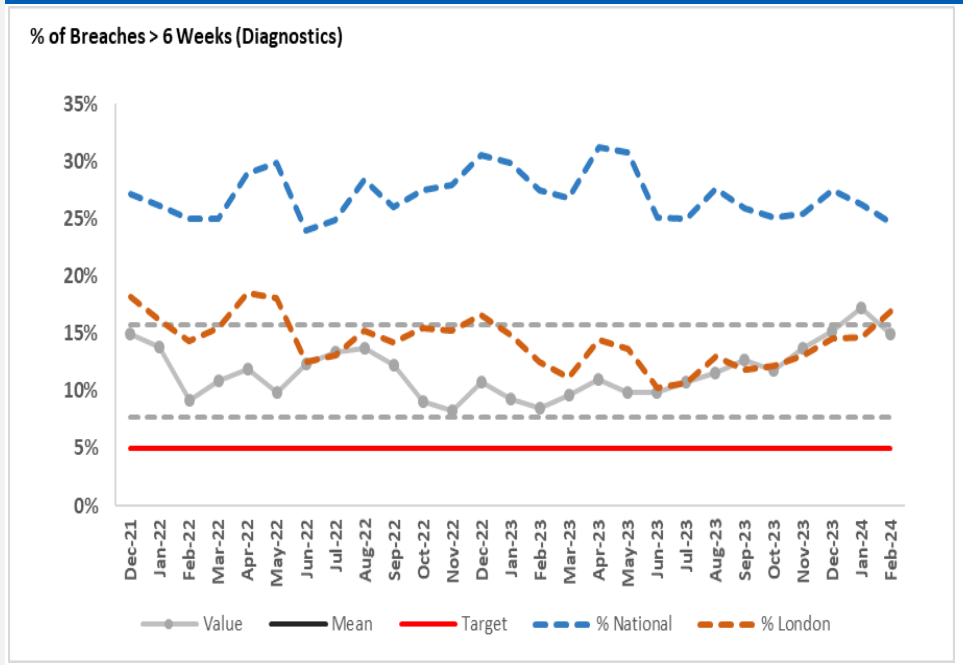


5.0%

ALLOWANCE

15.0%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: The overall performance has deteriorated. Diagnostics focus now includes all the smaller specialities. Audiology remains a challenge for all Trusts apart from CWFT and recovery plans are in place for all Trusts. Audiology overall is not expected to meet the DM01 standard with current resource until August 2024. Additional resources are being sought as well as CWFT providing mutual aid where appropriate. LNW/ THH data issues are now reducing.

Recovery Plan: Each Trust has a recovery trajectory to deliver DM01 by the end of Quarter 2 2024/25. This will be supported by the increase in activity through the CDC's.

Improvements: Parkview (Paediatric Audiology) capacity stood up mid-February 2024. Service forecast to return to compliance towards the end of March/early April 2024

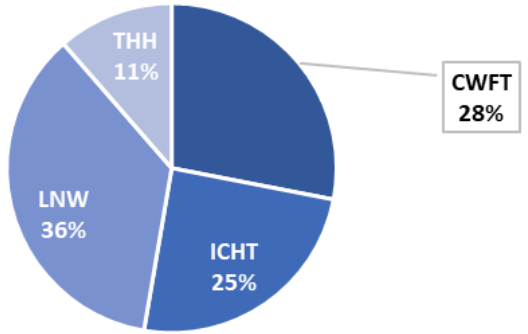
Forecast Risks: MRI capacity and downtime of current scanners, especially at ICHT continues to be a risk.

CURRENT PERFORMANCE

Waits for Diagnostic Tests: 6-Week Standard Feb-24

	Total Waiting List	Waits > 6 weeks	Difference from target	6 + weeks	Of which 13 + weeks
CWFT	14000	15.2%	-10.2%	2132	105
ICHT	16350	11.5%	-6.5%	1874	602
LNW	14544	18.8%	-13.8%	2729	1331
THH	5897	14.7%	-9.7%	866	407
APC	**50791**	**15.0%**	**-10.0%**	**7601**	**2445**

STRATIFICATION



Trust share of APC waits longer than standard

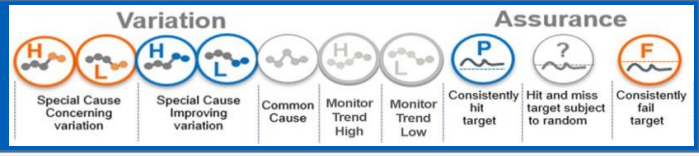
GOVERNANCE

Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

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

Operations Access to Cancer Specialist



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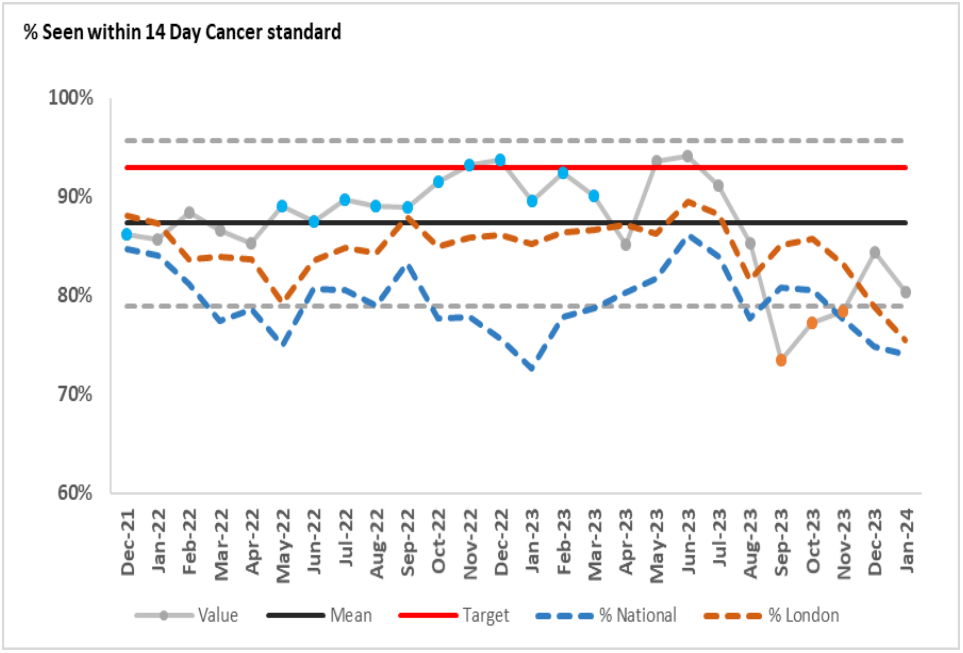


93%

STANDARD

80.4%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: 2WW performance standard is challenged with NWL not meeting the 93% standard mainly due to challenges post Cerner go live at LNW and THH; however month-on-month improvements can be seen at LNW.

Recovery Plan: Actions towards reducing waiting times for diagnostic tests, such as imaging scans, biopsies and increasing capacity in Straight to Test continue.

Improvements: Improving scheduling processes, expanding capacity through additional sessions, and monitoring timed pathways are the key areas of focus across the Trusts.

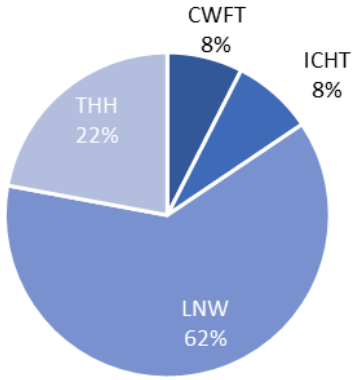
Forecast Risks: Ongoing planning remains crucial to mitigate risks and potential capacity loss resulting from Industrial Action, which could lead to workforce challenges and has contributed to the position deteriorating in December and January for LNW and THH as anticipated. Improvements are expected to be seen in February 2024 performance.

CURRENT PERFORMANCE

Wait to be Seen by a Cancer Specialist following an urgent GP Referral: Two Week Wait Standard Jan-24

	Total Seen	Two-week wait performance	Difference from target	14 + days	Of which	
					28 + days	Breast referrals
CWFT	2476	94.5%		136	15	21
ICHT	2533	94.2%		146	0	666
LNW	3024	62.6%	-29.4%	1130	295	1
THH	1216	67.1%	-24.9%	400	98	190
APC	**9249**	**80.4%**	**-11.6%**	**1812**	**408**	**878**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

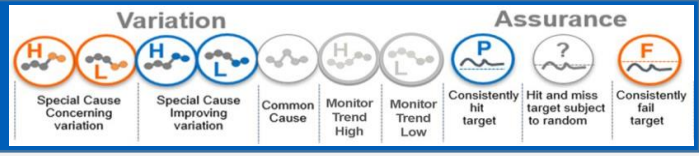
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

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

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

Operations

Access to Cancer Care (Faster Diagnosis)



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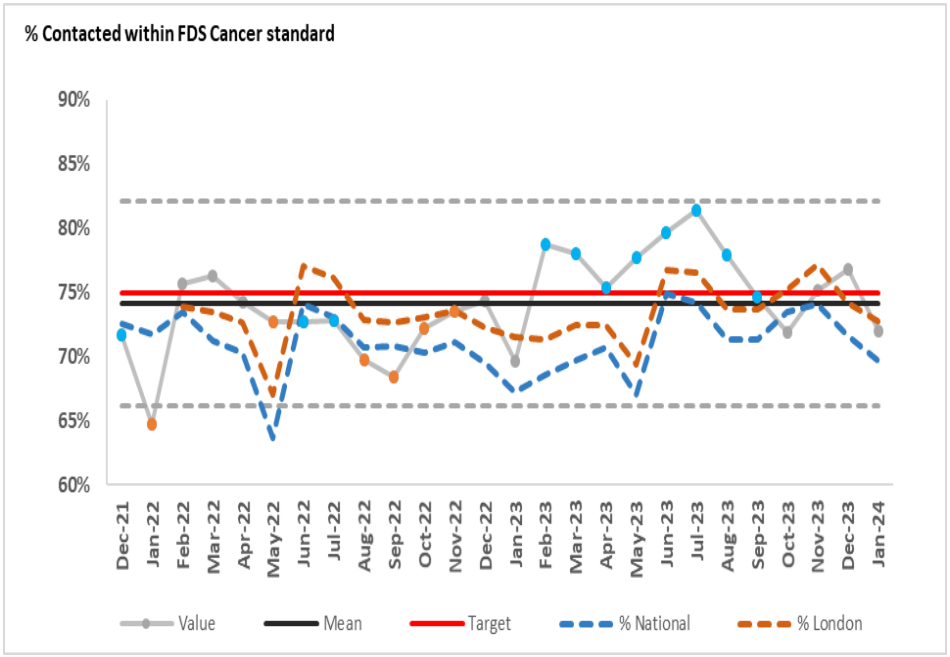


75%

STANDARD

72.0%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: FDS was challenged in January at 72%. Across all of NWL. December and January were significantly challenged months operationally due to reduced capacity due to leave and industrial action and Cerner go-live legacy impact.

Recovery Plan: Working with all trusts to recover cancer pathways.

Improvements: Providers and RMP are collaborating to ensure a continuous and dedicated delivery of FDS, with a primary focus on building resilience within the diagnostic pathways and ensuring strict adherence to best practice timed pathways.

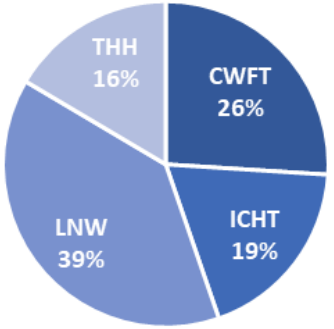
Forecast Risks: Continued planning of capacity for scheduled industrial action to protect cancer pathways as much as possible. Cerner implementation is a risk for tracking patients in a timely and proactive way through the diagnostic pathways. January position, as predicted, was impacted at THH and improvements expected from February 2024.

CURRENT PERFORMANCE

Access to Cancer Care (Faster Diagnosis) Jan-24

	Total Contacts	Faster Diagnosis performance	Difference from target	28 + days	Of which 62 + days
CWFT	2572	72.2%	-2.8%	714	140
ICHT	2668	80.8%		513	0
LNW	3326	68.0%	-7.0%	1065	330
THH	1228	63.1%	-11.9%	453	93
APC	**9794**	**72.0%**	**-3.0%**	**2745**	**563**

STRATIFICATION



Trust share of APC waits longer than standard

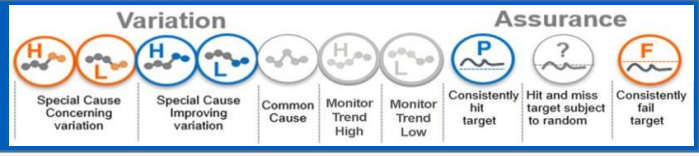
GOVERNANCE

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

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

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

Operations Cancer 31-Day Decision to treatment Combined Standard



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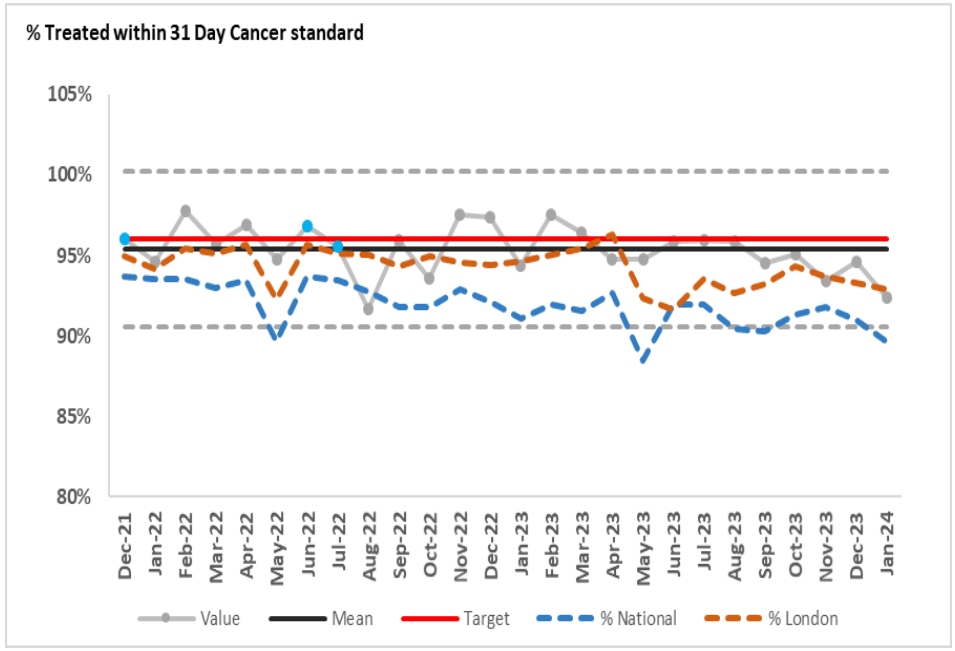


96%

STANDARD

92.4%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: The rise in referral rates has resulted in a notable increase in cancer treatments. However, the planned capacity to meet this heightened demand has been affected by industrial action and now Cerner implementation with planned reduced capacity, leading to a reduction in available appointments. The impact of these IA challenges has been particularly noticeable at ICHT as they are the primary tertiary referral centre for many pathways.

Recovery Plan: The Trusts are actively collaborating with RM Partners to conduct audits and create tumour-specific targeted action plans. These plans are designed with the necessary governance and resources to ensure effective delivery of the initiatives.

Improvements: Maintaining oversight and planning ahead of time for treatment pathways.

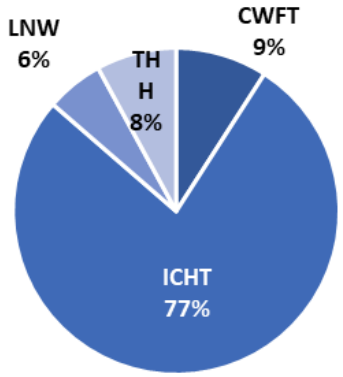
Forecast Risks: As referral rates continue to rise, there is a growing risk of a significant gap between demand and capacity due to workforce challenges. The potential for further industrial action could exacerbate this situation, making it even more difficult to meet the increasing demand for services.

CURRENT PERFORMANCE

Cancer 31-day decision to treatment combined standard Jan-24

	Total Treated	31 day performance	Difference from target	31 + days	Of which 62 + days
CWFT	186	95.7%	-0.3%	8	0
ICHT	687	90.1%	-5.9%	68	0
LNW	189	97.4%		5	0
THH	91	92.3%	-3.7%	7	2
APC	**1153**	**92.4%**	**-3.6%**	**88**	**2**

STRATIFICATION



Trust share of APC waits longer than standard

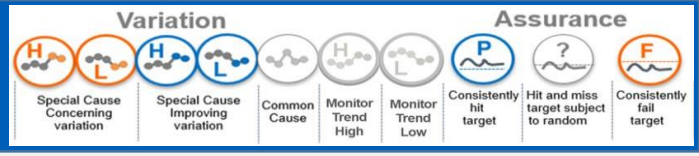
GOVERNANCE

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

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

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

Operations Referral to Cancer Treatment Pathways



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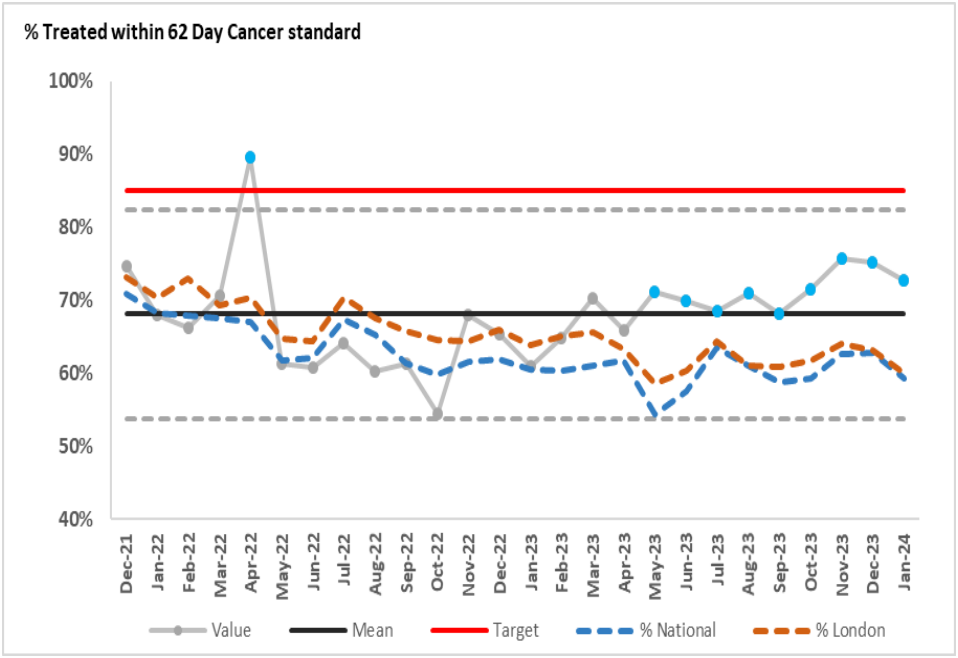


85%

STANDARD

72.7%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Performance against the 62-day standard remains challenged across NWL. There are system-wide pressures that are contributing to this including delays in inter-trust transfers and capacity constraints for treatment pathways due to strikes and holidays. However, NWL is the best performing ICB in London on 62-day performance comparatively.

Recovery Plan: Actions to focus on inter-trust transfers, earlier onward referral and maximising surgical capacity are being worked on.

Improvements: Strengthening the coordination and communication between multidisciplinary teams involved in cancer treatment to help avoid unnecessary delays and ensure timely initiation of treatment.

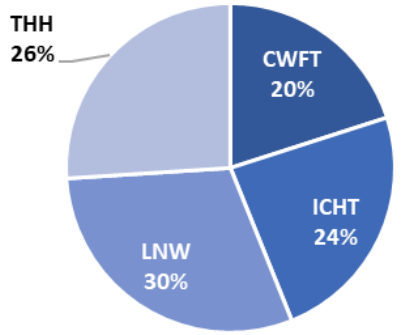
Forecast Risks: Workforce pressures and the potential for continued periods of Industrial action. Cerner implementation has disrupted capacity particularly at LNW, recovery actions are underway.

CURRENT PERFORMANCE

Unacceptable Waits for the Treatment of Cancer: 62-day Combined Standard Jan-24

	Total Treated	62 day performance	Difference from target	62 + days	Of which	Impacts on
					104 + days	Backlog 104 + days
CWFT	185.5	80.3%	-4.7%	36.5	16	25
ICHT	205	78.5%	-6.5%	44	0	62
LNW	188.5	70.6%	-14.4%	55.5	21	105
THH	87	47.1%	-37.9%	46	4	13
APC	**666**	**72.7%**	**-12.3%**	**182**	**41**	**205**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

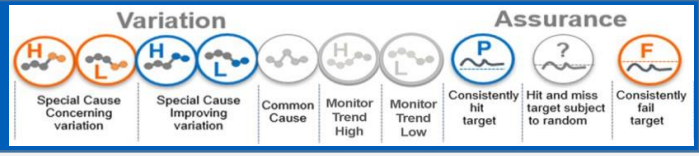
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

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

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

Demand and Capacity Measures

Operations Theatre Utilisation *(Uncapped)*



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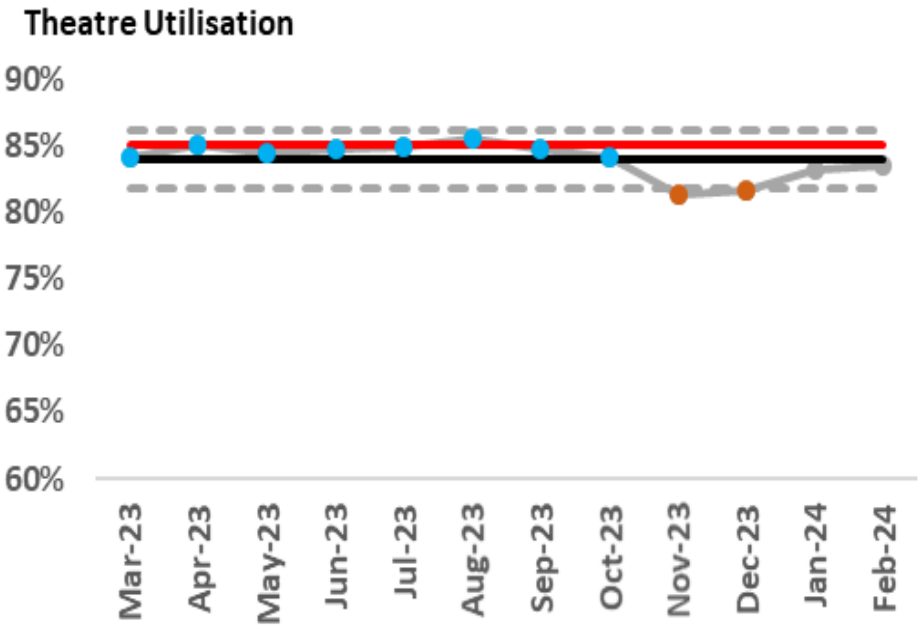

85%

STANDARD

83.5%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Theatre utilisation is very positive. All Trusts are looking at increasing use of sessions and other productivity measures rather than just utilisation for example dropped lists or patients cancelled on the day.

Recovery plan:. LNW have recovered post Cerner go live.

Improvement: Recovery noted post Cerner implementation for LNW and THH, with ongoing strong performance in CWFT and ICHT. THH, CWFT and ICHT remain in the top quartile nationally.

Future risk: Shortages in critical staffing groups

CURRENT PERFORMANCE

Theatre Utilisation Feb-24

	Planned operating time (hours)	Theatre utilisation	Difference from target	Unused time (hours)
CWFT	2890	82.1%	-2.9%	519
ICHT	4761	84.7%	-0.3%	730
LNW	3101	82.8%	-2.2%	533
THH	1192	84.0%	-1.0%	191
APC	**11944**	**83.5%**	**-1.5%**	**1973**

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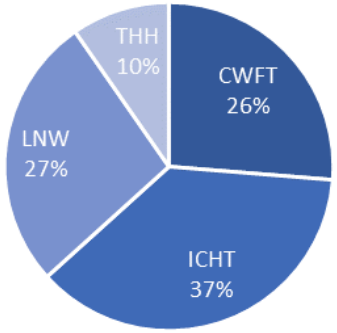


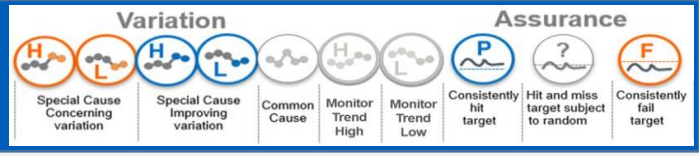
GOVERNANCE

Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

Data Assurance: tbc

Operations Outpatient Transformation



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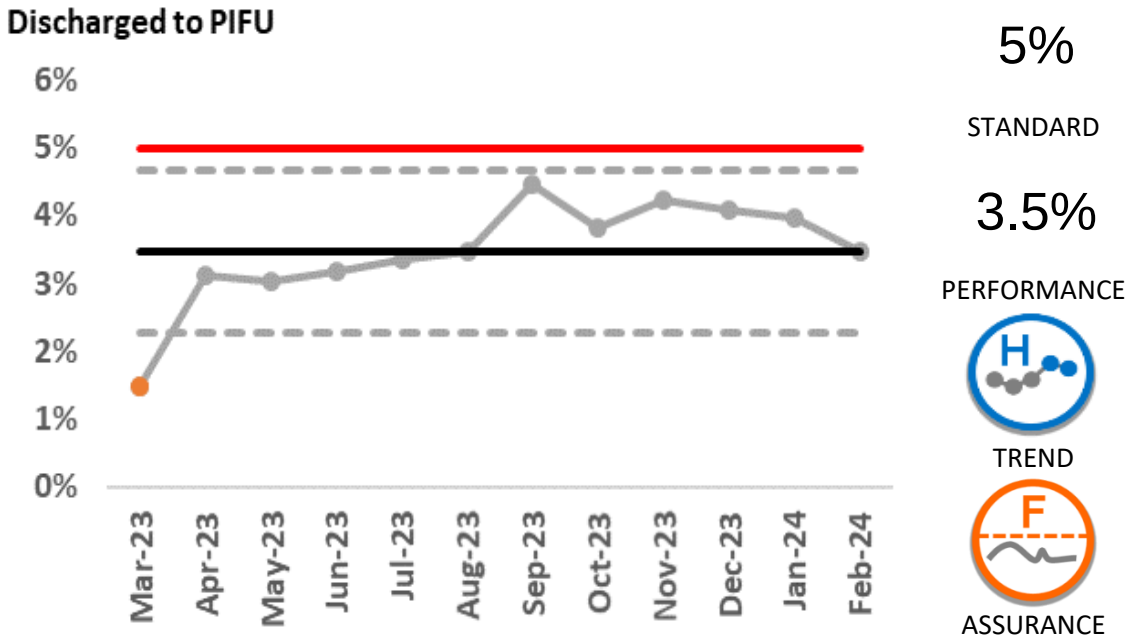

5%

STANDARD

3.5%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Pathways discharged to PIFU have stabilised under target at around 4%. A programme of work looking at those services with the greatest opportunity to utilise PIFU has been started looking at Rheumatology and Therapies.

Recovery plan: Outpatient improvement lead group being set up to standardise practice and increase to above the 5% target

Improvement: All Trusts continue to improve and the APC is above the peer average of 1.8% and the national average of 3.1%

Future risks: Stability, useability and interoperability of digital infrastructure

CURRENT PERFORMANCE

Outpatient Transformation Feb-24

	Total OP contacts	Discharged to PIFU	Difference from target	Moved / Discharged to PIFU	Impacts on		
					OPFA DNAs	OPFU DNAs	Virtual contacts
CWFT	68070	7.3%		4997	11.9%	8.9%	7415
ICHT	68096	0.9%	-4.1%	637	8.1%	7.0%	18066
LNW	50397	2.4%	-2.6%	1195	11.7%	10.7%	9765
THH	33553	2.8%	-2.2%	923	8.9%	10.0%	2629
APC	**220116**	**3.5%**	**-1.5%**	**7752**	**10.1%**	**8.7%**	**37875**

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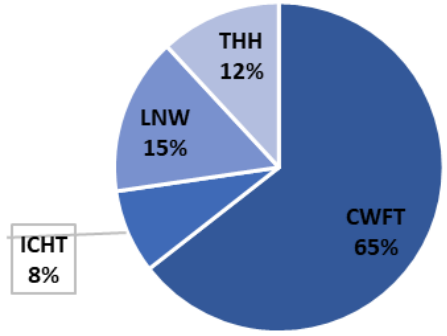


Trust share of APC discharges lower than standard

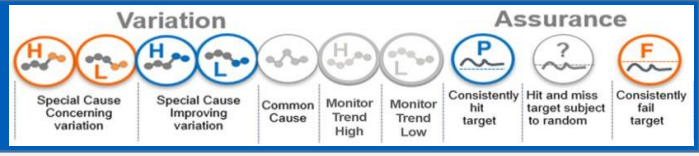
GOVERNANCE

Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

Data Assurance: tbc

Operations Critical Care



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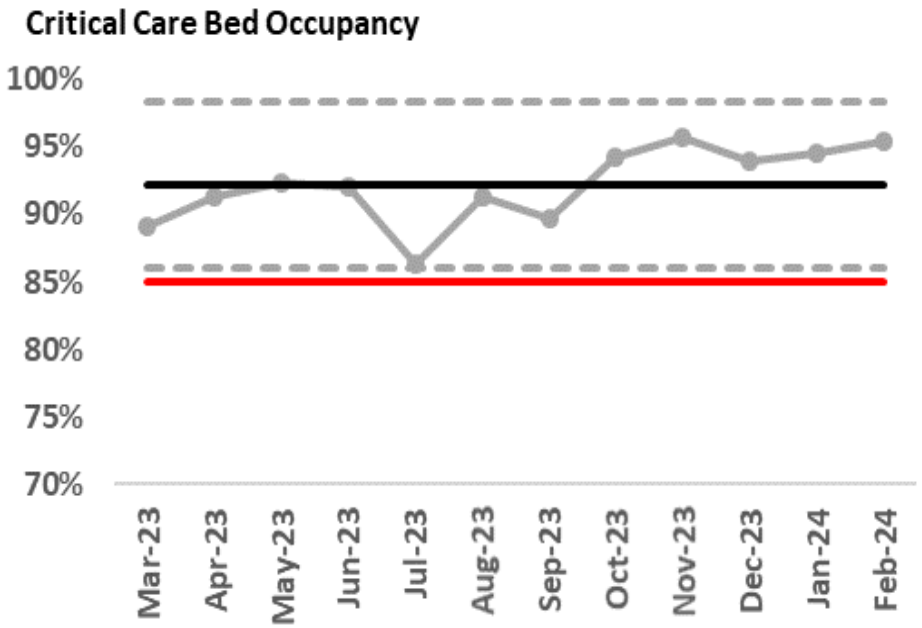


<85%

STANDARD

95.4%

PERFORMANCE

TREND

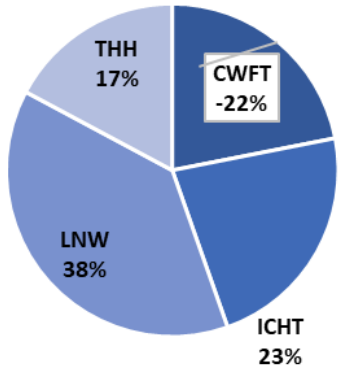
ASSURANCE

CURRENT PERFORMANCE

Critical Care Feb-24

	Available critical care beds	Bed occupancy	Difference from target	Unoccupied critical care beds
CWFT	20	105.3%	20.3%	-1.1
ICHT	94	99.3%	14.3%	0.7
LNW	56	88.3%	3.3%	6.6
THH	12	81.3%		2.2
APC	**182**	**95.4%**	**10.4%**	**8.4**

STRATIFICATION



NARRATIVE

Performance: Bed occupancy remains overall high since October 23.

Recovery Plan: There is a revised mutual aid policy and a surge plan if additional flow should be required across the APC.

Improvements: Not required at this time.

Forecast Risks: None.

Note: There is a review in progress to ensure alignment of occupancy reporting

GOVERNANCE

Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

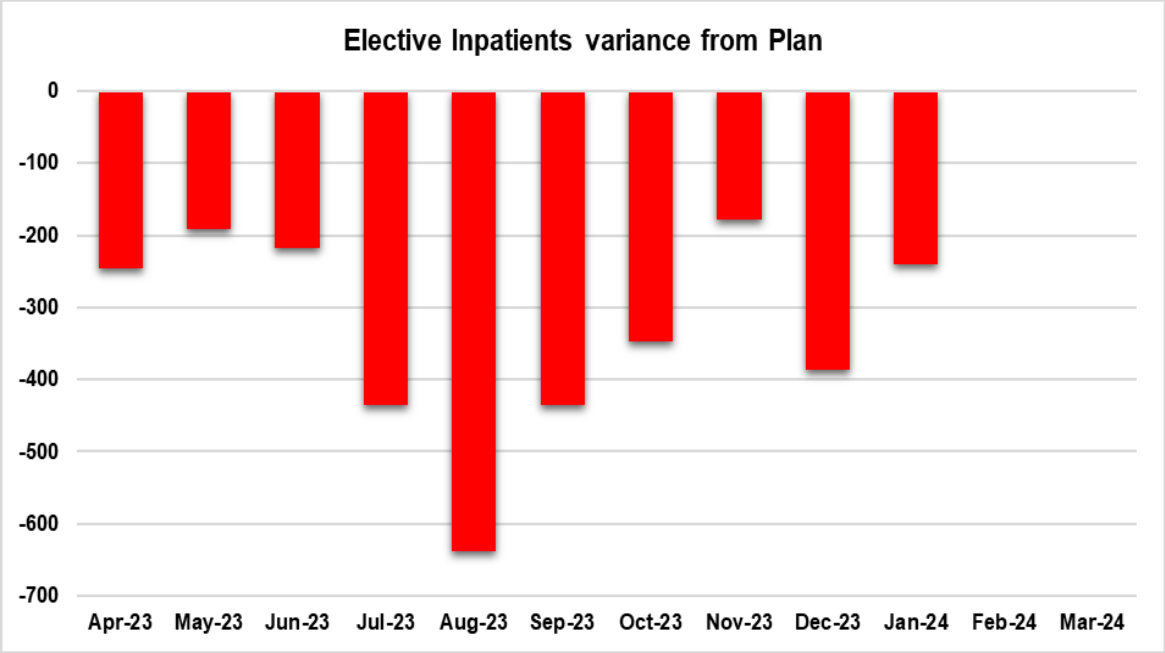
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Critical Care Board (Chair: Julian Redhead)

Data Assurance: tbc

Operating Plan Performance

Operating Plan Performance: Elective Inpatient

TREND



NARRATIVE

Performance: Elective activity improved marginally in January following industrial action. LNW showed significant recovery.

Recovery Plan: Additional insourcing being sourced for Quarter 4 and into next year providing this is below tariff and elective funding remains available.

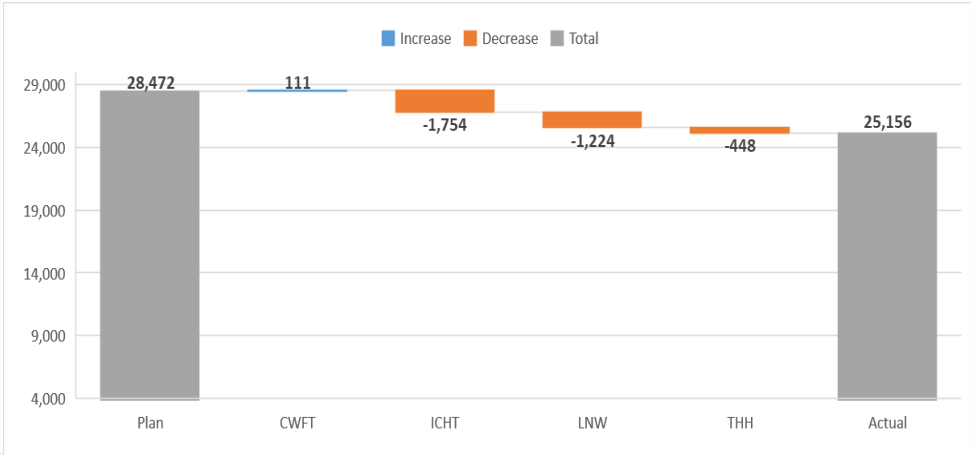
Improvements: CWFT, ICHT and THH are overdelivering on ERF overall.

Forecast Risks: Further junior doctor industrial action

CURRENT PERFORMANCE

	Current Month - Jan-24				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	516	639	123	23.9%	516	639	123	23.9%	5,369	5,480	111	2.1%
ICHT	1,443	1,141	-302	-20.9%	1,443	1,141	-302	-20.9%	13,487	11,733	-1,754	-13.0%
LNW	696	703	7	1.0%	696	703	7	1.0%	7,513	6,289	-1,224	-16.3%
THH	208	139	-69	-33.2%	208	139	-69	-33.2%	2,102	1,654	-448	-21.3%
APC	**2,862**	**2,622**	**-240**	**-8.4%**	**2,862**	**2,622**	**-240**	**-8.4%**	**28,472**	**25,156**	**-3,316**	**-11.6%**

STRATIFICATION



Year to date contribution to variance against plan

GOVERNANCE

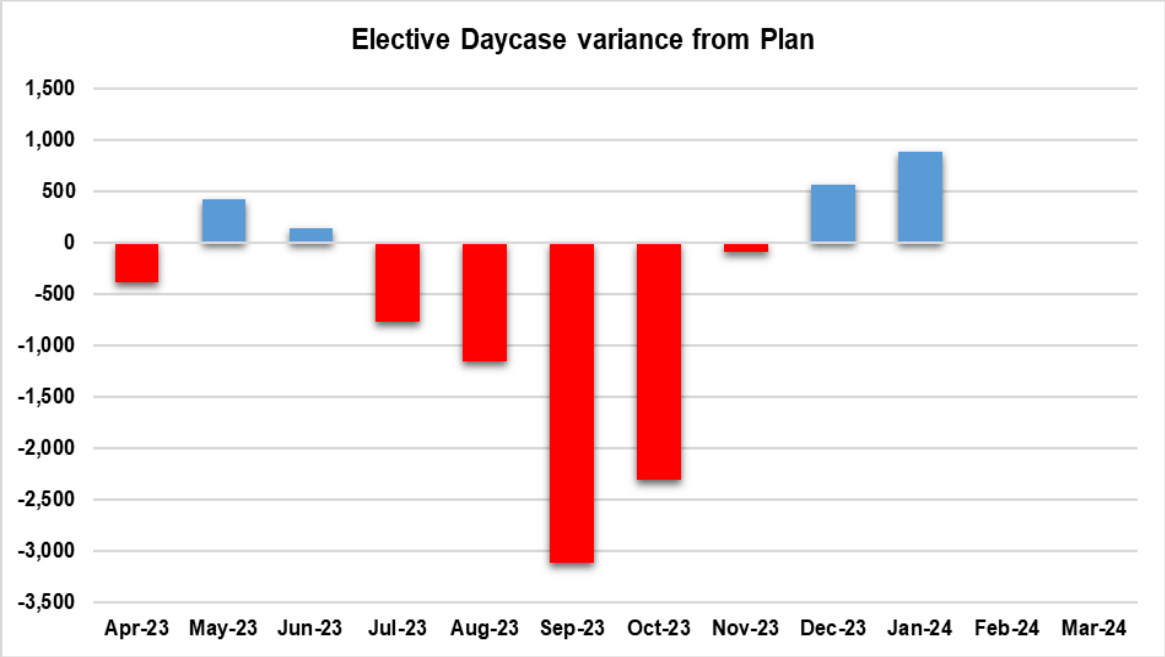
Senior Responsible Owner: Tina Benson, COO, THH

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

Data Assurance: tbc

Operating Plan Performance: Day Case

TREND



NARRATIVE

Performance: Day case activity is showing variation across Trusts.

Recovery Plan: Insourcing for endoscopy at THH has continued which links to the diagnostics recovery.

Improvements: THH has improved from previous months following Cerner implementation.

Forecast Risks: Key risks to delivery include any further industrial action.

CURRENT PERFORMANCE

	Current Month - Jan-24				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	5,023	6,004	981	19.5%	5,023	6,004	981	19.5%	48,887	54,233	5,346	10.9%
ICHT	9,431	9,407	-24	-0.3%	9,431	9,407	-24	-0.3%	88,089	84,881	-3,208	-3.6%
LNW	5,898	5,249	-649	-11.0%	5,898	5,249	-649	-11.0%	59,085	50,032	-9,053	-15.3%
THH	2,327	2,904	577	24.8%	2,327	2,904	577	24.8%	19,850	20,951	1,101	5.5%
APC	**22,679**	**23,564**	**885**	**3.9%**	**22,679**	**23,564**	**885**	**3.9%**	**215,911**	**210,097**	**-5,814**	**-2.7%**

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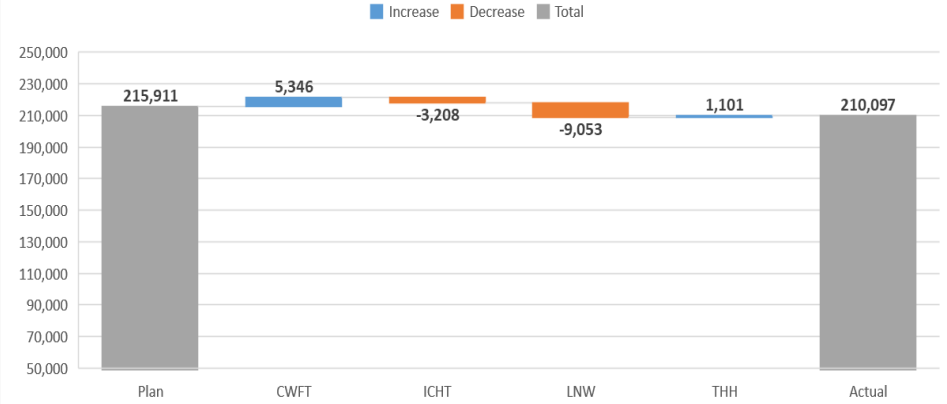


Year to date contribution to variance against plan

GOVERNANCE

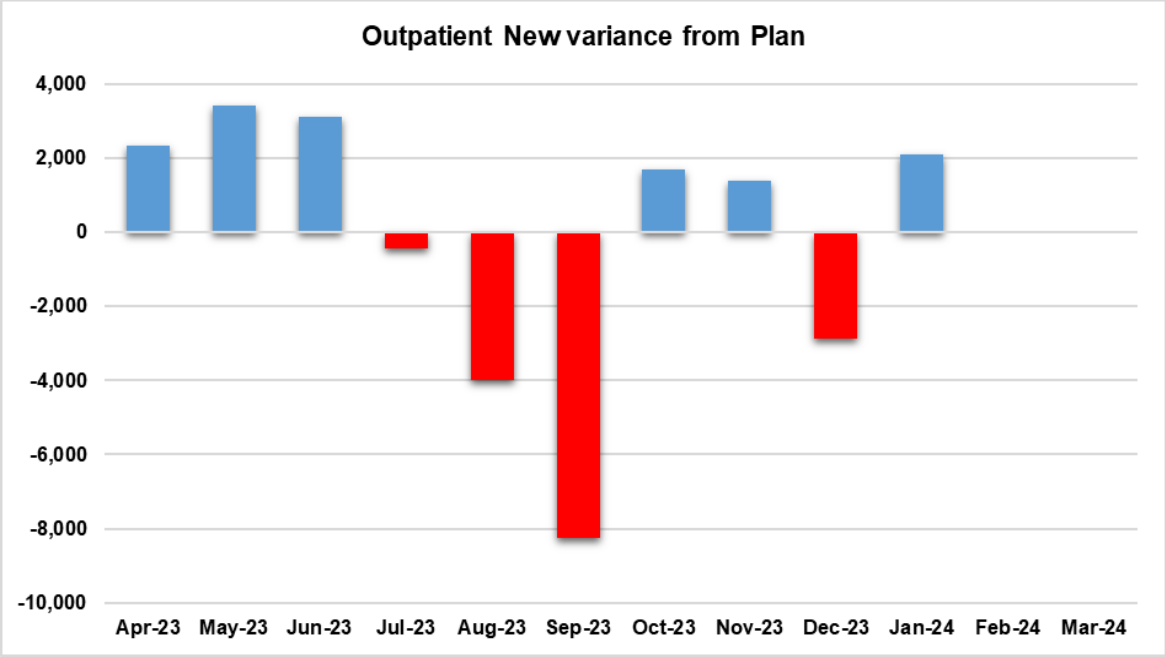
Senior Responsible Owner: Tina Benson, COO, THH

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

Data Assurance: tbc

Operating Plan Performance: Outpatient New

TREND



CURRENT PERFORMANCE

	Current Month - Jan-24				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	17,160	20,080	2,920	17.0%	17,160	20,080	2,920	17.0%	169,428	178,851	9,423	5.6%
ICHT	19,044	22,119	3,075	16.1%	19,044	22,119	3,075	16.1%	177,914	206,044	28,130	15.8%
LNW	23,786	19,731	-4,055	-17.0%	23,786	19,731	-4,055	-17.0%	239,110	195,811	-43,299	-18.1%
THH	8,186	8,353	167	2.0%	8,186	8,353	167	2.0%	77,652	81,858	4,206	5.4%
APC	**68,175**	**70,283**	**2,108**	**3.1%**	**68,175**	**70,283**	**2,108**	**3.1%**	**664,105**	**662,564**	**-1,541**	**-0.2%**

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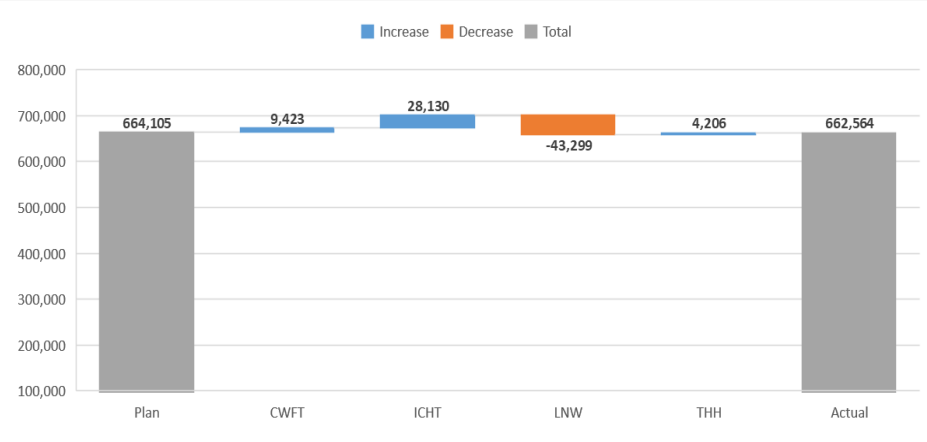


Year to date contribution to variance against plan

NARRATIVE

Performance: Outpatient New activity across the sector is now above plan and forecast to be on plan at year end.

Recovery Plan: The hardest element of activity to recover post Cerner EPR go-live is outpatients activity as the system requires a significant change in the way the clinicians document the patients journey. LNW activity is slowly increasing post go live, with a complete focus on patient safety and productivity recovery.

Improvements: All other sites have seen significant improvement in-month, bringing the APC very close to target with two further months to report.

Forecast Risks: Key risks to delivery any further industrial action.

GOVERNANCE

Senior Responsible Owner: Tina Benson, COO, THH

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

Data Assurance: tbc

Workforce Performance

Workforce Executive Summary

An overview of performance against all indicators, is shown in the balanced scorecard, using statistical process control variation assurance. In summary, there are three key workforce metrics currently performing as special cause improving variation with a further three performing as common cause variation. Within the workforce metrics, three (vacancy, turnover & core skills) are meeting the Acute Provider Collaborate agreed targets.

Vacancy rates at collaborative level are a special cause improving variation and are below the collaborative target of 10%. Over the past year the collaborative vacancy level has been steadily reducing and in February 2024 is 8.4%. This reduction in vacancies is the result of targeted recruitment campaigns, both at home and abroad, with a continuing focus to drive further improvement**.** Collaborative action is focussed on the hard to fill vacancies, which remain a cause for concern for those service areas.

Voluntary turnover continues as a special cause improving variation as, over the past year, there has been a steady reduction from 12.8% to the current position of 10.4% which is below the APC target of 12.0%. All Trusts have active retention projects and / or programmes and are part of a retention programme, supported by national resource, being initiated across the NWL ICS. The main Collaborative initiative on retention is the creation of a careers hub and a proposal for a common careers platform.

After a long period of improving 12-month rolling **sickness levels**, December saw a rise in the overall 12-month rolling position due to an increase at THH. Sickness levels have come back down in February and are within seasonal levels. All Trusts have plans in place to manage absence, particularly long-term absence. Trusts continue to work locally to re-deploy staff and mitigate safe staffing risks as required, which can result in a higher reliance on temporary staff with increased numbers of bank and agency shifts being requested and filled to mitigate staffing gaps due to sickness absence.

Agency spend, as a proportion of overall pay bill, is our productivity measure with a collective target set at 2%. Current performance for February 2024 was 2.2% and is a common cause variation. Reliance on agency workers is key for the delivery of some services, particularly where there is a national skills shortage such as for sonography and cardiac physiology and Trusts are working towards collective solutions in these areas. Continued collaborative work on temporary staffing remains the focus for reducing agency expenditure overall.

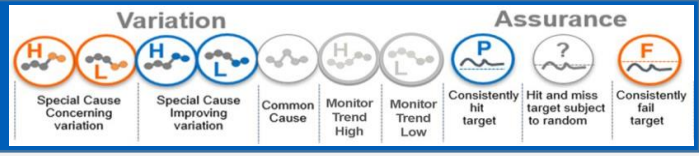
Completion rates for **non-medical Performance Development Reviews** (PDR), is an area of focus, albeit we have seen an improvement over the past eleven months with the metric continuing at a special cause improving variation. With the exception of non-medical appraisals at Imperial (which have a set window for completion) all Trusts operate a rolling programme for PDRs and are working towards the common target of 95% to drive improvement.

It has been agreed that for **Equality, Diversity and Inclusion** there will be a quarterly update on progress towards the Model Employer Goals. At Acute Collaborative Provider (ACP) Level BAME employees represent 61% of total workforce. To enable the ACP to achieve its 2025 MEG goals, each senior pay band needs to reflect 61% of BAME staff within each pay band. Included in this report is the latest quarterly update.

Escalations by Theme:

- Over-staffing against operating plan.
- EDI positive actions to address under-representation at senior levels.
- Winter staffing and Industrial action planning and preparedness.

Workforce Vacancies



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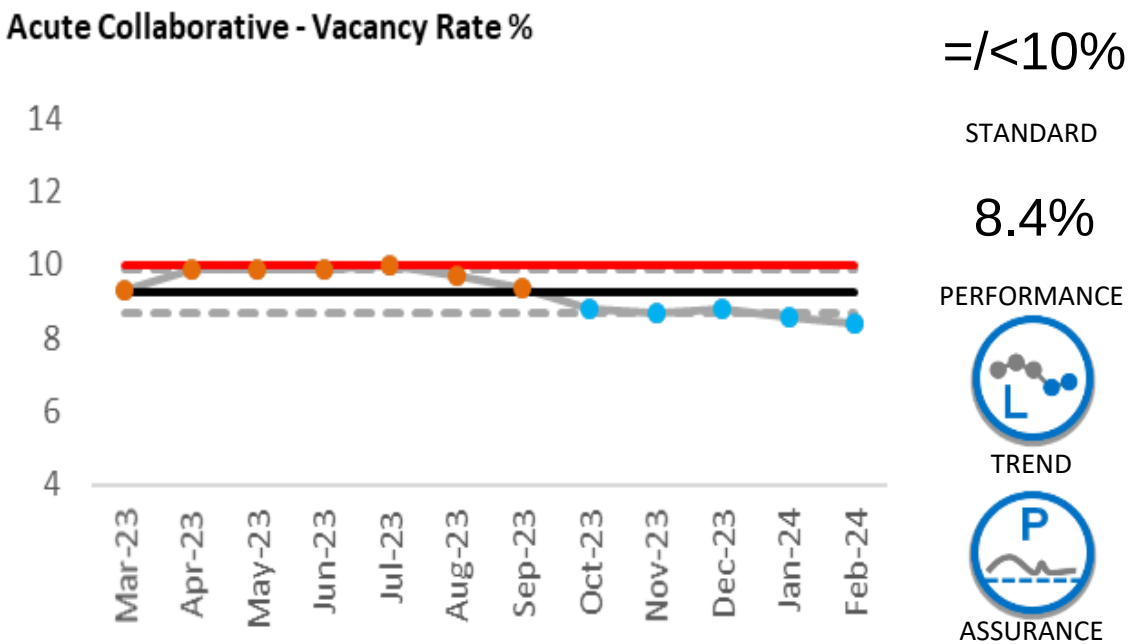


=/<10%

STANDARD

8.4%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Vacancy rates at collaborative level are consistently hitting target and are a special cause improving variation. Over the past year the collaborative vacancy level has been steadily reducing and in February 2024 was 8.4%. This reduction in vacancies is the result of targeted recruitment campaigns, both at home and abroad, with a continuing focus to drive further improvement.

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

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

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

Focus and resource is also being directed to support hard to recruit Consultant roles including those in Elderly Medicine and Anaesthetics.

Forecast Risks: High levels of vacancies puts additional pressure on bank staffing demand at a time of increased activity (elective recovery), industrial action and winter pressures.

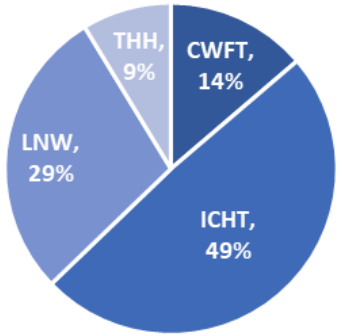
CURRENT PERFORMANCE

Vacancies

	Target %	Month 11 Vacancy Rate %	Variance to Target %	Vacancy WTE
CWFT	10%	5.7%	4.3%	411
ICHT	10%	9.6%	0.4%	1,467
LNW	10%	9.1%	0.9%	852
THH	10%	7.2%	2.8%	260
APC	**10%**	**8.4%**	**1.6%**	**2,989**

STRATIFICATION

Trust proportion of vacant WTE across the APC Month 11



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

Workforce Vacancies by Staff Group

Acute Trusts Staffing Group Vacancies - February 2024	Post WTE	Staff Inpost WTE	Vacant WTE	Vacancy Rate %
Admin & Clerical (bands 1/2/3/4/5/6)	4,849	4,444	405	8.3%
Allied Health Professional (Qualified bands 5+)	1,993	1,862	131	6.6%
Allied Health Professional (Unqualified bands 2/3/4)	350	288	61	17.6%
Ancillary	1,582	1,372	210	13.3%
Doctor (Career Grade)	263	216	47	17.9%
Doctor (Consultant)	2,237	2,162	75	3.4%
Doctor (Training & Trust Grade)	3,419	3,259	160	4.7%
Nursing & Midwifery (Qualified bands 5+)	11,945	10,831	1,114	9.3%
Nursing & Midwifery (Unqualified bands 2/3/4)	3,782	3,391	391	10.3%
Pharmacist	467	497	-30	-6.3%
Physician Associate	51	52	-1	-2.0%
Scientific & Technical (Qualified bands 5+)	1,479	1,354	125	8.5%
Scientific & Technical (Unqualified bands 2/3/4)	865	786	79	9.2%
Senior Manager (non-clinical bands 7/8/9/VSM)	2,124	1,904	221	10.4%
Other Staff	5	5	0	0.0%
Totals	35,411	32,422	2,989	8.4%

The table opposite shows current number of vacancies (WTE) and vacancy rates, for the Acute Provider Collaborative (APC), by staffing group.

The overall vacancy rate is 8.4% which has reduced by 0.9 percentage points over the past twelve months. In February 2023 the collective vacancy rate was 9.3%.

Qualified nursing and midwifery roles have a 9.3% vacancy rate representative of 1,114 WTE vacancies. Within this staff group are mental health nursing roles which are one of our top recruitment priorities. Temporary staff cover of these vacancies often attract high agency premia.

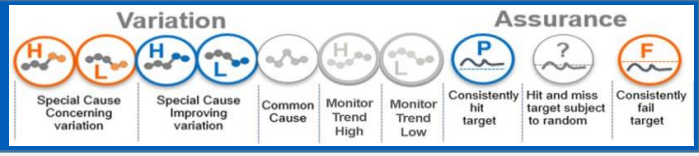
Just over 20.6% of current vacancies are non-clinical roles below band 7 - 405 WTE admin & clerical and 210 WTE ancillary roles.

Qualified scientific & therapeutic (125 WTE) account for 4.2% of the APC vacancies.

Clinical support roles at bands 2, 3 & 4 total 452 WTE / 15.1% of current vacancies.

Medical vacancies totalled 283 WTE at the end of February 2024.

Workforce Voluntary Turnover



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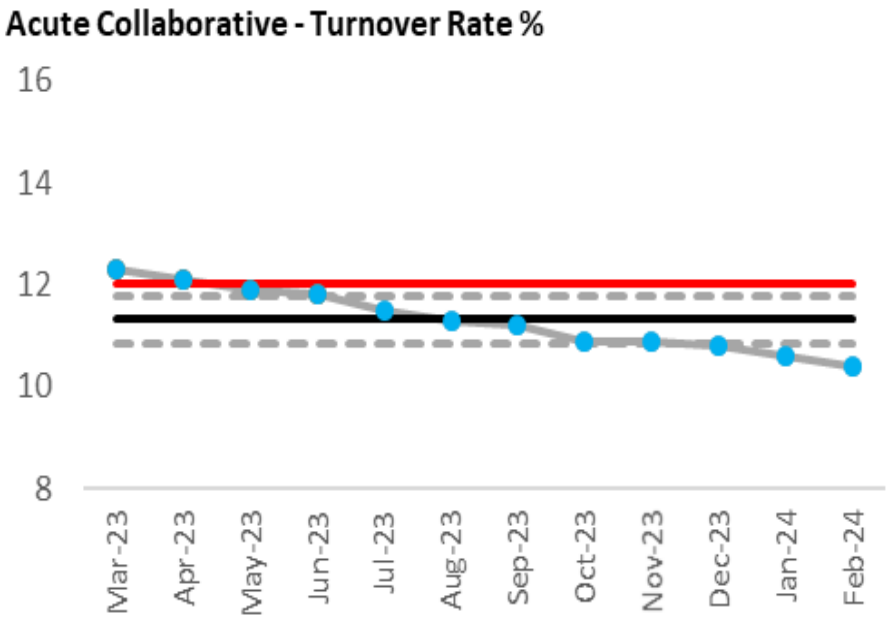


=/<12%

STANDARD

10.4%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Voluntary turnover continues as a special cause improving variation as, over the past year, there has been a steady reduction from 12.8% to the current position of 10.4% which is below the APC target of 12.0%.

With the exception of C&W, all Trusts are currently tracking below the 12.0% target. All Trusts have active retention projects and are part of a retention programme, supported by national resource, initiated across the NWL ICS. Acute Collaborative CPOs have shared details of existing retention initiatives to inform planning for future local or collaborative action.

Exit interviews and Stay Conversations continue with a particular focus on hotspot areas such as ICU, Midwifery and AHP staff. Feedback and insight is being fed back into Trust retention plans and actions.

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

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

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

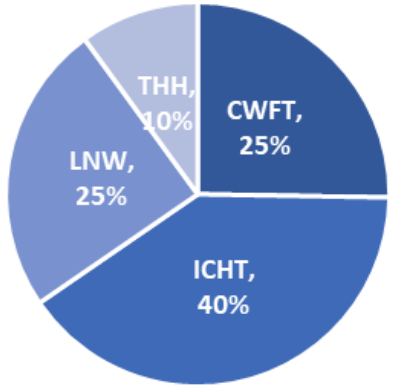
CURRENT PERFORMANCE

Voluntary Turnover

	Target %	Month 11 Turnover Rate %	Variance to Target %	Voluntary Leavers WTE (rolling 12 months)
CWFT	12%	12.2%	-0.2%	710
ICHT	12%	9.9%	2.1%	1,129
LNW	12%	10.3%	1.7%	689
THH	12%	10.8%	1.2%	282
APC	**12%**	**10.4%**	**1.6%**	**2,810**

STRATIFICATION

Trust proportion of voluntary leavers wte (rolling 12 months) across the APC Month 11



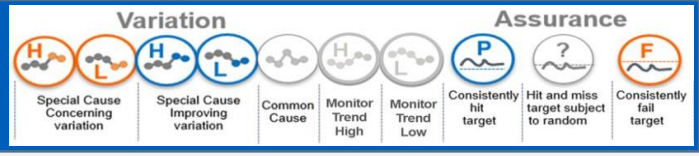
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

Workforce Sickness Absence



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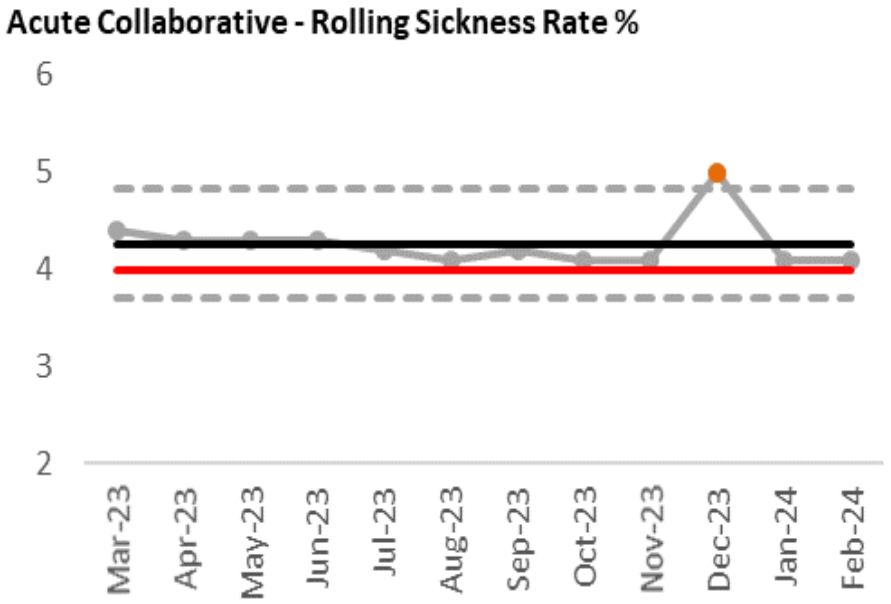


=/<4%

STANDARD

4.1%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: After a long period of improving 12-month rolling sickness levels, December saw a rise in the overall 12-month rolling position due to an increase at THH. Sickness levels have come back down in February and are within seasonal levels. All Trusts have plans in place to manage absence, particularly long-term absence.

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

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

Sickness levels are centrally captured and monitored daily for change with escalation to North West London Gold (NWL Gold) as required. Within this we monitor the levels of COVID absence to alert for increasing numbers to inform planning for both staffing and patient pathways.

Forecast Risks: Sickness absence levels which could be impacted by further Covid illness waves and winter illnesses.

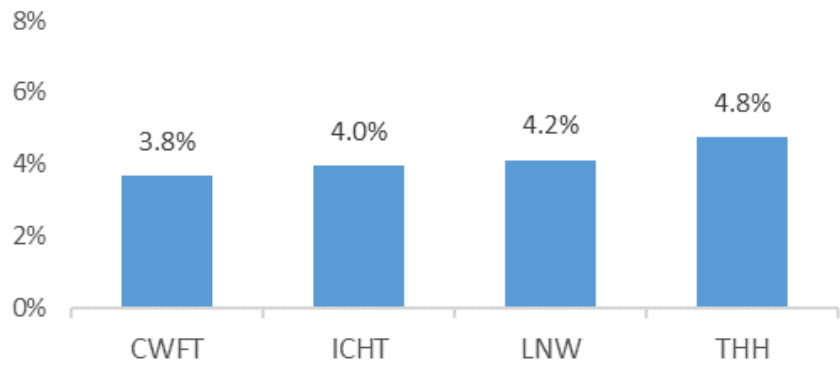
CURRENT PERFORMANCE

Rolling Sickness Absence

	Target %	Month 11 12 Month Rolling Sickness Absence Rate %	Variance to Target %	Month 11 In-Month Sickness Absence Rate %
CWFT	4%	3.8%	0.2%	3.8%
ICHT	4%	4.0%	0.0%	3.9%
LNW	4%	4.2%	-0.2%	4.1%
THH	4%	4.8%	-0.8%	4.4%
APC	**4%**	**4.1%**	**-0.1%**	**3.9%**

STRATIFICATION

12 Month Rolling Sickness Absence Rate % across the ACC Month 11



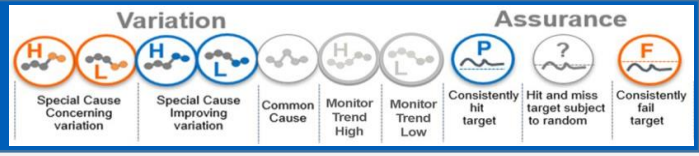
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

Workforce Productivity - Agency Spend



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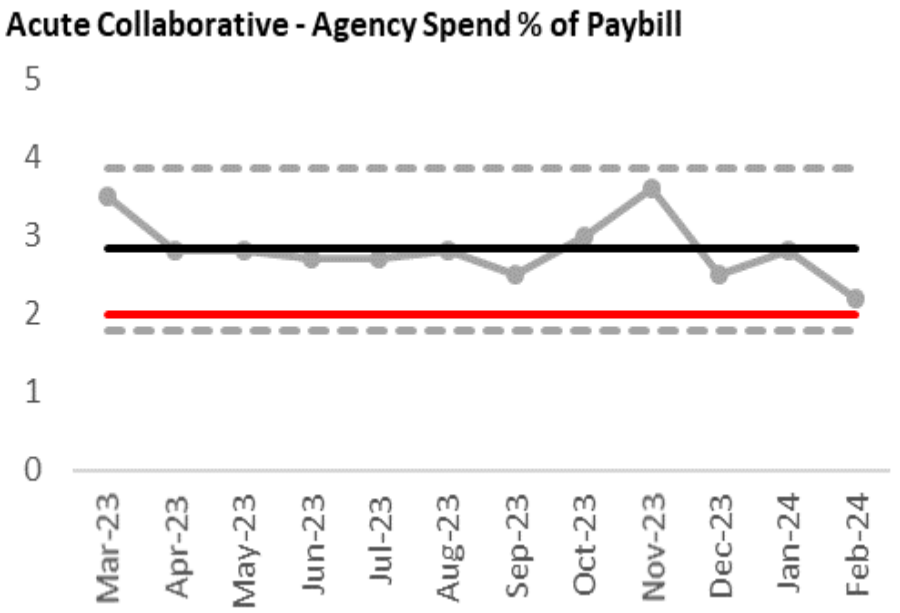


=/<2%

STANDARD

2.2%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Agency spend, as a proportion of overall pay bill, is our productivity measure with a collective target set at 2%. Current performance for February 2024 was 2.2% and is a common cause variation and back to levels previously reported this year after a rise in November.

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 physiology and Trusts are working towards collective solutions in these areas. 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.

Recovery Plan / Improvements: Increased demand on both agency and bank workers continues in response to seasonal sickness levels and higher acuity and dependency of patients; requiring the continued focus on recruitment to minimise the underlying vacancy position and associated temporary staffing fill.

Agency workers, whilst costing more than bank or substantive staffing, are essential for the delivery of some services where staff vacancies are nationally hard to recruit such as sonography, cardiac physiologists and pathology.

Forecast Risks: High levels of vacancies, puts additional pressure on bank staffing demand at a time of increased activity, industrial action and winter pressures.

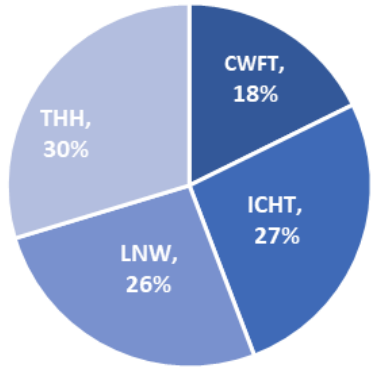
CURRENT PERFORMANCE

Productivity - Agency Spend

	Target %	Month 11 Agency Spend Rate %	Variance to Target %	Agency Spend £ (in Month)
CWFT	2%	2.1%	-0.1%	876,374
ICHT	2%	1.5%	0.5%	1,313,057
LNW	2%	2.9%	-0.9%	1,292,915
THH	2%	5.4%	-3.4%	1,470,507
APC	**2%**	**2.2%**	**-0.2%**	**4,952,852**

STRATIFICATION

Proportion of agency spend (£) by Trust across the APC For Month 11



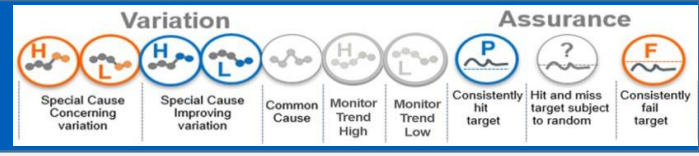
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

Workforce Non-Medical PDR



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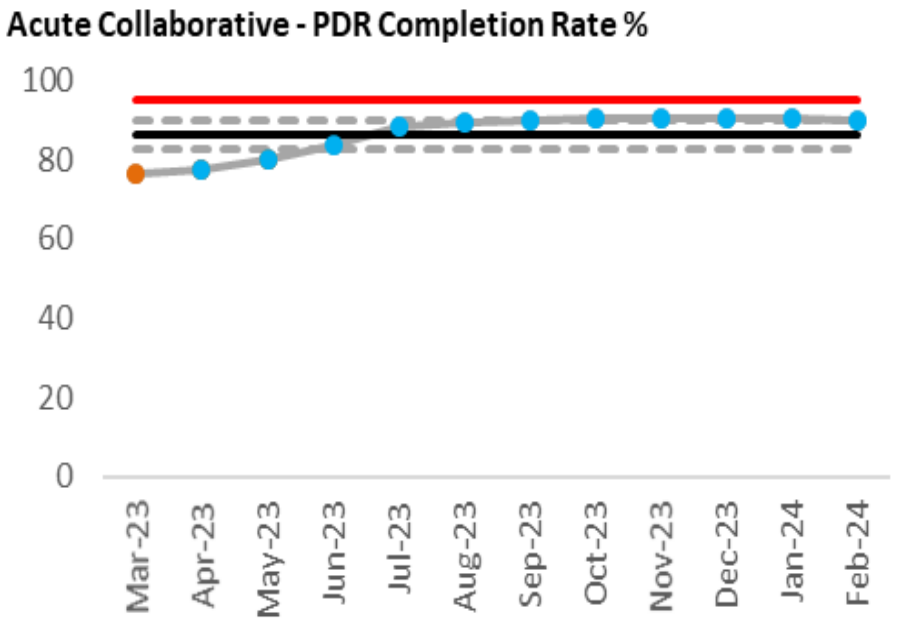


=/>95%

STANDARD

90.2%

PERFORMANCE

H

TREND

F

ASSURANCE

NARRATIVE

Performance: Completion rates for non-medical **Performance Development Reviews** (PDR), is an area of focus, albeit we have seen an improvement on the performance of this metric over the past ten months with the metric continuing to report a special cause improving variation.

With the exception of non-medical appraisals at Imperial (which have a set window for completion) all Trusts operate a rolling programme for PDRs and are working towards the common target of 95% to drive improvement.

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

Forecast Risks: Operational pressures continue to contribute to the challenge of conducting and completing the appraisal and PDR conversations as we go through a period of heightened elective recovery activity, industrial action and winter pressures.

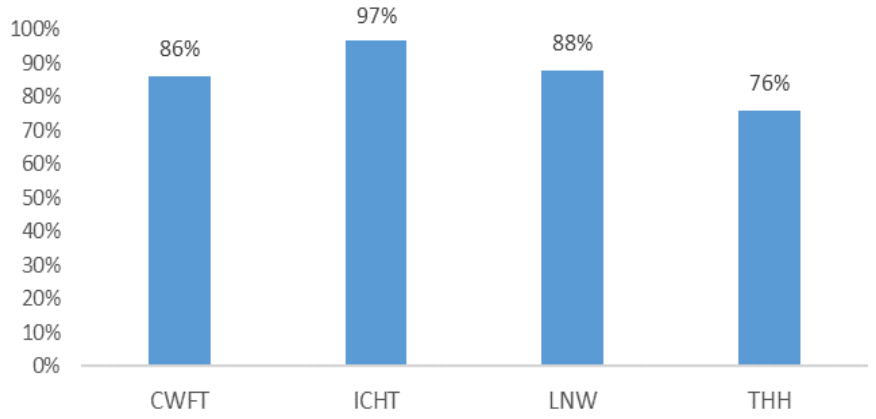
CURRENT PERFORMANCE

Non Medical PDR

	Target %	Month 11 PDR / Appraisal Rate %	Variance to Target %
CWFT	95%	86.3%	8.7%
ICHT	95%	96.7%	1.7%
LNW	95%	87.7%	7.3%
THH	95%	75.9%	19.1%
APC	**95%**	**90.2%**	**4.8%**

STRATIFICATION

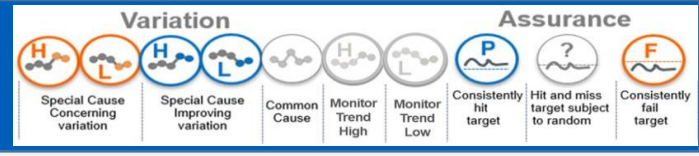
Month 11 Non-Medical PDR Rate % by Trust across the APC



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale
Committee: APC People Committee
Data Assurance: tbc

Workforce Core Skills Compliance



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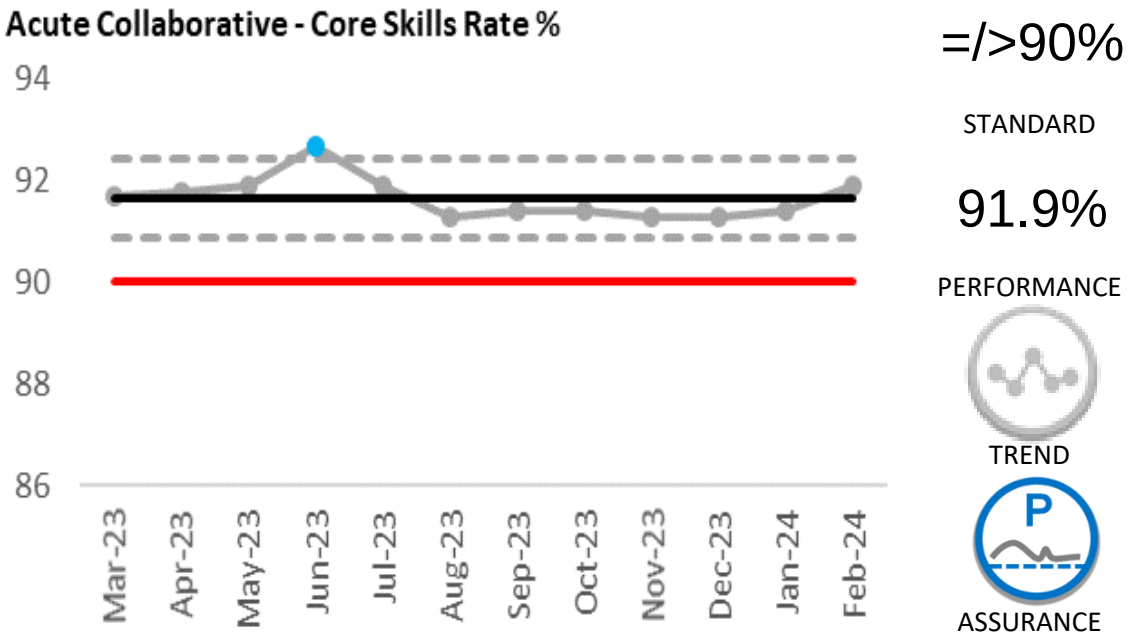


=/>90%

STANDARD

91.9%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Core Skills (statutory & mandatory training) compliance is essential in the delivery of safe patient care as well as supporting the safety of staff at work and their ability to carry out their roles and responsibilities in an informed, competent and safe way.
Apart from very temporary marginal reductions (new Oliver McGowan Training), all Trusts across the collaborative continue to perform well against the target for Core Skills compliance and it is not an area of concern at collaborative level.

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

Forecast Risks: None

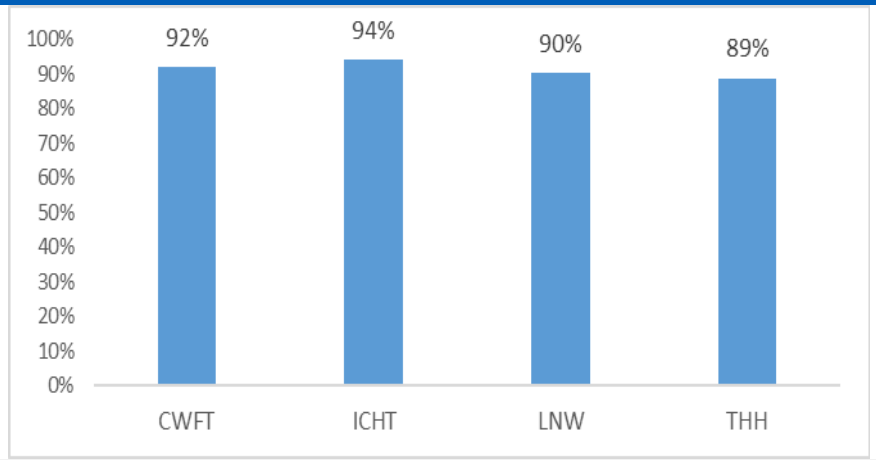
CURRENT PERFORMANCE

Core Skills Compliance

	Target %	Month 11 Core Skills Compliance Rate %	Variance to Target %
CWFT	90%	92.0%	2.0%
ICHT	90%	94.2%	4.2%
LNW	90%	90.4%	0.4%
THH	90%	88.9%	-1.1%
APC	**90%**	**91.9%**	**1.9%**

STRATIFICATION

Month 11 Core Skills Compliance Rate % by Trust across the APC

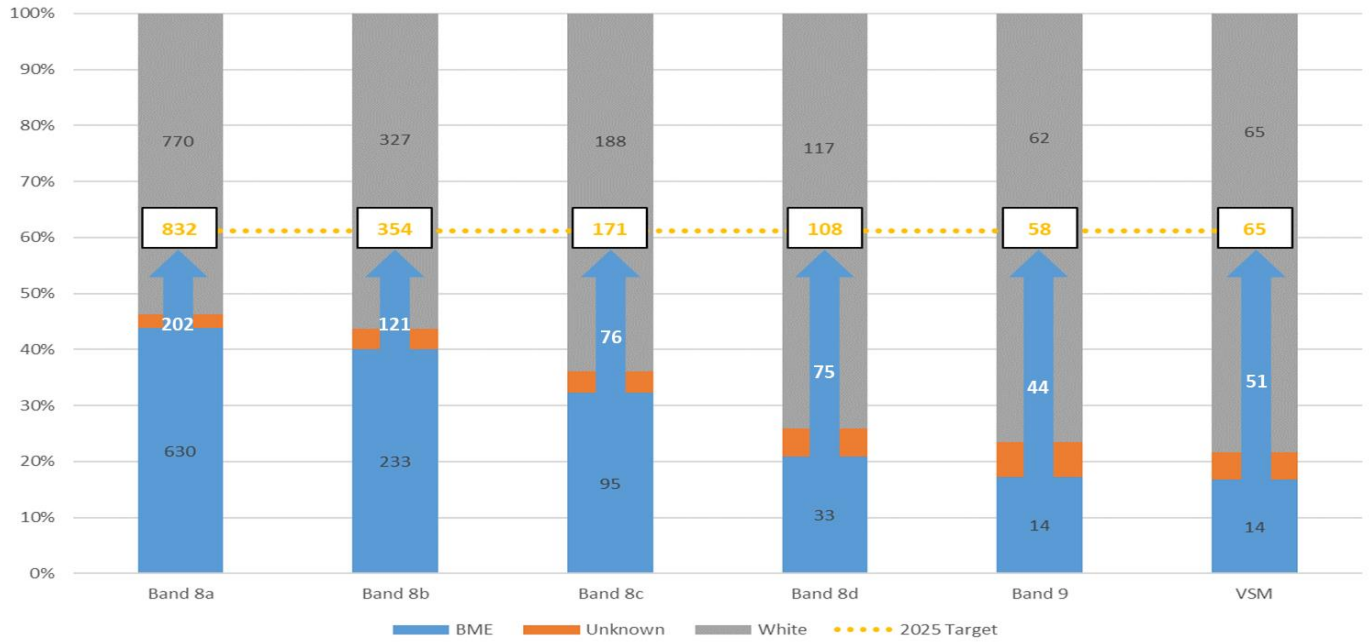


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale
Committee: APC People Committee
Data Assurance: tbc

Workforce Model Employer Goals - Overview

- 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)
- Model Employer Goals also assess the trajectory of recruitment required to reach equity by March 2025.
- The calculation which underpins MEG uses the difference between the proportion of known ethnicities of an organisation against existing proportion of known ethnicities within each band.
- Additional recruitment of staff from Black, Asian and minority ethnic groups is required for all bands in order for equity to be reached by March 2025.
- While the increase in numbers required to achieve equity varies across the AC all Trusts require improvements in all 8+ grades.
- Active analysis of recruitment and career progression to these grades is necessary to determine potential barriers and enablers to increase diversity e.g. inclusive recruitment training, diverse shortlisting and stakeholder panels and future leader programmes.
- There will be some interdependence between efforts to increase diversity at bands 6 and 7 and band 8 as workforce diversity begins significant decline at these grades also.
- Increasing diversity at band 9 and VSM grades is more challenging due to more limited experienced talent pool and may require focus on external recruitment and internal progression routes including secondment opportunities to gain exposure and leadership trials.

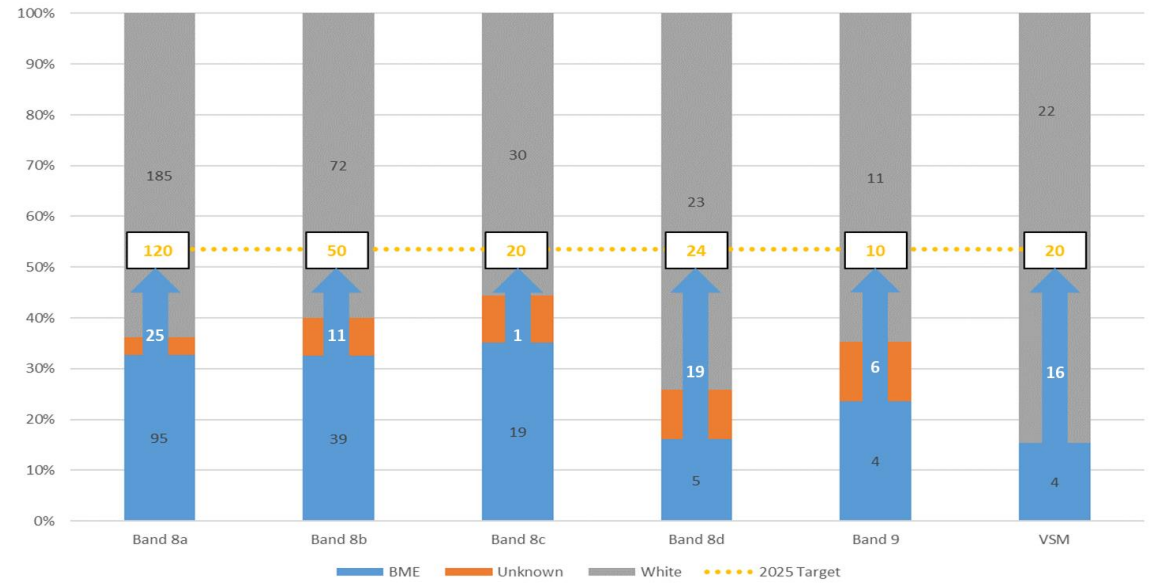


Actions being taken and developed to support MEG goals across the ACP at trust level are as follows (but not limited to);

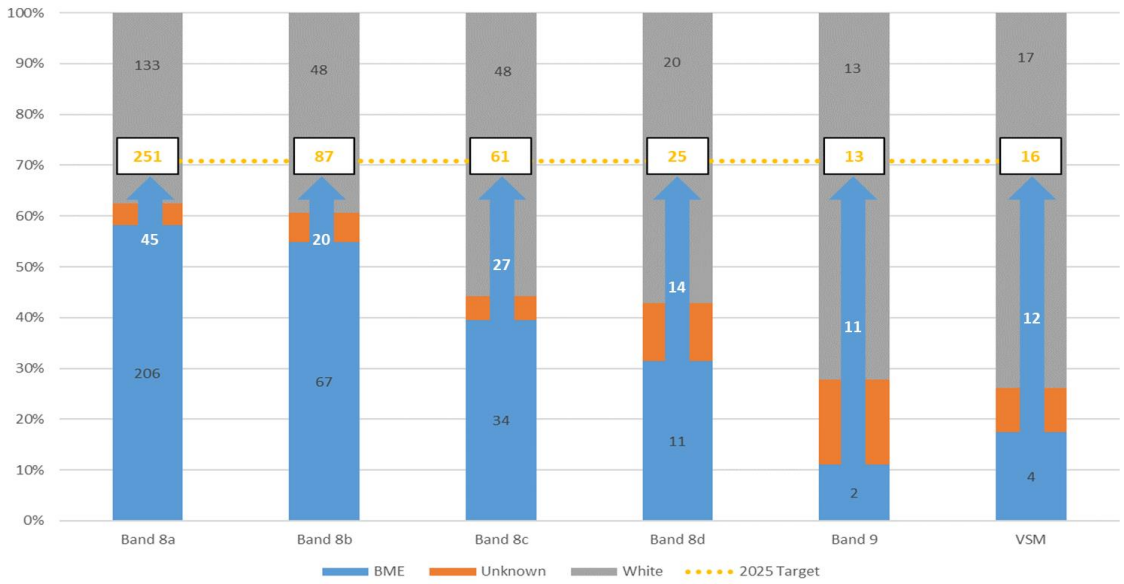
- Inclusive talent management strategies
- Succession planning to enable identifying, support and promotion of talent
- Inclusive recruitment means panels are gender-diverse and ethnically inclusive
- Diverse recruitment panels for all roles above band 7
- Regular monitoring and reporting on MEG targets

Workforce Model Employer Goals - Provider

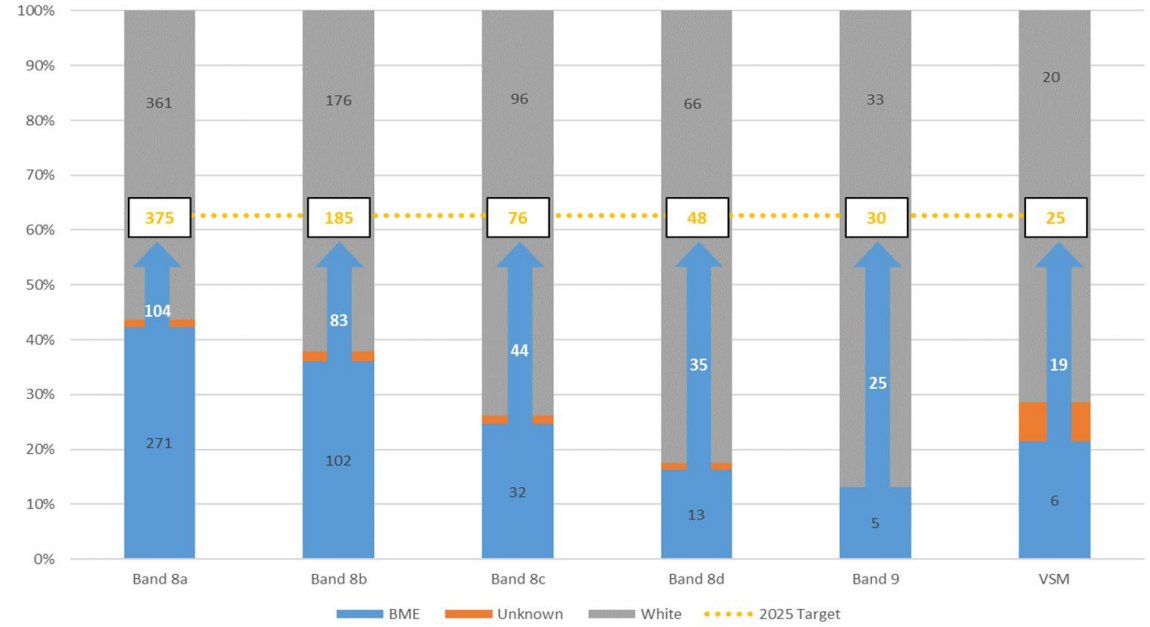
CWFT



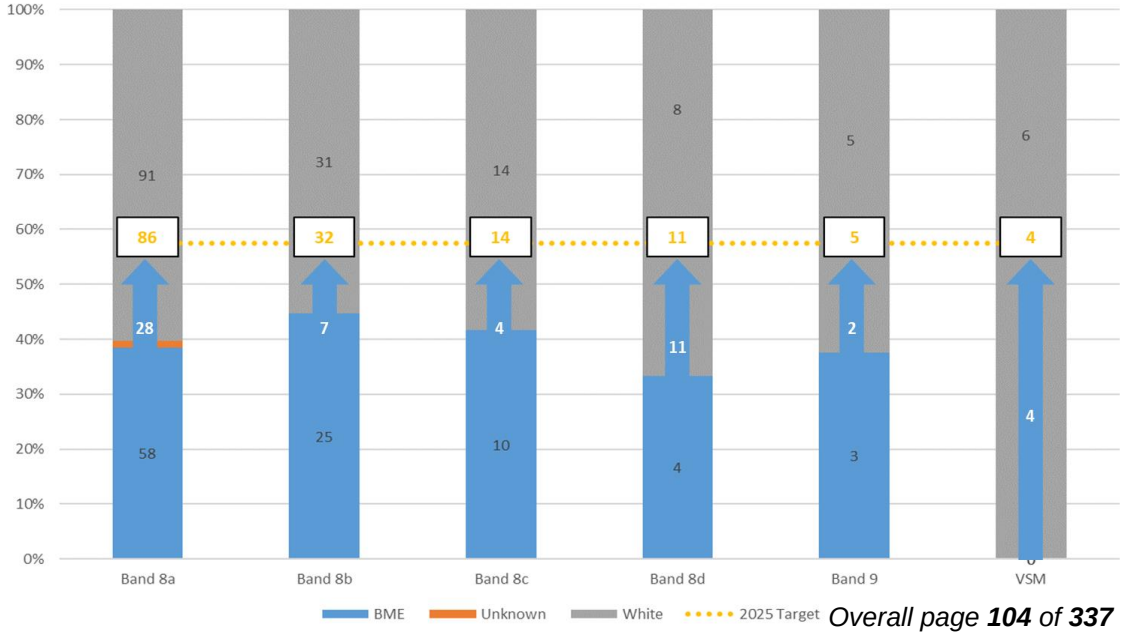
LNW



ICHT



THH



Finance

Finance Summary

Introduction:
The detailed Finance Report for the APC (Acute Provider Collaborative) is a separate report included in F&P Committee and Board in Common papers. This has been reviewed by the Acute CFO Group and covers the reporting period to Month 11 (Feb).

Performance:
At the end of month 11 the APC reports a deficit of £35.2m against a year-to-date deficit plan of £13.9m, thus reporting a £21.4m adverse variance to plan. The in-month surplus is £28.9m against a deficit plan of £1.6m, a £30.5m favourable variance to the in month plan. The monthly surplus is primarily due to the inclusion of NR funding to support financial recovery. LNW have also included a further £10m to mitigate against ERF lower than planned levels due to Cerner implementation. In addition, two trusts (CWFT & LNW) have included funding to mitigate against the impact of IA for months 9-11.
The forecast at Month 11 is a £0.470m deficit. This is at THH and includes a £2.6m transaction relating to the clearance of the site in preparation for the new hospital, partly offset by non-recurrent benefits.

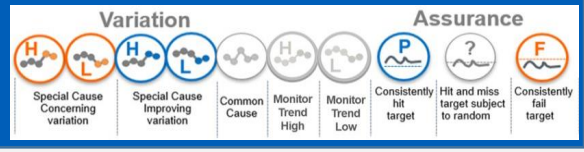
The main drivers of the YTD variance are:

1. Junior Doctors and Consultants' industrial action impact has been partially mitigated to date by additional funding. This relates to costs and income up to October, which will be fully mitigated by year end. Industrial action in Dec, Jan & Feb (c£24m) is also partially mitigated to date. Further central funding and an ICB contribution is agreed (£19.3m). The full year IA impact against the I&E bottom line is a £4m deficit.
2. CIP programme is under delivered by £29.4m (73% of YTD plan is delivered to date).
3. Inflation over funded levels caused a pressure of c£9m to date (includes additional income from the ICB).
4. Variable NHS Patient Care Income (ERF and other variable income) to month 11 is an overperformance £67.5m, of which £37m relates to ERF.
5. Operational overspends in clinical areas caused a further pressure on the budgets; in part mitigated by some non-recurrent benefits. This includes c£12m over budget on expenditure to support patients with mental health needs in our acute trusts.
6. Junior doctors pay award – the back dated pay award of 6% was paid in month 5. The tariff in contract income has been uplifted to fund the award; however, there is a shortfall in income over costs of c£8.3m to date.

Escalations:

- Forecast £0.470m deficit at THH as above.
- Funding received in the year to compensate for the impact of IA is c£4m short. IA is mitigated overall by utilising other income streams (namely ERF).

(Finance) Financial Delivery (I&E)



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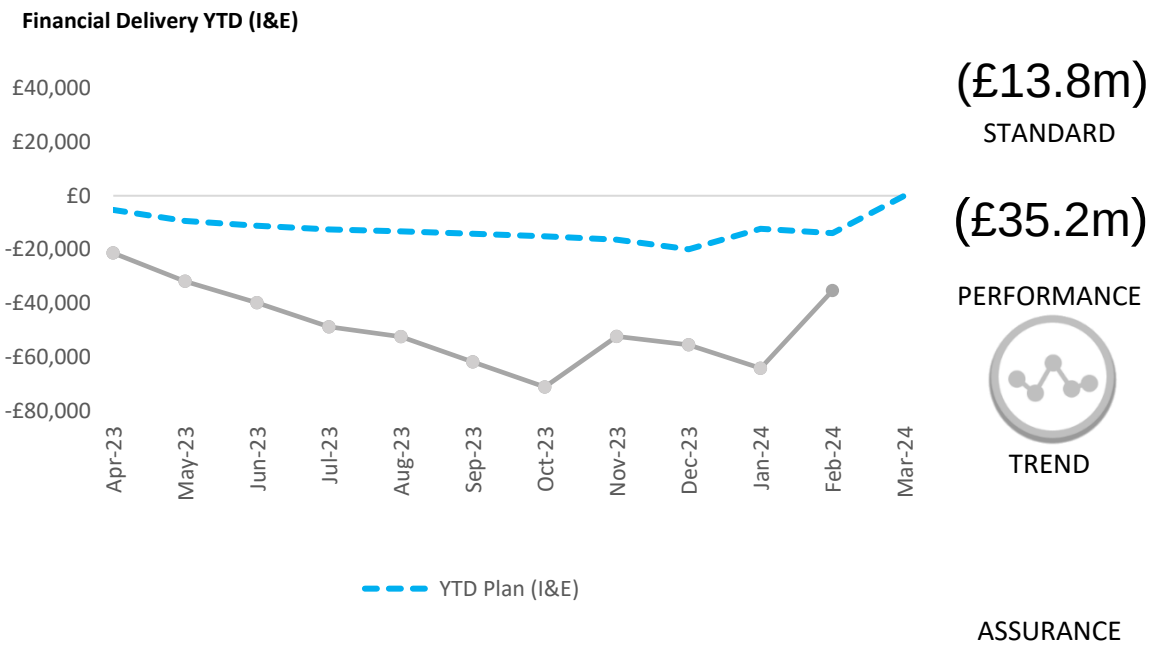


(£13.8m)
STANDARD

(£35.2m)
PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: YTD deficit of £35.2m, against a YTD plan of £13.8m deficit; hence reporting a £21.3m adverse variance to plan.

Recovery Plan: NR funding to support recovery plan (£15m) which includes £10m to support the ERF reduction in LNW because of Cerner. Funding agreed to (partially) cover IA impact M9-M11**.**

Improvements: Improvement in ERF over performance in month 11 (of £6.7m) . CIP delivery rate increased by 40% in month.

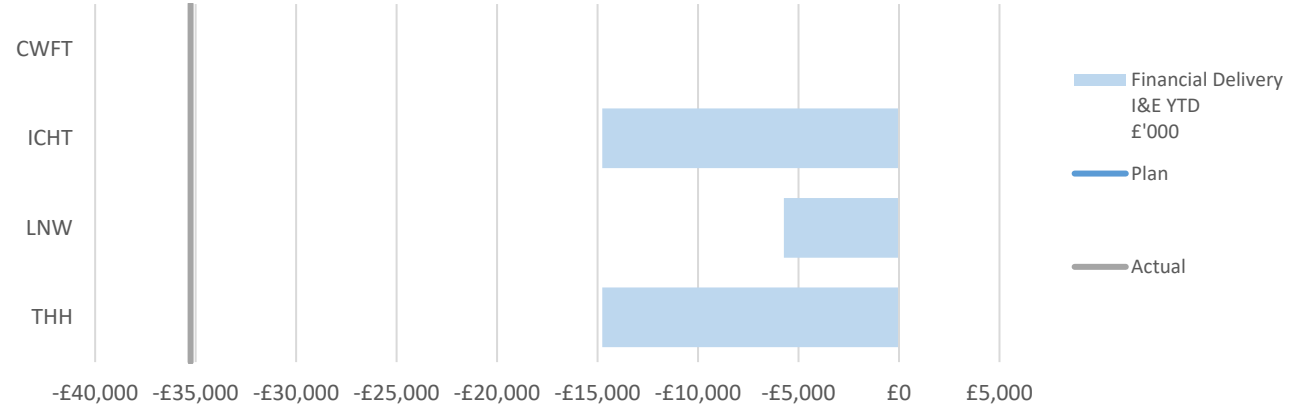
Forecast Risks: The forecast is £0.5m deficit, this is at THH and reflects a £2.6m transaction relating to the clearance of the site in preparation for the new hospital, partly offset by non-recurrent benefits .

CURRENT PERFORMANCE

Financial Delivery (I&E)

	Financial Delivery I&E YTD £'000	Variance from target YTD £'000	FOT £'000
CWFT	8	(11)	0
ICHT	(14761)	(14761)	0
LNW	(5729)	(7312)	
THH	(14765)	716	(470)
APC	**(35246)**	**(21367)**	**(470)**

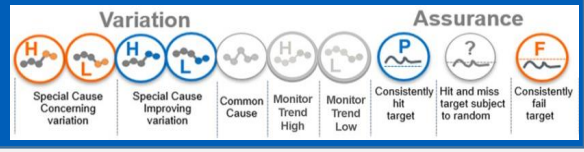
STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Jon Bell, Chief Financial Officer, THH
Committee: NWL Collaborative Finance and Performance Committee In Common
Data Assurance: Trust's Monthly Financial Monitoring Returns to ICB and NHSE

(Finance) Financial Delivery (CIP)



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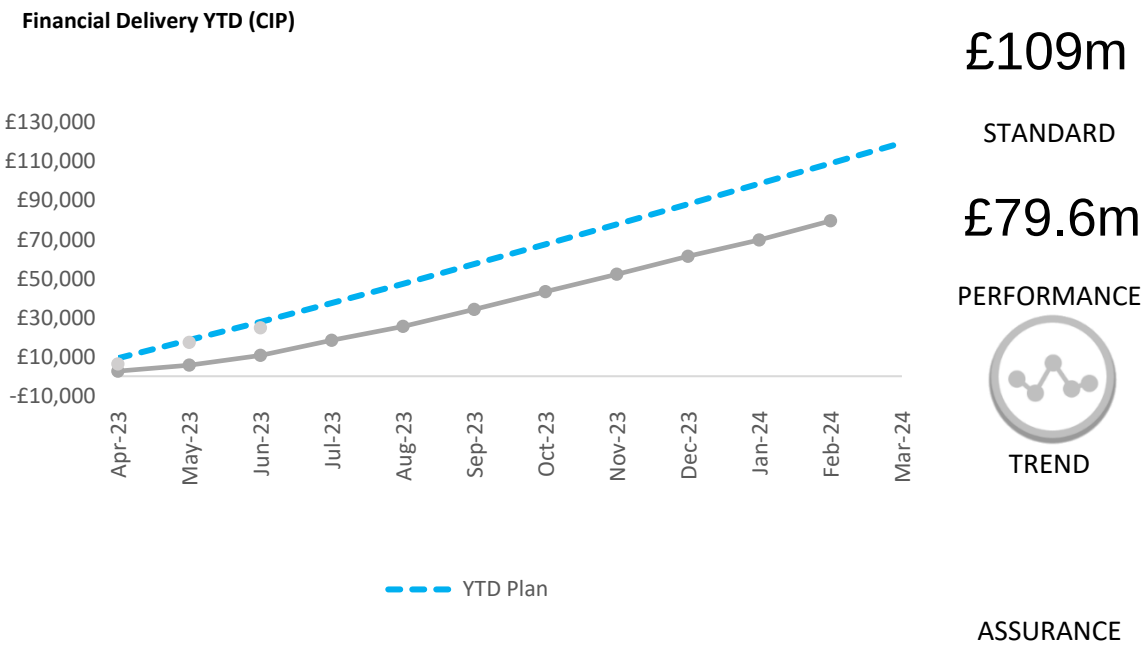


£109m

STANDARD

£79.6m

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: CIP delivery is £79.6m against a YTD plan of £109m, thus reporting a YTD adverse variance of £29.4m.

Recovery Plan: The 23/24 APC financial performance management process has been enacted. Peer to Peer review meetings have taken place to review CIP programmes forecasts and grip and control measures. Recovery plans and forecasts were reviewed and revised in month 8 and monitored thereafter.

Improvements: Monthly CIP delivery has improved month on month from an average of £7m in for m1-m10 to £9.8m in m11.

Forecast Risks: Forecasts include risks against CIP delivery. About half of the forecast delivery is via non- recurrent means which impacts on the underlying position.

CURRENT PERFORMANCE

Financial Delivery (CIP)

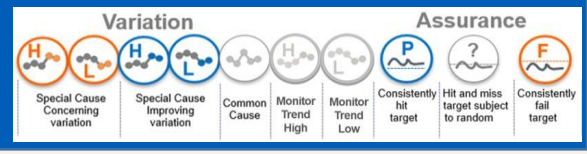
	CIP YTD £'000	CIP Variance YTD £'000	FOT £'000
CWFT	22026	466	23520
ICHT	22633	(26366)	53421
LNW	26563	(2587)	31800
THH	8361	(1000)	10757
APC	**79583**	**(29457)**	**119498**

STRATIFICATION

GOVERNANCE

Senior Responsible Owner: Jon Bell, Chief Financial Officer, THH
Committee: NWL Collaborative Finance and Performance Committee
Data Assurance: Trust's Monthly Financial Monitoring Returns to ICB and NHSE

(Finance) Capital Spend



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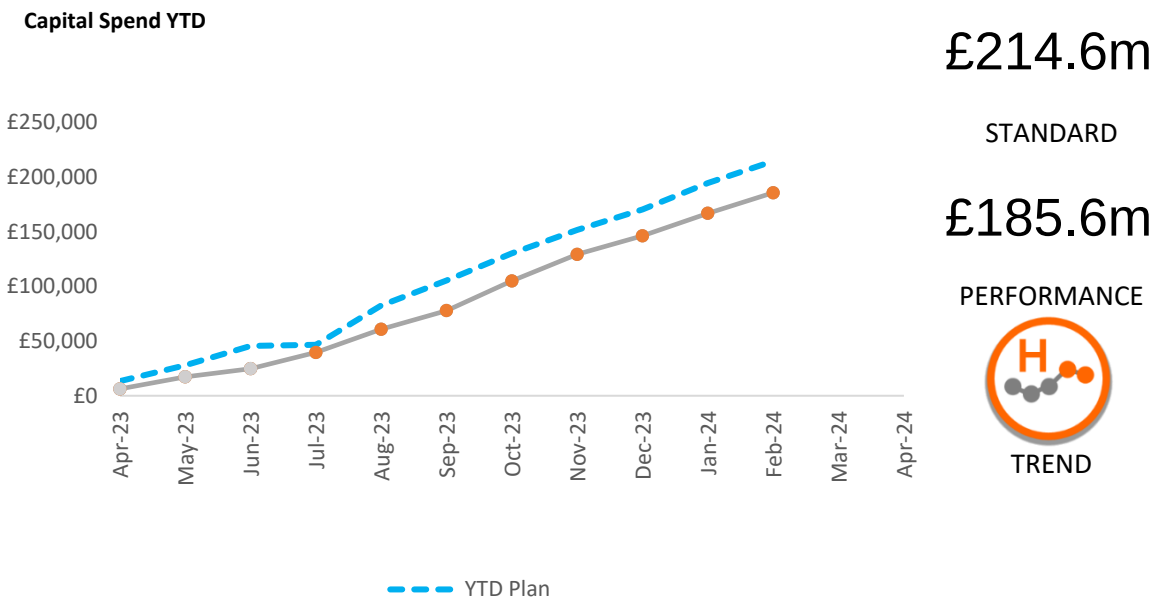


£214.6m

STANDARD

£185.6m

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Capital Spend

	YTD Spend £'000	YTD Variance £'000	Forecast Spend £'000
CWFT	31453	16028	47656
ICHT	57305	12811	86199
LNW	72971	(20166)	92015
THH	23922	20332	34602
APC	**185651**	**29005**	**260472**

STRATIFICATION

NARRATIVE

Performance:

Capital spend is £185.6m YTD against a YTD plan of £214.6m, therefore a £29m underspend reported. The forecast underspend at CWFT is due to the original plan including funding for other orgs which has now been distributed (but plans are not changed by NHSE)

Recovery Plan:

Capital plans include nationally funded schemes under the national capital programme (£91.4m) and the Targeted Investment funds (20.1m). In addition, LNW was granted additional funding to build a 32 bedded modular ward in June 2023.

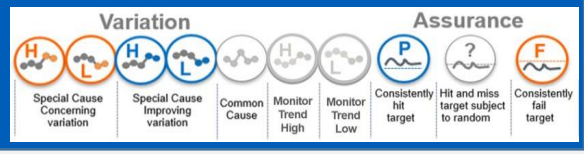
Forecast Risks:

It is expected all capital funds will be spent.

GOVERNANCE

Senior Responsible Owner: Jon Bell, Chief Financial Officer, THH
Committee: NWL Collaborative Finance and Performance Committee
Data Assurance: Trust's Monthly Financial Monitoring Returns to ICB and NHSE

(Finance) Elective Recovery Fund (All Commissioners)



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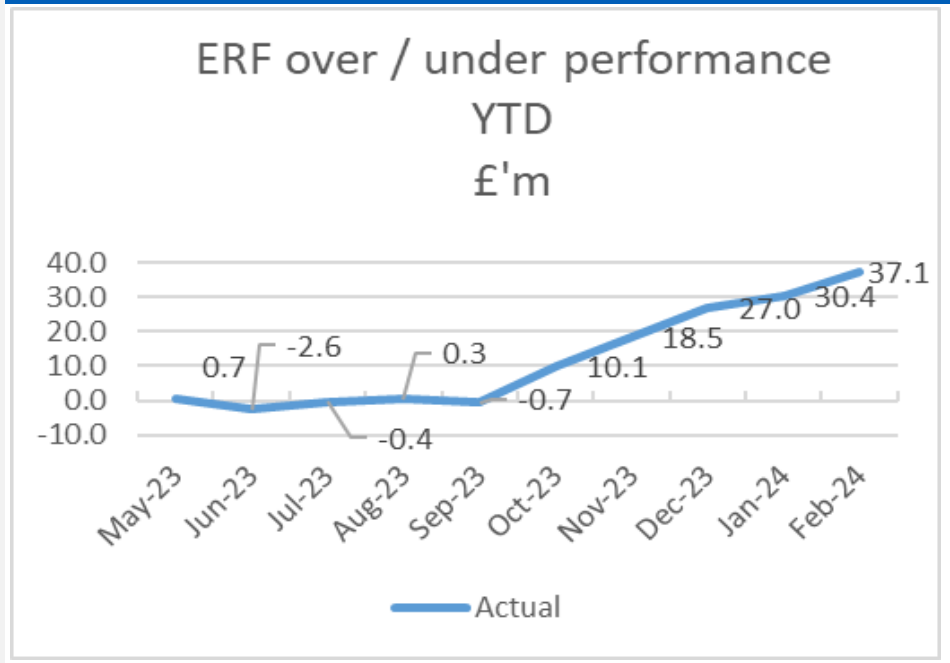


£000

STANDARD

£37.1m

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance:

ERF performance to the end of month 10 is a £37.1m overperformance. This is against all commissioners. There is an improvement in ERF overperformance in month 10 of £6.7m, notably at CWFT & THH. LNW ERF delivery is impacted by Cerner implementation.

Values are agreed between the APC and ICB by the APC ERF Working Group..

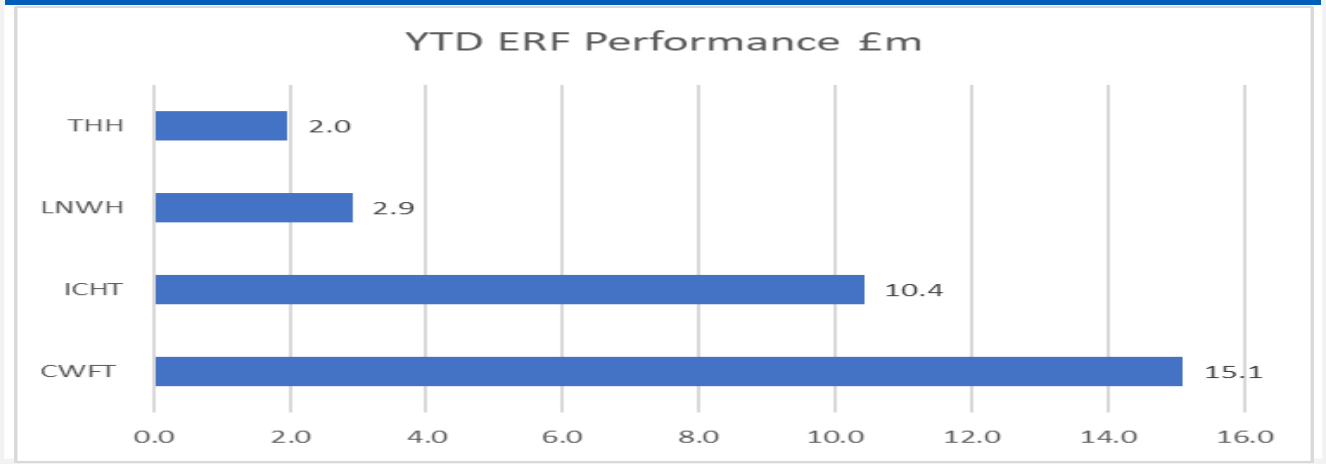
The target elective VWA for 2023/24 has been reduced by 4% (two tranches of 2%) to mitigate the impact of industrial action up to end of Oct.

CURRENT PERFORMANCE

Elective Recovery Performance (All Commissioners)

	ERF Performance YTD Actual £'000	ERF Performance (Movement from Month 10) £'000
CWFT	**17933**	**2886**
ICHT	**11585**	**1164**
LNW	**3418**	**500**
THH	**4093**	**2122**
APC	**37088**	**6671**

STRATIFICATION



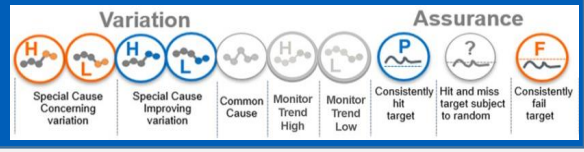
GOVERNANCE

Senior Responsible Owner: Jon Bell, Chief Financial Officer, THH

Committee: NWL Collaborative Finance and Performance Committee

Data Assurance: ICB & Trust Income Teams

(Finance) Cost Weighted Activity @ M10 (NWL Only)



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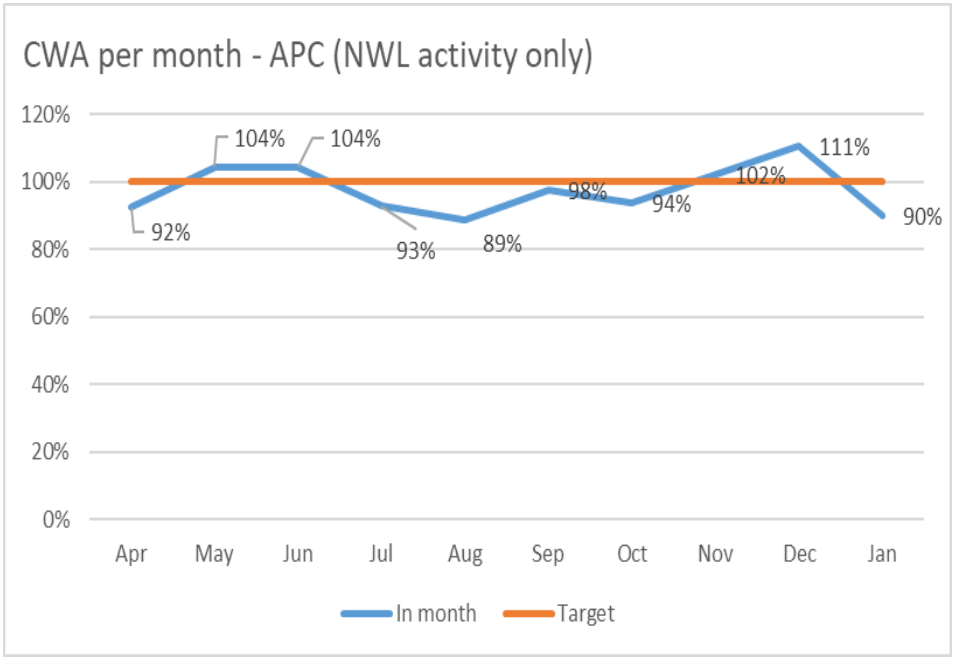


100%

STANDARD

96%

PERFORMANCE

TREND

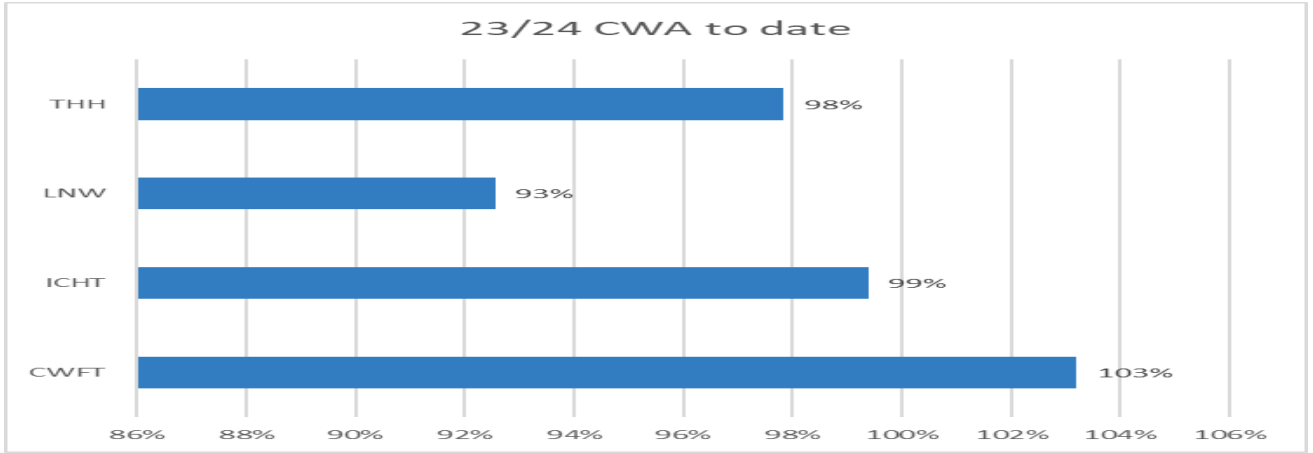
ASSURANCE

CURRENT PERFORMANCE

Cost Weighted Activity YTD (NWL only)

	CWA Performance Actual YTD	CWA Performance Expected YTD	Difference from Target
CWFT	**103%**	**100%**	**3%**
ICHT	**99%**	**100%**	**-1%**
LNW	**93%**	**100%**	**-7%**
THH	**98%**	**100%**	**-2%**
APC	**98%**	**100%**	**-2%**

STRATIFICATION



NARRATIVE

Performance:

Cost Weighted Activity – values up to Month 10. The value of activity in 2023/24 compared to the same period in 2019/20 (adjusted for inflation) is 98%, or 2% lower than 2019/20 (up to end of Dec).

This is a decline in Month 10 showing at 90% compared to 111% performance in month 9.

This is for NWL commissioned activity only (excluding specialised commissioning and non NWL ICBs).

GOVERNANCE

Senior Responsible Owner: Jon Bell, Chief Financial Officer, THH

Committee: NWL Collaborative Finance and Performance Committee

Data Assurance: Trust SLAM data reports

4.1 COLLABORATIVE QUALITY COMMITTEE CHAIR REPORT - STEVE GILL

REFERENCES

Only PDFs are attached

4.1 BIC Collaborative Quality Committee Chair's Report - March 2024.pdf

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

March 2024

Highlight Report

1. Purpose and Introduction

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

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

2. Key highlights

2.1. Deep Dive – Mental Health in Acute Trusts

2.1.1. The Committee undertook a deep dive into the care of mental health patients in acute trusts.

2.1.2. Four workstreams have been agreed:

- The policy workstream is responsible for reviewing existing policies, ensuring they are fit for purpose and developing joint policies.
- The education workstream is responsible for scoping the education offering across the NWL APC and exploring opportunities for joint learning.
- The environment workstream is responsible for developing enhanced clinical treatment areas for patients with acute mental health episodes, that are both safe for the patients and staff.
- The staffing workstream is responsible for determining the ideal staffing to manage the increased levels of patients requiring enhanced observation due to mental health concerns.

2.1.3. Work is being progressed to produce a joint mental health strategy across the four trusts of the NWL APC, which follows the work already in place at ICHT.

2.1.4. The Committee agreed that work will continue to escalate concerns to the Integrated Care Board on the current funding arrangements; to revisit the service-level agreements between the acute and mental health trusts; and create a shared education offer with a training needs analysis for all staff.

2.2. Review of Acute Provider Collaborative Quality Priority workstreams

2.2.1 The Committee received summary reports setting out progress with 4 of the priority workstreams from the executive leads. Key developments discussed by the Committee are highlighted below.

2.2.2 **End of Life Care**: The Committee noted that the work stream has focused on ensuring the data for the National Audit for Care at the End of Life (NACEL) is

consistent across the NWL APC. There is now consistent branding across three of the four trusts for end of life care, and the aim is for all trusts to provide the same offering.

2.2.3 **Deteriorating Patients**: The Committee noted that three of the four NWL APC trusts have adopted the deteriorating patient Commissioning for Quality and Innovation (CQUIN) and achieved their target for Q3. The National Institute for Health and Care Excellence (NICE) have published guidance on Sepsis and the collaborative group are progressing this work. Specific work has been done in the response to Martha's Rule.

2.2.4 **User Insights/Patient Experience**: The Committee noted that a formal group is now in place and they are working to align the systems across the four trusts, including the work around the classification of complaints. Joint procurement is continuing for a new patient survey platform and the group will explore the areas that patient and public engagement should align. An External Reference Group has been established and their terms of reference are being produced.

2.2.5 **Clinical Harm Reviews and Inequality**: The Committee noted that the common prioritisation framework is complete and it has been found that minimal harm to patient is caused by long waiting. Although the clinical harm processes are different, the prioritisation processes are standardised and when harm occurs it is reported and investigated via the incident reporting processes. It was therefore proposed that trusts continue with the current local processes and harm is reported locally through the trust to the Board in Common. The Committee agreed that this quality priority workstream is closed because assurance has been received that the processes are satisfactory.

2.3 Strategic Review of Nursing Staffing Models in Paediatric Emergency Department (ED)

2.3.1 The Committee noted that all four trusts of the NWL APC are complaint with the current regulatory requirements for paediatric emergency departments (EDs) nursing staff in the UK. It was noted that Northwick Park Hospital has the smallest number of registered paediatric nurses and as a result, they are amending their establishment. Recommendations include joint workforce planning and enhanced training programmes.

2.4. National Patient Safety Strategy and Quality System Standardisation

2.4.1. The Committee received a progress update on the implementation of the NHS patient safety strategy across the NWL APC. The final Patient Safety Incident Response Framework (PSIRF) policy and plans were submitted to the ICB at the beginning of March and closure trajectories for all incidents declared under the serious incident framework have been submitted with full transition planned in all trusts for early April 2024. Initial incident review and learning response templates continue to be piloted with learning incorporated into updated drafts. The agreed reporting metrics are in development, with learning response numbers are now included in the clinical outcomes dashboards.

2.5. Quality Equality, Diversity & Inclusion (EDI) Metrics

2.5.1. Information from the Whole Systems Integrated Care (WSIC) dashboards was presented to the Committee, including data on the referral pathways by ethnicity and deprivation. The teams are now working on interfacing WSIC and Cerner for all four trusts. The Committee noted the mortality data which has been broken down by ethnicity and continues to be a work in progress. Work continues to standardise the Equality Impact Assessment templates across the NWL APC; to analyse complaints by ethnicity; and to develop the Equity Index across the NWL APC.

2.5.2. The Committee agreed that focus should be given to the areas that trusts can impact; that agreement is reached on the common metrics and to understand the timeline where all metrics can be reported on a consistent basis; and to understand how the reporting can flow through the system so that areas are not double reported.

2.6. Learning from Deaths quarterly report

2.6.1. The Committee reviewed the combined NWL APC Q3 report incorporating all four trusts which outlines the key themes and outcomes from the learning from deaths processes.

2.6.2. The Committee noted that the report provides assurance regarding each Trust's processes to ensure scrutiny of, and learning from, deaths was in line with national guidance, with actions in place where the need to improve these further had been identified.

2.7. Health and Safety Annual Report 2022-23

2.7.1. The Committee received the combined health and safety annual report incorporating all four Trusts of the NWL APC, which outlines the work undertaken by the Trusts in 2022/23.

2.7.2. The Committee received assurance that the individual Trust annual health and safety reports had been reviewed in detail and approved by the Trust's local Quality Committee(s), except THHT who provided health and safety information via their Annual Reports and Accounts in 2022/23.

2.7.3. The report is provided to the NWL APC Board-in-common (BiC) for approval.

2.8. Trust Quality – Function Reports

2.8.1. The Committee received quality performance reports from each Trust, noting exceptions against key performance indicators and measures being taken to address areas of variance against target. See section 4 below – Escalation topics for BiC.

2.8.2. The Committee received assurance that key risks raised by each Trust were being managed appropriately and noted some common themes highlighted across all four reports including infection prevention and control.

2.8.3. The Committee were assured of the function and efficacy of each of the Trusts' quality committees.

2.9. Seven-Day Services Annual Report 2022-23

2.9.1. The Committee received the combined seven-day services annual report incorporating all four Trusts of the NWL APC, which outlines the work undertaken by the Trusts in 2022/23.

2.9.2. The individual Trust annual seven-day services reports had been reviewed in detail and approved by the Trust's local Quality Committee(s).

2.9.3. The Committee agreed that benchmarking should be undertaken across the NWL APC to articulate the appetite/threshold of 'significant variation' and noted that further information is required to understand the variations in the data.

2.9.4. A revised report will be presented to the Committee at its next meeting.

2.10. Acute Collaborative Quality Performance Report

2.10.1. The Committee received the collaborative quality performance reports. Nine Never Events were reported since January 2023, a Never Event review is in progress across the APC. Trusts are not meeting their benchmark for infection prevention and control (IPC) but are performing well nationally. The Maternity Friends and Family Test (FFT) and the ED FTT data is positive for three of the four trusts and the national target is being met.

2.10.2. The Committee noted the increase in the number of still births at THHFT, and that there have been four reported cases of suspected brain injury. Work is being done with the Local Maternity and Neonatal System (LMNS) on the adoption of interpretation services to support antenatal appointments.

2.11. National Care Quality Commission (CQC) Maternity Patient Experience Survey Results

2.11.1 The Committee received the individual Trust positions for the 2023 national CQC maternity patient experience survey. A common theme for improvement is communication with patients throughout the pathway. The results also suggest there are options for collaborative improvement work, specifically around information provision, this will be addressed through the maternity workstream and the LMNS.

2.12 Proposal for APC Quality Priorities 2024/25

2.12.1 The annual process is underway for the APC quality priorities. This will include the continuation of a number of existing priorities, and implementation of the new national safety standards for invasive procedures (NatSSIPs2), which was identified as an APC-wide improvement opportunity following a review of themes and learning from SIs and Never Events and is included in the list of draft local quality priorities for 2024/25 for three out of the four Trusts. The final priorities will be set out in a paper to the Committee in June with the project initiation documents for any new workstreams and a detailed plan for the year for any remaining priorities from 2023/24.

2.12.2 The Committee noted the process for the development of the quality accounts for each Trust, which follows the same process as the previous year. Approval will be delegated to the relevant Trust committee.

3. Positive assurances received

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

- Other key positive assurances received include:
  - Good progress is being made with the agreed quality priorities for the NWL APC, with a focus on aligning reporting and processes to enable improvements in quality of patient care.
  - The in-patient Friends and Family test scores in Maternity and A&E have seen improvement. This is a credit to staff that are effectively managing the current pressures.
  - Mortality rates continue to be lower than, or as expected, when compared nationally, with regular review of these occurring both internally and through the APC quality committee.
  - Improvements have been seen across all five domains of the National Maternity 2023 survey: antenatal, labour and birth, postnatal (ward) feeding, postnatal (community).

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

- **THHT Maternity:** Following the August CQC Maternity inspection at THHT, a report was published in February resulting in a cultural review and plan, an external still birth review, and a governance review of maternity services. A maternity improvement programme is being formed and support will be required, nationally, from the NWL APC and locally.

- **Never Events:** Three Never Events have been declared at ICHT and a fourth is being considered, each with different themes. Five Never Events have been declared at CWFT year to date and a review is being completed. A year's review of the Never Events has been undertaken across the four trusts and a common theme is surgical safety, which will be addressed in the 2024/25 quality priorities. Trusts will also participate in the national consultation relating to Never Events.

- **Mental Health Patients:** The impact on the care of mental health patients as result of the plans to reduce Whole Time Equivalents (WTEs) in mental health trusts. The number of WTEs are being increased in acute trusts to provide the care, but this remains an unsuitable setting for mental health patients.

- **IPC:** Increased infection rates with all four trusts breaching targets but the committee were assured robust local and APC controls and learning was in place.

- **PSIRF:** All four Trusts transitioning to PSIRF, a soft launch is underway with full implementation planned for April 2024.

- **IA:** The continued impact of industrial action.

5. Concerns outstanding

- Other than those noted above there are no significant additional concerns outstanding which require escalation to the Board.

6. Key actions commissioned

- Work will be undertaken to explore the reasons for the increased number of SIs reported since August 2023.

- Work will be undertaken to better understand how each Trust and the NWL APC compares to the London average and the national average in IPC performance.

7. Decisions made

- The Committee agreed to close the Clinical Harm Reviews and Inequality quality workstream.

- The Committee approved the forward plans which align the business of local quality committees across the Collaborative and the forward plan which confirms the core business of the Collaborative Quality Committee.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Deep Dive Mental Health in Acute Trusts	To discuss	10.	Governing Quality of Care from Local to Collaborative Level	To approve
2.	Strategic Review of Nursing Staffing Models in Paediatric ED	To discuss	11.	Learning from deaths quarterly reports – Quarter three 2023/24	To discuss
3.	Acute Collaborative Quality Performance Report	To discuss	12.	Health and Safety Annual Report Acute Collaborative Themes and Actions	To discuss
4.	Work Stream PIDs and Project Updates:	To discuss	13.	Seven Day Services Annual Report Acute Collaborative Themes and Actions	To discuss
5.	National CQC Maternity Patient Experience Survey Results	To discuss	14.	Next steps for Peer Reviews/Clinical Transformation	To discuss
6.	Proposal for APC Quality Priorities 2024/25	To discuss	15.	Agree next deep dive	To discuss
7.	National Patient Safety Strategy and Quality System Standardisation	To discuss	16.	Any Other Business	To discuss
8.	Quality EDI metrics and Action Plan	To discuss	17.	Committee forward planner	To note
9.	Trust Quality Committee – Function reports	To discuss			

9. Attendance

Members	December attendance
Steve Gill, Vice chair (CWFT), NED (THHT) (Chair)	**Y**
Syed Mohinuddin, Non-executive director (LNWH/CWFT)	**Y**
Linda Burke, Non-executive director (THHT/ICHT)	**Y**
Carolyn Downs, Non-executive director (ICHT/CWFT)	**Y**
Pippa Nightingale, Chief executive (LNWH)	**Y**
Julian Redhead, Medical director (ICHT)	**N**
Raymond Anakwe, Medical director (ICHT)	**Y**
Roger Chinn, Medical director (CWFT)	**Y**
Alan McGlennan, Chief Medical Officer (THHT)	**Y**
Jon Baker, Medical director (LNWH)	**Y**
Sarah Burton, Chief nurse (THHT)	**Y**
Robert Bleasdale, Chief nurse (CWFT)	**Y**
Janice Sigsworth, Chief nurse (ICHT)	**N**
Lisa Knight, Chief nurse (LNWH)	**Y**

4.2 LEARNING FROM DEATHS REPORT - JON BAKER

REFERENCES

Only PDFs are attached

4.2 BiC quarter three learning from deaths - Final v2.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 4.2
This report is: Public

Acute provider collaborative Learning from Deaths quarter three 2023/24 summary report

Author: Shona Maxwell
Job title: Chief of staff, Imperial College Healthcare NHS Trust

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

Purpose of report

Purpose: Information or for noting only

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

Report history

Trust Quality Committees
Various
Individual trust reports were reviewed at each quality committee and approved for onward submission.

Acute Provider Collaborative mortality surveillance meeting
07/03/2024
Trust reports were reviewed and the contents of this paper discussed and agreed.

Acute Provider Collaborative Quality Committee
25/03/2024
The committee noted the findings within the report and the on-going work of the mortality surveillance meeting to standardise key processes and metrics. The report was approved for onward submission to Board-in-common.

Executive summary and key messages

1.1. In line with national guidance each Trust provides a quarterly report to their quality committee on mortality surveillance and other learning from deaths processes. This report provides a summary of the quarter three 2023/24 reports.

1.2. Individual Trust reports are available in the reading room and provide assurance that deaths are being scrutinised in line with requirements and learning shared and acted upon through Trust governance processes.

1.3. Our mortality rates continue to be lower than, or as expected, when compared nationally, with regular review of these occurring both internally and through the APC quality committee. All Trusts have a “lower than expected” hospital standardised mortality ratio (HSMR) for the period October 2022 to September 2023. The Hillingdon Hospitals NHS Foundation Trust (THH) has an “as expected” standardised hospital mortality indicator (SHMI), although this is below the national benchmark of 100, with all others remaining “lower than expected”.

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

1.5. There were no new improvement themes identified this quarter. Work to improve care at the end of life, a consistent theme across most quarters, continues with local actions in place and joint work through the APC quality priority workstream.

1.6. All Trusts are investigating variations between observed and expected deaths by diagnostic group. Reviews undertaken in quarter three were presented to the APC mortality surveillance group in March. No new risks or themes were identified. The reviews are continuing and will be reported in each Trust’s quarterly reports once complete.

1.7. Changes have been made to standardise mortality review triggers and the Level 2 death review grading system used which were implemented to support improved comparison of outcomes and identification of cross-trust learning. Further work is now progressing to review how each Trust screens, refers, and completes these reviews. This will complete in March 2024, with recommendations reporting to the executive APC quality meeting and the APC mortality surveillance group.

1.8. Work undertaken to review palliative care coding has demonstrated variation. This may be due to a number of factors, including palliative care service provision or different processes in place to record when specialist palliative case has been provided. Improvement recommendations will be identified once the full review is completed.

Strategic priorities

Tick all that apply

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

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

Impact assessment

Tick all that apply

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

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

Main report

2. Learning and Improvements

2.1. Each Trust has processes in place to ensure learning from deaths happens after all in-hospital deaths and that this is shared and actions implemented where required.

2.2. There are no issues for escalation.

2.3. The key theme for improvement from reviews undertaken in this quarter relates to care at the end of life, including recognition and timely referral to palliative care, agreement and documentation of advanced care planning/treatment escalation plans and the involvement of patients and families in these processes. This theme is consistent with previous quarters with local trust work in place as well as an APC wide priority work stream, progress with which is reported separately to this committee.

2.4. At individual trust level the reviews show evidence of improvements in some key areas, as well as some themes for improvement including:

- **CWFT:** reviews highlight areas for improvement around communication between clinical teams, particularly at handover, and end of life care, both of which are quality priorities for the Trust.
- **ICHT:** reviews show evidence of sustained improvements in communication and team working. An area identified for improvement is recognising and responding to patients when they deteriorate, this has also been picked up in previous quarters and correlates

with incident data. Ten SJRs completed (16%) identified the importance of responding to patient deterioration and management and several instances where improvement is required. As well as the APC level quality priority, a trustwide safety improvement programme is in place; learning and improvements identified through these reviews have been fed into that programme.

- **LNW:** reviews have identified the need to increase use of Treatment Escalation Plans and individual care plans for patients with autism and learning disabilities. Improvement work is underway in these areas.
- **THH:** reviews completed in this quarter continue to identify good MDT communication and early identification of patient deterioration. Reviews also identified excellent communication with next of kin and regular communication with families ensuring their involvement in discussions and decision making.

3. Thematic Review

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

3.2. Mortality rates and numbers of deaths

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

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

3.2.3 HSMR and SHMI diagnostic group data has been reviewed by the APC mortality surveillance group, with variation noted. Trusts have agreed to review HSMR and SHMI diagnostic groups with a score above 100 to understand the differences. These include:

- **ICHT**: Non-Hodgkin's lymphoma, Intracranial injury, Acute Myocardial Infarction and Multiple myeloma.
- **LNW**: Cancer of liver and intrahepatic bile duct, Cardiac arrest and ventricular fibrillation, other psychoses, Residual codes, unclassified, Short gestation, low birth weight, and fetal growth reduction.
- **THH**: Other Perinatal Conditions, Open wounds of head, neck and trunk and Pancreatic disorders (not diabetes).

3.2.4 There were no diagnostic groups requiring further review at CWFT.

3.2.5 The outputs of local reviews are included in individual Trust learning from death reports and summarised below:

3.2.6 **ICHT**: completed reviews for two diagnostic groups (Non-Hodgkin's lymphoma and intracranial injury) identified no new clinical concerns and provided assurance that learning from death processes were followed in all cases. Reviews have now been completed of the AMI and multiple myeloma diagnostic groups and are being taken through internal governance processes; outcomes will be reported in the Q4 report. A reporting process has been set up to automate the triangulation of incident, mortality and clinical information from Datix and Cerner to support a rolling programme of reviews.

3.2.7 **LNW:** Review of diagnostic groups did not identify any new issues or emerging risks. Learning from the review has been used to develop actions which are being taken forward to improve the of end of life care processes and education in the Trust

3.2.8 **THH:** Reviews did not identify any clinical concerns.

3.2.9 The mortality surveillance group have agreed to continue with this programme of HSMR and SHMI reviews, with each Trust identifying diagnostic groups for review and then reporting findings on a quarterly basis so that the group can understand differences and identify any areas shared learning and improvement.

3.2.10 Site level HSMR data has been provided by Telstra Health UK and was discussed at the APC mortality surveillance group. The table below shows most recent data available. All reported sites are below 100 and sites shown in green have a low relative risk.

Provider Rolling 12 month HSMR	Oct 22 to Sep 23
ICH (St Mary's)	71.1
ICH (Charing Cross)	74.5
ICH (Hammersmith)	74.3
CWFT (ChelWest)	62.4
CWFT (West Middx)	76.9
HH (Hillingdon)	89.0
LNW (Northwick)	88.1
LNW (Ealing)	80.5
LNW (St Mark's)	81.4
National Benchmark	100.0

3.2.11 Queen Charlotte's and Chelsea Hospital (ICHT) and Mount Vernon (THH) have been removed from reporting as the numbers of deaths are very low which causes too much variation for the data to be used effectively.

3.3. Medical examiner reviews

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

3.3.2 Trusts continue to work collaboratively to expand medical examiner scrutiny to all non-coronial deaths occurring in NWL boroughs. The original date for the community pathway becoming a statutory requirement was April 2023 and the new NWL pathway went live ahead of this date to ensure readiness across the sector. However, the legislation was delayed and the Department of Health and Social Care have now confirmed that it will pass in April 2024.

3.3.3 Data on numbers of referrals from primary care, hospice, and independent sector providers is included in the ICHT and THH quarterly reports; these have continued to increase in Q3. THH scrutinised more deaths referred by community providers than inpatient acute deaths in this quarter.

3.3.4 A NWL task and finish group continues to meet to embed the pathway and encourage primary care to refer deaths ahead of the statute date.

3.3.5 All four Trusts have started to provide weekend ME scrutiny, prioritising urgent cases i.e. faith deaths requiring urgent body release and neonatal and paediatric deaths. Learning from each Trust will feed into collaborative work that aims to establish a shared weekend medical examiner service ahead of statutory implementation.

3.4. Level 2 reviews

3.4.1 Deaths where there are concerns, or which meet certain agreed criteria, are referred on by the medical examiner for a case note 'Level 2' review. The percentage of deaths referred for a Level 2 review during quarter two varies across each Trust, from 10% at LNW, 8% at THH, 15% at ICHT and 49% at CWFT. These referral rates are consistent with quarter two figures.

3.4.2 A shared set of 'triggers' for these reviews was implemented at the end of quarter one to allow consistent reporting on themes. CWFT have retained a local trigger where potential learning was identified at initial screening by consultants (28% of cases), this explains the higher percentage referral data.

3.4.3 'Unexpected deaths' was the most frequently used trigger at ICHT (75% of referrals). A review of the use of this trigger was completed by end of life and palliative care lead which found that a number of deaths were being categorised as unexpected which did not meet the National Audit of Care at the End of Life (NACEL) definition. The Trust has now adopted this national definition to standardise use of this trigger, and support more accurate assessment and coding. The report of this work has been shared with mortality leads across the other trusts as this is an opportunity for alignment across the collaborative.

3.4.4 'Unexpected deaths' accounted for almost 40% of LNW Level 2 reviews in this period, equal with the 'Concerns raised by family/carers' trigger. Referrals made by the Medical Examiner is the most frequently used trigger at THH (40% of cases referred) and CWFT (55% of cases referred).

3.4.5 Given the variation in screening, review methodology and reporting, the APC mortality surveillance group agreed to review this further, with recommendations then made to the executive led APC quality meeting. This will take place in March 2024.

3.4.6 All Trusts have implemented the CESDI scoring system to identify whether a death was avoidable in order to produce standard outputs from Level 2 reviews. Out of 197 completed in this quarter, one case where sub-optimal care might have contributed to the patient's outcome was identified (at ICHT).

3.4.7 Outcomes show low numbers of cases where definite issues are confirmed through level 2 review which is reassuring. For quarter three:

- **CWFT**: 106 completed with no cases of sub-optimal care that might have made a difference to the patient's outcome.
- **ICHT**: 63 completed with one case of sub-optimal care that might have made a difference to the patient's outcome. This case has been referred for an after action review (AAR) through the incident management process and will be discussed at the Trust death review panel once the investigation has been completed. Two cases were reviewed by the death review panel in Q3, both of which occurred outside of this quarter. One death was confirmed to be due to poor care relating to failure to recognise signs of deterioration; actions have been implemented within the service to support staff to undertake SBAR assessments, and the learning has been fed into the trust improvement programme. The panel found that there was no poor care in the other case reviewed.

- **LNW**: 15 completed with no cases of sub-optimal care identified.
- **THH**: 13 completed with no cases identified where different care may have affected the patient outcome.

3.5. Other mortality reviews

3.5.1 A number of other national processes are in place for review of deaths for specific cohorts of patients. These include the Perinatal mortality review tool (PMRT), Learning disability mortality review (LeDeR) and Child death overview panels (CDOP), which are described in the glossary below. Work has continued to align reporting of cases and outcomes from these process in each Trust and data is now being presented in scorecards.

3.5.2 Working with their local partners, THH have identified a number of reviews and improvement initiatives around CDOP, PMRT and LeDeR reviews.

3.5.3 ICHT have aligned PMRT reviews with adult death review processes for cases where sub-optimal care that could have affected the patient outcome has been identified. Work is underway to ensure recording and sharing learning from LeDeR and CDOP reviews is more robust.

3.5.4 Outcomes of these reviews will be included in all reports from next quarter.

4. Areas of focus

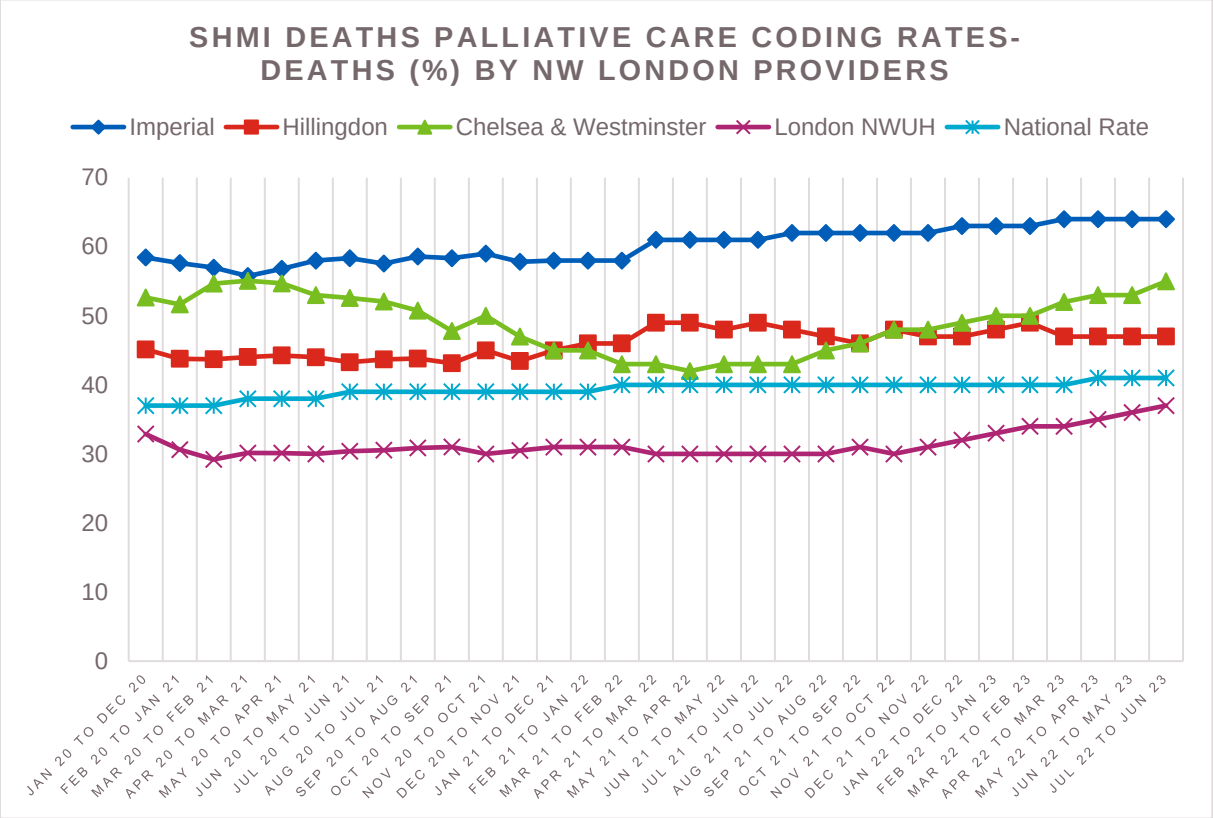
4.1. The APC mortality surveillance group is undertaking a review of palliative care clinical coding processes and discussed variation in palliative care coding in the March 2024 meeting.

4.2. The chart below shows the 12 month rolling SHMI palliative care rates and demonstrates variation, with the LNW rate lower than the other Trusts and below national average.

4.3. LNW have completed a palliative care coding audit and have identified a number of improvements in this area, including the recruitment of two consultant mortality validators to work with clinical coding teams to improve accuracy of mortality coding. ICHT have had similar roles in place for some time which has supported more accurate mortality coding.

4.4. Palliative care coding is under review at THH with their mortality coding leading joining local mortality surveillance meetings to monitor performance and discuss any issues or learning. THH transfer a high number of palliative care patients to their community beds which may impact their acute score for this metric. Reviews will continue.

4.5. No local actions were identified for CWFT or ICHT.



4.6. All Trusts have started to analyse ethnicity data for deceased patients and will start to report this through local mortality governance groups and in quarterly learning from death reports. Data has been included in quarter three reports for THH, LNW and ICHT with CWFT due to commence reporting in quarter four.

4.7. Ethnicity data from THH, LNW and ICHT shows that the same ethnicity categories are in use, with some minor differences in terminology used which could be aligned. THH are able to report on ethnicity for all deceased patients in quarter three, whereas data from ICHT (19.27%) and LNW (13.38%) includes patients where ethnicity is not known or stated.

4.8. The White British group makes up the highest proportion of deaths in each Trust. There are differences in the proportion of deaths in other ethnic groups which will be analysed through the mortality surveillance group. Below is data of all ethnic groups.

	LNW	ICHT	THH
Bangladeshi	0.00%	0.45%	0.00%
Black African	1.95%	4.76%	2.75%
Black Caribbean	3.61%	4.76%	0.55%
Chinese	0.15%	0.68%	0.55%
Indian	18.35%	5.44%	9.89%
Mixed white and Asian	0.45%	0.45%	0.00%
Mixed white and black African	0.00%	0.23%	0.00%
Mixed white and black Caribbean	0.00%	0.23%	0.00%
Not stated/Unknown	13.38%	19.27%	0.00%
Other Asian	10.23%	4.31%	10.44%
Other Black	1.20%	2.49%	0.55%

Other ethnic category	4.81%	15.42%	5.49%
Other mixed	0.45%	0.00%	0.00%
Pakistani	1.35%	1.13%	2.20%
White - British	34.74%	28.57%	56.04%
White - Irish	1.50%	2.72%	1.65%
White - other white	7.82%	9.07%	9.89%

4.9. The APC mortality surveillance group discussed work to analyse ethnicity data by comparing to data for all inpatient encounters and local populations. This will make the data increasingly meaningful in identifying areas of risk and where improvement is required. Work will continue locally, and progress will be reported in quarter four reports and discussed at the next mortality surveillance group. We recognise that until this is included the data is difficult to apply in practice.

4.10. Local areas of focus include:

- ICHT have introduced a new set of Specialty M&M standards across the Trust. Implementation plans have been developed by the divisions and progress will be monitored at the learning from deaths forum and reported through the quarterly LFD reports. Work is also underway to standardise the use of the 'Unexpected' Level 2 trigger by adopting the NACEL definition and training medical examiners of consistent use.
- THH have continued to adapt mortality surveillance reporting and processes following the implementation of Cerner. Reviews are also underway to align Specialty M&M meetings across the Trust and to improve the timeliness of Level 2 review completion.
- LNW now holds joint morbidity and mortality meetings with ITU, ED and Acute Medicine (incorporating HDU), enabling closer working between the teams with a view to preventing precipitant ITU admissions.
- All Trusts have started to work together to review current use of our mortality surveillance systems to identify areas of divergence and identify opportunities for standardisation and alignment. This will support the implementation of a shared system. Recommendations will be brought through local and APC mortality surveillance groups.
- Work is also underway to further align quarterly learning from death reports and performance scorecards with updates to be included in quarter four reports.

5. Conclusion

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

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

5.3. Agreed changes to processes for recording and reporting outcomes were implemented in this quarter and will over time improve how the collaborative uses data to identify and share learning from deaths. Implementation of these has initially highlighted the variation

which still exists in our processes. This is under review and recommendations will be agreed with the executives and then at the next APC mortality surveillance group.

5.4. Local reviews into HSMR and SHMI diagnostic groups will be overseen through the APC mortality surveillance group and will continue to be summarised in this report going forward.

6. Glossary

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

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

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

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

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

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

Appendix – Clinical outcomes performance report mortality data

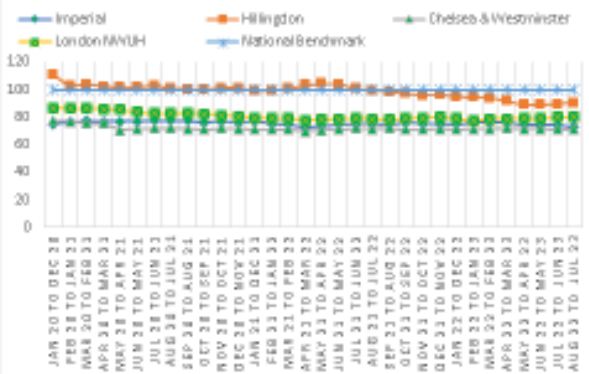
NHS
North West London
Acute Provider Collaborative

Integrated Performance Report
Clinical Outcomes

January 2024

(Patient) Summary Hospital-level Mortality Index

TREND



100
England Average

STANDARD

n/a

PERFORMANCE

n/a

TREND

n/a

ASSURANCE

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 (August 2022–July 2023) demonstrating similar figures to previous reporting periods. THH's rate is consistently 'as expected'.

Recovery Plan: None

Improvements: All Trusts are investigating variations between observed and expected deaths by diagnostic group and also where there is variance between HSMR and SHMI (above 100 and where statistically significant). Reviews will be presented to the next APC mortality surveillance group which will discuss themes and trends identified and agree actions to be taken forward including linking the data to peer reviews. This will be summarised in the LFD report to March APCQC.

Forecast Risks: N/A

CURRENT PERFORMANCE

Summary Hospital-level Mortality Index (SHMI) Year to July 2023

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	92570	71.04	Lower than expected
ICHT	98185	74.25	Lower than expected
LNW	103195	79.99	Lower than expected
THH	37040	91.36	as expected

STRATIFICATION

- The value and banding of the Summary Hospital-level Mortality Indicator ('SHMI') for the trust for the reporting period.
- The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
- It covers patients admitted to non-specialist acute trusts in England who died either while in hospital or within 30 days of discharge.
- SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

Data Assurance: Data is supplied and quality assured by Telstra Health

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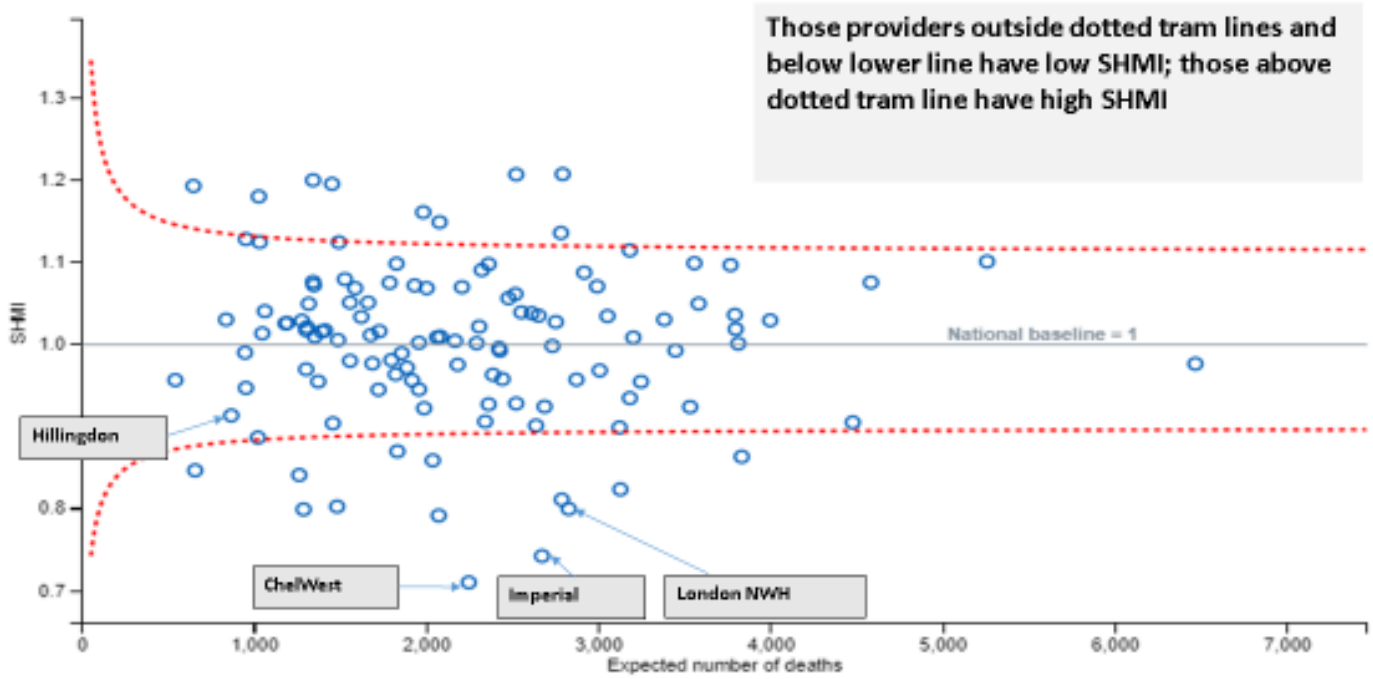
(Patient) Summary Hospital-level Mortality Index



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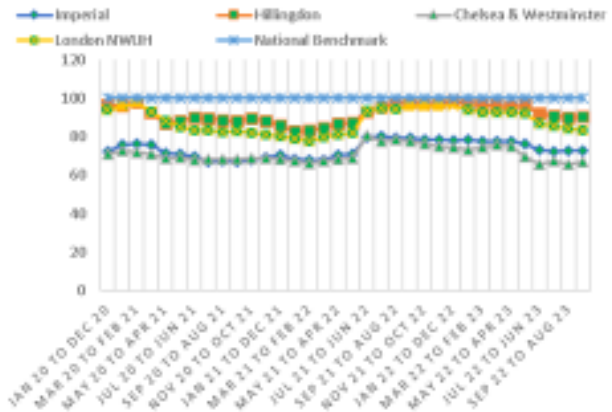
(Patient) Hospital Standardised Mortality Ratio

TREND



100
England Average

STANDARD

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

NARRATIVE

Performance: The most recent data (for the year October 2022 – September 2023) shows that each trust has a rolling 12-month ratio below the national benchmark. THH's rate has been steadily reducing and has been lower than expected for the last three months.

Recovery Plan: N/A

Improvements: All Trusts are reviewing variations between observed and expected deaths by diagnostic group and also where there is variance between HSMR and SHMI (above 100 and where statistically significant). Reviews will be presented to the next APC mortality surveillance group which will discuss themes and trends identified and agree actions to be taken forward including linking the data to peer reviews. This will be summarised in the LFD report to March APCOC.

Forecast Risks: N/A

CURRENT PERFORMANCE

Hospital Standardised Mortality Ratio (HSMR): Year to Sep 2023

	Provider Superspells	HSMR	HSMR - relative risk ranking
CWFT	46688	66.9	Lower than expected
KCH	68369	72.9	Lower than expected
LNW	59422	83.5	Lower than expected
THH	16200	90.4	Lower than expected

STRATIFICATION

- HSMR is a summary mortality indicator. It is based on a subset of 56 diagnosis groups that give rise to approximately 85% of in hospital deaths.
- It is adjusted for case mix, taking into account factors such as age, gender, comorbidities, palliative care coding, deprivation, month of admission, method of admission, admission source, number of previous emergency admissions, discharge year.
- Each patient has a 'risk' of death based on these factors. Risks are aggregated to give an expected number of deaths.
- The HSMR is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures and taking into account the adjustments outlined above.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

Data Assurance: Data is supplied and quality assured by Telstra Health

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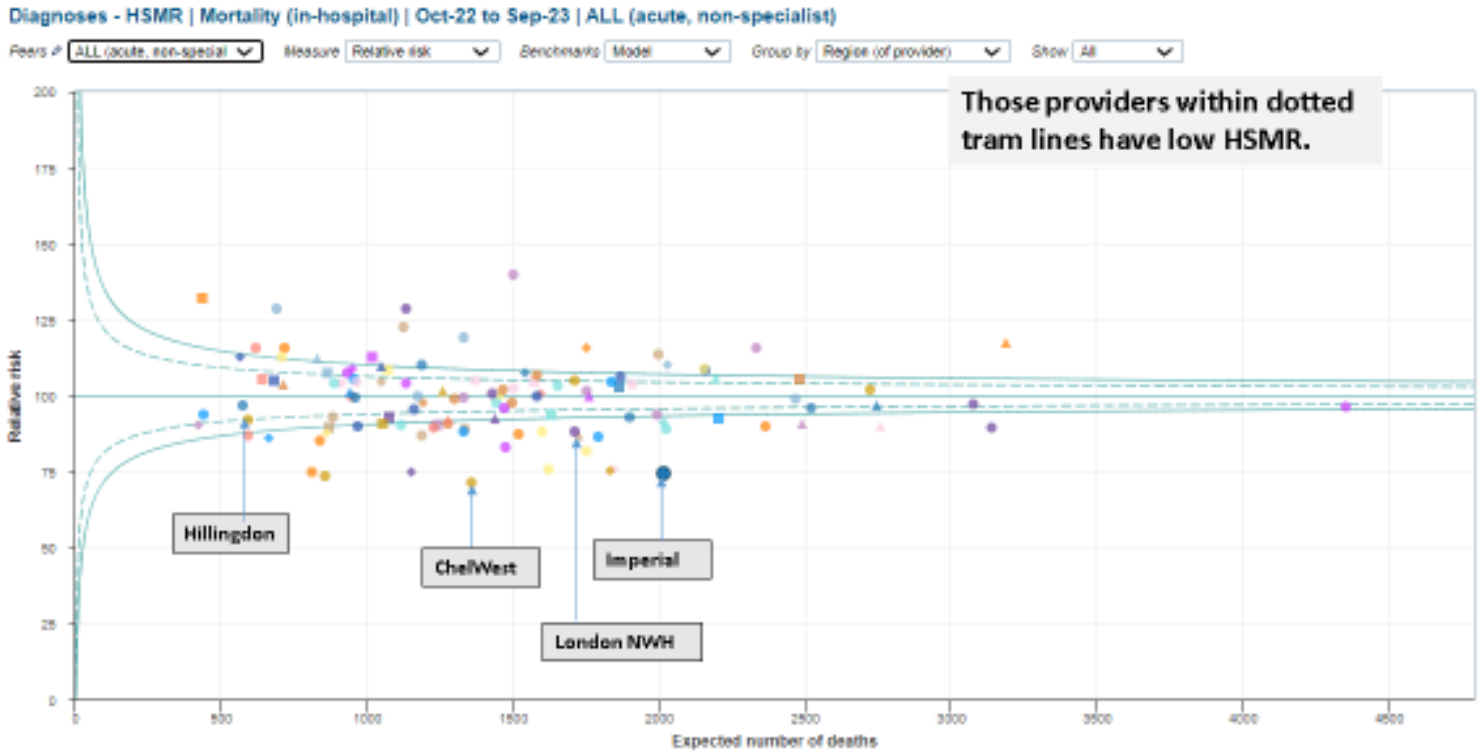
(Patient) Hospital Standardised Mortality Ratio



20

5.1 COLLABORATIVE PEOPLE COMMITTEE CHAIR REPORT -DAVID MOSS

REFERENCES

Only PDFs are attached

5.1 BIC Collaborative People Committee Chair's Report March 24.pdf

North West London Acute Provider Collaborative
Collaborative People Committee Chair's Highlight Report to the Board in Common – for discussion
March 2024

Highlight Report

1. Purpose and Introduction
1.1 The role of the People Collaborative Committee is:-

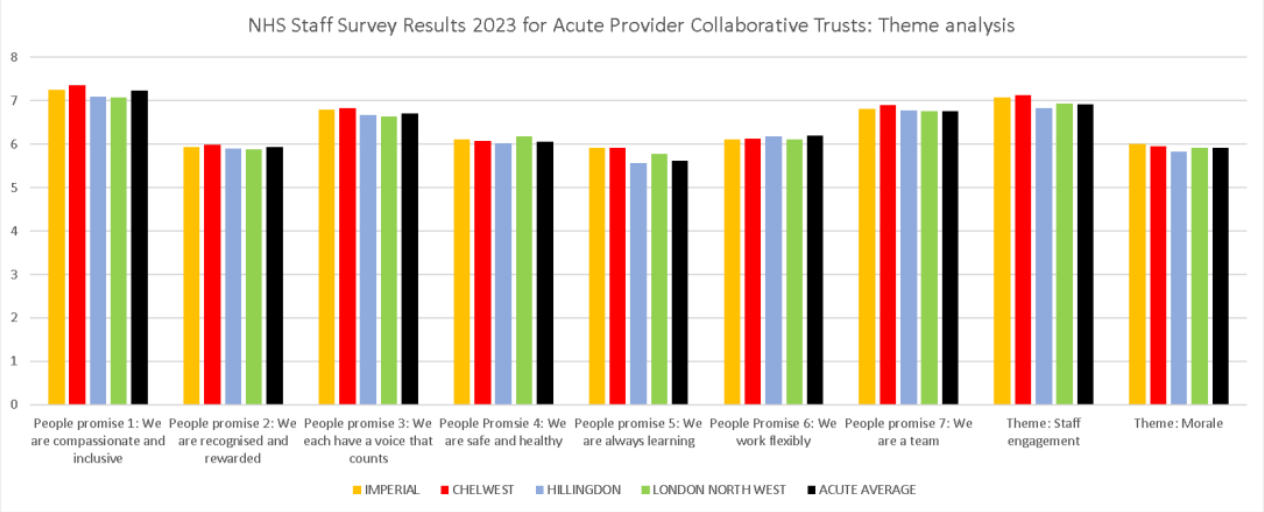
- To oversee and receive assurance that the Trust level People Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions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

2. Key Highlights

- Positive assurance gained on developing representative BAME leadership across Trusts in the Collaborative. At APC level, 46.0% of our staff, at bands 7-9 & VSM, are from a BAME background; varying at Trust level from 35.1% to 58.4%. All Trusts across the ICS agreed a 50% target for this metric by 2025. LNWH has met that target with 58.4% of bands 7-9 & VSM staff from a BAME background. Steady progress is seen at the other three Trusts.

- The Committee received the National Staff Survey results. Trust response rates ranged from 48% to 61%. The 4 Trusts in the APC show improvements in all themes since 2022. Work is ongoing at local levels and at collaborative level to identify improvement opportunities and key Collaborative people priority programmes for 2024/25 have been aligned to the staff survey findings. These are:-

    - Sustainable workforce
    - Workforce design and productivity
    - Equality, Diversity and Inclusion
    - Scaling People services



2.1 The Committee received an update on the delivery of the workforce priority objectives for 2023/24:

- Reduce premium rate temporary staffing expenditure –agency spend with this represented 2.8% or less of our collective spend for 8 months out of the last 10 months. Discussion ensued on the importance of reducing this further as a key component of the 24/25 financial plan
- Elective Orthopaedic Centre workforce transition – two theatres are now open with the further three to come on line in mid April 2024. 104 individuals are in post, 14 in the process of recruitment and there are currently 43 vacancies
- Recruitment hub for hard to fill vacancies - a collaborative approach to recruitment for hard to fill vacancies including international recruitment opportunities is under development
- Careers hub and staff transfer scheme – the need to move forward in developing arrangements for staff transfer schemes was discussed with the aim of enabling people to develop a fulfilling career within North West London
- Increase apprenticeship levy uptake - 1002 apprenticeships are in place across the Collaborative with Levy Usage at 44% year to date representing an average of 3% of total staff per organisation. A plan to increase the levy usage will be brought to the next meeting of the Committee. We noted that apprenticeship week awards, celebrations and activities have been successfully held across all four trusts over the past month .
- Reduce violence, aggression, bullying and discrimination – We are exploring the development of a standardised policy across the Collaborative with aligned media campaigns. Measurable metrics are to come to the next meeting to demonstrate whether actions and initiatives are making a difference to staff experience
    - Scaling up project uptake -An all-teams Engagement Event took place on 29th February involving 224 staff across the Collaborative. The outputs

from the engagement event have been used to indicate priority areas for the improvement plan and Senior Leadership Team (SLT) sponsors have been identified and aligned to each function to support design and delivery of priorities.

2.2 The Committee received and noted the Local Trust People Committee reports.

3. Positive Assurances Received

3.1 The Committee received positive assurance in the following areas:

- Vacancy rates at collaborative level are a special cause improving variation and are below the collaborative target of 10%.
- Voluntary turnover continues as a special cause improving variation as, over the past year, there has been a steady reduction from 12.8% to the current position of 10.6% which is below the Collaborative target of 12.0%.
- All Trusts have active retention projects and / or programmes and are part of a retention programme, supported by national resource, being initiated across the NWL ICS. The main Collaborative initiative on retention is the creation of a careers hub and a proposal for a common careers platform.
- After a long period of improving 12-month rolling sickness levels, December saw a rise in the overall 12-month rolling position due to an increase at THH. Sickness levels have come back down in January and are within seasonal levels. All Trusts have plans in place to manage absence, particularly long-term absence. Trusts continue to work locally to redeploy staff and mitigate safe staffing risks as required.
- Completion rates for non-medical Performance Development Reviews (PDR), is an area of focus, albeit we have seen an improvement over the past ten months with the metric continuing at a special cause improving variation. With the exception of non-medical appraisals at Imperial (which have a set window for completion) all Trusts operate a rolling programme for PDRs and are working towards the common target of 95% to drive improvement.

4. Key Risks to Escalate

4.1 The need for a sustainable and affordable workforce plan and the work to be done to achieve a sustainable run-rate.

5. Concerns Outstanding

None.

6. Key Actions Commissioned

- Identification of collaborative initiatives to support improvement in staff experience
- Identification of Key Performance Indicators to assess staff experience of violence and aggression

- Finalisation of the workforce plan 24/25

7. Decisions Made

Members of the Committee agreed to review the forward plan of the Committee to ensure sufficient focus is given to the benefits of strategic development of the collaborative people agenda and less time reviewing local performance.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	NWL APC People Priorities 23/24	Information /Noting	6.	Local Trust People Committee reports Actions and Escalations	Noting
2.	Acute Collaborative Dashboard	Assurance	7.	Committee Forward Thinking	Discussion
3.	NWL Workforce Risk Register	Assurance	8.		
4.	APC Staff Survey Results 2023	Information /Noting	9.		
5.	Workforce Operating Plan 24/25	Assurance	10.		

9. Attendance

Members:	March attendance
David Moss, Non-Executive Director, LNWH (Chair)	Y
Sim Scavazza, Non-Executive Director, ICHT	Y
Simon Morris, Non-Executive Director, THHFT	Y
Ajay Mehta, Non-Executive Director, CWFT	Y
Pippa Nightingale, Chief Executive (LNWH) and Collaborative Lead for People and Workforce	Y
Attendees:	
Matthew Swindells, Chair in Common	Y
Dawn Clift, Director of Corporate Affairs (LNWH)	Y
Lindsey Stafford-Scott, Interim Chief People Officer (CWFT)	Y
Phil Spivey, Chief People Officer (THHFT)	Y
Tracey Connage, Chief People Officer, (LNWH)	Y
Kevin Croft, Chief People Officer (ICHT)	Y
Alexia Pipe, Chief of Staff to Chair in Common	Y

5.2 APC IMPROVEMENT PLAN ? EDI ACTION PLAN PIPPA NIGHTINGALE SIM SCAVAZZA AND AJAY MEHTA

REFERENCES

Only PDFs are attached

- 5.2 BIC APC COVER - EDI Board member objectives.pdf
- 5.2a BIC Updated EDI objectives post discussion.pdf

NWL Acute Provider Collaborative Board in Common
16/04/2024
Item number: 5.2
This report is: Public

APC EDI Improvement Plan Steering Group – Recommendations on 24/25 board member objectives

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

Accountable director: Pippa Nightingale
Job title: Lead CEO, EDI Improvement Plan Steering Group

Purpose of report

Purpose: Decision or approval

Report history

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

APC EDI Improvement Plan Steering Group 29/02/2024 Noted as work in progress	**APC Executive Management Board** 07/03/2024 Supported	**APC EDI Improvement Plan Steering Group** 27/3/2024 Endorsed

Executive summary and key messages

The APC EDI Improvement Plan Steering Group was formed to develop recommendations for the NWL APC Board-in-Common on how we can advance equity and justice across our ways of working. This will include actions all patients and staff can expect within each organisation and collaborative initiatives to accelerate our progress.

Its initial discussions have prioritised developing recommendations to address the NHS England High Impact Action One: “Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable”.

The group recommends each board director should have two objectives:
- One common objective across the APC to change how we have conversations about equity

and to support everyone's own learning and development
- One NED or Executive Director specific objective depending on their role, focused on seeking measurable improvements on a specific, relevant metric.

The detail for these objectives, examples for this including links to measures prioritised by APC Committees and how progress should be measured is explained in detail in the supporting paper.

Subject to approval today, these objectives will now be incorporated into the 2024/25 annual appraisal and objective setting for every Board member and all Directors reporting to CEOs. If 2024/25 appraisal discussions have already taken place with an individual, a short further discussion should be scheduled with their appraiser before the end of May 2024 to additionally include these two equity, diversity and inclusion objectives.

The APC EDI Action Plan Steering Group continues to meet monthly. It is developing recommendations for further actions we should take which it will make to the Board-in-Common at the July 2024 meeting. These recommendations will encompass actions relevant for patients and staff, and include recommendations in response to the remaining High Impact Actions two to six from the NHSE EDI Action Plan.

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

Impacts staff appraisals

APC EDI Action Plan Steering Group: Background to developing these recommendations

- These recommendations have been developed by the APC EDI Improvement Plan Steering Group. This is co-chaired by two NEDs and includes representations from executives, staff and patients drawn from across the APC. These recommendations were endorsed by EMB on 7th March 2024 and their feedback comments have been incorporated.

- The Steering Group considered objectives each Board Director should have supporting equity, diversity and inclusion for 2024/25. In considering these objectives, the steering group agreed it was important to:
  - Support changes in our culture around and understanding about equity, racism, discrimination and justice
  - Ensure objectives are specific, for example considering individual population groups or individual outcomes, and measurable
  - Give directors choice about where and how they will commit their efforts

- Our recommendation is that all directors (non-executive directors, executive directors and trust executive team members[1]) have two objectives:
  - One common objective across the APC to change how we have conversations about equity and to support everyone's own learning and development
  - One NED or Executive Director/Executive team specific objective depending on their role, focused on seeking measurable improvements on a specific, relevant metric

- The APC EDI Action Plan Steering Group is now progressing other recommendations for other recommended High Impact Actions and further areas of improvement to consider. It will report back on these later in the Spring. Developing recommendations for board member objectives was prioritised so that they could be included in annual appraisal discussions

1 EMB recommended that any director reporting into CEO, whether they are a board member or not, should be included within these recommendations

Recommended EDI objectives for incorporation into 2024/25 board member and executive team appraisals

	Objective (written in first person)	Examples of options to choose from and incorporate into metric	How success will be measured
Common objective to support learning and understanding *(adopted by all board directors including chair and executive team members)*	To support a change in the conversations about equity in our board and its committees, such as our comfort in having discussions about racism, asking different questions and changing the actions being taken, and to support my own learning, commitment, behaviours and mindsets supporting equity I will undertake EDI training and education activities including… *(see next column)*	• Independent reading relevant for this topic • Completing training course(s), e.g., active bystander training • Attending conference(s) or masterclass(es) • Act as the exec/board sponsor for a staff inclusion network • Pairing with a staff member from a minority ethnicity background to support the staff member's professional progression and development and to break down boundaries between all staff members	• Evidence that identified activities have been undertaken • Progression into more senior leadership roles of paired staff • Anonymous qualitative feedback from paired staff members and board members on the experience • EDI questions will be included in the board effectiveness annual governance review, and responses evidence changes in the nature and comfort with conversations on equity
Non-Executive Director-specific objective	To support measurable improvements in the equity of our outcomes for patients and staff, I will use my leadership, influence and assurance responsibilities within ***[XX – see next column]*** board committee to promote an improvement in ***[XX – see next column]*** metric by March 2025 *Note: This would need to be tailored to the chair to reflect their role at the board-in-common rather than within an individual committee*	**Specific metrics prioritised by each committee such as:** **Quality:** Understanding mortality data in relation to ethnicity and reducing variation; understanding ethnicity of patients making formal complaints **Workforce:** Model Employment Goals including recruitment to achieve equity in senior roles and equity for staff in formal disciplinary processes **F&P:** Differences in waiting times for procedures or DNAs **Digital:** % of patients where there is a complete record of their EDI characteristics recorded in their care record **Estates:** How facilities designed to support different needs and equity	• Evidence from committee minutes about conversations incorporating equity and assurance of actions to support priority improvement areas • Measured improvement in metric agreed in the objective
Executive Director- or Executive Team member specific objective	To support measurable improvements in the equity of our outcomes for patients and staff, I will lead initiatives and improvements within my organisation to improve ***[XX – see next column]*** by March 2025 *Note: To support sharing, learning and standardisation across the APC, similar professional roles such as Chief Medical Officers could choose the same metric to target improvements within their organisation*	**Agree with CEO a specific, relevant metric for each Exec Director such as:** • WRES outcomes including relatively likelihood of appointment after shortlisting, relative likelihood of disciplinary action, or increase in proportion of minority ethnicity colleagues in senior roles • Reductions in bullying, violence and harassment experienced by staff • Specific improvements in quality outcomes such as the number of admissions to hospital or patient-centred experience priorities of patients with sickle cell disease • Improvement in research participation for patients from minority ethnicity backgrounds, or additional research trials in local needs previously underrepresented	• Measured improvement in metric agreed in the objective

Supporting accountability and tracking progress across all metrics

- *Publish consolidated list of objectives including metrics being influenced at the public board in April 2024*
- *Line manager reviews during regular performance discussions and annual appraisals*
- *Track progress against consolidated list of metrics agreed across objectives, with updates on latest figures available provided each quarter to relevant APC sub-committee*
- *Board discussion held at end of Q3 on lessons learnt and refinements of board objective setting process to incorporate into next financial year*
- *Publish report in April 2025 on overall progress against all these objectives and metrics, and updated objectives or metrics for next financial year (objectives may stay the same, if further improvement is being sought)*

6.1 COLLABORATIVE DATA AND DIGITAL COMMITTEE REPORT - STEVE GILL

REFERENCES

Only PDFs are attached

6.1 BIC Collaborative Digital and Data Chair's Report Final.pdf

North West London Acute Provider Collaborative (NWL APC)
Digital and Data (D&D) Committee Chair's Highlight Report to the Board in Common (BiC) – for discussion
March 2024

Highlight Report

1. Purpose and Introduction

The role of the D&D Committee is:-

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

2. Key Highlights

2.1 The NWL APC D&D Strategy

2.1.1 The Committee received an update on the APC D&D priorities for 2024/25. The five priorities have been drawn from the discussions at a workshop in October 2023 and align to the wider APC objectives and emerging strategy.

2.1.2 The 5 priorities are: -

- ICT Infrastructure – Long Term Investment Plan
- Oracle Cerner Electronic Patient Record (EPR) and associated ecosystem, with a particular emphasis on useability and reducing the burden on front line clinical staff
- Patient Empowerment & Shared Records
- Palantir Foundry Care Co-ordination – Managing Patient Flow and Capacity
- Develop a detailed Data Strategy and a plan for a Strategic Management Information Reporting Solution

2.1.3 After discussion it was agreed that the Strategic Management Information Reporting Systems will be implemented in 2024/25.

2.1.4 Further work around availability of funding and business critical areas will be provided at the next meeting in June.

2.2 Plan for the adoption of the NHS Federated Data Platform

2.2.1 The committee were provided with an update following the award of the contract for the NHS Federated Data Platform (FDP) and the work taking place across the APC to prepare for the migration of the various applications along with the detailed discussions taking place on how to re-position the FDP as part of our core infrastructure. The aim is to ensure that we are creating the conditions for the programme of work to succeed. This includes making sure that we have robust governance arrangements in place across the APC with regular meetings about the direction of travel and agreed scope of work and to ensure sufficient resources needed to deliver.

2.2.2 Seven FDP products will be deployed across the APC in 2024/25.

2.3 Equality, Diversity & Inclusion (EDI) Update

2.3.1 The Committee received current progress around the three D&D Committee EDI priorities.

- Increase the % of patients where there is a complete record of their EDI characteristics recorded in their care record (Target 90%)
- Increase the % of staff where there is a record of their EDI characteristics recorded in the electronic staff record (ESR) (Target 90%)
- Ensure that the process for procurement of hardware and software considers patient and staff accessibility.

2.3.2 It was acknowledged that these areas of work were due for delivery by April 2024 to ensure data was as complete and correct as possible to provide accurate information to support other APC Committees EDI priorities and that this had not happened. It was agreed that a plan for completing these tasks as quickly as possible would be developed and progress reviewed at the next meeting (see 5.2 below).

2.3.3 Further work will be undertaken on benchmarking and proposals for the next EDI targets areas for delivery 2024/25 will be brought to the next meeting (see 5.2 below).

2.4 ICT Risk Register

2.4.1 The committee received further update on the high-level risk register collating common risks and those that arise as a result of the collaboration across the APC.

2.4.2 Further work will be undertaken to include risk appetite, target risk scores, timelines of delivery and executive risk owners.

3. Positive Assurances Received

3.1 Update on the Cerner EPR Implementation at LNWH & THHT

3.1.1 The Committee received an update on the progress made towards stabilisation following the recent implementation of the Cerner EPR at LNWH and THHT and

progress towards defining the ongoing governance arrangements at the two Trusts as they transition to business-as-usual use of the system.

3.1.2 Following go live, LNWH put in place governance arrangements to oversee stabilisation and transition to business as usual. The LNWH Stabilisation Board has been tracking key metrics to assess progress towards business-as-usual use of the system. Task and finish groups were established to deliver projects to support this.

3.1.3 THHT set up similar arrangements, led by the project team rather than at project board level.

4. Key Risks to Escalate

4.1 Potentially insufficient ICT Infrastructure capital funding available in 2024/25, risks and mitigations being assessed.

4.2 Funding and resources re D&D priorities currently work in progress, further assessment at June APC D&D Committee.

5. Key Actions Commissioned

5.1 Further information on the APC D&D Strategy areas and availability of funding will be provided at the next meeting.
5.2 Further update on benchmarking data and information on 24/25 proposed EDI targets will be provided at the next meeting.
5.3 Further discussions on governance of the D&D risks (including ICT infrastructure and Cyber) will be undertaken.
5.4 Confirmation of the 7 FDP modules deployed / to be deployed across the APC: (i) Inpatients 360 (ii) Outpatients 360; Cancer 360 (iii) Timely Care Hub; (iv) Optica (discharge); (vi) Virtual Wards; (vii) Surgical Hub Centre (EOC)

6. Decisions Made

None

7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Cerner Implementation / Stabilisation at LNWH and THHT	For Information	6.	Equality & Diversity Update	For Discussion
2.	APC Digital and Data Strategy - Priorities for 2024/5	For Discussion	7.	Update on ICT governance arrangements	Verbal Update
3.	Update on the Cyber Strategy	For Discussion	8.	ICT Risk Register	For Information
4.	Plan for the adoption of the NHS Federated Platform (FDP)	For Discussion	9.	Forward Plan 2023/24	For Information
5.	ICT Capital Programme 2024/25 Update	For Discussion	10.		

8. Attendance

Members	December attendance
Steve Gill (D&D Chair; Vice Chair CWFT/NED THHT)	Y
Nick Gash (NED - ICHT/THHT)	Y
Neena Modi (NED – ICHT/CWFT)	N
Syed Mohinuddin (NED – LNWH/CWFT)	N
Simon Morris (NED – THHT/LNWH)	Y
Patricia Wright (Lead CEO - THHT)	Y
Simon Crawford (Director of Strategy – LNWH & Senior Information Risk Owner (SIRO) Representative)	Y
Kevin Jarrold (Joint Chief Information Officer – ICHT/CWFT)	Y
Robbie Cline (Joint Chief Information Officer – LNWH/THHT)	Y
Sanjay Gautama (Consultant anaesthetist & Chief Clinical Information Officer (CCIO) Representative)	Y
Bruno Botelho (NWL APC Programme Director & Operations Representative)	Y
Mathew Towers (Business Intelligence (BI) Representative)	N
In Attendance	
Matthew Swindells (NWL APC Chair in Common)	Y
Janet Campbell (Associate NED THHT)	Y
Alexia Pipe (Chief of Staff to the Chair in Common)	Y
Leigh Franklin (Assistant Trust Secretary - THHFT (minutes))	Y

7.1 COLLABORATIVE ESTATES AND SUSTAINABILITY COMMITTEE REPORT - BOB ALEXANDER

REFERENCES

Only PDFs are attached

7.1 BIC Collaborative Estates and Sustainability Committee - March 2024 final.pdf

North West London Acute Provider Collaborative (NWL APC)
Strategic Estates and Sustainability Committee Chair's Highlight Report to the NWL APC Board in Common (BiC) – for discussion
March 2024

Highlight Report

1. Purpose and Introduction

The role of the Collaborative Strategic Estates and sustainability Committee is:-

- To receive assurance that the Trust level processes governing estates are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee implementation of collaborative-wide interventions for short and medium term improvements in estates optimisation and usage, and sustainability.
- To receive assurance regarding capital planning and prioritisation across the Collaborative.
- To oversee and assure strategic change programmes to drive collaborative-wide and to oversee the development of the strategic direction of estates across the collaborative, including site optimisation and redevelopment.
- To oversee the consideration of strategic opportunities across the collaborative in relation to soft facilities management contracts.
- Ensuring equity is considered in all strategic estates development.

2. Key highlights

2.1 Update on green plan and sustainability plans

2.1.1 The Committee received a quarterly update on the work to deliver the interim target of 47% reduction carbon emissions across the Collaborative by 2028-2032.

2.1.2 The Committee previously requested a detailed decarbonisation report, which was being validated and anticipated this would be brought to the next Committee.

2.1.3 Standardisation and presentation of data was requested for future reports. However it was recognised that there would be exceptions particularly around the translation of consumption data from a number of sources.

2.1.4 The Committee requested that Green Plans for individual Trusts be brought a future meeting.

2.1.5 The Committee received the update.

2.2 Procurement Sustainability Update

2.2.1 The Committee received a report from North West London Procurement about embedding sustainability and social value outcomes in future procurement processes.

2.2.2 Sustainability criteria would be included in supplier tenders as part of the contract submission, and not just in the social value section, with measurable sustainability and social value KPIs.

2.2.3 The Committee discussed ways in which the changes could help local supply chain and agreed that suppliers meeting the London Living Wage should be non-negotiable in contracts.

2.2.4 The Committee noted the report.

2.3 Summary report from the Estates and Sustainability Executive Group

2.3.1 The Committee received the summary paper from the Estates and Sustainability Executive Group and noted the good progress made to date, noting in particular the update on the estates stocktake, benchmarking and the development of pipelines for contracts and business cases.

2.4 Process of business case approval and Equality Impact Assessment

2.4.1 The Committee considered proposals for its role, and how it could input into, the approval of capital related business cases.

2.4.2 The Committee noted the current APC scheme of delegation contained provision for input from this Committee (with amendment required to reflect the change in name and terms of reference for the Committee).

2.4.3 The Committee agreed that it should see draft Collaborative business cases for input to ensure it aligned with the APC, and provide a written commentary ahead of submission to the APC Finance and Performance Committee.

2.4.4 Trust-specific business plans needed to be reviewed against strategic importance and what consideration had been given as to whether a collaborative approach could be taken. This would be considered by the APC Executive Management Board.

2.4.5 The Committee agreed the Equality Impact Assessment to be used in business cases for capital projects to demonstrate consideration of physical accessibility. The EQIA would be included in the submission of future business cases.

2.5 Benchmarking the APC Estate

2.5.1 The Committee received a report which provided benchmarking data on the estate across the Collaborative. It was agreed the report would be reviewed through the APC Executive Management Board to identify areas to further review and action.

2.6 Major contracts register and procurement

2.6.1 The Committee noted Finance and Estates teams were working to develop a major contracts register and forward plan which would sit alongside the APC benchmarking data.

2.6.2 The Committee noted the report.

2.7 Capital Plan – Five Years Programme

2.7.1 The report outlined the evolving five year capital plan for the APC. Combined initial capital plans for five years totalled £1.6bn; however, this included anticipated central funding and funding for the redevelopment at The Hillingdon Hospital.

2.7.2 The Committee noted the report.

2.8 Critical Care at Northwick Park Hospital – Strategic Outline Case

2.8.1 The Committee noted the draft strategic outline business case for expansion of critical care capacity at Northwick Park Hospital.

2.9 Update on redevelopment plans

2.9.1 The Committee received a confidential briefing on the redevelopment plans for The Hillingdon Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Trust.

3. Positive assurances received

3.1 The Committee noted the positive update on the Green / Sustainability Plans.

3.2 The Committee noted the good work from North West London Procurement to embed sustainability and social value in future procurement.

3.3 The Committee noted the continued good work on the estates stocktake and the

expectation this work would dovetail with the wider APC strategy work.

4. Key risks to escalate

4.1 None highlighted at the March Committee, however the condition of the estate across the Collaborative and cost of backlog maintenance remains a significant risk.

5. Key actions commissioned

5.1 The Committee agreed standardisation of data and presentation was required for future sustainability reports and asked Green / Sustainability teams to agree what information could be compared with a trajectory to review progress against.

5.2 The Committee supported the process for approval of capital related business cases. However noted Trust-specific business plans needed to be reviewed for strategic importance and what consideration had been given as to whether a collaborative approach could be taken.

6. Decisions made

6.1 N/A

7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Update on green plan and sustainability plans	To receive	6.	Major Contracts Register and Procurement	To note
2.	Procurement Sustainability Update	To note	7.	Capital plans – Five Year Programme	To note
3.	Summary report from the Estates and Sustainability Executive Group	To note	8.	Critical Care at Northwick Park Hospital – Strategic Outline Case	To note
4.	Process of business case approval and Equality Impact Assessment	To note	9.	Update on redevelopment programmes - THHFT - ICHT	To receive
5.	Benchmarking the APC Estate	To note	10.	Committee forward planner	To note

8. Attendance Matrix

Members:	September Meeting
Bob Alexander, Vice Chair (ICHT) (Chair)	Y
Aman Dalvi, NED (CWFT/ICHT)	Y
Neville Manual, NED (THHFT/CWFT)	Y
David Moss, NED (LNWH/ICHT)	Y
Tim Orchard, Chief Executive (ICHT)	Y
Bob Klaber, Director of Strategy, Research and Innovation (ICHT)	Apologies
Virginia Massaro, CFO (CWFT)	Apologies
Jonathan Reid, CFO (LNWH)	Y
Jason Seez, Deputy CEO (THHFT)	Apologies
Janice Sigsworth, Chief Nurse (ICHT)	Apologies
Steve Wedgwood, Director of Estates (THHFT)	Y
In attendance:	
Huda As'ad, Associate NED (LNWH)	Y
Rachel Benton, Redevelopment Programme Director (THHFT)	Y

Peter Jenkinson, Director of Corporate Governance (ICHT and CWFT)	Y
Alexia Pipe, Chief of Staff – Chair's office	Y
Matt Tulley, Redevelopment Director (ICHT)	Y
Iona Twaddell, Senior Advisor to the CEO	Y
Eric Munro, Director of Estates and Facilities (ICHT)	Y
Mahroof Anwar, Sustainability Lead, London North West Procurement	Y
Philippa Healy, Business Manager (minutes)	Y
Lee Jackson, Managing Director, North West London Procurement	Y
Darshan Patel, Sustainability and Improvement Programme Manager – ICHT	Y
Lucinda Thompson, Sustainability Manager – CWFT	Y

8.1 COLLABORATIVE FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT - CATHERINE JERVIS

REFERENCES

Only PDFs are attached

8.1 BIC Collaborative Finance and Performance Committee Chair's Report - March 2024 - FINAL.pdf

North West London Acute Provider Collaborative
Collaborative Finance and Performance Committee Chair's Highlight Report to the Board in Common – for discussion
March 2024

Highlight Report

1.0 Purpose and Introduction

1.1 The purpose of this report is to provide the Board in Common (BiC) with assurance of the work undertaken by the Collaborative Finance and Performance Committee (FPC) at its last meeting held on 14 March 2024. The report is intended to provide any feedback to the BiC and request if further work within the Committee's remit is required.

1.2 The role of the Collaborative Committee is:

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

2.0 Key Highlights

2.1 Operational performance

The Committee considered month 10 (and some month 9) performance and heard that overall the North West London (NWL) Acute Provider Collaborative (APC) continued to perform well relative to other systems. Significant urgency and emergency care demand and industrial action impacted the position, including for elective pathways, long waiters and on the faster diagnostic standard (FDS) with some cancelled clinics.

All Trusts remain committed to delivering the 76% four hour standard for A&E, with Hillingdon and Imperial just under and London North West (LNW) and Chelsea and Westminster (CW) just over. There were a number of 78 week wait (ww) breaches, driven by industrial action. The hard work during a challenging period of winter pressures and industrial action was recognised by the committee members.

There was a discussion regarding inequalities and what is needed to better understand and address the issues. The Committee heard that the Digital and Data Committee discussed the importance of resolving the data issues within Cerner. It was agreed that work was needed to choose the indicators to track, noting that while deprivation was an important factor, it was ethnicity that the APC had agreed to focus on as the primary indicator. The further work on equalities, diversity and inclusion (EDI) being coordinated by the Hillingdon COO in relation to key operational performance indicators will be shared for discussion at the next Committee meeting.

2.1.1 Urgent and Emergency Care and Urgent Treatment Centre Review of Delivery and Performance: Overall there is good performance, including for ambulance handovers, with teams meeting to consider improvement noting Hillingdon were off-plan.

The specific report regarding Urgent Treatment Centres (UTCs) highlighted the progress in UTC performance since each trust had taken over the service, noting a small decline in demand. Performance had improved at all sites except for St Mary's. The initial focus has been on stabilising the services given the change in provider, and the plan now is to focus on improvement.

The issue with the costs per patient and contractual arrangement prior to and following the change in provider was noted, with the risk identified regarding the reported drop in activity and potential re-profiling of the contract by the ICB (noting that double counting had been a feature previously, but also that the Trust bids and projections were in line with the activity modelled before). The planned meeting with the ICB was highlighted and the need for operational as well as financial representation in the meeting was agreed.

The improved performance on type 2 and 3 was noted, it was advised however that this position masks some poor type 1 performance. The issue of funding/contract and risk of creating the wrong incentives was noted and this will be taken forward in the contract discussions with the ICB as commissioner. In response to questions about why the target is not being achieved given demand is lower than expected, the Committee was advised this was a result of the focus is on stabilising the service and a more detailed redesign is needed in terms of telephone booking-in and improved digital tools. There was further discussion about predictive modelling and mapping staffing rotas to known demand.

2.1.2 Diagnostics: The Committee heard about the workshops that had taken place over the past quarter and how there were initial plans shared but these required further detail and concrete actions. It was noted that additional capacity through the community diagnostic centres (CDCs) will be coming on line in the next quarter, creating additional capacity for all four organisations. The issue with some 13 week waits was noted. The work underway for the national audit was mentioned, regarding checks for patients overdue for surveillance and that they were going on to the list appropriately – given that surveillance was adversely impacted during the pandemic. The audit to date had shown a mostly compliant position for the APC but to note that further guidance is coming.

Overall there was concern regarding current position for some diagnostics, with a question about longer-term solutions vs an iterative response, querying whether there were clear demand and capacity plans. The wide variation in audiology waiting times was highlighted as a concern, with the outer trusts showing poorer performance than the inner trusts. A request was made for another metric to identify how long for example it would take for 90% of patients to be seen. The issue sparked a discussion about each trust's focus and where there was merit in a collaborative response, noting that this should be a prior discussion with CEOs and executives, driven by where there is variation and potential solutions through a collaborative approach.

2.1.3 Elective care: the Committee were advised of the overall rise in the patient tracking list (PTL), attributed in part to some data quality issues arising from the embedding of the Cerner system. There had been an uptick in 78ww for some trusts but down for others. When asked for a prediction on the end of year position LNW and Hillingdon were still forecasting a zero position with Imperial and CW potentially at 73 and 90 respectively – with a day by day focus on these patients in each organisation. The positive performance for Hillingdon was noted as a positive achievement, acknowledging the difference in size and ratio.

2.1.4 Cancer: the impact of industrial action was identified with lower performance against the FDS, 4-5% worse in January. The 31-day standard was largely static, along with an improved 62 day backlog – with LNW's concerted effort seeing the Trust under trajectory which was a good outcome, moving the sector to a better position overall. The positive work with the Royal Marsden (RM) Partners Cancer Alliance was highlighted, particularly in relation to equality, diversity and inclusion (EDI), plus a number of key posts in organisations funded through the partnership.

2.2 Financial performance and recovery

2.2.1 The Committee noted and discussed the month (m) 10 position as reported, but was also focussed on the year-end position as currently understood in each organisation.

The m10 position was much in line with the last month's reporting, still reflecting the challenges of industrial action, not quite achieving the cost improvement programme (CIP) targets, and rowing back on costs – so a continuation of the trend already begun. It was advised however that the m11 position did show a marked difference in that it included much of the agreed settlement from the ICB. This was broadly in line with the expectation, which was estimated at £24/25 million overall. Cash and capital positions were reported to be in line with expectations. In summary the APC was predicting an overall break-even position.

Each Trust's position was considered:

- **LNW** – the same CIP trend continued, a £5.7m deficit – with a plan to recover this by reviewing all lines noting the Cerner impact remains a risk to this with recovery and recording levels lower than expected. There are weekly meetings with the CEO and focussed worked with divisions. There is regular communication with NHS England (NHSE) regarding initial assumptions for elective recovery fund, which was being forecast by NHSE using a month 1-8 algorithm which would lead to an adverse impact on funds. Signs are that NHSE will amend this. Work continues to bring down all areas of expenditure.

- **Hillingdon** – while the m11 position looks favourable, there is an underlying issue with spend in January. One risk which looks likely to materialise is a technical charge arising from decant arrangements for the new build, which has adversely impacted the position leading to a forecast £0.5m end of year deficit. This creates a revenue pressure. There is a £1.7m 'hit' on the ERF, with a run rate that is still too high. Overall there is a risky forecast for the end of year position.

- **Imperial** – there was a £1.1m surplus in month, the recovery plan is delivering and the forecast outturn is breakeven assuming there is no further industrial action that is unfunded.

- **CW** – there was a £3m surplus in m11. The ERF over-performance is offsetting industrial action. There is currently a breakeven forecast for end of year and this looks to be on track.

Overall this position was recognised as positive, particularly given the challenging year and where the rest of the country currently is, noting how the additional work to treat patients had made a positive impact on the projected position.

However the need to live within budget, consistently deliver on CIP plans and address the underlying run rate, with strengthened productivity and efficiency was cited. Each

organisation must live within its means, understand their own run rate, deliver CIPs and then consider what to do collaboratively for those schemes that will have most impact.

The Committee agreed the following: to consider the outcome of work regarding each organisation's run rate to be shared. The work is underway, with data expected at the end of the month. Discussions will then follow first with CEOs and relevant executives in relation to variation and where there are opportunities for learning, sharing and action across the collaborative (noting the point above regarding each organisation living within their budgets).

2.3 Finance Plans 2024/25

The Committee was updated on the work underway to develop each Trust's plans for 2024/25. Initial submission to the ICB is due on 21 March, but there will still be a gap. There is further dialogue taking place, but there is more to do over the next month to develop the final plan.

The issue regarding non-recurrent funding from the ICB is being picked up, noting this is not helpful in terms of developing sound plans for the coming year. It was however advised that the APC needs to fully understand and record this so that a clear and unified position on 'unearned income' and what should be recurrent is presented to the ICB, including for example critical care funding.

The CIP plans overall are currently only at 50%, which is a better position than this time last year, but remains a challenge – extensive work with teams continues with proposed schemes being priced up.

A particular focus with Chief People Officer (CPO) colleagues was cited, noting the variation between staff in post and the overall establishments for each trust. The ICB have escalated the workforce plan elements noting the lack of alignment. The issue with workforce numbers and additional complexity given some services have moved in house, some have been outsourced, plus staff deployed to focus on certain things during the pandemic may not be focused on priorities or on business as usual (BAU), so a granular review regarding workforce is required and in progress.

The Committee was advised on the work to 'up the ante' regarding productivity, with a productivity board across the APC being established which will provide assurance to this Committee and the Board.

2.4 Business Plan – 2023/24 and 2024/25

The Committee received an update on the delivery of the 2023/24 business plan, and the Committee agreed that in future it should hold deep dives into the finance and performance aspects of the APC business plan to support a more collaborative discussion.

The Committee noted an update on the development of the plan for 2024/25, noting the alignment with the APC strategy development. The Committee noted there is further work to do in the development of collaborative programmes.

2.5 North West London Procurement Update

The Committee received a report summarising the lessons learned from the work and experience of the NWL Procurement Shared Service over its first year. The Committee

heard that there were areas identified for improvement and these were factored into a recovery plan which was going to the Procurement Shared Services Board. The lead for the service has acknowledged that there were issues that must be addressed. The experience provides an opportunity for improved transition for future shared services, such as the plans for HR and Finance. It was added that a letter had been produced by LNW in response to the challenges experienced, noting that issues had not always been escalated to the service as they should. There will be strengthened governance overall and greater oversight on performance. Executive members and attendees of the Committee confirmed that the data and information in the report was correct**.**

2.6 Financial Shared Services – Outline Business Case

The Committee was reminded that they had agreed the strategic outline case some time back. The OBC shows that there is a saving to be made following initial investment. Concern was noted given the experience of the procurement shared services and the Committee was advised that the learning would be factored in as the Full Business Case (FBC) is developed. Supplier engagement has commenced with some interest. The Committee was advised that the Trust CEOs are discussing the matter, including the plans for phasing and ensuring the APC's position is protected. Discussion on the target operating model took place including how this is being developed in parallel while a partner was sought for system aspects of the proposal. It was confirmed that one of the APC trusts will host the service with an APC CFO as the senior responsible officer (SRO). A discussion on the plans for a single team was discussed with some questions about this, noting no decisions should be taken until the risks and benefits were considered.

3.0 Positive Assurances Received

3.1 The Committee was assured regarding current performance against many of the constitutional standards, with some exceptions as noted below.

4.0 Key Risks to Escalate

4.1 The key risks noted were the continued impact of industrial impact in terms of performance and the financial position, the position in terms of the financial, operating and business plan for 2024/25 where there is work to do to finalise and then provide assurance, and diagnostic performance.

5.0 Concerns Outstanding

5.1 While the APC is projected to break-even at year-end, there is risk to the LNW and Hillingdon positions. The other issues of concern are UEC type 1 performance, 78ww, diagnostics and the business plan for 2024/25, noting the current gap.

6.0 Key Actions Commissioned

6.1 **Forward plan:** a more thorough refresh of the forward plan to ensure that the Committee is focusing on those issues and actions where there can be most impact – so a focus on collaborative matters, with the local F&P Committees focused on ensuring local delivery and performance.

6.2 **Diagnostics**: focus on position and recovery plans, with a discussion next time on whether there is a role for the APC to take collaborative action on this, and if so what this is. There was also a request for clearer metrics and trajectory regarding how long it would take to treat the majority of patients.

6.3 **Financial shared services:** further discussion and analysis of the risks and benefits of establishing one team before any further decisions are made.

6.4 **Run rate:** for the position for each trust to be clarified and shared with the Committee along with proposed actions to address any issues.

6.5 **Funding:** agree a common position on non-recurrent and 'unearned' income to make the case to the ICB for next year's and future funding.

6.6 **EDI and data:** an update at the next meeting regarding inequalities data and proposed metrics to track in relation to finance and particularly performance, ensuring a focus on ethnicity. The work being coordinated by Hillingdon's COO will be reported to the next collaborative meeting for discussion.

7.0 Decisions Made

7.1 None specifically in terms of strategy or business cases, but to note the actions agreed by the Committee as above.

8.0 Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Integrated Performance Report and operational performance updates on UEC, diagnostics, elective care, cancer	To note	6.	Business Plan 2024/25	To note
2.	Urgent Treatment Centres – Review of Delivery and Performance	To note	7.	NWL Procurement Service Update	To note
3.	Finance Report	To note	8.	Trust Level Committee Assurance Reports	To note
4.	Financial Recovery Report	To note	9.	Draft Forward Agenda Planner	To note
5.	2024/25 Financial Plans	To note			

9.0 Attendance

Members:	March attendance
Catherine Jervis, Non- executive director (NED) - (Chair)	Y
Patricia Gallan, NED, Chair of CWT F&PC	Y
Bob Alexander, NED, Chair of Imperial F&PC	Y
Loy Lobo, NED, Chair of LNW F&PC	Y
Lesley Watts, CEO, Chelsea and Westminster NHS FT and Collaborative Lead for Finance and Performance	Y
Attendees:	
Matthew Swindells, Chair of NWL Board in Common and Collaborative	Y
David Moss, NED, Vice Chair LNW (and outgoing chair of LNW F&PC)	Y
Tina Benson, Chief Operating Officer – Hillingdon	Y
Peter Chapman, Director of Finance - Chelwest	Y
Claire Hook, Chief Operating Officer - Imperial	apologies
Jazz Thind, Chief Financial Officer - Imperial	Y
Virginia Massaro, Chief Finance Officer - CWT	Y
Jon Bell, Chief Financial Officer - Hillingdon	Y
James Walters, Chief Operating Officer - LNW	Y
Jonathan Reid, Chief Financial Officer - LNW	Y
Jennifer Howells, Director of Strategic Finance and Operational Partnerships	Y
Peter Jenkinson, Director of Corporate Governance	Y
Laura Bewick, Deputy Chief Operating Officer and Hospital Director - CWT	Y
Karen Powell, Deputy Chief Operating Officer – Imperial	Y

Marie Price, Deputy Director Corporate Governance - CWT	Y
Alexia Pipe, Chief of Staff to the Chair	Y

8.2 FINANCIAL PERFORMANCE REPORT - JONATHAN REID

REFERENCES

Only PDFs are attached

8.2 BIC APC Finance Report - Month 11.pdf

8.2a BIC NWL Acute Collaborative M11 Financial Performance 2324 v1.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 8.2
This report is: Public

2023/24 NWL APC Month 11 Finance Report

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

Accountable director: Jonathan Reid
Job title: Chief Financial Officer, LNWHT – on behalf of the Acute CFOs

Purpose of report

Purpose: Assurance

This report sets out the financial position of the Collaborative at Month 11 (February 2024). The report sets out the combined income and expenditure position across the four Trusts and brings to the attention of the Board material variances and risks and provides updates on the capital and cash position. The Collaborative is forecasting breakeven at Month 11 across three of the Trusts, with a small adverse variance of £0.5m anticipated at Hillingdon Hospitals.

Report history

The Collaborative Finance Report is produced by Helen Berry on behalf of the Acute CFOs and is reviewed through the Acute CFO Group. It is shared with the Executive Management Group. The report is aligned with the internal reporting at each of the four Trusts.

NWL Acute CFOs	EMB	FPC
15/12/2023	09/01/2024	21/12/2023
Agreed	Agreed	Briefing (Headlines)

Executive summary and key messages

At the end of Month 11, the Collaborative has a combined deficit of £35.2m. An in-month surplus of £28.9m was delivered as a result of receipt of planned additional funding, including industrial action funding and Cerner support funding, from NWL ICB. Industrial action costs and income loss of £17.1m is included in the deficit of £35.2m and is expected to be substantially recovered in Month 12. The remaining deficit of £18.1m is driven by under-delivery of cost improvements, excess inflation and other cost pressures.

The Collaborative is forecasting breakeven at the end of Month 12, bar Hillingdon Hospitals which is anticipating a small (£0.47m) deficit driven by additional costs associated with the decant programme for the new hospital.

The Collaborative is forecasting delivery of 100% of the planned CIP programme of £119.5m, although only 47% of this delivery is recurrent. CFOs are working with colleagues across the Trusts to review options to strengthen recurrent delivery. The Collaborative is also forecasting delivery of the capital spend against the collective capital resource limit, with some finalisation of CRL by adjustments through dialogue with the ICB.

Strategic priorities

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

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

Impact assessment

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

Reason for private submission

N/A

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

NWL APC
2023/24 Month 11 (February 2024)
Financial Performance

Helen Berry, Associate Director of Finance.

March 2024

Executive Summary

Financial Performance

This paper describes the overall I&E performance to month 11 of the NWL APC, the main drivers and provides updates on the capital and cash position.

At the end of month 11 the APC reports a deficit of £35.2m against a year-to-date deficit plan of £13.9m, thus reporting a £21.4m adverse variance to plan. The in-month surplus is £28.9m against a deficit plan of £1.6m, a £30.5m favourable variance to in month plan.

The in-month surplus is primarily due to the inclusion of NR funding to support the I&E forecast position as agreed in Month 8. LNWH have also included a further £10m agreed to mitigate against ERF lower than planned levels due to Cerner implementation. In addition, two trusts have included funding to mitigate against the impact of IA (months 9-11). The IA impact in month 11 is £7.4m.

<u>The main drivers of the adverse YTD variance to plan are:</u>

Cost Improvement Programmes (CIP): The APC reports under delivery of its CIP plan to date at £29.4m adverse variance to plan, however the rate of CIP continues to improve at £9.8m in the month compared to the year-to-date average delivery of £6.9m (to the previous month). The year-to-date delivery is £69.8m and is met through both recurrent and non-recurrent means at £41.6m and £28.1m respectively. The forecast CIP delivery is to meet the annual target in full although there will be a significant degree of non-recurrent support to manage this position. Trusts monitor CIP delivery both by local governance processes within their respective organisations and by the APC via the monthly APC Business Plan updates to the Executive Management Board and Peer Review meetings.

Doctors' Industrial Action: The YTD impact of Industrial action is £63.2m, comprising £28.3m cost, £32.4m elective income and £2.5m other variable income. In Month 8, additional income was agreed to cover the cost impact up to month 7 (£16.6m) and a further reduction of 2% to the ERF baseline (£11.2m). Taking these two values with the first 2% reduction to the ERF baseline (agreed in August, (£11.2m) means the impact of industrial action (to the end of Oct) is fully mitigated for the APC in total. Industrial action was also held in three months December through to February with an impact of c£24.2m, this is partially mitigated to date by further IA central funding and ICB additional NR funding. Two trusts (LNWH & CWFT) accounted for this additional funding in M11, and ICHT & THH will account for it in Month 12. The overall adverse variance to date caused by IA is £17.1m. At the end of the year there is a shortfall on IA costs over funding of £4.1m.

Inflation: Excess inflation (over funded values) is estimated to contribute £9m YTD to the adverse variance and £10.8m full year impact.

Cont'd overleaf……

Executive Summary - continued

NHS Contract Income Performance :. To month 11, the APC has reported a favourable variance of £67.5m across its variable NHS patient care contracts, comprising £37m of ERF and £30.5m under the "non-ERF" part of the contract, which is primarily pass through drugs and devices (thus an equal and opposite cost response). This overperformance value includes the additional income accounted for in response to the 4% elective activity value target adjustment. Excluding the impact of industrial action (the income reduction compensated by the 4% mitigation), the position on ERF would be £48.1m overperformance to date.

Junior doctors pay award: the pay award of 6% was paid in August (backdated to April). Tariff income has been adjusted to reflect the additional cost, however for all trusts there is shortfall of income over cost. To month 11 this is estimated as £8.3m for the APC, with an estimated full year impact of c£9m, which contributes to the overall deficit.

Expenditure on supporting patients with additional mental health needs. During the second half of the year, spend on RMNs and HCAs to support patients in our hospitals with mental health needs emerged as a key driver of the adverse variance to plan, estimated as contributing £11.8m to the overall adverse variance to the end of month 11.

Operational Pressures / run rate overspends: Expenditure on operational pressures have caused overspends against budgets, across a range of clinical services including theatres, ICU, clinical supplies and drugs.

2023/24 Financial Performance Management Process.

Peer to Peer CFO meetings have taken place throughout the financial year, the latest one on 12th Jan focused on the year end forecast and the impact in Q4 of the financial control measures in the financial recovery plan. An Extraordinary F&P CIC meeting was held on 26th January to reconfirm the recovery plan.

Forecast:

The forecast is breakeven, except for THH which is a £470k deficit. Included within this THH deficit is a £2.6m transaction relating to the clearance of the site in preparation for the new hospital, partly offset by non-recurrent benefits.

APC Financial Performance at Month 11

NWL Acute Collaborative (Month 11 Financial Performance)

2023/24	In Month Plan £000	In Month Actuals £000	In Month variance £000	Year to date Plan £000	Year to date Actual £000	Year to date Var £000	YTD variance %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	302,955	367,546	64,591	3,324,023	3,562,855	238,832	7.2%	3,626,316	3,893,819	267,503
Pay	(183,632)	(203,442)	(19,810)	(2,020,873)	(2,183,424)	(162,551)	-8.0%	(2,204,650)	(2,378,230)	(173,580)
Non-Pay	(116,913)	(131,876)	(14,963)	(1,281,517)	(1,376,910)	(95,393)	-7.4%	(1,398,883)	(1,486,920)	(88,037)
Non Oper	(3,990)	(3,328)	662	(35,513)	(37,767)	(2,254)	-6.3%	(22,783)	(29,140)	(6,357)
Total	**(1,580)**	**28,900**	**30,480**	**(13,880)**	**(35,246)**	**(21,367)**		**(0)**	**(470)**	**(470)**

The table shows the month 11 financial performance of the APC, by I&E category, a £21.4m YTD adverse variance to plan and a favourable in month variance of £30.5m.

<u>The main drivers of the variance to plan are:</u>

- Income – The favourable variance to plan is driven by ERF and non-ERF patient care contracts' overperformance, additional income received to mitigate against the cost of industrial action (to date); additional non recurrent support in year per the recovery plan (£15m); funding for the UTCs at all trusts (with corresponding costs in pay and non-pay) which were not included in the start budget; income to account for the higher cost of the AfC and junior doctors pay settlement (over tariff funded levels).

- Expenditure (Pay and Non pay) – adverse variance : the cost of doctors' industrial action, CIP under delivery, operational pressures and inflation, RMN overspend, incremental cost of the AfC and medical pay award (over tariff funded level) and UTC expenditure (compensated by income as above) and excess unfunded inflation, particularly in utilities and FM contracts.

APC Financial Performance at Month 11 by Trust

NWL Acute Collaborative (Month 11 Financial Performance by Trust)

2023/24	In Month Plan	In Month Actuals	In Month variance	Year to date Plan	Year to date Actual	Year to date Var	Year to date (deficit) / surplus as a % of YTD income	Annual Plan	Annual Forecast	Forecast Variance
	£000	£000	£000	£000	£000	£000	%	£000	£000	£000
CWFT	10	3,035	3,024	18	8	(11)	0%	0	0	0
ICHT	0	1,148	1,148	0	(14,761)	(14,761)	-1%	0	0	0
LNWH	(714)	18,514	19,228	1,583	(5,729)	(7,312)	-1%	0	0	0
THH	(876)	6,205	7,081	(15,481)	(14,765)	716	-4%	(0)	(470)	(470)
Total	**(1,580)**	**28,900**	**30,480**	**(13,880)**	**(35,246)**	**(21,367)**	**-1%**	**(0)**	**(470)**	**(470)**

The table shows the month 11 financial performance by Trust. All trusts report adverse variances to plan YTD apart from THH.
In month 11 CWFT and LNWH accounted for M9-M11 funding mitigations for IA in these months. In addition, LNWH accounted for a £10m mitigation against ERF reduction in performance due to Cerner.

Narrative highlighting the main reasons for the organisation's material variances is reported on slide 16.

Forecast **:** The forecast is to meet the overall financial plan (breakeven) in line with the financial recovery plan for three trusts. THH updated its forecast at month 11, included in the THH forecast deficit is a £2.6m transaction relating to the clearance of the site in preparation for the new hospital, partly offset by non-recurrent benefits.

APC Financial Performance – Doctors' Industrial Action M9-M11

Table 1

IA Funding	IA impact M9-M11				Funding			
M9-M11 Impact	M9	M10	M11	Total	IA funding (NHSE)	ERF benefit	ICB addtl	Total funding
	£m	£m	£m	£m	£m	£m	£m	£m
CWFT	(0.76)	(2.48)	(0.75)	(3.98)	0.55	3.43	0	3.98
ICHT	(3.10)	(4.63)	(3.25)	(10.97)	9.72	0.58	0.67	10.97
LNWH	(1.80)	(3.20)	(2.50)	(7.50)	6.92	0	0.58	7.5
THH	(0.52)	(0.62)	(0.84)	(1.98)	0.83	1.15	0	1.98
APC	(6.17)	(10.93)	(7.34)	(24.44)	18.02	5.16	1.25	24.43

Table 2

IA Funding	IA impact M9-M11				Funding accounted for to M11				
M9-M11 Impact	M9	M10	M11	Total	IA funding (NHSE)	ERF benefit	ICB addtl	Total funding	Residual to account for in M12
	£m	£m	£m	£m	£m	£m	£m	£m	£m
CWFT	(0.76)	(2.48)	(0.75)	(3.98)	0.55	3.43	0	3.98	0.00
ICHT	(3.10)	(4.63)	(3.25)	(10.97)	0	0	0	0	10.97
LNWH	(1.80)	(3.20)	(2.50)	(7.50)	6.92	0	0.58	7.5	0.00
THH	(0.52)	(0.62)	(0.84)	(1.98)	0	1.15	0	1.15	0.83
APC	(6.17)	(10.93)	(7.34)	(24.44)	7.47	4.58	0.58	12.63	17.79

Table 1: Funding M9-M11 IA

- The impact of industrial action held in December, January and February is £24.4m. (costs and Income).
- The ICB received funding from NHSE totalling 18m for the APC trusts to mitigate against this IA impact. This was the full and final settlement which falls short of the actual impact of £24.4m.
- To meet some of the shortfall the ICB funded a further £1.25m. The residual gap is made up by assigning additional ERF income allocated for 23/24, this is the difference in performance comparing NHSE assessment of 23/24 ERF performance to the ICB/Provider assessments of ERF year end forecast performance.
- By using this methodology to mitigate against the IA impact it can be seen in Table 1 above that the trusts who benefit from higher levels of additional ERF performance receive a lower proportion of the IA funding allocation. Also, this means that for the APC, IA in the year is not completely mitigated by funding received specifically to cover the financial impact of IA.

Table 2: M9-M11 IA costs and funding in I&E position

- To month 11 not all trusts accounted for this additional income in their positions.
- CWFT and LNWH accounted for it in full, THH only accounted for the ERF benefit element and ICHT did not account for any. Income as above will be accounted for in month 12.

APC Financial Performance – Doctors' Industrial Action YTD

Table 3 : Month 11 YTD - net impact of Doctor's industrial action

2023/24 M11	Cost	Elective (ERF) Income loss	Other variable Income loss	Total	Add'l ERF to M11 (1st 2%)	Add'l ERF to M11 (2nd 2%)	Funding to cover IA cost to M7	Funding for M9-M11 IA	Addtl ICB allocation M11	Net impact of IA in I&E YTD
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	(6,553)	(4,829)	(1,165)	(12,547)	2,295	2,189	3,948	551	0	(3,564)
ICHT	(10,419)	(15,224)	(1,543)	(27,186)	4,324	4,492	6,287	0	0	(12,083)
LNWH	(8,108)	(9,746)	0	(17,854)	2,919	2,872	4,308	6,920	580	(255)
THH	(3,231)	(2,602)	227	(5,606)	1,157	1,142	2,051	0	0	(1,255)
Total	**(28,310)**	**(32,402)**	**(2,481)**	**(63,193)**	**10,695**	**10,696**	**16,594**	**7,471**	**580**	**(17,157)**

Table 4 : 23/24 IA impact Costs and Funding

2023/24 M11	Cost	Elective (ERF) Income loss	Other variable Income loss	Total	Add'l ERF (1st 2%)	Add'l ERF (2nd 2%)	Funding to cover IA cost to M7	Funding for M9-M11 IA	Addtl ICB allocation M11	Net impact of IA in I&E YTD
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	(6,553)	(4,829)	(1,165)	(12,547)	2,494	2,380	3,948	551	0	(3,174)
ICHT	(10,419)	(15,224)	(1,543)	(27,186)	4,700	4,883	6,287	9,720	670	(926)
LNWH	(8,108)	(9,746)	0	(17,854)	3,173	3,122	4,308	6,920	580	249
THH	(3,231)	(2,602)	227	(5,606)	1,258	1,242	2,051	830	0	(225)
Total	**(28,310)**	**(32,402)**	**(2,481)**	**(63,193)**	**11,625**	**11,626**	**16,594**	**18,021**	**1,250**	(4,077)

Table 3: YTD impact of IA

- The YTD impact on the cost base is £28.3m to date and on income, a reduction of £32.4m elective income and £2.5m other variable income (private patient and other non-ERF variable income). Total £63.2m.
- The total cost and income impact of IA up to the end of month 7 is partially mitigated: funding received to cover costs to m7 and the year-to-date additional funding by tranches 1 and 2 of the 2% reductions to the ERF baseline .
- For the M9-M11 IA impact, funding is agreed to cover this as per the previous slide. Two trusts have included this income in month 11: CWFT & LNWH ICHT per the table above.
- The YTD impact caused by IA to date is an adverse variance of £17.2m

Table 4: Full year impact of IA

- This table shows the total annual cost and income loss resulting from IA (£63.2m) against all the relevant income streams received to mitigate IA.
- This leaves a residual gap of £4.1m unmitigated. LNWH is fully mitigated but the other three trusts fall short.
- The above doesn't include additional ERF received arising from the difference between NHSE's assessment of ERF overperformance and the ICB/provider view. This is £5.1m per previous slide.

APC Financial Performance Month 11 – Excess inflation

Estimate of YTD excess inflation

Inflation over funded levels	YTD M11 Excess Cost	YTD M11 funding	Net excess inflation pressure M10	FY forecast estimate	FY Inflation funding	Net excess inflation pressure FY
	£000	£000	£000	£000	£000	£000
CWFT	(2,554)	902	(1,652)	(2,940)	984	(1,956)
ICHT	(4,992)	2,459	(2,533)	(5,446)	2,683	(2,763)
LNWH	(5,407)	1,810	(3,597)	(5,898)	1,974	(3,924)
THH	(2,171)	982	(1,189)	(3,200)	1,071	(2,129)
Total	**(15,123)**	**6,153**	**(8,970)**	**(17,484)**	**6,712**	**(10,772)**

Excess inflation is the cost pressure caused by higher prices for services in excess of the amount funded in the national tariff (income). Tariffs were uplifted by 5.5% to account for inflationary pressures, which have fallen short of actual inflation for many goods and services, most notably soft and hard FM contracts, utilities, rates and rental.

The table notes the year-to-date estimate of net excess inflation, contributing to the adverse variance to plan. This is estimated at c£9m, which includes £6.1m of additional excess inflation funding to date.

APC position Month 11 net of IA & Excess Inflation

2023/24	M11 YTD Actual £000	M11 YTD IA&Infl £000	M11 YTD Actual Net of IA/ERF 4%/ Infl £000	M11 YTD plan £000	M11 YTD variance exl; IA/ERF 4%/Infl impact £000
CWFT	**8**	**5,216**	**5,223**	**18**	**5,205**
ICHT	**(14,761)**	**14,616**	**(145)**	**0**	**(145)**
LNWH	**(5,729)**	**1,852**	**(3,877)**	**1,583**	**(5,460)**
THH	**(14,765)**	**452**	**(14,312)**	**(15,481)**	**1,169**
Total	**(35,246)**	**22,135**	**(13,111)**	**(13,880)**	**769**

- The table notes the estimated variance to plan removing the impact of IA (net of additional funding) and excess inflation.
- The IA additional funding includes the M9-M11 included for LNWH & CWFT, comprising of IA cost mitigation funding and ICB additional contribution.
- This notes a favourable variance to plan of £0.7m.
- The next slide reports the detail of this “underlying” run rate by month. Note only the impact of IA (costs and associated funding) and excess inflation is removed in arriving at the underlying position.
- The APC’s underlying position for month 11 is a £27.1m, this is due to additional funding included per the recovery plan and an extra £10m for LNWH Cerner ERF shortfall, and further ERF benefit included at CWFT & THH.

APC : Month 11 run rate

Monthly actual run rate movement (stripping out industrial action impact & inflation)

2023/24	Month 1 run rate £000	less IA & excess inflation £000	Month 1 (net) £000	Month 2 run rate (No IA) £000	less excess inflation £000	Month 2 (net) £000	Month 3 run rate £000	less IA & excess inflation £000	Month 3 (net) £000	Month 4 run rate £000	less IA & excess inflation £000	Month 4 (net) £000
CWFT	(1,616)	1,897	**281**	**(24)**	150	**126**	(1,210)	1,263	**53**	(1,565)	1,944	**378**
ICHT	(10,481)	2,906	**(7,575)**	**(4,304)**	230	**(4,074)**	(1,555)	1,743	**188**	(574)	3,488	**2,914**
LNWH	(6,418)	1,965	**(4,452)**	**(3,331)**	327	**(3,004)**	(1,820)	1,990	**170**	(3,331)	2,584	**(747)**
THH	(2,790)	869	**(1,921)**	**(2,848)**	108	**(2,740)**	(3,392)	537	**(2,855)**	(3,484)	864	**(2,620)**
Total	(21,305)	7,637	**(13,667)**	**(10,507)**	815	**(9,691)**	(7,977)	5,533	**(2,444)**	(8,954)	8,879	**(75)**

	Month 5 run rate £000	* less IA & excess inflation £000	Month 5 (net) £000	Month 6 run rate £000	less IA & excess inflation £000	Month 6 (net) £000	Month 7 run rate £000	less IA & excess inflation £000	Month 7 (net) £000	Month 8 run rate £000	** less IA & excess inflation £000	Month 8 (net) £000
CWFT	485	571	**1,056**	3,014	1,082	**4,096**	272	1,255	**1,527**	130	(69)	**61**
ICHT	(1,232)	2,399	**1,167**	(3,658)	2,662	**(996)**	(4,173)	1,859	**(2,314)**	9,588	(9,751)	**(164)**
LNWH	(1,492)	879	**(613)**	(4,870)	1,578	**(3,291)**	(2,864)	1,467	**(1,397)**	6,673	(8,358)	**(1,685)**
THH	(1,428)	80	**(1,348)**	(3,892)	595	**(3,297)**	(2,516)	593	**(1,923)**	2,404	(4,880)	**(2,477)**
Total	**(3,666)**	**3,929**	**263**	**(9,406)**	**5,918**	**(3,488)**	**(9,280)**	**5,173**	**(4,107)**	**18,794**	**(23,059)**	**(4,265)**

	Month 9 run rate £000	less IA & excess inflation £000	Month 9 (net) £000	Month 10 run rate £000	less IA & excess inflation £000	Month 10 (net) £000	Month 11 run rate £000	less IA & excess inflation £000	Month 11 (net) £000
CWFT	(706)	697	**(9)**	(1,807)	(3,600)	**(5,407)**	3,035	28	**3,063**
ICHT	4,735	2,311	**7,046**	(4,254)	4,092	**(163)**	1,148	2,677	**3,824**
LNWH	(6,375)	1,598	**(4,777)**	(416)	3,023	**2,608**	18,514	(5,202)	**13,312**
THH	(799)	415	**(384)**	(2,224)	533	**(1,691)**	6,205	738	**6,943**
Total	**(3,145)**	**5,020**	**1,875**	**(8,701)**	**4,048**	**(4,653)**	**28,900**	**(1,759)**	**27,142**

The table notes the reported and "underlying" run rate. Only the impact of IA (costs and associated funding) and excess inflation is removed in arriving at the underlying position.

APC Month 11 Elective Income – 4% baseline adjustment

In 2023/24 elective activity is paid for on a cost and volume (variable) basis. The elective activity plan includes “ERF” PODs - day case, elective, outpatient firsts and outpatient procedures. These are subject to national VWA targets and national pricing.

In addition, NHS patient care contracts includes other planned care PODs which are for local agreement, and paid for on a variable basis, these are outpatient & diagnostics unbundled; pass through drugs and excluded devices.

For the ERF PODs the original 2023/24 target VWA %’s, against the (repriced) 19/20 baseline are:

2023/24 VWA % targets (ERF PODS)	LNWH	CWFT	ICHT	THH	NWL ICB
	%	%	%	%	%
NWL activity	108	115	104	106	109
ALL ICS activity	109	113	104	105	

The annual VWA targets were reduced by 2%, (at month 5) and a further 2% reduction was announced in November. From month 8, ERF is calculated using these new baselines (4% lower than the original targets above).

Elective 4% target adjustment impact

	Impact of 4% ERF baseline adjust (FY)	YTD impact (based on working days)	YTD accrued for in M11 accounts (est)
Trust	£000	£000	£000
CWFT	4,874	4,484	4,484
ICHT	9,583	8,816	8,816
LNWH	6,295	5,791	5,791
THH	2,500	2,300	2,300
Total APC	**23,251**	**21,391**	**21,391**

The elective target VWA for 2023/24 was reduced by 4% (2% announced in August and a further 2% announced in November), to mitigate the impact of doctors' industrial action (to the end of October).

The table above notes that the impact over the whole year is additional ERF income of £23.2m. To month 11, a proportion of this has been included – based on the number of working days / calendar days to the end of Feb, at £21.4m.

All four trusts recognise the impact of the 4% adjustment in their accounts..

APC Month 11 NHS Income Contract – Performance

NHS Contract Income under/overperformance to end of Month 11

	NWL ICB ERF	Spec Comm ERF	Non NWL ICB ERF	Total ERF	NWL Other variable	Spec Comm Other	Non NWL Other	Total Other Variabl	Total
Trust	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	15,138	(840)	3,696	**17,993**	1,693	4,687	1,214	**7,595**	**25,588**
ICHT	9,047	3,415	(876)	**11,585**	5,002	11,765	1,277	**18,043**	**29,628**
LNWH	4,968	(2,175)	626	**3,418**	349	1,279	(116)	**1,513**	**4,931**
THH	5,923	(107)	(1,723)	**4,093**	1,800	1,500	(1)	**3,299**	**7,391**
Total APC	**35,075**	**292**	**1,722**	**37,088**	**8,844**	**19,231**	**2,374**	**30,450**	**67,538**

The APC reports a £67.5m favourable impact caused by variable NHS contract income performance to month 11. This comprises £37.1m over performance of ERF and £30.4m over performance on the locally agreed PODs. To note the majority of overperformance assigned to the variable locally agreed PODs is from pass through drugs where there will be a compensating cost response.

There has been an improvement in contract income performance in month 10 of £9.9m : £6.7m on ERF (driven by performance at THH and CWFT) and £3.2m on locally agreed PODs..

Trust	Elective perf before IA impact	IA impact on elective income	IA addtl (4%)	Elective perf reported
CWFT	17,993	4,829	(4,484)	18,339
ICHT	11,585	15,224	(8,816)	17,993
LNWH	3,418	9,746	(5,791)	7,373
THH	4,093	2,602	(2,300)	4,395
Total	**37,088**	**32,402**	**(21,391)**	**48,100**

The table shows ERF income performance net of the impact of industrial action (which is a reduction of £32.4m contract income mitigated by the additional £26.1m to date for the 4% target reduction.

£48.1m overperformance would be reported without industrial action, (to note includes all commissioners).

APC Month 11 CIP Summary

	YTD plan			YTD actuals			YTD Var	Annual Plan			Annual Forecast			Fcast Variance
Efficiency Month 11	R £000	NR £000	Total £000	R £000	NR £000	Total £000	£000	R £000	NR £000	Total £000	R £000	NR £000	Total £000	Total £000
CWFT	21,560	0	21,560	13,230	8,796	22,026	466	23,520	0	23,520	14,459	9,061	23,520	0
ICHT	48,969	0	48,969	13,783	8,850	22,633	(26,336)	53,421	0	53,421	15,583	37,838	53,421	0
LNWH	29,150	0	29,150	13,768	12,795	26,563	(2,587)	31,800	0	31,800	15,857	15,943	31,800	0
THH	9,361	0	9,361	8,361	0	8,361	(1,000)	10,757	0	10,757	10,757	0	10,757	0
Total	**109,040**	**0**	**109,040**	**49,141**	**30,442**	**79,583**	**(29,457)**	**119,498**	**0**	**119,498**	**56,656**	**62,842**	**119,498**	**0**
% delivery of plan				**45%**	**28%**	**73%**					**47%**	**53%**	**100%**	

- The CIP plan for the APC in 2023/24 is £119.5m or 3.2% of income. The CIP plan is profiled in equal 12ths at three trusts; THH has an increasing profile throughout the year.
- At Month 11 the APC is £29.5m under delivered at £79.6m against a year-to-date plan of £109.1m. £30.4m has been classed as non-recurrent CIP. CWFT has met it's CIP plan to date, the other three trusts are under delivering.
- To date 73% of the year-to-date plan is delivered. Month on month there is a step up in delivery at £9.8m in month 11 compared to £7m per month up to month 10.
- At month 11, the forecast expectation is to meet the annual CIP plan in full, noting risks in the forecast, including the use of non-recurrent support.

<u>Actions to address CIP identification and delivery:</u>

- Collaborative Productivity & Efficiency group – sharing knowledge on schemes, identification, reporting and governance. Each trust delivered a comprehensive run through of their 23/24 schemes during December and January to the other trusts which supported 24/25 CIP planning.
- Enhanced financial, grip and control measures in place in Q4, presented at the January 12th CFO Peer Review session.
- APC Business plan CIP delivery workstream with CFO SROs.
- Collaborative and joint working throughout the APC by the Acute Financial Performance escalation in place in 2023/24.

APC Month 11 Capital Summary

The APC Capital Plan for 2023/24 is £262.5m, comprising schemes funded from trust capital and national funding.

To note expenditure on capital might exceed the CRL (capital resource limit) where projects are funded from other sources such as additional grants and donations.

The national schemes are funded from the DHSC national capital programme and the Targeted Investment Fund, noted in the table below:

National Programme	£000
Community Diagnostic Centres	31,679
Diagnostic Digital Capability Programme	387
Endoscopy - Increasing Capacity	6,247
Front Line Digitisation	972
New Hospital Programme (THH)	26,200
UEC Capacity	26,000
Total	91,485
Targeted Investment Fund	£000
Elective Recovery	20,141
Total	20,141
Total - DHSC programmes	**111,626**

Capital	M11 2023/24			Annual 2023/24		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	47,481	31,453	16,028	82,200	47,656	34,544
ICHT	70,116	57,305	12,811	76,448	86,199	(9,751)
LNWHT	52,805	72,971	(20,166)	55,404	92,015	(36,611)
THH	44,254	23,922	20,332	48,427	34,602	13,825
Total	**214,656**	**185,651**	**29,005**	**262,479**	**260,472**	**2,007**

At Month 11, the APC has spent £185.6m on capital, against the year-to-date plan of £214.7m, a £29m underspend.
The forecast variance to plan, is £2m underspent , although likely capital funds will be spent.
The overspend at LNWH is due to additional capital funding granted for a new 32 bed modular ward at LNWH and additional front line digital funding. The underspend at CWFT reflects NWL ICS reserves held by the Trust at planning stage, now allocated out to relevant organisations. For ICHT the current forecast overspend is a timing issue and all things being equal, the CRL is expected to be updated to include: cash backed PDC funding not yet reflected, disposal proceeds due and anticipated capital cover for the impact of IFRS16. The THH underspend reflects a timing issue relating to the new hospital build.

APC Month 11 Cash

The APC cash balance stood at £342.8m at the end of Feb, an increase of £33.5m in the month. Since the end of the previous financial year the balance has fallen by £66.4m (16%) per the table.

The in-month increase is driven by cash deposits at LNWH and THH in month 11 and reflect non recurrent funding received from the ICB in line with the recovery plan, and in addition (at LNWH) the permitted draw down of PDC ahead of capital expenditure .

Since March 23 two trusts (ICHT and LNWH) report a reduction in cash balances. CWFT and THH reports an increase.

The reduction in cash in the two trusts is primarily driven by the I&E deficit position including unrealised efficiencies, the use of NR benefits, movements in working capital (debtors increase), and capital spend.

NWL APC Cash Balance				
Trust	**31-Mar-23**	**29-Feb-24**	**Movement YTD**	**Movement in month**
	£m	**£m**	**£m**	**£m**
CWFT	160.2	164.7	4.5	3.1
ICHT	179.2	122.9	(56.3)	0.7
LNWH	50.1	32.2	(17.9)	21.1
THH	19.7	22.9	3.3	8.6
Total	**409.2**	**342.8**	**(66.4)**	**33.5**

APC Trust Summary Narrative

CWFT:

At month 11 the Trust is reporting an in-month surplus of £3.03m and a year-to-date surplus of £0.01m This is £3.02m favourable against plan in month and a YTD adverse variance of £0.01m. Industrial action net of funding has created a £3.9m pressure up to February; which is a combination of cost (£6.6m), income loss (£6.0m), partially offset by funding (£8.7m). Non-pay inflation above the funded levels, which relates to a number of specific items such as utilities, PFI and Hard FM (£1.8m), which is net of new inflation funding received from NWL ICB.

The position includes ERF over-performance of £16.4m, offset by associated costs of £13.5m – net benefit of £2.9m; and other items totalling £2.4m; including CNST Maternity Incentive Scheme Bonus payment of £4.1m and balance sheet and other various items of (£1.8m). CIP delivery is ahead of plan £0.5m ytd.

The Trust's forecast is now breakeven, which accounts for additional funding received this month to offset cost pressures from the December to February Industrial Action.

ICHT:

At the end of Month 11, the Trust reports an in-month surplus of £1.1m and a year-to-date deficit of £14.8m, which is in line with the revised forecast for month 11. The YTD favourable variance on income of £69.4m is namely due to £11.8m R&D and £3.7m of Education and Training income offset by costs and £53.9m of patient care contract variances due primarily to ERF performance and pass through drugs and devices (compensated by costs).

The YTD £46.6m adverse variance against pay is driven by the under delivery of CIPs, RMN/specialling spend and pay award pressures. The non-pay overspend of £44.4m is driven by pass through drugs and devices of £23.7m (offset by clinical income); under delivery on efficiencies of £8.8m (predominantly within clinical divisions) and residual excess unfunded inflation. The year-to-date delivery against a planned efficiency target of £48.9m is £22.6m, an under-delivery of £24.8m.

The forecast is breakeven, enabled by additional funding agreed for IA mitigation and additional ERF overperformance (totalling £11m). This will be accounted for in Month 12.

LNWH:

The Income & Expenditure (I&E) position to January is a deficit of £5.7m, a variance to plan of £7.3m.

The YTD variance is driven by a number of factors, including estimated Cerner implementation income loss £9.5m, our assessment of unfunded excess inflationary pressures of £3.6m and CIP shortfall of £2.6m. The Cerner income loss has been mitigated by additional support from NWLICB of £10m.

ERF overperformance to date is estimated at £2.9m, this reflects prolonged underperformance in the post-Cerner period.

Included in the YTD variance is c £18.6m (above plan) non-recurring financial flexibilities that support the overall position.

CIP delivery YTD is £26.6m against a plan of £29.2m, delivery to date includes £12m of non-recurrent efficiencies. The forecast is breakeven reflecting funding of M9-M11 IA.

THH:

At M11, the Trust is reporting a YTD deficit of £14.8m, a favourable variance to plan of £0.7m. In the month this is due to non-recurrent ICB funding for IA and APC support, plus overperformance on ERF– an £8.0m benefit overall. Additionally, £1.7m was released from balance sheet above the level that had been estimated in the M7 forecast. Excluding the additional balance sheet adjustments, pay costs in M11 were £3.0m above the spend in M10, and £1.2m higher than the average for M1 to M7, £0.9m of this relates to LCEA accrued in month. On non-pay, spend was £0.9m below M10 spend level driven largely by reduction in spend within corporate services. Agency spend overall is running significantly above the target spend for agency due to continuing RMN pressure and winter pressures.

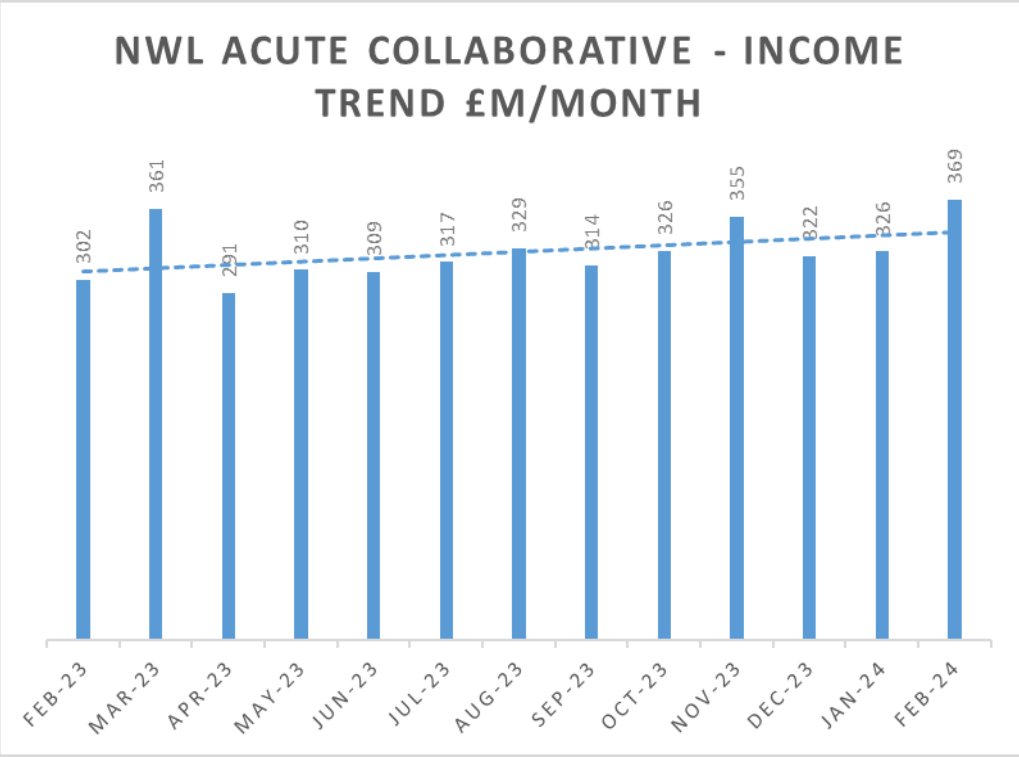
M11 reports an in-month surplus position on income of £11.0m driven by £4.0m ICB NR Support funding, £2.2m Industrial Action support, ERF over-performance accounts for £1.8m.

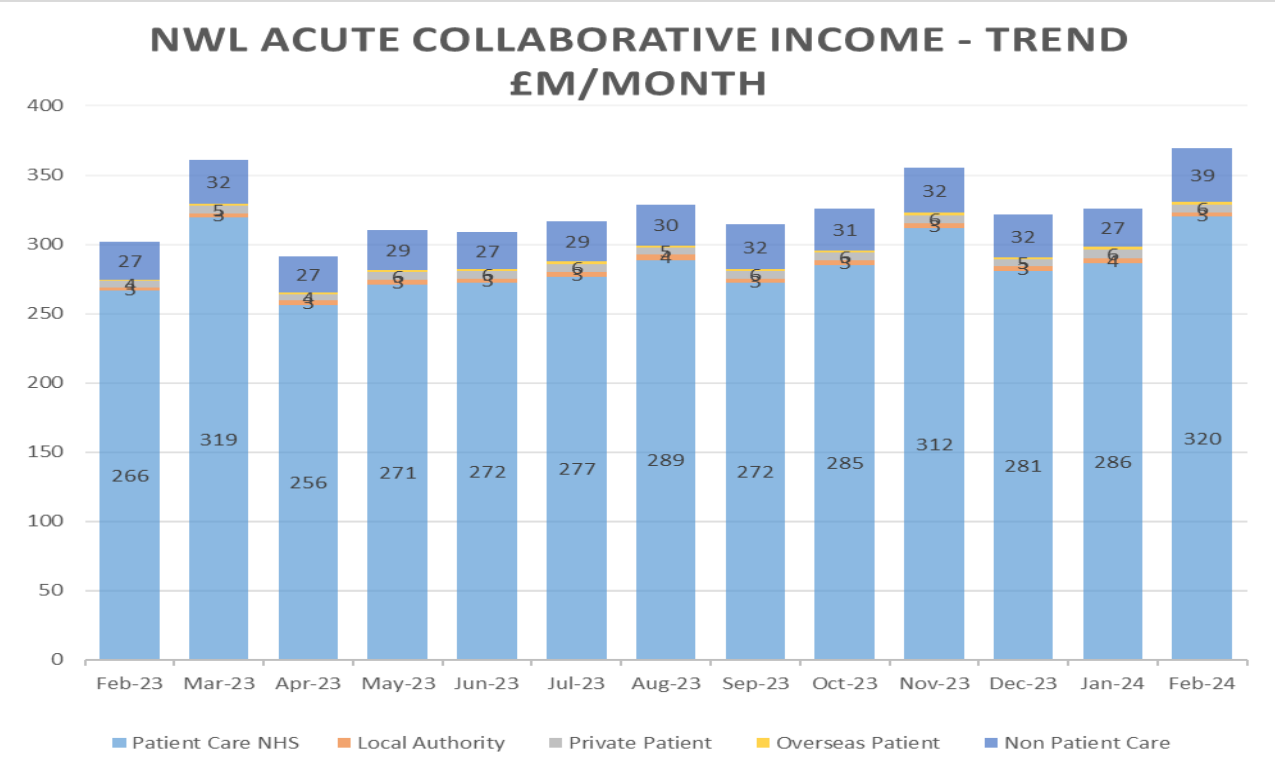
The forecast is for a deficit of £0.47m. Included within this is a £2.6m transaction relating to the clearance of the site in preparation for the new hospital, partly offset by non-recurrent benefits

Appendix 1

NWL APC Income & Expenditure Trends at Month 11

NWL APC Income Trend

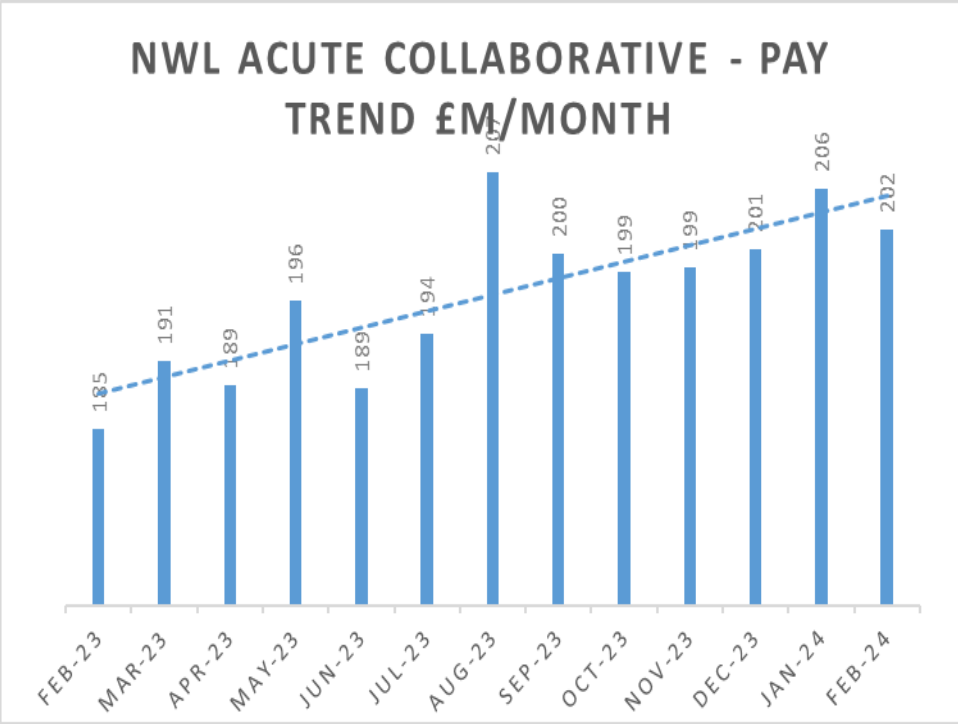


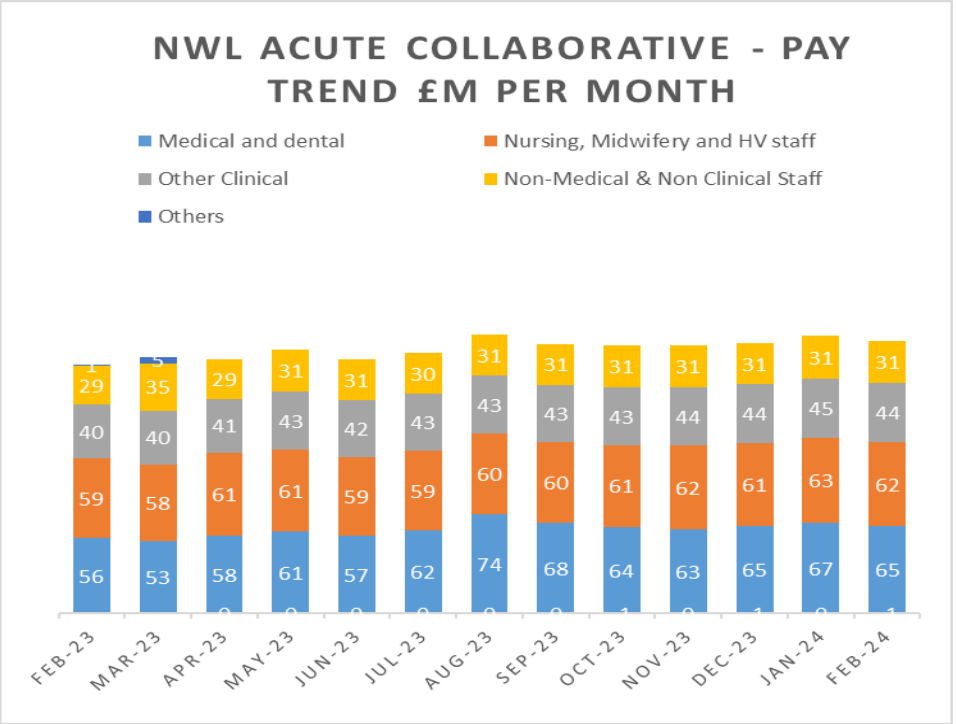


The graphs show the monthly income trend for the APC. Figures are absolute; however, March 23 value has been adjusted to remove material one off income: income received for the non-consolidated AfC pay award and additional employers pension charges. The residual March 23 spike accounts for non-recurrent income received at the end of the year and other year-end adjustments made.

The increase in income in February 24 is due to additional non recurrent funding being recognised to cover IA from December to February (at CWFT and LNWH).
In Aug 2023/24, the medical pay award was paid (backdated from April), the corresponding YTD funding causes an increase in income in the month. In Nov 23, additional funding is accounted for to cover IA impact up to the end of Oct, hence the increase here. Overall monthly income has increased by 9% on average, over 2022/23.

NWL APC Pay Trend





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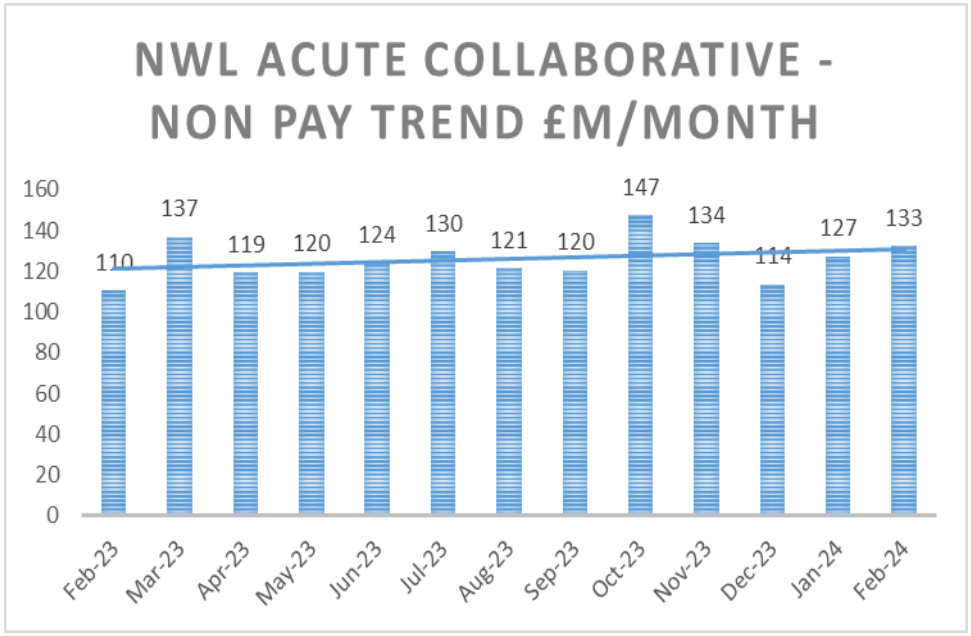
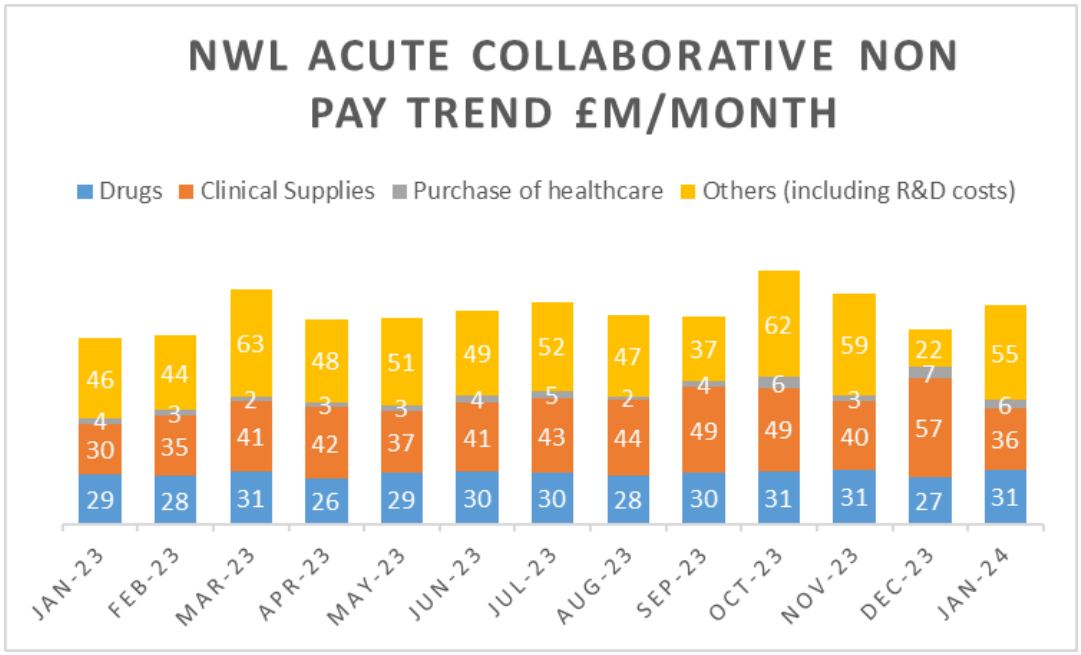
The graphs shows the pay trend of the APC. Figures are absolute; however March 2023 has been adjusted for material items: the non-consolidated AfC pay award and the additional employers pension charges.

The reduction in pay on February compared to March is due to the IA cost pressure being lower. Pay has increased by an average of **10%.** To note AfC pay award of 5%, junior doctors pay award of 6.5% and pay costs of the UTCs are new in 2023/24 contributing to the increase. In addition, the pay pressure associated with industrial action, also contributes. In August, the junior doctors pay award was paid (backdated to April) which causes the spike here.

NWL APC – Non Pay Trend





The graphs show the non-pay trend of the APC.

Non pay has increased by 11% in 2023/24 compared to 2022/23 , a major factor is the continuing increases to inflation across utilities, rates, facilities management contracts (increase here is c7%), and drugs and clinical supplies have also increased (by 9% and 16%).

8.3 ACUTE PROVIDER COLLABORATIVE BUSINESS PLANS ? PRIORITIES, OPERATING AND FINANCIAL - LESLEY WATTS

REFERENCES

Only PDFs are attached

8.3 BIC APC Board - Business Operational Planning 2024-25 final.pdf

8.3a BIC Business Operational Planning BIC - April 2024_ final.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 8.3
This report is: Public

Finance, Business & Operational Planning for 2024/25

Author: Jonathan Reid
Job title: Chief Financial Officer, LNWHT

Accountable director: Jonathan Reid
Job title: Chief Financial Officer, LNWHT

Purpose of report

Purpose: Information or for noting only

The Committee are asked to note the progress on the development of the operational and business plans for 2024/25

Report history

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

NWL CFO Group
Various
Noted – note also updated date since that meeting

NWL APC EMB
13/03/2024
Noted – note also updated data since that meeting

NWL APC FPC
14/03/2024
Noted – note also updated data since that meeting

Executive summary and key messages

This paper provides a summary of the developing Finance, Operating, Workforce and Business Plans. Trusts are expected to submit a firm draft plan to the NHSE teams on 2nd May, which will support a move towards the finalisation of the plan. The Collaborative Finance and Performance Committee reviewed the draft plans in March, providing valuable insight and advice on next steps. Each Trust has presented an interim plan to their Finance and Performance Committee, so that budgets can be set. The finalised plan will be signed off at each Trust, post the final 2nd May submission, with a discussion via the Collaborative FPC in late April if the Board considers that appropriate.

The key issues of note are the work in train through the CFOs to reduce the financial 'planning gap' estimated at £25-50m, and the finalisation of the workforce plans – both of these issues are in escalated discussion with the ICB, with a view to resolution before the final submission. Work on the Business Plan is less developed, given the focus on operational planning, but is in hand, with most schemes rolling forward into 2024/25 as an interim plan until the Collaborative Strategy is finalised.

The Board in Common is asked to:

- Note that the respective Finance & Performance committees have reviewed draft plans
- Note the current draft plans and actions required to finalise plans
- Delegate authority to their respective Finance & Performance committees to approve submission of break-even final plans by 2 May.

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

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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

Operational, Financial and Business Planning: Collaborative Board-in-Common

Jonathan Reid, CFO LNWHT

16 April 2024

Executive Summary

- Since November, the Trusts have been working on the plans for 2024/25. Draft financial, operational and business plans have been under discussion within and across the Collaborative, and with the ICB and Collaborative partners in other sectors. Draft plans were considered at the most recent Collaborative Finance and Performance Committee – and the Committee recognised the progress to date, but noted the need to wait for confirmed planning guidance before finalisation of the plans.

- All Trusts now have approved provisional financial, operational and workforce plans at their Trust Finance & Performance Committees. Planning Guidance was released on 28 March 2024. On initial review, there are no material issues which would invalidate the existing planning approach implemented. There is a national planning submission timetable, aiming for finalised plans by 2 May, and Trusts are working with the ICB to finalise plans by that date.

- Collaborative plans have high, but achievable, ambitions for operational performance. However, draft financial plans have a combined deficit of £109.6m. Additional income is under discussion with the ICB and NHSE, with an estimated value of £93m, but there are areas of additional cost pressure (e.g. UTC models, Cerner implementation costs), leading to a residual net deficit of £26.5m. In line with discussions at the last Board Development Day, we will need to develop a three-year financial trajectory for reduction in unearned income to secure the non-recurrent/'unearned' funding from the ICB – this will be a key piece of work during April for the CFOs.

- Given the position, CFOs are working on approaches to identify £25-50m of additional opportunity to bridge the gap and mitigate against income not recovered and met w/c 8/4 to provide an update and report to EMB and the Board-in-Common. Delivering a balanced plan will be challenging for both the ICB and the Collaborative- but remains the ambition and the clear expectation of the Board.

Executive Summary

- The draft financial plan includes cost improvement ambitions of £127.8m, which is a significant ask and greater than 2023/24. This paper describes the work in hand to strengthen development and delivery of CIP plans and to broaden out the focus to include Collaborative schemes. The Collaborative will also echo planned NHSE productivity reporting, starting at an early point in the financial year.

- The collective activity plans deliver the ICB ambition of a minimum of 117% Cost Weighted Activity (activity against a 2019/20 baseline, adjusted for inflation/price change), with a combined value calculated by the ICB of 118%. Trusts have set ambitious plans for ERF recovery and delivery of elective activity at marginal or reduced cost will be key to delivery of the Collaborative's financial plan. This will be a particular area of focus for LNWH who have been focusing on recovery their activity levels post-Cerner.

- The ICB has set an ambition for a reduction in urgent and emergency care activity for the year, which is not fully met in the Collaborative's plans, reflecting concerns over the level of demand. The Collaborative has set plans to meet the 78% A&E 4hr ambition, and these are credible, based on current performance. Urgent and emergency care is funded on a block and requires close partnership working – in the coming year, there will be discussions with partners and the ICB around baseline activity levels via true-up, around funding for the UTC, around the additional costs and risks of cohorting, around the pressures on Registered Mental Health nursing and 'special' support for patients and delivery of the Criteria to Reside ambition (top quartile).

- The workforce plan for the Collaborative has been 'escalated' in discussions with the ICB, with intensive work in train to understand the drivers of workforce growth since 2019/20. The ICB, following NHSE lines of enquiry, was anticipating a plan showing a material reduction in workforce levels from 2023/24 outturn levels. The submitted plans show a reduction of 198 wtes (from a workforce of c35,856) – noting that the collective financial plan remains a draft deficit of £109.6m.

Executive Summary

- The CEO Workforce lead has commissioned a review by each Trust of movements in WTEs (whole time equivalents) since 2019/20, alongside an analysis of business cases and other key drivers of movements. At the same time, the ICB has commissioned an external review of all business cases approved in the past two years across all Trusts in NWL, starting with the Collaborative. It is anticipated that this will lead to the identification of opportunities for cost reduction or productivity improvement.

- Finally, the Business Plan refresh is in hand. The key programmes have been carried forward from 2023/24 into 2024/25 as the Strategy is developed – but the recent Board Development Day provided a series of opportunities to strengthen the infrastructure of the plan, including the priorities, the focus on EDI and inequality, and the level of ambition. Work is in hand to develop trajectories and KPIs for each of the key delivery plans, and this is being evaluated in the context of the refreshed planning guidance issued in March 2024.

- Taken together, colleagues across all four Trusts have developed a very ambitious and significant plan for 2024/25. This needs further review and evaluation in the context of moving to breakeven and further testing against the requirements of the national planning guidance. However, the Board are asked to approve this provisional plan for 2024/25, noting that finalised plans will be completed and agreed at Trust Finance and Performance Committees in April and early May. The finalised plan for 2024/25 will be confirmed by the Collaborative Finance and Performance Committee in advance of the next Board-in-Common meeting – and, as in 2023/24, progress will be monitored through both regular updates to the Board and regular review in the relevant sub-Committees, with a particular emphasis at the Finance and Performance Committee.

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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

Financial Plan - Headlines

April Board-in-Common

Developing our Financial Plans

- The four Trusts within the Collaborative have each briefed their Finance and Performance Committees on the approach utilised to develop the Collaborative Financial Plan. This has involved agreeing and utilising a standard set of assumptions with NWL ICB – based on indicative national planning guidance and including local assumptions. These assumptions have been reviewed by the Collaborative Finance and Performance Committee and are consistent and in line with assumptions in other part of London.

- At the same time, the Collaborative and the ICB has been working on identifying the 'underlying financial position' and the balance between earned and unearned income. The underlying position has been initially valued at £414m, but the most recent submission has seen a decrease to £396m – but this is considered by the CFOs as overstated. Trusts have an identified reliance on 'unearned income' of £255-£320m (again, subject to debate), and are seeking to develop a plan to reduce reliance on this income. This information has not been included in this paper as it is subject to review and will be considered at the next Finance & Performance Committee.

- The current submitted plan is a deficit of £109.6m, but it is anticipated that this gap will reduce to £89.2m based on some of the near-agreed assumptions. The key negotiation in w/c 8/4 is securing agreement on the £66m non-recurrent support and an underlying issue on Urgent Treatment Centres – if this can be resolved, then the Collaborative deficit is £26.5m.

- Working on the basis that agreement can be reached on these issues, the CFOs are working on bolstering design, development and delivery of the £128.5m CIP target for the year (with 50% identified), and on identifying further opportunities to reduce the planning gap by £26-50m (the differential being to mitigate any unagreed income). Key opportunities in this respect are the workforce and business case review, supported by the ICB, and the emergent Collaborative schemes. This is an absolute priority for the CFOs during April, recognising that it is the Boards expectation the Collaborative will achieve a break-even plan for 2024/25.

Applying the agreed ICB and Collaborative Planning Assumption

NB ICHT numbers are being reviewed to ensure consistency with internal/external reporting.

The planning assumptions applied to the Collaborative and developed in partnership with the ICB have led to the following formal submission to ICB/NHSE, showing the movement from outturn (pre-IA funding) to underlying to plan. Assumptions have been consistently applied – the Collaborative has a residual deficit of £109.6m as at this planning submission. **Note that the ICHT plan has improved to £32m following the plan submission.**

Moving to the Underlying Position and Start Plan - Collaborative	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	NWL ACUTE PROVIDER COLLABORATIVE
	Plan	Plan	Plan	Plan	Plan
	£'000	£'000	£'000	£'000	£'000
Adjusted financial performance surplus/(deficit) outturn year	(2,595)	(9,122)	(4,600)	(1,300)	(17,617)
Commissioner non recurrent outturn year	(45,683)	(104,319)	(140,797)	(63,253)	(354,052)
Non recurrent efficiencies outturn year	(4,574)	(11,145)	(14,071)	(4,938)	(34,728)
Non recurrent grip and control measures outturn year		0	0		0
Non operating and gains and losses and donations outturn year	6,841	(5,486)	(967)	(12,750)	(12,362)
FYE strategic change and efficiency outturn year		1,506	0	8,970	10,476
FYE operational cost pressures and mitigations outturn year		0	0	4,776	4,776
Industrial action outturn year	1,937	0	7,046	(2,748)	6,235
Other outturn year	6,104	(6,399)	(12,920)	14,637	1,422
Underlying financial performance surplus/(deficit) outturn year	(37,970)	(134,965)	(166,309)	(56,606)	(395,850)
Price/tariff changes	(14,086)	(14,386)	(2,448)	(11,520)	(42,440)
Volume changes (non-strategic initiaves)	2,257	13,840	30,470		46,567
Non-recurrent commissioner resources and spend	17,893	53,228	65,048	30,327	166,496
Non operating and gains and losses and donations	(2,064)	29	(1,220)	4,255	1,000
Efficiency/Strategic Initiatives	21,718	49,999	34,846	12,000	118,563
Other	(1,495)	(4,645)	2,198		(3,942)
Adjusted financial performance surplus/(deficit) planning year	(13,747)	(36,900)	(37,415)	(21,544)	(109,606)

Draft Consolidated Collaborative Financial Plan

Applying the planning assumptions across the Trusts leads to the consolidated financial plan below. This will be reviewed over the next few weeks, as the Trust and the ICB seek to deliver a breakeven financial plan. At this stage, it is anticipated that income will increase by some £93m, with cost reducing (after further cost pressures) by a further £26m. **Note that the ICHT plan has improved to £32m following the plan submission.**

	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	NWL ACUTE PROVIDER COLLABORATIVE
	Plan 24/25	Plan 24/25	Plan 24/25	Plan 24/25	Plan 24/25
	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	802,358	1,490,913	865,878	306,637	3,465,786
Other operating income	89,050	161,178	66,272	35,848	352,348
Total Income	**891,408**	**1,652,091**	**932,150**	**342,485**	**3,818,134**
Employee expenses - Substantive	(435,095)	(878,362)	(529,835)	(191,839)	(2,035,131)
Employee expenses - Bank	(62,934)	(89,650)	(71,967)	(28,128)	(252,679)
Employee expenses - Agency	(16,482)	(16,759)	(16,096)	(16,356)	(65,693)
Employee expenses - Other	(1,997)	(347)	6,900	(31)	4,525
Operating expenses (excluding employee expenses)	(368,574)	(695,273)	(337,665)	(123,497)	(1,525,009)
Operating Surplus / (deficit)	**6,326**	**(28,300)**	**(16,513)**	**(17,366)**	**(55,853)**
Non operating expenditure	(12,143)	(10,943)	(18,987)	(4,427)	(46,500)
Surplus/(deficit) for the period/year	**(5,817)**	**(39,243)**	**(35,500)**	**(21,793)**	**(102,353)**
Other adjustments to get to adjusted financial performance	(7,930)	2,343	(1,915)	249	(7,253)
Adjusted financial performance surplus/(deficit)	**(13,747)**	**(36,900)**	**(37,415)**	**(21,544)**	**(109,606)**

Collaborative Planning Gap

- The submitted plan has a shortfall of £109.6m, with further allocations to be issued, and a CIP of £128m. **Note that the ICHT plan has improved to £32m following the plan submission.** The emerging joint plan with the ICB suggests a potential improvement to £89.2m of substantially agreed adjustments.
- The Collaborative and the ICB are discussing the allocation of non-recurrent funding per the 23/24 model of £66m, as well as challenges around the contract form and delivery models for UTC. Working on the assumption that the £66m will be secured (which is unconfirmed), this leaves an anticipated financial gap of £26.5m. This will increase when LNWHT adds the costs of London Living Wage and Cerner implementation.
- The level of risk within the plans varies and CFOs are also reviewing the consistency of assumptions to balance risk across the Collaborative. In addition, a number of key areas of potential pressure have yet to be worked through – non-pay inflation, assets under construction, etc.
- The CFOs are meeting w/c 8/4 to look at options to identify between £25-50m in opportunities to reduce the deficit to breakeven. This includes review of ERF, review of workforce and the business case review currently in hand.

	CWFT	ICHT	LNWH	THH	Total
	£000	£000	£000	£000	£000
Formally Submitted Plan 24/25 21.03	**(13,757)**	**(36,900)**	**(37,415)**	**(21,544)**	**(109,616)**
Substantially Agreed Changes					
Critical care income adjustment		(16,400)			(16,400)
Microsoft licences contract change	*(74)*	*0*	*(397)*	*0*	*(471)*
Covid testing income	*0*			*372*	372
Modular ward FYE NHSE capacity funding			7,000		7,000
NR funding (BS)	0	10,000	10,000	0	20,000
CWFT reimbursement	4,000	0	(800)	0	3,200
Excess inflation funding	984	2,683	1,974	1,071	6,712
Refreshed Plan 2024/25 pre £66m	**(8,847)**	**(40,617)**	**(19,638)**	**(20,101)**	**(89,203)**
NR funding 23/24 (£66m) and UTC					
Critical Care	*2,547*	*16,400*	*3,184*	*1,191*	*23,322*
True up	*8,442*	*0*	*15,000*	*0*	*23,442*
Other	*0*	*9,250*	*0*	*10,000*	*19,250*
UTC costs	*0*	*(1,800)*	*(1,500)*	*0*	*(3,300)*
Estimated Plan 24/25	***2,142***	***(16,767)***	***(2,954)***	***(8,910)***	***(26,489)***

Development and Delivery of Cost Improvements

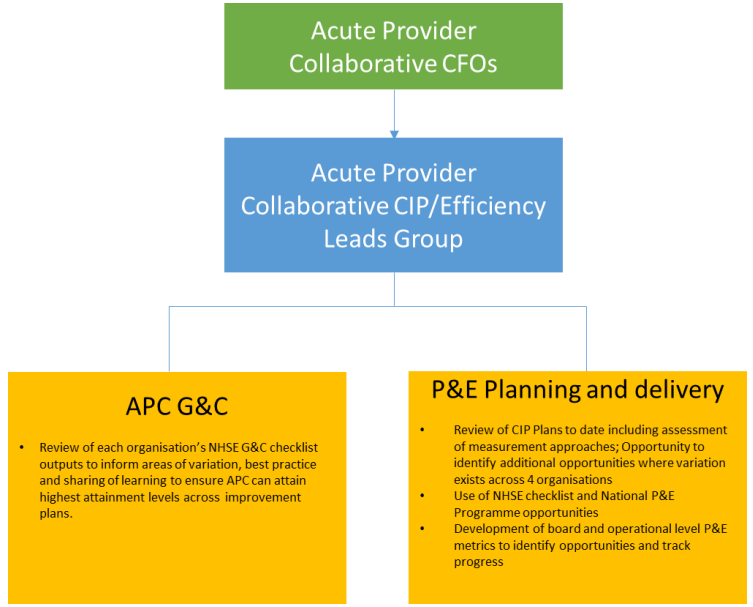
The latest CIP planning submissions show an improvement in identification to 49%, with Trusts continuing to press for improved planning for 2024/25 compared to 2023/24.

This leaves a balance of £65.5m of CIP schemes to find in addition to addressing the planning gap – this is a priority area of focus for the next month.

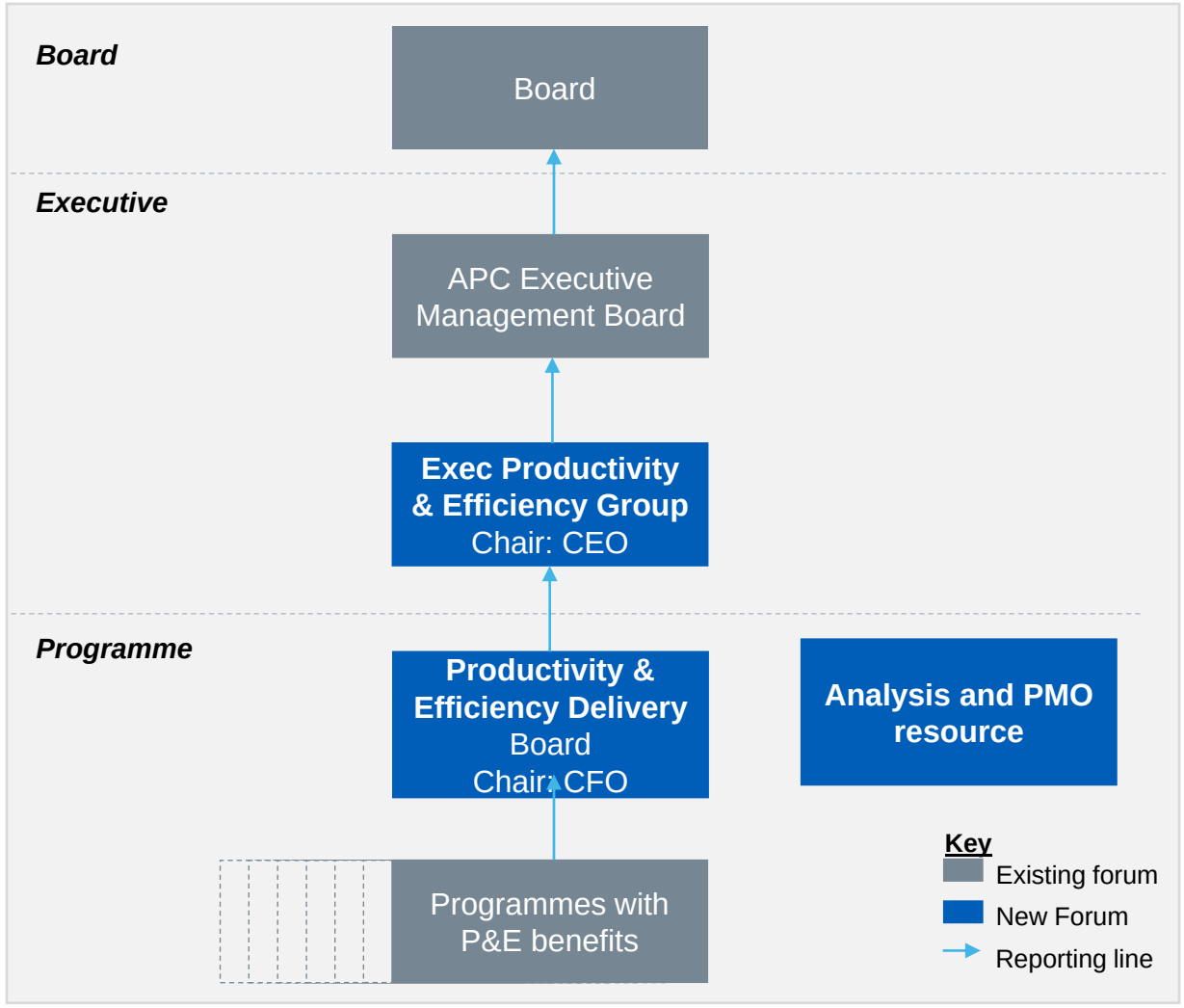
The Collaborative have secured new additional resource to support the Collaborative with recent experience from NHS England efficiency team and have commissioned an internal review of CIP delivery as well as Grip & Control. The work is ongoing and will report to the CFO group.

In addition, CFOs have agreed the need to strengthen the governance, resourcing and support of in-year CIP programme across the Trusts, around the emerging Collaborative schemes, and around the review of productivity and efficiency – this aligns with the Business Plan ambition of strengthening focus on productivity and efficiency, as well as workforce planning.

CIP Identification	Plan £'000	Identified £'000	% identified £'000
CWFT	23,520	14,232	61%
ICHT	58,177	15,474	27%
LNWH	34,846	21,379	61%
THH	12,000	12,000	100%
Collaborative	**128,543**	**63,085**	**49%**



Strengthening Oversight of Productivity



- The CFOs have consulted with the COOs and are working up options for a Collaborative Productivity & Efficiency Group, aimed at supporting a broader improvement in P&E across the whole Collaborative. This would hold us collectively to account for delivery, co-ordinate and steer actions, and would also support the development and delivery of key metrics in line with the emerging NHSE approach.

Productivity calculation		Focus areas	Potential productivity metrics
Productivity (outputs / inputs, %)	Outputs (weighted activity, £)	Inpatient	Mean variation in NEIP 1+ bed day LOS (%)
			No criteria to reside rate (%)
			Care hours per patient day (CHPPD, #)
		A&E	Mean ambulance handover time (min)
			A&E attendances per emergency medical WTE (#)
		Outpatient	OPFA and OPROC per consultant WTEs (#)
		Theatres	Surgical cases per medical WTEs in surg. specialties (#)
			Capped theatre utilisation (%)
			Org. level day case rates for BADS procedures (%)
		Diagnostic	Imaging turnaround time (min)
	Inputs (real-terms operating expenditure, £)	Pay costs	Total staff cost per £1,000 value weighted activity (£)
			Turnover rate (%)
			Sickness and absence rate (%)
			B&A spend as a proportion of pay costs (%)
			e-job planning attainment level (%)
			e-rostering attainment level (%)
		Non-pay costs	National medicines optimisation opportunity size (£)
			Cost of running corporate services per £100m turnover (£)
			Estates and facilities cost per square metre (£)

Bridging the Gap - Developing our Priority Collaborative Schemes

Key to improving our underlying position is the development and delivery of our underlying schemes. These are summarised below, and the CFOs and COOs are working to develop a full set of projects and programmes to support these schemes. This will require additional resourcing, which is being progressed in partnership with the ICB. The CFO ambition is to have these trajectories finalised by the end of April.

No	Programme	CFO/COO Lead	Opportunity	24/25 Target	25/26 Target	26/27 Target
1	Critical Care	Virginia Massaro	£10-30M	tbc		
2	Outpatients Improvement	Tina Benson	£4.6M	Tbc		
3	Cerner	James Walters	£10-20M (Business Case)	£tbc		
4	Elective Orthopaedic Centre	James Walters	£3.9M	£3.9m		
5	Opthalmology	Tina Benson	TBC			
6	Mental Health Spending in Acute Sector	Jazz Thind	£6-8m			

No	DRAFT Programme	CFO/COO Lead TBC	Opportunity	24/25 Target	25/26 Target	26/26 Target
7	UEC flow: LOS/Discharges	Claire Hook	TBC			
8	UEC flow:	Claire Hook	£15-£20m (NCC)			
9	UEC flow : SDEC	Claire Hook	Coding/True-Up?			
10	Corporate Consolidation	Jon Bell	TBC			
11	CRG Workstreams	Jonathan Reid	TBC			
12	Independent Sector Contracts	Jonathan Reid	£3-5m			
13	Theatre Productivity		Additional ERF? Cost Reduction			

Bridging the Gap - Reviewing our Workforce Requirements

CFOs and CPOs are working closely on a review of workforce requirements alongside the financial planning process.

	CWFT	THH	ICHT	LNWH	Collaborative
Movment in WTEs - March 20-25	**534**	**575**	**2,473**	**1,120**	**4,702**
Overestablished Posts - December 2023	227	198	427	380	1,232
Implied Planned Increase	307	377	2,046	740	3,470

Note: LNWHT transferred 345 wte out for community services understating the movement

Part 1: Understanding the Baseline – How did we get here?

The ICB has commissioned an external third party to review all of the business cases in the last two years, based on THH.

1. Review the key movements within the Trusts and make a determination – planned (business case)/unplanned (overspend).

2. For unplanned (1,232 wte), make a decision on next steps – regularise/mitigate/remove.

3. For planned (3,470 wte), review all business cases and agree on benefits realisation actions.

Part 2: Understanding the Requirement and Benchmarking

1. Agree with CMOs, CNOs, COOs & CFOs the priority services to review (using costing and benchmarking information).

2. Set up a rolling programme of activity-v-workforce reviews with an aim to reduce cost base by x%/move to a standard cost/activity ratio (tbc).

3. Flow this work into the Collaborative programme of major projects.

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London North West University Healthcare NHS Trust

Operating Plan - Headlines

7 March 2024

NWL In Sector Providers – Cost Weighted Activity – Extract from ICB Operating Plan

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Ordinary spells	113.6%	105.2%	103.4%	109.5%	110.5%	112.2%	110.6%	114.2%	117.1%	123.8%	111.0%	104.6%	111.1%
Day cases	124.7%	125.3%	122.9%	126.3%	129.6%	126.3%	126.6%	127.6%	135.4%	127.2%	128.0%	123.3%	126.8%
Outpatient procedures	96.4%	94.7%	90.3%	92.5%	98.9%	100.0%	101.1%	97.0%	104.7%	96.2%	97.7%	97.0%	97.1%
Outpatient first attendances without a procedure	105.4%	103.9%	102.7%	103.6%	110.5%	108.5%	105.3%	103.6%	110.5%	102.1%	103.4%	102.3%	105.0%
Cost-weighted activity (cumulative)	112.4%	111.3%	110.2%	110.4%	111.3%	111.8%	112.0%	112.2%	112.9%	113.0%	113.0%	112.7%	112.7%
Impact of pathways avoided through A&G	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%
CWA (cumulative) (incl. A&G)	117.5%	116.4%	115.3%	115.5%	116.4%	116.9%	117.1%	117.2%	118.0%	118.1%	118.1%	117.7%	117.7%

Assumptions

- 19/20 baseline used from 24/25 template
- Advice and guidance -NWL 5.1% apportioned over acute trusts and included in total.
- 24/25 tariff
- 19/20 baseline adjustments used in 23/24 plan
- Target based on same activity to derive 117% CWA but lower because inflated baselines

Note that these are ICB calculated figures, using Trust submitted data at a point in time, and this may not align with internal Trust assumptions as the plans evolve. The teams are working to ensure alignment across the two data sets.

Cancer & Diagnostics – Extract from ICB Operatin

Note that these are ICB calculated figures, using Trust submitted data at a point in time, and this may not align with internal Trust assumptions as the plans evolve. The teams are working to ensure alignment across the two data sets.

Indicator name	2024/25 Proposed Target	LNW	THH	CW	ICHT	NWL Providers
Percentage of people waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	77% Compliance at March 2025	77%	77%	77%	77%	77%
31 days combined treatments.	96% Compliance at March 2025	96%	96%	96%	96%	96%
62 days combined including consultant upgrade.	70% Compliance at March 2025	85%	85%	85%	85%	85%
Cancer 62-day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period	Maximum 460	150	60	100	150	460

Diagnostic Waiting Times – Ambition to ensure less than 5% wait more than 6 weeks by March-25

Indicator name	LNW	THH	CW	ICHT	NWL Providers	NWL ICB
Diagnostic 6-week performance - Magnetic Resonance Imaging	5.0%	1.4%	5.0%	5.0%	4.7%	4.7%
Diagnostic 6-week performance - Computed Tomography	2.0%	0.3%	5.0%	1.9%	2.5%	2.9%
Diagnostic 6-week performance - Non-Obstetric Ultrasound	2.0%	3.0%	5.0%	4.0%	3.6%	3.4%
Diagnostic 6-week performance - Colonoscopy	5.0%	4.9%	4.8%	1.0%	3.9%	3.8%
Diagnostic 6-week performance - Flexi Sigmoidoscopy	5.0%	4.2%	4.8%	0.7%	4.0%	3.6%
Diagnostic 6-week performance - Gastroscopy	5.0%	4.5%	5.0%	1.0%	2.9%	2.9%
Diagnostic 6-week performance - Echocardiography	5.0%	4.7%	5.0%	5.3%	5.1%	4.9%
Diagnostic 6-week performance - DEXA	0.2%		4.5%	1.6%	2.1%	4.1%
Diagnostic 6-week performance - Audio	10.0%	0.0%	4.3%	1.9%	2.3%	1.8%

Referral to treatment (RTT) – Extract from ICB Operating Plan

Metric	Ambition	LNW	THH	CW	ICHT	NWL Providers
RTT >52 weeks	50% of April 2024 position by March 2025	50%	50%	68%	66%	59%
RTT >52 weeks, aged <18 years	% of April 2024 position vs March 2025	50%	51%	53%	11%	49%
RTT >65 weeks	Zero by September 2024	0	0	90	0	90
RTT Waiting List	Eliminate 23/24 growth – Mar 23 vs March 25	114%	87%	107%	97%	100%
Admitted RTT Clock Stops	108% of 2023/24	121%	108%	103%	100%	105%
Non-Admitted RTT Clock Stops	108% of 2023/24	118%	99%	102%	101%	105%
Clock Starts	% of 2024/25 YTD	101%	109%	100%	100%	101%

- NWL ambition to reduce patients waiting over 65 weeks to zero by September has been met by ICHT, THH and LNWH, with CW planning to achieve zero by October 2024.
- NWL ambition to reduce patients waiting over 52 weeks by half by March 2025 is met by THH and LNW.
- LNWH and CW are not planning to reduce total waiting list back to March 2023 level.

Note that these are ICB calculated figures, using Trust submitted data at a point in time, and this may not align with internal Trust assumptions as the plans evolve. The teams are working to ensure alignment across the two datasets.

Urgent and Emergency Care – Extract from ICB Operating Plan

Indicator name	2024/25 Proposed Target	LNW	THH	CW	ICHT	NWL Providers
Percentage all types A&E Attendances where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer.	78% by March 2025	80.0%	77.1%	80.0%	77.1%	78.8%
Percentage of attendances at type 1 A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer.		55.5%	52.9%	76.4%	55.4%	63.0%
Percentage of attendances at other type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer.		98.0%	98.1%	93.0%	97.6%	97.2%

- The national ambition to achieve 78% by March 2025 is not met by ICHT and THH.

Note that these are ICB calculated figures, using Trust submitted data at a point in time, and this may not align with internal Trust assumptions as the plans evolve. The teams are working to ensure alignment across the two data sets.

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Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Workforce Planning 2024/25

Draft 2024/25 Workforce Plan

The 2024/25 draft workforce plan covers all four NWL Acute Provider Trusts and is subject to change. The Chief People Officers are working to ensure that the workforce plan reflects delivery of the Trusts activity and financial plans for 2024/25, through review and right-sizing of staffing; working together in a coordinated way with common principles, assumptions and methodology. This workforce plan must be realistic and achievable and so we have not included a proxy cost improvement WTE reduction without the detail of how to deliver it; some identified CIPs have been included, as have, known funded and agreed service changes effective in 2024/25.

Our starting point is the month 11 staffing position with out-turn adjustments which, against the live and funded Trusts post establishments, is 1,086 WTE adverse. The current main drivers to this over-establishment are the use of additional specialling and Registered Mental Health Nurses to support safe and appropriate care for our patients, industrial action staffing mitigations and the staffing of the Urgent Treatment Centres. Trusts are continuing work to identify staffing changes required in order to deliver the 2024/25 activity plans within the available financial envelope in the most productive and efficient way possible; using their current variance to post establishment position to bring staffing levels back to the funded establishments in the first instance.

In addition, each Trust is conducting a review of all agreed business cases from the past four years (2020/21 to 2023/24). This review is to ensure that the expected activity and financial changes have been realised with a view to reviewing any workforce investment if not.

The national workforce planning template requires us to summarise the plan by staffing type (substantive, bank, agency), by staffing group and by role which requires a detailed understanding of WTE changes as well as the phasing of these by month. Trusts are still awaiting the release of the National Planning Guidance for 2024/25 from NHSE and the final plans are expected to be submitted in May.

Draft 2024/25 Workforce Plan

APC - draft WFP Submission (21.03.2024)	Out-turn Establishment 2023/24	Out-turn Staffing 2023/24	Out-turn Variance Staffing to Post WTE 2023/24	Plan Draft 24/25 Establishment V.4	Plan Draft 24/25 Total Staffing out-turn V.4	Plan Staffing + - WTE Change to out-turn position V.4	Plan % change draft 24/25 Staffing WTE against Jan-24 staffing position
Chelsea and Westminster Hospital NHS Foundation Trust	7,319	7,691	372	7,349	7,431	-260	-3.4%
Imperial College Healthcare NHS Trust	15,300	15,660	360	15,305	15,695	35	0.2%
London North West University Healthcare Trust	9,378	9,654	276	9,333	9,599	-55	-0.6%
The Hillingdon Hospitals NHS Foundation Trust	3,780	3,858	78	3,869	3,940	82	2.1%
NWL ICB	**35,777**	**36,863**	**1,086**	**35,856**	**36,665**	**-198**	**-0.5%**

The current draft workforce plan for 2024/25, for the NWL Acute Provider Collaborative, shows a planned staffing reduction of 198 WTE (0.5%). The plan is still in development and will change as decisions and plans are confirmed over the coming weeks. Planning considerations include safe staffing requirements, agreed service changes, known TUPE transfers, cost improvement plans, international recruitment, temporary staffing requirements and impact of agreed business cases.

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Business Planning 2024/25

Refreshing the Business Plan – Interim Plan

- At each monthly meeting of Executive Management Board, progress against the key priorities articulated within the Business Plan is reviewed. These were reviewed at Q3 by the Collaborative FPC.

- A summary of the RAG rating is shown here. As the plan for 2024/25 develops, work is starting to develop key KPIs and trajectories to support delivery of the 2024/25 business plan. Given that the majority of the trajectories will be building on priorities identified for 2024/25, and the schemes are in large part rolling forward as the Strategy develops, this should be achievable as we move towards the start of the coming financial year.

- In addition to the monthly highlight report, EMB also receives detailed Deep Dives into key areas. For example, in March, EMB received a detailed deep dive review into the progress in the Mental Health work from from the SRO, Lisa Knight, noting the solid progress on this workstream.

Q3 Summary of Progress	Q3
Priorities Rated as Red	1
Priorities Rated as Amber	17
Priorities Rated as Green	4
Priorities still in Development Phase (note 3 emergent)	5
	27

- At the end of Q3, there are 27 priority projects – noting that 3 of these are still emergent as the work of the Strategic Estates and Sustainability Group takes shape. 17 are amber, 4 are green, and 1 is red – but it is recognised that the RAG rating are contestable.

- It is likely that a number of schemes would change classification as trajectories and KPIs are firmed up, allowing for a move from amber to green. This will be one of the ways in which the plan is strengthened for 2024/25. This will be completed by the end of April.

Summary of Priorities and Status – March EMB

Quality Priorities	Q3
Priority	**Rating**
Clinical harm review, access and inequality	A
Infection prevention and control	n/a
Peer review	A
User insights and focus	A
Care of the deteriorating patient	A
End of life care	A
Maternity and Neonatal – delivery plan	A
Mental health in an acute setting	n/a
Implement new national patient safety strategy	A
Incident and risk management system	A

Workforce Priorities - January 2024	
Priority	**Q3**
Reduce premium rate staffing expenditure	A
Elective orthopaedic centre workforce transition	A
Recruitment hub for hard to fill vacancies	A
Careers hub and staff transfer scheme	A
Increase apprenticeship levy uptake	A
Reduce violence, aggression, bullying and discrimination	A

Digital Transformation Priorities - January 2024	
Priority	**Q3**
Finalise the APC Digital and Data Strategy	G
Implementation and Optimisation of Cerner system	G
Federated Data Platform	A

Finance & Performance Priorities - January 2024	
Priority	**Q3**
Delivery of the activity targets in the 23/24 operational plan	G
Support Services Consolidation	G
Jointly develop and support a programme of discharge planning and reducing medically optimised patient LOS with ICB and collaborative partners	A
Agree a programme of efficiency and productivity for £66m, reducing reliance on ICB support for 23/24 and improving our financial sustainability	R
Outpatient Transformation	A

Emergent New Priorities	
Priority	**Q3**
Estates Stock-Take - APC	n/a
Estates Contracts Register and Forward Plan	n/a
Capital Plan for the Acute Collaborative	n/a

Q3 Summary of Progress	Q3
Priorities Rated as Red	1
Priorities Rated as Amber	17
Priorities Rated as Green	4
Priorities still in Development Phase (note 3 emergent)	5
24	27

Business Planning Priorities for 2024/25

Carried Forward Priorities from 2023/24

Quality Priorities
Clinical harm review, access and inequality
Infection prevention and control
Peer review
User insights and focus
Care of the deteriorating patient
End of life care
Maternity and Neonatal – delivery plan
Mental health in an acute setting
Implement new national patient safety strategy
Incident and risk management system

Workforce Priorities - January 2024
Reduce premium rate staffing expenditure
Recruitment hub for hard to fill vacancies
Careers hub and staff transfer scheme
Increase apprenticeship levy uptake
Reduce violence, aggression, bullying and discrimination

Finance & Performance Priorities - January 2024
Delivery of the activity targets in the operational plan
Support Services Consolidation
Discharge Planning/Flow - Joint Programme?
Agree a programme of efficiency and productivity, reducing reliance on ICB support and improving our financial sustainability
Outpatient Transformation

Digital Transformation Priorities - January 2024
Finalise the APC Digital and Data Strategy
Implementation and Optimisation of Cerner system
Improving patient flow and capacity using care co-ordination solution

Emergent New Work
Estates Stock-Take - APC
Estates Contracts Register and Forward Plan
Capital Plan for the Acute Collaborative

Enhancements for 2024/25

- Enhanced focus on inequalities and sustainability; much greater use of data and action on EDI
- Clearer alignment of priorities
- Development of clear KPIs and trajectories for recovery
- Refresh of key workforce plans to take account of 7 day working
- Strategic financial plan – covering 3 or more years, to link with Strategy – and trajectory for improvement and associated KPIs (e.g. productivity and efficiency).

Appendix – Activity Submissions to the ICB

Acute Activity – NWL Providers (1)

Total In Sector Providers - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP	96.9%	93.2%	97.8%	98.2%	105.9%	104.5%	100.7%	97.1%	102.6%	99.6%	100.9%	98.4%	99.5%		
PIFU	PIFU	2.4%	2.5%	2.5%	2.6%	2.6%	2.8%	2.9%	3.0%	3.0%	3.1%	3.3%	3.5%	2.9%	5% of Total OP to PIFU	NWL
OP	Consultant-led 1st OP	108.9%	102.4%	107.5%	106.7%	119.3%	120.1%	115.4%	111.0%	121.2%	112.3%	113.4%	111.0%	112.1%	108% of 23/24	NWL
OP	Consultant-led FU OP	100.8%	96.2%	101.9%	103.2%	112.4%	110.2%	104.9%	99.7%	107.9%	103.5%	104.6%	102.4%	103.7%	<100% of 23/24 by Mar-25	NWL
OP	OP Procedures	110.7%	104.7%	104.3%	102.0%	114.1%	118.4%	116.5%	117.9%	112.3%	113.3%	114.4%	112.4%	111.5%	108% of 23/24	NWL
OP	OP 1st no Proc	104.7%	99.7%	105.7%	105.3%	117.0%	116.7%	108.7%	109.9%	106.9%	108.2%	109.6%	106.9%	108.1%	108% of 23/24	NWL
OP	OP FU no Proc	87.4%	84.0%	89.1%	90.7%	97.4%	95.0%	89.8%	91.5%	89.1%	90.3%	91.5%	89.2%	90.3%	<100% of 23/24 by Mar-25	NWL
OP	OP FU w/o proc %	51.5%	51.9%	51.2%	51.2%	50.9%	51.0%	50.9%	51.0%	51.3%	51.3%	51.3%	51.3%	51.2%		
OP	Proportion of all OP that were 1st appointments, or FU with proc	48.5%	48.1%	48.8%	48.8%	49.1%	49.0%	49.1%	49.0%	48.7%	48.7%	48.7%	48.7%	48.8%	>=46% of 23/24	National
Elective	Total elective spells	102.7%	99.6%	104.4%	105.4%	112.5%	114.9%	113.2%	106.9%	105.7%	106.8%	108.0%	105.5%	107.0%	108% of 23/24	NWL
Elective	Elective day case spells	100.9%	98.1%	102.6%	103.7%	110.1%	113.0%	111.3%	105.6%	103.1%	104.4%	106.0%	103.6%	105.1%		
Elective	Elective ordinary spells	119.0%	112.2%	120.5%	120.8%	132.9%	131.3%	129.9%	117.4%	128.5%	127.0%	123.8%	121.4%	123.5%		
Elective	Elective day case spells - Children under 18 years of age	131.6%	112.2%	101.0%	123.8%	113.8%	137.1%	136.7%	120.3%	114.9%				120.4%		
Elective	Elective ordinary spells - Children under 18 years of age	116.9%	101.3%	91.5%	113.1%	105.1%	117.3%	121.5%	102.7%	94.6%				106.7%		
A&E	All Type attendances	100.7%	99.2%	97.1%	98.9%	101.4%	99.1%	99.0%	97.9%	97.9%	97.8%	100.9%	99.3%	99.1%	<100% of 23/24	NWL
A&E	All Type attendances seen <4hrs	77.5%	77.7%	78.1%	78.3%	78.2%	78.0%	77.3%	76.3%	76.1%	76.6%	77.2%	78.8%	77.5%	>=80% performance	NWL
A&E	Type 1 attendances	99.20%	98.90%	97.50%	97.50%	100.30%	98.20%	97.50%	97.90%	97.70%	97.60%	99.10%	97.90%	98.2%	<100% of 23/24	NWL
A&E	Type 1 attendances seen <4hrs	62.8%	63.0%	63.8%	64.0%	63.9%	63.8%	62.4%	61.4%	61.1%	61.7%	62.8%	65.5%	63.0%		
A&E	Other Type attendances	102.9%	99.6%	96.7%	100.7%	103.0%	100.3%	101.1%	98.0%	98.1%	98.1%	103.6%	101.3%	100.2%	<100% of 23/24	NWL
A&E	Other Type attendances seen <4hrs	97.3%	97.4%	97.3%	97.4%	97.4%	97.4%	97.4%	96.9%	96.8%	96.9%	97.0%	97.2%	97.2%		
SDEC	SDEC	4,766	5,049	4,905	5,086	4,900	5,073	5,349	5,224	5,026	5,090	4,602	5,058	60,128		
NEL	Non-elective spells	105.4%	101.1%	99.9%	100.4%	106.5%	100.9%	96.5%	93.1%	93.5%	100.0%	100.0%	100.0%	99.6%	<100% of 23/24	NWL
NEL	Non-elective spells with a length of stay of zero days	107.9%	100.2%	101.2%	98.1%	110.4%	104.7%	93.0%	90.5%	91.5%	100.3%	100.3%	100.3%	99.5%		
NEL	Non-elective spells with a length of stay of 1 or more days	104.0%	101.7%	99.2%	101.8%	104.2%	98.7%	98.8%	94.7%	94.8%	99.9%	99.9%	99.9%	99.7%		

Acute Activity – NWL Providers (2)

Total In Sector Providers - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	11,581	11,049	10,603	10,136	9,693	9,298	8,827	8,324	8,002	7,552	7,108	6,675	6,675	50% of Mar-24 (Apr-24 plans used as proxy)	NWL
RTT	Number of 52+ week RTT waits - <18 years	875	843	796	748	705	660	619	578	536	496	456	429	429		
RTT	Number of 65+ week RTT waits	1,727	1,430	1,122	785	480	90	-	-	-	-	-	-	-	Zero by Sep-24	National
RTT	RTT waiting list	294,287	291,759	289,926	287,093	285,260	283,440	281,597	278,591	276,086	273,580	271,075	268,069	268,069		
RTT	RTT completed admitted pathways	107.7%	96.1%	104.5%	111.0%	110.7%	112.5%	106.5%	100.9%	105.8%	105.9%	102.8%	102.1%	105.4%	108% of 23/24	NWL
RTT	RTT completed non-admitted pathways	102.4%	98.4%	104.6%	102.1%	116.1%	115.2%	107.2%	98.7%	103.9%	104.7%	106.1%	103.3%	104.9%		
RTT	New RTT pathways (clock starts)	104.5%	98.6%	96.7%	101.7%	101.0%	102.1%	104.2%	100.7%					101.1%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	88.6%	91.4%	101.0%	95.1%	100.8%	99.0%	103.7%	104.3%	102.6%	99.9%	100.0%	100.1%	98.6%	Activity at 108% of 23/24	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	90.1%	95.5%	101.3%	95.1%	99.3%	97.3%	96.9%	96.2%	93.3%	98.0%	98.8%	98.9%	96.6%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	98.9%	94.3%	107.9%	104.8%	102.4%	97.4%	104.3%	99.4%	100.2%	96.0%	97.6%	96.8%	99.9%		
Diagnostics	Diagnostic Tests - Colonoscopy	106.8%	98.3%	113.8%	120.9%	97.0%	122.6%	137.2%	113.9%	109.5%	103.2%	108.3%	108.6%	111.1%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	117.6%	96.1%	84.4%	121.0%	94.2%	111.1%	112.1%	124.0%	113.3%	102.7%	110.0%	108.7%	107.0%		
Diagnostics	Diagnostic Tests - Gastroscopy	108.3%	100.7%	123.9%	119.3%	101.6%	114.1%	116.7%	117.3%	112.3%	111.8%	116.4%	112.3%	112.6%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	88.0%	82.0%	100.9%	94.4%	102.9%	114.7%	120.5%	104.3%	107.1%	99.4%	103.9%	104.2%	101.2%		
Diagnostics	Diagnostic Tests - DEXA Scan	77.8%	99.2%	120.8%	123.6%	121.9%	190.7%	128.5%	138.0%	138.4%	126.4%	126.6%	115.7%	123.0%		
Diagnostics	Diagnostics Tests - Audiology	96.8%	88.1%	115.5%	117.4%	122.6%	124.6%	113.8%	96.2%	112.1%	127.9%	118.6%	95.0%	110.3%		
ACC	Adult Critical Care Bed occupancy	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%		
G&A	General and Acute day bed available	406	406	406	406	406	406	406	406	406	406	406	406	406		
G&A	General and Acute overnight beds occupancy - Total	93.6%	93.6%	93.4%	93.3%	93.1%	93.7%	94.8%	94.9%	93.9%	93.5%	93.7%	93.6%	93.6%	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds occupancy - adult	94.1%	93.9%	93.7%	93.7%	93.5%	94.1%	95.1%	95.2%	94.4%	93.9%	94.1%	94.0%	94.0%		
G&A	Average number of overnight G&A beds occupancy - paediatric	85.0%	87.6%	87.6%	85.6%	85.6%	86.9%	88.2%	88.2%	85.3%	85.3%	85.9%	85.9%	85.9%		
LoS	LoS - reducing 21 days LoS and over	98.5%	100.3%	106.5%	102.9%	103.8%	99.7%	96.6%	95.4%	95.7%	85.6%			98.2%	5% reduction MoM from 23/24 position	NWL
CTR	% beds occupied by patients not meeting criteria to reside	15.0%	14.7%	14.5%	14.3%	14.0%	13.7%	13.0%	12.6%	12.4%	12.2%	12.0%	11.9%	11.9%	Reduction to top quartile performance: 11.42%	NWL
Cancer	Cancer 62-day pathways - total patients seen	74.0%	76.0%	78.0%	79.4%	80.3%	81.3%	82.8%	82.4%	82.5%	82.8%	85.4%	85.5%	80.8%	70% by Mar-25	NWL
Cancer	Cancer 28 day waits (faster diagnosis standard)	75.0%	75.0%	76.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	FDD standard of 77% by Mar-25	National

Summary – LNWHT 1

LNWHT - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP	98.8%	91.7%	100.1%	100.4%	128.1%	134.2%	114.9%	104.5%	114.0%	107.0%	106.9%	107.0%	107.8%		
PIFU	PIFU	2.0%	2.1%	2.2%	2.3%	2.5%	2.7%	2.9%	3.2%	3.5%	3.9%	4.3%	5.0%	3.0%	5% of Total OP to PIFU	NWL
OP	Consultant-led 1st OP	100.6%	93.0%	100.3%	99.2%	130.6%	151.8%	135.5%	125.2%	140.5%	113.9%	113.9%	114.0%	115.6%	108% of 23/24	NWL
OP	Consultant-led FU OP	92.8%	83.5%	92.0%	93.7%	120.8%	125.6%	102.0%	88.8%	99.9%	96.7%	96.7%	96.7%	97.9%	<100% of 23/24 by Mar-25	NWL
OP	OP Procedures	102.8%	99.3%	105.5%	106.9%	160.0%	277.4%	117.0%	117.0%	117.0%	117.0%	117.0%	117.0%	120.2%	108% of 23/24	NWL
OP	OP 1st no Proc	92.6%	85.8%	94.0%	92.7%	117.8%	129.1%	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%	99.3%	108% of 23/24	NWL
OP	OP FU no Proc	77.8%	70.3%	76.5%	78.2%	98.0%	95.0%	80.9%	80.9%	80.9%	80.9%	80.9%	81.0%	81.2%	<100% of 23/24	NWL
OP	OP FU w/o proc %	44.5%	44.5%	44.5%	44.5%	44.5%	44.5%	44.5%	44.5%	44.5%	44.5%	44.5%	44.5%	44.5%		
OP	Proportion of all OP that were 1st appointments, or FU with proc	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	>=46% of 23/24	National
Elective	Total elective spells	113.9%	100.7%	108.2%	110.5%	139.2%	160.8%	155.6%	140.0%	133.3%	122.6%	122.6%	122.6%	125.2%	108% of 23/24	NWL
Elective	Elective day case spells	109.9%	97.5%	104.7%	106.9%	133.2%	154.9%	150.3%	135.4%	128.8%	116.7%	118.4%	118.3%	120.7%		
Elective	Elective ordinary spells	152.3%	130.0%	140.3%	144.6%	203.3%	219.5%	205.6%	183.3%	176.1%	191.0%	163.5%	165.0%	168.8%		
Elective	Elective day case spells - Children under 18 years of age	142.1%	86.9%	82.1%	89.5%	140.4%	513.6%	344.4%	228.3%	129.5%				137.1%		
Elective	Elective ordinary spells - Children under 18 years of age	105.3%	90.9%	73.1%	129.4%	100.0%	400.0%	550.0%	333.3%	190.0%				141.1%		
A&E	All Type attendances	106.3%	101.3%	94.7%	101.2%	108.4%	100.9%	99.4%	97.4%	97.3%	97.0%	100.4%	100.4%	100.3%	<100% of 23/24	NWL
A&E	All Type attendances seen <4hrs	77.0%	77.5%	77.9%	78.9%	78.9%	77.9%	77.0%	76.5%	76.0%	77.0%	77.9%	80.0%	77.7%	>=80% performance	NWL
A&E	Type 1 attendances	103.90%	102.90%	97.40%	99.80%	108.00%	100.10%	97.10%	98.90%	98.20%	97.90%	100.00%	100.00%	100.3%	<100% of 23/24	NWL
A&E	Type 1 attendances seen <4hrs	54.0%	55.0%	56.0%	58.0%	58.0%	56.0%	54.0%	53.0%	52.0%	54.0%	56.0%	60.1%	55.5%		
A&E	Other Type attendances	108.6%	100.0%	92.4%	102.4%	108.8%	101.7%	101.6%	96.1%	96.4%	96.3%	100.8%	100.8%	100.3%	<100% of 23/24	NWL
A&E	Other Type attendances seen <4hrs	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.2%	98.0%		
SDEC	SDEC	672	672	640	736	672	672	736	672	640	704	640	672	8,128		
NEL	Non-elective spells	107.4%	100.7%	99.3%	100.7%	115.5%	107.4%	95.9%	90.9%	89.7%	100.4%	100.4%	100.4%	100.3%	<100% of 23/24	NWL
NEL	Non-elective spells with a length of stay of zero days	108.3%	96.6%	98.7%	97.9%	125.3%	117.2%	92.5%	89.3%	89.1%	100.1%	100.1%	100.1%	100.3%		
NEL	Non-elective spells with a length of stay of 1 or more days	106.6%	104.9%	100.0%	103.3%	107.8%	99.7%	99.3%	92.5%	90.2%	100.7%	100.6%	100.7%	100.3%		

Summary – LNWHT 2

LNWHT - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	4,907	4,594	4,380	4,166	3,952	3,738	3,523	3,309	3,095	2,881	2,667	2,453	2,453	50% of Mar-24 (Apr-24 plans used as proxy)	NWL
RTT	Number of 52+ week RTT waits - <18 years	520	496	472	448	424	400	377	353	329	305	281	262	262		
RTT	Number of 65+ week RTT waits	418	334	251	167	84	-	-	-	-	-	-	-	-	Zero by Sep-24	National
RTT	RTT waiting list	101,900	100,720	99,540	98,360	97,180	96,013	94,823	92,970	91,118	89,265	87,413	85,560	85,560		
RTT	RTT completed admitted pathways	113.5%	89.3%	99.1%	106.8%	142.8%	194.3%	151.3%	152.9%	115.5%	115.6%	115.5%	115.5%	120.9%	108% of 23/24	NWL
RTT	RTT completed non-admitted pathways	104.9%	92.4%	100.7%	102.4%	151.4%	186.9%	140.7%	116.5%	116.3%	116.3%	116.3%	116.3%	117.6%		
RTT	New RTT pathways (clock starts)	106.7%	90.8%	88.7%	100.3%	103.2%	105.5%	112.5%	102.1%					100.8%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	90.4%	100.6%	117.0%	112.0%	122.2%	119.7%	119.6%	134.2%	135.1%	120.1%	120.4%	120.8%	116.9%	Activity at 108% of 23/24	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	86.3%	97.9%	110.0%	100.4%	109.4%	110.4%	105.4%	104.2%	94.1%	106.5%	109.2%	109.8%	103.3%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	97.8%	92.9%	109.7%	105.2%	121.2%	107.0%	116.6%	110.0%	121.6%	111.4%	111.7%	111.9%	109.2%		
Diagnostics	Diagnostic Tests - Colonoscopy	114.1%	102.0%	98.9%	97.7%	56.1%	162.7%	155.7%	173.7%	143.8%	109.5%	109.5%	109.5%	109.8%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	143.6%	89.4%	93.6%	100.0%	66.9%	130.2%	154.6%	250.7%	158.4%	116.6%	116.8%	116.7%	115.5%		
Diagnostics	Diagnostic Tests - Gastroscopy	129.3%	128.6%	159.8%	114.5%	73.0%	163.1%	160.2%	226.6%	162.6%	143.4%	150.6%	136.4%	137.5%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	87.9%	86.8%	98.5%	98.6%	101.4%	139.2%	122.6%	104.5%	125.5%	110.2%	110.1%	110.2%	106.1%		
Diagnostics	Diagnostic Tests - DEXA Scan	101.5%	141.7%	186.2%	179.2%	181.3%	194.2%	193.3%	193.6%	201.7%	185.3%	187.7%	189.4%	177.6%		
Diagnostics	Diagnostics Tests - Audiology	82.5%	70.6%	111.1%	104.1%	248.4%	140.0%	133.2%	68.8%	122.2%	124.7%	125.0%	124.9%	108.8%		
ACC	Adult Critical Care Bed occupancy	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%		
G&A	General and Acute day bed available	155	155	155	155	155	155	155	155	155	155	155	155	155		
G&A	General and Acute overnight beds occupancy - Total	95.5%	95.4%	95.4%	95.4%	95.4%	95.4%	96.1%	96.1%	96.1%	96.1%	96.1%	96.1%	96.1%	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds occupancy - adult	95.6%	95.5%	95.5%	95.5%	95.5%	95.5%	96.2%	96.2%	96.2%	96.2%	96.2%	96.2%	96.2%		
G&A	Average number of overnight G&A beds occupancy - paediatric	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%		
LoS	LoS - reducing 21 days LoS and over	107.3%	108.4%	121.1%	121.9%	127.1%	122.9%	103.4%	110.4%	114.6%	90.9%			111.8%	5% reduction MoM from 23/24 position	NWL
CTR	% beds occupied by patients not meeting criteria to reside	10.0%	9.7%	9.5%	9.5%	9.4%	9.4%	8.7%	8.7%	8.5%	8.5%	8.4%	8.4%	8.4%	Reduction to top quartile performance: 11.42%	NWL
Cancer	Cancer 62-day pathways - total patients seen	70.1%	72.3%	74.1%	75.8%	78.3%	80.1%	81.9%	81.3%	82.3%	81.0%	85.4%	85.5%	79.0%	70% by Mar-25	NWL
Cancer	Cancer 28 day waits (faster diagnosis standard)	75.0%	75.0%	76.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	FDD standard of 77% by Mar-25	National

Summary – THH 1

THH - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		
PIFU	PIFU	3.5%	3.7%	3.9%	4.1%	4.3%	4.5%	4.7%	4.9%	5.1%	5.3%	5.5%	5.7%	4.6%	5% of Total OP to PIFU	NWL
OP	Consultant-led 1st OP	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	108% of 23/24	NWL
OP	Consultant-led FU OP	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	<100% of 23/24 by Mar-25	NWL
OP	OP Procedures	102.9%	102.9%	102.9%	102.9%	102.9%	102.9%	102.9%	102.9%	102.9%	102.9%	102.9%	102.9%	102.9%	108% of 23/24	NWL
OP	OP 1st no Proc	115.3%	115.3%	115.3%	115.3%	115.3%	115.3%	115.3%	115.3%	115.3%	115.3%	115.3%	115.3%	115.3%	108% of 23/24	NWL
OP	OP FU no Proc	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	<100% of 23/24	NWL
OP	OP FU w/o proc %	41.8%	44.0%	43.4%	43.4%	41.5%	45.2%	43.0%	43.0%	43.0%	43.0%	43.0%	43.0%	43.2%		
OP	Proportion of all OP that were 1st appointments, or FU with proc	58.2%	56.0%	56.6%	56.6%	58.5%	54.8%	57.0%	57.0%	57.0%	57.0%	57.0%	57.0%	56.8%	>=46% of 23/24	National
Elective	Total elective spells	107.5%	107.3%	107.3%	107.0%	107.6%	107.1%	107.2%	107.3%	107.2%	107.3%	107.3%	107.3%	107.3%	108% of 23/24	NWL
Elective	Elective day case spells	106.0%	105.9%	106.0%	106.0%	106.0%	105.9%	105.9%	106.0%	106.0%	105.9%	106.0%	106.0%	106.0%		
Elective	Elective ordinary spells	124.1%	123.8%	124.1%	124.2%	123.8%	124.1%	123.7%	123.9%	124.0%	124.0%	123.8%	123.7%	123.9%		
Elective	Elective day case spells - Children under 18 years of age	111.1%	100.0%	85.9%	103.0%	90.2%	94.9%	98.9%	90.2%	100.0%				97.0%		
Elective	Elective ordinary spells - Children under 18 years of age		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				0.0%		
A&E	All Type attendances	99.6%	99.6%	99.7%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	<100% of 23/24	NWL
A&E	All Type attendances seen <4hrs	75.7%	75.9%	76.4%	75.6%	75.6%	76.1%	77.1%	77.3%	77.5%	76.5%	75.2%	77.1%	76.3%	>=80% performance	NWL
A&E	Type 1 attendances	98.80%	98.80%	98.80%	98.80%	98.80%	98.80%	98.80%	98.80%	98.80%	98.80%	98.80%	98.80%	98.8%	<100% of 23/24	NWL
A&E	Type 1 attendances seen <4hrs	53.0%	51.0%	52.0%	51.0%	52.0%	52.0%	54.0%	55.0%	56.0%	54.0%	51.0%	53.9%	52.9%		
A&E	Other Type attendances	100.4%	100.4%	100.4%	100.4%	100.4%	100.4%	100.4%	100.4%	100.4%	100.4%	100.4%	100.4%	100.4%	<100% of 23/24	NWL
A&E	Other Type attendances seen <4hrs	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.9%	98.1%		
SDEC	SDEC	605	625	605	625	625	605	625	605	625	625	565	625	7,360		
NEL	Non-elective spells	104.7%	104.7%	104.7%	104.5%	104.8%	104.6%	104.6%	105.5%	105.7%	104.8%	104.9%	104.8%	104.9%	<100% of 23/24	NWL
NEL	Non-elective spells with a length of stay of zero days	99.2%	99.3%	99.3%	99.3%	99.3%	99.3%	99.2%	99.4%	99.4%	99.3%	99.3%	99.3%	99.3%		
NEL	Non-elective spells with a length of stay of 1 or more days	108.1%	108.1%	108.2%	108.1%	108.2%	108.1%	108.1%	108.2%	108.1%	108.1%	108.1%	108.1%	108.1%		

Summary – THH 2

THH - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	1,308	1,243	1,177	1,112	1,059	994	929	876	824	772	719	654	654	50% of Mar-24 (Apr-24 plans used as proxy)	NWL
RTT	Number of 52+ week RTT waits - <18 years	93	88	84	79	75	71	66	62	59	55	51	47	47		
RTT	Number of 65+ week RTT waits	30	20	10	-	-	-	-	-	-	-	-	-	-	Zero by Sep-24	National
RTT	RTT waiting list	30,525	30,205	29,885	29,565	29,245	28,925	28,605	28,285	27,965	27,645	27,325	27,005	27,005		
RTT	RTT completed admitted pathways	108.3%	108.3%	108.3%	108.4%	108.3%	108.4%	108.3%	108.3%	108.3%	108.4%	108.3%	108.3%	108.3%	108% of 23/24	NWL
RTT	RTT completed non-admitted pathways	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%		
RTT	New RTT pathways (clock starts)	124.7%	112.3%	97.2%	117.1%	102.1%	106.9%	111.8%	102.1%					109.2%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	98.4%	98.4%	98.4%	98.5%	98.4%	98.5%	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	Activity at 108% of 23/24	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	105.4%	105.4%	105.4%	105.4%	105.4%	105.4%	105.4%	105.5%	105.5%	105.4%	105.4%	105.4%	105.4%		
Diagnostics	Diagnostic Tests - Colonoscopy	116.3%	116.1%	115.9%	116.3%	116.2%	116.1%	116.3%	116.4%	116.4%	116.1%	116.4%	116.3%	116.2%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	123.8%	124.0%	124.4%	123.7%	125.0%	122.9%	124.4%	123.8%	124.0%	122.5%	125.0%	123.7%	123.9%		
Diagnostics	Diagnostic Tests - Gastroscopy	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	103.8%	103.8%	103.8%	103.8%	103.7%	103.8%	103.8%	103.7%	103.8%	103.7%	103.7%	103.7%	103.8%		
Diagnostics	Diagnostic Tests - DEXA Scan															
Diagnostics	Diagnostics Tests - Audiology	93.3%	93.2%	93.2%	93.2%	93.3%	93.2%	93.3%	93.3%	93.3%	93.2%	93.3%	93.3%	93.3%		
ACC	Adult Critical Care Bed occupancy	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%		
G&A	General and Acute day bed available	34	34	34	34	34	34	34	34	34	34	34	34	34		
G&A	General and Acute overnight beds occupancy - Total	95.3%	94.7%	92.7%	91.9%	90.5%	91.9%	95.3%	96.2%	95.7%	92.2%	94.2%	93.3%	93.3%	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds occupancy - adult	97.3%	95.5%	93.4%	93.4%	91.9%	92.8%	95.8%	96.8%	96.8%	93.0%	94.9%	94.0%	94.0%		
G&A	Average number of overnight G&A beds occupancy - paediatric	66.7%	83.3%	83.3%	70.8%	70.8%	79.2%	87.5%	87.5%	79.2%	79.2%	83.3%	83.3%	83.3%		
LoS	LoS - reducing 21 days LoS and over	60.3%	53.2%	58.6%	54.7%	51.9%	51.3%	52.6%	48.8%	43.6%	45.6%			51.6%	5% reduction MoM from 23/24 position	NWL
CTR	% beds occupied by patients not meeting criteria to reside	7.7%	7.8%	8.0%	8.0%	8.1%	8.1%	7.8%	6.9%	6.9%	7.2%	7.1%	8.0%	8.0%	Reduction to top quartile performance: 11.42%	NWL
Cancer	Cancer 62-day pathways - total patients seen	71.9%	74.1%	75.3%	77.4%	80.0%	80.0%	81.7%	80.0%	81.5%	83.1%	85.2%	85.9%	79.7%	70% by Mar-25	NWL
Cancer	Cancer 28 day waits (faster diagnosis standard)	75.0%	75.0%	76.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.1%	77.0%	77.1%	77.0%	77.0%	FDD standard of 77% by Mar-25	National

Summary – CWFT 1

ChelWest - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP	98.6%	98.4%	98.8%	98.3%	98.5%	98.1%	98.0%	97.8%	95.6%	98.9%	103.8%	94.2%	98.2%		
PIFU	PIFU	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5% of Total OP to PIFU	NWL
OP	Consultant-led 1st OP	94.9%	94.1%	95.3%	93.7%	94.0%	93.5%	93.0%	92.9%	90.6%	94.3%	98.7%	89.6%	93.7%	108% of 23/24	NWL
OP	Consultant-led FU OP	101.9%	101.9%	102.0%	101.3%	101.7%	101.6%	101.7%	101.6%	101.6%	102.7%	107.6%	97.6%	101.9%	<100% of 23/24 by Mar-25	NWL
OP	OP Procedures	97.6%	97.5%	97.5%	95.3%	96.2%	95.5%	119.4%	126.3%	98.7%	103.6%	108.9%	98.8%	102.7%	108% of 23/24	NWL
OP	OP 1st no Proc	97.9%	97.1%	97.8%	97.8%	98.6%	97.8%	102.5%	107.2%	95.7%	100.8%	106.1%	96.0%	99.6%	108% of 23/24	NWL
OP	OP FU no Proc	88.9%	89.2%	89.4%	89.2%	90.1%	90.1%	89.5%	96.0%	86.7%	91.4%	96.0%	86.9%	90.3%	<100% of 23/24	NWL
OP	OP FU w/o proc %	56.1%	56.6%	54.5%	54.1%	53.9%	53.0%	53.0%	53.5%	54.7%	54.8%	54.7%	54.7%	54.5%		
OP	Proportion of all OP that were 1st appointments, or FU with proc	43.9%	43.4%	45.5%	45.9%	46.1%	47.0%	47.0%	46.5%	45.3%	45.2%	45.3%	45.3%	45.5%	>=46% of 23/24	National
Elective	Total elective spells	87.7%	88.2%	88.0%	87.1%	87.3%	88.3%	87.0%	88.7%	78.4%	87.5%	92.4%	82.3%	86.9%	108% of 23/24	NWL
Elective	Elective day case spells	86.7%	87.4%	86.8%	86.5%	86.0%	87.3%	86.0%	87.5%	75.6%	85.6%	90.6%	80.6%	85.6%		
Elective	Elective ordinary spells	98.8%	97.0%	101.3%	93.5%	99.2%	98.0%	95.7%	99.5%	103.4%	102.7%	105.9%	95.8%	99.3%		
Elective	Elective day case spells - Children under 18 years of age	128.8%	116.3%	102.1%	126.3%	111.2%	112.7%	115.4%	107.7%	94.0%				111.7%		
Elective	Elective ordinary spells - Children under 18 years of age	113.0%	114.0%	95.7%	114.5%	109.4%	109.1%	108.1%	106.5%	79.6%				105.0%		
A&E	All Type attendances	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	<100% of 23/24	NWL
A&E	All Type attendances seen <4hrs	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	>=80% performance	NWL
A&E	Type 1 attendances	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.0%	<100% of 23/24	NWL
A&E	Type 1 attendances seen <4hrs	76.4%	76.3%	76.3%	76.4%	76.4%	76.6%	76.3%	76.2%	76.1%	76.2%	77.0%	76.9%	76.4%		
A&E	Other Type attendances	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	94.8%	95.0%	95.0%	<100% of 23/24	NWL
A&E	Other Type attendances seen <4hrs	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		
SDEC	SDEC	997	1,177	1,168	1,149	1,027	1,303	1,412	1,454	1,185	1,185	1,071	1,185	14,313		
NEL	Non-elective spells	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	<100% of 23/24	NWL
NEL	Non-elective spells with a length of stay of zero days	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
NEL	Non-elective spells with a length of stay of 1 or more days	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		

Summary – CWFT 2

ChelWest - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	1,596	1,546	1,496	1,454	1,404	1,354	1,304	1,253	1,203	1,153	1,103	1,085	1,085	50% of Mar-24 (Apr-24 plans used as proxy)	NWL
RTT	Number of 52+ week RTT waits - <18 years	218	208	198	188	178	168	158	148	138	128	118	115	115		
RTT	Number of 65+ week RTT waits	425	375	300	250	200	90	-	-	-	-	-	-	-	Zero by Sep-24	National
RTT	RTT waiting list	62,695	62,000	62,000	61,000	61,000	61,000	61,000	60,500	60,500	60,500	60,500	60,000	60,000		
RTT	RTT completed admitted pathways	107.7%	104.3%	103.9%	121.8%	96.0%	100.1%	109.5%	95.3%	106.3%	106.7%	93.8%	90.7%	103.0%	108% of 23/24	NWL
RTT	RTT completed non-admitted pathways	101.6%	102.7%	118.8%	111.5%	106.5%	98.3%	103.5%	92.0%	95.5%	99.1%	105.2%	92.7%	102.0%		
RTT	New RTT pathways (clock starts)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Activity at 108% of 23/24	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	101.9%	96.0%	104.5%	104.2%	87.6%	91.7%	98.1%	96.5%	89.4%	74.7%	80.1%	77.0%	91.9%		
Diagnostics	Diagnostic Tests - Colonoscopy	192.0%	116.0%	161.1%	144.8%	153.6%	102.4%	124.4%	119.8%	101.9%	87.3%	108.2%	109.4%	123.0%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	139.1%	90.1%	55.6%	130.6%	115.7%	90.1%	87.0%	101.3%	85.6%	87.4%	106.0%	102.9%	97.1%		
Diagnostics	Diagnostic Tests - Gastroscopy	115.2%	83.3%	115.3%	123.4%	145.2%	96.2%	87.6%	79.6%	89.7%	89.6%	98.0%	98.7%	100.0%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	73.1%	48.8%	112.0%	82.1%	140.8%	159.5%	204.9%	145.2%	114.1%	104.9%	126.7%	127.8%	113.0%		
Diagnostics	Diagnostic Tests - DEXA Scan	61.3%	82.6%	102.6%	118.5%	106.0%	101.8%	109.3%	144.1%	118.8%	103.2%	101.7%	69.1%	100.6%		
Diagnostics	Diagnostics Tests - Audiology	115.8%	97.2%	176.9%	172.8%	148.4%	161.1%	128.7%	122.7%	149.5%	190.6%	162.7%	91.7%	142.8%		
ACC	Adult Critical Care Bed occupancy	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		
G&A	General and Acute day bed available	21	21	21	21	21	21	21	21	21	21	21	21	21		
G&A	General and Acute overnight beds occupancy - Total	92.1%	92.1%	92.1%	92.1%	92.1%	93.9%	95.8%	95.8%	95.8%	95.8%	95.8%	95.8%	95.8%	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds occupancy - adult	92.0%	92.0%	92.0%	92.0%	92.0%	94.1%	96.1%	96.1%	96.1%	96.1%	96.1%	96.1%	96.1%		
G&A	Average number of overnight G&A beds occupancy - paediatric	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%		
LoS	LoS - reducing 21 days LoS and over	95.9%	108.8%	112.9%	110.5%	109.8%	107.6%	109.9%	102.0%	96.8%	76.5%			102.0%	5% reduction MoM from 23/24 position	NWL
CTR	% beds occupied by patients not meeting criteria to reside	16.2%	15.9%	15.6%	15.3%	15.0%	14.3%	13.7%	13.4%	13.1%	12.8%	12.5%	12.2%	12.2%	Reduction to top quartile performance: 11.42%	NWL
Cancer	Cancer 62-day pathways - total patients seen	80.4%	80.8%	81.3%	82.4%	82.1%	82.8%	84.2%	85.4%	85.4%	85.4%	85.4%	85.4%	83.4%	70% by Mar-25	NWL
Cancer	Cancer 28 day waits (faster diagnosis standard)	75.0%	75.0%	76.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	FDD standard of 77% by Mar-25	National

Summary – ICHT 1

ICHT - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP	93.8%	89.0%	95.4%	96.5%	101.0%	96.3%	95.1%	91.6%	101.6%	95.9%	95.9%	95.9%	95.5%		
PIFU	PIFU	0.7%	0.7%	0.7%	0.6%	0.7%	0.7%	0.6%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	5% of Total OP to PIFU	NWL
OP	Consultant-led 1st OP	133.4%	119.8%	127.4%	128.0%	137.5%	127.9%	125.1%	118.8%	139.3%	130.4%	130.4%	130.4%	128.7%	108% of 23/24	NWL
OP	Consultant-led FU OP	105.2%	100.2%	108.6%	110.9%	117.1%	110.7%	109.8%	105.4%	118.6%	109.0%	109.0%	109.0%	109.3%	<100% of 23/24 by Mar-25	NWL
OP	OP Procedures	127.9%	113.4%	107.5%	102.4%	108.1%	100.1%	120.6%	120.6%	120.6%	120.6%	120.6%	120.6%	114.5%	108% of 23/24	NWL
OP	OP 1st no Proc	119.5%	110.4%	120.6%	121.5%	133.8%	124.5%	121.7%	121.7%	121.7%	121.7%	121.7%	121.7%	121.5%	108% of 23/24	NWL
OP	OP FU no Proc	89.6%	85.6%	94.3%	97.5%	101.3%	97.1%	93.1%	93.1%	93.1%	93.1%	93.1%	93.1%	93.6%	<100% of 23/24	NWL
OP	OP FU w/o proc %	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%		
OP	Proportion of all OP that were 1st appointments, or FU with proc	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	>=46% of 23/24	National
Elective	Total elective spells	103.5%	104.0%	110.8%	112.6%	113.2%	110.6%	109.7%	100.9%	106.6%	108.3%	108.3%	108.3%	108.0%	108% of 23/24	NWL
Elective	Elective day case spells	102.6%	103.6%	109.9%	111.8%	112.1%	109.8%	108.7%	101.1%	104.8%	107.4%	107.4%	107.5%	107.2%		
Elective	Elective ordinary spells	109.9%	107.4%	116.8%	118.7%	121.1%	115.9%	117.4%	99.6%	120.7%	114.7%	114.7%	114.6%	114.0%		
Elective	Elective day case spells - Children under 18 years of age	133.3%	121.8%	110.0%	142.1%	112.0%	134.0%	134.9%	118.9%	132.0%				125.9%		
Elective	Elective ordinary spells - Children under 18 years of age	121.5%	97.4%	96.4%	112.7%	110.8%	115.3%	125.3%	90.4%	108.0%				107.7%		
A&E	All Type attendances	101.0%	101.0%	101.0%	99.9%	101.0%	101.0%	102.3%	101.0%	101.0%	101.0%	108.6%	102.5%	101.7%	<100% of 23/24	NWL
A&E	All Type attendances seen <4hrs	76.4%	76.7%	77.1%	77.1%	77.1%	77.1%	75.0%	71.5%	71.5%	72.5%	74.8%	77.1%	75.4%	>=80% performance	NWL
A&E	Type 1 attendances	101.00%	101.00%	101.00%	98.50%	101.00%	101.00%	101.00%	101.00%	101.00%	101.00%	104.80%	100.00%	101.0%	<100% of 23/24	NWL
A&E	Type 1 attendances seen <4hrs	56.6%	56.8%	57.5%	57.6%	58.5%	58.6%	54.1%	50.1%	50.5%	50.9%	54.5%	59.3%	55.4%		
A&E	Other Type attendances	101.0%	101.0%	101.0%	101.5%	101.0%	101.0%	103.8%	101.0%	101.0%	101.0%	112.9%	105.4%	102.5%	<100% of 23/24	NWL
A&E	Other Type attendances seen <4hrs	98.0%	98.2%	98.2%	98.2%	98.2%	98.2%	98.3%	96.8%	96.6%	96.7%	96.7%	96.7%	97.6%		
SDEC	SDEC	2,492	2,575	2,492	2,576	2,576	2,493	2,576	2,493	2,576	2,576	2,326	2,576	30,327		
NEL	Non-elective spells	112.7%	105.5%	102.8%	102.9%	105.3%	95.6%	95.3%	89.7%	93.2%	102.0%	102.0%	102.0%	100.4%	<100% of 23/24	NWL
NEL	Non-elective spells with a length of stay of zero days	127.6%	118.6%	117.2%	101.4%	100.9%	90.9%	88.5%	85.6%	90.5%	107.1%	107.2%	107.1%	102.0%		
NEL	Non-elective spells with a length of stay of 1 or more days	108.0%	101.3%	98.2%	103.5%	107.0%	97.5%	98.1%	91.4%	94.2%	100.2%	100.2%	100.2%	99.8%		

Summary – ICHT 2

ICHT - Planned activity / performance as % of 2023-24 baseline		2024-25														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	3,770	3,666	3,550	3,404	3,278	3,212	3,071	2,886	2,880	2,746	2,619	2,483	2,483	50% of Mar-24 (Apr-24 plans used as proxy)	NWL
RTT	Number of 52+ week RTT waits - <18 years	44	51	42	33	28	21	18	15	10	8	6	5	5		
RTT	Number of 65+ week RTT waits	854	701	561	368	196	-	-	-	-	-	-	-	-	Zero by Sep-24	National
RTT	RTT waiting list	99,167	98,834	98,501	98,168	97,835	97,502	97,169	96,836	96,503	96,170	95,837	95,504	95,504		
RTT	RTT completed admitted pathways	105.2%	92.2%	106.2%	108.3%	107.6%	101.0%	92.4%	88.3%	101.0%	101.0%	101.0%	101.0%	100.0%	108% of 23/24	NWL
RTT	RTT completed non-admitted pathways	102.3%	100.2%	102.3%	98.3%	109.1%	103.2%	96.5%	92.8%	102.7%	102.7%	102.7%	102.7%	101.1%		
RTT	New RTT pathways (clock starts)	100.1%	100.1%	100.1%	100.2%	100.1%	100.1%	100.1%	100.1%					100.1%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	81.8%	82.5%	93.4%	84.1%	90.8%	88.5%	97.4%	92.9%	89.9%	90.0%	90.0%	90.0%	89.0%	Activity at 108% of 23/24	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	82.5%	88.9%	96.2%	85.9%	91.1%	85.4%	87.2%	86.2%	85.2%	89.5%	89.5%	89.5%	87.9%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	94.5%	89.8%	110.5%	104.7%	99.4%	91.2%	98.8%	91.0%	91.4%	98.2%	98.2%	98.2%	96.9%		
Diagnostics	Diagnostic Tests - Colonoscopy	77.6%	81.3%	100.0%	129.5%	127.4%	118.7%	146.2%	86.0%	93.8%	105.1%	105.2%	105.1%	103.2%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	77.0%	107.0%	102.0%	149.4%	125.9%	124.4%	118.0%	84.9%	105.2%	101.8%	102.0%	101.9%	105.6%		
Diagnostics	Diagnostic Tests - Gastroscopy	89.3%	91.6%	106.0%	133.2%	123.2%	102.0%	118.7%	89.7%	96.2%	105.8%	105.8%	105.9%	104.4%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	93.0%	92.5%	94.7%	94.8%	87.8%	85.4%	90.1%	87.2%	92.6%	87.1%	87.1%	87.1%	89.8%		
Diagnostics	Diagnostic Tests - DEXA Scan	76.1%	79.0%	83.3%	81.9%	84.5%		92.6%	86.7%	100.7%	95.2%	95.3%	94.9%	95.4%		
Diagnostics	Diagnostics Tests - Audiology	89.7%	83.3%	81.6%	85.3%	97.8%	108.3%	108.9%	78.8%	84.4%	92.1%	92.1%	92.2%	90.4%		
ACC	Adult Critical Care Bed occupancy	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%		
G&A	General and Acute day bed available	196	196	196	196	196	196	196	196	196	196	196	196	196		
G&A	General and Acute overnight beds occupancy - Total	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	89.6%	89.6%	89.6%	89.6%	89.6%	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds occupancy - adult	93.1%	93.1%	93.1%	93.1%	93.1%	93.1%	93.1%	93.1%	90.4%	90.4%	90.4%	90.4%	90.4%		
G&A	Average number of overnight G&A beds occupancy - paediatric	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	68.6%	68.6%	68.6%	68.6%	68.6%		
LoS	LoS - reducing 21 days LoS and over	103.8%	103.4%	105.9%	99.1%	100.5%	94.3%	97.2%	95.6%	100.8%	102.9%			100.3%	5% reduction MoM from 23/24 position	NWL
CTR	% beds occupied by patients not meeting criteria to reside	21.8%	21.4%	21.0%	20.5%	20.1%	19.5%	19.1%	18.7%	18.2%	17.8%	17.3%	16.9%	16.9%	Reduction to top quartile performance: 11.42%	NWL
Cancer	Cancer 62-day pathways - total patients seen	73.3%	76.2%	79.9%	81.0%	80.8%	81.9%	82.9%	81.9%	81.0%	82.2%	85.3%	85.5%	81.0%	70% by Mar-25	NWL
Cancer	Cancer 28 day waits (faster diagnosis standard)	75.0%	75.0%	76.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	FDD standard of 77% by Mar-25	National

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Appendix 2:

Working Paper –
5 Year Capital Plans for the Acute Collaborative
Report to the Estates and Sustainability Committee

Version 2

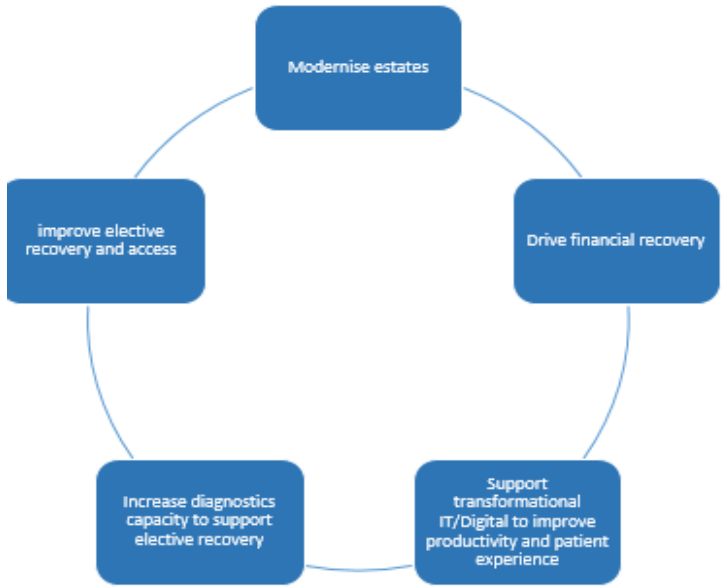
Executive Summary

- This paper is the second iteration of a regular report to the Committee, setting out the combined capital plans for the Collaborative. It shows the most recent capital plans submitted to the ICB – but note that there is a dynamic planning process underway so these figures may change slightly. The combined initial capital plans for five years total £1.6bn, but this includes anticipated central funding and a new hospital build. CFOs are considering how to develop the discussions around our collective five year plan.
- Capital budgets are allocated initially to ICBs, using a national methodology. The ICB then – collaboratively with the CFO group – agrees an allocation of capital across Trusts, using agreed prioritisation methods and addressing shortfalls in the process (for example, the challenges of hosting LAS). Trusts are then given their initial capital allocations for a rolling two-to-three year period. Both the ICB and the Trusts have developed five year capital plans. The ICS has developed a five year NWL Capital Strategy, which was considered at a previous Committee meeting. The Collaborative CFOs are reviewing options and are anticipating developing a Collaborative Capital Strategy in Q1+Q2 of next year.
- Note the difference between the CRL (capital resource limit) allocation and cash generated by depreciation. A Trust's CRL can differ, leading to a net cash subsidy or gain from the capital allocation. Later versions of this report will explore cash. Trusts all manage their capital allocations in year and across years through a version of the 'Capital Review Group' typically reporting to the Executive Team and the Finance Committee. This enables the balancing of in-year priorities.
- Each Trust has developed a five year capital plan and these are collated and summarised in this paper. Trust capital plans do differ from the ICB capital plans where Trusts are anticipating or expecting some form of national funding, and there is over time some work that the CFOs can do to support the Committee by testing the consistency and realism of these assumptions. Trust capital plans are reviewed by their Finance Committees and aligned with Trust Strategies. As the Collaborative Strategy develops, the CFOs and Committee can work on alignment and prioritisation within the Collaborative.
- Finally, a key challenge for all Trusts is the level of backlog maintenance within their estates. This paper provides a brief summary of the total of backlog maintenance across the Trusts and an indication of the expenditure on backlog maintenance taken from the Model Hospital analysis for the year 2021/22. This analysis needs further work as there are variations in the approach taken to recording expenditure against backlog maintenance (as the recording rules leave Trusts with a degree of discretion) – and the CFOs will work over time with the Directors of Estates to move towards a consistent approach to recording this activity.

NWL Capital Priorities

- Through the ICB CFO group, NWL has agreed a series of capital priorities within an overall capital strategy. The key priorities are shown below. It is important to highlight that this is an approach to allocating across Trusts, rather than within Trusts – where individual Trusts will have adopted different approaches, recognising their specific needs and investment requirements. The Committee has indicated its view that the CFOs should should develop a Collaborative Capital Strategy, which is aligned with the ICB Strategy and support delivery and this will be undertaken in Q1+Q2.

NWL ICS Capital Strategy – At a glance



North West London
Integrated Care System

The ICS capital strategy is emergent and linked to the evolving wider NWL strategic aims (**support health and well-being; address inequalities; improve access; closer to home; happy healthy lives for CYP; productive & high quality**). To support this, the key areas of focus for NWL ICS in the 5 years to 2028/29 is :

- **Modernise ageing estates:**- Invest capital to maintain ageing estates /new builds to deliver patient care in a safe environment and meet regulatory compliance.
- **Improve elective recovery and access:**- Improve elective recovery and access through expanding wards, modular operating theatres, upgrading outpatient spaces etc.
- **Drive financial recovery:**- Support capital schemes that are cost neutral/provide I&E benefits, improve productivity and drive efficiencies.
- **Increase diagnostics capacity:**- Increase diagnostic activity and reduce patient waiting times/ expansion in community diagnostics to bring care closer to home.
- **IT/Digital:**- key enabler to transform healthcare in NWL. Adopt digital technology on the frontline to improve productivity, increase optionality and access.

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North West London

Backlog Maintenance in the Collaborative

- Model Hospital data has been used to pull together an indicative record of the levels of submitted backlog maintenance for the Collaborative and the Trusts. Some caution should be noted with this data, given the degree of discretion allowed in recording. However, this data does align with the estates conditions described to the Committee in other papers, and with the size of Trusts. The impact of PFI hospitals and new builds can also be observed in the varying levels of backlog maintenance. Further work will be undertaken with the Estates Directors over the coming months to review and consider approaches to capital allocation which address the challenges of backlog maintenance.

Model Hospital Data for the 2021/22 Years					
	Backlog Maintenance Costs	Backlog Maintenance	Critical Infrastructure Risk	Investment to reduce Backlog Maintenance	Investment to reduce Critical Backlog
	£m	£/m2	£m	£m	£m
ICHT	736.05	2,350.37	709.64	17.42	16.75
LNWH	249.70	1,206.71	78.53	5.24	2.32
THH	155.00	1,891.14	141.41	12.05	10.00
CWFT	3.75	29.66	3.27	3.75	3.27
	1,144.50		**932.85**	**38.46**	**32.34**

Summary of Capital Plans - Collaborative

Collaborative Capital Plans	Sum of Year Ending 24/25 £'000	Sum of Year Ending 25/26 £'000	Sum of Year Ending 26/27 £'000	Sum of Year Ending 27/28 £'000	Sum of Year Ending 29/30 £'000	Sum of 5 Year Plan £'000
Backlog Maintenance - Moderate and low risk	-	1,500	2,000	2,000	2,000	7,500
Backlog Maintenance - Significant and high risk (CIR)	56,736	41,306	45,173	47,954	48,304	239,473
Equipment - clinical diagnostics	6,603	5,940	3,778	3,500	5,000	24,821
Equipment - clinical Other	14,475	9,634	9,825	10,017	10,311	54,262
Equipment - clinical theatres & critical care	3,900	4,000	4,000	4,000	4,000	19,900
Equipment - non clinical	2,000	2,000	3,000	4,000	4,000	15,000
IT - Clinical Systems	2,961	729	729	729	729	5,877
IT - Cybersecurity, Infrastructure/Networking	211	450	450	450	450	2,011
IT - Hardware	2,250	2,000	811	2,000	2,373	9,434
IT - Other	13,502	17,771	15,021	15,021	15,021	76,336
New Build	1,281					1,281
New Build - Diagnostics	29,595	17,352	10,285	1,064		58,296
New Build - Land, buildings and dwellings	47,400	26,200	101,200	301,200	301,200	777,200
New Build - Multiple areas/ Other	-	5,000	15,000	7,000		27,000
New Build - Theatres & critical care	14,059	23,019	38,671	29,113	-	104,862
Other - including investment property	9,550	7,870	18,138	18,563	18,716	72,837
Other - Intangible assets	3,946	4,000	3,500	4,550	4,550	20,546
Plant and machinery	5,620	16,822	16,140	21,196	19,837	79,615
Property, land and buildings	- 500	-	-	-	-	- 500
Routine maintenance (non-backlog) - Land, Buildings and dwellings	4,897	4,684	4,502	4,575	4,095	22,753
Other/Overprogramming at LNWH	- 10,791	- 2,000				- 12,791
Grand Total	**207,695**	**188,277**	**292,223**	**476,932**	**440,586**	**1,605,713**

- This table sets out the combined expenditure across the Collaborative in the key expenditure categories.
- The table is built up from the individual Trust five-year plans which were submitted to the ICB in February 2024. These plans continue to be refined and developed.
- Also included in this pack are further details on the composition of the capital plans and expenditure, by Trust, and by DH Central Programme.
- Over time, through this Committee, we will look at the relationship between capital spend and estates condition, as well as strategic plans.

Summary of Capital Plans - Collaborative

- This table sets out the latest draft five year capital plans by Trust – for CWFT and ICHT.

Trust Capital Plans	Sum of Year Ending 24/25 £'000	Sum of Year Ending 25/26 £'000	Sum of Year Ending 26/27 £'000	Sum of Year Ending 27/28 £'000	Sum of Year Ending 29/30 £'000	Sum of 5 Year Plan £'000
CWFT	**54,650**	**28,630**	**28,449**	**28,477**	**28,697**	**168,903**
Backlog Maintenance - Significant and high risk (CIR)	5,664	4,156	9,723	12,954	12,954	45,451
Equipment - non clinical	2,000	2,000	3,000	4,000	4,000	15,000
New Build - Diagnostics	29,595	17,352	10,285	1,064		58,296
New Build - Land, buildings and dwellings	21,300					21,300
Other - Intangible assets	3,946	4,000	3,500	4,550	4,550	20,546
Plant and machinery	369	1,000		3,940	5,004	10,313
Routine maintenance (non-backlog) - Land, Buildings and dwe	2,567	2,122	1,941	1,969	2,189	10,788
(blank)	- 10,791	- 2,000				- 12,791
ICHT	**79,449**	**61,204**	**61,041**	**61,280**	**61,527**	**324,501**
Backlog Maintenance - Significant and high risk (CIR)	24,867	23,000	23,000	23,000	23,000	116,867
Equipment - clinical diagnostics	6,603	5,940	2,278	2,000	2,000	18,821
Equipment - clinical Other	11,895	6,534	6,625	6,717	6,811	38,582
Equipment - clinical theatres & critical care	3,900	4,000	4,000	4,000	4,000	19,900
IT - Clinical Systems	2,181	729	729	729	729	5,097
IT - Other	10,793	10,771	6,271	6,271	6,271	40,377
New Build	1,281					1,281
New Build - Theatres & critical care	8,379	2,360	-	-	-	10,739
Other - including investment property	9,550	7,870	18,138	18,563	18,716	72,837

Summary of Capital Plans - Trusts

- This table sets out the latest draft five year capital plans by Trust – for LNWH and THH. Note the impact of the new build.

Trust Capital Plans	Sum of Year Ending 24/25 £'000	Sum of Year Ending 25/26 £'000	Sum of Year Ending 26/27 £'000	Sum of Year Ending 27/28 £'000	Sum of Year Ending 29/30 £'000	Sum of 5 Year Plan £'000
LNWHT	**32,663**	**57,543**	**86,783**	**71,225**	**34,412**	**282,626**
Backlog Maintenance - Moderate and low risk	-	1,500	2,000	2,000	2,000	7,500
Backlog Maintenance - Significant and high risk (CIR)	16,805	5,950	7,450	7,000	7,350	44,555
Equipment - clinical diagnostics	-	-	1,500	1,500	3,000	6,000
Equipment - clinical Other	2,580	3,100	3,200	3,300	3,500	15,680
IT - Clinical Systems	780					780
IT - Cybersecurity, Infrastructure/Networking	211	450	450	450	450	2,011
IT - Hardware	2,250	2,000	811	2,000	2,373	9,434
IT - Other	973	4,000	4,000	4,000	4,000	16,973
New Build - Multiple areas/ Other	-	5,000	15,000	7,000		27,000
New Build - Theatres & critical care	5,680	20,659	38,671	29,113		94,123
Plant and machinery	1,054	12,322	11,140	12,256	9,833	46,605
Routine maintenance (non-backlog) - Land, Buildings and dwe	2,330	2,562	2,561	2,606	1,906	11,965
THH	**40,933**	**40,900**	**115,950**	**315,950**	**315,950**	**829,683**
Backlog Maintenance - Significant and high risk (CIR)	9,400	8,200	5,000	5,000	5,000	32,600
IT - Other	1,736	3,000	4,750	4,750	4,750	18,986
New Build - Land, buildings and dwellings	26,100	26,200	101,200	301,200	301,200	755,900
Plant and machinery	4,197	3,500	5,000	5,000	5,000	22,697
Property, land and buildings	- 500	-	-	-	-	- 500

Funding Sources for the Trust Plans

- This table sets out the assumptions for additional funding from other sources by the Trust, primarily at THH (New Hospitals Programme) and LNWH (to be confirmed). CFOs will be reviewing these assumptions for the next iteration of this paper.

Row Labels	Sum of Year Ending 24/25 £'000	Sum of Year Ending 25/26 £'000	Sum of Year Ending 26/27 £'000	Sum of Year Ending 27/28 £'000	Sum of Year Ending 29/30 £'000	Sum of 5 Year Plan £'000
CWFT	**54,650**	**28,630**	**28,449**	**28,477**	**28,697**	**168,903**
Internally Funded	45,235	30,630	28,449	28,477	28,697	161,488
PDC	20,206					20,206
(blank)	- 10,791	- 2,000				- 12,791
ICHT	**79,449**	**61,204**	**61,041**	**61,280**	**61,527**	**324,501**
Internally Funded	77,358	61,204	61,041	61,280	61,527	322,410
PDC	2,091	-	-	-	-	2,091
LNWHT	**32,663**	**57,543**	**86,783**	**71,225**	**34,412**	**282,626**
Internally Funded	25,703	31,884	33,112	35,112	34,412	160,223
PDC	6,960	25,659	53,671	36,113		122,403
THH	**40,933**	**40,900**	**115,950**	**315,950**	**315,950**	**829,683**
Internally Funded	15,333	14,700	14,750	14,750	14,750	74,283
PDC	26,100	26,200	101,200	301,200	301,200	755,900
(blank)	- 500	-	-	-	-	- 500
Grand Total	**207,695**	**188,277**	**292,223**	**476,932**	**440,586**	**1,605,713**

Summary and Next Steps

- This paper is the second iteration of the regular report to the Collaborative Committee, setting out the combined capital plans for the Collaborative. It shows the capital plans submitted to the ICB earlier this year (and a further refresh is expected in March 2024, so there may be some local variation for this iteration).
- A number of further pieces of work are discussed in this paper – including the development of a capital strategy and prioritisation approach, a review of the approaches to backlog maintenance, and a review of the consistency of assumption around 'additional capital.' These were not progressed in Q3&Q4 2023/24, and the CFOs will agree a plan to progress this work in 2024/25, during Q1 and Q2.
- Over time, this report should be refined to develop into a coherent capital strategy for the NWL Collaborative, aligned with the developing Collaborative Strategy.
- In the short term, Trusts continue working on their financial plans for 2024/25. The indicative plans are included in this pack, and Trust CFOs and Estates Directors are working on the internal allocation and prioritisation process.
- As the Trust plans are finalised, these can be brought to this Committee for review and consideration – recognising that the Trust Finance Committees will have a key role in overseeing and supporting this process for the individual organisations.

9.1 REPORTS FROM TRUST AUDIT COMMITTEES - NEVILLE MANUEL, AMAN DALVI, NICK GASH, BALJIT UBHEY

To note the reports:
- The Hillingdon Hospitals NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- London North West University Healthcare NHS Trust

REFERENCES

Only PDFs are attached

9.1 BIC Audit & Risk Commitee Reports cover sheet.pdf

9.1a BiC Apr 24 THH ARC Chairs Report Feb 2024 FINAL.pdf

9.1b BIC NWL CWT Audit and Risk Committee Chair's Report March 24 - FINAL1.pdf

9.1c BIC ICHT ARC Chairs Report - BiC March 2024 (DAJHPJ).pdf

9.1d BIC ARC Chair's Report LNWH February FINAL.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 9.1
This report is: Public

Audit and Risk Committee Chairs' Report

Accountable director: Neville Manuel, Non-Executive Director and Audit Committee Chair - The Hillingdon Hospitals NHS Foundation Trust

Aman Dalvi, Non-Executive Director and Audit Committee Chair – Chelsea & Westminster NHS Foundation Trust

Nick Gash, Non-Executive Director and Audit Committee Chair – Imperial College Healthcare NHS Trust

Baljit Ubhey, Non-Executive Director and Audit Committee Chair – London North West University Healthcare NHS Trust

Purpose of report

Purpose: Information or for noting only

Report history

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

The Hillingdon Hospitals NHS Foundation Trust
Audit and Risk Committee
19 February 2024

London North West University Healthcare NHS Trust
Audit and Risk Committee
16 February 2024

Chelsea & Westminster NHS Foundation Trust
Audit and Risk Committee
28 March 2024

Imperial College Healthcare NHS Trust
Audit, Risk and Governance Committee
13 March 2024

Executive summary and key messages

Attached are the highlight report form the Audit and Risk Committee Meetings:-

- The Hillingdon Hospital NHS Foundation Trust (19 February 2024

- Chelsea & Westminster Hospital NHS Foundation Trust (28 March 2024)
- Imperial College Healthcare NHS Trust (13 March 2024)
- London North West University Healthcare NHS Trust (16 February 2024)

The Board in Common is asked to note the key findings in each of the reports and items escalated to the Board in Common from the individual Audit Committees.

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

North West London Acute Provider Collaborative
The Hillingdon Hospitals NHS Foundation Trust

Audit and Risk Committee (ARC) Chair's Highlight Report to the Board in Common

Date of Audit and Risk Committee: 19 February 2024

Highlight Report

1. Key Highlights

1.1 External Audit

1.1.1 The committee welcomed the new Trust External Auditors 'Azets' to their first Audit and Risk Committee at the Trust since their appointment. The committee received a verbal update from the External Auditors highlighting that planning work and engagement with the Trust was well underway and the team were currently at a draft plan stage. No new significant new risks have been identified at this stage differing from those previously identified.

1.1.2 The committee will receive the External Audit Plan and progress report at its next meeting.

1.2 Internal Audit

1.2.1 The Committee received five Internal Audit Progress reports. Of the two audits completed, the committee noted the rating, findings and recommendations as follows:

Name	Design rating	Effectiveness Rating
Planned and Reactive Maintenance	Moderate	Moderate
North West London acute provider collaborative governance	N/A	N/A

1.2.2 The committee noted Fieldwork is in progress for the following audits/reviews:

- Key financial systems – payroll
- Patient safety
- Cost improvement programmes (CIPs) delivery
- Equality, diversity and inclusion (EDI)
- Data quality (Cerner implementation).

1.2.3 As well as planning for the following review:

- Data security protection toolkit (final terms of reference issued) – fieldwork planned to commence on 1 March 2024.

1.2.3 The committee noted 14 recommendations were due for follow up in advance of this meeting:

- 5 are now complete: Data Security and Protection Toolkit (1 medium priority), Divisional Governance (1 medium priority) and Patient Discharge (3 medium priority)
- 9 are overdue: Accounts Receivable (2 medium priority), Data Security and Protection Toolkit (1 medium priority), Appraisals (1 high priority), Stock and Stores Management (4 medium priority) and Patient Discharge (1 Medium priority). The committee sought and received assurance from the executive that these recommendations will be closed by the revised timelines.

1.3.4 The Committee received the draft Internal Audit Plan for 2024/25 noting work ongoing to try and ensure alignment across the APC where possible. approved the Internal Audit Plan for 2024/25.

1.3 Counter Fraud Progress Report

1.3.1 The committee received and noted the Counter Fraud progress report covering activity between November – 10th November 2023. In this period the team has received two new referral and two cases have been closed. There are three open cases under active investigation by the Local Counter Fraud Service (LCFS) and a further two being led by another NHS body.

1.3.2 The committee noted ongoing proactive work being undertaken by the LCFS.

1.3.3 The committee received and noted the NHS CFA Benchmarking data:

- Whilst the number of cases opened and closed by the Trust appears lower than the national average, it is likely that these are distorted by cases being loaded onto the system which are non-criminal (i.e. loading all cases before an assessment is made of the likelihood of an offence being identified) resulting in low sanction averages per organisation.
- Trust costs are broadly in line with national averages for organisations with a similar headcount. The costs do not factor in High Cost Area Supplements.
- In relation closed cases, nationally, the most prevalent fraud type investigated was Working Whilst Sick, accounting for 350 of some 1,300 closed cases. Other prevalent types included Overtime/Time sheet (266) and Mandate fraud (88). There were a high number of unclassified or “other” types. The majority of the 1,300 closed cases did not result in any form of sanction with 128 delivered nationally.

1.4 Finance

The committee noted:

1.4.1 Review of losses and special payments: No write offs were requested in quarter 3 of 2023-24 (Oct to Dec 2023), nor the approval of any special payments.

1.4.2 Review of non-compliance with SFIs: Waiver usage, both from a value and volume perspective, has continued to fall during 2023-24 to date after a peak at the 2021-22 year end. In the last six months, waivers have only been used twice. Procurement record, track and report any non-compliance monthly to the finance team.

1.4.3 Debtors and creditors: The significant progress made in managing creditors has fallen from that last reported period, primarily due to cash constraints. The combination of a front-loaded (and internally funded) capital programme and the Trust's current revenue run rate has significantly increased the amount of non-pay spend going through Accounts Payable.

1.4.4 This has had a detrimental effect on the Better Payment Practice Code (BPPC) performance; the invoices paid within 30 days has reduced from 91% to 83% to a point where performance is a similar level to March 2023. We expect the cash position to have improved by year end following receipt of Public Dividend Capital to fund capital expenditure, as well as revenue support from the ICB. This will allow the team to clear the backlog and report stronger performance going into 2024-25.

1.4.5 Aged debtor balances have grown throughout the year to date, reflecting resource issues in the team. Finance has put in place some additional resource to manage the issues arising and return the Trust where it is chasing and collecting debts efficiently.

1.4.6 Aged debtor balances are £4.9m higher than the level at the last year end, and have increased steadily during the year, there was a sharp inrease in November of this year due to high value NHS SLA invoices being raised for Q1 – Q3. After increases during the current year, NHS organisations now account for 46% of aged debt, overseas visitors 40% and non-NHS organisations approximately 14%. The Trust still has high levels of bad and doubtful debt provision in place against all of these debts, particularly against overseas visitors' debt.

1.5 Grip and Control

The committee noted:

1.5.1 There has been good progress with the Grip and Control programme since the last update in September 2023, specifically within Procurement, including the new items previously reported.

1.5.3 Of the 59 main items, 26 are complete (22 in September 2023) and 33 are in progress. Of the 97 sub-items, 31 are complete (28 in September 2023) and 60 are in progress.

1.5.4 The Trust is taking and adpated approach to the new G&C checklist, which is being piloted by the Trust, as part of embedding the programme into business-as-usual.

1.5.5 Positive feedback was received by NHSE following the review of the G&C programme that was included in their assessment of the NOF 4 exit criteria.

1.6 Progress against External Audit Recommendations

1.6.1 The committee received and noted actions and progress to the external audit recommendations following the 2022/23 audit.

1.6.2 Good progress has been made in starting responses to the recommendations (the number of lines of enquiry not started has reduced from 31 to 3). Equally, these are flagged as not started because the related processes are expected to start later in the financial year (imminently in some cases).

1.6.3 However, a significant number are still in progress (31), and some are flagged as being behind the timescale expected for completion. Some key areas are shown as complete, such as capital expenditure controls and arrangements, as well as processes for mapping income and expenditure. Some additions to the team in financial services have reduced the level of risk around year end in that area.

1.6.4 The committee will continue to closely monitor progress ahead of the 2023/24 audit.

1.7 Timetable for the Annual Report and Accounts

1.7.1 The Committee noted that the draft accounts are required by 24 April 2024, with audited accounts and Annual Report due for submission by 28 June 2024.

1.8 Business Plan Quarter 3 Report

1.8.1 The committee received and noted the Business Plan progress report for quarter 3 2023/24.

1.9 Health and Safety Report

1.9.1 The committee received a summary of the work of the Health, Safety and Environment Committees (HSEC). The committee noted work progressing to implement a Health and Safety assurance dashboard, and received the outline assurance rating against a range of Health and Safety indicators which form the assurance dashboard. The HSEC is working on developing an action plan for hazardous substances, closing the sharps safety action plan and establishing a task a finish group to further develop the Trusts arrangements to reduce the risks to staff from work-related stress and musculoskeletal disorders.

1.9.2 The committee noted that the London Fire Brigade enforcement notice has now been removed from the public register and a 5-year program for fire improvement works is being implemented.

1.9.3 There were no escalations from the HSEC to the Audit and Risk Committee.

1.10 Board Assurance Framework

1.10.1 The committee received and noted the Board Assurance Framework and Corporate risks scoring 12 and above for quarter 3 2023/24.

1.11 Report from the Risk Management Group

1.11.1 The Committee received assurance and noted:

- The Trust's Risk Management KPIs.
- The Trust's Risk Management Training arrangements.
- A Summary of work undertaken by the Trust Risk Management Group.
- There were no risks escalated to the Audit and Risk Committee from the Risk Management Group.

2 Positive Assurances Received

2.1. The Internal Audit plan for 2023/24 is on track.

2.2 Good progress continues to be made in delivering the green and sustainability plan.

3 Key Risks to Escalate

None

4 Concerns Outstanding

None

5 Key Actions Commissioned

A regular Cyber assurance report to be presented to the committee.

6 Decisions Made

6.1 **Counter Fraud Policy –** The Committee approved the Trusts Counter Fraud Policy.

7 Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	External Audit Progress Update	Assurance	9.	Health and Safety Report	Assurance
2.	Internal Audit Reports	Assurance	10.	Board Assurance Framework	Assurance
3.	Counter Fraud Report	Assurance	11.	Report from the Risk Management Group	Assurance
4.	Finance Report	Assurance			
5.	Grip and Control	Assurance			
6.	Progress against External Audit Recommendations	Assurance			
7.	Timetable for the Annual Report and Accounts	Assurance			
8.	Business Plan Q3 Report	Approve			

3 Attendance

Members	February attendance
Neville Manuel – Chair	Y
Nick Gash – NED	Y
Patricia Gallan - NED	Y
Attendees	
Patricia Wright (CEO)	Y
Jon Bell (CFO)	Y
Gavin Newby (Deputy CFO)	Y
Jonathan Ware (Head if Financial Services)	Y
Janine Combrinck (Internal Audit)	Y
Paul Grady (External Audit)	Y
Azola Dudula (External Audit)	Y
Simon Lane (Counter Fraud)	Y
Nicole McGlaughlin (Counter Fraud)	Y
James Brind (Head of Health and Safety)	Y
Vikas Sharma (Trust Secretary)	Y

North West London Acute Provider Collaborative
Chelsea and Westminster NHS Foundation Trust - Audit and Risk Committee
Chair's Highlight Report to the Board in Common

Highlight Report of the meeting held on 28 March 2024

1.0 Purpose and Introduction

1.1 The purpose of this report is to update the Board in Common (BiC) about the meeting of the Trust's Audit and Risk Committee held on 28 March 2024.

2.0 Key Highlights

2.1 Local Counter Fraud Service (LCFS) Update

2.1.1 The Committee was updated on the draft annual *'Counter Fraud Functional Standard Return'* (CFFSR), noting that overall each element had been rated 'green' with the one exception of training which was rated 'amber given' uptake to the training and survey. RSM updated on a new methodology for awareness review and assessment, with an integrated survey and which is intended to be implemented in 2024/25. This should support a move to a green position.

2.1.2 The Committee was advised on the progress with 'Requirement 12' in relation to declarations of interest compliance, noting the significant improvement on the position when compared to the previous year, with no areas of concern raised. The focus for 2024/25 was to build upon the progress in 2023/24, to further increase compliance and usage of the online portal.

2.2 Internal Audit

2.2.1 The Committee heard about the positive progress in addressing internal audit recommendations, with an improved position since the last meeting. There were 17 recommendations due to be actioned in advance of the meeting, with eight completed and nine overdue, leading to an overall position of 73% complete, 3% not due and 24% overdue. While the scope for further improvement was acknowledged, the Committee welcomed the closing down of several long-standing actions.

2.2.2 The Committee was updated on the outcome of four internal audits, with final reports provided for: recruitment and retention, equality, diversity and inclusion (EDI), contract management and procurement, and North West London (NWL) Acute Provider Collaborative (APC) governance. Fieldwork is in progress for the following audits/reviews: facilities and estates management, patient communication, cultural maturity and the data security and protection toolkit.

2.2.3 In respect of EDI, which was an advisory report, the Committee was informed that the ratings were a mix of 3 and 4 (out of 5) scores, with the overall reflection that while the strategic direction and 'tone from the top' was strong, there was more required in terms of practical steps. BDO advised that the findings were in line with, and slightly ahead of, equivalent organisations.

2.3.4 With regard to the audit on contract management, the Committee noted that the report identified a number of issues to be addressed, many of which were known. The CFO

advised that procurement had accepted the recommendations, noting that gaps in documentation was an issue linked to the transfer to the new procurement service and that there was a recovery plan in place, with additional resource allocated. The recruitment and retention audit presented a positive picture overall, with some minor actions to address, including the exit interview/questionnaire process. The NWL governance audit had been seen at the Committee and board previously, however the point was made in terms of actions taken in response, that each organisation has governance in place to ensure they are held to account for what they do, noting the board plays an important role in protecting patients and staff.

2.4 External Audit

2.4.1 The Committee received a brief report, with nothing of concern to note. The planning for end of year was complete in preparation for the forthcoming process for annual accounts and report.

2.5 Risk and Board Assurance Frameworks

2.5.1 The Board Assurance Framework (BAF) was considered by the Committee, noting a largely stable picture in terms of the scores. One risk score had reduced - 'Growing for the Future', moving from 12 to 9, owing to a number of factors including the sustained reduction of the Trust's vacancy rate to 5.41% at the end of January 2024 and reduction in voluntary turnover.

2.5.2 The Risk Assurance Framework (RAF) was reviewed noting some updates to the policy and work underway to ensure teams provide updates and are more realistic in terms of the target scores set for end of year.

2.6 Cyber Security

2.6.1 A detailed update on this was provided noting the work underway to strengthen security with regard to medical devices and the establishment of multi-factor authentication for all Trust email account holders. The recent Board member training on cyber security was highlighted as positive, with a suggestion that this is repeated and conducted with more time allocated.

2.7 Information Governance (IG) Update

2.7.1 The Committee received a report on current performance against IG standards, noting the good rate of mandatory training compliance at 93%, for which there are plans to improve. Freedom of Information (FOI) compliance was improved on last quarter, with good progress with regard to Subject Access Request (SAR) compliance. While the backlog for SARs had now been addressed, the Committee advised that there must be a focus on improving the turnaround times. The Committee was assured of the plans in place and progress in relation to the Data Security and Protection Toolkit (DSPT) submission in June.

2.8 Annual report and accounts timetable

2.8.1 This was noted, with the Committee advised that plans were on track and no known issues at this point in terms of delivering the report and accounts in line with requirements. The Committee was advised that the Board would be asked to delegate authority for sign off of the report and accounts to this Committee in June.

2.9 Code of Governance self-assessment

2.9.1 The self-assessment was reviewed noting an overall high degree of compliance against the updated NHS England Provider Code of Governance. There were no areas of non-compliance and eight identified as 'partial' with clear actions at a Trust and collaborative level to fully demonstrate compliance.

2.10 Committee effectiveness review and terms of reference update

2.10.1 The Committee considered the results of the effectiveness survey, noting an overall positive degree of assurance with the Committee's work over the past year. Progress on EDI was acknowledged as work in progress and a finding common with that of other committees within the Trust and the APC – with this as a priority action for 2024/25. More generally, a discussion followed regarding the limitations of effectiveness surveys and how it would be useful to conduct a more thorough review to ensure the Committee is fulfilling its role as a key aspect of Trust governance with the broader oversight remit. It was suggested that this may, for example, be through reviewing whether auditors have picked anything up that the Committee should have been aware of. The minor updates to the terms of reference we approved by the Committee.

2.11 Policies for approval

2.11.1 The annual updates to the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) were considered and approved, noting these were in the main minor with an addition of strengthened wording on the process for engaging auditors for non-audit work and raising the threshold for single tender waivers (STWs) in line with fellow Trusts. Minor updates to the Losses and Special Payments policy were agreed, again reflecting new job titles and corrections since the previous review two years ago.

2.12 International Financial Reporting Standards (IFRS) Report

2.12.1 The report was noted, including the advice of the new standard (IFRS 17) coming into effect for the public sector in 2025/26 and not expected to have any material impact this coming financial year. The report also updated on IFRS16 in respect of PFI for which the impacts are not included in the Trust adjusted financial performance.

2.13 Losses and Special Payments

The report was noted, with the issue re private patients highlighted as one for attention.

2.14 Waiver of Standing Financial Instructions (SFIs)

The Committee noted the improved position in respect of SFIs.

3.0 Positive Assurances Received

3.1 The Committee received assurance on a range of matters as described above: the Trust self-assessments in countering fraud and against the code of governance; the planning for annual accounts and report; updated and robust policies and processes; positive progress for the Trust overall with regard to EDI (noting more to do) and recruitment and retention; improved FOI performance and DSPT submission readiness; and the general effectiveness of the Committee's performance over the past year.

4.0 Key Risks to Escalate

4.1 No specific risks to escalate.

5.0 Concerns Outstanding

5.1 None.

6.0 Key Actions Commissioned

6.1 Continued focus on improving the turnaround times for SARs.

7.0 Decisions Made

7.1 Approved the updates to the terms of reference, SFIs, SoD and the Losses and Special Payments Policy.

8.0 Summary Agenda

No.	Agenda Item	Purpose
1.	Noted- E governance approval for write-off of old debt (04/03/24)	Noting
2.	Counter Fraud Progress Report and Draft Annual Submission	
3.	Internal Audit (IA) • 2023/24 Progress Report • Internal Audit Reports	Noting
4.	External Audit Plan 2023/24 Progress Report	Noting
5.	Board Assurance Framework	Noting
6.	Risk Assurance Framework	Noting
7.	Cyber Security Report	Noting
8.	Information Governance Update	Noting
9.	Annual Report and Accounts Timetable	Noting
10.	Code of Governance Self-Assessment	Noting
11.	Review of Committee Effectiveness and Terms of Reference Update	Approval
12.	Policies for Approval- : SFIs, SoD, Losses and Special Payments Policy	Approval
13.	International Financial Reporting Standards (IFRS) Report	Noting
14.	Losses and Special Payments including Write Offs	Noting
15.	Waiver of SFIs	Noting
16.	Audit Committee Forward plan	Noting

9.0 2023 / 24 Attendance Matrix

Meeting held on 28 March 2024

	Attended	Apologies received
Members:		
Aman Dalvi, Non-executive director (NED) and Committee Chair	✓	
Catherine Jervis, NED		✓
Syed Mohinuddin, NED	✓	
Attended:		
Virginia Massaro, Chief Financial Officer - Chelwest	✓*	
Lesley Watts, Chief Executive Officer	✓	
Robert Bleasdale, Chief Nursing Officer	✓	
Peter Chapman Deputy Director of Finance	✓	
Peter Jenkinson, Director of Corporate Governance	✓	

Marie Price, Deputy Director Corporate Governance	✓	
Pushpak Nayak, Associate Director of IT Operations	✓	
Bishmah Rahman, BDO	✓	
Janine Combrinck, BDO	✓	
Shrey Choudhary, BDO	✓	
Shoaib Zahid, BDO	✓	
Matthew Wilson, RSM	✓	
Natalie Nelson, RSM		✓
Laura Rogers, Deloitte		✓
Craig Wisdom, Deloitte	✓	

*for majority of meeting

Chelsea and Westminster Hospital NHS Foundation Trust
The Hillingdon Hospitals NHS Foundation Trust
Imperial College Healthcare NHS Trust
London North West University Healthcare NHS Trust

North West London Acute Provider Collaborative
Imperial College Healthcare NHS Trust
Audit and Risk Committee Chair's Highlight Report to the Board in Common

Date of Audit and Risk Committee: 13th March 2024

Highlight Report

1. Key Highlights

1.1 External Audit

The Committee received an update on progress against the external audit plan and the recommendations from the 2022/23 audit, noting that the auditors had completed an interim audit visit in February 2024 and progress on the audit at this stage was significantly ahead of previous years. This provided a solid basis for delivering the final audit of the accounts more smoothly in April – June 2024.

The Committee received and approved the proposed fee for the audit of the 2023/24 accounts.

1.2 Accounting Treatments

The Committee received the report outlining the approach to a number of significant accounting treatments which would be applied to the 2023/24 financial accounts, noting this was relatively consistent to the previous years. The Committee also noted two additional reports providing details on areas of the audit identified as significant risks; land and building property valuation, and existence of assets.

1.3 Annual accounts/report approach and timetable

The Committee received the report setting out the approach being taken to develop the annual report and accounts for 2023/24 and the timescales for approval, noting that the draft accounts deadline for NHS bodies is 24 April 2024. The deadline for submission of the final accounts to NHS England is noon on Friday 28 June 2024.

1.4 Draft internal audit risk assessment and plan 2024-25

The Committee received and approved the draft internal audit plan for 2024/25 noting that one of the first reviews would focus on the Fit and Proper Person Test (FPPT) requirements which had potential links across the Acute Provider Collaborative (APC). The remaining reviews were derived from reflections on previous work, and had been linked to the Trust strategic goals.

1.5 Counter fraud progress report and draft plan 2024/25

The Committee received the local counter fraud progress report outlining progress against the 2023/24 annual plan, noting that the proactive work for the year was now complete. The Committee also received and approved the proposed schedule for delivering the 2024/25 counter fraud plan

1.6 Management response to Acute Provider Collaborative: Governance internal audit

The Committee noted progress made against the recommendations from the collaborative governance internal audit which included the development of a collaborative strategy and work to improve local Board engagement and oversight.

1.7 Review of financial governance documents: Standing Financial Instructions, Standing Orders, Scheme of Delegated Financial Authority & Scheme of Reserved & Delegated Powers
The Committee reviewed and approved the updated governance documents made up of the Standing Financial Instructions, Standing Orders, Scheme of Delegated Financial Authorities and Scheme of Reserved and Delegated Powers.

1.8 Risk and Assurance Report including Board Assurance Framework (BAF)
The Committee received the report providing an update on the corporate risk register, the corporate risk profile and board assurance framework process and noted that the Executive Risk Committee (EMB Risk) had reviewed and discussed the Board Assurance Framework in detail by strategic goal at the January and February meetings. The Committee noted the summary page of the Board Assurance Framework highlighting the risk area, risk description, current risk score, the executive lead and lead board committee. Next steps would be to develop a risk per page outlining the full risk and mechanisms in place for managing those risks, and further updates would be provided at the committees in May 2024. The Committee were pleased with the proposed approach and approved the risks allocated to this committee.

1.9 Cyber Security Dashboard – To include update on business continuity cyber exercise and IT Disaster Recovery
The Committee received the report outlining the core activities currently being undertaken to manage cyber risks, which were predominately focused on infrastructure and application remediation. The report also detailed the cyber security dashboards, in addition to updates on upcoming initiatives. It was highlighted that the Trust continued to rank in the lower risk category for workstations and medium risk for Server estate.

1.10 Update on the finance systems strategy – Outline Business Case for North West London finance systems & transactional services consolidation
The Committee were updated on the progress of the proposed North West London (NWL) project to procure a joint finance system.

1.11 Losses and Compensation report (Quarter 3)
The Committee noted the report outlining losses and special payments approved throughout Quarter 3 of the 2023/24 financial year.

1.12 Tender Waiver Report (June – Nov)
The Committee noted the report setting out the number and value of tender waivers authorised during Quarter 3 of the financial year 2023/2024.

2. Positive Assurances Received

2.1 Internal audit progress report
The Committee received the internal audit progress report, and noted that the harm review process, risk management (BAF), acute provider collaborative governance review and temporary staffing audits had been finalised. All of the reviews had received a rating of significant assurance with minor improvement opportunities.

2.2 Code of Governance and Fit and Proper Persons
The Committee received an update against our Code of Governance self-assessment and the revised Fit and Proper Persons requirements, noting that the deadline for submission

had been extended to September 2024, however the Trust were on track to meet the initial timeline of the end of March 2024.

2.3 FIOC Committee Annual report

The Committee received the annual report from the Finance, Investment & Operations Committee which provided assurance on the effectiveness of the committee and to escalate any key risks. It was noted that the committee regularly received and reviewed reports in relation to the Trusts performance against agreed corporate and divisional budgets, cost improvement plans and the capital programme. A number of risk and assurance deep dives had been undertaken into business planning for 2023/24 and the committee had considered various business cases for major investment throughout the year prior to approval at Trust board; these included the Hard FM contract, the contract for the managed service provision for the cardiac catheterisation laboratories, the extension of the patient transport contract and the financial aspects of the strategic outline case for Charing Cross and Hammersmith Hospitals. The Committee also received regular summaries of business cases that had been approved by the Executive. Committee member noted that these meetings were supplemented by regular touchpoints between the Chair, Chief Finance Officer, and Chief Operations Officer to ensure that any issues or challenges that may arise are dealt with appropriately.

2.4 Emergency Preparedness Resilience & Response Annual report

The Committee received the report providing an overview of the Emergency Preparedness, Resilience and Response (EPRR) activities and incidents from February 2023 to January 2024, and an update on the NHS England EPRR Assurance outcome and Trust action plan associated with EPRR for the current year. The Committee noted that there had been a number of table top exercises over the previous year, and were assured that the Trust continues to progress following a robust training and exercising programme, continuous learning from incidents and ongoing partnership working with multi-agency colleagues.

3. Key Risks to Escalate

None

4. Concerns Outstanding

None

5. Key Actions Commissioned

None

6. Decisions Made

None

7. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	External Audit Report			To note	11.	Code of Governance and Fit and Proper Persons			To note
2.	Accounting Treatments			To note	12.	FIOC Committee Annual report / Deep Dive			Assurance
3.	Annual accounts/report approach and timetable			Approval	13.	Emergency Preparedness Resilience & Response Annual report			Assurance

4.	Internal audit progress report including final internal reports			To note	**14.**	Cyber Security Dashboard – To include update on business continuity cyber exercise and IT Disaster Recovery			Assurance
5.	Counter fraud progress report			To note	**15.**	Update on the finance systems strategy – Outline Business Case for North West London finance systems & transactional services consolidation			To note
6.	Draft Internal audit risk assessment and plan 2024-25			Approval	**16.**	Losses and Compensation report			To note
7.	Draft Counter Fraud plan 2024-25			Approval	**13.**	Tender Waiver Report			To note
8.	Management response to Acute Provider Collaborative: Governance internal audit			Assurance					
9.	Review of financial governance documents: Standing Financial Instructions, Standing Orders, Scheme of Delegated Financial Authority & Scheme of Reserved & Delegated Powers			Approval	**15.**				
10.	Risk and Assurance Report including Board Assurance Framework			To note	**16.**				

8. Attendance

Members:	March Attendance
Nick Gash, Chair (ICHT)	Y
Bob Alexander, Non-executive Director (ICHT)	Y
Linda Burke, Non-executive director (THHFT)	Y
Loy Lobo, Non-executive director (LNWT)	Y
Tim Orchard, Chief executive (ICHT)	Y
Julian Redhead, Medical director (ICHT)	N
Jazz Thind, Chief Finance Officer (ICHT)	Y
Janice Sigsworth, Chief Nurse (ICHT)	N

North West London Acute Provider Collaborative
London North West University Healthcare NHS Trust
Audit and Risk Committee Chair's Highlight Report to the Board in Common
Date of Audit and Risk Committee: 16 February 2024

Highlight Report

1. Key Highlights

Audit

Internal Audit Report

1.1 Two audits were completed: NWL APC governance review and Equality, Diversity and Inclusion Maturity Assessment. The Mental Health Act Compliance and the Deprivation of Liberty Safeguards audits have been drafted and management responses have been sought.

1.2 The Committee received assurance that the 2023/24 internal audit plan will be delivered on time.

1.3 Overdue recommendations relate to the Key Financial Systems – Inventory audit and the Procurement team. The Procurement team will attend the next meeting to formally report on the reasons for the delay.

External Audit Report

1.4 The Committee received the strategy and audit plan for the year ending 31 March 2024. Key changes relate to the impact of changes in the block/activity revenue contracts and money in the system, and the IFRS 16 application to PFIs. The national deadline for the submission of the audited accounts is 28 June 2024.

External Audit Recommendations Tracker

1.5 The Committee received a tracker detailing the progress being made on the ISA260 recommendations. Of the total outstanding recommendations, eleven have been implemented and seven are in progress.

Counter Fraud Report

1.6 The Committee received a summary of work that has taken place since the last meeting. The Counter Fraud Authority have advised all Trusts to participate in their procurement exercise, which will review due diligence and contract management for recently signed contracts.

Risk

Board Assurance Framework

1.7 The Committee received the refreshed Board Assurance Framework following a review of the principal risks by members of the Board. A number of new principal risks largely related

to staffing have been identified and the risks will be presented to Board Committees for further scrutiny and discussion.

Risk Report

1.8 Two new risks relating to Emergency and Ambulatory Care and the fire evacuation plan were accepted onto the register. The Risk and Compliance Group have scrutinised the risks and are satisfied that there are good controls and contingency arrangements in place to manage the situation.

Governance

Policy Tracker

1.9 The Committee noted the continued increase in reporting on in-date policies. 89% of policies are reported to now be in date and meetings continue with Executive colleagues to meet 95% compliance by the end of March.

Board Committee Effectiveness Reviews

1.10 The board committee effectiveness review process has commenced, and surveys have been issued to all members and regular attendees across all four trusts of the NWL APC. The results will be reported to each committee in March/April and a full report will be presented to the Audit and Risk Committee.

Debt Write Offs

1.11 The team undertook a review of overseas visitor debt, salary overpayment debt and other non-NHS debts. It was recommended to the Chief Financial Officer and Chief Executive Officer the write-off of 831 debts with an aggregate value of £2.6m for which collection options have been exhausted. Overseas visitor debt accounts for approximately £2.551m of the total.

Single Tender Waiver Report

1.12 The Committee received the report noting that five tender waivers have been processed. A new single tender waiver process form has been agreed and will be implemented from 2024/25.

Lands and Buildings Valuation

1.13 The Committee noted the requirement for the desktop valuation, the assumptions for the valuation and the potential impact on the Trust's 2023/24 accounts.

2 Positive Assurances Received

Equality, Diversity and Inclusion Maturity Assessment

2.1 BDO's EDI Specialists worked through the EDI Maturity Assessment tool and scored the Trust Mature (Level 4) in the Tone from the Top domain and Defined (Level 3) in four domains: Governance, Compliance and Strategy; Structure; Policies, Procedures, Training and Development; and Measurement, Accountability and Continuous Improvement. The team acknowledged the good work arising from the refreshed Trust strategy, collaborative working and the MWRES and WRES reviews. For the Trust to progress to the next level, there is a requirement for the strong intent to be converted to actual impact.

Emergency Preparedness, Resilience and Response (EPRR) Assurance Report

2.2 Following the submission to NHS England in August 2023 and the peer assessment in October 2023, the Trust received 62/62 green ratings for the core standards and 10/10

green ratings for the deep dive assessment of the Trust's EPRR Training preparedness. Overall, the Trust was assessed as fully compliant with arrangements for 2023/2024.

Policy Tracker

2.3 Since the last report, there has been an increase from 83% to 89% of policies that are in date. Plans to ratify the remaining out of date policies are in progress.

Better Payments Practice Code

2.4 The cumulative performance of the Trust for the first 10 months of the year remains at 95% for payment of non-NHS invoices and 91% for NHS invoices.

3 Key Risks to Escalate

3.1 None

4 Concerns Outstanding

4.1 None

5 Key Actions Commissioned

Equality, Diversity and Inclusion Maturity Assessment

5.1 The Committee agreed that the local People Committee should have oversight of the action plans arising from the report to monitor progress and implementation.

2024/25 Internal Audit Annual Plan

5.2 The internal auditors will explore whether there is opportunity to align areas of the proposed internal audit plan across the NWL APC.

Board Committee Effectiveness Reviews

5.3 Committee Chairs will be invited to present the results of their reviews to the Audit and Risk Committee on a rotational basis through the year, and to discuss any other matter of internal controls.

6 Decisions Made

Going Concern Assumption

6.1 The Committee agreed the going concern assessment and the preparation of the Trust's financial statements for the year ended 31st March 2024 on the basis of the going concern assumption.

7 Summary Agenda

16 February 2024

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Cancer Data Set recommendations – Progress Report	Assurance	10.	Emergency Preparedness, Resilience and Response (EPRR) Assurance Report	Assurance
2.	Internal Audit Report	Assurance	11.	Better Payment Practice Code Performance	Assurance

3.	External Audit Report	Assurance	12.	Debt Write-Offs	Assurance
4.	ISA260 Recommendations – update on implementation	Assurance	13.	Single Tender Waivers Report	Assurance
5.	Counter Fraud Report	Assurance	14.	Losses and Compensation Report	Assurance
6.	Board Assurance Framework	Assurance	15.	Review of Accounting Policies and Assumptions	Assurance
7.	Risk Report	Assurance	16.	Going Concern Assumption	Assurance
8.	Policy Tracker	Assurance	17.	Land and Buildings Valuation	Assurance
9.	Board Committee Effectiveness Annual Reviews	Assurance	18.	Summary Year End Accounts Timetable	Assurance

8. Attendance

Members:	February attendance
Baljit Ubhey, NED (Chair)	Y
Bob Alexander, NED	Y
Ajay Mehta, NED	Y
Attendees	
Pippa Nightingale, Chief Executive Officer	Y
Jonathan Reid, Chief Financial Officer	Y
Jon Baker, Chief Medical Officer	Y
James Walters, Chief Operating Officer	Y
Dawn Clift, Director of Corporate Affairs	Y
Dominic Sharp, Associate Director of Finance – Financial Control	Y
Colin McDonnell, Head of Emergency Preparedness, Resilience and Response	Y
Fleur Nieboer, External Audit Partner (KPMG)	Y
Rachit Babbar, External Audit Manager (KPMG)	Y
Janine Combrink, Internal Audit Director (BDO)	Y
Shrey Choudhary, Internal Audit Assistant Manager (BDO)	Y
James Shortall, Counter Fraud Manager (BDO)	Y
Nikki Walcott, Acting Head of Corporate Governance	Y

9.2 REVISING THE ACUTE PROVIDER COLLABORATIVE GOVERNANCE ARRANGEMENTS - PETER JENKINSON

REFERENCES

Only PDFs are attached

9.2 BiC - April 2024 - revising the APC governance arrangements v2.0.pdf

NWL Acute Provider Collaborative Board in Common
16/04/2024
Item number: 9.2
This report is: Public

Revising the Acute Provider Collaborative Governance Arrangements

Author:
Job title: Peter Jenkinson, Director of Corporate Governance

Accountable director:
Job title: Matthew Swindells, Chair

Purpose of report

Purpose: Decision or approval

The purpose of this paper is to propose amendment to the Scheme of Delegated Authority for the four Trusts within the North West London Acute Provider Collaborative, to strengthen the level of Trust-level engagement and oversight.

The paper also outlines additional work to follow, to mitigate any impact on the capacity for board members to accommodate additional meetings and to maximise the effectiveness of the Collaborative governance arrangements.

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 purpose of this paper is to propose amendment to the Scheme of Delegated Authority for the four Trusts within the North West London Acute Provider Collaborative (the 'Collaborative'), to strengthen the level of Trust-level engagement and oversight.

The paper also outlines additional work to follow, to mitigate any impact on the capacity for board members to accommodate additional meetings and to maximise the effectiveness of the Collaborative governance arrangements by clarifying the relationship between Board and

Collaborative committees.

The internal audit review of the collaborative governance arrangements, completed in November 2022, concluded that the governance model for the Collaborative is operating appropriately overall to enable the individual Trust Boards to fulfil their required duties, but highlighted some areas for improvement to the existing model. Recommendations included further development of the model to strengthen the level of local engagement and oversight, and to ensure individual Trust issues are discussed adequately.

Board development sessions run by each Trust during February have reinforced the need to strengthen this level of the Collaborative governance arrangements, to ensure we develop effective unitary boards of each Trust with sufficient Trust-level engagement and oversight.

We are currently developing the APC strategy. As part of that work, we will need to define and agree the vision for organisational structure for the Collaborative. Unless there is a change to the overall governance arrangements for the four Trusts, the four Trust Boards remain the core governance mechanisms for each Trust, responsible for setting strategy and delivery of statutory and regulatory requirements. As a Collaborative, the four boards work together to deliver common strategic priorities where those priorities add common value. However, each Trust Board remains responsible for the delivery of their respective trust duties.

Therefore we need to ensure that each Trust develops and retains an effective unitary board, responsible for delivery of statutory and regulatory requirements at a Trust level, while not making any changes that compromise the core principle of the Collaborative – four Boards meeting together as a Board in Common and working together on areas of common interest that provide value to the Collaborative.

CEOs and Vice Chairs have considered a number of options to strengthen the existing governance arrangements at local Trust level, including establishing separate trust board meetings, extending the remit of audit committees and merging board committees. The preferred option has also been discussed with non-executive and executive directors.

The proposal, for approval by each of the four Trust Boards, is to remove the existing NED triangulation meetings and for each Trust Board delegate authority for the establishment of a Standing Committee of the Trust Board. While it will be for each Trust Board to approve the terms of reference for their respective Standing Committee, there are some common standards to be applied across all four that ensure triangulation of assurance across Board-level committees, and assurance that local issues are being addressed. Each Standing Committee will report to the Trust Board, meeting as part of the Board in Common.

Without other changes to the Collaborative governance model, these additional meetings will add to the existing time commitment of board members, non-executive and executive. It is therefore proposed that other meetings are also reviewed, to ensure the overall governance model remains effective – that board committees provide assurance regarding delivery of Trust priorities and Collaborative committees add value to that by overseeing delivery of collaborative priorities – and that board members have the capacity to discharge their duties appropriately. We will therefore review terms of reference, including frequency and purpose, of board and collaborative level committees, as well as removing where possible ‘informal’ meetings that are no longer required.

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

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

Click to describe impact

Main report

1.0 Background

1.1 At the last meeting of the Board in Common, in January 2024, the Trust Boards received the findings and recommendations from the internal audit review of the governance arrangements for the Acute Provider Collaborative (the Collaborative).

1.2 The internal audit review of the collaborative governance arrangements, completed in November 2022, concluded that the governance model for the Collaborative is operating appropriately overall to enable the individual Trust Boards to fulfil their required duties. However, they highlighted some areas for improvement to the existing model. Findings and recommendations included further development of the model to strengthen the level of local engagement and oversight, and to ensure individual Trust issues are discussed adequately.

1.3 Findings and recommendations relating to the Trust level governance included:

- 'Given the importance of knowing each other and engendering trust within local Trust Boards, we encourage the Trusts to consider ways in which each Trust Board may be periodically brought together in full'.

- Since the move to Board in Common meetings under the approved governance model for the collaborative, local Trust Boards no longer meet together in full to discuss only Trust-specific matters. This is also not achieved through the sub-committees as they do not include all Trust Board members. If this matter is not addressed there is a risk that local relationships will deteriorate at the expense of the collaborative working, impacting both the overall strength of the unitary Trust Boards and their ability to support collaborative working.
- Given the importance of knowing each other and engendering trust within local Trust Boards, we encourage the Trusts to consider ways in which each Trust Board may be periodically brought together in full.

1.4 Recommendations were also made regarding the capacity of board members to discharge their duties and the effectiveness of the current meeting structure, including 'informal' meetings:

- The structure as it stands already needs to be streamlined (covered by our audit points 4 and 5 below) and consideration may want to be given to removing some of the Trust Board Cabinet meetings, triangulation meetings and informal dialogue sessions.
- We have also noted that there is a high level of duplication of reporting between the local Committees, collaborative committees and the Board in Common. There is an incorrect perception by some that the local Committees report into the collaborative committees which report into the Board in Common. The collaborative committees should focus on the collaborative matters and the local Committees should have a direct line of reporting into the Trust Board where necessary.

1.5 We currently have various mitigations in place to address the risk of local Trust Board engagement and oversight, including NED Triangulation meetings, the re-launch of board member visit programmes in each Trust and Trust Board development sessions run in February 2024. However, we recognise the need to strengthen the existing mitigations.

1.6 As part of the development of the Collaborative strategy, we will need to review the governance structure required to oversee the delivery of the strategy, including the purpose of the collaborative-level committees. We also need to identify ways to streamline the meeting structure to minimise the time commitment of executive and non-executive Board members.

1.7 However it is important that we address the risk of Trust-level governance in the short-term, while we develop the strategy and any longer-term changes to the governance model.

2.0 Proposal

2.1 Unless there is a change to the overall governance arrangements for the four Trusts, the four Trust Boards remain the core governance mechanisms for each Trust, responsible for setting strategy and delivery of statutory and regulatory requirements. As a Collaborative, the four boards work together to deliver common strategic priorities where those priorities add common value. However, each Trust Board remains responsible for the delivery of their respective trust duties.

2.2 Therefore we need to ensure that each Trust develops and retains an effective unitary board, responsible for delivery of statutory and regulatory requirements at a Trust level, while not making any changes that compromise the core principle of the Collaborative – four Boards meeting together as a Board in Common and working together on areas of common interest that provide value to the Collaborative.

2.3 CEOs and Vice Chairs have considered a number of options to strengthen the existing governance arrangements at local Trust level, including establishing separate trust board meetings, extending the remit of audit committees and merging board committees. The preferred option has also been discussed with non-executive and executive directors.

Proposed change

2.4 The proposal, for approval by each of the four Trust Boards, is to remove the existing NED triangulation meetings and for each Trust Board delegate authority for the establishment of a Standing Committee of the Trust Board.

2.5 The Standing Committee will provide an opportunity for each Trust Board to consider Trust performance, issues and risks, and receive assurance from executive directors, across all domains, and to provide assurance to the Trust Board, meeting in public as part of the Board in Common, that local issues and risks are being managed. It will provide a formal, structured meeting to receive reports from the Board committees (via chairs' reports) and to triangulate across the various domains, to provide an integrated view of performance and risk across the Trust. Decision-making will remain the remit of the Trust Board, in the Board in Common meeting, although Trust Boards may agree to delegate authority to their respective Standing Committee to approve Trust-level business cases.

2.6 While it will be for each Trust Board to approve the terms of reference for their respective Standing Committee, there are some common standards to be applied across all four that ensure triangulation of assurance across Board-level committees, and provide assurance that local issues are being addressed:

- Membership will include voting NEDs and Exec directors of that Board. Meetings may be chaired by the Chair or Vice Chair.
- Papers for meetings, including agendas and minutes, will be published.
- Meetings should be face to face where possible.
- Standing items should include:
    - CEO report
    - Integrated performance and quality report
    - Summary reports from Board-level committees
- Each Trust standing committee will provide a written summary report to the Board in Common, providing Trust Board with the assurance regarding local action
- Frequency will be at least quarterly, one of which can form part of the Trust Annual General Meeting. Standing Committee meetings may include 'deep dive' sessions into any areas of strategic priorities, to replace the need for Trust Board development sessions.
- Trusts may wish to also consider the alignment and frequency of board level committees, to align with a quarterly reporting cycle and reduce time commitment further.

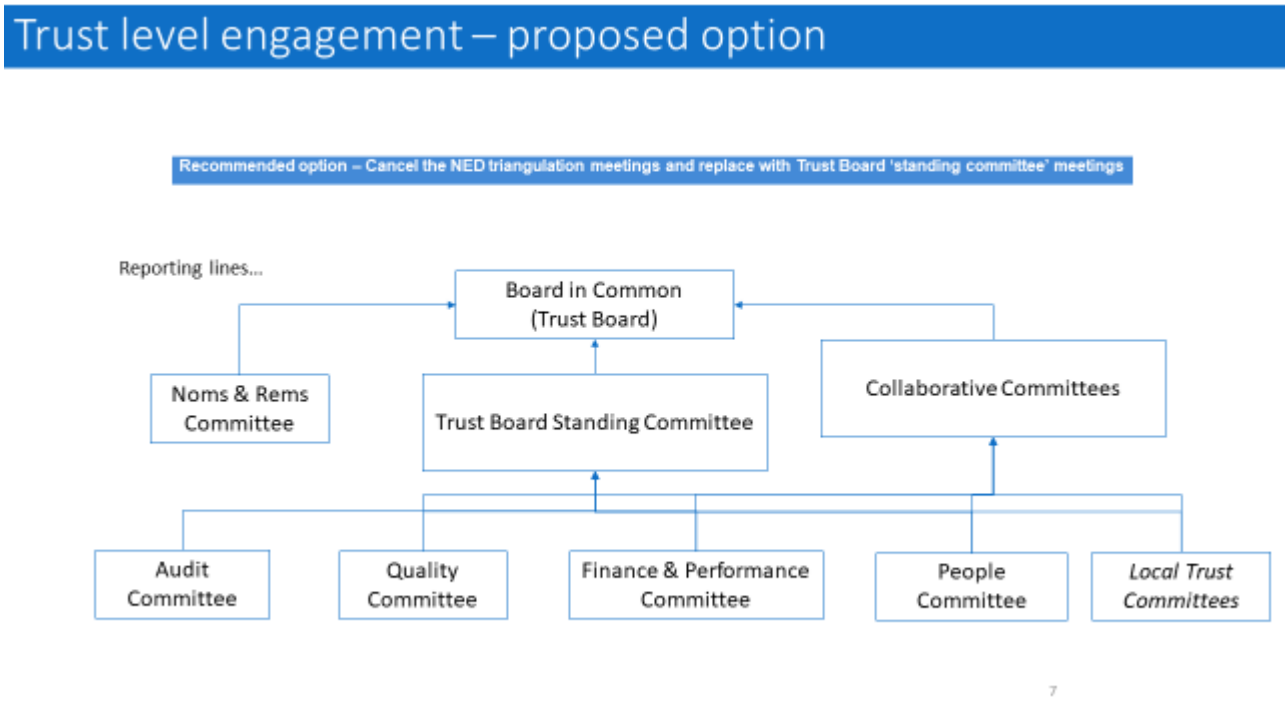


Figure 1 – reporting lines for Trust Standing Committees

Evaluation

2.7 Regular meetings of a Trust Board standing committee will support the development of the unitary boards for each Trust, while not compromising the principles of the Board in Common. Having a single meeting that brings together the key trust level issues following the Board committee meetings, will allow all Board members to understand Trust level performance and key issues / assurances, without needing to attend individual Board committee meetings, and will allow local issues to be discussed by Board members before the Board in Common meeting.

2.8 This arrangement will create a direct reporting line between board committees and the Board, rather than via the Collaborative committees (Board committees report to Trust Standing Committee and Standing Committee reports to Trust Board), supporting existing scheme of delegated authority and accountability. NEDs will be able to discharge their duties to the Boards they are members of, in shaping the Trust strategy, holding the executive to account for delivery of strategy, and assuring that risks are managed effectively.

2.9 This preferred option does not change public transparency at Trust level. While there is no evidence that this is a significant risk currently, it would be mitigated by publication of papers for each of the Trust Standing Committees on Trust websites and formal reporting from standing committees to the Trust Board, which meets in public.

Other changes – addressing capacity and effectiveness risks

2.10 The internal auditors also made recommendations regarding the streamlining and effectiveness of the wider governance model, recommending that the meeting structure needs to be streamlined and consideration given to removing some of the existing meetings such as Board in Common Cabinet meetings, triangulation meetings and informal dialogue sessions. They also identified duplication of reporting between the local Committees, collaborative committees and the Board in Common. They recommended a review of the purpose and reporting lines between Trust Board

committees and collaborative committees so that collaborative committees focus on the collaborative matters and the local committees have a direct line of reporting into the Trust Board where necessary.

2.10 Without other changes to the Collaborative governance model, it is clear that these additional Standing Committee meetings will add to the existing time commitment of board members, both non-executive and executive.

2.11 It is therefore proposed that other meetings are also reviewed, to ensure the overall governance model remains effective – that board committees provide assurance regarding delivery of Trust priorities and Collaborative committees add value to that by overseeing delivery of collaborative priorities – and that board members have the capacity to discharge their duties appropriately. We will therefore review the terms of reference, including frequency and purpose, of board and collaborative level committees, as well as removing where possible 'informal' meetings that are no longer required. This can be done in conjunction with the development of the Collaborative strategy.

3.0 Conclusion

3.1 In response to findings and recommendations in the internal audit review of the Collaborative governance arrangements, various options have been considered to strengthen the Trust level oversight and engagement without compromising the core principles of the governance model – four Trust Boards meeting together and benefitting from agreeing and delivering common priorities where these add value.

3.2 That option appraisal has identified a preferred option – to cancel the existing NED triangulation meetings and to establish Standing Committees of the Trust Boards, with delegated authority from each Trust Board to meet as a committee of the Board.

3.3 Standing Committees will allow all members of a Trust Board to understand Trust level performance and key issues / assurances, without needing to attend all Board committee meetings, and will allow local issues to be discussed by Board members, with assurance being provided to the Trust Board, meeting in public as part of the Board in Common meeting.

4.0 Recommendations

4.1 Trust Boards are asked to:

- Approve the delegated authority to establish Standing Committees of the Trust Board, with detailed terms of reference to be agreed by each Standing Committee / Trust Board.
- Agree to further review other aspects of the Collaborative governance structure and amend as appropriate, to clarify the relationship between Board and Collaborative committees, strengthen and streamline the focus on forward thinking at collaborative level and assurance at local Trust level, and mitigate any risks regarding capacity of board members.

9.3 DELEGATED AUTHORITIES TO PROVIDER TRUST COMMITTEES - PETER JENKINSON

REFERENCES

Only PDFs are attached

9.3 BIC Delegated authorities BiC April 24.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 9.3
This report is: Public

Delegated Authorities to provider Trust Committees

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

Accountable directors: Peter Jenkinson, Director of Corporate Governance (ICHT & CWFT)
Dawn Clift, Director of Corporate Affairs (LNWH)

Purpose of report

Purpose: Decision or approval

This paper seeks approval of the proposed delegated authorities from the respective Trust Boards to the local Board Committees as per the schedule within the report.

Schedule 1: The Board of Chelsea and Westminster Hospital NHS Foundation Trust is asked to approve.
Schedule 2: The Board of Imperial College Healthcare NHS Trust is asked to approve.
Schedule 3: The Board of London North West University Healthcare NHS Trust is asked to approve.
Schedule 4: The Board of The Hillingdon Hospitals NHS Foundation Trust is asked to approve.

Report history

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

N/A 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

Ahead of the establishment of the NWL Acute Provider Collaborative in September 2022, it was agreed that the following items would be reserved for local Trust Board approval ahead of submissions/publication as required as part of the NHS year end process:

- Annual report and accounts
- Quality Account
- Self-certifications for Non Foundation Trusts
- Self-certifications for Foundation Trusts
- Modern Slavery Act Statement

We are now seeking to delegate sign off of these reports to the relevant Trust Quality or Audit and Risk Committee as laid out in the schedules below.

This request for delegation is consistent with the process undertaken in recent years (prior to the establishment of the NWL Acute Provider Collaborative) by the respective Trust Boards, where delegated authority was supported by the Trust Boards. The expectation of delegation has been discussed at the recent meetings of the relevant Board Committees.

Schedule 1: The Board of Chelsea and Westminster Hospital NHS Foundation Trust is asked to approve the following delegations:

Item	Board Committee	Submission	By when
Audited Annual Report and Accounts 2023/24 Quality Account 2023/24	Audit & Risk Committee Quality & Safety Committee	NHS England Publication to Trust website	28 June 2024
Self-certification: General Condition 6 (GC6) & Continuity of services condition (CoS7) of the NHS Provider License	Audit & Risk Committee	Publication to Trust website	31 May 2024
Self-certification: Condition 4 Corporate Governance Statement	Audit & Risk Committee	Publication to Trust website	28 June 2024
Modern Slavery Act Statement	Audit & Risk Committee	Publication to Trust website	31 May 2024

<u>Schedule 2:</u> The Board of Imperial College Healthcare NHS Trust is asked to approve the following delegations

Item	Board Committee	Submission	By when
Audited Annual Report and Accounts 2023/24 Quality Account 2023/24	Audit Committee Quality Committee	NHS England Publication to Trust website	28 June 2024
Self-certification: General Condition 6 (GC6) of the NHS Provider License	Audit Committee	Publication to Trust website	31 May 2024
Self-certification: Condition 4 Corporate Governance Statement	Audit Committee	Publication to Trust website	28 June 2024
Modern Slavery Act Statement	Audit Committee	Publication to Trust website	31 May 2024

<u>Schedule 3:</u> The Board of London North West University Hospitals NHS Trust is asked to approve the following delegations

Item	Board Committee	Submission	By when
Audited Annual Report and Accounts 2023/24 Quality Account 2023/24	Audit & Risk Committee Quality & Safety Committee	NHS England Publication to Trust website	28 June 2024
Self-certification: General Condition 6 (GC6) of the NHS Provider License	Audit & Risk Committee	Publication to Trust website	31 May 2024
Self-certification: Condition 4 Corporate Governance Statement	Audit & Risk Committee	Publication to Trust website	28 June 2024
Modern Slavery Act Statement	Audit & Risk Committee	Publication to Trust website	31 May 2024

Schedule 4: The Board of The Hillingdon Hospitals NHS Foundation Trust is asked to approve the following delegations

Item	Board Committee	Submission	By when
Audited Annual Report and Accounts 2023/24 Quality Account 2023/24	Audit & Risk Committee Quality & Safety Committee	NHS England Publication to Trust website	28 June 2024
Self-certification: General Condition 6 (GC6) & Continuity of services condition (CoS7) of the NHS Provider License	Audit & Risk Committee	Publication to Trust website	31 May 2024
Self-certification: Condition 4 Corporate Governance Statement	Audit & Risk Committee	Publication to Trust website	28 June 2024
Modern Slavery Act Statement	Audit & Risk Committee	Publication to Trust website	31 May 2024

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

10.1 EXECUTIVE MANAGEMENT BOARD (EMB) SUMMARY - TIM ORCHARD

REFERENCES

Only PDFs are attached

10.1 BIC APC EMB Chairs cover sheet.pdf

10.1a BIC APC EMB Chair's Report - April 2024 v03.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 10.1
This report is: Public

Executive Management Board (EMB) Summary

Author: Iona Twaddell
Job title: Senior Advisor to the CEO (ICHT)

Accountable director: Prof Tim Orchard
Job title: CEO (CHT) and Chair of EMB

Purpose of report

Purpose: Assurance

The Board in Common is requested to receive assurance from the North West London Acute Provider Collaborative Executive Management Board

Report history

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

N/A

Executive summary and key messages

The role of the North West London Provider Collaborative Executive Management Board is:

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

Key discussion items are summarised.

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

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

April 2024

Highlight Report

1. Purpose and Introduction

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

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

2. Key highlights

The APC EMB met on 5 February 2024 and 7 March 2024. Key discussion items are summarised below.

2.1. Performance reporting

2.1.1. At each meeting, the APC EMB reviewed quality, workforce, operational and finance performance across the Trusts, receiving assurance on outliers and activity ongoing to address variation. The latest version of the performance report is presented at this meeting.

2.2. Business planning

2.2.1. The APC EMB discussed the 2024/25 business planning process and the need to understand productivity. This has been discussed at the Board in Common development session and an update is presented at this meeting.

2.3. APC Strategy

2.3.1. The APC EMB discussed the APC strategy development, approving the suggested diagnostic of key issues developed through research and engagement. The APC EMB also supported and gave advice on the engagement approach for the next few months to develop the response and action plan for the strategy. This has been discussed at the Board in Common development session.

2.4. Updates and assurance on collaborative projects

2.4.1. The APC EMB receives monthly updates on progress in developing and

implementing the Collaborative business plan and strategic priorities. These include the projects within the quality, workforce, finance and performance and digital transformation workstreams.

2.4.2. The APC EMB undertook a deep dive on mental health to understand the work ongoing at a sector level and the mitigation of the risks of treating patients with mental health needs in acute hospital settings. This work is overseen by the Integrated Care Board (ICB) Urgent Care Mental Health Group which is attended by all four acute trusts, mental health trusts and the ICB team. The current work includes mapping the mental health patient journey through emergency departments to understand delays. The APC EMB noted the four workstreams that have been instigated, on policy, education, environment and staffing.

2.4.3. The APC EMB received monthly updates and assurance on the corporate programme board and clinical pathways board. The APC EMB noted the importance of clinical networks across NWL and the need to be clear on our ask for them, with the potential to standardise clinical pathways across the sector.

2.4.4. The APC EMB received an update on sector priorities, including Urgent and Emergency Care (UEC), diagnostics and planned care.

2.4.5. The APC EMB reviewed the serious incident (SI) themes across the collaborative over the last 12 months which encompassed incidents reported with a harm level of ‘severe’ or ‘extreme’ as well as never events. The APC EMB were assured that most of the themes were common across all four trusts and included maternity/obstetric incidents, treatment/diagnostic delays, incidents related to invasive procedures, falls and pressure ulcers and were reflected in local improvement priorities or included in their Patient Safety Incident Response Plans (PSIRPs) as part of the Patient Safety Incident Response Framework (PSIRF) implementation. The APC quality priorities for 2024/25 were under review and would be confirmed at the APC EMB in April 2024.

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

- **Elective orthopaedic centre (EOC)**: The APC EMB received assurance that Q4 was being used to improve pathways, gain partner confidence, resolve teething issues and complete all activities required for the shift to full capability (five theatres) from 15 April 2024. This included an update on the estates workstream which remained red due to the 12 week delay to construction, but there was confidence that construction would be completed by 29 March and the two additional theatres would be commissioned before the go live date. The APC EMB also asked for further consideration of the criteria for patients treated at the EOC and whether the criteria can be extended to ASA3 patients to make best use of the new operating theatre capacity.

- **EDI action plan:** The APC EMB received updates from the newly developed APC EDI Improvement Plan Steering Group on progress with the recommendations to address the NHS England High Impact Action One: "Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable". The APC EMB supported the proposal that each board director should have two objectives: one common objective across the APC to change how we have conversations about equity and to support everyone's own learning and development and one non-executive or executive director specific objective depending on their role, focused on seeking measurable improvements on a specific, relevant metric

- **Ophthalmology**: APC EMB received regular updates on ophthalmology in NWL, including that there is progress being made but challenges and delays in the UEC ophthalmology workstream.

- **Scaling people services**: The APC EMB received an update on the collaborative programme to improve and scale up people services following review by each of the four executive management teams and were pleased to note that in September 2023, the APC were chosen as a national Vanguard for scaling up people services and were provided with £125k to progress the work. This required us to complete the 'discovery phase' using the national scaling guide by 31 December. The APC EMB shared their support to proceed with the work on scaling people services, to inform proposals for priorities and implementation plan for 2024/25.

- **Major trauma network annual report**: The APC EMB received and noted the Major Trauma Network annual report which detailed activity during 2023/24 and the quality and performance of the agreed key performance indicators. It was noted that there were no immediate risks or serious concerns for the network itself, thought the sustained and continuing growth in trauma activity across the sector year on year was challenging for all units within the network.

3. Attendance of members

The APC EMB is attended by all 4 CEOs and a representative of each 'functional group' of executive roles. The executive representatives will rotate every six months, but rotations are be staggered to maintain continuity and avoid a completely new Board every six months.

The current membership is:

- **CEOs** – Tim Orchard, ICHT (Chair), Lesley Watts, CWFT, Pippa Nightingale, LNWH, Patricia Wright, THHFT
- **Chief Financial Officer** representative – Jonathan Reid, LNWH

- **Chief Operating Officer** representative – Claire Hook, ICHT
- **Medical Director** representative – Alan McGlennan, THHFT
- **Chief Nurse** representative – Robert Bleasdale, CWFT
- **Chief People Officer** representative –Tracey Connage LNWH
- **Strategy lead** representative – Simon Crawford, LNWH
- **Chief Information Officer** representative – Robbie Cline, CIO LNWH & THHFT
- **Collaborative Director of Corporate Governance** – Peter Jenkinson, Collaborative
- **Communications** representative – Michelle Dixon, ICHT

10.2 REPORTS FROM THE CHIEF EXECUTIVE OFFICERS - PIPPA NIGHTINGALE, LESLEY WATTS, TIM ORCHARD, PATRICIA WRIGHT

To note the reports:
- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- London North West University Healthcare NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust

REFERENCES

Only PDFs are attached

10.2 BIC CEO Reports Cover Sheet.pdf

10.2a BIC Board in Common LNWH CEO Public Report April 2024.pdf

10.2b BIC CWT Board in Common CEO Public Report April 24 - ED3.pdf

10.2c BIC ICHT CEO Public Report - April 2024 - FINAL.pdf

10.2d BIC THHFT CEO Public Report - March 2024.pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 10.2
This report is: Public

Chief Executive Officers Reports

Accountable director: Pippa Nightingale, CEO (LNWH)
Lesley Watts, CEO (CWFT)
Prof Tim Orchard, CEO (ICHT)
Patricia Wright, CEO (THHFT)

Purpose of report

Purpose: Information or for noting only

The Board in Common is asked to note the reports

Report history

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

N/A

Executive summary and key messages

The Board is asked to note the key findings in each of the reports and items escalated to the Board in Common from the individual CEOs for the Trusts of:

- London North West Hospitals NHS Trust
- Chelsea and Westminster Hospital NHS Trust
- Imperial College Healthcare NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust

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

Chief Executive Officer's Report – London North West University Healthcare NHS Trust (LNWH)

Accountable director: Pippa Nightingale
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

1.1 The junior doctors' strike (from Saturday 24 February to Wednesday 28 February 2024) affected all inpatient and outpatients' services at Central Middlesex Hospital, Ealing Hospital, Northwick Park Hospital, and St. Mark's Hospital.

Unfortunately, we had to cancel many appointments and planned procedures. We have contacted all patients affected and are arranging new appointment dates for as soon as possible.

As with previous industrial action, extensive communications work on social media has highlighted the anticipated impact of each strike to local people.

Careful planning and huge support from our clinical teams has allowed us to continue running emergency care safely during these periods, while also demonstrating our respect for our colleagues' right to strike.

Our maternity services remained open as usual. Gold Command was run throughout both periods of industrial action so that staff could rapidly escalate urgent issues.

1.2 We have received the results for the 2023 staff survey. More than 4,200 staff (50%) completed the 2023 survey, meaning our results represent the breadth of views across LNWH.

We've made steady improvements across a wide range of areas compared to previous years, reflecting the work we've done to improve equity, compassionate leadership, and staff's ability to get involved with decisions. The results also highlight the areas where we've made improvements but can still do better.

Compared to the previous year we have improved for 64 questions and stayed about the same for 33 questions. We did not deteriorate significantly for any questions compared with our 2022 results.

Based on what staff have told us, we have identified three key areas where we need to do more to improve your experience at work. These are: culture and behaviour, equity, and leadership development. I have written to staff detailing some of the specific actions we'll take under each of these themes. These aren't the only improvements we'll make this year, but they are pieces of work where we've got a good starting point to make

changes.

Overall our results show that what we're doing is working. Now we must keep up the focus and energy that's helped us get to this point so we can be ambitious about our goals for this year.

1.3 The new Willesden Eyecare Centre opened on the 20 March 2024. The centre is an extension of ophthalmology services provided at Central Middlesex Hospital. Some diagnostics previously undertaken at Central Middlesex have moved to the new centre, which also provides additional capacity.

The new centre has been established in response to a 2022 NHS review of eyecare services and follows a public engagement programme undertaken across north west London in 2023. It will improve access to eyecare services in north west London and enable patients to be seen away from the hospital for diagnostics, review and regular monitoring of eye conditions. It is expected to manage around 10,000 patients each year.

Demand for ophthalmology services is expected to expand by over 10% in the next five years, and now accounts for 9% of all outpatient appointments.

Higher than average rates of sight loss in some north west London boroughs, including Brent, Ealing and Harrow, suggest that there may be inequalities in how eye health is delivered across north west London. We have been working with the North West London Integrated Care System and other NHS providers to consider approaches to management that may help reduce this variation.

2. Quality and safety

2.1 Our quality and safety team continue to provide extensive training for employees across LNWH on using the new national patient safety incident response framework, or PSIRF.

Workshops on initial incident reviews, after action reviews, thematic reviews and compassionate involvement and engagement have all taken place regularly over recent months, as the new model becomes our means of learning from and preventing incidents.

We have already begun to use the framework to analyse incident themes and consider ways in which we can change and improve our systems, while also providing a more compassionate and engaging process for families and loved ones. We will continue to monitor the process as we learn to use it most effectively.

2.2 We have run internal communications on safeguarding and sharing information when young people are at risk. Staff have been reminded to share information the relevant local authority if they identify a child or young person who is already suffering harm or who is at risk of harm. Also, if they identify an adult who may be a risk to children or

young people in their care or to whom they may have access. This information is shared by completing a safeguarding children referral on Cerner EPR.

Staff have also been advised that sharing information in this way is supported by law. The Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) allow for the sharing of information for trying to prevent or lessen a serious risk or threat to a child's mental and physical wellbeing.

3. Operational performance

3.1 Emergency department performance reported 77.4% for February 2024 against the 4-hour standard as we continue to work toward the year-end operating plan trajectory. This is the third highest performance in London for the 18 acute trusts reporting against this standard. 93.6% of patients were treated within 12 hours against the 98% standard.

Key actions underway include:

- The ambulance 45-minute London-wide handover process continues which is benefiting handover times but does place additional pressure on acute flow.
- The Trust winter plan has been fully mobilised to increase staffing and bedded capacity from October 2023 through to spring 2024.
- The new 32-bed acute medical unit at Northwick Park is now planned to open in April.
- The winter A&E SDEC pathway is in full operation supporting 4-hour flow.
- The REACH model has been incorporated into the Single Point of Access to support demand management and streaming away from A&E.
- The LNWH Flow Model is now part of the Trust's operating procedures to assist daily patient flow alongside daily patient allocation to ambulatory care.
- Continued focus is underway to increase daily discharges and use of the discharge lounges across sites.

3.2 Cancer waiting times: The number of patients over 62 days saw a reduction in February and significant reduction is expected by the end of March in line with our operating plan.

Ongoing industrial actions and the challenges posed by the Cerner implementation have resulted in reduction in outpatient and diagnostic capacity. The Trust is actively working to address these issues to improve patient care.

The final position for January 2024 (reporting a month in arrears) was:

- 2-week wait for suspected cancer: reported 62.6% against the 93% standard
- 28-day faster diagnosis: reported 68.0% against the 75% standard
- 62-day wait for treatment following GP referral: reported 60.6% against the 85% national standard.

The key next steps are underway to maximise capacity as we progress through the continued industrial action dates and recovery periods in addition to tracking next steps daily to progress to diagnosis and treatment.

3.3 18 weeks referral to treatment: our 78-week position ended February with 155 patients waiting over 78 weeks, which is a reduction from the previous month and in line with the Trust's forecast.

The planned industrial action in February did have a significant impact on this position for the coming months. However, the Trust remains committed to having a small number of 78-week breaches at the end of March due to complexity as well as some patient choice deferments of dates.

Ongoing industrial actions and data quality problems following the Cerner implementation are still impacting the 52-week position. To tackle this, we've implemented a comprehensive recovery plan involving mutual aid, outsourcing, and addressing internal capacity challenges. The number of 52-week breaches has remained stable over the past three months.

4. Finance and estates

4.1 Finance: At the end of Month 11, the Trust is reporting a year to date deficit of £5.7m. The Trust has received industrial action funding from, and via, NWL ICB, and additional income to reflect operational pressures in year, which has mitigated the delay in the receipt of asset transaction proceeds. Industrial action funding has covered the additional £7.5m of cost and lost income arising from the industrial action in Months 9-11.

In addition, the Trust has received Cerner funding support from the ICB to reflect challenges in activity and income post-implementation. Over and above this income support for activity loss, the Trust has been able to reach agreement with NHS England on the implied forecast, and hence payment, of Elective Recovery Funding for the financial year. This is a significant step forward in reducing the income risks for the current financial year, although careful management of the financial position will be required to deliver the forecast of breakeven for the financial year.

Delivery of Cost Improvement Plans (CIP) has improved in month, in line with the trend of recent months. The Trust is forecasting full delivery of its plans for the year, albeit with a material non-recurrent component. Additionally, divisional teams have worked hard in recent months to help shape the CIP programme for 2024/25, and over 50% of the target has now been identified.

Capital expenditure is forecast to meet the Capital Resource Limit target in year, and this is the outcome of diligent and hard work by colleagues across the organisation given the

material increases in the budget over the course of the financial year.

Cash balances have improved, although the non-recurrent nature of much of our delivery over the last twelve months means that we continue to keep a close eye on cash movements into and out of the organisation.

The Trust has developed, in partnership with the ICB and partners within the Collaborative, a draft financial plan and provisional budgets for 2024/25 in advance of the issue of national planning guidance. This plan will be considered by the Trust Finance and Performance Committee on 5 April 2024. It is stretching, reflecting the financial pressures on both the APC and NWL ICB, with a Cost Improvement Plan target of £35.1m, and a need to continue to improve activity undertaken, activity recording and coding post-Cerner, and productivity across all our service lines. The Trust has made good progress in previous years and will continue to work on improving financial sustainability in the new financial year.

4.2 Estates and Facilities: The end of the financial year marks the handover to the Trust of the Elective Orthopaedic Centre at Central Middlesex Hospital, and the Modular Unit at Northwick Park Hospital (the formal handover of the Community Diagnostic Centre at Ealing will take place early in the new financial year). These significant projects have come in on budget and will commence full capacity/operation shortly.

Plans are now confirmed and finalised for the major refurbishment of our Endoscopy Suite at Northwick Park Hospital, creating the capacity and facilities for our clinical teams to continue their improvements in productivity, efficiency and patient experience.

These major projects are only a part of the broader programme of works which have been taking place across our three sites, including significant investment in backlog maintenance and the management of the sites.

A full programme of works for 2024/25 has been agreed through our Medical Devices Group and our Capital Review Group, and will also be considered by the Trust Finance and Performance Committee on the 5 April 2024.

5. People

5.1 The role of non-executive champion for freedom to speak has been taken up by Baljit Ubhey, the chair of our Audit Committee. Baljit is deeply committed to working with us on further developing a culture of transparency, honesty and confidence in raising concerns.

5.4 Loy Lobo has joined our board as a new non-executive director. Loy brings an enormous range of experience to LNWH, having led significant digital transformation work across the NHS. He has held pivotal roles in various educational and accelerator programmes and is a Fellow of the Royal Society of Medicine. I very much look forward to working with him.

6. Equity, diversity and inclusion

6.1 We shared our medical workforce race equality standard (MWRES) deep dive report with colleagues at the beginning of the year.

The report has identified several areas for us to focus on, from career progression to eliminating discrimination from patients, the public and colleagues. Importantly, it considered not only quantitative data from a range of sources, but also qualitative information offering real insight into the impact that these numbers have on real lives.

LNWH is by no means an outlier in these results, but the deep dive clearly shows how important it is to continue our work against racism specifically and against the intersectional impact of discrimination more generally. We remain the only NHS trust in the country to review this data in so much detail, which I hope demonstrates our commitment in this area to both our employees and to our patients.

We have identified and begun work on several actions. Our new anti-racism statement will be incorporated into all recruitment material, while a new role in our Chief Medical Officer's office will lead on EDI issues relating to doctors. Updates to our violence and aggression policy, as well as to our freedom to speak up processes, will also be key in addressing many of the issues identified in the report.

I am very grateful to our independent authors, Yvonne Coghill and Owen Chinembiri, as well as to LNWH doctors Miss Evelyn Mensah, ophthalmology clinical lead and WRES expert, and Dr Anu Obaro, radiology consultant and co-chair of our Staff Equity, Engagement and Experience Committee, who led the work to produce our deep dive reports.

6.2 We have completed a review of our freedom to speak up processes, which included a wide range of interviews with people from across LNWH, as well as a review of our staff survey results, policies, and reports. We also ran an anonymous online poll where staff could tell us about any barriers to speaking up at LNWH.

I have written to staff to explain how we have used the review as the basis for strengthening our freedom to speak up processes. I have also invited staff to apply to become a freedom to speak up guardian. We know we need to do more to support our guardians and champions in their vital work. That will include offering them protected time for their role, so they can give you the kind of dedicated help needed.

Also as reported in 5.3, Baljit Ubhey has become our non-executive champion for freedom to speak up. Baljit is looking forward to working closely both with our guardians and champions and with our wider teams.

6.3 This quarter we have marked Easter, Holi and Ramadan with messages on our internal and social media channels. We frequently promote events associated with religious festivals taking place across the Trust, and endeavour to cover the main ones that are

important to, and reflective of, our diverse colleagues and communities.

7. LNWH updates

7.1 In March we were delighted to welcome young people from Ealing's special educational needs and disabilities hub for a tour of Ealing Hospital.

The group had the opportunity to observe and chat to people working across several different departments and professions. Our Medirest team explained how the catering service produces 1,000 meals a day for the hospital, and healthcare assistants explained the types of jobs performed by nurses and healthcare assistants.

The group also visited the pharmacy and had the opportunity to see the pharmacy robot working and delivering medicines.

8. Research and innovation

8.1 We have advised staff about the introduction of new medical imaging software - Isla. The software works on any web browser, so it can use it on an LNWH phone or tablet, or on staff's own personal phones.

The software stores the images securely and they are accessible from Cerner EPR. However, staff have been reminded not store medical images their personal phone or tablet, or to a personal cloud. Indeed, as part of the launch we're introducing new rules for using personal devices.

Staff have said it's much quicker and easier if they can use your own phone. That's why we're introducing this software, and the new rules, to make it easier for staff while keeping our patients' records secure.

8.2 After winning funding from the Royal Marsden Partners Cancer Alliance and using a structured surveillance model developed by Imperial College, LNWH is one of two hospital trusts chosen to improve uptake of the potentially lifesaving abdominal ultrasound.

A twice-yearly scan could save the lives of thousands of people from Hepatocellular Carcinoma (HCC) the fastest rising cancer in the UK. HCC is an aggressive form of liver cancer that is primarily fuelled by increases in alcohol consumption, obesity and Hepatitis B.

LNWH had 160 identified patients, but following a detailed check of patient records this number rose to 660. The non-compliance rate dropped from 84% to 20% in the past year. An early diagnosis makes a huge difference as HCC is almost impossible to detect without an abdominal scan yet it is very treatable if caught early.

9. Stakeholder engagement

9.1 Ealing Save our NHS visited Ealing Hospital on the 19 January to learn about the latest developments on the site, including progress with Community Diagnostic Centre opening in the summer.

9.2 Prof Mark Britnell, Kings Fund Trustee and visiting UCL Professor, and John Pope CEO of the National Association of Primary Care, visited Central Middlesex Hospital on the 24 January. The hospital is home to the new North West London Elective Orthopaedic Centre which began a phased opening in December 2023 and is set to move to full capacity in the spring.

9.3 As part of a national research project, Healthwatch Ealing visited the Ealing Community Diagnostic Centre on the 30 January to capture on-the-ground insight into patients' experiences.

The centre currently provides MRI and Ultrasound imaging. A range of additional diagnostic services will be provided after construction work is complete in July.

The Healthwatch team will revisit the centre again in the summer when it is running at full diagnostic capacity.

9.4 Pat Cullen, General Secretary of the Royal College of Nursing visited Northwick Park Hospital on the 15 February to meet members.

10. Recognition and celebrating success.

10.1 LNWH has won the Trust of the Year Award at the annual GG2 Leadership and Diversity Awards for its work championing diversity and encouraging an inclusive working environment.

Judges praised our positive approach to tackling racism with the publication of an anti-racism action plan, encouraging greater diversity on our board as well as being the first to trust to undertake an external review of its race workforce standards.
It was a lovely surprise to pick up the award but much work remains to be done so onwards and upwards.

10.2 Rose Amankwaah, theatre matron at Central Middlesex Hospital, has been speaking to the press about her plans to retire after an extraordinary five decades at LNWH. Rose featured across national and international media, including the BBC, Sky and ITV.

In her youth Rose was known as 'the fastest woman in Africa', when she competed in competitions including the Africa Games, the Commonwealth Games, and even the Olympics.
Last year, Rose received a Silver Medal Award from the NHS's Chief Nurse, Dame Ruth May, in recognition of her service.

10.3 Kabiru Ogundipe, a porter at Northwick Park Hospital, has been voted Porter of the Year at the annual MyPorter awards which celebrate the work of non-clinical staff.

Kabiru has worked at the hospital for the past eleven years and was cited in the awards

for his response to an attempted suicide when a patient jumped from a window and he was among the first responders.

10.4 Taran Tatla, an ENT consultant at Northwick Park Hospital, has been made President Elect of ENT UK, one of the most influential roles governing ear, nose throat, head and neck surgery in the country. Taran's focus during his two-year tenure will be greater multidisciplinary training and use of digital technology.

10.5 Antoniya Zaeva, Medirest General Manager at Ealing Hospital, who has won the leadership of the year category at the national MyCleaning awards.

The MyCleaning awards are organised in collaboration with NHS England and receive hundreds of entries from across the UK's healthcare sector. They recognise the unsung heroes within healthcare, shining a spotlight on the great, essential work they do.

10.6 Pearl Avery, Kay Crook and Tracey Tyrrell from our inflammatory bowel disease team have been credentialed by the Royal College of Nursing as IBD advanced clinical practitioners.

Pearl, Kay and Tracey have been sponsored in this achievement by Crohn's & Colitis UK and continue to work with the organisation to raise awareness about these conditions at LNWH.

They are among the first 10 IBD advanced clinical practitioners in the UK – a fantastic success with great benefits for both patients and our wider clinical team.

Chief Executive Officer's Report – Chelsea and Westminster Hospital NHS Foundation Trust

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

1.0 Key messages

Winter has presented a number of challenges, particularly for our colleagues who have been managing the increasing demand in our urgent treatment centre (UTC) and emergency department (ED) services. In February 2024, A&E 4-hour performance was 81.78%, which was the highest in London. Overall, activity levels were strong despite industrial action and winter pressures. Our operational teams remain focused on expediting long waiting pathways, and enhanced oversight and targeted interventions continue for at-risk specialities. Our focus on performance and discharge has ranked us consistently in London through the months of February and March and we are placed 8th nationally, despite managing through periods of industrial action and a rising demand of our services. This is thanks to the unwavering commitment and team work of all our staff.

Site developments continue to move forward at our hospital sites, and I am pleased to see the progress underway for our development projects—the Ambulatory Diagnostic Centre (ADC) at our West Middlesex Hospital site and the Treatment Centre refurbishment at Chelsea Hospital. As we commence works for the ADC, we are also ensuring that we involve local residents and staff on our plans with regular scheduled engagement events.

Our work within digital innovation has been recognised nationally with a number of our staff and services being shortlisted in the national HSJ Digital Awards for our pilot artificial intelligence (AI) project and for Digital Leader of the Year. Dora is an AI solution supporting patients through the cataract pathway, by delivering routine clinical conversations, booking appointments and check-ups, freeing up clinician time for work further along the care pathway. Our staff have also led and contributed to the national tech conference 'Rewired', leading on a number of talks on AI and Femtech for gynaecology treatment.

The results of the NHS Staff Survey 2023 show that the Trust is rated number two in London among our acute hospital peers as a place to work and is recognised as one of the leading trusts nationwide. This achievement offers valuable insight into our organisation's strengths and demonstrates what it is like to work and receive care at the Trust.

While the overall results are hugely positive there are areas we continue to need to improve—including the violence and discrimination our colleagues face at work which we

know has a huge impact. We will continue our focus to make Chelsea and Westminster Hospital NHS Foundation Trust a safe place to work where everyone can thrive.

2.0 Quality and safety

2.1 **Summary:** Over the past quarter the Trust is confirmed as compliant with all elements of year five of the Maternity Incentive Scheme. The level of Never Events is at five year to date, and a review of barriers is being completed. The new Patient Safety Incident Framework (PSIRF) methodology is being utilised across all services, but the trajectory for compliance with training remains a focus and is monitored through the Trust governance structure.

2.2 **Quality Priorities** – the proposed priorities for the year 2024/25 are: deteriorating patients, tobacco and smoking reduction, improving care for our frail patients, patient experience (nutrition and hydration) and continued implementation of PSIRF.

2.3 **Infection Control** - infections are running above thresholds locally, noting that this is consistent with the sector, regional and national picture. Clostridium Difficile (C. diff) infections are at 31 year to date. No lapses of care have been identified in the newly identified cases and the need for correct testing of patients has been reinforced. One Trust-attributed case of MRSA was also recorded for January 2024 (bringing the figure to a total of four cases year to date).

2.4 **Complaints** –97% of complaints were responded to within the 25-day KPI (target 95%) during January 2024, an improvement on the position last quarter. Compliance with responding to PALS concerns within five working days was at 91% (KPI 90%).

2.5 **Patient experience** – Admitted patients across both main hospital sites continue to report positive experiences of their care and the response rate to the Friends and Family Test survey remains over 35% of patients. A&E satisfaction rates remain consistent with previous months and themes from feedback continue to be shared with respective leads. Response rates for these areas is 2-3 times above the national average. Women accessing maternity care at Chelsea reported an improved experience in January compared to previous months. Findings where experience could be better have been shared with leads to support with ongoing improvement work.

3.0 Operational performance

3.1 A&E 4-hr waiting times, the Trust reported a combined performance of 81.87% with 24,661 attendances, which continues on a month-on-month improvement. Our urgent and emergency care (UEC) Winter Plan continues to focus on performance throughout the UEC pathway, from ED to discharges.

The Trust continued to make progress on reducing backlogs, as the 65ww and 78ww are showing corresponding decreases, despite another challenging period of industrial action and winter pressures. However, there was a slight increase in the 52ww cohort, and it is anticipated that the majority of those in this cohort are on a non-admitted pathway and require outpatient or diagnostic services. The NHS drive to book and see patients in the RTT long-waiting cohorts is expected to support improving this position. These patients are tracked and reported through the weekly Trust Elective Access meeting.

Cancer (Final Previous Month, Unvalidated Current month) 62-Day: The 62-day combined target was not compliant in January 2024. The unvalidated position for February 2024 is 82.39%, impacted by a high volume of breaches in Urology. Diagnostics have been somewhat challenged with reduced capacity following equipment failures in CT and MRI, which has had an adverse impact on this target. Recovery plans to improve diagnostic capacity are in place and monitored at the appropriate forums. 28-Day faster diagnosis standard (FDS): Performance against the FDS target was not compliant in January 2024 with a performance of 72.24%.

The February 2024 unvalidated position shows an improved position of 81.36%. 31-Day: The 31-day combined target was not compliant in January 2024, with a performance of 95.7%. The February 2024 unvalidated position shows an improved position with a performance of 98.44%. The cancer services are leading a weekly assurance meeting for those tumour sites that are driving some of the underperformance. These meetings are having a positive effect.

4.0 Finance and estates

4.1 Finance:

At month 11 the Trust is reporting a year to date adjusted surplus of £0.01m, this is £0.01m adverse against the year to date (YTD) plan. The YTD position is largely driven by;

- Consultant and Junior Doctors industrial action has created a £3.9m pressure, which is a combination of cost (£6.6m) and income loss (£6.0m), partially offset by funding (£8.7m);
- Non-pay inflation above the funded levels of £1.8m;
- Other items totalling a benefit of £2.4m; including CNST Maternity Incentive Scheme Bonus payment of £4.1m and balance sheet and other various items of (£1.8m);
- Cost Improvement Programme (CIP) delivery is ahead of plan £0.5m YTD;
- Elective recovery fund (ERF) over-performance £16.4m, offset by associated costs of £13.5m, net benefit of £2.9m.

The Trust's forecast is now breakeven, which accounts for additional funding received this month to offset cost pressures from the December to February industrial action. The capital spend at month 11 is £32.68m against a plan of £43.99m, due to timing differences in the capital programme. The gross forecast is £49.23m.

At the end of month 11 the cash balance was £164.74m.

4.2 Estates:

4.2.1 Treatment Centre at Chelsea and Westminster

The construction works on the lower ground floor at Chelsea are now moving at pace, with construction of walls now starting in the new Therapies Outpatient Department and admin areas. The construction is part of wider works linked to the redevelopment of the Treatment Centre, which will help increase its footprint by more than 70% and add two additional theatres. The Treatment Centre redevelopment will also improve recovery facilities for patients by developing a new overnight recovery area, thereby allowing more complex procedures to take place.

4.2.2 **Ambulatory Diagnostic Centre (ADC) at West Middlesex**

Construction work has commenced in March 2024 and aims to be complete by summer 2026.The new five-storey facility will provide vital diagnostic and treatment services in cancer, renal and imaging for local residents in Hounslow, Richmond and Ealing. It aims to reduce health inequalities, improve patient outcomes and provide care closer to home – freeing up space in the main hospital for inpatient care. Cancer and renal disease account for one of the largest health impacts for the local population. The ADC will double capacity for these services, ensuring that the local community can access treatment locally. The new £80 million investment is the largest capital project that the Trust has ever run, which includes a £16.5 million capital grant from NHS England. The centre will support outpatient care and will offer day services for patients, opening approximately 12 hours per day, six days a week.

5.0 People

5.1 The results of the NHS Staff Survey 2023 have been published, with more than half of our staff (51%) staff sharing their experience of working at Chelsea and Westminster Hospital NHS Foundation Trust, as well as our Bank only staff. Our Trust has been rated number two in London as a place to work and recognised as one of the leading trusts nationwide. I am encouraged and incredibly proud of the results for our Trust, which is a tribute to the work of more than 6,700 colleagues. Overall, our results indicate high levels of engagement, recognition and learning as more staff than ever are sharing their experiences. We also score higher than average for being compassionate and inclusive, and our staff feel that they have a voice that counts.

While the overall results are hugely positive, there are areas we continue to need to improve—including the violence and discrimination our colleagues face at work, which we know has a huge impact on everyone who works here. We will continue our focus to make Chelsea and Westminster Hospital NHS Foundation Trust a safe place to work where everyone can thrive.

5.2 We continue to run our core health and wellbeing (H&WB) offer consisting of ‘Healthy Mind, Healthy Body’, ‘Healthy Living’ and ‘Feeling Safe’. We have continued with quarterly ‘Wellfest’ events where staff have access to self-care webinars, mindfulness sessions, bike doctor days, financial advice and interaction with a wide range of information and resource stalls from Schwartz rounds to Staff Networks. Mental Health First Aiders (MHFA) continue to offer support across the Trust, visiting wards and departments and working closely with managers. Our Wellbeing Lead is now a certified MHFA trainer and is training more staff to increase the number of MHFAs (currently 143). Our 110 Wellbeing Champions continue to be popular, providing support during industrial action periods and supporting the Trust wide vaccination programme and staff survey campaigns. We have continued contract reviews on a number of our H&WB related contracts to identify further opportunities for staff, increase awareness and enable equitable access. These include contracts offering salary sacrifice, psychological support, emergency childcare and nursery partnership options.

5.3 On 11 March, we launched the NHS-specific Team Leader Apprenticeship programme, developed in partnership with Harrow, Richmond, and Uxbridge College (HRUC). This aligns the apprenticeship standard with NHS-specific activities, allowing staff to learn on the job and apply new skills in their existing role within the NHS. The pilot cohort comprises staff from Chelsea and Westminster and Hillingdon Hospitals Trusts across a

range of teams including: research, nursing, midwifery, facilities, therapies, administrative and clerical. On completion, apprentices may apply to become an associate with the Chartered Management Institute (professional body for leaders and managers).

6.0 Equity, diversity and inclusion

6.1 In March we celebrated the contribution of our women on International Women's Day (IWD) 2024 with a week of events, talks and stalls right across the organisation. Our clinicians also led on our first women's health forum at West Mid which involved women from the Polish Society, the Asian Women's Resource Centre and the Hounslow Women's network, that brought together recommendations and steps that support better patient experience from all our communities. This has led to wider work linked with our patient experience team for positive progress.

A number of clinicians also took part in a local Women Convention and Expo event at the Hilton Hotel at Syon Park and met with community engagement officers, community groups and women's champions. Building these relationships within our community will be vital as we work collaboratively to tackle women's health inequalities.

6.2 Ramadan: we have been supporting the wellbeing and work environment for our staff observing the holy period of Ramadan with prayer mats provided and guidance to all our staff on supporting colleagues who are fasting during this period.

6.3 International Transgender Day of Visibility (TDoV) on 31st March is an important date for our services and staff, as it is dedicated to celebrating transgender and non-binary people. To mark this, we hosted a number of events with various members of staff, as well as a special guest from Trans Radio UK.

7.0 Chelsea and Westminster NHS Trust updates

7.1 The expansion of the Chelsea Centre for Gender Surgery (CCGS) aligns with Trust vision to become an international centre of excellence in Gender-affirming care. The remote monitoring pathway for TransPlus service users on hormone therapy will enable greater follow-up capacity without the need for service users to travel to a clinic in London. This is particularly important given the increase in proportion of service users living outside of London. We have increased awareness of *'Sexual Health Hounslow'* through campaigns and outreach re dermatology, also with improved coding to increase the accurate recording of activity, especially around outpatient procedures.

7.2 I am pleased to announce the launch of the Older Adult Cancer Service (OACS), which will see its first patients this month. The team aims to optimise care for older patients who are starting cancer treatment by offering holistic, one-stop clinic appointments with access to a specialist multidisciplinary team, including oncology and care of the elderly doctors, clinical nurse specialists, physiotherapists, occupational therapists and pharmacists. Oncology teams will be able to refer patients directly to the OACS.

7.3 We marked Endometriosis Action Month, a condition that affects 1 in 10 women. We continue to be leaders in women's health research and hosted patient engagement events across both sites to offer further information and support to those who have been diagnosed, as they consider their treatment options. In collaboration with NHS England,

Consultant Gynaecologist Dr Manou Manpreet Kaur at the Trust has supported a number of digital channels on the support available.

7.4 The Hot Topics in Global Health conference is set to take place on 13 and 14 May 2024 at Chelsea and Westminster Hospital. This two-day international conference aims to address the challenges and priorities of global health, particularly in low resource settings.

Clinicians and non-governmental organisation (NGO) workers, in various specialties such as neonatal and child health, maternal health, mental health, infectious diseases will take part. Speakers will include delegates from The Royal College of Paediatrics and Child Health, The Royal College of Physicians, The Royal College of Obstetricians and Gynaecologists, The London School of Hygiene and Tropical Medicine, Liverpool School of Tropical Medicine and The David Nott Foundation.

8.0 Research and innovation

8.1 Our Annual Report on Research was considered this quarter, setting out the impressive record of research and innovation within the Trust, along with an update on the implementation of the Research and Development Strategy. Our strategy sets out the aim of giving everyone the opportunity to take part in research with the objective of creating an environment which gives all those living in North West London or working in the Trust the opportunity to take part in research. The key focus for the coming year is to ensure that our research activities are further extended on the West Middlesex as well as Chelsea site, and to reflect the demographic profile of local residents. Above all the research undertaken must not only be interesting, but be translated into the improved care and experience of our patients.

9.0 Stakeholder engagement

9.1 Recognition and celebrating success.

9.1.1 We celebrated 10 years of Dean Street Express, our pioneering sexual health clinic, reflecting on a decade of ground-breaking achievements and innovations that have shaped the landscape of sexual health and HIV care in London. Dean Street Express, based in the heart of Soho, offered a unique one-stop shop approach, with walk-in appointments and testing onsite for sexually transmitted infections (STIs) with rapid results back in six hours, a method since recognised internationally as a first of its kind. The clinic has performed over 520,000 HIV tests over the past 10 years, as the dedicated team continue to work towards the Government's goal of eliminating HIV transmission in the UK by 2030.

A number of our staff joined the national health tech conference Rewired this year held in Birmingham. Our Digital Operations team joined NHS England to lead on a talk on the increasing role of AI and the need for health systems to focus on data quality. The Women's Health Research clinical leaders from West Mid also presented on the benefits of virtual reality to reduce pain and anxiety for procedures. Well done to everyone involved, highlighting our commitment to innovation and implementing beneficial health technology, while prioritising patient safety.

9.1.2 I am pleased to announce that the HIV team behind Klick have been awarded the Most Effective Contribution to Clinical Redesign Award in the HSJ Partnership Awards. The team attended the awards ceremony, where they were recognised as winners in this category for their work in redesigning clinical support for people living with stable HIV.

9.1.3 Christina Sothinathan, Innovation Business Partner, has also been shortlisted as Digital Leader of the Year. Christina works in the CW Innovation team and supports the Trust to implement digital solutions—including AI—to safely improve patient pathways and efficiency at the Trust.

9.1.4 The Heart Failure team at the Trust were recognised as finalists at the HSJ Partnership Awards in the HealthTech Partnership of the Year category. In collaboration with Patients Know Best, we have adopted a digital-first approach which exemplifies how digital solutions can enhance patient care and support patients living with heart failure.

9.1.5 Congratulations to Sandra De Oliveira Camillo, Healthcare Assistant in the Early Pregnancy Unit at the Chelsea site, who has been awarded the NHS Chief Nursing Officer and Chief Midwifery Officer Support Worker Excellence Award. Sandra has been recognised for this esteemed award due to her achievements in areas including patient care, respect, dignity, compassion and promoting equality, diversity and inclusion. Thank you for all your hard work, Sandra, and well done on this achievement.

Chief Executive Officer's Report – Imperial College Healthcare NHS Trust

Accountable director: Professor Tim Orchard
Job title: Chief Executive Officer

1 Key messages

1.1 I am pleased to welcome Loy Lobo who started as an Imperial College Healthcare NED on 15 February. I would like to thank Janet Rubin for all her work as a NED for Imperial College Healthcare since 2022, she will be much missed.

1.2 I am delighted that we achieved our third year of consecutive improvement in the 2023 national NHS staff survey. With one of the highest response rates, we are now above the acute trust average in seven out of nine themes, up from five out of nine in 2022 and three out of nine in 2021. We saw statistically significant increases in responses for eight out of nine themes this year. We continue to have particularly high scores for 'engagement' and 'opportunities to learn'.

1.3 We have been working to progress the redevelopment of our hospitals, in particular St Mary's Hospital. We ran an engagement programme with patients and local communities through January to get early input on our proposals. Almost everyone who responded expressed their support for a full rebuild, as well as sharing their views on what the future St Mary's should provide and considerations for the wider Paddington basin area. We are now awaiting a decision on funding from the Government's New Hospital Programme to allow us to move onto detailed design and planning for the new St Mary's. This would represent the furthest progress towards a rebuild we have ever made. For our Charing Cross Hospital and Hammersmith Hospital refurbishment and rebuild schemes – also part of the New Hospital Programme – we remain on track to submit first-stage business cases shortly.

1.4 On 29 January, we launched 'call for concern', enabling patients, relatives and carers to contact a clinical response team directly, at any time of day, if they are concerned that staff on the ward are not recognising that a patient's condition is deteriorating. The response team, who already work closely with colleagues across our hospitals when a patient is very unwell, will assess the situation and take any action that's needed. This service, based on one developed by the Royal Berkshire NHS Foundation Trust, also meets many requirements of Martha's Rule, a national initiative to help identify and respond quickly to patients whose condition deteriorates while in hospital, named after 13-year old Martha Mills who died from sepsis while in hospital.

1.5 We officially opened our Wembley Community Diagnostic Centre on 1 February. This is the second of three community diagnostic centres for north west London to help bring down waiting times by increasing capacity for diagnostic tests for cancer and other serious illnesses. The purpose-built centre in Wembley opened its door to patients on 15 January and runs seven days a week, 8am-8pm, offering over 30,000 MRI and CT scans each year.

1.6 In terms of our operational performance, we are meeting the national target to treat and discharge or admit at least 76 per cent of A&E patients within four hours. We have also

maintained some of the fastest ambulance handover times in London, achieving 97.4 per cent of handovers within 30 minutes during March. As a result, the Trust is eligible for additional capital funding in 2024/25, which will be used to further support our Urgent and Emergency Care services. We have increased our planned care capacity to help tackle longer waiting times, by both improving our theatre efficiency and putting on specialty-specific theatres lists at Charing Cross on Saturdays. We now consistently use 95 per cent of our theatre sessions each week, with over 85 per cent of each session spent in active patient treatment. This puts us in the top ten of NHS trusts nationally for theatre productivity. We have eliminated waits of over two years and are on track to do the same for waits over 78 weeks by the end of April 2024. Just over 750 patients had been waiting over 65 weeks as of the end of March and our next target will be to bring that number down as quickly as possible. At the same time, we remain focused on minimising waiting times for patients who need treatment urgently. We have consistently met the faster diagnostic standard – which requires that at least 75 per cent of patients with suspected cancer are diagnosed nor given the all clear within 28 days of referral – and initiated treatment for at least 70 per cent of patients with a cancer diagnosis within 62 days.

1.7 Financially, at the end of February, we reported an in-month surplus of £1.1m (in line with revised forecast) and a year-to-date deficit of £14.7m. We expect to deliver our break even plan for the end of the financial year.

2 Quality and safety

2.1 We continue to maintain good performance against key quality measures. Mortality rates are consistently amongst the lowest in the NHS, incident reporting rates have increased which is positive, and harm levels are well below national averages.

2.2 We declared four never events between January and March 2024, all with different themes (one was an insulin overdose, one was where blood products were transfused to the wrong patient, one involved an unintentionally retained spinal needle used as a level check during surgery and the final one declared on 28 March involved an oral liquid given intravenously through a central line). Fortunately, there was minimal patient harm. Local immediate actions were implemented and trust-wide improvement work is underway through existing priority workstreams. We have also introduced a new safety improvement priority to ensure positive patient identification.

2.3 We have exceeded our thresholds for nationally-mandated infection prevention and control (IPC) targets, in the context of an increase nationally. Trust-wide improvement work, focused on hand hygiene, is progressing well. We provide intensive support to areas with an increase in infections and we have a particular focus on ensuring hand hygiene best practice amongst medical staff who have the lowest compliance according to our audit data.

2.4 We are narrowly missing our target for giving antibiotics within one hour to at least 90 per cent of patients flagging as potentially having sepsis. Analysis of the data shows that a large number of confirmed cases do not represent true sepsis and reviews show that most patients with sepsis are being treated appropriately, with minimal harm identified due to the delays. We are developing a new deterioration and sepsis pathway, alongside processes for screening and assessment of sepsis in response to new national guidance.

2.5 NHSE London has commended four of our specialties for training of doctors for sustained improvement in the General Medical Council's (GMC) national training results (gastroenterology, respiratory medicine, intensive care medicine and core surgical training). However, in January NHSE visited the trust in response to concerns about the experience

and training in neurosurgery and the specialty has been placed into the GMC's enhanced monitoring process. A full action plan is in place with enhanced internal support. NHSE is satisfied with our planned actions and the progress made so far.

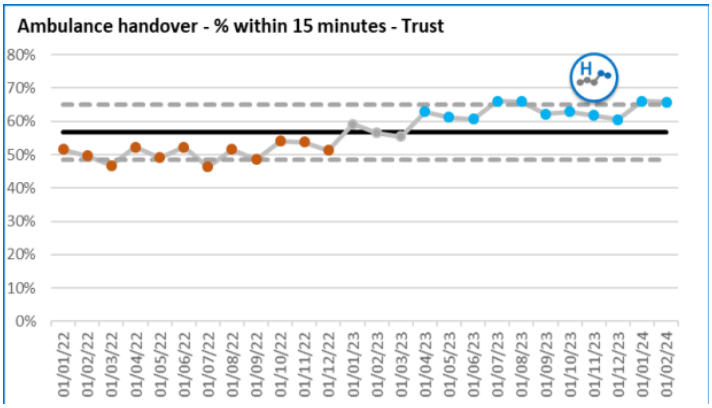
2.6 Our maternity and neonatal services continue to be very busy, with activity consistently above plan. Actions are in place to ensure continued patient safety, including increasing clinics at Queen Charlotte's and Chelsea Hospital and increasing staffing levels. Despite the pressures, we successfully delivered all elements of the CNST Maternity Incentive Scheme (year 5) by the deadline.

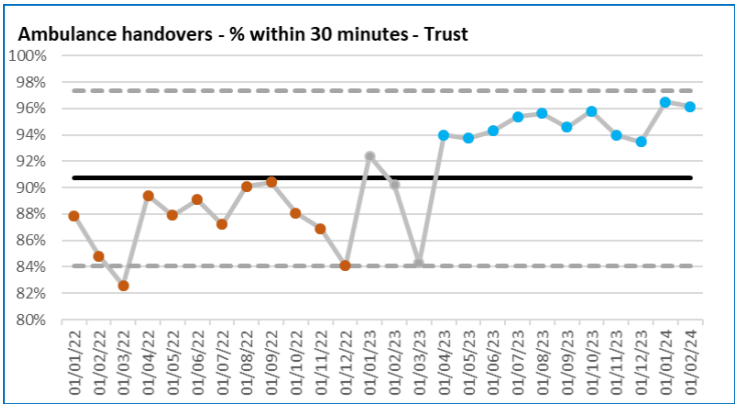
2.7 We continue to progress well with implementation of the new national patient safety incident response framework (PSIRF) and are ready to fully transition in April, pending approval of our final policy and plan from the Integrated Care Board. We are already starting to see good examples of positive compassionate engagement in our response to safety incidents; embedding this fully will be our main focus for 2024/25 to ensure we fully realise the benefits of PSIRF for our patients, staff and communities.

2.8 A Regulation 28 'Prevention of Future Deaths' (PFD) report has been issued by the coroner to Central and North West London NHS Foundation Trust, the Metropolitan Police and NHS England following a complex and distressing inquest into the death of a patient at St Mary's Hospital emergency department. The PFD was not directed at the Trust as the coroner was satisfied with the preventative actions we had taken, however we are reviewing the document to ensure we have learnt all we can.

3 Operational performance

3.1 Our emergency departments continue to consistently deliver some of the shortest ambulance handover times within London, with 96.1 and 97.4 per cent of handovers taking place within 30 minutes in February and March 2024 respectively. In the same period, we met the standard to see and admit or treat and discharge 76 per cent of patients arriving at an urgent treatment centre or emergency department within 4 hours, having not done so since September 2023. From November, our monthly performance improved consecutively and we are confident that we will be able to continue to exceed the national standard in 2024/25.





3.2 We continue to focus on reducing waiting times for planned care, ensuring that those waiting are prioritised according to clinical need and that we minimise the risk of patients being impacted multiple times by industrial action. The continuing strikes have put additional pressure on our services, resulting in a number of cancellations and increased waits, which has meant that we are behind our original plan to reduce waiting times to less than 65 weeks by the end of March 2024. We have developing further plans to get

back on track and facilitated additional weekend theatre lists between January and March 2024.

3.3 The number of patients on a cancer pathway for more than 62 days remains better than trajectory, although waiting times in some tumour groups are longer than we would like. We are currently above the national target of 70 per cent, with 75.7 per cent performance. We expect this target to increase and have detailed plans in place to improve our performance. We have continued to meet the faster diagnostic standard, which requires that 75 per cent of patients be diagnosed or have cancer ruled out within 28 days of referral. Our performance for February was 87.5 per cent and was the tenth consecutive month in which we met the standard.

3.4 The percentage of patients waiting over six weeks for their diagnostic test or procedure is higher than we would like it to be, at 11.5 per cent in February 2024 compared to the national target of 5 per cent. We have since improved our position and are currently working through a recovery plan to return to the previously good performance of within 1 per cent of the target by October 2024. There have been some particular challenges to our diagnostic performance recently: a review of local tracking lists within Neurophysiology highlighted additional waiting patients; and the reliability of our ageing imaging equipment remains an ongoing risk.

4 Financial performance

4.1 At the end of February, the Trust reported an in-month surplus of £1.1m (in line with revised forecast) and a year-to-date deficit of £14.7m. The key drivers of the year to date position remain: under-delivery against an equally-phased cost improvement plan; additional inflationary costs above funded levels; run rate pressures in pay and non-pay and the unfunded financial impact of the last round of industrial action between December 2023 and February 2024 amounting to £11.0m. With the financial recovery plan delivering the financial benefits identified and the further impact of industrial action being offset by new funding in March 2024; the Trust continues to forecast a breakeven position. The recovery action plan was formulated as part of the resubmission process and continues to be tracked on a weekly basis.

4.2 The 2023/24 gross capital programme for February stands at £91.6m, with £86.2m of this scoring against the capital resource limit. The Trust has spent £60.0m (82%) against the year to date plan. This shows an improvement when compared to the same period in previous years. The forecast based on February results remains on track to deliver against plan noting that £3.0m has been offered to the Integrated Care Board to support other organisations.

4.3 The cash balance stands at £122.9m; a reduction of £56.3m from the start of the year.

5 Workforce update

Staff survey

5.1 The 2023 NHS Staff survey results were published on 7 March 2023 and show our third consecutive year of improvement as well as our highest ever response rate at 61 per cent, well above the acute trust median response rate of 45 per cent. This means we have heard the views of 8,530 staff and we can be confident that the scores genuinely reflect the views of our diverse workforce. The Trust is now above the acute trust average in seven out of nine themes, up from five out of nine in 2022 and three out of nine in 2021. We saw statistically significant increases in responses for eight out of nine themes this year.

5.2 We continue to have particularly high scores for ‘engagement’ and ‘opportunities to learn’, as well as moving further ahead on the proportion of staff who would recommend our hospitals as a place to work or be treated, at 8 and 10 percentage points above the acute trust average respectively. We also saw one of our biggest improvements in ‘morale’.

5.3 I am particularly encouraged by the fact we have seen increased scores in areas where we have been focusing our improvement efforts. Our scores increased for all four questions under the theme ‘we are compassionate and inclusive’, moving above the average overall for acute trusts for the first time. Over the past five years, we have invested in a range of initiatives to promote equality, diversity and inclusion, including establishing our first dedicated workforce equality, diversity and inclusion team, facilitating the expansion of our staff networks and implementing measures to encourage fairness in recruitment. I believe our ‘improvement through people management’ programme – that has currently been completed by 1,880 of our line managers, with more taking part every month – has also helped us to do better on scores for questions under the theme ‘we are a team’.

5.4 There is more to do but I’m delighted that we are seeing progress. We also need to focus on areas where we haven’t done as well, including ‘flexible working' and ‘reward and recognition', where our scores are at or just below the acute trust average.

Update on industrial action

5.5 There have been two periods of junior doctor strike action in January and February. There has been no confirmation of further strike action at this stage, though the BMA’s junior doctor members have extended their mandate for industrial action until September 2024, including a mandate for action short of strike. Consultant BMA members have now received a new pay offer and have been recommended to accept in a ballot taking place between 14 March and 3 April. BMA SAS doctor members rejected their initial pay offer, by a majority of 62.3 per cent. Talks between the Government and SAS trade unions have resumed.

Equality, diversity and inclusion (EDI)

5.6 We obtained a special commendation from the Greater London Authority on the Mayor of London’s Design Lab Project for our Inclusive Recruitment programme. Our healthcare fellowship programme is planning for an additional cohort as well as a graduation ceremony.

5.7 We have now completed the first phase of our engaging for equity and inclusion programme, with 105 sessions taking place, involving over 1,000 staff as well as 11 community groups. A report summarising feedback and suggested actions that came out of the sessions will be published shortly. We will be engaging further, to test the findings as well as drafts of our first anti-racism and anti-discrimination statements, all feeding into an updated EDI strategy in September.

5.8 The Workforce Race Equality Indicators from the staff survey show decreases in staff experiences of discrimination and improvements in representation, although experiences of bullying and harassment remain areas of concern. Work has been conducted with the workforce race equality steering group to align the action plan to divisional and professional work programmes.

Senior management changes

5.9 I'm delighted that in January, Claire Hook began as Deputy Chief Executive. We also have appointed Karen Powell (Hospital Director, St Mary's) and Ian Bateman as Deputy COOs. Ian will also take on the role of Hospital Director for Hammersmith Hospital.

5.10 Merlyn Marsden (previously Hospital Director for Charing Cross Hospital) has been appointed as director of services and engagement for our private care service. Congratulations to Merlyn. Our senior site nurse practitioner team led by Andy Brittin and Judy Mee will oversee day-to-day operational running of Charing Cross in the interim.

6 Regulatory compliance - Care Quality Commission (CQC) update

6.1 The CQC launched its new regulatory framework and methodology in January 2024. We have been advised that the Trust continues not to be considered high risk and no Trust service has been identified as a risk.

6.2 In February, the CQC published the results of its annual survey of experiences of maternity care in England. 388 people giving birth at Imperial College Healthcare between 1 and 28 February 2023 were included in the survey. There were no statistically significant changes in our scores compared with the 2022 survey, except for one question where our score increased. Our results for most of the 54 questions in the survey remained in line with those for the other 120 trusts surveyed. We will be reviewing the experience data to aim to match the Outstanding rating from the CQC.

7 Green plan

7.1 We have completed work to refresh our Green Plan, which now covers the period 1 April 2024 to 31 March 2027. It builds on our progress and achievements over the last three years, with over 50 green projects initiated and a fall in our NHS carbon footprint by 14 per cent in the three years since 2019/20 (from 55,724 to 48,139 tCO2e).

7.2 Delivering this refreshed Green Plan will mean that by 31 March 2027 our NHS carbon footprint should have fallen to less than 36,879 tCO2e. This equates to an estimated 18 per cent reduction over the 3-year period of this refreshed Green Plan or a 34 per cent reduction on our 2019/20 baseline.

8 Research and innovation

8.1 We have set up an artificial intelligence (AI) steering group to bring together work in this area and to develop a strategy and evaluation framework. We will co-produce our strategic approach with our patients and staff to help ensure equitable access to the benefits of AI. This focus on co-production and actively addressing some of the potential bias within AI is central to our work. We are considering opportunities for AI across several user case areas, including the use of AI for: clinical delivery and new models of care, clinical and patient administration, and corporate functions.

8.2 As we approach the end of 2023/24, the total number of patients we have recruited into NIHR Portfolio clinical studies and trials is very close to 19,000. This represents the highest number in any year for 10 years. 407 individual studies recruited at least one patient and 104 of those were commercially sponsored trials. This is the Trust's highest ever number of commercial trials recruiting in a given year.

8.3 Six months ago we introduced challenging new internal targets for the speed with which we set up clinical research studies. The impact has been positive - the median number of days to set-up of commercial trials (starting at HRA approval date) has dropped from 193 days in the first 3 months of 2023 to 59 days in the last 3 months of the same year.

8.4 The Imperial Health Knowledge Bank (IHKB) went live recently as a 'soft' launch. This is a major BRC-funded initiative under which Trust patients give consent to be contacted for suitable research studies in future, to use their clinical data in a secure way, and to provide additional blood samples for future research. Wider communications and full launch will take place shortly – 137 patients have already signed up.

8.5 Paddington Life Sciences Partners, in partnership with the Association of British HealthTech Industries and the Shelford Group, hosted a networking event between NHS and industry. Discussions focused on using digital and data technologies for transformation, the clinical research and innovation infrastructure at Imperial, and engaging diverse communities in research.

8.6 In February, the ARC Outreach Alliance: Young People's Open Minds in Northwest London, won the inaugural NIHR Imperial BRC Public and Patient Involvement and Engagement (PPIE) competition, in recognition of their efforts to involve children and young people in research.

8.7 Recent research highlights include:

- A study that demonstrated for the first time how combining medical imaging with AI can be used to provide a 'virtual biopsy' for cancer patients. It used AI to extract information about the chemical makeup of lung tumours from medical scans.
- A study examining the potential cognitive deficits caused by infection with the COVID-19 virus.
- Early findings that a DNA-tailored diet could help manage blood glucose and reduce the risk of progressing to type 2 diabetes in high-risk individuals.
- Some of our patients have become the first in the UK to receive a new treatment that could help their bodies recognise and fight cancer cells. The experimental therapy is being evaluated for safety and its potential for treating melanoma, lung cancer and other 'solid tumour' cancers as part of a global trial
- A clinical validation study led by the Trust and Imperial College London's Brain Tumour Research Centre of Excellence Research has found that a simple blood test could help diagnose the deadliest form of brain cancer.
- Glaucoma patients at the Western Eye can now be offered an innovative laser treatment, following the opening of a new clinical research registry.

9 Estates and redevelopment update

9.1 We are continuing to deliver an estates and infrastructure investment plan for the short to medium term, focusing on addressing urgent backlog maintenance and improving ways of working. These schemes include:

- Second phase of improvements to 3 West Ward at Charing Cross, including more consultation and waiting rooms
- Improved clinical facilities and patient access in the Irvine vascular studies department at St Mary's – due to be completed by the end of April 2024.
- Creating a new library, staff resource and community engagement space in a fully refurbished education centre within the Mint Wing at St Mary's, replacing the existing library in the medical school building – due to be completed this autumn. The project will be supported by Imperial Health Charity, thanks to a very generous donation from Baron Paul of Marylebone.
- We are improving our staff lounge at St Mary's Hospital, transforming some of the café in the QEQM building into a staff-only lounge and modernising the public eating area. Work has now begun on this and is due to completed in early July.

9.2 We have been awarded a further £34.7m from the Public Sector Decarbonisation Scheme (PSDS), which we will use to install heat pumps at Hammersmith Hospital. This should reduce our carbon usage by 4,270 tonnes per year.

9.3 I attended the official opening of the Wembley community diagnostic centre (CDC) on 1 February 2024. This is the second of three CDCs in north west London. We will run this centre and are running the Willesden centre which opened last summer. The third centre, in Ealing, is due to open later this spring and will be managed by London North West University Healthcare NHS Trust. The centres aim to bring down waiting times by together offering around 180,000 diagnostic tests for cancer and other serious illnesses each year. Located on existing NHS sites close to significant clusters of deprivation, they also aim to help reduce health inequalities. The purpose-built Wembley Community Diagnostic Centre had its first patients on 15 January 2024 and is running seven days a week, 8am-8pm. It will offer over 30,000 MRI and CT scans each year. Professor Sir Mike Richards, who led a major review of diagnostic services in 2020 that initiated the CDC programme, cut the ribbon on the official opening day, along with CDC colleagues, Brent councillors Neil Nerva and Ketan Sheth, local MP Barry Gardiner and NHS leaders.

Redevelopment

9.4 We ran an engagement programme with patients and local communities through January to get early input on our proposals for the redevelopment of St Mary's. This included pop-up events, a webinar and survey. We sent flyers to 11,959 local addresses surrounding the hospital promoting the events 300 survey responses and had 232 attendees at our events. Almost everyone who responded expressed their support for a full rebuild, as well as sharing their views on what the future St Mary's should provide and considerations for the wider Paddington basin area.

9.5 We submitted a business case to support the design and planning development for St Mary's which we are awaiting a decision on. The funding supports the RIBA 2 design development stage. The Trust and New Hospital Programme have agreed the best commercial approach is for the planning for the new hospital and future life sciences/commercial development to be progressed by the Trust in parallel. We are in the process of identifying a commercial development management partner to support this.

9.6 We have made a submission for fees to support the plans for the redevelopment of Charing Cross and Hammersmith Hospitals. We anticipate hearing about the level of support during April. We are currently appointing the design teams to progress these projects and expect the design team will be in place by the end of May.

10 Stakeholder engagement and visits

10.1 Below is a summary of significant meetings I have had with stakeholders:

- I briefed local Councillors on our plans for the redevelopment of St Mary's, meeting some of the Councillors from Little Venice ward on 4 January 2024 and the Hyde Park Councillors on 19 January 2024
- Andy Slaughter MP, 23 January 2024
- Cllr Ketan Sheth, London Borough of Brent, 7 February, 7 March 2024
- Felicity Buchan MP, 7 February 2024
- Cllr Nafsika Butler-Thalassis and Cllr Concia Albert, City of Westminster, 15 February 2024
- Nickie Aiken MP, 18 March 2024

10.2 We have also hosted several visits to the Trust, including

- On 15 February 2024, Councillors from Westminster City Council attended St Mary's Hospital for a tour and a discussion about our plans for the redevelopment of the hospital. Attendees included Cllr Adam Hug (the leader of the Council), Cllr Nafsika Butler-Thalassis, Cllr Geoff Barraclough, Cllr Concia Albert and Bernie Flaherty (Deputy Chief Executive).
- On 1 February 2024, the Rt Hon Andrew Stephenson MP visited St Mary's Hospital to learn more about our elective recovery progress so far and further work needed.
- On 7 February 2024, we welcomed Baroness Scott of Bybrook, Parliamentary Under Secretary of State at the Department for Levelling Up, Housing and Communities, to St Mary's. She heard about our ongoing work supporting people affected by the Grenfell Tower fire through our children's and adult respiratory long term monitoring services.
- On 21 February 2024, Sarah-Jane Marsh, National Director of Urgent and Emergency Care, visited St Mary's Hospital to see the emergency department and was impressed by our patient-centred approach.

10.3 We also welcomed BBC London news who broadcast a segment on the need for redevelopment of St Mary's on 21 February 2024.

11 Recognition and celebrating success

11.1 I'm delighted that we have now been formally accredited as a Veteran Aware Trust in recognition of our commitment to providing healthcare to veterans and their families. The Trust hosts Op-Restore on behalf of NHS England which has the responsibility for providing a network of care to veterans across the country and this accreditation is recognition of the great work undertaken by Shehan Hettiaratchy and his team who have been tireless advocates for veterans.

11.2 We have received am NHS Pastoral Care Quality Award to recognise our work in international recruitment and high-quality pastoral care to internationally educated nurses and midwives.

11.3 At our Apprenticeship Conference held on Tuesday 6 February, Abiodun Fakoya won Apprentice of the Year and an Individual Achievement award. Starting as a housekeeper at our Trust, Abiodun progressed into a role in human resources (HR), with the support of the Business Administrator apprenticeship. She will soon start her next apprenticeship qualification in HR Administration

11.4 Congratulations to Professor Alun Davies, honorary consultant surgeon and clinical director of private care, and Professor Graham Cooke, honorary consultant, who have been appointed as senior investigators by the National Institute of Health and Care Research (NIHR). These awards are given to those who are deemed to be the most outstanding leaders of patient and people-based research funded by the NIHR.

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

Accountable director: Patricia Wright
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

1.1 The Trust has had a number of inspections reports and external reviews over the past months. These have highlighted areas of good practice and areas for improvement as per section 2.1. Notably the CQC maternity report downgraded the service from 'Good' (in 2018) to 'Requires improvement' following their inspection in August 2023 (report published February 2024) which is clearly disappointing. The Trust has taken a proactive approach to responding to these inspections and external reviews and progress will be closely monitored through our Trust and Collaborative Governance arrangements.

1.2 The 2023 NHS Staff Survey results have been published, and our scores show a year-on-year improvement across all seven people promise elements. The results will inform the development of our People Strategy actions for 2024/25 actions as well as inform the continual review of the EDI action plan.

1.3 A huge thank you to staff as we've had some real successes this financial year which we can be proud of. Going into 2024/25 we're in a much more stable position to continue to improve and built upon the solid foundation we have achieved.

2. Quality and Safety

2.1 In August 2023, Hillingdon Maternity Services were visited by the CQC, who carried out an inspection focussing on the Safe and Well-Led domains as part of a nationwide maternal services inspection programme. The inspection report was published on 14th February 2024. The service received a rating of 'Requires Improvement' for maternity services with both 'Safe' and 'Well Led' domains rated as 'Requires Improvement'. As a result of the inspection, the CQC has identified fourteen 'Must Do' and eleven 'Should Do' actions that the Trust must address. The Trust has not received any other form of enforcement notices or sanctions following the inspection. The Trust is addressing the concerns raised by the CQC through the 'Maternity Improvement Plan' which will form part of a wider 'Maternity and Neonatal Improvement Programme' jointly led by the Chief Nurse and Chief Medical Officer. Delivery of this programme through 2024/25 will be a key priority for the organisation.

2.2 CQC inspectors conducted an announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the diagnostic imaging service at Hillingdon Hospital on 16 January 2024. The report has highlighted multiple areas of good practice around different aspect of the Ionising Radiation regulations including governance arrangements, referral guidelines, research, audit etc. The report

has identified one area for improvement which the department is currently working to improve on. Well done to the whole Radiology Team.

2.3 The British Orthopaedic Association (BOA) was invited to review THHFT Orthopaedic service following a report of "outlier" status in the National Joint Registry. Their review in February 2024 was followed by a letter of initial feedback which did not identify any patient safety concerns; however some high level recommendations were received from this initial feedback highlighting areas for improvement (procedural, monitoring and governance) and the Trust is responding to these in anticipation of the full report from the BOA which is expected in April 2024.

2.4 The Trust has launched the new nationwide-led Patient Safety Incident Response Framework (PSIRF) which sets out a new approach to developing and maintaining effective systems and processes for responding to incidents. This went live with the Learn from Patient Safety Events (LFPSE) reporting service on 18th March 2024.

3. Operational performance

3.1 Urgent and Emergency Care: A&E all types performance hit 78.5% end of March against a target of 76%. The Trust continues to focus on sustaining and improving on current A&E performance.

3.2 Elective Activity: The Trust has outperformed operating plan targets every month this financial year despite ongoing industrial action.

3.3 Theatre Productivity: The Trust is in the national top quartile for capped theatre utilisation.

3.4 Reduction in Long Waiting Patient List: The Trust has performed well in reducing the number of long waiting patients in line with national ambitions achieving (by the end of March 2024):

- 0 x 104 week waiting patients
- 0 x 78 week waiting patients
- 2 x 65 week waiting patients (unvalidated by 31 March)
- The Trust has reduced the number of patients waiting over 52 weeks for elective care by over 50% in 2023-24

3.5 Faster Diagnosis Standard (FDS) for Cancer: The Trust achieved 76.8% FDS in February 2024 against a target of 75%.

4. Financial performance

4.1 Overall, the Trust was £0.7m favourable to plan for the year to 29th February following receipt of £6.2m of income originally planned to be received in Month 12 plus £1.8m of additional ERF income thanks to continued improvement on elective recovery.

4.2 The efficiency plan has delivered £15.7m worth of cost savings to the end of February 2024, compared to targeted savings of £16.4m. The focus over the last few weeks has been on developing the savings plans for 2024/25.

4.3 The Capital plan is £4.8m underspent against its adjusted YTD plan, the full plan is forecast to be utilised by year end.

5. People

5.1 The 2023 NHS Staff Survey results have been published, and our scores show a year-on-year improvement across all seven people promise elements. The results will inform the development of our People Strategy actions for 2024/25 actions as well as inform the continual review of the EDI action plan.

5.2 Philip Spivey joined the Trust on secondment as our new chief people officer on Monday 5 February. He joined the Trust from London North West University Healthcare NHS Trust where he was the deputy chief people officer for seven years, and has recently led workforce workstreams within the Acute Provider Collaborative.

5.3 We are delighted to announce that Non-Executive Director, Vineeta Manchanda, will be joining THHFT on 1st May 2024. She will chair the Audit Committee here and at Chelsea and Westminster Hospital NHS Foundation Trust, and she will be a member of the Quality and Safety Committee and the Finance and Performance Committee. I would also like to take the opportunity to thank our outgoing Audit Committee chair, Non-Executive Director Neville Manuel for his contribution to the Trust and the APC.

5.4 Recently, a group of talented young adults with learning disabilities completed an internship at Hillingdon Hospital as part of DFN Project SEARCH's scheme. The project is a one-year transition to work programme for young people who come to the Trust for intensive work placements. It is supported by the charity Hillingdon Autistic Care and Support. From this intake, one of the interns, Leo Hunt, has even made it a permanent move by securing a paid position as a staff bank porter.

5.5 The Trust held a healthcare assistants recruitment day on Thursday 1 February 2024. Twenty one substantive and 13 bank posts were offered on the day.

5.6 The Trust launched its new staff intranet in March 2024 after lots of planning and preparation. The new intranet is more user friendly, engaging, has an improved search function, and is also available on mobile devices, which is a significant benefit to clinical staff. Staff have fed back very positively about the update and are engaged in ensuring information is kept up to date.

5.7 Following direct feedback from staff we launched our new weekly bulletin alongside the launch of the new intranet. Staff said that the daily newsletter was too frequent and found it hard to decipher what information was most important to them. The new bulletin, which is emailed to all staff every Monday, categorises news and information so staff can scan it quickly and obtain the relevant information to them and their job role.

6. Equality, Diversity and Inclusion (EDI) update

6.1 The Trust's disability network has been relaunched as 'Able 4 All'. The new name reflects a shift in the conversation around disabilities, with a greater emphasis on how the Trust can proactively build environments and cultures that enable everyone to perform at their best, whether or not staff have an identified or disclosed disability.

7. Hillingdon Hospital Redevelopment

7.1 We welcomed the Secretary of State for Health and Social Care, Victoria Atkins, and local MP Steve Tuckwell to the hospital on Thursday 22 February, to talk through the plans for a new Hillingdon Hospital. As well as a presentation, our guests met with staff and patients on Kennedy Ward at the top of the main tower, getting a first-hand view of why building a new Hillingdon Hospital that is fit for the future is so important.

7.2 A new set of videos are due to be released in March, speaking to members of the community about why we need a new Hillingdon Hospital. The first of which has already been published.

8. Updates from the Council of Governors (CoG)

8.1 The Trust held a briefing session for our governors on 6th February 2024. The session was designed to provide the governors with a greater understanding and insight of the Integrated Quality and Performance Report.

8.2 The CoG met formally on 14th March 2024. The Governors received reports from the Chair and CEO as well as reports relating to quality and performance, our draft quality priorities, the recent CQC maternity inspection report and our staff survey results.

8.3 The Governors also supported and noted a proposed timetable to appoint to our Medical/Dental staff governor vacancy which aims to commence in April and conclude in May 2024.

9. Research and innovation

9.1 The Trust's cardiology department is now using Change Healthcare echocardiography reporting software. The new software enables measurements and images to be imported automatically to a template and go straight on to the system, instead of information being gathered manually, reducing the likelihood of errors and making the process more efficient.

10. Stakeholder engagement

10.1 On Monday 5 February, Patricia Wright, CEO, hosted Hayes and Harlington Labour MP John McDonnell for an informal briefing on the Trust's latest activities and achievements.

11. Recognition and celebrating success

11.1 One of the Trust's leading surgeons has been elected to prestigious positions within the Royal College of Surgeons of England (RCSEng). Yasser Mohsen has been elected Chair of the Court of Examiners, within the Royal College of Surgeons of England (RCSEng), a key role in shaping the future of surgical training in England. He will also join the College Council, a governing body that sets the strategic direction for the RCSEng, which strives to advance surgical excellence. Mr Mohsen has acknowledged the hospital's management for their encouragement of his national and international

endeavours, which have significantly elevated Hillingdon's profile within the surgical community.

11.2 The Trust was honoured with the prestigious NHS Pastoral Care Quality Award as part of NHS England's International Recruitment Programme in February. The NHS Pastoral Care Quality Award is a testament to our commitment and dedication to generating a supportive and inclusive environment by providing exceptional pastoral care to internationally educated nurses and midwives throughout the recruitment process and their time within the organisation. The award also specifically acknowledges our outstanding efforts in ensuring the wellbeing, integration, and professional development of internationally recruited nurses and midwives.

11.3 The Hillingdon Hospital achieved the highest patient food score and the fourth highest cleanliness score in the country for the 2023 Patient Led Assessment of Care of Environment (PLACE) survey, with the Trust's scores being above average in all domains.

11.4 Members of the colorectal team (in particular, consultant colorectal surgeons Alistair Slesser and Alistair Myers) marked a major landmark within the department carrying out 25 surgical complex procedures using the new Da Vinci robot. The introduction of robotic surgery brings the Trust into line with other trusts in NWL.

11. REPORTS FOR INFORMATION ONLY

11.1 USE OF THE TRUST SEAL - PETER JENKINSON

REFERENCES

Only PDFs are attached

11.1 BIC Trust seal annual report 2324 (PJ).pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 11.1
This report is: Public

Trust Seal Annual Report

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

Accountable director: Peter Jenkinson & Dawn Clift
Job title: Director of Corporate Governance (ICHT & CWFT) & Director of Corporate Affairs (LNWH)

Purpose of report

Purpose: Information or for noting only

The Trusts' standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis. The report includes the use of the Trust seal during FY 2023/24 for all four Trusts within the Acute Provider Collaborative.

The Board in Common is asked to note the report and the use of the Trust Seal.

Report history

Outline committees or meetings where this item has been considered before being presented to this meeting: N/A

Executive summary and key messages

The Trust's standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis. The report includes the use of the Trust seal during FY 2023/24 for all four Trusts within the Acute Provider Collaborative.

The Board in Common is asked to note the report and appendices and the use of the Trust Seal.

The appendices detail each Trust's use of their seal:

Appendix 1: Chelsea & Westminster NHS Foundation Trust
Appendix 2: The Hillingdon Hospitals NHS Foundation Trust
Appendix 3: Imperial College Healthcare NHS Trust

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

Reporting use of the Trust seal enables review of the contracts, property agreements and other documentation that has been entered into during the year, acting as a control to reduce risk of misuse

Reason for private submission

Tick all that apply

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

If other, explain why

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Appendix 1

Use of the Trust Seal

This report covers the period April 2023 to March 2024.

Seal No.	Date	Description
219	25/04/2023	Basement and Ground Floor 34-35 Dean Street, London WID 4PR Lease between Dalness Estates Limited and Chelsea and Westminster Hospital NHS Foundation Trust
220	22/06/2023	ACAI (Dean Street) Ltd.and Chelsea and Westminster NHS Foundation Trust liaise relating to second floor, 37 Dean st, London W1D 4PS
221	24/08/2023	CW+ and Chelsea and Westminster NHS Foundation Trust Deed of Surrender, Units E and F, 369 Fulham Rd, London. SW10
222	02/11/2023	Deed treaty to land to the East of the Marjory Warren Building at West Middlesex TW7 6AF (ADC Project)
223	01/12/2023	The Mayor and Burgesses of the London Borough of Hounslow as Authority and Chelsea and Westminster Hospital Foundation Trust as Provider, Contract for the Provision of Integrated Sexual Health Services
224	22/12/2023	Licence for Alterations in Relation to Second Floor, 37 Dean Street, London W1D 4PS between Acai (Dean Street) Ltd. And CWH NHS FT
225	29/01/2024	Tenancy at Will relating to Part of West Middlesex University Hospital between CWH NHS FT and Alliance Medical Ltd.

226	29/01/2024	Deed of Surrender to Part of West Middlesex University Hospital between CWH NHS FT and Alliance Medical Ltd.
227	07/02/2024	Deeds of Adherence between the Existing Partners of the North West London Occupational Health shared Service Partnership and the Hillingdon Hospital NHS Foundation Trust
228	23/02/2024	56 Dean Street – licence to alter
229	22/03/2024	Funding agreement between CW NHS FT and The Mayor and Burgesses of the London Borough of Hounslow Ambulatory Diagnostic Centre (ADC) CW Hospital, 369 Fulham Rd, London SW10 9 NH

Magdalena Farias, Corporate Governance Administrator, CWFT

Appendix 2

Use of Trust Seal

The report covers the period April 2023- March 2024

Seal number	Document Details	Parties	Date Signed & Sealed
0021	Surrender of leasehold properties at Ground Floor for North and South, Building 4, Square One, Southall Lane, Heston	Between THHFT - CB Southall Investments LLP	05/07/2023
0022	Draft Section 106 Agreement for Execution as a Deed	Between THHFT - Mishcon de Rya	11/10/2023
0023	THHFT & East & North Herts - Lease Agreement	Between THHFT & East & North Herts	10/11/2023
0024	THHFT & Siemens Healthcare Ltd - License for Alterations	Between THHFT & Siemans	19/12/2023
0025	THHFT & Siemens Healthcare Ltd - Lease	Between THHFT & Siemans	19/12/2023
0026	THHFT & AECOM Ltd - NEC4 Professional Service Contract Relating to PM	Between THHFT & AECOM Ltd	19/12/2023
0027	THHFT & AECOM Ltd - NEC4 Professional Service Contract Relating to MEP	Between THHFT & AECOM Ltd	19/12/2023
0028	Western Building Systems Ltd	Between Alan Wood partnership & THHFT & Western Building Systems	19/12/2023

0029	Mullinsallagh Ltd T/A Eden Fabrications	Between THHFT Mullinsallagh Ltd & Western Building Systems	19/12/2023
0030	Milbank concrete Products Ltd	Between Milbank Concrete Products & THHFT & Western Building systems Ltd	19/12/2023
0031	Mullinsallagh Ltd T/A Eden Fabrications	Between Mullinsallagh Ltd T/A Eden Fabrications and Western Systems Ltd	24/01/2024
0032	Milbank concrete Products Ltd	Between Milbank Concrete Products & THHFT & Western Building systems Ltd	24/01/2024
0033	JCT - ICD 2016 Intermediate Building Contract - Conversion of old ITU into 13 bed ward space	Storm Building Ltd & THHFT	24/01/2024
0034	WT Partnership - Old ICU Reconfiguration to 14 Bed space	WT Partnerships Quantity Surveyors & THHFT	24/01/2024
0035	Deed of Adherence NWL Occupational Health share partnership	CNWL / Chelsea & Westminster / THHFT	14/02/2024
0036	Lease of the Incinerator Site at Hillingdon Hospital	Between THHFT and Medisort Limited	27/03/2024
0037	Operation Agreement - Engrossment for the Incinerator at Hillingdon Hospital	Between THHFT and Medisort Limited	27/03/2024

Leigh Franklin, Assistant Trust Secretary, THHFT

Appendix 3 Use of the Trust Seal

This table is a record of the use of the Trust seal as required by the Trust Standing Orders from 1 April 2023 – 31 March 2024

Seal No.	Parties	Nature of transaction requiring affixment of seal	Date sealed
275	Imperial College Healthcare NHS Trust and Playfords Ltd and Breathe Energy Ltd	Sub-contractor collateral warranties in relation to designing and building decarbonisation measures at Charing Cross Hospital and Hammersmith Hospital	19/07/2023
276	Imperial College Healthcare NHS Trust and Gardiner and Theobald LLP	St Mary's Hospital design project management	26/07/2023
277	Imperial College Healthcare NHS Trust and Aecom Limited	St Mary's Hospital design quantity surveying	26/07/2023
278	Imperial College Healthcare NHS Trust and Aecom Limited	St Mary's Hospital design mechanical, electrical and plumbing engineering services	26/07/2023
279	Imperial College Healthcare NHS Trust and Lexica Health and Life Sciences Consultancy Limited	St Mary's Hospital design healthcare planning	26/07/2023
280	Imperial College Healthcare NHS Trust and Ramboll UK Limited	St Mary's Hospital design civil and structural engineering services	26/07/2023
281	Imperial College Healthcare NHS Trust and HOK international Limited	St Mary's Hospital design architect and master planning	26/07/2023

Seal No.	Parties	Nature of transaction requiring affixment of seal	Date sealed
282	Imperial College Healthcare NHS Trust and Imperial Charity and Great Western Developments Limited	Sub lease of parts of flank walls in outpatients and Winston Churchill building.	23/08/2023
283	Imperial College Healthcare NHS Trust and Natwest Bank PLC	Lease for ATM at Hammersmith Hospital	28/09/2023
284	Imperial College Healthcare NHS Trust and Breathe Energy Limited	Decarbonisation works at Charing Cross Hospital and Hammersmith Hospital	7/12/2023
285	Imperial College Healthcare NHS Trust and Verses Arthritis	Collaboration agreement relating to the joint sale of land at the Charing Cross site.	6/3/2024
286	Imperial College Healthcare NHS Trust and Central and North West London NHS Trust	A lease of premises at the Dumbell Building, St Mary's Hospital	6/3/2024
287	Imperial College Healthcare NHS Trust and A2 Site Investigation Limited	Ground investigation works at St Mary's Hospital	20/03/2024

Jessica Hargreaves, Deputy Director of Corporate Governance, ICHT

Appendix 4

Use of the Trust Seal

This report covers the period April 2022 to March 2023.

Seal No.	Date sealed	Description
2024/01	27/03/2024	Bowel Cancer Screening Services, Ethical Wall Agreement - NHS England ("the Authority") of Wellington House, 133 – 135 Waterloo Road, London and London North West University Healthcare NHS Trust of Northwick Park Hospital ("the Counterparty").

Rachael Thomas, Acting Corporate Governance Manager, LNWH

11.2 HEALTH AND SAFETY ANNUAL REPORT 2022-23 - JONATHAN REID

REFERENCES

Only PDFs are attached

11.2 BIC Collaborative Health and Safety Annual Report 22-23 (3).pdf

NWL Acute Provider Collaborative Board in Common (Public)
16/04/2024
Item number: 11.2
This report is: Public

Health and Safety Annual Report 2022-23

Author: Michelle Stark
Job title: Associate Director Estates & Facilities (Compliance, Fire & Health & Safety)

Accountable director: Jonathan Reid
Job title: Chief Financial Officer

Individual Trust Annual Health and Safety Reports 2022/2023 Authors:

- Chelsea and Westminster Hospital NHS Foundation Trust – V. Richards-Head of Risk and Assurance
- Imperial College Healthcare NHS Trust – M. Hall – Associate Director of Health, Safety and Working Environment
- London North West University Healthcare NHS Trust (LNWH) – M. Stark – Associate Director Estates & Facilities (Compliance, Fire & Health & Safety)
- The Hillingdon Hospitals NHS Foundation Trust – No annual health and safety report for 2022/2023, alternative report and information provided by J. Brind, the new Trust Head of Health and Safety

Purpose of report

Purpose: Assurance

The Board in Common is requested to:

Approve this summary of the health and safety annual reports for the trusts in the Collaborative covering the period 1 April 2022 to 31 March 2023 and receive assurance that each Trust has individual local robust arrangements in place to scrutinise the management of health and safety.
Receive this report with a recommendation of approval from the APC Quality Committee.

Note: The Hillingdon Hospitals NHS Foundation Trust did not produce an Annual Health and Safety Report for the period, but included health and safety information in their Annual Reports and Accounts 2022-2023.

Report history

Individual annual reports for each organisation have been presented to individual Trust's Sub-Board Committee, with the exception of Hillingdon who provided health and safety information via their Annual Reports and Accounts 2022-2023. This summary report has been considered by the APC Quality Committee and is recommended for approval to the Board in Common.

Executive summary and key messages

This paper summarises the health and safety reports for the period 1 April 2022 to 31 March 2023 for the four Trusts, comprising the North West London Acute Provider Collaborative. The four Trusts (in alphabetical order) are:

- Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)
- Imperial College Healthcare NHS Trust (ICHT)
- London North West University Healthcare NHS Trust (LNWHT)
- The Hillingdon Hospitals NHS Foundation Trust (THHFT)

Each individual Trust has submitted its own annual health and safety report to its relevant sub-board Committee, with the exception of The Hillingdon Hospitals NHS Foundation Trust who included health and safety Information in their 2022-2023 Annual Reports and Accounts.

Strategic priorities

Tick all that apply

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

Impact assessment

Tick all that apply

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

It is a legal requirement to manage health and safety, which includes managing risks and taking practical steps to protect workers and others affected by work activities from harm.

Reason for private submission

Tick all that apply.

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

North West London Acute Provider Collaborative Annual Health and Safety Reports 2022-23

1. **The Governance of health and safety across the Collaborative**

   Each of the four Trusts within the Collaborative can provide assurance that:

   - They have a health and safety governance framework in place, which is regularly reviewed and updated as necessary. This includes managing risks and taking practical steps to protect workers and others affected by work activities from harm, ensuring arrangements are in place to make the right plans, implement those plans, check they are working and act if they are not.
   - They review in advance the management arrangements for any health and safety topics thought to be of current key interest to the Regulator (e.g., V&A, manual handling, sharps), identifying any areas requiring improvement and take effective corrective action.
   - Health and safety risk management is an integral day-to-day part of its activities to ensure that non-clinical safety risks are managed and are committed to carrying out their work in a way that ensures the safety and health of its staff, patients, service users and any others who might be affected by its undertaking.
   - They have a named Executive Director responsible for health and safety.
   - They have a dedicated in-house health and safety service in place to support the named Executive Director, providing competent advice (in conjunction with other specialist areas in the Trust) as required by legislation.
   - They have an established on-line Incident Reporting System “Datix” in place.
   - Effective systems are in place to provide and monitor statutory and mandatory training.
   - Health and safety is considered at local level and reported at Executive and sub–Board level.
   - They have a Health and Safety Policy in place that is in date and reflects legislation and regulatory requirements.

1.1 Health and Safety Committees/Group and Health and Safety Related Sub-Groups: The role of a Health and Safety Committee/Group is to provide assurances regarding all health and safety matters arising from the Trust's undertaking.

Trust	Committee/Group Name	Chair
CWFT	Health, Safety and Environment Risk Group	Chief Nursing Officer
ICHT	Trust Health and Safety Committee	Chief People Officer
LNWH	Corporate Health, Safety, Security & Environment Group	Chief Finance Officer
THHFT	Health, Safety and Environment Committee	Chief Operating Officer

Table 1: Health and Safety Committees/Groups

Each of the four Trust's Committees/Groups are chaired by its respective named Executive Director, who has delegated responsibility for health and safety, within each Trust. The Committees/Groups are a strategic level consultative, advisory, and decision-making body for health and safety affecting, primarily, employees, patients, third party partners, contractors, visitors, and members of the public. They are responsible for consulting on, monitoring, managing, and reviewing the adequacy and effectiveness of Trust's health and safety management arrangements. This includes reviewing the effectiveness of risk controls, and monitoring compliance and performance.

Each of the four Trusts have associated health and safety related sub-groups. As Appendix 1.

1.2 Health and Safety Key Performance Indicators and Dashboard: Each Trust has health and safety key performance indicators and/or dashboards in place to manage and monitor health and safety, and identify and manage risks, putting in place corrective actions as required. Performance and risks are overseen by each respective Trust's Committees/Groups and corresponding governance structure.

1.3 Incident Reporting: Incident reporting is a fundamental tool of risk management in each Trust, the aim of which is to collect information about adverse incidents, including near misses, ill health, and hazards, which help to facilitate wider organisational learning. Each of the four Trusts use a digital risk management information system "Datix" which is designed to collect and manage data on adverse events. Trusts, produce information, trend analysis and lessons learnt throughout the year on reported

incidents, and communicate these and share lessons learnt through their respective governance arrangements.

The four Trusts have clearly defined processes and procedures to follow in the events of Serious Incidents (SIs). During the reporting period two Trusts reported health and safety related SIs. These were fully investigated and reported on, with appropriate actions put in place and communicated in line with each Trust's relevant policy.

Trust	SI Details
CWFT	RIDDOR related incident - amputation to an operative's top of fingers by door
LNWHT	Legionella incident

Table 2: Health & Safety Related SI Reported

1.4 Health and Safety Policy: Health and safety legislation requires that a health and safety policy is in place. Each Trust's health and safety policy follows regulatory requirements and describes the arrangements in place to enable them to comply with its obligation under the Health and Safety at Work. Etc. Act 1974 and the Act's relevant statutory provisions.

1.5 Statutory and Mandatory Training: Each of the four Trusts reported on, monitored, and oversaw statutory and mandatory training related to health and safety, albeit in varying reporting formats and categories provided in their reports. Table 3 provides an overview of the common main reported training.

Trust	Training Reported (Key: Green indicate target met, amber not met)	Target 90 %
CWFT	Health and Safety Fire	95% 91%
ICHT	Health and Safety Fire Manual Handling	92.7% 91.8% 93.3%
LNWHT	Health and Safety Fire Manual Handling Level 1 (E-Learning) Manual Handling Level 2 (Face to Face) Manual Handling Level 2 (E-Learning)	94% 87% 91% 88% 85%
THHFT	Health, Safety and Welfare Manual Handling Level 1 Manual Handling Level 2 (Face to Face) Fire Safety	95.4% 91.9% 92.4% 89.6%

Table 3: Common Main Reported Training

2 Health and Safety Regulator

2.1 Health and Safety Executive Investigations and Enforcements: The main regulator/ enforcing authority is the Health and Safety Executive (HSE) (although, the CQC, fire services and other agencies also have responsibilities). Table 4 details HSE investigations and enforcement actions during 2022/2023.

Trust	Details	Outcome
CWFT	None	N/A
ICHT	None	N/A
LNWHT	None	N/A
THHFT	Inspected by the HSE regarding the management and prevention of sharps injuries.	Improvement notice received

Table 4: HSE Investigations and Enforcement Action

In September 2022, THHFT site was inspected by the HSE regarding the management and prevention of sharps injuries and the Radiology Department was servied with a related improvement notice.

The Trust developed an action plan which was managed by the Sharps Safety Group and overseen by the Chief Operating Officer and the Executive Director of Nursing.

At a follow up meeting with the HSE in January 2023, the HSE Inspector provided positive feedback regarding the Trust's approach to the improvement notice, with confirmation form the HSE in March 2023, that the requirements of the improvement notice had been complied with.

2.2 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) These regulations apply to the healthcare sector and requires each Trust to report deaths, 'specified injuries' to workers, over seven-day incapacitation of a worker, certain occupational diseases, and dangerous occurrences that 'arise out of or in connection with work'. The four Trusts had effective systems in place for reporting RIDDOR reportable incidents. Overall, the four Trusts combined reported a total of 113 RIDDOR incidents to the HSE. 42.5% were reported by CWFT, 36.5% were reported by ICHT, 14% were reported by LNWHT and 7% reported by THHFT.

Chart 1 details the total number of RIDDOR reportable incidents reported for each of the Trusts, reporting of which is overseen by each Trust's respective health and safety service.

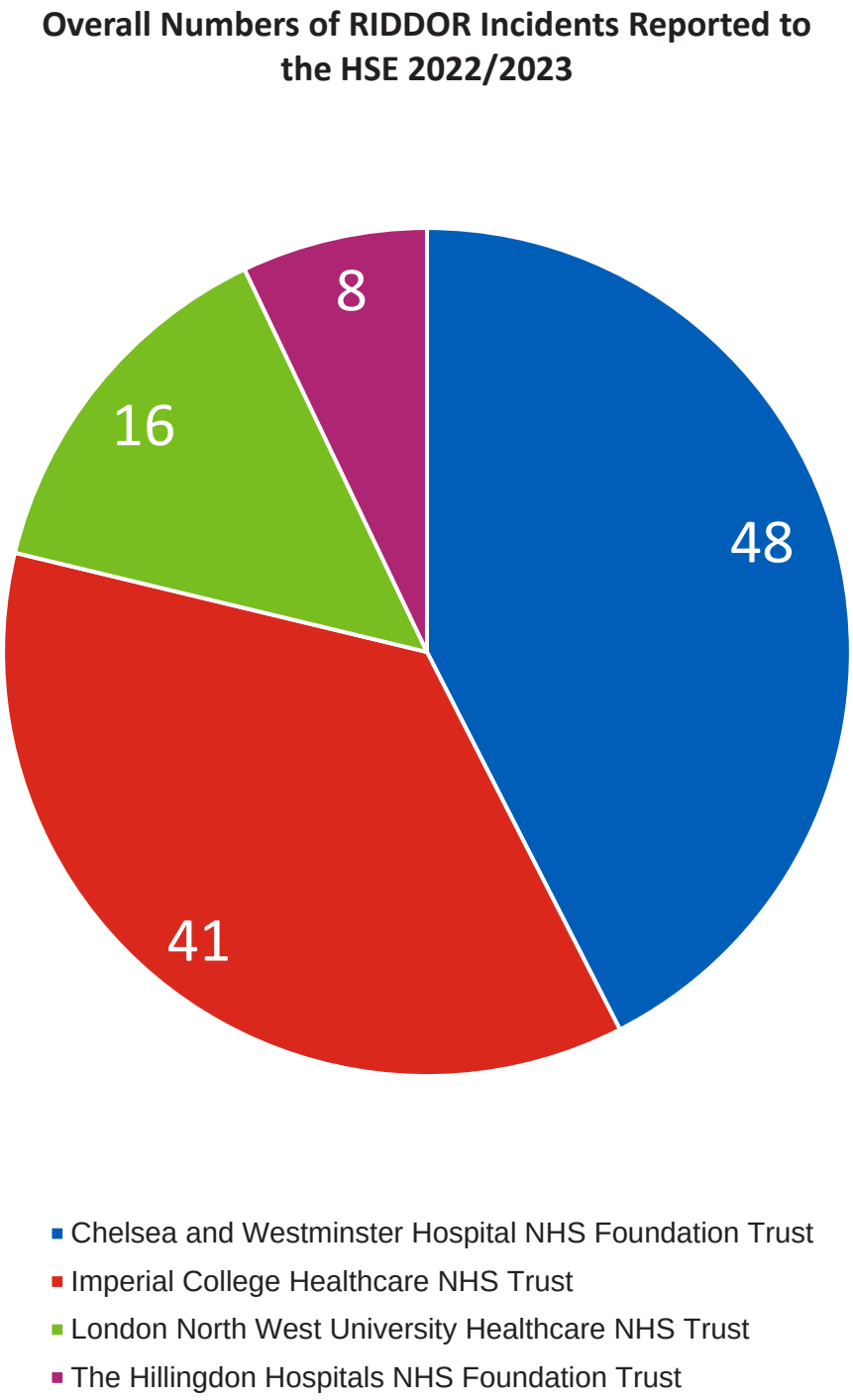


Chart 1: Total RIDDOR Reports to HSE Per Trust

Details and breakdowns of each specific RIDDOR report made to the HSE, was reported on, and overseen by each respective Trust Committees/Groups and governance structure.

Table 5 details the specific RIDDOR details reported for each Trust.

CWFT	
Contact/exposure to harmful substances	22
Accidental release of harmful substances	2
Handling, lifting, or carrying	9
Falls, trips or slips	6
Physically assaulted by a person	4
Hit by object	2
Tendonitis	1
Contact with electricity	1
Major injury (amputation)	1
Total	48
ICHT	
Dangerous occurrence	2
Violence & aggression	6
Musculoskeletal (MSK)	11
Staff falls	21
Patient fall	1
Total	41
LNWHT	
RIDDOR Category Incapacitation 7+days	
Physical assault	3
Staff slip, trip, fall	1
Moving & handing	8
Hit by object	1
RIDDOR Category Dangerous occurrence	
Sharps	2
RIDDOR Category Non-workers	
Patient fall and fracture	1
Total	16
THHFT	
RIDDOR Category over 7-day injury staff	7
RIDDOR Category major injury	1
Total	8

Table 5: Categories Identified per Trust for each RIDDOR Report

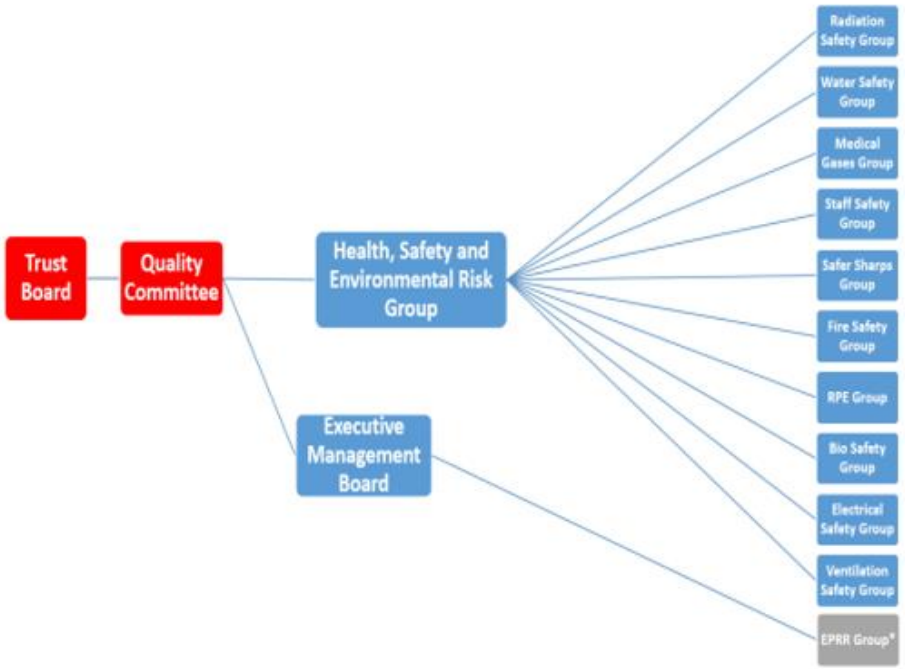
3. Networking and Collaborative

Currently 3 out of the 4 Trust's meet regularly as part of a wider general health and safety leads networking group, sharing best practice and professional networking support.

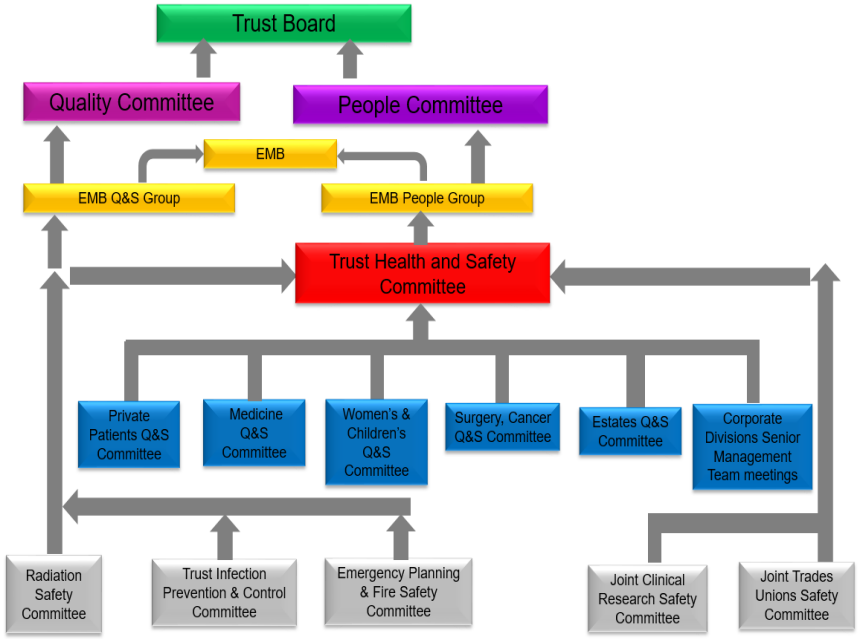
Whilst the individual governance requirements of each Trust must be maintained, to support the collaborative, all 4 Trusts will form and commit to a dedicated collaborative working group in order to work towards aligning common reporting criteria, discussing and sharing practices, agreeing on best practice, and look to further improve processes collectively across the collaborative.

Appendix 1 –Collaborative Health and Safety Arrangements

Chelsea and Westminster Hospital NHS Foundation Trust



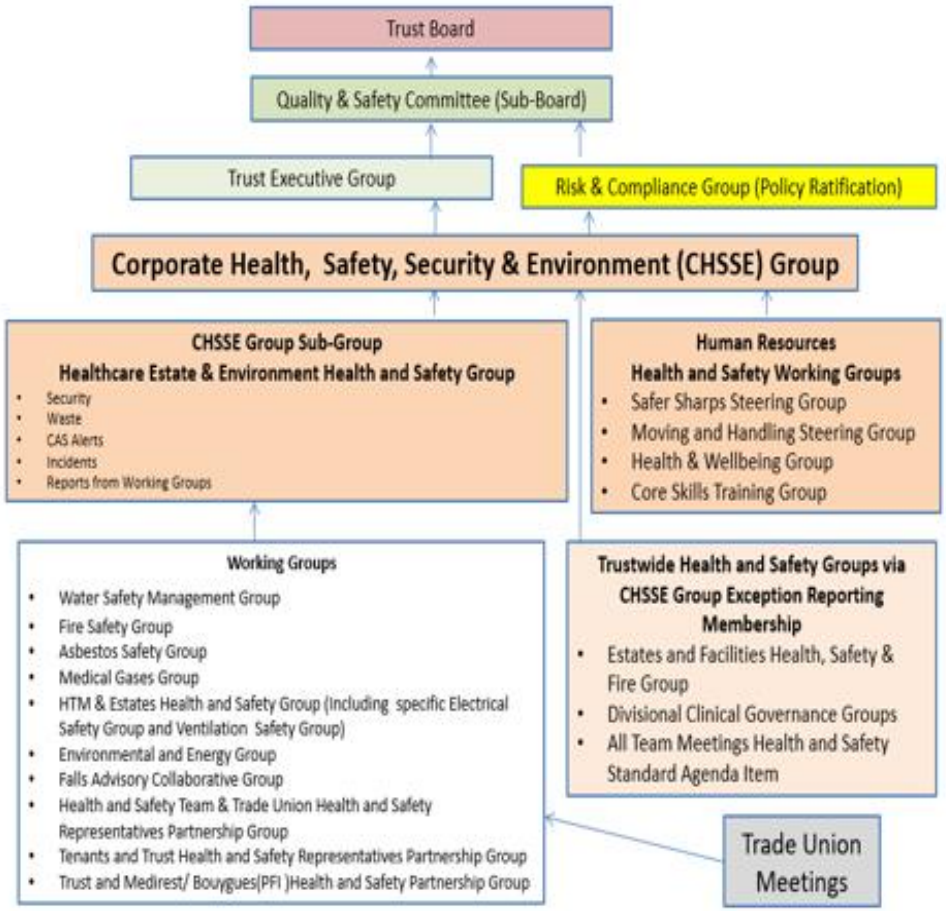
Imperial College Healthcare NHS Trust



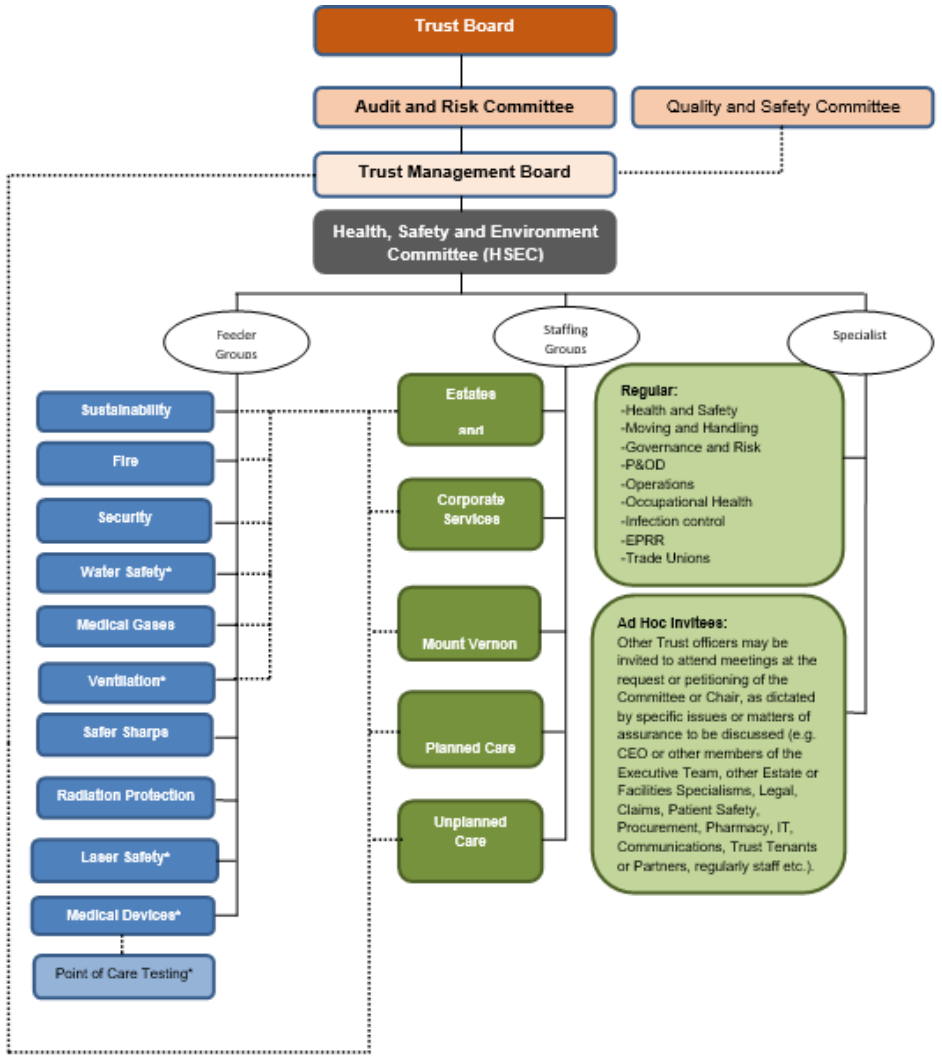
Sub-Groups

- Estates and Facilities Compliance Quality and Safety Committee.
- Violence and Aggression Steering Group
- Water Safety Committee
- Ventilation Safety Group
- Falls Steering Group

London North West University Healthcare NHS Trust



The Hillingdon Hospitals NHS Foundation Trust



12.1 ANY OTHER BUSINESS - NIL ADVISED

13 QUESTIONS FROM THE MEMBERS OF THE PUBLIC

13.1 THE CHAIR WILL INITIALLY TAKE ONE QUESTION PER PERSON AND COME BACK TO PEOPLE WHO HAVE MORE THAN ONE QUESTION WHEN EVERYONE HAS HAD A CHANCE, IF TIME ALLOWS - MATTHEW SWINDELLS

DATE AND TIME OF NEXT MEETING

16 July 2024
Venue to be confirmed