NHS

**North West London
Acute Provider Collaborative**

NORTH WEST LONDON ACUTE PROVIDER COLLABORATIVE BOARD IN COMMON - PUBLIC

NORTH WEST LONDON ACUTE PROVIDER COLLABORATIVE BOARD IN COMMON - PUBLIC

📅 16 July 2024

🕐 09:00 GMT+1 Europe/London

📍 Meeting Rooms 5 & 6, 4th Floor, Hilton London Wembley, Lakeside Way, Wembley Park, Wembley, HA9 0BU

AGENDA

0. AGENDA

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

NHS

**North West London
Acute Provider Collaborative**

**North West London Acute Provider Collaborative
Board in Common - Public
Tuesday 16 July 2024, 09.00-12.00**

**Meeting Rooms 5 & 6, 4th Floor, Hilton London Wembley,
Lakeside Way, Wembley Park, Wembley, HA9 0BU**

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

A G E N D A

Time	Item No.	Title of Agenda Item	Lead	Enc
09.00	1.0	Welcome and Apologies for Absence	Chair in Common Matthew Swindells	Verbal
	1.1	Declarations of Interest	Matthew Swindells	Verbal
	1.2	Minutes of the previous NWL Acute Provider Collaborative Board Meeting held on 16 April 2024	Matthew Swindells	1.2
	1.3	Matters Arising and Action Log	Matthew Swindells	1.3
09.05	1.4	Patient Story – from a sickle cell group member who had care with LNWH and ICHT *To note the patient story*	Pippa Nightingale	1.4
2. Strategy				
09.20	2.1	Acute Provider Collaborative Strategy *To approve the emerging APC strategy*	Tim Orchard	2.1
	2.2	Clinical Pathways Programme *To consider the proposed programme*	Tim Orchard	2.2
3. Report from the Chair in Common				
09.50	3.1	Report from the Chair in Common *To note the report*	Matthew Swindells	3.1
	3.2	Board in Common Cabinet Summary *To note any items discussed at the Board in Common Cabinet meetings*	Matthew Swindells	3.2
4. Integrated Quality and Performance Report				
10.00	4.1	Integrated Quality, Workforce, Performance and Finance Report *To receive the integrated performance report*	Patricia Wright Pippa Nightingale Lesley Watts	4.1

5. Quality				
10.30	5.1	Collaborative Quality Committee Chair Report *To note the report*	Steve Gill	5.1
	5.2	Learning from Deaths report *To note the report*	Jon Baker	5.2
6. Workforce				
10.45	6.1	Collaborative People Committee Chair Report *To note the report*	David Moss	6.1
	6.2	APC Improvement Plan – EDI Action Plan *To approve the EDI action plan*	Pippa Nightingale	6.2
7. Data and Digital				
11.00	7.1	Collaborative Data and Digital Committee Report *To note the report*	Steve Gill	7.1
8. Estates and Sustainability				
11.10	8.1	Collaborative Strategic Estates and Sustainability Committee Report *To note the report*	Bob Alexander	8.1
9. Finance and Performance				
11.15	9.1	Collaborative Finance and Performance Committee Chair Report *To note the report*	Catherine Jervis	9.1
	9.2	Financial performance report *To receive the financial performance report*	Jon Bell	9.2
	9.3	Acute Provider Collaborative and Trust Business Plans – Priorities, Operating and Financial *To note the plan*	Lesley Watts	9.3
10. Audit				
11.35	10.1	Acute Provider Collaborative Governance Model and Scheme of Delegation *To approve the revised governance model and scheme of delegation*	Peter Jenkinson	10.1
11. Chief Executive Officers				
11.40	11.1	Executive Management Board (EMB) Summary *To note any items discussed at the EMB meetings*	Tim Orchard	11.1
	11.2	Reports from the Chief Executive Officers and Trust Standing Committees *To note the reports* • London North West University Healthcare NHS Trust • The Hillingdon Hospitals NHS Foundation Trust	Pippa Nightingale/ David Moss Patricia Wright/ Catherine Jervis	11.2a, b 11.2c, d

		• Imperial College Healthcare NHS Trust	Tim Orchard/ Bob Alexander	11.2e, f
		• Chelsea and Westminster Hospital NHS Foundation Trust *CWFT Trust Standing Committee is taking place on 18 July 2024. The agenda is included for information.*	Lesley Watts/Steve Gill	11.2g, h
12. Reports for Information Only				
	12.1	Nil Advised		
13. Any Other Business				
	13.1	Nil Advised		
14. Questions from Members of the Public				
	14.1	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				
15 October 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

🔵 Standing item   👤 Chair in Common, Matthew Swindells   🕐 09.00

1.1 DECLARATIONS OF INTEREST

● Discussion Item　　　👤 Matthew Swindells

1.2 MINUTES OF THE PREVIOUS NWL ACUTE PROVIDER COLLABORATIVE BOARD MEETING HELD ON 16 APRIL 2024

● Decision Item   👤 Matthew Swindells

REFERENCES   Only PDFs are attached

📄 1.2 Draft BiC public minutes 16 April 2024 v2.pdf

North West London Acute Provider Collaborative Board in Common
Meeting in Public
Tuesday 16 April 2024
The Legends Room, Brentford Football Club, Brentford

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)
Mr David Moss	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 Ajay Metha	Non-Executive Director (CWFT & LNWH)
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)
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)

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	Mr Kevin Croft	Chief People Officer (ICHT)
	Mr Phil Spivey	Chief People Office (THHFT)
	Ms Tracey Connage	Chief People Officer (LNWH)
	Ms Lindsey Stafford-Scott	Interim Chief People Officer (CWFT)
	Mr Peter Jenkinson	Director of Corporate Governance (ICHT & CWFT)
	Emer Delaney	Director of Communications (CWFT)
	Michelle Dixon	Director of Engagement & Experience (ICHT)
	Ms Alexia Pipe	Chief of Staff
	Mr Vikas Sharma	Trust Secretary (THHFT)
	Ms Leigh Franklin	Assistant Trust Secretary (THHFT) Minutes

Apologies for Absence

Ms Sim Scavazza	Non-Executive Director (ICHT & LNWH)
Professor Neena Modi	Non-Executive Director (ICHT & CWFT)

Minute Ref		Action
1.0	**Welcome and Apologies for Absence**	
1.0.1	Mathew Swindells (MS), the Chair, welcomed everyone to the public Board in Common.	
1.0.2	Apologies were noted from Sim Scavazza and Neena Modi.	
1.1	**Declarations of Interest**	
1.1.1	Peter Jenkinson (PJ) presented the annual Register of Interests for all four Acute Provider Trusts in North West London (NWL), he advised that there are interim updates of the register during the year and they are published on the NWL microsite and respective Trust websites. There were two minor amendments to the published paper as follows: - • Non-Executive Director Loy Lobo's interest in the Digital Health Council should be recorded as a 'Non-Financial Personal Interest' rather than a 'Financial Interest'. • Executive Director Claire Hook's sole interest should be recorded as 'Director: Hook Medico Legal Ltd' rather than 'Chartered Director: Hook Medico Legal Ltd'. 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 16 January 2024**	
1.2.1	The Board in Common **approved** the minutes of the Board in Common meeting held on 16 January 2024, with the following amendment: - Item 4.2 – change name from Oliver Gowen to Oliver McGowen.	
1.3	**Matters Arising and Action Log**	
1.3.1	The Board noted no outstanding actions from previous meetings.	

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1.4	**Patient Story**	
1.4.1	The Board welcomed Gemma Marshall a patient and staff member, who reflected on her experience when being referred from her GP to the ENT clinic. Under patient choice Gemma had requested a referral to The Hillingdon Hospitals NHS Foundation Trust but as a Hertfordshire residence this had proved difficult to facilitate but after returning to her GP Practice this was finally arranged. Gemma was seen at the ENT clinic in Hillingdon in early October 2023 and after a cancellation due to Covid had her operation in early February at Central Middlesex Hospital. Overall, other than the frustrations of the initial referral, the process was very efficient, and all staff involved were caring, welcoming helpful and professional. **The Board in Common thanked Gemma for sharing her experience and were pleased to note the story and feedback.**	
2.1	**Report from the Chair in Common** MS presented his report to the Board in Common MS on behalf of the board thanked Neville Manuel Non-Executive Director (NED) 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 years and at Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) since September 2022, he has contributed an enormous amount to the Trusts in his time with us. MS welcomed Loy Lobo officially on to the Board in Common, who joined as NED at LNWH and ICHT in February and announced that 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. As the last financial year comes to a close we look back at some of the achievements in the APC; 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; we have again delivered more elective activity compared to pre-COVID levels. We continue to provide safe acute hospital care, as measured by the Summary Hospital-level Mortality Indicator, of any ICS in England. MS thanked the leadership and staff for all they achieved in the last year, in difficult circumstances we are making great progress and people are doing tremendous work for our communities.	

	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. There has been a major refurbishment of the Western Eye Hospital; 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. 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 is 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. MS noted which was a commitment of staff and efforts of the leadership, he again thanked them for the work they are doing. **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 the following: • The Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) – Ambulatory Diagnostics Centre Equipping – Outline Business Case • The Imperial College Healthcare NHS Trust (ICHT) – Food supply contract award • The Hillingdon Hospitals NHS Foundation Trust – Energy Generation Centre (incinerator) Lease and Operating Contract **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. Clare Hook (CH) provided the following update on Performance: The data pack contains charts showing the trend over time at APC level for each metric, with in-month and rolling 12-month data for each trust. National and regional benchmarks are added, where available, to aid comparisons. It is acknowledged that although we are doing well, we are still someway from where we would like to be, and the hard work and effort will be continued into next year to ensure continued improvement. Urgent and Emergency care performance; we had a plan to reach 76% of all patients attending the emergency department to be treated within 4 hours. Three of our trusts achieved this in February and all four in the month of March, we also improved our ambulance handover times and decreasing very long waits in the emergency departments. We are now focussed on continuing to sustain that performance and will be reviewing an improvement plan for the coming year.	

James Walters (JW) provided an update on cancer performance, good compared to other areas in London and nationally, January data was impacted on by both industrial action and high demand in the urgent treatment centres. LNWH and THHFT continue to recover from their Cerner go live and the stabilisation performance is gradually improving. The sector delivered a compliant trajectory against the backlog performance in patients waiting over 62 days and this remains the main focus area of challenge.

Tina Benson (TB) provided an update on the area of Electives and Diagnostics:

THHFT have zero 78 weeks at the end of March and all other Trusts are below 50, all Trusts are committed to clear 78 week waits by the end of June 2024. We continue to work on the downward trajectories for 65 week waits and 52 week waits. In Diagnostics all trusts have seen a deteriorating position and are working together to look at ensuring delivery

Lesley Watts (LW) advised that in the area of discharge although there have been some improvements there continue to be challenges and we are working daily with community, mental health, and local authorities to ensure we discharge patients as efficiently as possible.

Nick Gash (NG) asked how confident are we that the changes described are embedded and will continue to be delivered. LW advised that one of the benefits of the collaborative is learning from each other on pathways and cultural approach and although there has been a push for the end of year all Trusts will be looking to ensure they sustain performance in the coming year.

Alan Mcglennan (AM) provided the following update for Quality:
The Mortality rates shows a rolling 12 month ratio below the national benchmark. 2 Never Events were recorded this month which makes a total of 11 in year, on analysis these are procedural and there are robust processes in place to identify and investigate incidents and implement actions. Infection prevention and control is still reporting above the national thresholds and the APC are working with the ICS to review this area.

David Moss (DM) asked how we are sharing Health & Safety learning across the APC, Pippa Nightingale (PN) advised that the Health & Safety annual report was taken to the APC quality committee last month, it did identify differences between trusts, and we have agreed to standardise the reporting and learning and will look at how we share that learning over the coming months.

Rob Bleasdale (RB) provided the following update for Maternity:
There has been an increase in the still birth rate across the APC to 14 cases in January, although on further review February has dropped down to 6 cases. Looking at the year-to-date numbers three of the four Trusts are below the national target of 3.3, with THHFT exceeding that threshold a stillbirth review at THHFT is being undertaken.

Pippa Nightingale (PN) provided the following update on Workforce:

	At a collaborative level the vacancy rates are below the target of 10% and in February is 8.4% and is the result of targeted recruitment campaigns action is now focussed on hard to fill vacancies. Non-medical performance development reviews continue to be an area of focus and although there has been some improvement all Trust are working towards the common target of 95%. Tracey Connage (TC) added that at an APC level BAME employees represent 61% of the total workforce and there are actions being undertaken to develop Model Employer Goals across the APC at trust level. Pat Gallan (PG) said that the biggest BAME gap is in the most senior areas and is there an action plan and timescales on how this might be address, TC advised that each trust has an equality plan and WRES goals, that will look at future leader grades and realistic programmes for staff in transitional grades. Jon Bell (JB) provided the following update on Finance: The report provided an update on month 11 finance, but JB advised that after considerable work at end of year the APC have reported a breakeven position. David Moss (DM) asked that despite the continued pressure on finances the break-even position has not been at the expense of patient safety. LW advised that we do ensure that we constantly triangulate and the performance results show the continued commitment to patients despite the financial challenges. **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 the key areas of focus of the Committee had been the stillbirth rate at THHFT and mitigating actions in place, recent never events at ICHT 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 impact on the care of mental health patients as a result of the reduction of whole-time equivalents (WTE) in mental health trusts, increased infection rates with all four trusts breaching targets, although there are robust local controls and learning in place and the Patient Safety Investigation Review Framework (PSIRF) implementation. Patricia Wright (PW) formally reported to the Board that following the August CQC Maternity inspection at THHFT, a report was published in February, disappointingly moving the THHFT Maternity services from Good to Requires Improvement, there were 14 must do actions and 11 should do actions with no enforcement notices or specific sanctions. The CQC inspection happened at a time when the trust had already started to identify some concerns overall and had commissioned as part of a maternity and neonatal improvement programme a number of external reviews looking at still births and a cultural review. A maternity improvement programme of work is in place and will be monitoring progress closely.	

	The Board in Common noted the report.	
4.2	**Learning from deaths report** Jon Baker (JB) 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 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. Work undertaken to review Palliative care coding has demonstrated variation. This may be due to a number of factors; improvement recommendations will be identified once the full review is completed. All Trusts have started to analyse ethnicity data for deceased patients and will start to report this through local mortality governance groups and in the quarterly leaning from deaths report. **The Board in Common noted the report.**	
5.1	**Collaborative People Committee Chair's report** David Moss (DM) presented the Chair's report and highlighted that a lot of work is being undertaken in the equality, diversity and inclusion area and all trusts across the ICS have agreed a 50% target for BAME leadership staff band 7-9 and VSM. The committee received the national staff survey results with all trusts performing relatively well, work is ongoing locally and collaboratively to identify improvement opportunities and key collaborative people priority programmes for 2024/25. A key risk highlighted is the need for a sustainable affordable workforce plan and one that can achieve a sustainable run rate. Patricia Gallan (PG) asked where the NHS people plan fits into the delivery of the workforce plan. PN advised that all four trusts are signed up to the people promise and the people promise is the implementation plan that will deliver elements of the plan and we have aligned national, APC and local plans. **The Board in Common noted the report.**	
5.2	**APC Improvement Plan – EDI Action Plan** Ajay Metha (AM) presented the report highlighting the development of the APC EDI Improvement plan steering group that has developed recommendations for the NWL APC Board in Common on how to advance equality and justice across ways of working, the group recommended each board director should have two objectives:	

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	• 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. It is proposed that these objectives will be incorporated into the 24/25 annual appraisal and objective setting for Board members and all Directors reporting to CEOs. The Group will continue to meet monthly and will develop further recommendations that will be taken to the July 2024 Board-in-Common. The Board discussed the need to set challenging and measurable targets and ensure we address unconscious bias. Carolyn Downs (CD) suggested that we include the issue of measurement of local populations to ensure effective measurement of data. **The Board in Common agreed the proposal to ensure these objectives are now incorporated into the 2024/25 annual appraisal and objective setting for every Board member and all Directors reporting to CEOs.**	Action
6.1	**Collaborative Data and Digital Committee Chair's report** SG presented the report highlighting that the Committee had focused on a number of areas, the progress towards stabilisation following the recent implementation of Cerner Electronic Patient Record (EPR) at both LNWH and THHFT. The risks around potential insufficient Information and Communication Technology (ICT) infrastructure capital funding available in 2024/25 and risks and mitigations being assessed. Agreed the Digital & Data priorities for 2024/25. Received the current progress around the EDI priorities and how we might accelerate progress to ensure the correct data is available for all areas. The Federated Data Platform (FDP) that NWL APC is taking a leading role nationally and 7 FDP products have so far been deployed 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 and highlighted that the committee had supported the process for approval of capital related business cases, however it noted that trust specific business plans needed to be reviewed for strategic importance and what consideration had been given to whether a collaborative approach could be taken. The committee noted a key risk in the condition of the estate across the collaborative and that the cost of backlog maintenance remains a significant risk. Steve Gill (SG) asked what the risks were around backlog maintenance. BA advised that locally trusts will be working through the areas of backlog maintenance and specific areas of risk and how those will be managed, there is some work currently in place with Estates directors across the APC.	

	The Board in Common noted the report.	
8.1	**Collaborative finance and performance committee Chair's report** Catherine Jervis (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 is keen to ensure there are clear demand and capacity plans in place. There was concern regarding the current position for some diagnostics areas and further discussion on position and recovery will take place at the next meeting. There were discussions on inequalities data and proposed metrics in relation to finance and performance and with further work to be done which will report to the next meeting. The Committee received the outline business case for the financial shared services and agreed to take forward to the full business case noting that no decision would be taken until the risks and benefits were considered. **The Board in Common noted the report.**	
8.2	**Financial performance report** The Board in Common noted the month 11 (February 2024) finance report.	
8.3	**Acute Provider Collaborative Business Plans** John Bell (JB) provided the key issues of note; 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 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 Collaborative Finance and Performance Committee (FPC) 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 plans will be signed off at each Trust, post the final 2 May submission to NHS England, with a discussion via the Collaborative FPC in late April if the Board considers that appropriate. The Board discussed whether the design of the current workforce was in fact providing the most efficient and cost-effective way of working and the opportunities to review workforce design in the future. **The Board in Common noted the report and agreed to delegate authority to their respective Finance & Performance committees to approve submission of break-even final plans by 2 May 2024.**	Action
9.1	**Reports from Trust Audit Committees** The Board in Common received the reports from the most recent Trust Audit Committees. NG advised that the chairs of each local Audit committee had	

	met as a collaborative, one of the items discussed was around the development of a shared board assurance framework for the APC and work has started on this. **The Board in Common noted the reports.**	
9.2	**Revising the Acute Provider Collaborative Governance Arrangements** Peter Jenkinson (PJ) advised the Board in Common that 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. 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 APC 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. **The Board in Common approved 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.** **The Board in Common also agreed to further review other aspects of the APC governance structure and amend as appropriate.**	

9.3	**Delegated Authorities to Provider Trust Committees 2024/25**
	Peter Jenkinson (PJ) presented the report and sought the approval of the Board in Common to delegate authority to the relevant Trust Committees to approve the following reports:
	
	  • Annual Reports and Accounts
	  • Quality Account	

	• Self-certifications for Non-Foundation Trusts • Self-certifications for Foundation Trusts • Modern Slavery Act Statement • **The Board of Chelsea and Westminster Hospital NHS Foundation approved its delegated authorities as per schedule 1 of the report.** • **The Board of Imperial College Healthcare NHS Trust approved its delegated authorities as per schedule 2 of the report.** • **The Board of London Northwest University Healthcare NHS Trust approved its delegated authorities as per schedule 3 of the report.** • **The Board of The Hillingdon Hospitals NHS Foundation Trust approved its delegated authorities as per schedule 4 of the report.**	
10.1	**Executive Management Board summary report** Tim Orchard (TO) presented the summary report from the Acute Provider Collaborative Executive Management Board (APC EMB) meetings held in February 2024 and March 2024. Nick Gash (NG) asked if the rotation of executive representatives was working to ensure breadth of views across all areas. TO advised that it was probably too early at this stage but have agreed to formally review after one year. **The Board in Common noted the report.**	
10.2	**Reports from the Chief Executive Officers** London North West University Healthcare NHS Trust PN advised that the staff survey results for 2023 showed a steady improvement across a wide range of areas with improved scores in 64 questions and stayed the same in 33 questions. Overall, the results show that what the Trust is doing is working and will continue to keep up the focus and energy. PN also advised that the Willesden eyecare centre opened in March 2024. The two new theatres at the Elective Orthopaedic Centre and the Modular Unit ward have been handed over and have come in on budget and will commence operation shortly. We also opened the Willesden Eye Centre recently which came in on time too. PN noted that LNWH won the Trust of the Year Award at the annual GG2 leadership and diversity awards for its work championing diversity and encouraging an inclusive environment. That Rose Amankwaah, theatre matron had retired after five decades at the trust. Kabiru Ogundipe, was voted porter of the year at the annual MyPorter awards. Taran Tatla, an ENT consultant, has been made President Elect of ENT UK. Chelsea and Westminster Hospital NHS Foundation Trust LW advised that the results of the staff survey show that the Trust is rated number two in London among acute hospital peers as a place to work and is recognised as one of the leading trusts nationwide. LW also advised that the Trust had performed well in operational performance and continues to make progress in reducing backlogs.	

	LW congratulated Sandra De Oliveira Camillo, Healthcare Assistant who has been awarded the NHS Chief Nursing office and Chief Midwifery Officer Support Worker Excellence Award.	
	Imperial College Healthcare NHS Trust TO advised that the trust had launched 'call for concern' based on Martha's Rule enabling patients, relatives, and carers to contact a clinical response team directly, at any time of day. The Wembley community diagnostic centre had been officially opened on 1 February. The Staff survey results show the third consecutive year of improvement as well as the highest response rate at 61%. The Trust received a special commendation from the Greater London Authority on the Mayor of London design lab project for inclusive recruitment. The Trust has now completed the first phase of engaging for equity and inclusion programme, involving over 1000 staff. TO also advised that the Trust has now been formally accredited as a Veteran Aware Trust in recognition of the commitment to providing healthcare to veterans and their families. The Trust receive a NHS Pastoral Care Quality Award in recognition of the work in international recruitment. Abiodun Fakoya won Apprentice of the year and an individual achievement award. The Hillingdon Hospitals NHS Foundation Trust PW advised that CQC inspectors conducted an inspection of compliance with 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, and audit. PW also advised that the Trust Staff survey results and the scores show a year-on-year improvement. PW thanked the operational and clinical staff for all their work to ensure a strong finance and operational performance. There was also recognition to Yasser Mohsen who has been elected Chair of the Court of Examiners within the Royal College of Surgeons. The Trust was also honoured with the prestigious NHS Pastoral Care Quality Award as part of the NHS England's International Recruitment Programme. **The Board in Common noted the reports.**	
11.1	**Use of the Trust Seal** Peter Jenkinson (PJ) presented the report which covered the use of the seal across all four Trusts in the Collaborative within the last 12 months. **The Board in Common received and noted the report.**	

11.2	**Health and Safety Annual Report 2022-23** Jonathan Reid (JR) presented the paper that summarises the health and safety report for period 1 April to 31 March 2023 for all four Trust. David Moss (DM) suggested that a health and safety story would be beneficial to the Board in Common in a future meeting. **The Board in Common noted the report and the ongoing development and the approach to safety.**	**Action**
12.0	**Questions from members of the Public**	
12.1	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.	
12.2	The Chair drew the meeting to a close and thanked the Board and members of public for joining the meeting.	

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1.3 MATTERS ARISING AND ACTION LOG

● Discussion Item   👤 Matthew Swindells

REFERENCES

📄 1.3 BiC (public) - Action Log Apr 24.pdf

North West London Acute Provider Collaborative

Board in Common (public) Action Log

Matters Arising and Action Log   **Status:** For noting

Meeting Date: 16 July 2024   **Lead Responsibility and Paper Author: Matthew Swindells**

Purpose

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

Part 1: Actions from Previous Meetings Remaining Open

Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
5.2	APC Improvement Plan – EDI Action Plan	The Board discussed the need to set challenging and measurable targets and ensure we address unconscious bias. Carolyn Downs (CD) suggested that we include the issue of measurement of local populations to ensure effective measurement of data.	Pippa Nightingale	Presenting People focused EDI plan at next board in common. This is Stage 1 of developing comprehensive EDI action plan. Stage 2 will be forming a group including patient and staff representatives to engage and agree plans that address consideration and	July 2024

					measurable of local equitable population health outcomes. This will be included in the EDI paper at the BIC on 16th July.	
8.3	Acute Provider Collaborative Business Plans	The Board in Common agreed to delegate authority to their respective Finance & Performance committees to approve submission of break-even final plans by 2 May 2024.	Trust Finance & Performance Committees	Action complete.	May 2024
11.2	Health & Safety Annual Report 2022-23	It was suggested that a health & Safety story would be beneficial at a future Board in Common Meeting.	Jonathan Reid	This topic will be covered at a future BiC meeting.	TBC

Part 2: Actions previously outstanding but now completed

Meeting Date	Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes & Status
January 2023	4.1.4	Integrated Quality, Workforce and Performance Report	An update on stakeholder engagement (user insights) to be presented to a future board in common meeting.	Michelle Dixon	The scorecard will provide more information on patient/user-focused measures. This is now formally part of one of the priority work strands of the collaborative quality group and progress will be reported through the collaborative quality committee.
January 2023	4.1.10	Integrated Quality, Workforce and	Patient flow data to be included in the report going forwards.	Patricia Wright	Discharge data now included in the IQPR.

		Performance Report			

1.4 PATIENT STORY - FROM A SICKLE CELL GROUP MEMBER

● Discussion Item   👤 Pippa Nightingale   🕐 09.05

REFERENCES

Only PDFs are attached

📕 1.4 Patient Story cover sheet 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

NHS

NWL Acute Provider Collaborative Board in Common
16/07/2024
Item number: 1.4
This report is: Public

Patient Story – from a sickle cell group member

Author:	Lisa Knight
Job title:	Chief Nurse, LNWH
Accountable director:	Pippa Nightingale
Job title:	Chief Executive Officer, LNWH

Purpose of report

Purpose: Information or for noting only

Report history

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

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

Executive summary and key messages

This paper introduces our patient story, to be told by Reia Dacosta, who was diagnosed with sickle cell disease at birth and receives care in North West London. Reia will speak of her experience of care across three of our hospital sites: Central Middlesex, Hammersmith and Northwick Park.

Hearing patient stories at our meetings is valuable in supporting quality improvement discussions at both strategic and operational levels. Hearing the voices of patients directly enables greater understanding of the issues affecting patients and learning from both the positive and less positive experiences.

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

NWL Acute Collaborative committee cover note

☐	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

Click to describe impact

Reason for private submission

Tick all that apply

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

2.1 ACUTE PROVIDER COLLABORATIVE STRATEGY

● Decision Item   👤 Tim Orchard   🕐 09.20

REFERENCES   Only PDFs are attached

📄 2.1a APC Strategy cover sheet 20240716.pdf

📄 2.1b APC_Strategy_vF 240710_.pdf

NHS

NWL Acute Provider Collaborative Board in Common
16/07/2024
Item number: 2.1
This report is: Confidential

NWL Acute Provider Collaborative Strategy 2024-2027

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

Accountable director: Tim Orchard
Job title: Lead CEO, APC Strategy

Purpose of report

Purpose: Decision or approval – approval of APC Strategy

Report history

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

All APC Board in Common Committees and Joint Executive Group during June	**APC Executive Management Board**
Click or tap to enter a date. Endorsed direction and provided input which has been incorporated	05/07/2024 Approved

Executive summary and key messages

We present the first strategy for the APC for approval. This has been developed since December through engagement of over 1,300 staff, along with patient groups, executive leadership, and our partners.

Our vision for the next three years is that:

"We will use our collective expertise, resource and partnerships to set and raise standards of care for our patients, offer the best care available to everyone, and to be one of the best places to work in the NHS."

NWL Acute Collaborative committee cover note

We aspire to do things as well as we can across our collaborative. We will look for what best practice is and work to deliver this in each organisation. We believe by aligning our best practices to the best in north west London (NWL), the best in the NHS and the best in the world we can more quickly and effectively achieve our individual goals to the benefit of our local communities, within the financial constraints that we face.

We are asking every service, large or small, to re-imagine its future around the needs of patients, populations, and place, and not the limitations of serving separate NHS organisations. We will use our collective research, innovation, and continuous improvement to continually raise these standards. All our data will be shared transparently across our collaborative to inspire ideas and measure improvements to make sure changes are implemented effectively.

Our strategy sets out our context, our vision, the diagnostic of our situation, our response, our action plan encompassing our major themes of work, how we will measure progress and how we will make this progress happen across the NWL APC.

As we come to the end of this phase of work, a special thanks to the project team without whom this strategy would not have been possible: Liz Bennett, Kishan Karia, Daniel McDonnell, Neetu Sharma, Iona Twaddell, and Kate Wilkinson.

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

Our strategy encompasses our approach to making improvements and will influence all areas of our work

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

NWL Acute Collaborative committee cover note

Reason for private submission

Tick all that apply

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

North West London Acute Provide Collaborative Strategy 2024-2027

Contents

Foreword

The 2.2 million people living in north west London rightly expect healthcare to be delivered based around their needs and not NHS structures. Our strategy takes a significant step forward in putting their expectations first. Building on what our teams have achieved to date, it outlines our focus to deliver high quality, equitable and sustainable health care. This is an aspiration which can only be achieved by working together and combining our knowledge, skills, and experience.

Our strategy describes our approach to engage our staff and maximise our collective expertise, resource, and partnerships to set and raise standards of care for our patients, offer the best care available to everyone, and be one of the best places to work in the NHS.

This strategy sits above and supports our individual trust strategies. We believe by aligning our best practices to the best in north west London, the best in the NHS and the best in the world we can more quickly and effectively achieve our individual goals to the benefit of our local communities, within the financial constraints that we face.

Our shared approach to improvement supports our roles in the North West London Integrated Care System. We will focus on improvements that are shared priorities agreed with our partners and the service leadership within our organisations. This strategy will strengthen how we make changes together across our acute services so that we can work with our partners to address complex, system-wide issues more effectively in the years ahead.

This strategy sets out our mandate for change. We aspire to do things as well as we can across our collaborative. We will look for what best practice is and work to deliver this in each organisation. As such, we are asking every service, large or small, to re-imagine its future around the needs of patients, populations, and place, and not the limitations of serving separate NHS organisations. We will use our collective research, innovation, and continuous improvement to continually raise these standards. All our data will be shared transparently across our collaborative to inspire ideas and measure improvements to make sure changes are implemented effectively.

This strategy is an invitation to join our movement for improvement. We now want our staff to be open, curious and transparent as they collaborate with colleagues across north west London and provider excellent clinical outcomes, equity, access, and experience for our patients and communities.

Matthew Swindells, Tim Orchard, Lesley Watts, Pippa Nightingale and Patricia Wright

1. Introduction

1.1 What is the North West London Acute Provider Collaborative

1.1.1 Our North West London Acute Provider Collaborative (APC) came into being in September 2022 and includes the four acute trusts in north west London:

- 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

1.1.2 Between us, we run 12 hospitals across eight boroughs. We employ 33,000 staff and serve a local population of around 2.2 million with a combined expenditure of approximately £4bn annually. We also provide regional, national, and international specialist services.

1.1.3 The APC is a collaborative of four statutory organisations, each with a trust board that is responsible for setting strategy and delivering statutory and regulatory requirements for each trust. While each trust board remains responsible for the delivery of their respective trust duties, we have agreed key principles regarding how we work together, including taking collective responsibility for the success of the collaborative. As a collaborative, the four boards work together through the Board in Common to hold each other to account and deliver common strategic priorities that have collective value. We are all part of the North West London Integrated Care System and committed to supporting improvements in the health and wellbeing for our population and reducing inequalities in outcomes, access, and experience.

1.1.4 This approach means the trusts remain independent organisations, with their own strategies and work closely with their local authorities, patient groups, and other partners. But being a collaborative means we can raise the quality and efficiency of our services and make more effective use of our collective resources to provide better care, for more people, more fairly.

1.1.5 We have an Executive Management Board for our APC, to allow executive decision making within the collaborative. Our Board in Common assures and oversees progress and performance through thematic collaborative committees such as Quality, People, Finance and Performance, Digital, and Estates and Net Zero.

1.2 Who do we support

1.2.1 Most of our patients come from across north west London, though our specialist services support regional, national, and international patients. Our local population is amongst the most diverse in England with people from nearly 200 ethnicities. While our population is younger than average, where median ages are between 35 and 40 in each borough compared to an English median of 40, there are many people aged over 65 where demand for acute healthcare is highest. Our population is expected to grow by 800,000 people over the next 20 years. This growth is concentrated in those aged 20-29 and amongst over 60s which will increase healthcare demand.

1.2.2 Although north west London is slightly wealthier than national averages, one in eight of our residents live in the 20% of the poorest neighbourhoods in England. Health inequalities in life expectancy are stark and increasing with a 20-year gap between the most and least deprived members of our local communities. Health inequalities are also very local where there can be a 15-year gap in life expectancy between neighbourhoods within a 15-minute walk of each other. People in our poorer neighbourhoods develop multi-morbidity 10-15 years earlier than people in wealthier neighbourhoods. Long term conditions with the greatest local prevalence are asthma, depression, diabetes, hypertension, and chronic heart disease. Lifestyle factors including obesity have negative impacts, and compared to England averages:

- four of our boroughs have a higher smoking prevalence.
- seven boroughs having higher hospital admissions due to alcohol.
- seven boroughs have lower number of adults meeting the '5-a-day' recommended fruit and vegetable intake.
- four boroughs have higher proportion of physically inactive adults.

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2. Our mission

2.1 How we work together
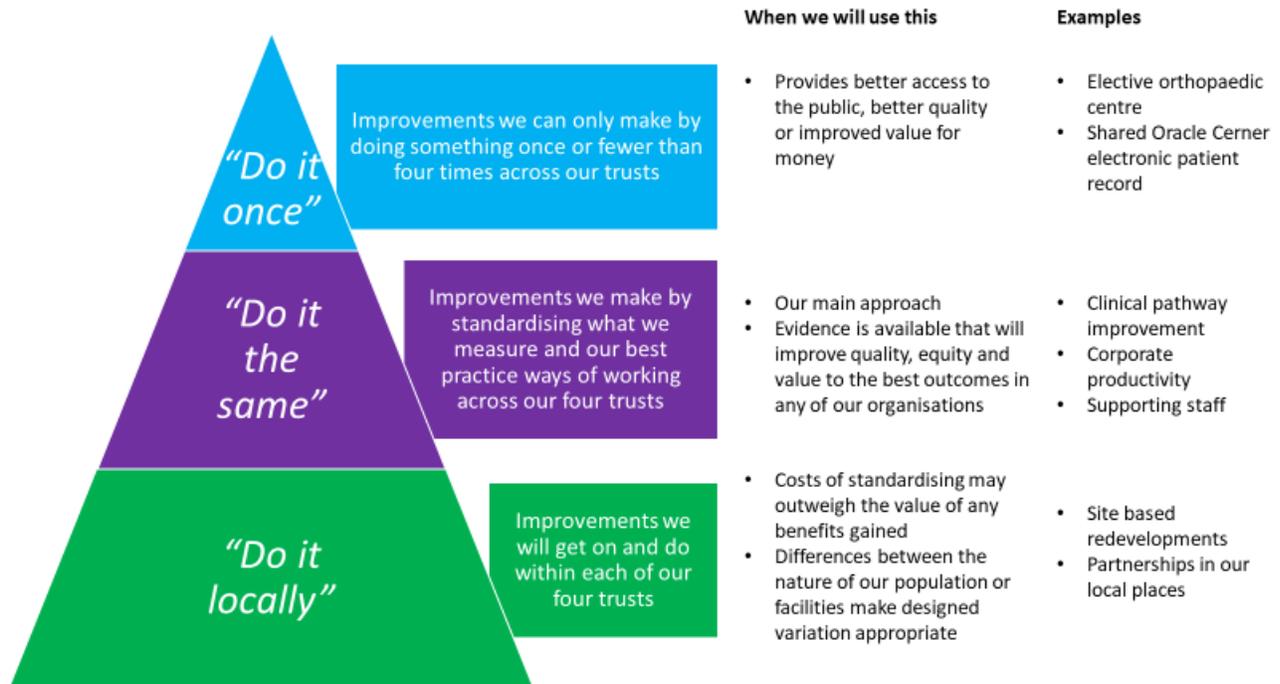
2.1.1 Our APC approach to how we should intervene is to view improvement through three lenses:

- **"Do it once":** What should we do once or fewer than four times, on behalf of everybody? We don't see centralisation as a "good" in its own right, but something that we should do if it provides better access to the public, better quality, or improved value for money. We expect a small number of important functions to move in this direction in the coming years.
- **"Do it the same":** What should we do four times, but adopt a common definition of best practice and measurement everywhere? This is an area which takes advantage of the wide variety best practice guidance that is available alongside our local benchmarking to drive improvement. We expect a significant movement towards this approach in the coming years.
- **"Do it locally":** What simply should be defined and managed locally? These are areas where standardisation would simply add bureaucracy and cost or where difference in the nature of our local communities or our facilities makes designed variation appropriate.

<center>5</center>

2.1.2 Our governance supports this approach to working together. Each of our CEO leads a thematic workstream such as Quality or People and Inclusion. These workstreams progress priorities that have been agreed across our collaborative, including initiatives such as the Elective Orthopaedic Centre, where we are providing one service together. Initiatives are supported by teams drawn together across our four organisations, with implementation of standardised ways of working managed within each organisation. Progress and performance are assured by our Board in Common and its committee structure.

2.2 What we achieved together so far

2.2.1 Our four trusts have been collaborating since before the pandemic with initiatives such as the NIHR Clinical Research Network and West London Children's Healthcare. This rapidly accelerated in response to COVID-19 with sharing of ITU resources, collaboration for vaccine development and delivery and working together across clinical and operational teams to support our patients access safe, timely care.

2.2.2 Since our APC was established, our collaborative approach has helped us to:

- Offer patients waiting for an operation to have their operation sooner by moving to a hospital managed by another trust if there is more capacity for that service.
- Expand a single electronic patient record system to cover all 12 hospitals of the four acute trusts, bringing immediate benefits for patients whose records and information can be shared with healthcare providers across sites so they can receive seamless care and creating huge potential for improvements in population health through data-led research.
- Improve inpatient orthopaedic care across the sector with the opening of the North West London Elective Orthopaedic Centre. This has allowed us to bring together routine, low complexity orthopaedic procedures in a single centre of excellence which will improve outcomes, allow us to treat more patients more efficiently, and reduce the risk of operations being cancelled due to urgent and emergency care pressure.

2.2.3 Our individual trust strategies share many similar priorities, including a focus on quality of care, equity, sustainability, and people. Engagement with staff when developing this strategy has highlighted the value they place on collaborating with colleagues doing similar roles in partner trusts and desire for opportunities for joint efforts and shared learning to increase. These principles and behaviours of partnership give us a strong foundation for more collaborative working.

2.3 Our statement of intent and long-term ambitions

2.3.1 In October 2022 our board-in-common agreed a statement of intention and vision for collaboration. As we looked ahead over the next ten years, we set out with the ambition to:
- Create the best acute provider system in the NHS, which is admired around the world.
- Create the best place to work in the NHS with the opportunity for staff to develop their careers and fulfil their aspirations within north west London.
- Constantly challenge the status-quo to drive more effective and efficient healthcare and maximise what can be achieved with the available funding.
- Work with local academic institutions and businesses to create a global centre for health research and innovation with supports better healthcare and creates jobs in north west London.
- Work with our partners to the NHS, local government, the voluntary and the commercial sector to help create a healthier, more prosperous, fairer north west London.

2.4 Why we need a strategy and its scope

2.4.1 We need an APC strategy to guide and prioritise how we more effectively work together as four organisations. This will support the implementation of each of our individual strategies and the shared priorities and joint forward plan agreed with our partners in the North West London Integrated Care System. This strategy describes how we have agreed an approach to making improvements that harness our collective resources and expertise for the equitable benefit of our patients, communities, and staff – and describes what collaboration can deliver beyond what individual trusts can do alone. This approach includes shared principles and priorities that will help each of us learn quicker, improve faster, provide higher quality care and be more productive than we ever could alone.

2.4.2 Across our trusts, we are proud to offer truly excellent services in many areas. But we also recognise that there is variation in care quality, how our patients access our services, the experiences they have, what their outcomes are across north west London, and the opportunities for our staff. This is reflected in significant variations in health outcomes, life expectancy and healthy life expectancy within our population, and staff feedback. We believe that everyone should be entitled to the same high standards of care, employment, and opportunities that we offer when we are working at our best in our collaborative.

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2.4.3 For this strategy, we sought to answer: *"How can the APC most effectively use our collective resources to provide better, more equitable care for the population of north west London, over the next three years?"*

2.4.4 The APC strategy sits above the organisational strategies and sets out what we will work on as a collaborative, focusing on the things we can only do most effectively together.

2.4.5 This document uses our approach to how we should intervene and sets out the actions we need to prioritise over the next three years to meet our shared ambitions of higher quality care within, and greater equity across, our organisations. Our shared priorities focus on enablers such as data, skills, and networks of expertise that empower our staff to lead local and collaborative improvements towards our shard goals and improvements within each organisation.

2.4.6 Each trust remains an individual organisation with its own organisational strategy. We will continue to have individual trust priorities and approaches. This strategy has been developed recognising fixed points, including that we will each remain independent and that there are some things we will all continue to do, for example providing emergency and maternity services to our local populations.

2.4.7 We will also be working closely with other north west London partners (for example the integrated care board) to deliver wider healthcare priorities across our area. This includes support towards our local ICS strategy and across the nine priorities agreed in the Joint Forward Plan published in April 2024. Our contribution to this plan will be strongest in reducing inequalities and improving health outcomes, providing the right care in the right place, transforming maternity care, increase cancer detection rates and delivering faster access to treatment, and transforming the way planned care works. Our strategy has been developed considering how we can use our collective resources and a shared approach to improvement to meet these expectations.

2.5 Approach we took to creating our strategy including our wide-ranging engagement

2.5.1 We have engaged over 1,300 staff on our APC Strategy across all four trusts, including:

- Leadership workshops to identify opportunities and challenges.
- APC-wide online staff survey.
- Engagement during each individual trust's leadership briefings and all staff meetings.

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- APC-wide online workshops.
- Board development workshops.

2.5.2 We also pursued targeted engagement opportunities with patients and members of the public through existing forums and reached out to trusted partners across health, social, voluntary, academic, and other sectors to test our approach. We used numerous local data sources collected during recent engagements with staff, patients, and our local communities, as well as regional and national sources to understand current public opinion and perspectives.

2.5.3 We developed our strategy in a similar way to how we treat our patients. First, we developed a "diagnostic" of our current context, opportunities, and challenges. This is like when we seek to understand what root causes are creating a patient's needs and the outcomes they want to achieve. Informed by our diagnostic, we prioritised a "response" that we believe would best achieve our vision given everything we face and have available to build upon. This "response" then informed our "action plan" to make sure we are implementing changes effectively and measure progress along the way, in the same way we set out treatment plans for our patients to get the care they need.

3. Our vision

3.1 Our vision for the next three years is that:

We will use our collective expertise, resource, and partnerships to set and raise standards of care for our patients, offer the best care available to everyone, and to be one of the best places to work in the NHS.

3.2 This vision has been developed through engagement with our staff and will communicate our immediate aspirations towards our longer-term statement of intent agreed in October 2022.

4. Our diagnosis

4.0.1 Through our diagnostic, we have sought to identify the most critical challenges to achieving this vision and the strengths we can use to help us.

4.1 Strengths

We can build on our strengths to achieve our vision and address shared challenges. Our strengths include:

4.1.1 **Quality:** Across our organisations, we have some of the best standardised hospital mortality ratios in the NHS demonstrating safe and effective care. We have countless examples of leading services, clinical outcomes and practice, innovation, and positive patient experiences to learn from and share.

4.1.2 **People:** The APC has a significant diversity of our staff which offers deep connections with our communities and world-leading breadth of skills, expertise, and lived experience. Our people are a priority across our trusts and our collective Staff Survey results show we have strengths in staff development and teamwork.

4.1.3 **Digital:** We have the same electronic patient record in use across all our organisations, which gives us a platform for measuring, understanding, and addressing unwarranted clinical variation.

4.1.4 **Research and innovation:** Strong research infrastructure, partnerships and assets means we are well placed to combine research and innovation opportunities, including the use of large datasets that can support life sciences innovation such as AI, immunotherapies, genomic medicine, and gene editing.

4.1.5 **Individual strengths:** Each trust has local approaches, cultures, and expertise which they can share learning and leadership to the benefit of all.

4.2 Challenges

4.2.1 The key challenges we together face are:

4.2.2 **Variations in our clinical outcomes and patient experience**: While we have some of the best clinical outcomes in the NHS, our patients experience different clinical outcomes between our organisations and have different experiences depending on where and by who they are treated. All the trusts have different strengths but there are significant variations across common services between our organisations and at times within organisations. This includes access to clinical research and trials of leading medicine, which varies markedly according to the hospital in which you are treated and should be viewed as a health inequality. Often our services have not been effectively and equitably co-designed around patient and population health needs. Sometimes patient outcomes and their experience of care is poor.

4.2.3 **Performance and access:** When viewed in a national context, our operational performance is good. However, our patients experience significant differences in access to timely services within and across all our organisations. Our performance reflects a nationwide context made more challenging by Covid, and we all have patients waiting more than 52 weeks for elective care, more than six weeks for diagnostics, and more than 12 hours for emergency admission or treatment. Patients have frequently shared their perspective that they value the quality of our care once they have accessed our services but are anxious about how long they may have to wait to do so and how poorly information while waiting can be communicated.

4.2.4 **Finance and productivity:** When benchmarked nationally and within London our hospitals are amongst the most efficient, all with reference cost lower than the national average. However, there is no question that the NHS is seen a reduction in productivity since pre-COVID and whilst ours is one of the smallest drops in the NHS, it is there nonetheless, and efficiency varies between services across all our organisations. Financial pressures on our organisations are great and our staff are working hard, so we must find way to improve efficiency by changing the way we work, making sure care is always provided in the most appropriate setting, investing in new equipment, and investing in information technology to deliver more care and a better working environment within the resources available.

4.2.5 **Staff engagement and inclusion:** Our staff surveys show staff engagement and wellbeing is increasing across our APC but is still little better than 2020. This is an ongoing challenge for us all. There are variations in how empowered and engaged our staff feel in improving services. We need to do more to make sure our staff feel included and belong,

especially our global majority staff and staff recruited internationally as their feedback is worse than average. In addition, our workforce will continue to experience significant change and challenge, driven by growing patient needs such as multimorbidity, new technologies, and wider pressures including local housing costs and quality, and cost of living.

4.2.6 **Estates:** Some of our estates are in poor condition. Of the top ten trusts with highest backlog maintenance in the country, three of these are in north west London. This leads to staff having to take workarounds, impacts our productivity, and means we have a poorer environment and experience for patients and staff. Two trusts have significant redevelopment projects for their estates.

4.2.7 **Changing local context:** We recognise that there is lots changing around our organisations, including population need and declining public perceptions of the NHS. We need to work better with our partners on these issues which impact us all. Our challenges include:

- We need to respond to the shared priorities in north west London including population health management, timely discharge, maternity, cancer care and planned care. However, this takes place against a background of relative immaturity in system working, where there are unclear lines of accountability between partners and unestablished abilities to hold each other to account. This includes relationships within our APC where we are now building greater trust and collaborative ways of working after many years of public policies encouraging competition and difference between our organisations.
- There are changing population health needs and population health management approaches. There is now much greater recognition that targeting unwarranted variations in patients with multi-morbidities, from minority ethnicities and higher areas of deprivation will see the greatest gains in equity and support overall improvements in outcomes.
- Public/patient trust in the NHS has eroded since its highest point in 2010 and this fall has accelerated since Covid. Declining public support has consequences including increasing incidents of aggression and violence towards our staff.

5. Our response

Best in global health
- Continuous improvement journey
- Incorporate best practice wherever it occurs being aware of published literature
- Promote research and innovation to set leading standards

Best in the NHS
- Use existing sources like GIRFT, NICE and Model Hospital

Best in north west London
- Real-time measurement and benchmarking
- Address unwarranted variation

5.0.1 The patients we care for across north west London and beyond should have access to the same high and rising standards and achieve excellent outcomes wherever they access our services.

5.0.2 Our vision is to use our collective resources to set and raise our standards of care and offer the best care available to everyone. To do this, our approach to change will be to work with each other, patients, partners, and communities to understand and agree what the best outcomes are, what best practice looks like in north west London, the NHS and in global health to achieve these outcomes, and then use our data to evidence and support improvements to consistently achieve and then raise these standards. Aligning to best practice is our means to deliver the results of better patient care, more productive and better value services and being the best place to work. It means that all our staff will engage with colleagues across our APC, patients, communities, and partners to understand where there is variation, what the ideal model would look like and raise standards across our APC to meet that best practice.

5.1 Our priority improvement objectives

As we encourage and enable change across our organisations, we will expect every leader and clinician to consider three priority objectives in their thinking and improvement. They need to consider how their efforts and changes will:

1. Improve equity, outcomes, and access for our patients, working with patients, communities and partners to understand problems from their perspective and implement best practice and best value solutions.
2. Adopt the most productive, sustainable, and efficient ways of working.
3. Be one of the best places to work in the NHS.

5.1.2 These improvement objectives collectively reinforce and support each other. Improving quality and value leads to better performance, which leads to greater productivity, which leads to a more fulfilling and effective working environment. Providing high-quality, equitable care and access is the right thing to do. It also supports productivity, as getting things right first time, every time, supports reductions in waste and cost. Higher quality care and lower costs increase value. Focusing on value means we prioritise our limited resources towards what makes the biggest difference to patients' health and outcomes. We know a commitment to high quality care and value will engage our staff and is only possible by making the most of their talents and potential, and therefore supports being a great place to work.

5.1.3 When setting our ways of working and standards to the ones in our APC that achieve the best outcomes and the best value, we believe these same practices will most frequently also be more productive and lower cost. These efficiencies from scaling better value care and ways of working will be needed to address our underlying financial deficit and be reinvested in clinical improvements and functions like digital and organisational development where additional resources are needed to enable our response.

5.2 Our approach to improvement

5.2.1 We will work closely with our patients, communities, and partners to incorporate what best practice means for them into our approach, and at the same time improve how we work with our patients and communities as a collaborative. Working together, we will use the existing evidence as to what best practice is today, combined with the deep experience of our patients, insights from our partners and our research and innovation to set new higher standards.

5.2.2 Evidence for what is best practice may be within our trusts already, or we may find it nationally or globally. The great advantage of our collaboration and common digital tools over working alone is that we can always compare our outcomes and value across north west London to learn from each other, identify the best local practice, and identify where poor outcomes need to be prioritised for improvement. Our ambition though is not limited to what is best practice or best value within our trusts. Where it exists, we will seek the insights and comparisons nationally such as Getting It Right First Time (GIRFT) to match the best in the NHS. We will also look for learning from globally leading organisations, along with research we are undertaking, to raise our standards and continuously improve to provide the best in global health. Working in this collaborative approach will support excellent and improving outcomes for our patients, not just levelling out the care we provide to achieve average local outcomes.

5.2.3 Having engaged widely and agreed best practice standards, we will use our data and digital tools to better measure and benchmark outcomes including clinical care, access to services, patient experience, value, and productivity. We will share and constantly update these insights in timely ways to support teams continuously improve towards and beyond best practice standards. Our teams will be able to proactively use our shared data, improved training on improvement skills, networks of expertise formed across our APC and shared values of curiosity, openness, and excellence to make positive changes. By aligning to best practice, and constantly learning and improving together, we can raise standards and value across our APC and constantly drive better practice. We believe working together to empower our staff and creating a collaborative movement for improvement is the most effective way to equitably improve outcomes, access, experience, and value for our patients.

5.2.4 As a final nuance to our approach, there may be times that the value created from aligning to best practice costs more than the effort to standardise these changes across our organisations. Our focus on value means we expect there are a few improvements that are best done once and together, many that will be supported by standardising how we work, and some that are best left to each organisation to improve independently.

5.3 Why this approach

We have prioritised this response over the other alternatives we considered because it:

- Helps us meet our statement of intent and vision by offering a guiding set of principles for working together including involving patients and staff in designing improvements, transparency about performance, openness to learning and sharing,

and encouraging consistency. This approach is as relevant to all our areas of activity including supporting our people, other corporate services and how we play our part in our local communities.

- Creates a strong foundation, including with joined-up information, new staff networks, and organisational development to provide a future platform for potential bolder, innovative improvements and changes across our organisations and working with partners to transform the health and care system in north west London.
- Focuses on action and continuous improvement for immediate benefits over planning more complicated and potentially disengaging service configurations.
- Address our challenging context, including improving poor and variable care outcomes and experiences by adopting consistent, evidence-based best practice, and working within available financial resources where we will generate efficiencies.
- Focuses on where we can add value as a collaborative over and above what individual trusts can achieve.

5.4 What this means for our people

5.4.1 We will adopt a collaborative approach to how our staff work. We expect them to determine best practice first across the collaborative, then the NHS and beyond for their area of expertise. It is about how we work together as much as we work on. This change model is the same whether it is a dedicated team supporting an initiative prioritised across our collaborative, or people looking at ways of continuously improving how they work and provide care. It is as applicable to linen services as to pharmacy as to the redesign of a clinical pathway. It means our staff need to change how they think and act when making changes to use their curiosity about how their service or teams' outcomes compare to others in our APC and beyond and what they can learn or share with others.

5.4.2 This approach cannot be successful if it is simply a series of top-down initiatives. We know we cannot prioritise dedicated resources and improvement efforts against everything at the same time. The implementation of this strategy will be a combination of the prioritisation of centrally sponsored change programmes and local initiatives.

5.4.3 The Board will begin with issues, pathways, and functions where our APC agrees with teams that the evidence shows our patient outcomes are poor, where we have significant variation between our organisations, where we offer poor value, or where there are significant sustainability challenges. These priorities will inform where there is senior

leadership facilitating and focusing support to improve things using our collaborative approach.

5.4.4 At the same time, we believe this change approach will drive progress over many areas by engaging and using the ideas, experience, and skills from our 33,000 staff. In all their work and improvement efforts, the same principles and approaches should be applied. We will help them use data, benchmarks, best practice evidence, networks, learning and sharing across our collaborative, and co-design with patients and communities to support improvements against any issue. The challenge of comparing your outcomes transparently with others is intended to promote a culture valuing high performance and excellence. Senior leaders will need to support teams in this with the data and improvement skills training they need, as well as clear governance arrangements and lines of accountability to ensure decision making not slowed down by the complexity of working across four organisations.

5.4.5 This means our approach to change can guide us across everything we do for the next three years, from improving patient outcomes to providing better career opportunities and to meeting our social responsibilities as anchor organisations in our communities. This is not a safe or easy approach, but requires significant changes in our cultures, use of data, and empowerment of our staff to lead improvements and innovation through a bottom-up movement. It also requires greater engagement and co-production with patients, communities, and partners to deliver best practice and better value. Our commitment to align to best practices puts our population and patients before our individual institutional interests or historic ways of working.

5.4.6 In our action plan that follows, we identify initiatives for which executives will be accountable and that will be prioritised for dedicated collaborative support. Our model of change and these three objectives applies to any change we do. This is because we want our teams to be ambitious, impatient, and support this same change model and process. When they see an issue and are making continuous improvements in what we do, they will need to prioritise these three objectives. Wherever someone is working and providing care, you will be working together and learning from across our four trusts.

5.4.7 This means we expect in three years' time:
- Patients will access high-quality care sooner, find their experience more personalised and centred around their needs, and benefit from excellent, equitable clinical outcomes whichever hospital they attend in north west London.
- Partners will benefit from consistent ways of working and communicating information and be working closely with APC colleagues progressing shared priorities across north west London.

- Staff will move more easily across trusts, be able to apply their curiosity to explore timely information on how their team performs and compares to others, have stronger networks and working relationships across organisations, deliver better care and will see noticeable improvements in north west London as a place to work.

5.4.8 In developing this strategy we have reflected what working together adds above each trust. As an example, working alone all our strategies seek to improve the quality of our care. Without our collaboration, we would have our teams implementing their own ideas and, where they can, translating external best practice examples. By working together and guided by our response, we can quickly provide comparable insights to benchmark every element of our performance, share expertise, and identify ways to improve that can quickly be scaled. This will support our teams more quickly raise standards of care and support each of our organisations implement priorities within our strategies.

6. Our action plan

6.0.1 Our response applies to all our areas of work together as a collaborative. In the following section, we have outlined what this will look like in practice over the next three years and the actions we will take across critical areas. For each, we explain how the area links to our overall response; what will be different for patients, partners, and staff in 3-years' time; our main actions in this area; how we will measure progress; who will be responsible; and immediate next steps.

6.0.2 We publish this strategy while already progressing some immediate initiatives we have agreed as a collaborative and manage through our governance structure and Committees. These are supported by this strategy and our approach to sharing and standardising best practice.

6.1. Clinical outcomes

6.1.1 **How does this link to our overall response?**
To improve and to reduce variation in outcomes, equity, experience, and access for patients, we will work to make sure we set the same high standards of care across our collaborative, constantly improving and aligning our approach to what evidence shows is best practice for delivering excellent patient outcomes. We will involve patients, communities in partners in prioritising the clinical outcomes and experiences that matter most to them and to apply and set the best practice ways of working needed to achieve these equitably.

6.1.2 We will choose where to focus our efforts to raise standards depending on where we see poor outcomes, significant variation in patient outcomes, equity, and experience, and where we know there are issues to access services due to long waits. We will use clinical pathways as our primary approach to organising our collaborative improvement efforts and prioritised initiatives. We will support our staff engage with our patients, communities, and our partners, because we know that care does not begin and end in our hospitals which means improvements need to support better health and ways of working across our system. This will also help us address the challenges of supporting improvements across our system and population health.

6.1.3 Patient needs are though complex and are not organised neatly into pathways. Although our primary approach will be pathways, we will support clinical networks and identify where we can work together to improve outcomes across population groups such

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as children and young people, patient segments such as people with multiple long-term conditions or serious mental illness, and cross-cutting outcomes such as care at the end of life.

6.1.4 We believe that as well as delivering better, more equitable care, aligning to best practice will be more productive and cost efficient. This means that improvements should be achieved within our existing resources. In practice, we expect reductions in the average cost of care from some of our pathways and services to enable us to agree prioritised investments that improve clinical outcomes and equity in other pathways and services.

6.1.6 **What will be different for patients, partners, and staff in 3-years' time?**
- Patients will access excellent care, experience, and outcomes whichever hospital they attend in north west London. They will have greater choice in accessing care across sites, for example when needing diagnostics, and digitally because of greater consistency in how we work. Their experience will be better because many pathways have been redesigned incorporating co-design and co-production principles.
- Partners will benefit from consistent ways of working and communicating information about our patients. Best practices in providing care and expertise outside of acute hospitals will have been incorporated into redesigned pathways.
- Staff will follow best practice pathways with clinical tools, systems, and ways of working designed to make the easiest thing to do the best thing to do. They will have closer working relationships with their peers across our APC, comparing their clinical outcomes transparently, openly, and curiously to learn and share good practice.

6.1.7 **What are the critical actions?**
- Each specialty will choose at least one priority pathway each year to improve, raising standards and aligning our approach across the collaborative to best practice to improve patient outcomes. Pathways will be prioritised by key factors such as poor outcomes across all trusts, variation between trusts, inequity between population groups, workforce challenges, patient volumes, and costs. These priority pathway improvements will be sponsored by executive leaders who will use these initiatives to test, strengthen and accelerate common enablers like access to data, integration into digital tools, and skills training that can then be used to support a broader movement of improvement.

- Clinical networks across our APC will discover and understand what each organisation is doing, the outcomes they achieve, and agree the few outcomes measures they will prioritise.
- The clinical networks will engage widely with patients, communities, and staff, as well as looking at local, national, and international evidence, to understand best practice for this pathway and work to implement this across north west London. Clinical outcomes, performance and productivity data will be shared visibly and transparently, so we can benchmark across other organisations, national or international practice.
- Complementing the focus on pathways, we will implement improvements and best practice standards across quality themes where efforts are already making progress, including infection prevention and control, mental health in an acute setting, care of the deteriorating patients, end of life care and user insights and focus.

6.1.8 How will we measure progress?
- Across our APC we will track the prioritised pathways and the outcomes agreed by the clinical teams and expect to see improving quality standards and reduced variation between sites, teams, and individuals.
- Our quality governance will continue to closely track and measure our outcomes in pathways that are not prioritised for improvement each year. We would expect their current performance to be at least stable, if not gradually improving, as local teams and innovations support continuous improvement.
- We will also track progress by measuring our overall strategy metrics.

6.1.9 Who will be responsible for this?
- Each specialty/pathway will also have a clinical lead and a Specialty Leadership Group, comprising of a clinical representative from each trust. This group will be responsible for pathway redesign.
- Each CEO in the collaborative will oversee the progress of several specialties. Improvement support will be organised from within the lead CEO's trust, such as project management or analytical capacity. The CEOs will have responsibility for reporting progress and escalating any issues to our APC Executive Management Board.
- For outcomes that cut across clinical pathways, the Collaborative Quality workstream and its lead CEO, reporting into our APC Quality Committee, will be responsible for overseeing improvements. This includes areas such as specific

patient populations like children and young people, segments like patients with multiple long-term conditions, or cross-cutting themes like mental health in an acute setting.

6.1.9 **What are the immediate next steps?**

- Appointing clinical leads and the specialty leadership group to begin the specialty redesign.
- Agreeing priority pathways for the first year of the strategy, agreeing the priority outcomes, the best practices to achieve these and how to implement these consistently across our APC.
- Progress and finalise implementation of improvements and best practice across collaborative quality priorities.

6.2 Performance and productivity

6.2.1 **How does this link to our overall response?**

Access, performance and how we value patients time have important impacts on patients experience and are a priority amongst our local communities. They also impact clinical outcomes, reducing the risks of deterioration and complications. Increasing our productivity is the fastest way to expand our capacity to support patients who need care.

6.2.2 We will work to set and raise standards of performance and reduce variation between our organisations by agreeing and implementing the most productive ways of working. Reducing waste and getting the most value from our resources will support improvements in patient care, performance and create opportunities to reinvest and redeploy savings into innovations that improve quality. It will also improve staff experiences by addressing frustrations that waste time and unsustainable workloads.

6.2.3 **What will be different for patients, partners, and staff in 3-years' time?**

- Patients will have shorter waits for care than today. Significant progress will have been made to restore NHS constitutional standards in planned care pathways, fewer people will have long waits for emergency care, and fewer patients will be delayed reaching the most appropriate care setting once they are medically fit. Patients will experience a much greater focus on their convenience and value of their time, with services implementing shared best practices such as "one-stop shop" models and making it easier to share and access information and care remotely.

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- Partners will find it easier to get specialist advice to help people they also support. Where we interact such as at discharges, improvements in productive and efficient processes will reduce the delays and confusion that can happen today.
- Staff will find work easier and more rewarding because of reductions in the frustrating obstacles, waits, and waste that get in their way of providing excellent care.

6.2.4 **What are the critical actions?**
- Improvements to performance and productivity will be integrated with efforts to align best practices within clinical pathways and support services, because excellent quality outcomes, equity, and experience are directly linked to access.
    - o In prioritising the pathways we will address first, we will consider where there are variations in or poorer performance in access to services, because this impacts on our potential to achieve excellent, equitable clinical outcomes.
    - o Best practices adopted will incorporate measures and evidence to improve performance, productivity, efficiency, and value alongside quality.
    - o Improvements in non-clinical support services will prioritise improvements in productivity while maintaining and improving current performance, so that resources can be reinvested in improving clinical outcomes and digital enablers.
- We will set and raise standards on common clinical enablers that significantly impact performance and productivity by standardising our ways of working and systems to achieve best practices, including patient scheduling, waiting list management, outpatient clinic administration, operating theatre utilisation, average inpatient length of stay, and discharge processes. Improvements in the productivity and value of these common enablers will support overall reductions in cost to address our underlying deficit and allow prioritised reinvestments to improve clinical outcomes.
- Information about performance and productivity measures will be shared transparently across our organisations and incorporated into shared dashboards to support learning and improvement. These measures will include outcomes including session/clinic utilisation, turnaround times, average length of stay, workforce models, premium pay rates, non-pay expenditures, and estate/asset utilisation.

6.2.5 **How will we measure progress?**

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We will track productivity and performance measures within each specialty, across each trust to support shared accountability and across our APC to support prioritisation in where we need to share best practices and act differently.

6.2.6 Priority measures to demonstrate improvement are:

- Elimination of patients waiting over 52 weeks from referral to treatment.
- Improvement against the 18-week wait referral to treatment time NHS constitutional standard.
- Reduction in patients waiting more than 12-hours and 4-hours when attending Accident and Emergency Departments.
- Reduction in the number of patients medically fit for discharge but occupying an acute bed.
- Reductions in the average cost per weighted activity unit.

6.2.7 **Who will be responsible for this?**

Improvements will be primarily led through the clinical pathway and non-clinical support services initiatives. Action across common enablers supporting performance and productivity will be overseen by the Chief Operating Officers. Improvements supporting improved measurement of productivity and resource utilisation will be led by the Chief Financial Officers. Collectively, they will report progress through to the Finance and Performance workstream and its lead CEO, with our APC Finance and Performance Sub Committee assuring direction.

6.2.8 **What are the immediate next steps?**

Support the clinical pathways and non-clinical support services improvement initiatives to identify best practices and standardise across our organisations.

6.3 Research and innovation

6.3.1 **How does it link to the guiding policy?**

North west London is home to excellent research and innovation assets, including a world class academic institution and global industry. There are also strong, longstanding working relationships and collaborations between partners, most notably through the NIHR North West London Clinical Research Network. The result has been significant numbers of patients benefitting from access to the latest treatments and technologies, and at the same time staff have benefited from the experience of being involved in their development

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and delivery. We know that participation in research trials improves outcomes for our patients, as well as providing skills development for our staff.

6.3.2 Research's biggest challenge across the country is that there is significant variation in access to research participation and innovation for different population groups, and this is the same issue in north west London. To provide better access to patients, more opportunities for staff and to further attract academic and industry partners and investment, we need to unrelentingly focus on improving equitable access to research trials and innovation in north west London.

6.3.3 Increasing commercial research partnerships will create a virtuous cycle of increasing our income and resources, which can be invested into broader support for research and innovation. New sources of income will help us address our underlying financial deficit and they also bring wider economic benefits for the UK economy.

6.3.4 Broadening staff access to research will support recruitment and retention of talented, innovative colleagues and make our APC one of the best places to work in the NHS.

6.3.5 **What will be different for patients, partners, and staff in three years' time?**

- The population we serve will have improved equity of access to research trials that they are eligible for, and overall numbers of research participants will increase. This will mean that patients across the collaborative will have more equitable access to the newest treatments, technologies, and procedures, benefitting in turn from improved outcomes.
- Academic and industry partners will find it easier to work in north west London than other parts of the NHS, with simpler, efficient processes to establishing feasibility and then research, and with access to a larger, more diverse population.
- Staff will be able to conduct research with more support, across wider networks of partners and with improved research skills.

6.3.6 **What are the critical actions?**
- Promote a research and innovation culture.
  - o Continue to invest in growing and widening access to our research networks that support the development of connections, peer learning, and staff training in research skills.
  - o Place greater emphasis on research and innovation within job roles and descriptions to build a skilled, multi-disciplinary workforce.
  - o Actively promote a culture of learning and curiosity to support research and innovation, through consistent leadership across our APC.

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- Grow the breadth, depth, and impact of our trusted research environment.
  - To grow the breadth, depth, and impact of our existing NIHR BRC hosted trusted research environment, we need to strengthen collaboration and partnership between the research teams working across trusts and universities in north west London. This also means adapting the governance around data to ensure all key stakeholders can influence decision making to support trust and engagement.
  - As a collaborative we will adopt best practice ways of working to speed up effective trial set-up times to our partners.
  - We will use the systems and tools already available to us to support the identification of patients who meet study/trial inclusion criteria across our APC rather than by individual trust.
- Reduce the inequality of access to research and trials across the collaborative.
  - Access to research and trials should be determined by your clinical appropriateness, not the site on which they have their diagnosis or treatment.
  - Not every hospital will be awash with Chief Investigators, but every CI should be thinking about how their study or trial can be easily accessed by clinicians and patients across the collaborative.
  - As a collaborative we will identify and adopt the best model to support the spread of research across the collaborative.
- Improve management and coordination to help colleagues lead innovation, as the administration in research is a significant burden. By improving the coordination of R&D, ethics, and administrative functions will support staff to focus time and resource towards conducting research and adopting innovation.

6.3.7 Potential measures of progress

- Develop a new measurement to track rolling monthly recruitment to all studies and clinical trials, to drive an increase in the total number of trials, the percentage of trials available in the UK that could be available to our patients that are available, and the number of patients recruited across the trials.
- Develop new measures to contextualise recruitment to trials with population level eligibility data to understand and improve the equity of access.
- 90% of commercial studies open at the first site within 60 days of the HRA approval.
- Proportion of open studies on track, delivering to time, and target.
- Establishment to first participant recruited.
- Patient and staff experience of research.

6.3.8 Who will be responsible for this?

- Within our APC, this work will be led by our Research and Innovation functions reporting into their responsible Executive Director and then our APC Executive

Management Board. Overall progress will be overseen by the Quality workstream and our APC Quality and Safety Committee.

- Improvements within our APC will be complemented by working with the North West London Research and Innovation Board.
- The research and innovation landscape is complex and undergoing transition. It is vital to gain a shared understanding of structures, roles, and responsibilities across north west London, further broadening opportunities and links with our other health and care partners.

6.3.9 **What are the immediate next steps?**

- Establishing a shared understanding of structures, roles and responsibilities for research and innovation across north west London.
- Build on the existing working with the NIHR Clinical Research Network to develop opportunities for APC Research leaders and other staff to build connections and collaborations.
- Identify and align to best practice on centralising and streamlining approval and support processes, including data sharing.
- Review job roles across north west London with specific focus on attracting and encouraging staff with research and innovation skills, knowledge, and commitment.
- Develop new measurement to better track the equity of access to clinical trials across our APC.

6.4 Data and digital

6.4.1 **How does this link to guiding policy?**

Data and digital tools are a critical enabler for us to raise standards of care and productivity across the collaborative and promote innovation. To know what to improve and how, we need to know what we are currently doing and how we compare across each other and benchmarked to best practice nationally and internationally. Using common digital tools such as our single electronic patient record, using the NHS App and common dashboards will enable us to measure, compare and provide immediate insights on patient outcomes and our organisational efficiency consistently and transparently. This underpins empowering staff to improve, by giving them the information and insights to encourage their curiosity about their quality, performance, and productivity and how they can learn from and with others across our APC. The scale of our shared infrastructure, including our single electronic patient record, offers enormous innovative potential supporting research and application of leading-edge technologies such as Artificial Intelligence which offer incredible potential to provide higher quality care, greater personalisation of patient experiences and increase staff productivity.

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6.4.2 Data and digital will support excellent outcomes and better experiences by supporting patient empowerment, convenience, greater personalisation, and standardisation to best practice. Economies of scale, adoption of innovations such as automation, and best practices to improve productivity and efficiency will create savings. However, we expect that enhancements in analytical capacity and infrastructure will require reinvestment of savings made from digital and other corporate services. Improved digital tools and empowerment of staff to use them wherever they are working will make our APC a much better place to work.

6.4.3 What will be different for patients, partners, and staff in 3-years' time?

- Patients are empowered to access, use, and update their information including viewing clinical results, book and change appointments, and finding out about potential research trials that could support their care. They find it easier to communicate with their multidisciplinary team and access information and support that empowers them to manage their condition.
- Partners have access to consistent information across our APC where they interact with pathways, such as patients' readiness for discharge.
- Leaders will have the data they need to improve their services and inform conversations with colleagues and other organisations within our APC.
- Staff are much more curious about what the data shows and are using it to improve their services. They can easily and transparently access up-to-date information across our APC that helps understand where our best practices outcomes, performance and productivity are achieved and how their service or function compares. They find it easy to work across all our sites and access because of the digital infrastructure. Staff will be adopting tools that support their productivity, such as manging patient flow through our organisations and with our partners, ambient documentation, and system generated discharge summaries.

6.4.4 What are the critical actions?

- Build common clinical outcome, performance and efficiency strategic reporting solutions that provide transparent, comparable insights and benchmarks from service to site to trust and APC, with real-time functions and interoperable data connections with the systems we use across our APC. Dedicated expertise will be established to work directly with teams to use their curiosity about their data and insights from front-line patient care to measure and improve quality.
- Standardise and enhance our digital applications, infrastructure, data sharing, governance and security, data standards, and data quality across our APC to achieve better quality, staff experience and greater cost efficiency. This should be

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anchored around our existing infrastructure of Oracle Cerner electronic patient record, CCS/Federated Data Platform, and the NHS App, and we should aim to move onto the same systems or jointly procure solutions as contracts are renewed wherever possible.

- o Invest and support an on-going programme to optimise Oracle Cerner electronic patient record and its associated ecosystem. This will include scaling best practice training, workflow, and design throughout the system, addressing "paper-based" processes still sat alongside such as some tertiary referrals, and realising the benefits from its installation across our trusts.
- o Develop and deploy the existing CCS platforms to support patient flow, transparent capacity utilisation and further use cases across emergency flow, elective productivity, cancer care, diagnostics and waiting list management.
- Move towards creating collaborative teams that provide high-quality support for systems and infrastructure, support seamless working across sites, and achieve economies of scale.
- Use our digital and analytical strengths to empower patients, promote patient-centred design, staff curiosity and data literacy, and greater equity.
  - o Design digital into empowering patient decision making, improving patient experience, supporting equity, and user centred design of best practice pathways. This includes enriching information in shared care records for patient access and joining up with partners, such as the London Care Record, and support to patient-facing tools that make their experience accessing information and managing their healthcare more convenient.
  - o Provide training and support to all staff on digital literacy and using our digital tools and applications to their fullest extent to support patient outcomes, analysis, and productivity (e.g., automating tasks).
  - o Improve the completeness of information we have about patients such as their protected characteristics by making it easier to share it and use this to inform insights about and improvements in the equity of our outcomes.
  - o Expect and encourage all staff to be more curious about data and how they can use it to improve clinical outcomes and productivity.

6.4.5 How will we measure progress?

- User adoption and usage of common APC dashboards.
- Reduction in the number of digital systems being used for similar functions and tasks.
- Completeness of data about patients protected characteristics and outcomes.

- Volume of patient transactions such as accessing information or rebooking appointments managed through digital channels.
- Staff feedback on accessing systems irrespective of location, system performance and uptime, responsiveness to enhancement for core systems including Cerner, and whether they would recommend our analytical support and digital support to other colleagues.
- Reduction in the cost per user of IT infrastructure and support.

6.4.6 Who will be responsible for this?

- Our digital teams are already working closely together, including joint functions in place between London North West Healthcare and Hillingdon Hospitals, and Chelsea and Westminster Hospitals and Imperial College Healthcare. The Chief Information Officers and their teams will lead improvements across our infrastructure, systems, and support services. Analytical improvements will be overseen by the COOs and CIOs.
- Progress will be assured and tracked by the Digital and Data Working Group chaired by its lead CEO, and our APC Digital and Data Committee.

6.4.7 What are the immediate next steps?
- Finalise our data strategy to determine details of approach, standards and investment priorities.
- Established shared, dedicated collaborative expert resource able to develop integrated clinical outcome and productivity dashboards in support of clinical pathway and corporate process improvements.
- Create register of digital applications and systems by function, including their contractual end dates.

6.5 People

6.5.1 How does this link to our guiding policy?

High-quality and equitable care depends on our staff. Aligning to best practices across our organisations improves the equity of career opportunities, personal development, experience, wellbeing, empowerment, and engagement our staff. This will support attracting and retaining talented colleagues from our local community and beyond. Our staff will be able to have exciting career opportunities moving between our APC organisations, helping us better connect and share best practices. Savings from reducing unwarranted costs, such as more expensive interim or agency support, can be reinvested

in supporting education, development, and wellbeing, which will also help improve the quality of our care.

6.5.2 Changes in other areas like clinical pathways will impact the people who work for us and the expected impacts on staff have been described in previous sections. We also need to adopt consistent best practices in people policies and processes, including recruitment, onboarding, education, training and development, recognition, reward, wellbeing, and support. Doing so will promote equity and consistency in experiences and enable staff to work and collaborate across our trusts more easily. This supports our vision of being one of the best places to work in the NHS, and addresses our challenge of inequitable opportunities and experiences amongst our staff.

6.5.3 What will be different for patients, partners, and staff in 3-years' time?

- Patients will experience higher quality care driven by staff who are happier and empowered in their roles. Increased diversity and equity for our staff, including in senior leadership roles, will support deeper connections with the communities that we serve by employing more people who are representative of our local population.
- Partners will be linked into our training and employment opportunities amongst our local communities as part of our anchor institution responsibilities.
- Staff will have more opportunities to grow their careers and skills without needing to leave north west London. This will include short-term secondments or rotations, collaborative projects, and development programmes. A higher quality staff wellbeing offer will support our people to be happier and thrive at work.

6.5.4 What are the critical actions?
- Align all our people and employment policies and processes to best practice so that staff are treated and supported fairly, consistently, and equitably.
    - Agree shared policies and approaches to creating policies across all people policies (leave, flexible working, etc.), bullying, harassment, discrimination and violence, disciplinary and performance management.
    - Establish a unified recruitment and onboarding process, with recruitment to posts where possible from within our APC to encourage succession planning, talent development and promotion opportunities from within our APC.
    - Implement improvements so that everyone finds it easy and seamless to work across sites and trusts. This includes easy access to apply and join

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shared bank, skills and mandatory training passport, honorary contracts automatically in place to visit other sites, and making it easier for individuals to work and support short projects or needs across organisations.

- Implement our equity, diversity, and inclusion action plan to support fairer and more just employment practices and outcomes.
  - Create dashboards transparently sharing employment outcomes across our APC to learn, share and support alignment to best practice.
  - Implement best practices in recruitment, induction (with particular focus on international recruits), reasonable adjustments, bullying, harassment, discrimination, and violence.
- Increase the breadth and quality of our education and training programme opportunities for our staff by sharing access and best practices.
  - Allow staff access to education and training programmes already happening across our APC to support connections between our organisations and increase consistency of practice.
  - Where we offer similar training schemes, identify the best practice training approach based on staff development outcomes and their feedback, and scale these as standard best practice across our APC.
  - Create common skills, knowledge, and experience passports for our staff to track, evidence and plan their education needs across our APC.
  - Increase the number of joint APC programmes for learning and development, using our collective buying power and influence, including to address skill gaps and support apprenticeships for new and existing workforce roles.
- Identify the best practices across our APC that support staff wellbeing, employment and health and invest in scaling these across our APC. This could include digital tools, support for staff mental and physical health, supporting staff communities and networks, and dedicated support for international recruits.
- Develop best practice talent management functions to proactively and equitable identify high performers across organisations, provide pairing, coaching, mentoring, and sponsorship opportunities to develop network and career moving within and across APC organisations.

6.5.5 **How will we measure progress?**

- Staff who would recommend our APC as a place to work.
- Average staff vacancies, turnover and sickness.
- NHS Staff Survey score for diversity and equity.

- Staff in senior band, VSM and consultant medical roles reflect the diversity of our local community.

6.5.6 Who will be responsible for this?

- Our Chief People Officers are jointly leading a Scaling People Services programme which has been conducting deep and broad engagement and co-design since 2023. Their progress will be overseen by the People and Inclusion workstream chaired by its lead CEO, and assured by our APC People Committee.

6.5.7 What are the immediate next steps?

- Implement the immediate priorities agreed through our Scaling People Services programme and Equity, Diversity, and Inclusion Action Plan.

6.6 Estates and sustainability

6.6.1 How does this link to our overall response?

The experiences and quality of care experience by our patients, the daily working life of our staff and their productivity, and significant local impacts such as our sustainability all depend on our estate. Across our collaborative, we have a larger physical footprint than the Pentagon. Within the three-year timeframe of our strategy, we are not planning for significant differences in our estates beyond progressing major hospital rebuild programmes. However, we will align our best practices across our organisations in how we use, maintain, and enhance our physical assets while learning from shared, transparent information to support higher quality care, better staff experiences, and leverage our buying power as a Collaborative to reduce costs.

6.6.2 There are numerous ways that aligning best practices in estates and sustainability supports improvements in quality, efficiency, and staff experience. This includes:
- Sharing best practices in the thoughtful use and redevelopment of our buildings, sites, and spaces to support patients, widen access to community spaces and support the local economy as anchor institutions.
- Implementing our Net Zero plans to reduce our environmental impact, including saving costs from lower energy utilisation.

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- Procuring, designing, and assessing our estates and facilities to support better facilities for staff and patients and more effective use of our limited resources, in particular ensuring our services are accessible to all.

6.6.3 What will be different for patients, partners, and staff in 3-years' time?

- Patients visiting our buildings will find them to be more accessible and easier to use, access, and attend services.
- Partners will see improvements in our hospitals' efficiency and sustainability, showing real differences in carbon emissions and a more joined up approach to facilities contracts. Our hospitals will be using more local suppliers, supporting our local economy. Local communities will benefit from wider access to our facilities and spaces to support local health and wellbeing.
- Staff will see improvements to their facilities and working environment with a consistent offer across our APC. It will be easier to work between hospitals with the same or similar facilities and estates processes in place.

6.6.4 What are the critical actions?

- Develop shared best practice standards in staff facilities and agree a common approach to deploy our routine maintenance investments to ensure quick enhancements towards these standards that staff recognise as beneficial.
- Assess where we can get most value from shared services for estates and facilities contracts (e.g., where there is significant variation or specialty services). This could include inpatient catering, linen/laundry, and non-emergency patient transport.
- Develop a shared view of carbon emissions and other environmental impacts such as landfill waste across trusts with regular reporting and greater transparency. Share and scale successful local sustainability initiatives and adaption plans to accelerate our progress on reducing our environmental impacts and being better prepared for a more uncertain climate.
- Develop greater understanding of vacant or 'under-used' estate and our utilisation of our physical assets to make best use of this as a collaborative, such as supporting innovative clinical pathways and services supported by staff working across our organisations.
- Incorporate social value and anchor institution responsibilities into re-development planning, and share our learning and expertise from recent major redevelopments, such as the community diagnostic centres.

6.6.5 How will we measure progress?

- Assess the accessibility of our estates.
- Staff feedback on the quality of their working environment and facilities.
- Tonnes of CO2 emitted – whether we are on track with reducing our CO2 emissions in line with our carbon budgets.
- % vacant or 'under-used' estate.
- Total Hard FM and Soft FM costs per m^2.

6.6.6 **Who will be responsible for this?**

- The executive strategic estates and sustainability group chaired by its lead CEO will be accountable for this work, reporting to the Strategic Estates and Sustainability Committee.

6.6.7 **What are the immediate next steps?**

- Develop a shared approach for our NHS Carbon Footprint data and measurement.
- Share and spread initiatives that have shown demonstrable benefit to carbon and financial savings (an example of this would be around the PC Power-down solution implemented at Imperial in early 2021 now spreading to the other trusts).
- Share learning of approach to Green Plan across trusts (an example would be in application for Public Decarbonisation Grants and large-scale nitrous oxide waste mitigation).
- Align our approach to collecting and sharing estates and facilities data and understanding where there are opportunities to align contracts.
- For areas of high variation in estates and facilities, work to align approaches across the collaborative.

6.7 Other non-clinical and support services

6.7.1 **How does this link to guiding policy?**

Effective non-clinical and support services enable excellent outcomes by ensuring our staff have everything they need to care for our patients.

6.7.2 Standardisation of corporate workflows, systems and processes will simplify future opportunities to rapidly scale best practices that will improve outcomes for patients and staff, whilst also supporting greater resilience and sustainability across our APC. Cost efficiencies achieved through adopting best practices will help address our underlying deficit and be re-invested in further improvements and enhancements to digital and analytical capacity.

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6.7.3 What will be different for patients, partners, and staff in 3-years' time?

- Patients will notice happier staff who have the tools and support they need to do their work more effectively. They will find it easier to communicate with our organisations and find out information about our services.
- Partners will experience greater consistency in working with trusts such as when planning future workforce and education needs across north west London, and in some instances may work with one person or team representing on behalf of our APC.
- Staff will experience high-quality support from corporate services and systems, which are more efficient and cost-effective. This will make it easier and quicker to answer questions about their employment or support they need, replace or order supplies they need to provide best practice care, and get estates and facilities issues fixed more quickly. Staff in corporate service teams can expect to have access to consistent knowledge and skills, making it easier to move across sites and share best practices.

6.7.4 What are the critical actions?
- Embed and realise benefits including cost efficiencies from existing joint programmes, including procurement, payroll, transactional financial services, and scaling people services.
- Across other corporate and non-clinical function, review current policies, processes, and procedures to prioritise where there is the greatest opportunity in improve performance and cost effectiveness from alignment to best practice. We anticipate the priorities to be where there are:
    - Areas where there are known performance and productivity risks or gaps from external best practice benchmarking.
    - High-volume and highly standardised corporate areas where economies of scale could offer significant gains in efficiency and productivity.
    - Areas that require specialised knowledge or skill so that having one aligned and unified best practice approach will reduce the need for outside expertise or advice.
- Develop consistent approaches to transparent information sharing and reporting across corporate services to enable improved planning and robust evaluation of outcomes, including the efficiency and productivity of any support at each location to identify best practice and improvement opportunities.

6.7.5 How will we measure progress?

- Reduction in the average costs of support services.
- Reduction in errors or issues in the service (e.g., for payroll a reduction in overpayments).
- Increase in responsiveness and turnaround times of corporate services.
- Increase in staff who would recommend the support they receive from our corporate services.

6.7.6 Who will be responsible for this?

- Executive leadership of our corporate functions will be responsible for directing the collaborative work across their teams.
- The Finance and Performance Workstream and its lead CEO will be accountable for the improved performance and cost of corporate and non-clinical functions, reporting into our APC Collaborative Finance and Performance Committee.

6.7.7 What are the immediate next steps?
- Continue implementing agreed priority initiatives.
- Agree priority areas for improvement from the second half of this financial year.

6.8 Anchor institution responsibilities

6.8.1 How does it link to the guiding policy?

As the largest single employer in north west London, we are also committed as anchor organisations, meaning we have an important presence in our local places, to support local economic development, wellbeing, and improve the health of north west London. We will align how we work together to best deliver on our ambitions as anchor institutions. These include ensuring more local recruitment from our local communities, including expanding apprenticeships, using collective buying power to support local businesses, and working closely with local organisations to share expertise and building our understanding of needs to support population health and wellbeing.

6.8.2 These actions support higher quality and equitable care as we engage with communities and support population health outcomes. Improved recruitment from our local communities and collective use of our buying power will help us use resources more efficiently.

6.8.3 What will be different for patients, partners, and staff in three years' time?

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- Patients will have access to care and specialist expertise connected into their neighbourhoods. Numerous care pathways will have been redesigned to effectively promote population health outcomes and sustainable health improvements, not just effective treatments to sickness.
- Partners will find it easier to work with APC organisations as they can quickly reach an appropriate local contact when the context of their need is local, or a single, shared voice when the context is regional. Local partners will have their voice heard more within our APC.
- Staff will have personally rewarding opportunities to connect and support their local community, such as encouraging aspiration within local schools or leading engagement with local community, voluntary and faith groups.

6.8.4 What are the critical actions?

- Identify and align best practices in meeting our anchor organisation responsibilities, in areas including education, employment, economic development and sustainability. Determine whether best practice can best be best achieved working once across our APC or locally with different partners, and implement the steps needed to achieve this.
- Share and standardise our approach to partnership working within each trust, while each trust retains independent local leadership and relationships.

6.8.5 Potential measures of progress

- Proportion of non-pay expenditure conducted through north west London businesses.
- Number of apprenticeships supported and new staff recruited who have home address in north west London.

6.8.6 Who will be responsible for this?

Each trust has organised its external collaboration and engagement functions differently. Progress in this area will be overseen by collected group of Strategy and Communication directors, who will be responsible for coordinating and facilitating connections across our organisations and tracking best practice with updates shared with our APC Executive Management Board. Our anchor institution responsibilities will be overseen our APC People and Inclusion workstream and its lead CEO, because of the importance of local employment, reporting to our APC People Committee.

6.8.7 What are the immediate next steps?

- Conduct a discovery exercise on existing anchor responsibility strategies and initiatives across each APC trust and share this best practice.
- Agree priority areas and initiatives to align best practices from the second half of the financial year.

7. Measuring our progress

7.1 Data and information will be central to all our improvements. When addressing a challenge or considering potential improvements, we will first agree the outcome measures that will demonstrate whether any changes we make are an improvement. We will then align to the best practices that achieve these outcomes. For each initiative or improvement effort, demonstrating increases in the average outcome measures and the equity of this outcome will be our evidence of progress.

7.2 We have also prioritised a small number of outcomes to help us understand and track whether our response and efforts are supporting progress towards achieving our vision. These outcome measures have been chosen because they collectively measure patient clinical outcomes, access to services, productivity, and staff experience. They can also be used at every level from across our APC to individual trusts, each site and into individual services and teams. Supporting these metrics, collaborative teams and improvement initiatives will need to set out the important supporting metrics in their area where progress and improvement is needed. Improvements in these metrics will contribute to progress in these prioritised measures and mitigate risks of perverse behaviour and incentives from having too narrow a focus on simple metrics in a complex system.

7.3 Irrespective of the metric and whether it is from this strategic list or a supporting area, we will judge success only when we see these measures improve across our APC and simultaneously having a smaller range between each of our trusts. This is because we are committed to raising standards so our median performance goes up, and more equitable outcomes across our organisations meaning ranges between the highest and lowest performing trusts should go down.

7.4 Our recommended measures to track overall progress and success of our strategy are:

Outcome	Rationale	APC median	Range (scores of the highest and lowest performing trusts)
% of friends and family who would recommend the care they received	Our core purpose is caring for patients, and this measure reflects their feedback on our quality	95.7% *April 2024*	ICHT – 96.2% THH – 94.5%
% of staff recommending the care provided by their organisation for their friends and family	Our staff know our services better than anyone, and this measure reflects their confidence in what we provide	66.0% *2023 National Staff Survey*	CWFT – 77.08% THH – 52.52%
Standardised Hospital Mortality Index	Safety and effectiveness are at the heart of quality. This measure benchmarks our care	0.80 *Feb 23 to Jan 24*	CWFT - 1715/2435 - 0.7 THH - 905/940 - 0.94
% of people admitted, transferred or discharged from A&E within 4 hours	Swift access to urgent and emergency care supports better clinical outcomes and patient experiences	78.0% *April 2024*	CWFT – 81.7% ICHT - 76.2%
Number of people waiting more than 52 weeks from referral to treatment for planned care	Long waiting times are significant driver of current public dissatisfaction with the NHS and a nationally agreed priority to improve. Reductions are only possible through combination of higher quality care, productivity and expanding our capacity by being a great place to work. Over the next three years, this waiting period will come down towards the 18-week NHS Constitutional Standard.	Total: 9819 patients *April 2024*	LNWH – 4193 patients THH – 492 patients

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% of patients treated who have been recruited into a clinical trial over the last 12 months	Expanding access to clinical trials supports improve care quality and equity	*New measure to be developed*	*New measure to be developed*
% staff recommending their organisation as a place to work	We are committed to be the best place to work in the NHS and this is a direct measure of our progress	63.38% *2023 National Staff Survey*	CWFT – 70.07% THH – 52.53%
Cost per Weighted Activity Unit	This measures whether we are aligning to best practice in productivity and cost efficiency	98.5% (Cost Weighted Activity @ m10)	CWFT – 103% LNW - 93%

7.5 These priorities strategy measures will be reported to every board-in-common to track quarterly progress. We will create automated dashboard that will allow ward-to-board exploration of performance of each of these strategy metrics to understand our progress and variation.

8. Making it happen

8.0.1 Implementing this ambitious approach successfully is not just about the specific actions we take, but the support structures, values, behaviours, and ways of working that will help us effectively tackle unforeseen challenges and opportunities. Our strategy is a commitment to think and act differently through our work together. Change is difficult but will be more likely to succeed with reinforcements and role models.

8.1 Conditions for success

8.1.1 For our strategy to be successful we will need to make sure we have support structures including the organisational development and technical change skills across our organisation, be able to transparently use our data to support improvement and evolve this in an agile way to respond to curious questions, and support closer, central coordination across our four trusts to drive out variation rather than encouraging it to flourish.

8.1.2 **Organisational development and technical change skills:** Change is difficult and requires skills and knowledge. Our collaboration depends on existing and new teams and networks working in new ways. We will prioritise the organisational development capacity that will help strengthen and improve the cultures, behaviours, mindsets, and ways of working that enable sustainable change.

8.1.3 Our staff need to be able to connect and network with counterparts across our organisations. These may be people in similar roles, or people determined to make improvements in similar areas. Our organisational development support will need to make these connections easier so that networks of expertise and interest can grow and connect across our 33,000 staff. We will learn from other multi-site, geographically distributed organisations as we recognise this is a new challenge for us.

8.1.4 We believe people working together on improvements is one of the best ways to build trust, understanding, and teamwork. Our approach invites and expects staff to connect across teams and organisations to work together identifying areas for improvement and implementing best practices. However, new teams do not always work well together immediately. Teams working across independent organisations will need to rely less on hierarchy. Our organisational development support will be updated to provide training on forming high performing teams, routines to support effective communication and accountability, and managing disagreements across peers.

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8.1.5 Complementing this organisational development capacity, we will prioritise upskilling and support on technical improvement skills within team in collaborative training programmes. This will create new connections, networks, and support us adopt the best practice training and tools that lead to effective, sustainable, inclusive change. This will help strengthen cross-APC team performance as they will use the common tools and principles for collaborative improvements, avoiding delays from having to agree which individual organisation's approach or template is the right one or duplicating outputs.

8.1.6 Senior leaders and managers will also be supported to change their mindsets, behaviours, and ways of working as role models for our collaborative approach. This will include training to provide more coaching and mentoring that empowers their teams use the data, share openly with others, and apply their creativity to improve outcomes. They will be supported to encourage decision making as close as possible to the patient, even when working and standardising across our organisations, to avoid every change being bottlenecked by multiple layers of governance. We need these changes to support a broad movement for improvement that harnesses our collaborative talents and resources.

8.1.7 **Using data:** Our approach is underpinned by transparency. This is led by data that is available and analysed across organisations. It is complemented by a commitment to openness with peers, rather than being defensive or protective. Given the importance of the data and information sharing, dedicated capacity to develop shared dashboards on common infrastructure is vital and will be prioritised. How our analytical teams work with services will also change. Our analytical teams will need to work with teams focused on improvement to agree the priority outcomes, how they can be effectively measured through our clinical and data systems, where we may need to make compromises, and then quickly build something useful that visualises these metrics and can be automatically updated. This is different to static information requests being sent to information teams.

8.1.8 We have set finalising our data strategy as an immediate priority. Any dashboards will need to be scalable and shareable across our APC. This means that as we develop priority outcomes to support a service improve, we will always seek to compare this across our organisations, be able to measure in greater detail by sites, individual teams, and clinicians, and incorporate external best practice benchmarks when these are available.

8.1.9 The potential demand on creating insights and dashboards like this though could easily exceed our available capacity. This means that we need complementary ways of working that support our teams access and use our information. We will create common, shared dashboards and data environments where teams can build their own views and

access information themselves without needing specialist analytical resources. This means that we must also train and support our clinical and operational teams on how they can use analytical skills to understand problems, develop improvement ideas, and act on insights. We will share best practice in ways of visualising and tracking improvements, such as statistical process control charts. This supports us have common, shared training approaches and makes it easy for multidisciplinary teams to quickly understand new dashboards. We will also train staff to make full and effective use of national and regional data tools, such as Model Hospital and the FDP/CCS solutions.

8.1.10 Dashboards and information will also be more accessible to teams as they work to help them understand their real-time performance. We already use large screens in clinical areas to support operational flow and decision making, such as the Timely Care Hub dashboards. We will expand this way of working to help teams track improvement and alignment to best practice in real time.

8.1.11 Putting these improvements in how we share and use data also requires a change in the expectations of our staff. We believe that when given better access to useful information, our staff will apply their inherent curiosity and creativity to improve services and outcomes. This change in how we work will create virtuous cycles where new outcome measures and innovations identify and create new possibilities to further raise our standards. Alongside expecting these changes, our leaders will need to role model using this information and hold our teams to account in how they are applying it to improve services.

8.1.12 **Coordinating progress:** We have prioritised aligning best practices across four sovereign organisations. This means everyone's role includes responsibility for collaboration, transparency and sharing. With a broad, ambitious programme we need to be able to analyse and track progress, identify risks, delays, and potential interdependencies, and prioritise targeted interventions. We will align programme and project management approaches to the best practices in our APC to give consistent, clear, and concise information on each area. Our resources are constrained so we will agree how we can best collaborate across organisations to support this synthesis efficiently and effectively. Progress will be reported each month to our APC Executive Management Board. This will also support peer accountability between organisations on progress and how we are meeting our shared commitments.

8.2 Values, behaviours, and ways of working

8.2.1 The guiding policy of raising standards by aligning to best practice emphasises continuous improvement, collaboration, and seeking the highest standards of care. By striving for a culture of excellence and innovation, we ensure that our organisations consistently achieve the best outcomes for patients, build efficient partnerships, and provide a supportive work environment for staff. Achieving these outcomes is dependent on the quality of team working and team climate.

8.2.2 While each APC organisation will maintain its own culture and values, we collectively embrace a clear shared vision and APC values of curiosity, openness, transparency, and excellence. We are committed to changing how we solve problems. When we come across an issue, challenge, or risk within an organisation, we will first explore how others in our APC have solved it, the outcomes they achieve, and what we can do to align to best practice. When agreeing best practices, we will anchor on patient and community needs, not institutional needs, knowing we can address these collaboratively together. This shared APC culture layered into our trust cultures will support the movement for change and improvement described in our approach.

8.2.3 Recognition and future career development within our APC will be linked to exemplifying these values and ways of working. Other actions we will implement to promote these shared APC values and behaviours include:

- Introduce consistent communication and messages across our APC, such as regular all-staff meetings and digital communications promoting APC programmes, opportunities, and successes.
- Establishing rotational posts around and across our APC to expand colleagues networks, skillsets and experiences, whilst drawing together shared ways of working and common values.
- Creating clinical and staff community networks to grow connections and share best practice across our APC workforce in areas that matter most to people.

8.3 Risks and their mitigations

8.3.1 *Deploying dedicated resources to support this strategy*

The progression of implementing strategic objectives could be delayed by resource availability, upfront investment, and compatibility with on-going programmes. These

challenges can be mitigated through assurance and governance structures tracking progress and supporting prioritisation, the ability to learn and adapt, and redeploying existing staff from lower value individual trust programmes to higher impact collaborative programmes.

8.3.2 *Industrial/operational disruption*

There is a risk that industrial action or operational pressures could distract from long-term strategic change and improvement, preventing staff from engaging and participating. To mitigate this, a primarily bottom-up approach that remains relevant and aligns with best practices can save time by reducing duplication and interdependent designs. Additionally, a broad approach allows for the involvement of many people.

8.3.3 *Changes in national priorities*

Trusts have multiple collaborative arrangements with other providers and wider partners, each with differing demands. Shifts in national and local policy may require rapid adjustments, disrupting ongoing initiatives. The core of the strategy is to align with best practices, ensuring relevance in addressing external requirements. The strategy was developed with a clear diagnostic that anticipates likely demands, and is aligned with the North West London ICS Joint Forward Plan.

8.3.4 *Availability of resources and investment*

With limited resources and investment, there's a risk of overextending resources during the transition phase, which could strain existing systems. To mitigate this, rolling out collaborative initiatives in phases will prevent overwhelming capacity for change. Establishing clear metrics to monitor the impact of the collaborative strategy on care quality, resource utilisation, and financial performance can effectively support strategic priorities.

9.Conclusion

8.1 Our strategy sets out a clear vision for the way that we work together as an Acute Provider Collaborative. Our guiding policy will support us and our partners to make sure residents experience the same excellent quality of care regardless of where they receive it, and make sure that the Acute Provider Collaborative is one of the best places to work in the NHS.

8.2 This strategy supports each of our trusts to work towards the shared priorities outlined in their individual strategies, including a focus on quality of care, equity, sustainability, and our people, and outlines how we are going to work together as a collaborative to accelerate our progress.

8.3 The co-creation of this strategy demonstrates how far we have come, and we express our gratitude to everyone who has been involved in its development.

2.2 CLINICAL PATHWAYS PROGRAMME

● Discussion Item   👤 Tim Orchard

REFERENCES   Only PDFs are attached

📄 2.2 Clinical Pathways alignment - draft framework - BIC July 2024 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

NHS

NWL Acute Provider Collaborative Board in Common (Public)

16/07/2024

Item number: 2.2

This report is: Public

Clinical Pathways – framework for alignment to best practice

Author: Iona Twaddell, Peter Jenkinson

Job title: Enter author job title

Accountable director: Tim Orchard

Job title: Chief Executive (ICHT) and Chair, APC EMB

Purpose of report

Purpose: Information or for noting only

The purpose of this paper is to outline the proposed framework for a programme to deliver on the Acute Provider Collaborative (APC) strategy's key aim of aligning to best practice. The proposal is for specialties that are common across the APC to work together to reduce variation in their approaches and improve patient care. In the first year of the strategy, each specialty will be asked to align one clinical pathway to best practice. This should reduce variation, improve outcomes and raise standards.

This framework is shared with the Board in Common for information, to accompany the APC strategy.

Report history

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

Acute CEOs' Group	29/05/2024	Approval to recommend to APC EMB
APC EMB	05/06/2024	Approval of framework
Acute CEOs' group	26/06/2024	Approval of framework
APC EMB	05/07/2024	Approval of framework

Process of business case approval (cover sheet and main paper)

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

NHS

Executive summary and key messages

We know patients have different experiences when they interact with different Trusts and there is unacceptable variation in patient outcomes across North West London. Therefore, the APC strategy, expected to be approved by Board in Common in July 2024 has a key strategic priority of reducing unwarranted variation and inequality across North West London through aligning to best practice.

In line with this guiding approach, all specialties that are common across the APC will be asked to work together to improve standards of care for patients and reduce variation across how specialties work in North West London. All four Trusts will work together and with patients to set out a common approach to align one of their pathways to best practice. This will be an iterative and ongoing process, but as a start in the first year of the strategy we will ask that each specialty aligns/standardises at least one major pathway across the APC in 2024/25 (with further to follow in future years).

This paper sets out the framework for this programme. Each of the APC CEOs will take responsibility for a group of specialties. Pathway alignment will be led by an APC pathways clinical lead, with representatives from each Trust forming a Specialty Leadership Group. This Specialty Leadership Group will be accountable to APC EMB, via a lead CEO, for delivery of the aligned pathways.

Resource for the work will come from within existing teams in each specialty, with operational support from the lead CEO's Trust. There will be some central transformation and improvement resource for specialties to draw on where needed. APC EMB will oversee the delivery of this programme of work, with CEOs reporting on their respective pathways.

This proposed framework is shared with the Board in Common to note, alongside the APC strategy.

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

Process of business case approval (cover sheet and main paper)

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

What consideration has been given to impact on equity of access, including areas of deprivation or disadvantage to specific disabilities?

This process will aim to reduce inequalities and variation amongst care with patients.

Main Paper

1.   Background
1.1   In developing the strategy for the NWL acute provider collaborative (APC), a strong focus has emerged on reducing inequality and unwarranted variation. A key method to tackle this is to align across the Trusts in the APC, raising standards of care in all Trusts, working in the same way, to best practice. This approach can be applied to all aspects of activity across the collaborative, using measures relating to clinical and operational excellence, but we will start with clinical pathways.

1.2   In the first year of the strategy, each specialty will be asked to standardise/align to best practice one major clinical pathway, reducing variation across the collaborative and improving standard for patients.

1.3   The purpose of this paper is to set out a proposed approach to achieve this.

2.   Proposals
2.1   We have identified 27 specialties that are provided by all four trusts (see list in annex 1). Within these specialties, we believe there is variation in how patient pathways are delivered between the Trusts and by aligning our approach across the collaborative we can raise standards of care.

2.2   The proposal is that each of these specialties works together across Trusts to improve outcomes and reduce variation. Together, they will identify one patient pathway to standardise, and work to align their processes and approaches to meet best practice, whether this best practice already exists within one Trust, or is found regionally or nationally, or from patient and user feedback.

2.3   Each specialty will report to a lead CEO who, along with key colleagues, will advise on the pathway redesign and approve the recommendations of the specialties. The lead CEOs will report to APC EMB. APC EMB will agree the pathways recommended by the specialty leadership group and collectively monitor delivery.

2.4   Specialties will use data and evidence (including outcome/quality measures, patient experience, volumes, cost) to identify where the biggest issues that they can address are, and therefore where they should focus. This may be where there is biggest variation across Trusts, low performance across the collaborative or high patient

volumes. Then, working with clinical and non-clinical colleagues across the APC and with patients, specialty teams will identify a priority pathway, or aspect of care, and align the way we do this across the whole APC in 2024/25. This should reduce variation in care for patients across the APC and improve patient experience and outcomes.

2.5   The intention is then to extend this framework to further pathways or areas of care in future years.

Process of pathway redesign

2.6   We have considered the lessons from the previous patient pathways work in designing this approach. We will support specialties to deliver this approach by providing a toolkit that specialties can follow. The broad approach will be below, though we will refine further considering the handover from the patient pathways programme.
- Phase 1: discovery – establishing current state/ determining a pathway to align
- Phase 2: planning – designing future state/ determining best practice in this pathway
- Phase 3: implementation – determining how to implement this best practice

2.7   Each of these phases will have a gateway, with the lead CEO approving the specialty to move to the next phase, with reporting to APC EMB for assurance.

2.8   Some key principles that specialties will need to follow include:

- **Co-production** – patient and user input and involvement will be essential in re-designing specialty pathways.
- **Multi-disciplinary approach** to change – improvement and alignment to best practice will involve clinicians (doctors, nurses, AHPs) as well as management and operational colleagues. They will work closely together, across all four Trusts and with patients, to understand the issues and the best ways to address them.
- **Data and evidence** is needed to decide what should be aligned across the APC and to track progress in delivering better, less variable care. Specialties will need to show clear evidence and data both in identifying pathways to address and in identifying solutions. These will be existing metrics, such as from model healthcare system, waiting list data, cost data and volumes. It is crucial that user insights and patient experience also feature in the evidence.

Phase 1 – Discovery – choosing a pathway/establish current state

2.9   Specialties will recommend an initial pathway to align. They will likely have a hypothesis for areas that can be approved based in their experience, but will need to evidence their choice based on data including: patient volumes, clinical outcomes/quality data, patient experience measures, national and international guidance/best practice and productivity/cost data.

2.10   They may choose a pathway that shows greatest variation on these metrics, where there is consistently poor performance across the APC or where there is the greatest volume of patients and therefore largest potential impact.

2.11   The Lead CEO and their team will challenge this approach to ensure that aligning the chosen pathway will have clear potential impact.

Phase 2 – Planning - Determining best practice/design future state

2.12   Specialties will then consider what best practice in this pathway is using multiple inputs including regional, national and international data and patient feedback.

2.13   Specialties will map out what the pathway should be, based on clear evidence they have gathered and suggest how they will achieve this. They will also agree KPIs to measure success. The Lead CEO and their team will then approve this 'to be' state of the ideal pathway and the plan to get there.

2.14   There will be lay representation in both phases 2 and 3 to ensure that a new pathway is patient-centred. Each pathway will have access to appropriate support from a central pool of expertise (including improvement, transformation and BI support), via the CEO-led oversight groups.

Phase 3 – implementation - Implementing best practice

2.15   Specialties will implement changes to align across the collaborative, aligning pathways and services where necessary. We expect the first year's changes to be deliverable within existing budgets. However, if through this work more fundamental changes are shown to be best practice, including requiring investment, the lead CEO will review the proposal and initiate an APC-wide discussion on what changes would be practical and impactful.

2.16   The specialties will define and track agreed metrics to measure the impact of any changes.

Outline programme timeline

2.17   The aim is to have new, aligned, pathways implemented by the start of the new financial year (April 2025), at which point we will review the process and determine further pathways and ways of working together. The timing of each pathway will be agreed with the lead CEO and APC EMB.

2.18   The speed at which different specialties progress will depend on many factors including the extent of current working relationships, but the lead CEOs (reporting to APC EMB) will review progress and will agree when pathways are ready to move to the next stage.

Governance and leadership

2.19   Each CEO will oversee the progress of a quarter of the pathways. They will have responsibility for reporting progress and escalating any issues to the APC EMB.

2.20   CEOs will convene an oversight group to oversee their specialties. This is likely to include their Medical Director, Nurse Director and COO, along with any other senior clinicians.

2.21   For each specialty/pathway, there will be an APC pathways clinical lead responsible for the pathway redesign, along with clinical representatives for each Trust and the

general manager within the lead CEO's Trust. Together, they will form a *Specialty Leadership Group.*

2.22   This means there will be four clinicians responsible for each pathway across the APC (one APC pathway clinical lead and three specialty leadership group members). These clinicians will become the acute representatives for the relevant CRG. The CRG may be engaged on the pathway alignment work, as part of its whole system pathway work, but is not directly responsible for pathways wholly within the APC. There will be no additional PAs for this work across the Trusts, though there may be some reallocation of PAs / review of existing priorities within the existing PAs (not to the detriment of patient care).

2.23   Operational and managerial colleagues across all Trusts will be engaged in this work and others may need to join the main project team as required.

2.24   The CEOs' oversight groups will keep track of the specialty leadership group's work and challenge them. There will be a monthly written progress update for APC EMB to note, with further detail on issues raised by exception. This will replace the work of the existing APC pathways group, which will therefore be stood down when the current projects are complete.

2.25   Central APC resource (the existing APC EMB PMO support) will support co-ordination and keep track of the overall programme. Specialties will also have access to appropriate support from a central pool of expertise, via the CEO-led oversight groups, for advice and to share useful resources/tools. This central resource will not lead projects, but support specialties in delivery where appropriate.

3.   Recommendations
3.1   The Board in Common is asked to:

- Note the approach to clinical pathways redesign to implement the APC strategy

Annex 1: List of specialties and CEO leadership

Specialty	Lead CEO
Dermatology	Lesley Watts (CWFT)
Diabetes and endocrinology	Lesley Watts (CWFT)
General Surgery	Lesley Watts (CWFT)
HIV/GUM	Lesley Watts (CWFT)
Respiratory	Lesley Watts (CWFT)
Vascular	Lesley Watts (CWFT)
Paediatrics	Lesley Watts (CWFT)
Anaesthetics	Patricia Wright (THHFT)
Breast	Patricia Wright (THHFT)
Haematology	Patricia Wright (THHFT)
Ophthalmology	Patricia Wright (THHFT)
Pain Management	Patricia Wright (THHFT)
Geriatrics and frailty medicine	Patricia Wright (THHFT)
Colorectal	Pippa Nightingale (LNWH)
Ear, Nose and Throat	Pippa Nightingale (LNWH)
Gynaecology	Pippa Nightingale (LNWH)
Maternity / neonatology	Pippa Nightingale (LNWH)
Orthopaedics	Pippa Nightingale (LNWH)
Rheumatology	Pippa Nightingale (LNWH)
Urology	Pippa Nightingale (LNWH)
Cancer and oncology	Tim Orchard (ICHT)
Endoscopy	Tim Orchard (ICHT)
Imaging	Tim Orchard (ICHT)
Neurology/ stroke	Tim Orchard (ICHT)
Cardiology	Tim Orchard (ICHT)
Gastroenterology	Tim Orchard (ICHT)
Hepatology	Tim Orchard (ICHT)

3.1 REPORT FROM THE CHAIR IN COMMON

● Discussion Item   👤 Matthew Swindells   🕐 09.50

REFERENCES
Only PDFs are attached

📕 3.1 Chairs Report to the Board in Common 16 July 2024 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

NHS

NWL Acute Provider Collaborative Board in Common (Public)
16/07/2024
Item number: 3.1
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	Committee name	Committee name
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.
What was the outcome?	What was the outcome?	What was the outcome?

Executive summary and key messages

This report provides an update from the Chair in Common across the North West London Acute Provider 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

Chair's Report

☒ 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

Chair's Report

1.   New Government, North West London election results

1.1   We started this month with a general election and a new Government. I want to congratulate our local MPs who were re-elected, we look forward to continuing to work with you in the coming years; David Simmons, John McDonnell, Dawn Butler, Barry Gardiner, Ruth Cadbury, Rupa Huq, James Murray, Deirde Costigan, Seema Malhotra, Andy Slaughter, Bob Blackman, Gareth Thomos and Georgia Gould.

1.1   Welcome and congratulations to our newly elected MPs, Danny Beale, Ben Coleman, Rachel Blake and Joe Powell, we look forward to getting to know you and engaging you in the work to support and develop our hospitals for our local communities.

1.2   Finally farewell to those who lost their seats, they were, without exception, tireless champions for their local hospitals and we wish them the best of luck in the future. Thanks to Steve Tuckwell, Greg Hands, Nickie Aiken and Felicity Buchan.

1.4   We had a number of candidates visit St Marys during the election campaign:

- Local parliamentary candidates Felicity Buchan and Tim Barnes, alongside Victoria Atkins, secretary of state for health and social care, visited St Mary's on 28 May

- Local parliamentary candidates Rachel Blake and Joe Powell, alongside Wes Streeting, shadow secretary of state for health and social care, visited St Mary's on 4 June.

1.5   As everyone will know, within the North West London Acute Provider Collaborative, we have some of the worst hospital estate in the NHS. In particular, Hillingdon Hospital and St Mary's Hospital are generally accepted as being in desperate need of demolition and replace, but Hammersmith, Charing Cross, Northwick Park and Ealing hospitals are in need of significant investment. When the previous government announced its "40 new hospitals programme", Hillingdon and St Mary's were identified for rebuild and Hammersmith and Charing Cross were scheduled for investment.

1.6   At the start of the election campaign in June 2024, Wes Streeting who is now Secretary of State for Health, visited St Mary's Hospital and said to the television cameras that "if Labour wins the general election, it will build a brand new St. Mary's Hospital in Paddington." He also repeated his commitment to Hillingdon Hospital, in June 2024 he had said that the next Labour Government will deliver the modern state of the art hospital that the people of Hillingdon need, and this would be achieved in the first term of a Labour Government.

1.7   We are now waiting for the new government to turn these promises into action. The business case for the New Hospitals Programme (NHP) is waiting for the new Government to give it the go-ahead. As we have said before, NHP need to urgently agree the finalised design, budget envelope and timeline for the new Hillingdon Hospital, incorporating a clear process for the appointment of a contractor to build the hospital, in order for the new Hillingdon Hospital to be open in the first term of the Labour Government. St Mary's

Chair's Report

requires urgent confirmation of the full funding required to commence at pace the design of the new hospital, which will be one of England's premier academic specialist hospitals.

1.8   We are giving the new government a few days to unpack their pencil cases and find their lockers, then we will be re-engaging in trying to get the decisions necessary to make the promises to local people a reality.

2.   The Acute Provider Collaborative

2.1   At today's Board in Common we bring our APC strategy for final sign off, we have been developing the approach and document over 2024. Our starting principle was "How can the APC most effectively use our collective resources to provide better, more equitable care for the population of North West London, over the next three years?".

2.2   A team made up of colleagues from each of our four organisations has supported analysis, wide ranging engagement with staff, patients and partners, and facilitated discussions at numerous meetings. Our model of change is focusing on aligning to best practice, raising and reinforcing standards so patients across all of NWL acute providers have access to the same high standard of care, no matter where they live. This strategy focuses on how we move services to adopt best practice across NWL, eliminating unwarranted variation. We will do this by first spreading the best in NWL to all our providers; then by bringing in the best in the NHS, using existing sources like Get It Right First Time (GIRFT) to measure ourselves nationally; and then by looking at the best in global health, research and innovation to set leading standards and be on a continuous improvement journey.

2.3   The APC Equity, Diversity and Inclusion (EDI) Action Plan 2024 to 2026: Phase 1 – People report will also be presented to the Board today, it has been developed by the APC EDI Improvement Plan Steering Group which was formed in early 2024 to work on recommendations for the Board in Common on how we can advance equity and justice across our ways of working. This first phase has focused on our people and the second phase will look specifically at patients and communities. The plans will include actions all patients and staff can expect within each organisation and collaborative initiatives to accelerate our progress for equity, diversity and inclusion.

3.   Appointments and Recruitment

3.1   We are coming toward the end of the terms of office for two of our brilliant Vice Chairs (VCs), Catherine Jervis, Vice Chair at The Hillingdon Hospitals NHS Foundation Trust (THHFT) and Steve Gill, Vice Chair at Chelsea and Westminster Hospital NHS Foundation Trust (CWFT).

3.2   Catherine will be leaving at the end of September and this BiC will be her last for the NWL APC. I would like to take this opportunity to thank Catherine on behalf of the Board in Common for all her hard work and dedication over the last six years, especially her focus on improving THHFT performance and culture and supporting their transition out of National Oversight Framework (NOF) 4. Though Catherine may be moving away from NWL, I am pleased she has recently taken on a NED role at Surrey and Sussex

Healthcare NHS Trust and her expertise is still benefiting the NHS.

3.3   Steve we still have for another Board meeting.

3.4   An Expression of Interest (EOI) process was launched in May to all Non-executive Directors within the North West London Acute Provider Collaborative for the THHFT and CWFT VC positions. I am delighted to confirm Patricia Gallen will be the next VC at CWFT, she will remain a Non Executive Director (NED) at THHFT. Carolyn Downs has been appointed VC at THHFT, she will remain as a NED on the Board at CWFT but will step down as a NED at Imperial College Healthcare NHS Trust (ICHT) at the end of September. Patricia and Carolyn, joined the Board in Common last year and have bought valuable insight in understanding complex organisations. In order to ensure a smooth handover we have kicked off the recruitment process already, working with the Councils of Governors.

3.5   We are currently recruiting for the two vacant NED posts, which are:

- Board member for Imperial College Healthcare NHS Trust, where they will chair the Quality Committee, and board member for Chelsea and Westminster Hospital NHS Foundation Trust, where they will be a member of the People Committee and the Finance and Performance Committee.

- Board member for Chelsea and Westminster Hospital NHS Foundation Trust, where they will chair the Finance and Performance Committee, and board member for The Hillingdon Hospitals NHS Foundation Trust, where they will be a member of the Quality and Safety Committee and the Audit Committee.

3.6   Jon Bell, Chief Finance Officer at THHFT is also leaving the Trust, and this will be his last BiC. Jon has worked across several of the hospitals during his time working in NWL and has been an integral part of our finance community. I want to thank Jon for all his work at THHFT and across the APC.

3.7   I mentioned in my last Board report that Vineeta Manchanda was joining the BiC, she officially started on 1 May and has made a very positive impact already across the APC.

4.   Fit and Proper Person Test (FPPT) requirements

4.1   The Fit and Proper Person Test (FPPT) checks which each NHS organisation is required to conduct have been taking place across all four organisations. These checks are to carry out a FPPT to ensure board members are, and remain, suitable for their role, the APC checks for this year have been completed and submitted to NHSE for their June deadline.

4.2   The framework was developed 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.

Chair's Report

5. LNWH Research and Innovation Annual Conference

5.1 LNWH recently ran their Research and Innovation annual conference, it was my privilege to be the keynote speaker at the conference this year. It was a great opportunity for clinicians at LNWH, academic, community and industry partners to hear the innovative work being carried out at the Trust and I was able to share the vision for the APC and the role research plays in that vision.

6. King's Birthday Honours

6.1 Finally, I want to congratulate Professor Janice Sigsworth CBE, director of nursing at ICHT. She has been awarded a damehood for her services to nursing and contribution to embedding genomics into nursing and midwifery practice. Janice has been the Trust's director of nursing since 2008, though started her nursing training at Charing Cross Hospital in 1980. Janice was previously awarded a CBE in the 2018 Queen's Birthday Honours for services to nursing.

6.2 Congratulations to all staff across all four Trusts who received awards in the latest King's birthday honours.

3.2 BOARD IN COMMON CABINET SUMMARY

● Discussion Item   👤 Matthew Swindells

REFERENCES   Only PDFs are attached

📄 3.2 BiC Cabinet Committee Summary 14 May and 11 June 2024.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

NHS

NWL Acute Provider Collaborative Board in Common (Public)

16/07/2024

Item number: 3.2

This report is: Public

Board in Common Cabinet – Committee Summary

Author and Job Title: Philippa Park, Executive Assistant to the Chair

Accountable director: Matthew Swindells
Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

This paper provides an update on items discussed at the Board in Common Cabinet held on 14 May and 11 June 2024.

Report history

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

Board in Common Cabinet 14/05/2024 What was the outcome?	**Board in Common Cabinet** 11/06/2024 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. **Imperial College Healthcare NHS Trust (ICHT) – Charing Cross and Hammersmith hospitals procurement bids**

1.1 Members of the ICHT Board approved the business case to select preferred bidders for the various specialists required for the design team for the Charing Cross and Hammersmith hospitals builds. Should the Trust decide not to proceed with the next stage of design work, there was no financial commitment and the Trust retained the ability to terminate the contracts with written notice. The paper was previously presented and approved by ICHT's Finance, Investment and Operations Committee on 8 May 2024.

2. Imperial College Healthcare NHS Trust (ICHT) – Registered nurse degree apprenticeship business case

2.1 Members of the ICHT Board agreed the business case. The paper outlined the rationale, and cost of funding, for a planned intake of 125 registered nurse degree apprenticeships (RNDAs) over the next five years as part of the strategic approach to ensure we have sufficient nursing workforce to meet future demand. The paper was previously presented and approved at ICHT's Finance, Improvement and Operations Committee.

3. CQC National Review of Paediatric Audiology / Hearing Services

3.1 Members of the Cabinet approved the four reports from the Trusts on behalf of the Board in Common. In April the CQC launched a national review of children's hearing service pathways. The primary aim of the review was to establish a baseline of the safety and quality of children's hearing services across England. The reports had been through CEOs and the Executive team, and Cabinet noted that there were no significant issues in terms of submission, with appropriate assurance mechanisms in place.

4. Imperial College Healthcare NHS Trust (ICHT) – St Mary's Hospital Redevelopment RIBA Stage 2 Contract Variation

4.1 Members of the ICHT Board approved the contract variation. It was confirmed that this was not money the trust would spend until they had been given it by National Hospital Programme (NHP). ICHT were comfortable that the uplift was acceptable from the Executive point of view and Bob Alexander had approved this contract variation by taking Chair's Action as Chair of the Trust's Finance, Investment and Operations 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 14 May and 11 June 2024 were:

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

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

ICHT
- An issue with Neurosurgery training was flagged. ICHT had a visit from HEE six weeks ago who had raised concerns about medical training.
- The current Secretary of State and the Shadow Secretary of State had visited St Mary's Hospital in early June. Wes Streeting had announced that Labour will rebuild St Mary's Hospital.

THHFT
- The Cabinet received an update on the Maternity Improvement Programme. The Duty of Candour process had begun, with letters sent and contact with families has started. Initial work with the Maternity Safety Support Programme (MSSP) National Team was well received. Lesley Watts is now acting as Board Advisor specifically on Maternity and had agreed the scope of the role with Patricia Wright.
- The National Hospitals Programme (NHP) had come to THHFT to discuss design 2.0 the new hospital build.

LNWH

- There had been an issue with Health and Safety and fire regulations at the Trust and LNWH had now been given a formal notice that they are in breach of the fire regulations. A formal letter had gone to Rob Hurd (ICB CE) to notify him of the risk and to ask what the system approach would be to tackle the increase of ambulance demand.

CWFT
- ICHT had been asked to help with Ophthalmology.

6. Acute Provider Collaborative Executive Management Board

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

7. Planning and Strategy

7.2 At the May meeting, the Cabinet discussed and agreed the approach to the Board in Common Development Session on 21 May 2024, noting the need to ensure adequate Board engagement in the draft strategy ahead of the July Board in Common meeting. The Chair noted the importance of having focused time, at the June collaborative committees, to pick up key areas aligned to them.

7.3 The Cabinet noted that Trust Standing Committees would commence from June onwards, with a committee summary report taken to the Board in Common meeting later the same month. It was also noted that the review of the collaborative committee terms of reference and forward plans was being undertaken with the main change being to include further wording around overseeing and receiving assurance from Trust-level Committees; it was anticipated that the updated terms of reference would be presented to the June collaborative committees. It was further noted that discussions needed to take place with Collaborative Committee Chairs around forward plans to focus on forward looking, with escalation of risk from Trust-level Committees. All four Trusts were asked to confirm, ahead of the July Board in Common meeting, the cycle for their Board Committees.

8 Board in Common and governance model

8.1 The Cabinet reviewed the draft agendas (public and private) for the July Board in Common meeting and discussed the order of the meetings. An updated scheme of delegation will be brought to the July Board in Common for approval, which will include proposed changes to the governance model.

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

4.1 INTEGRATED QUALITY, WORKFORCE, PERFORMANCE AND FINANCE REPORT

● Discussion Item   👤 Patricia Wright|Pippa Nightingale|Lesley Watts   🕐 10.00

REFERENCES

Only PDFs are attached

📄 4.1a BIC Performance Report Cover Sheet (July 24).pdf

📄 4.1b BIC Performance Report - May 2024 _final (004).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

NHS

NWL Acute Provider Collaborative Board in Common (Public)
16/07/2024
Item number: 4.1
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

Purpose of report

Purpose: Assurance

This report provides an overview of performance across the APC for month 02 2024 with some lag indicators reporting at month 01. 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 has occurred in Q1 to determine the shape and content of the report in 2024-25. This work will be refined during July/Aug 2024.

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

Data in the report has been through local Trust Performance Committees	The Report was presented to Executive Management Board on 5 July 2024

Executive summary and key messages

The attached report provides APC and Trust-level data for April 2024 for metrics reported one month in arrears and May 2024 data.

Further work has been undertaken during June to review the KPIs included in the report and the presentation format so that a full set of comparative information is available for 2024-25. This work requires iteration during July/August 2024 and will be available to EMB and BIC sub-committees in September 24 with a fully revised report being presented to the Board in Common in October 24 (backdated to April 2024).

NWL Acute Collaborative committee cover note

Equality metrics have been identified across the score card domains, but further work is required to ensure these are presented in a meaningful way, either integrated into the performance report or as a separate report. This work will also be undertaken during July/August 2024 and will be available to EMB and BIC sub-committees in September 24 for sign off prior to presentation to BIC in October 2024.

Overall, performance has remained at levels above local and national targets on the majority of metrics, although close scrutiny will be required on UEC and elective performance to ensure national targets are met. Pressures on beds continues due to high numbers of patients not meeting the criteria to reside.

The finance position is described in more detail in the full finance report, but current deviation from plans is a cause for concern.

Escalation: **None**

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

All apply

Reason for private submission

Tick all that apply

☐   Commercial confidence
☐   Patient confidentiality
☐   Staff confidentiality

☐ Other exceptional circumstances

Integrated Performance Report

May 2024 data

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

received by EMB and BIC July 2024

Introduction:

The attached report provides APC and Trust-level data for April 2024 for metrics reported one month in arrears and May 2024 data.

Further work has been undertaken during June to review the KPIs included in the report and the presentation format so that a full set of comparative information is available for 2024-25. This work requires iteration during July/August 2024 and will be available to EMB and BIC sub-committees in September 24 with a fully revised report being presented to the Board in Common in October 24 (backdated to April 2024).

Equality metrics have been identified across the score card domains, but further work is required to ensure these are presented in a meaningful way, either integrated into the performance report or as a separate report. This work will also be undertaken during July/August 2024 and will be available to EMB and BIC sub-committees in September 24 for sign off prior to presentation to BIC in October 2024.

Performance:

Overall, performance has remained at levels above local and national targets on the majority of metrics, although close scrutiny will be required on UEC and elective performance to ensure national targets are met. Pressures on beds continues due to high numbers of patients not meeting the criteria to reside.

The finance position is described in more detail in the full finance report, but current deviation from plans is a cause for concern.

Escalation: None

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

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.

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

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

3

Balanced Scorecard

(**NOTE:** Maternity metrics are reported separately currently)

Variation / Assurance legend
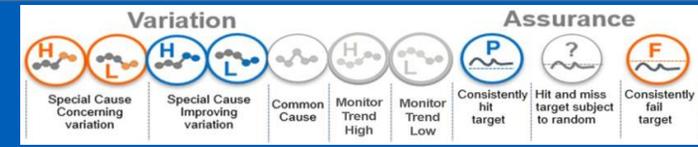
Quality

Quality	Expected	Actual	Trend	Assurance
Reporting rate of patient safety incidents per 1000 bed days	≥54.9	54.47	H	?
Serious Incidents	n/a	0.17	L	
Patient safety incidents with severe/major harm	<0.26%	0.15%		?
Patient safety incidents with extreme harm/death	<0.14%	0.09%		?
Healthcare Associated c. Difficile Infections	n/a	20		
Healthcare Associated E. coli blood stream Infections	n/a	42		
Healthcare Associated MRSA blood stream Infections	0	3		
Formal complaints received per 1000 staff	n/a	7.76		
Good experience reported by inpatients	≥94%	95.5%		P
Good experience reported for maternity services	≥90%	88.6%		?
Good experience reported for emergency depts.	≥74%	84.3%	H	?
VTE Risk Assessments Completed	≥95%	96.9%	H	?

Performance

Performance	Expected	Actual	Trend	Assurance
Ambulance handover waits	≥90%	85.2%		F
Waits in urgent and emergency care > 4 hours	≥78%	76.7%		F
Waits in urgent and emergency care > 12 hours	≤2%	3.9%		F
Referral to treatment waits > 52 weeks	≤2%	3.4%	H	F
Access to diagnostics > 6 Weeks	≤5.0%	17.1%		F
Access to cancer specialist < 14 days	≥93%	79.2%	L	F
Access to Cancer Care (Faster Diagnosis) < 28 days	≥75%	75.5%		P
Cancer First Treatment from Diagnosis < 31 days	≥96%	93.1%		F
Referral to Cancer Treatment Pathways < 62 days	≥85%	74.2%	H	F
Theatre Utilisations (Hrs)	≥85%	83.6%		?
Outpatient Transformation - PIFU	≥5%	3.5%	H	F
Critical Care – Unoccupied Beds	≤85%	92.9%		?

Workforce

Workforce	Expected	Actual	Trend	Assurance
Vacancy Rate	≤10%	9.4%		P
Voluntary Turnover Rate	≤12%	10.6%	L	P
Sickness Absence Rate	≤4%	4.0%		?
Agency spend	≤2%	2.5%		?
Non-medical appraisals	≥95%	89.9%		F
Core skills compliance	≥90%	91.7%		P

Finance

Finance	Expected YTD £m	Actual YTD £m	Variance YTD £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m		
Financial Delivery (I&E)	(6.1)	(23.9)	(17.8)	0	0.0	0.0		
Financial Delivery (CIP)	28.0	11.7	(9.1)	140.7	140.7	0.0		
YTD Capital Spend - £m	17.8	15.2	2.6	239.4	239.4	0.0		
	-	-	-	-	-	-		
	-	-	-	-	-	-		

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 May, standards (where they exist) were met for the majority of metrics. Mortality rates and harm levels remain low, and the incident reporting rate trend is increasing which is positive. Our patient experience 'FFT' results are consistently above national and London averages.
- In April, all Trusts transitioned from the Serious Incident (SI) framework to the PSIRF (patient safety incident response framework). The SI metric has therefore been changed to reflect all incidents reported externally on STEIS, encompassing SIs declared prior to full transition as well as PSIIs. The trend shows a reduction in cases declared since the pilots began, with the lowest rate in April 2024, when we fully transitioned. PSIRF encourages proportionate response to incidents, focused on opportunities for learning so the reduction is in line with expectation. As we move forward, we will include additional 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.
- Data for VTE risk assessment is now being reported from Cerner for all trusts. This has resulted in an improvement at APC level with the target achieved on a rolling 12-month basis as well as in-month.

Areas where we are consistently adverse to target include:
- IPC: all trusts exceeded their annual thresholds for FY 2023/24 for the three mandatorily reportable healthcare associated infections included in this dashboard. Increases are being seen nationally. Thresholds have not yet been published by NHSE for 2024/25. Work is underway with BI to include bed day rates and/or national rates to allow additional 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 increase in Q3 and Q4 2023/24. 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.
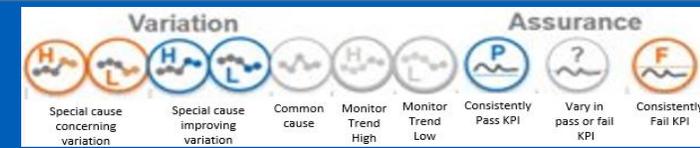
Key Actions: All areas of variance in the data are being managed with action plans in place to support improvement. There are examples where areas of variance align to the agreed quality priority work streams and where the actions planned will drive further improvement across the APC. Current actions include:
- Implementation of the new incident management system, once the procurement process has been completed (expected April 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. A broader set of complaints metrics has been drafted following a series of workshops with the complaints leads across the four trusts. Once agreed, these will be monitored locally with a quarterly report to APCQC starting in September 2024 setting out any themes, variation or opportunities for learning. Work is underway to jointly re-tender for patient survey platforms which will include wider thinking on capturing patient feedback. The new system is expected to be in place in July 2024.
- 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 June and summarised in the quarterly learning from deaths reports to APCQC and BiC. No new risks or themes were identified.
- A review of SIs declared in 2023/24 across the APC, encompassing incidents reported with a harm level of severe or extreme and never events, was presented to APCQC in June. 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. Implementation of NatSSIPs2 has been confirmed as a new APC quality priority (a key theme from never events).
- A review of the APC quality priorities has been undertaken 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 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.
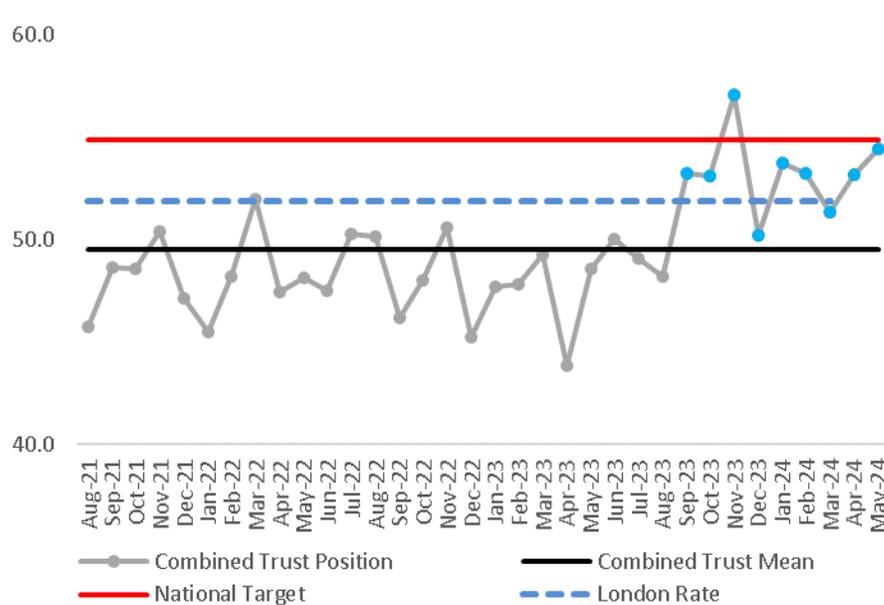
Patient Focus

TREND

Reporting rate of patient safety incidents per 1,000 bed days

Legend:
- Combined Trust Position
- National Target
- Combined Trust Mean
- London Rate

≥54.9
STANDARD

54.47
PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

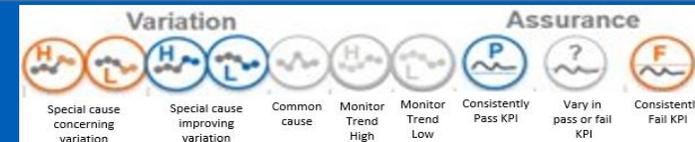|	Total bed days	Reporting Rate	Difference from Standard	Patient Safety Incidents	12 Month Rolling Reporting Rate
CWFT	26,295	43.47	-11.43	1,143	45.35
ICHT	29,631	72.73		2,155	65.40
LNW	31,656	49.03	-5.87	1,552	47.83
THH	13,498	48.60	-6.30	656	45.61
APC	101,080	54.47	-0.43	5,506	52.26

STRATIFICATION

Legend:
- Reporting Rate
- APC Average
- Standard

NARRATIVE

Performance: In May, the patient safety incident reporting rate per 1,000 bed days was just below the standard (national average) at APC level, although there has been a recent overall increase with a period of 9 months above the mean which is a positive measure of safety culture. ICHT consistently meet the target. Each trust reviews incidents in detail through their quality governance framework with no risks or new issues to escalate to the executive.

Recovery Plan: All Trusts have now implemented LFPSE; the transition is providing opportunity for training and communications to encourage reporting.

Improvements: The procurement process for the new incident reporting management system continues; however there have been some delays and a revised timeline has been developed. The new system is now expected to be in place by April 2025. 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). 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. This is being reviewed through the appropriate ICT governance routes with approval expected in July before a proof of concept is built.

Forecast Risks: N/A.

GOVERNANCE

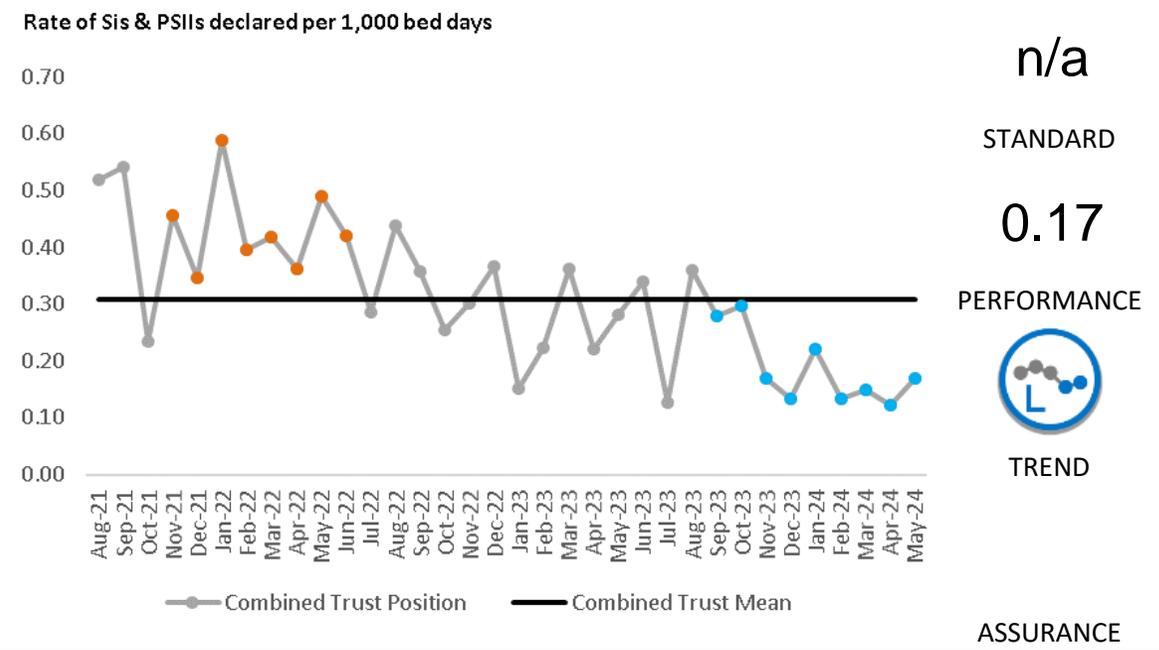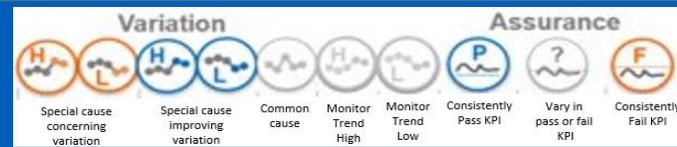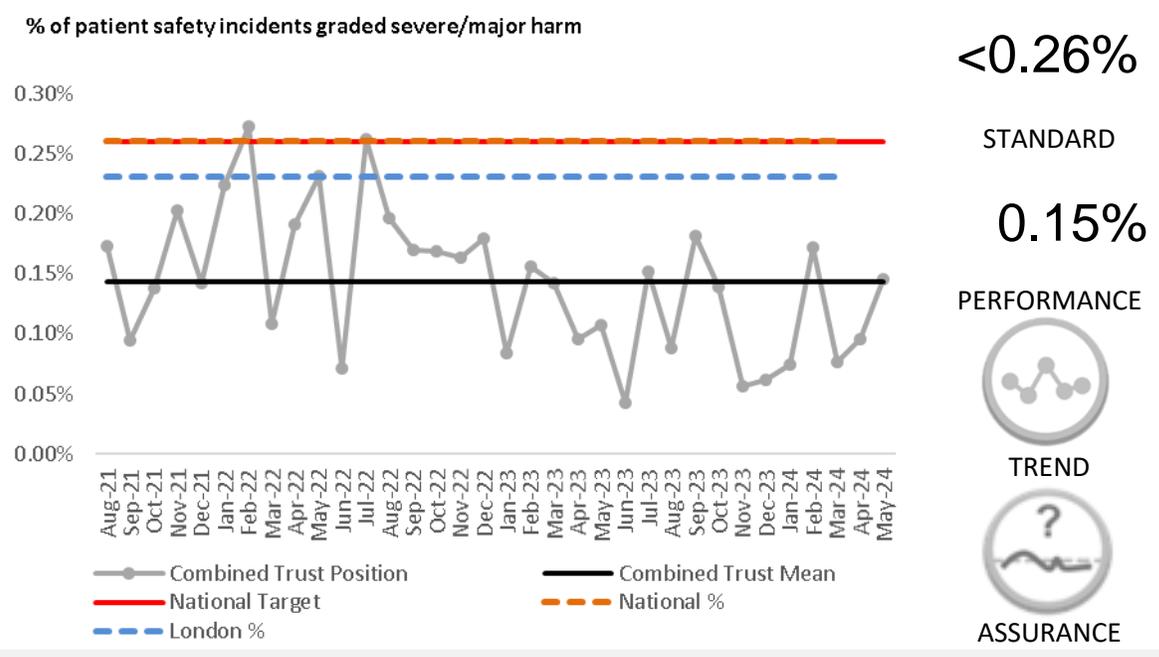**Senior Responsible Owner:** Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Incidents reported on STEIS (SIs/PSIIs)

Variation / Assurance legend

TREND

Rate of SIs & PSIIs declared per 1,000 bed days

Legend: —●— Combined Trust Position   —— Combined Trust Mean

n/a
STANDARD

0.17
PERFORMANCE

L
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total bed days	In Month SIs & PSIIs	Reporting Rate	12 Month Rolling SIs & PSIIs	12 Month Rolling Reporting Rate
CWFT	26,295	5	0.19	36	0.12
ICHT	29,631	6	0.20	109	0.31
LNW	31,656	4	0.13	48	0.13
THH	13,498	2	0.15	47	0.31
APC	**101,080**	**17**	**0.17**	**240**	**0.21**

STRATIFICATION

Legend: Reporting Rate, APC Average

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. This data includes SIs declared under the old framework, and PSIIs declared under the new PSIRF and reported externally on STEIS. At APC level, the trend shows special cause variation with a reduction in the number declared which would be expected with PSIRF encouraging proportionate response to incidents, focused on opportunities for learning.
There were no never events reported in May 2024.

Recovery Plan: N/A

Improvements: Implementation of NatSSIPs2 (new national safety standards for invasive procedures) has been confirmed as a new APC quality priority to support a standardised approach across all trusts. This was agreed following a review of never event themes across the APC. The project initiation document is in development.
Additional metrics will be added to this dashboard as we collect data on experience of those involved, the alternative learning responses used and outcomes linked to safety improvement plans.

Forecast Risks: We are working with 2 incident management systems while we complete SIs declared prior to PSIRF transition. Delays in completion and resource requirements are being managed with risks locally held.

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.

9

# (Patient) Patient Safety Incidents with Severe/Major Harms

Variation | Assurance

Special cause concerning variation | Special cause improving variation | Common cause | Monitor Trend High | Monitor Trend Low | Consistently Pass KPI | Vary in pass or fail KPI | Consistently Fail KPI

TREND

% of patient safety incidents graded severe/major harm

Legend: Combined Trust Position; Combined Trust Mean; National Target; National %; London %

<0.26% STANDARD

0.15% PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Patient Safety Incidents	% Incidents	Difference from Standard	Severe/ Major Harm	12 Month Rolling % Incidents
CWFT	1143	0.09%		1	0.13%
ICHT	2155	0.09%		2	0.10%
LNW	1552	0.26%		4	0.06%
THH	656	0.15%		1	0.19%
APC	**5,506**	**0.15%**		**8**	**0.11%**

STRATIFICATION

Legend: % Incidents; APC Average; Standard
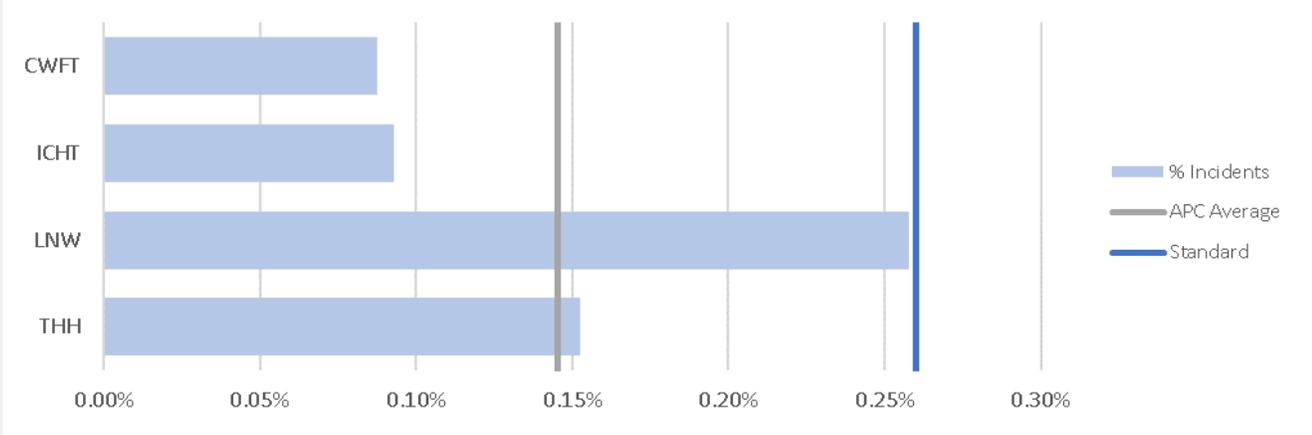
NARRATIVE

Performance: All trusts are below national average on rolling 12-month and in-month data. Harm levels at THH have reduced following completion of final investigation reports and is confirmed as an accurate record of actual harm. Cases reported in April are under investigation and include:
- CWFT: n=1. Delayed diagnosis of Kawasaki's disease.
- ICHT: n=2 . Case 1: Unexpected cardiac arrest following elective surgery. Case 2: Delay in transfer and treatment of a patient with sepsis. Review underway to consider the increase in diagnosis and procedure related incidents, with the aim of identifying improvement plans where the themes are not linked to existing work.
- LNW: Case 1: Removal of intercostal chest drain, resulting in bleeding from the wound site and consequent deterioration. Case 2: Failure to recognise and manage deterioration in ED. Case 3: Upper GI bleed following suspected perforation of a nasogastric tube. Case 4: Patient lost to follow up - delayed diagnosis of malignancy.
- THH: n=1. Major Obstetric Haemorrhage following spontaneous vaginal delivery.

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 have been approved through trust governance processes. Themes and areas for improvement are included. Work continues through APC steering groups for themes previously identified, including care of the deteriorating patient.
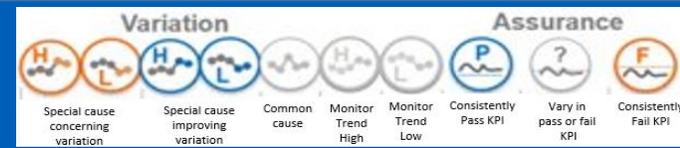**Forecast Risks:** We do not anticipate any risks, the numbers are low and continuously monitored.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW
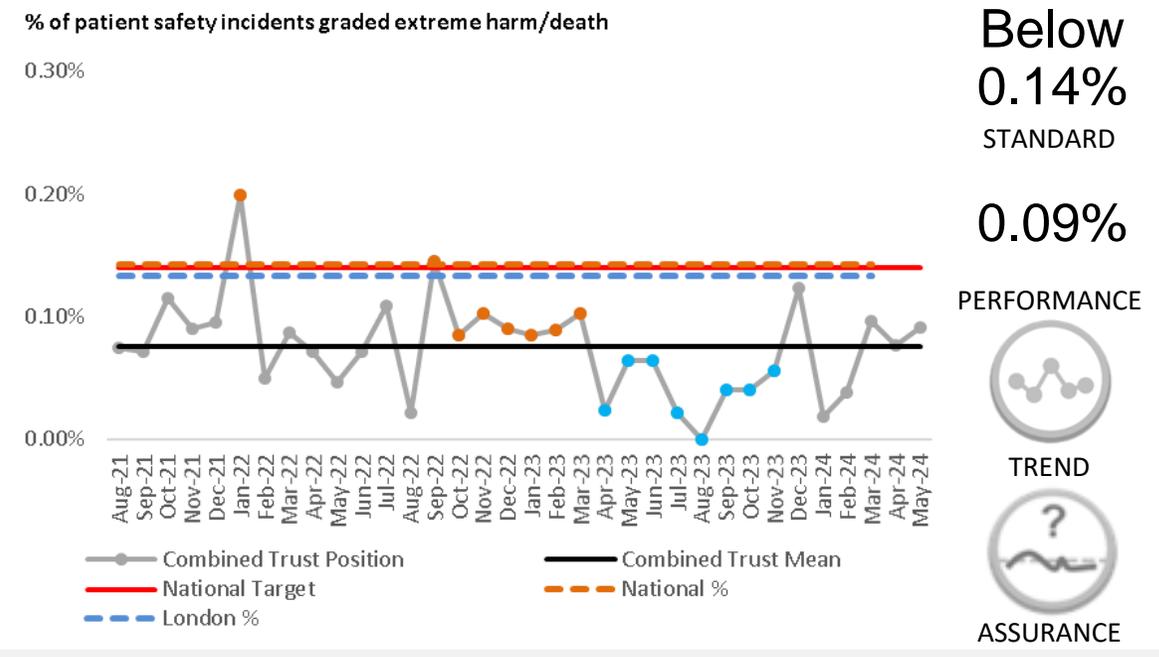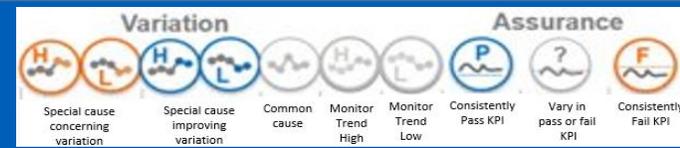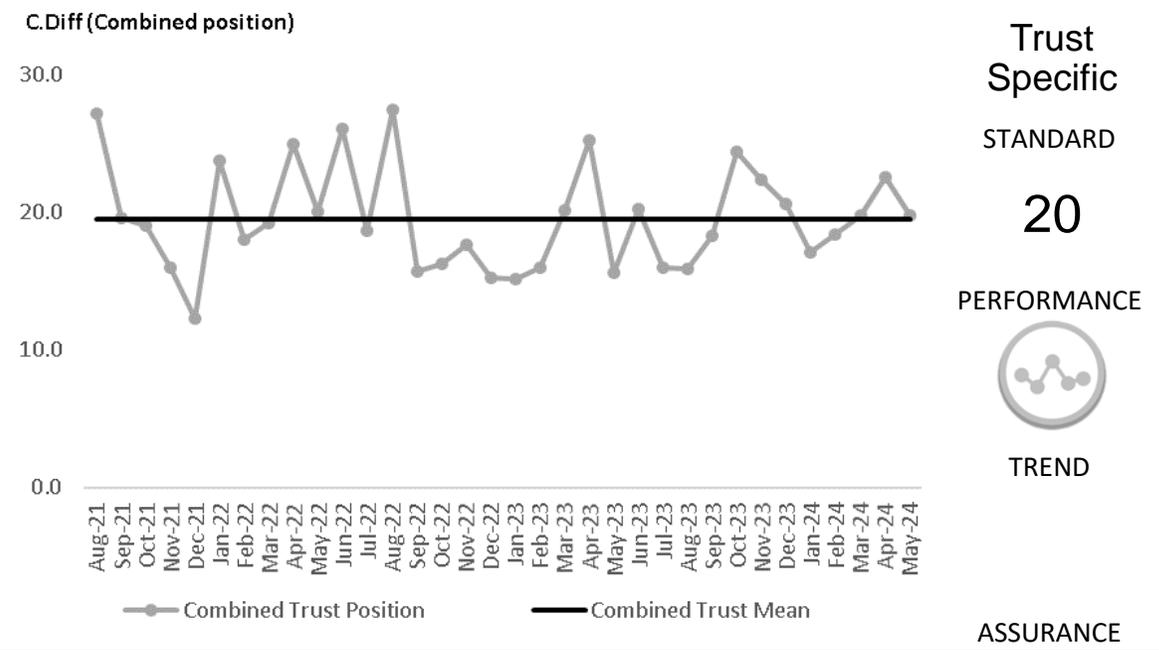**Committee:** Acute provider collaborative executive management board
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

10

(Patient) Patient Safety Incidents with Extreme Harms/Death

Variation

Special cause concerning variation | Special cause improving variation | Common cause | Monitor Trend High | Monitor Trend Low

Assurance

Consistently Pass KPI | Vary in pass or fail KPI | Consistently Fail KPI

TREND

% of patient safety incidents graded extreme harm/death

Legend:
- Combined Trust Position
- Combined Trust Mean
- National Target
- National %
- London %

Below **0.14%** STANDARD

0.09% PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Patient Safety Incidents	% Incidents	Difference from Standard	Extreme Harm/ Death	12 Month Rolling % Incidents
CWFT	1143	0.09%		1	0.03%
ICHT	2155	0.09%		2	0.07%
LNW	1552	0.06%		1	0.04%
THH	656	0.15%	0.01%	1	0.09%
APC	**5,506**	**0.09%**		**5**	**0.06%**

STRATIFICATION

Legend:
- % Incidents
- APC Average
- Standard

NARRATIVE

Performance: We are below national average at APC and in all trusts on a rolling 12 month basis. This is also the case in month with the exception of THH which is just above. The cases reported in May are under investigation:
- CWFT: n=1. Unexpected neonatal death linked to a medication error.
- ICHT: n=2. Case 1: Neonatal death Case 2: Potential failure to rescue a deteriorating patient.
- LNW: n=1. Harm downgraded following initial investigation.
- THH: n=1. Patient fall outside UTC following attendance at ED - investigation is underway to identify whether there were any missed opportunities in ED and the appropriateness of discharge.

Recovery Plan: N/A

Improvements: 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.

11

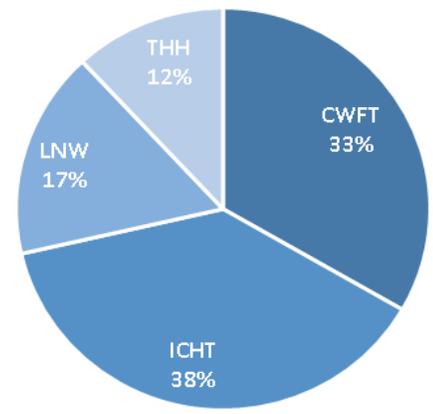# (Patient) Healthcare Associated C.Difficile Infections

Variation | Assurance

Special cause concerning variation | Special cause improving variation | Common cause | Monitor Trend High | Monitor Trend Low | Consistently Pass KPI | Vary in pass or fail KPI | Consistently Fail KPI

TREND

C.Diff (Combined position)

Legend: Combined Trust Position — Combined Trust Mean

Trust Specific

STANDARD

20

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Count of c.Diff cases in month	Count of c.Diff cases in year (FY 24/25)	Trust Threshold (FY 24/25)	Difference from Threshold
CWFT	8	14		
ICHT	8	16		
LNW	1	7		
THH	3	5		
APC	20	**42**		

STRATIFICATION

Pie chart:
- THH 12%
- CWFT 33%
- LNW 17%
- ICHT 38%

Trust share of APC count of infections in year

NARRATIVE

Performance: NHSE have not yet published thresholds for 2024/25. In May 2024, there were 20 cases reported. Work is underway with BI to include national averages and trust rates based on bed days to allow for more meaningful comparison.

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. Data on time to isolation/de-isolation, number of patients treated in a side room and number of patients requiring commodes is being collated across all 4 Trusts for review at the APC working group. 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 in place with the initial focus is on C. diff as outlined above.
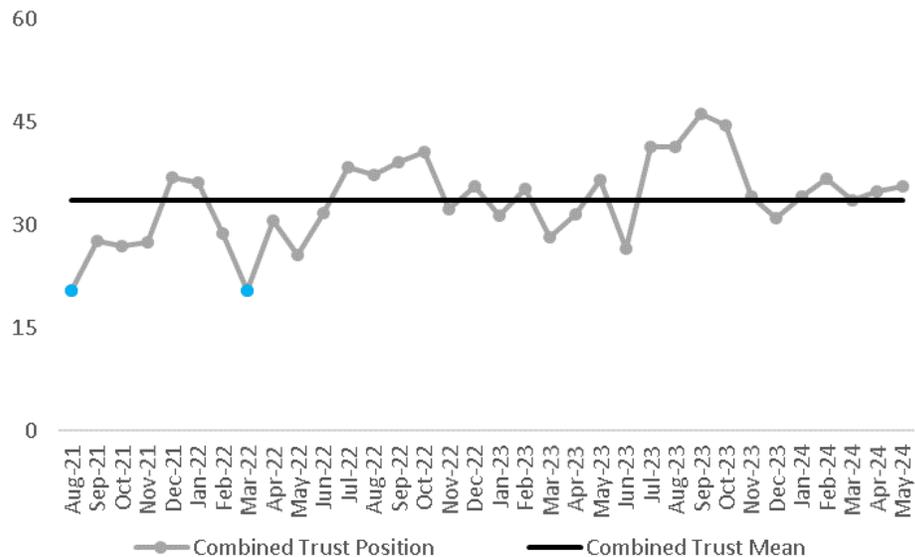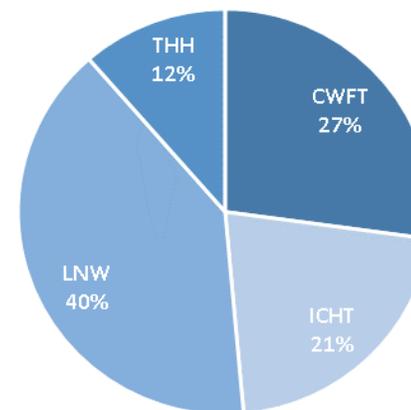**Forecast Risks:** N/A

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

Variation | Assurance

Special cause concerning variation | Special cause improving variation | Common cause | Monitor Trend High | Monitor Trend Low | Consistently Pass KPI | Vary in pass or fail KPI | Consistently Fail KPI
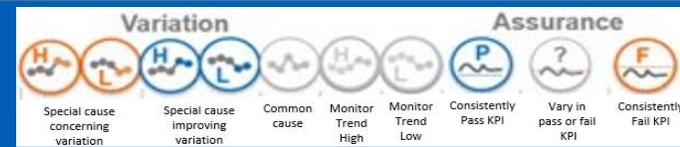
TREND

E.coli blood stream infection (Combined position)

Combined Trust Position — Combined Trust Mean

Trust Specific

STANDARD

36

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Count of E.Coli BSIs in month	Count of E.Coli BSIs in year (FY 24/25)	Trust Threshold (FY 24/25)	Difference from Threshold
CWFT	9	19		
ICHT	10	15		
LNW	14	28		
THH	3	8		
APC	**36**	**70**		

STRATIFICATION

THH 12%
CWFT 27%
LNW 40%
ICHT 21%

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 May. Thresholds have not been set nationally, work is underway with BI to include national averages and trust rates based on bed days to allow for more meaningful comparison.

Recovery Plan: The ICB is focused on reduction of E.coli blood stream infections in line with the NHS Long Term Plan. 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.
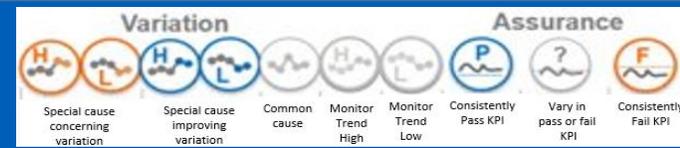
Forecast Risks: N/A

GOVERNANCE

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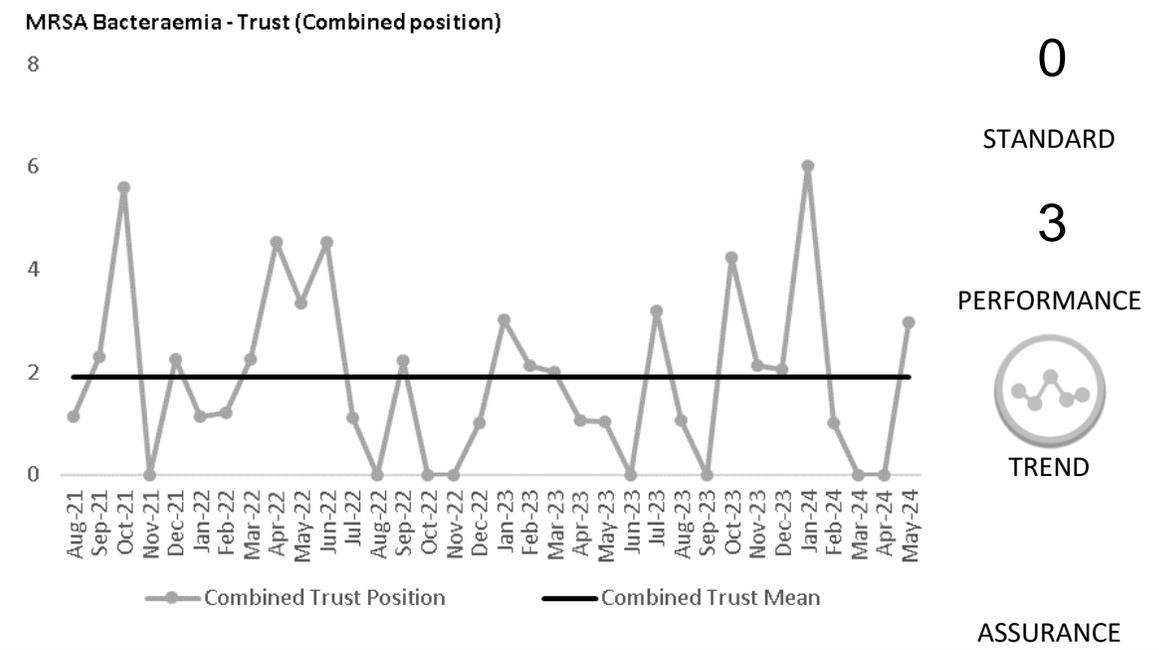
Committee: Acute provider collaborative executive management board

Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.
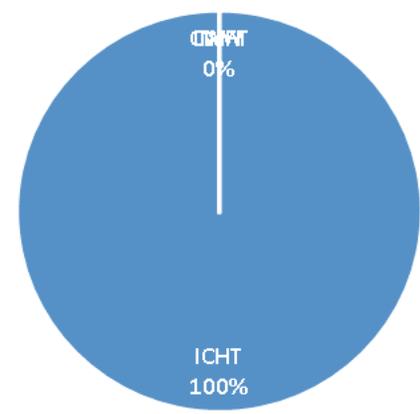
(Patient) Healthcare Associated MRSA Infections

Variation | Assurance

Special cause concerning variation | Special cause improving variation | Common cause | Monitor Trend High | Monitor Trend Low | Consistently Pass KPI | Vary in pass or fail KPI | Consistently Fail KPI

TREND

MRSA Bacteraemia - Trust (Combined position)

Combined Trust Position — Combined Trust Mean

0
STANDARD

3
PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Count of MRSA BSIs in month	Count of MRSA BSIs in year (FY 24/25)	Trust Threshold (FY 24/25)	Difference from Threshold
CWFT	0	0	0	
ICHT	3	3	0	-3.0
LNW	0	0	0	
THH	0	0	0	
APC	**3**	**3**	**0**	**-3.0**

STRATIFICATION

CWFT 0%

ICHT 100%

Trust share of APC count of infections in year

NARRATIVE

Performance: Work is underway with BI to include national averages and trust rates based on bed days to allow for more meaningful comparison.

There were three MRSA BSIs reported in May within the APC against a threshold of 0. All three occurred at ICHT. There are no epidemiological links between the cases.

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. ICHT have identified improvements related to invasive line care and MRSA screening, which have been added to the IPC annual workplan in addition to the hand hygiene improvement plan already underway.
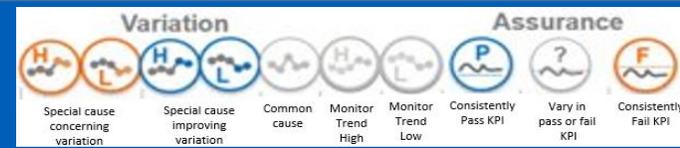
Improvements: A review of these cases will feed into the APC priority workstream to support identification of collective action or learning. Each trust has improvement work in place in response to these infections, the outcomes of which will report into the APC work stream and any shared learning planned accordingly.
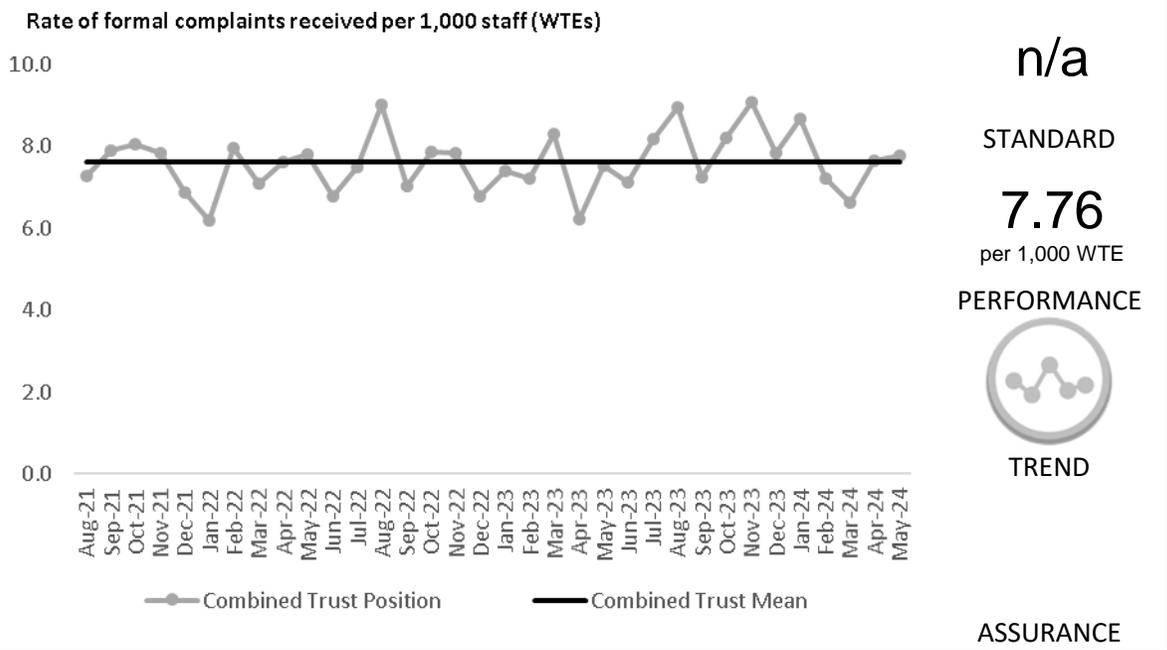
Forecast Risks: N/A

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.

14

(Patient) Formal Complaints

Variation   **Assurance**

Special cause concerning variation | Special cause improving variation | Common cause | Monitor Trend High | Monitor Trend Low | Consistently Pass KPI | Vary in pass or fail KPI | Consistently Fail KPI

TREND

Rate of formal complaints received per 1,000 staff (WTEs)

Legend: Combined Trust Position — Combined Trust Mean

n/a

STANDARD

7.76

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	6.33	44	5.57
ICHT	13,663	6.51	89	6.79
LNW	9,518	9.98	95	10.28
THH	3,620	9.39	34	10.02
APC	**33,752**	**7.76**	**262**	**7.88**

STRATIFICATION

Pie chart: THH 13%, CWFT 17%, ICHT 34%, LNW 36%
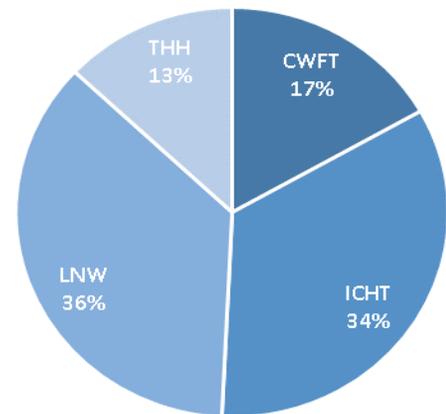
NARRATIVE

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 slight increase in month. The rate in May was 7.76, just above the mean. Rates vary at trust level, with LNW having the highest rate in month and across the last 12 months. Each trust monitors complaint performance and activity. There has been a small recent increase in LNW in cases related to delays in treatment which is consistent with incidents which is under review.

Recovery Plan: N/A

Improvements: A broader set of complaints metrics has been drafted and is being reviewed across the four APC trusts. Once agreed, these will be monitored locally with a quarterly report to APCQC starting in September 2024 setting out any themes, variation or opportunities for learning.
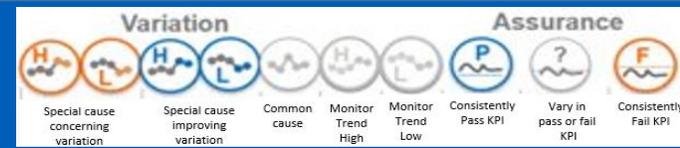
Forecast Risks: None.

GOVERNANCE

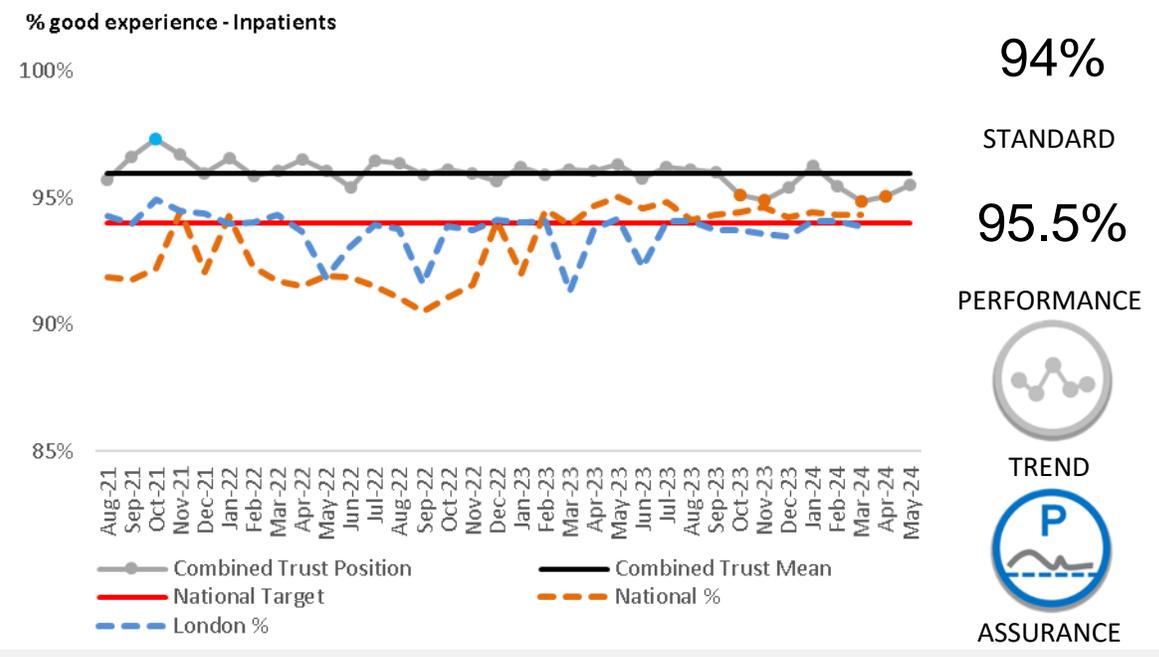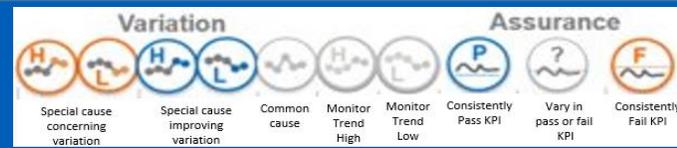**Senior Responsible Owner:** Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

15

(Patient) Inpatient Friends & Family Test

TREND

% good experience - Inpatients

- Combined Trust Position
- National Target
- London %
- Combined Trust Mean
- National %

94%
STANDARD

95.5%
PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	832	96.3%		801	95.8%
ICHT	2,376	95.6%		2,271	96.3%
LNW	3,678	96.3%		3,541	95.4%
THH	1,547	93.3%	-0.7%	1,443	94.3%
APC	**8,433**	**95.5%**		**8,056**	**95.5%**

STRATIFICATION

- Good Experience
- APC Average
- Standard

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 March 2024 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 joint procurement plan for a patient survey platform is now in place, which will support better identification of areas for collaborative improvement once implemented (expected in July 2024).

Forecast Risks: Continued workforce and operational pressures 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.
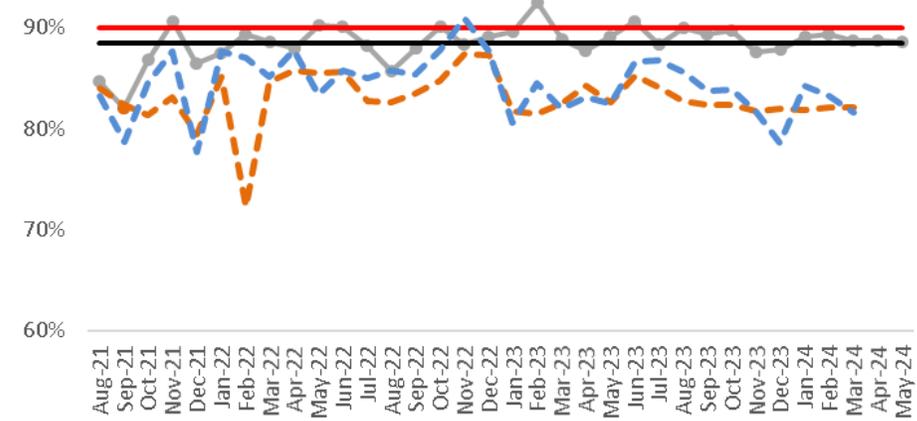
Variation

| Special cause concerning variation | Special cause improving variation | Common cause | Monitor Trend High | Monitor Trend Low |

Assurance

| Consistently Pass KPI | Vary in pass or fail KPI | Consistently Fail KPI |

TREND

% good experience - maternity

- Combined Trust Position
- Combined Trust Mean
- National Target
- National %
- London %

90% STANDARD

88.6% PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	185	87.0%	-3.0%	161	89.8%
ICHT	145	84.8%	-5.2%	123	88.9%
LNW	71	90.1%		64	89.5%
THH	290	91.0%		264	88.0%
APC	**691**	**88.6%**	**-1.4%**	**612**	**89.0%**

STRATIFICATION

- Good Experience
- APC Average
- Standard

NARRATIVE

Performance: At APC level, the percentage of patients who report a good experience varies, with performance just below the standard on a rolling 12-month basis and in-month. In April, CWFT and ICHT are below the target.

Recovery Plan: ICHT's rate fluctuates, although there has been a recent reduction in patient satisfaction within the postnatal wards coinciding with a reduced participation rate. Work is underway within maternity to improve this by providing iPads on the wards. Comments from maternity patients frequently highlight staff shortages as a factor. CWFT's rate declined slightly in May, themes include communication and environment. Air conditioning units are on order for both sites. LNW's response rate remains low due to lack of a digital solution to drive responses – paper based feedback and QR codes are currently provided in each area. A digital solution will be considered following completion of the current Cerner phase.
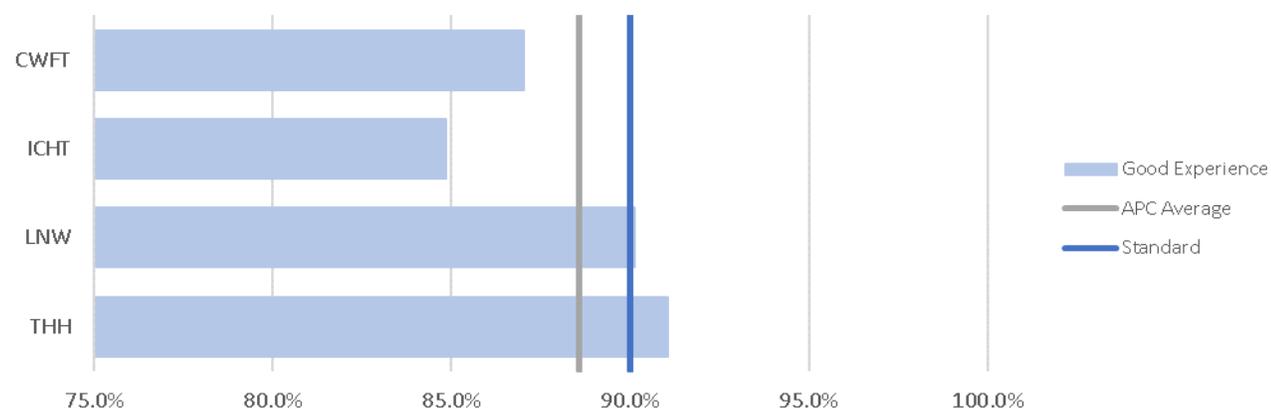
Improvements: A summary of the CQC's survey of maternity patients was reported to APCQC in March. There is an opportunity for collaborative improvement regarding information provision to patients and families which will now be taken forward by the maternity APC workstream and through the LMNS.

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.
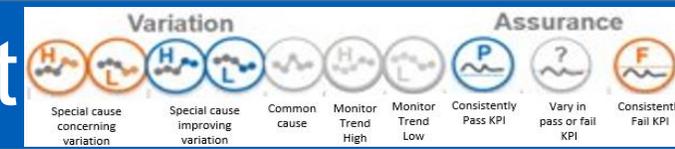
GOVERNANCE

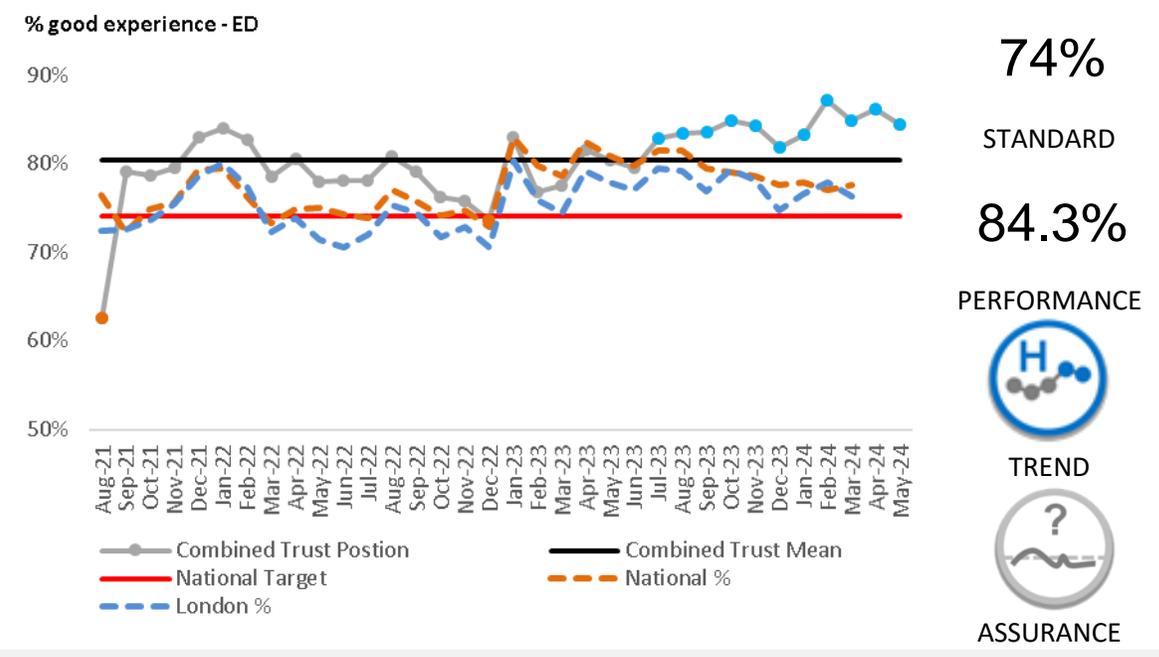**Senior Responsible Owner:** Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

17

Variation | **Assurance**

Special cause concerning variation | Special cause improving variation | Common cause | Monitor Trend High | Monitor Trend Low | Consistently Pass KPI | Vary in pass or fail KPI | Consistently Fail KPI

TREND

% good experience - ED

Combined Trust Postion — Combined Trust Mean — National Target — National % — London %

74%
STANDARD

84.3%
PERFORMANCE

(H) TREND

(?) ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	3,915	81.0%		3,173	82.0%
ICHT	1,164	82.6%		962	82.9%
LNW	4,465	89.4%		3,993	89.0%
THH	852	75.2%		641	74.3%
APC	**10,396**	**84.3%**		**8,769**	**84.1%**

STRATIFICATION

Good Experience — APC Average — Standard

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 met the standard in April.

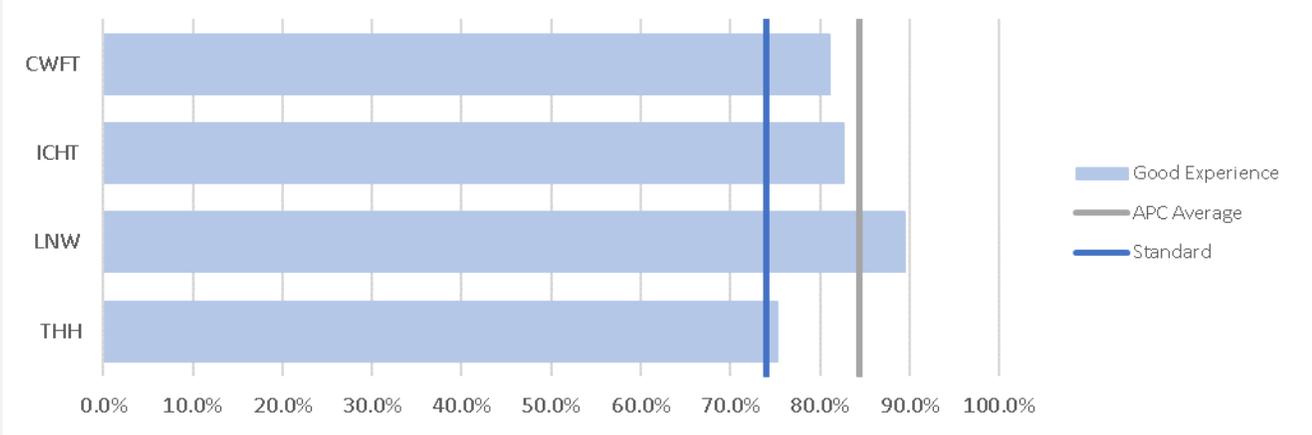**Recovery Plan:** Not applicable.

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: On-going workforce and operational pressures may have a detrimental impact on patient experience.
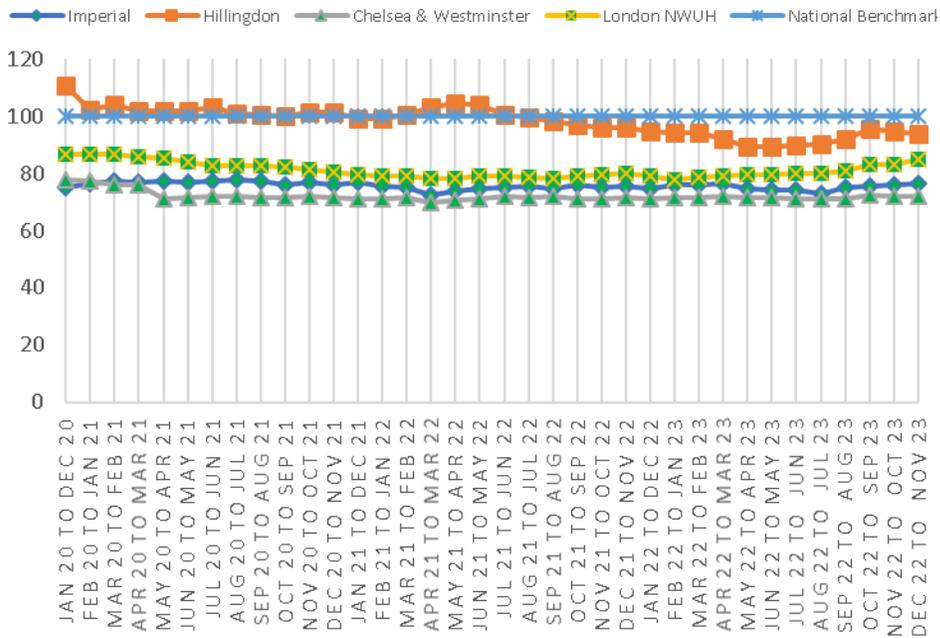
GOVERNANCE

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.

18

(Patient) Summary Hospital-level Mortality Index

TREND

Legend: Imperial — Hillingdon — Chelsea & Westminster — London NWUH — National Benchmark

100
England Average
STANDARD

n/a
PERFORMANCE

n/a
TREND

n/a
ASSURANCE

CURRENT PERFORMANCE

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	93950	71.95	Lower than expected
ICHT	101830	76.57	Lower than expected
LNW	102105	84.79	Lower than expected
THH	37635	93.68	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'.

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 (December 2022– November 2023). 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 four were presented to the APC mortality surveillance group in June and were summarised in the quarterly learning from deaths reports to APCQC and BiC. No new risks or themes were identified.

Forecast Risks: NHS England has made changes to the SHMI methodology, which will be applied for next month's data (data to December 2023). The indicator now includes Covid-19 activity and excludes hospices and 'specialist' sites. This is likely to have an impact on SHMI rates across the APC.
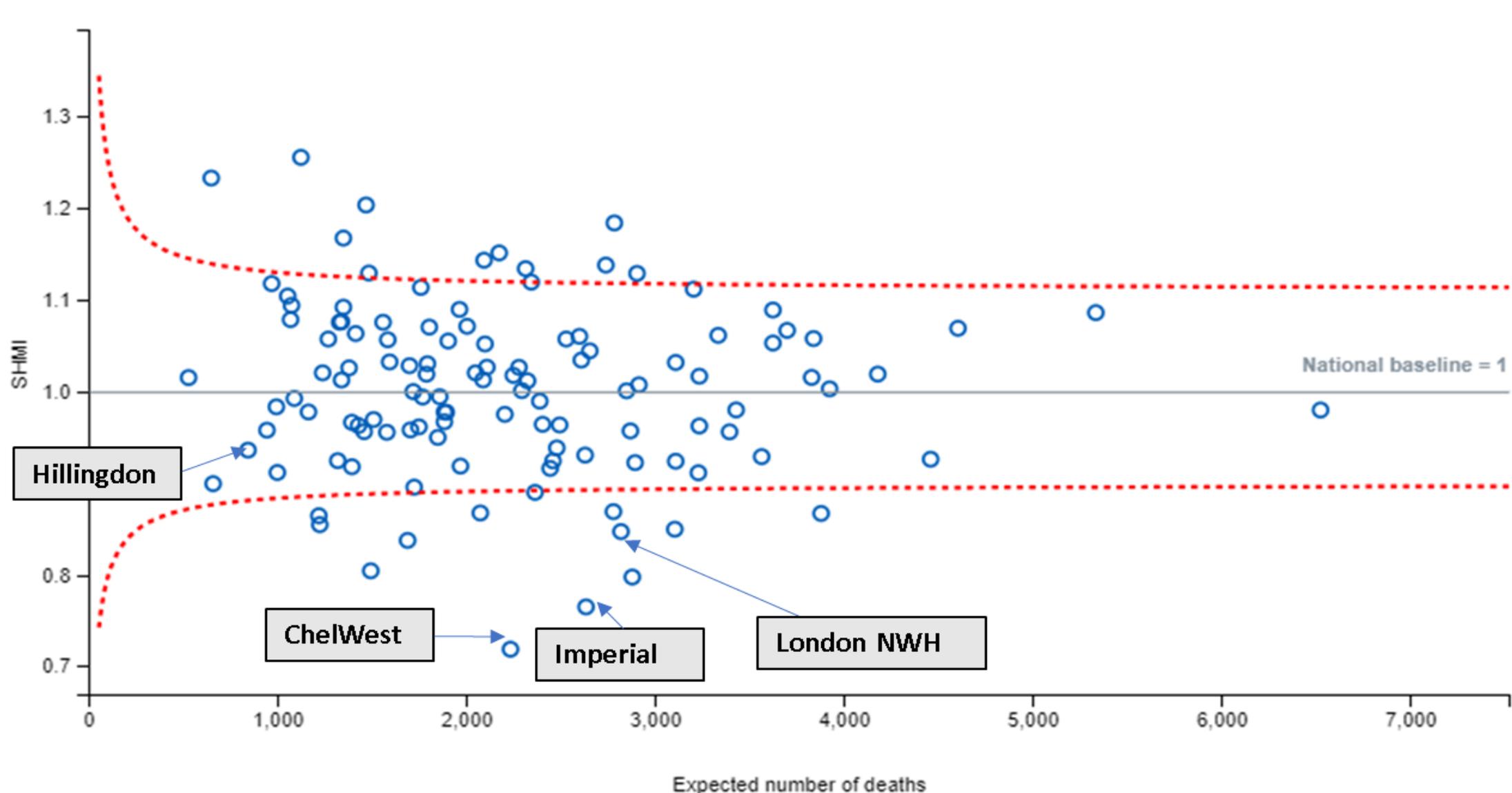
GOVERNANCE

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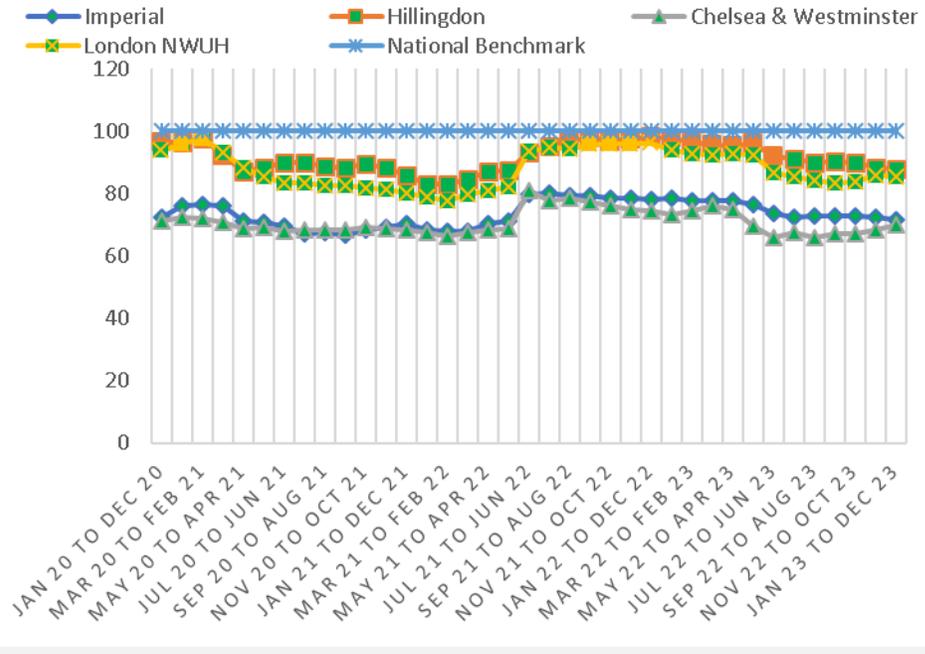**Committee:** Acute provider collaborative executive management board
Data Assurance: Data is supplied and quality assured by Telstra Health

20

(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

	Provider Superspells	HSMR	HSMR- relative risk ranking
CWFT	48077	70.0	Lower than expected
ICHT	68277	71.7	Lower than expected
LNW	58536	85.5	Lower than expected
THH	15950	87.9	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 January – December 2023) shows that each trust has a rolling 12-month ratio which is lower than expected and below the national benchmark. N.B. Due to data quality issues within NHSE this data is the same as reported in the April dashboard – this should be resolved before next month.

Recovery Plan: N/A

Improvements: All Trusts are investigating variations between observed and expected deaths by diagnostic group. Reviews undertaken in quarter four were presented to the APC mortality surveillance group in June 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

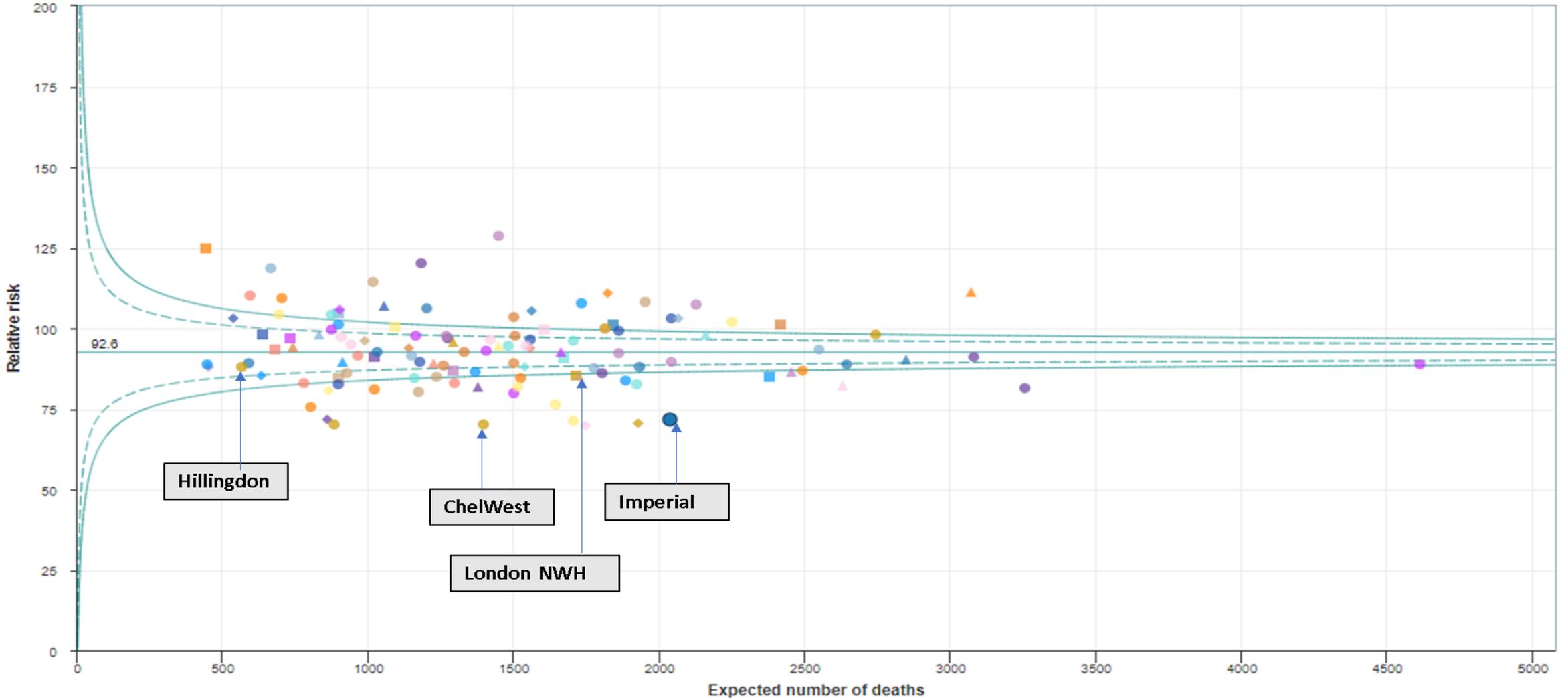**Senior Responsible Owner:** Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board
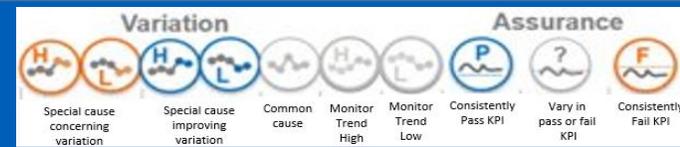**Data Assurance:** Data is supplied and quality assured by Telstra Health

21

(Patient) Hospital Standardised Mortality Ratio

(Patient) VTE Risk Assessments Completed

Variation | Assurance
Special cause concerning variation | Special cause improving variation | Common cause | Monitor Trend High | Monitor Trend Low | Consistently Pass KPI | Vary in pass or fail KPI | Consistently Fail KPI

TREND

% VTE risks completed

95%
STANDARD

96.9%
PERFORMANCE

TREND (H)

ASSURANCE (P)

Legend: Combined Trust Position | Combined Trust Mean | National Target

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	7,606	96.5%		7,340	94.7%
ICHT	16,732	97.4%		16,303	97.2%
LNW	11,448	97.8%		11,196	97.1%
THH	4,536	93.7%	-1.3%	4,252	89.9%
APC	**40,322**	**96.9%**		**39,091**	**95.8%**

STRATIFICATION

Legend: VTE Risk Assessments | APC Average | Standard
(Bar chart showing CWFT, ICHT, LNW, THH)

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. LNW and THH have commenced reporting from Cerner which has resulted in an improvement at APC level. We are above the standard in month and across the last 12 months, with the trend chart showing special cause improving variation in May. CWFT, ICHT and LNW met the standard in month. THH has identified some issues with the data in Cerner which are being addressed. Although an improvement is already being seen as a result of the changes being made, they remain slightly below target in month.
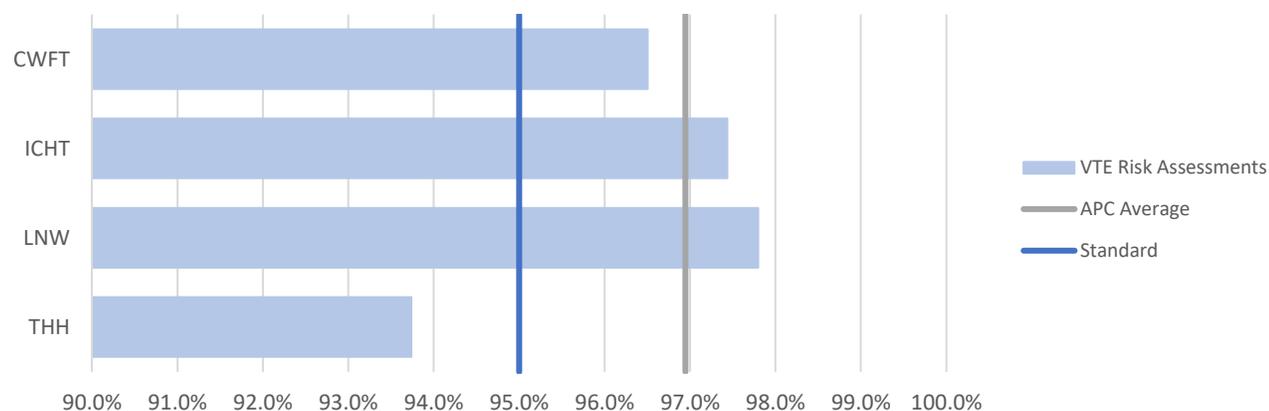
Recovery Plan: N/A

Improvements: 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.

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.

Integrated Performance Report
Maternity

April 2024

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 births (2023/24)	Neonatal care provision
Chelsea & Westminster Hospital Foundation Trust (CWFT)	Chelsea & Westminster Hospital	4,988	Level 3
	West Middlesex Hospital	4,419	Special care baby unit
Imperial College Healthcare NHS Trust (ICHT)	Queen Charlotte's and Chelsea Hospital	5,603	Level 3
	St Mary's Hospital	3,034	Level 2
London North West Hospitals NHS Trust (LNW)	Northwick Park Hospital	3,774	Level 2
The Hillingdon Hospitals (THH)	Hillingdon Hospital	4,029	Level 2
Total births		**25,847**	

Maternity	Expected	Actual	Trend	Assurance
Crude still birth rate 24+0 (per 1000 birth rate)	3.3	3.3		?
Number of neonatal intrapartum brain injuries as escalated to MNSI	N/A	4		
Pre-Term births	8%	6.8%		?
Neonatal Crude Deaths from 22+0 weeks onwards up to 28 days post birth (per 1000 birth rate)	0.94	2.8		?
Maternal Deaths	0	1		?

Trend

Common Cause	
Concern High	
Concern Low	
Improvement High	
Improvement Low	
Monitor Trend High	
Monitor Trend Low	

Assurance

Fail	
Pass	
Flip Flop	

Metric definition

APC metric	Metric Name	New Definition
Still Birth rate	Number of still births	Number of stillbirths – babies born showing no signs of life at 24 weeks or more gestation (please note as an example if a loss occurred at 22+5 and the baby was born at 36 weeks- it is counted here)
Number of suspected intrapartum brain injuries escalated to MNSI	Number of suspected intrapartum brain injuries - reported by unit of birth as per Maternity and Newborn Safety Investigation (MNSI)	MNSI criteria: Baby must have been born following labour. Baby must have been born at least 37 complete weeks of gestation. Baby experienced a potential severe brain injury at birth. The brain injury must meet the RCOG definition
Pre-Term Births	Early Preterm births (Total Number of live Births <= 31+6 weeks)	Early Preterm births (Total Number of live Births before or equal to 31+6 weeks)
	Late Preterm births (Total Number of live Births >= 32+0 and <= 36+6 weeks)	Late Preterm births (Total Number of live Births between or equal to 32+0 - 36+6 weeks)
Neonatal Crude Deaths up to 28 days post birth (per 1000 births rate)	Number of neonatal deaths (24+0 - 40+ weeks)	Number of neonatal deaths 24+0 - 40+ weeks. In or out of sector.
	Number of neonatal deaths (22+0- 23+6 weeks)	Number of neonatal deaths 22+0- 23+6 (As required as part of MBRACCE reporting)- reported as required for Perinatal Mortality Review Tool (site of death- any neonatal death up to 28 days/ that died in any areas)
Maternal Deaths	Maternal Deaths	Number deaths

The data in this dashboard is for month 1 (April 2024). Work is underway to improve the timeliness of the data for these metrics.

Following identification of discrepancies between the internally reported data at ICHT and the data in the ICB and LMNS scorecards, which feeds the APC maternity dashboard, all APC trusts were asked to review and validate their data for 2023/24 for neonatal deaths, stillbirths and suspected intrapartum brain injuries. This validated data is included in this report.

Changes to the definitions for the metrics in this dashboard have been agreed to ensure alignment with national definitions. Work is on-going to include these, and validated historic data, in this dashboard. Additional metrics have been proposed for inclusion and are being reviewed at the APC quality meeting and within each Trust. These will be added once approved.
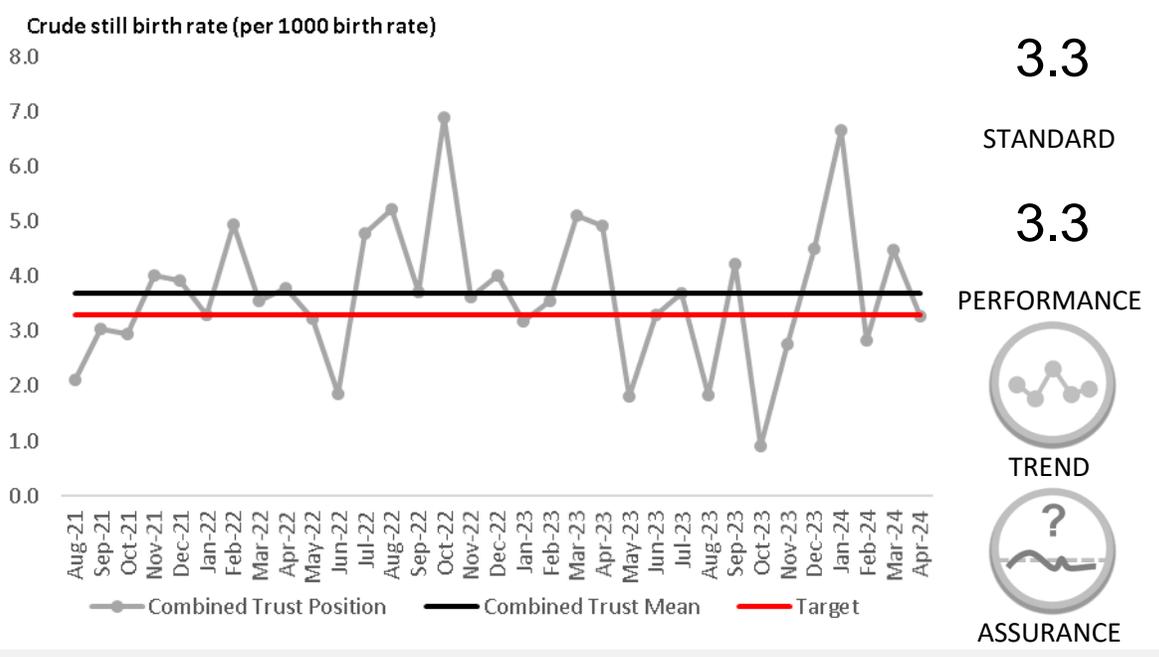
(Maternity) Crude still birth rate (per 1000 birth rate)

Variation / Assurance legend

TREND

Crude still birth rate (per 1000 birth rate) — line chart showing Combined Trust Position, Combined Trust Mean, and Target from Aug-21 to Apr-24.

3.3 STANDARD

3.3 PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Total Births	Total Still Births	Crude Still Birth Rate	Crude Still Birth Rate YTD	Difference from Standard
CWFT	821	3	3.7	3.7	0.35
ICHT	700	2	2.9	2.9	
LNW	305	2	6.6	6.6	3.26
THH	317	0	0.0	0.0	
APC	**2143**	**7**	**3.3**	**3.3**	

STRATIFICATION

Crude Still Birth Rate (per 1,000 birth rate) By Trust — line chart with CWFT, ICHT, LNW, THH from Aug-21 to Apr-24.

NARRATIVE

Performance: The APC stillbirth rate just met the standard in April. There were 7 stillbirths reported. From next month this data will include late fetal losses (between 22+ and 23+6 weeks).
- CWFT – 3 cases – Case 1: IUD at 28 weeks – fetal ultrasound showed abnormalities. Case 2: presented to triage at 24+1 weeks with a history of heavy vaginal bleeding and abdominal pain. No fetus or placenta could be seen on scan, and was considered likely she had undergone a stillbirth. Case 3: presented to maternity triage at 40+2 with reduced fetal movements. IUD confirmed.
- ICHT – 2 cases – Case 1: IUD confirmed at routine appointment at 33+1 weeks – known Trisomy 18 and cardiac anomalies. Case 2: Intrapartum Stillbirth at 41+1 weeks whilst an inpatient.
- LNW – 2 cases – Case 1: patient unbooked in UK presented to triage at 32+4 weeks with reduced fetal movements. IUD confirmed. Case 2: 25+ out of hospital birth of twins. Twin one confirmed as a stillbirth. The second baby was resuscitated, stabilised and transferred to QCCH for cooling where they subsequently died.

Recovery Plan: All cases will be investigated via PMRT to identify learning and actions. A review of all stillbirths across the APC is underway to identify any additional themes and learning and review health inequalities. Outcomes will be reported to APCQC in September and summarised in this dashboard.
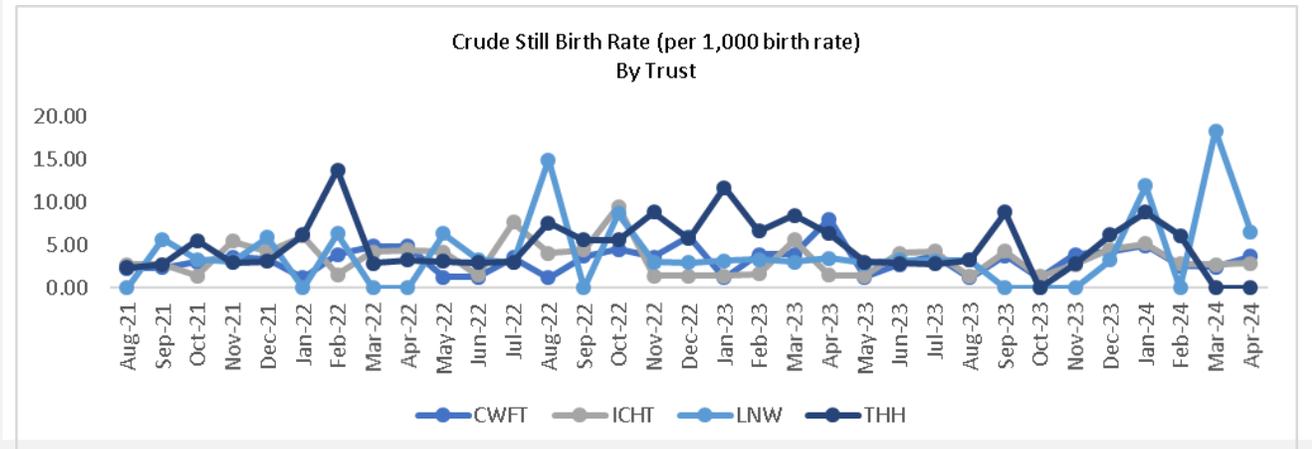
Improvements: Local improvements are being implemented at each trust for example at CWFT the length of appointments in community settings have been extended and a working group in place to review translation services. At ICHT counselling services for patients transferred for level 3 neonatal care are being reviewed with a focus on the risk assessments and documentation of personalised care plans.
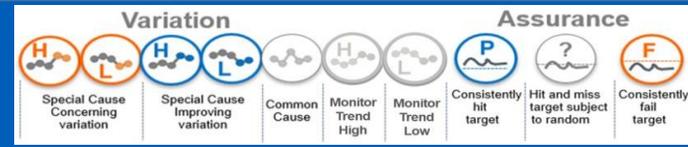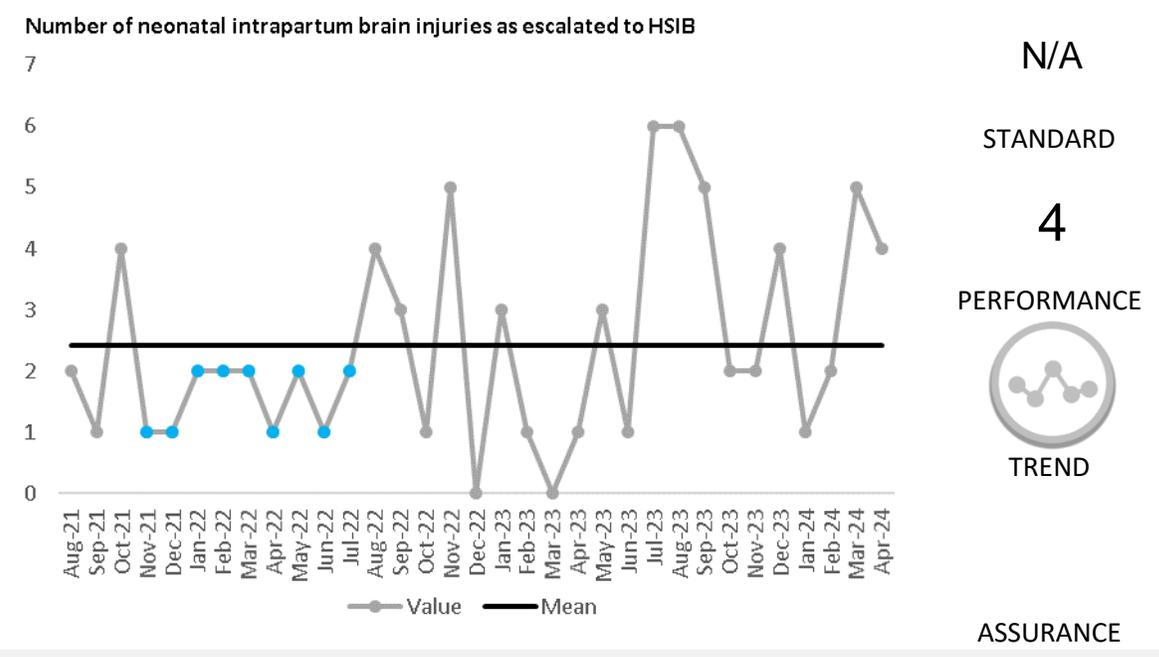
Forecast Risks: N/A

GOVERNANCE

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

(Maternity) Neonatal intrapartum brain injuries (suspected)

TREND

Number of neonatal intrapartum brain injuries as escalated to HSIB

Value — Mean

STANDARD: N/A

PERFORMANCE: 4

TREND

ASSURANCE

CURRENT PERFORMANCE

	Total Births	Brain Injuries in Month	Brain Injuries FYTD
CWFT	821	2	2
ICHT	700	0	0
LNW	305	2	2
THH	317	0	0
APC	**2143**	**4**	**4**

STRATIFICATION

Brain Injuries in Month — APC Average

NARRATIVE

Performance: There were four cases of suspected intrapartum brain injury in NWL in April. **From next month this data will be reported as a rate per 1000 births with an agreed standard.**

- CW: Case 1: Baby required cooling after being born in poor condition following a Kiwi Birth – late decels in second stage of labour. Baby sadly died (see neonatal death slide). Case 2: Admitted in labour 41+4 - pathological CTG and instrumental birth. Deteriorating condition in SCBU and cooling commenced. Normal MRI.
- LNW: Case 1: Induction of labour for reduced fetal movements. Baby admitted to NNU and transferred for cooling with suspected HIE grade 2-3. Case 2: 25+ out of hospital birth of twin boys. Twin two was resuscitated, stabilised and transferred to QCCH for cooling where they subsequently died (see neonatal death slide).

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 North West London.
Recovery Plan: A significant improvement project on escalation commenced at CWFT in June as this is a theme from completed MNSI investigations, alongside a change in practice to move to physiological fetal monitoring interpretation in 2024.
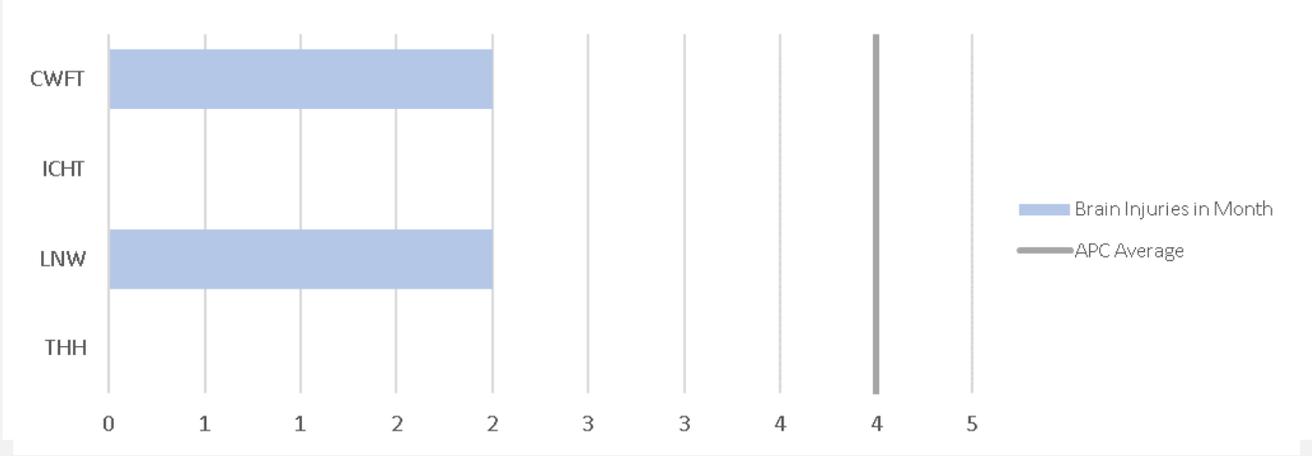**Improvements:** A full review of all cases during 2023/24 including learning and outcomes, is being carried out by the LMNS and all providers will report their updates in their Q1 Quality &Safety report. The combined position and learning will be reported through the Quality Committee. Improvements will be confirmed as part of this report once complete.
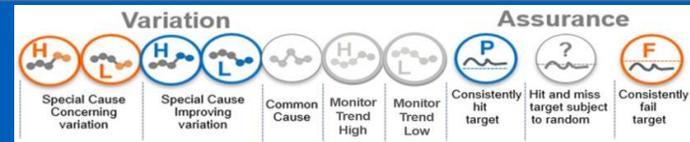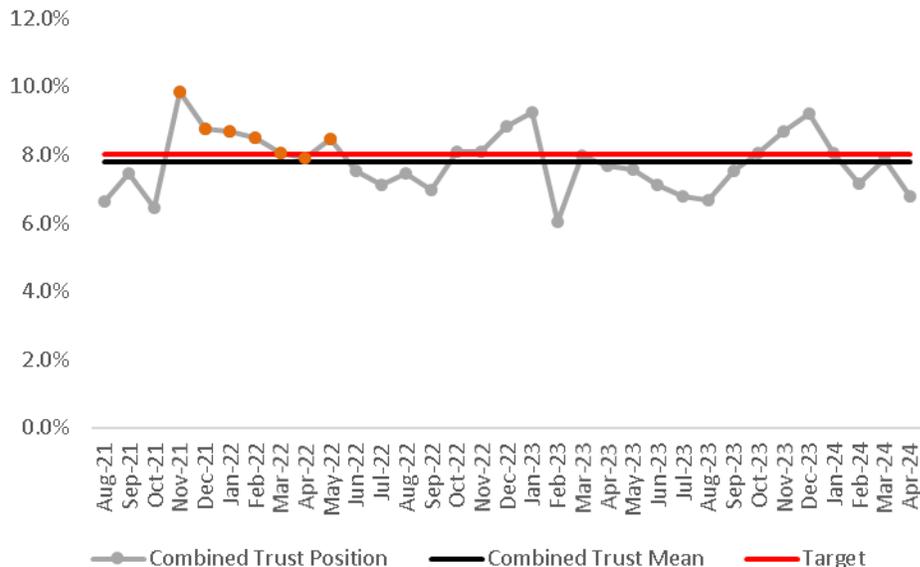**Forecast Risks:** N/A

GOVERNANCE

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

(Maternity) Preterm Births

TREND

Pre-term Birth Rate

8%

STANDARD

6.8%

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Pre-Term Births	Number of early Pre-Term Births	Number of Late Pre-Term Births	Total Births	Pre-term Birth Rate	Difference from Threshold
CWFT	49	10	39	821	6.0%	
ICHT	67	12	55	700	9.6%	1.57%
LNW	29	4	25	305	9.5%	1.51%
THH	0	0	0	317	0.0%	
APC	**145**	**26**	**119**	**2143**	**6.8%**	

STRATIFICATION

NARRATIVE

Performance: In month, NWL had a pre-term birth rate of 6.8% which is below the standard. ICHT and LNW are just above standard. As a tertiary referral centre ICHT have a higher number of preterm births compared to other Trusts across the sector; there are no concerns to escalate.

Recovery Plan: In 2023/24 CWFT saw 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 and has reduced over the last two months to below the standard.
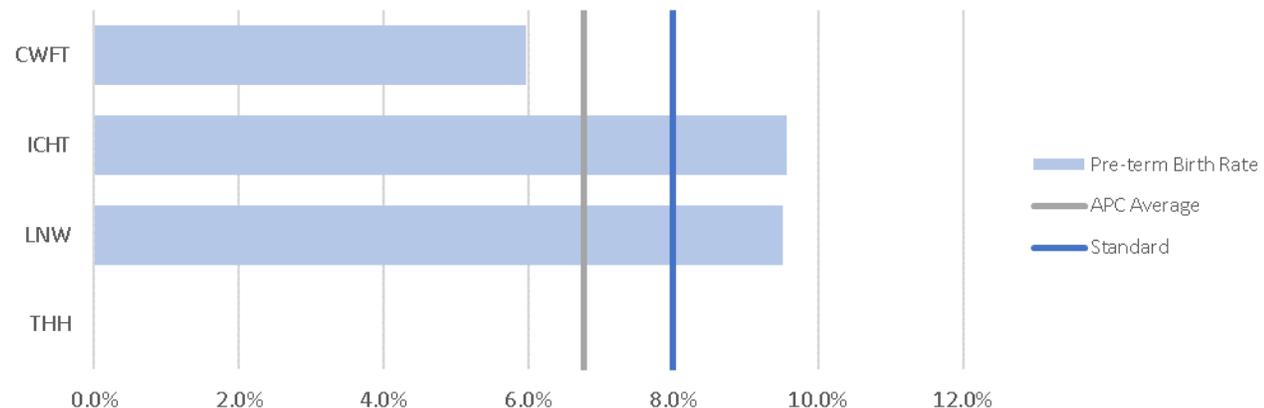
Improvements: LNW is setting up a preterm birth working group with the aim of focusing on their local data/audit/guidelines and some wider QI initiatives to review rates. The APC is undertaking a review of all preterm births and IUT across both sites at CWFT as part of the business case development to support service redesign of the level 2 NICU as well as the preterm birth antenatal service at WM site.
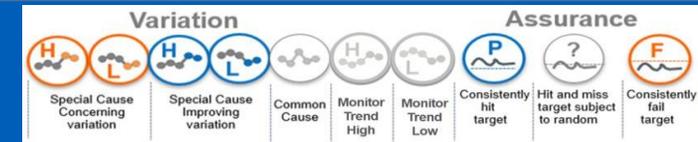
Forecast Risks: No risks identified.

GOVERNANCE

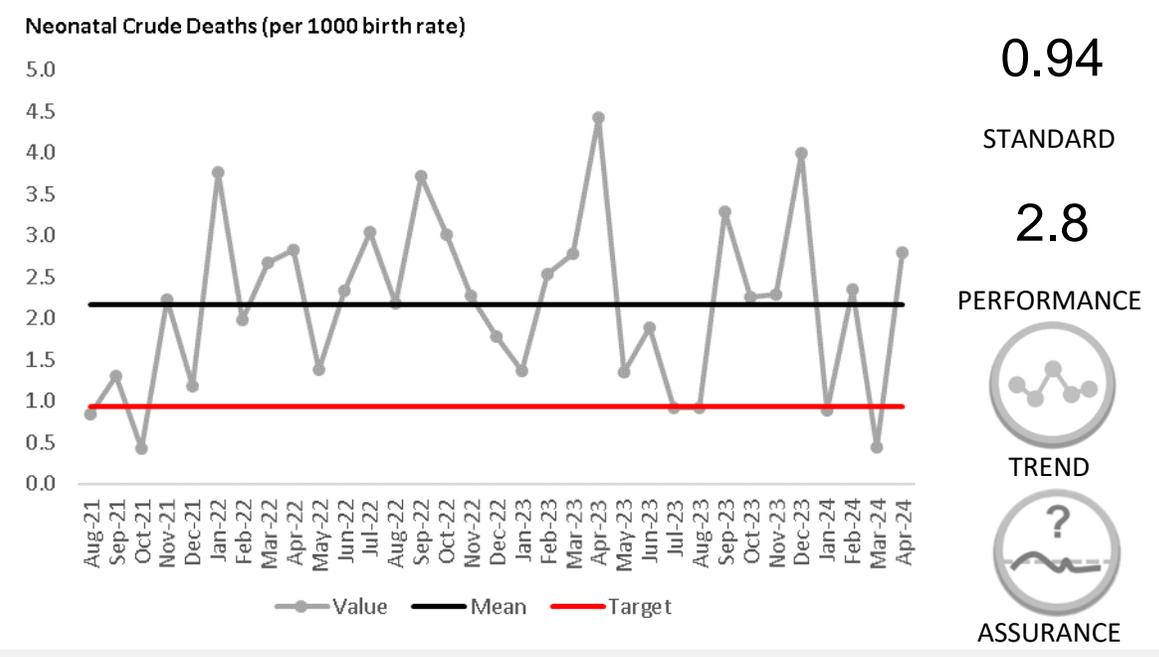**Senior Responsible Owner:** Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board

Variation | **Assurance**

(Special Cause Concerning variation, Special Cause Improving variation, Common Cause, Monitor Trend High, Monitor Trend Low, Consistently hit target, Hit and miss target subject to random, Consistently fail target)

TREND

Neonatal Crude Deaths (per 1000 birth rate)

Legend: Value — Mean — Target

0.94
STANDARD

2.8
PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Neonatal Deaths	Number of neonatal deaths (22+0- 23+6 weeks)	Number of neonatal deaths (24+0 - 40+ weeks)	Total Births	Crude neonatal death rate (per 1000 birth rate)	Difference from Threshold
CWFT	4	1	3	821	4.9	3.9
ICHT	1	0	1	700	1.4	0.5
LNW	0	0	0	305	0.0	
THH	1	0	1	317	3.2	2.2
APC	**6**	**1**	**5**	**2143**	**2.8**	**1.9**

STRATIFICATION

Legend: Crude neonatal death rate (per 1000 birth rate), APC Average, Standard

NARRATIVE

Performance: This metric now includes all neonatal deaths between 22+0 and 40+ weeks in alignment with the national metrics. The crude neonatal death rate at APC level was above target in April. There were six cases across the APC.

- CWFT: 4 cases. Case 1: See intrapartum brain injury slide. Case 2: baby born at Kingston Hospital following abnormal CTG on 4th growth centile – died 8 hours following transfer. Case 3: Booked at Kingston, arrived via ambulance, born at 23+4 weeks, died 3 hours later. Case 4: Baby born in good condition but deteriorated over the next few hours and was transferred to GOSH for further care where they died (likely undiagnosed genetic lung condition).
- ICHT: 1 case. Out of hospital birth of dichorionic diamniotic twin pregnancy at LNW. Twin 2 transferred to QCCH for Level 3 care and sadly died on day 7 of life.
- THH: 1 case. 32+1 Neonatal death at 12hrs of age after category two c-section for PPROM and pathological CTG. Maternal HVS grew group B strep, results back post-delivery. Both mother and baby treated with antibiotics. Transferred to Level 3 unit after resuscitation attempts.

All cases are being appropriately investigated.

Recovery Plan: A review of neonatal deaths cross-site in 23-24 is in progress at CWFT and will be reported in the Q1 Q&S report in July.

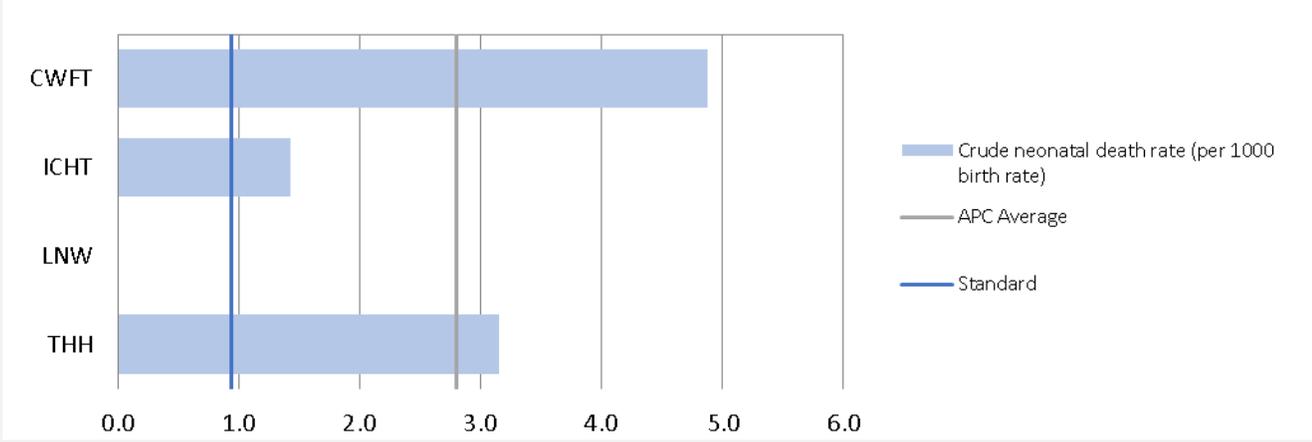**Improvements:** The Neonatal CRG and the Trust teams will continue to monitor any new cases.

Forecast Risks: None identified.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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Variation | **Assurance**

Special Cause Concerning variation | Special Cause Improving variation | Common Cause | Monitor Trend High | Monitor Trend Low | Consistently hit target | Hit and miss target subject to random | Consistently fail target

TREND

Maternal Deaths

0

STANDARD

1

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Maternal Deaths	Total Births	Difference from Threshold
CWFT	1	821	1.00
ICHT	0	700	
LNW	0	305	
THH	0	317	
APC	**1**	**2143**	**1.00**

STRATIFICATION

Number of Maternal Deaths
APC Average
Standard

NARRATIVE

Performance: There was one maternal death reported in April at CWFT. This was a White British woman, first pregnancy. At 25 weeks she was diagnosed with an aggressive cancer with signs of metastases and sadly died months after giving birth.

Recovery Plan: N/A
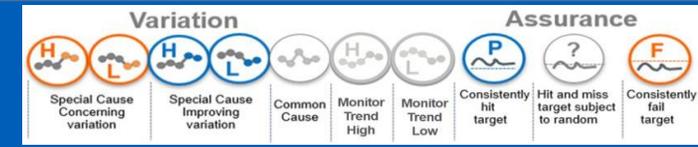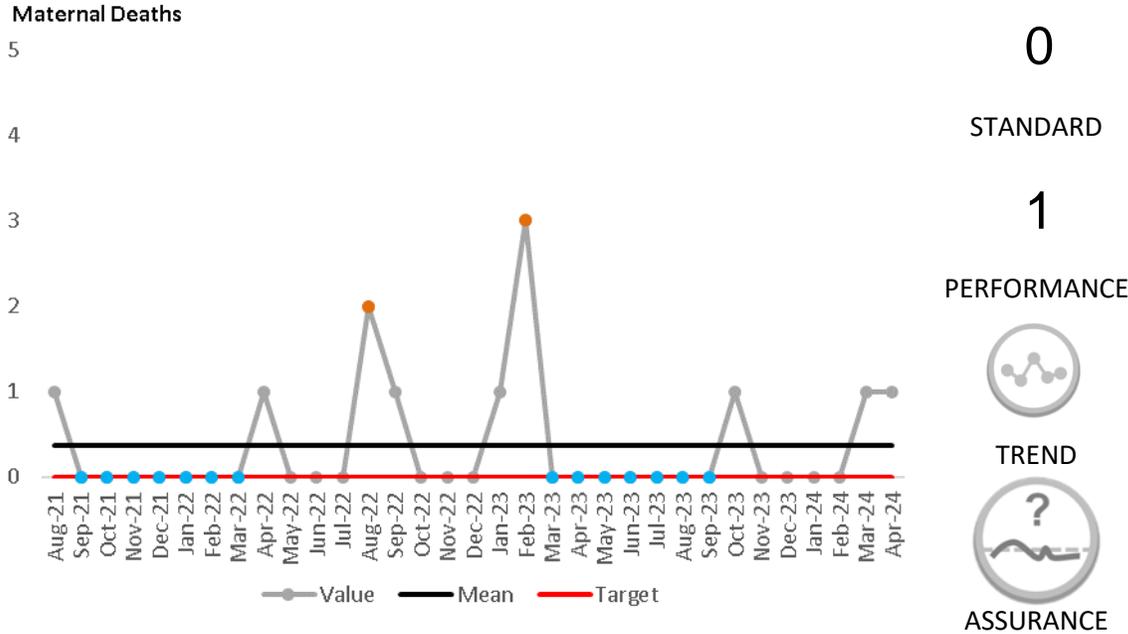
Improvements: N/A

Forecast Risks: No current risks.

GOVERNANCE

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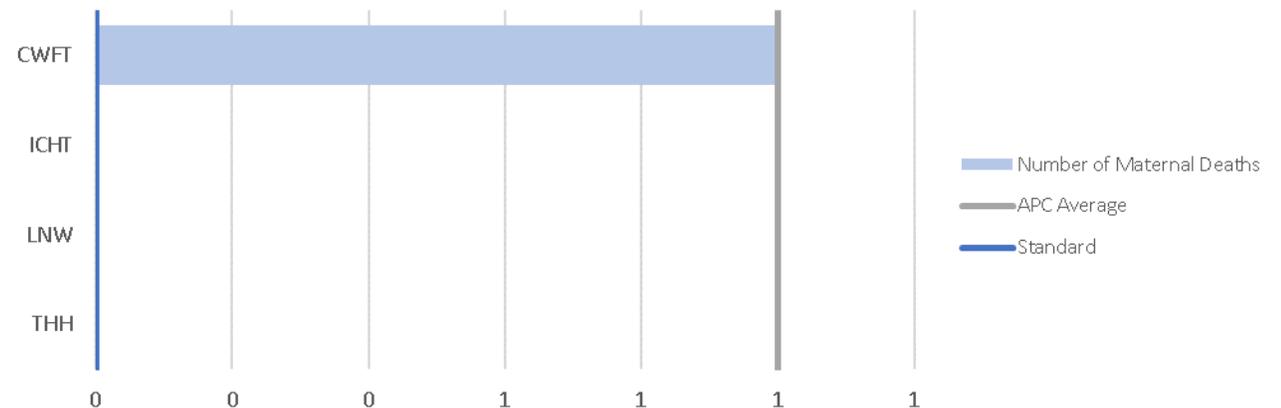**Committee:** Acute provider collaborative executive management board

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Operational Performance

This is a report on the operational performance of the APC for the period ending May 2024 except for cancer which is April 2024. The key points are:

Performance:

•UEC pathways are stable, but there is still pressure on all Trusts to maintain flow.
•Long-waiting patients have decreased, with NWL performing well nationally.
•Theatre utilisation is high, and attention is now focused on cancelled sessions and sessions not utilised.
•Cancer performance has been sustained, meeting the 28-Day Faster Diagnosis Standard, but there is still a need for improvement in the 31-day standard.
•Diagnostics has stabilised below target, and all Trusts have recovery plans in place.

Key Actions:

•To improve UEC performance to 78%.

Escalations:

•DM01 (Definitive Measure 01) is unlikely to be consistently achieved until Quarter 2 of 2024-25 due to ageing equipment issues at ICHT and Audiology.
•Ongoing strike action poses a risk to most standards.
•Unfunded beds continue to be open across all Trust sites due to high levels of patients who no longer meet the criteria to reside.

Overall, the APC is performing well, with some areas of improvement, but there are still challenges to address, particularly with regards to UEC targets and ageing equipment.
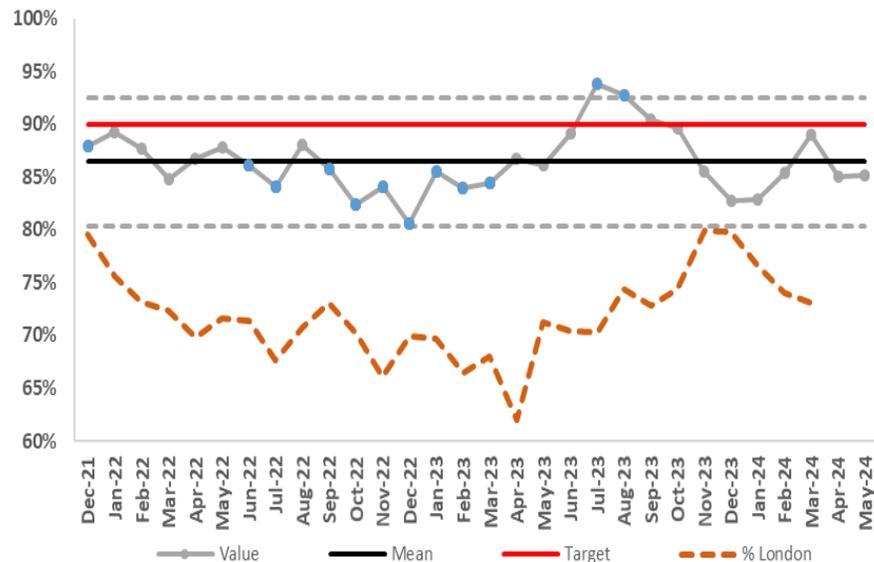
Ambulance Handover Waits

TREND

30 mins Breach Performance (LAS)

Legend: —○— Value — Mean — Target - - - % London

90%
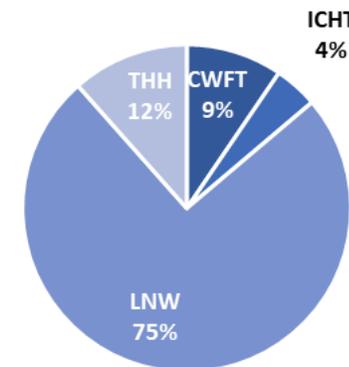
STANDARD

85.2%

PERFORMANCE

TREND

F

ASSURANCE

CURRENT PERFORMANCE

LAS Handover Waits within the thirty minute standard May-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	3366	94.9%		172	8	1772	223
ICHT	2873	97.3%		78	0	861	94
LNW	3931	65.6%	-24.4%	1354	42	2645	1516
THH	2045	89.8%	-0.2%	209	6	831	183
APC	**12215**	**85.2%**	**-4.8%**	**1813**	**56**	**6109**	**2016**

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. 85.2% of ambulances were handed over within 30 minutes in May 2024 against a target of 90%.

Recovery plan: 30 minute handover was challenged at LNW during May 2024, although there has been improvement in 60 minute handover times. 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. We are also reviewing how we use the LAS escalation process at times of peak pressure.

Improvements: The acute collaborative was the first in London to pilot and implement the new LAS standard operating procedure for immediate handover at 45 minutes. The process is now embedded as business as usual.

Forecast risks: Continued increases in the number of conveyances.
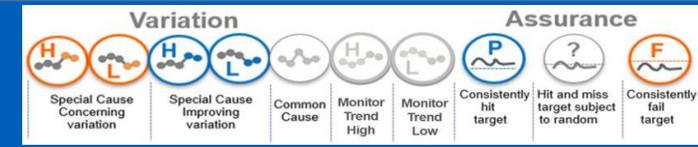
GOVERNANCE

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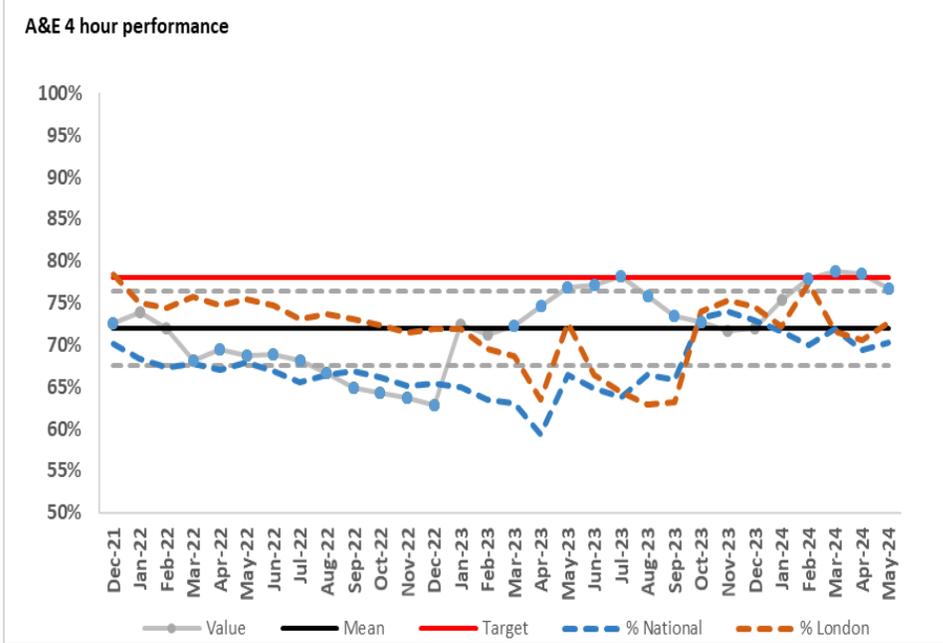**Committee:** APC EMB (Chair: Tim Orchard); NWL UEC Board (Chair: Rob Hurd)
Data Assurance: These figures are provided by LAS

Urgent & Emergency Department Waits

Variation | Assurance

H L	H L		H	L	P	?	F
Special Cause Concerning variation	Special Cause Improving variation	Common Cause	Monitor Trend High	Monitor Trend Low	Consistently hit target	Hit and miss target subject to random	Consistently fail target

TREND

A&E 4 hour performance

Legend: Value, Mean, Target, % National, % London

78%

STANDARD

76.7%

PERFORMANCE

TREND

F

ASSURANCE

CURRENT PERFORMANCE

Time spend in Emergency Department: 4-Hour Standard May-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	27835	80.68%		5378	5146	75.8%	232	96.5%	1584
ICHT	24431	76.1%	-1.9%	5851	5242	68.0%	609	92.5%	5440
LNW	29924	74.0%	-4.0%	7772	7504	46.1%	268	98.3%	1242
THH	13121	75.8%	-2.2%	3170	3085	49.1%	85	98.8%	2046
APC	**95311**	**76.7%**	**-1.3%**	**22171**	**20977**	**63.6%**	**1194**	**96.8%**	**10312**

STRATIFICATION

THH 14% | CWFT 24% | LNW 35% | ICHT 27%

Trust share of APC waits longer than standard

NARRATIVE

Performance: Performance against the 4-hour standard was 76.7% (from 78.4% in the previous month).

Recovery plan: Work continues across the North West London UEC programme to reduce demand and waits across the pathway to achieve the national objective to achieve a minimum of 78% of patients seen within 4 hours by March 2025. Each Trust has an updated action plan that includes a range of measures to improve and sustain performance and maintain safe levels of care.

Improvements: The improvement plans are built on progress made during 2023/24 as well as the NHSE best practice guidance for Urgent and Emergency Care issued earlier this year.
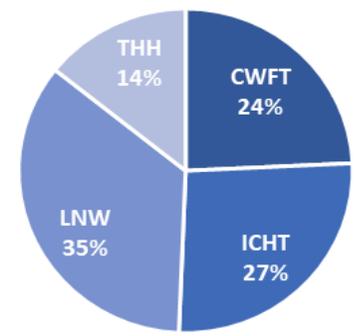
Forecast risks: Increases in demand, continued delays with discharge for medically optimised patients, impact of industrial action.
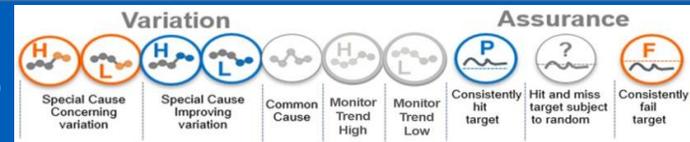
GOVERNANCE

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

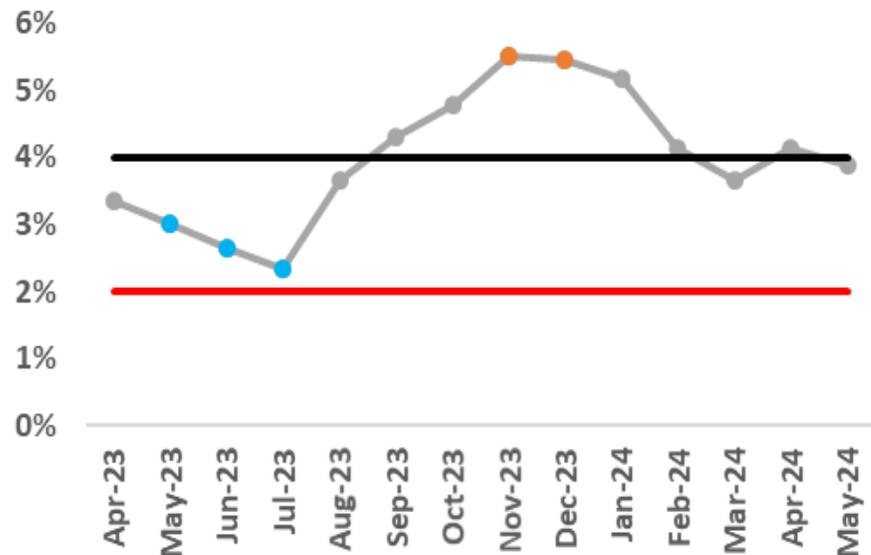**Committee:** APC EMB (Chair: Tim Orchard); NWL UEC Board (Chair: Rob Hurd)

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

Variation					Assurance		
Special Cause Concerning variation	Special Cause Improving variation	Common Cause	Monitor Trend High	Monitor Trend Low	Consistently hit target	Hit and miss target subject to random	Consistently fail target

TREND

% of Patients > 12 Hours

2.0%

ALLOWANCE

3.9%

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 12-Hour waits May-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	27835	1.7%		478	478	0	61
ICHT	24431	3.1%	-1.1%	757	757	0	108
LNW	29924	6.4%	-4.4%	1928	1928	0	432
THH	13121	4.0%	-2.0%	531	531	0	13
APC	**95311**	**3.9%**	**-1.9%**	**3694**	**3694**	**0**	**614**

STRATIFICATION

THH 14%
CWFT 13%
ICHT 21%
LNW 52%

Trust share of APC waits longer than standard

NARRATIVE

Performance: Waits in the ED are linked to flow through the hospital as well as those waiting for beds outside the hospital. There has been an overall decrease in the proportion of patients waiting 12-hours or more from their time of arrival.

Recovery plan: 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 of 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 and industrial action.

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)

37

Discharge – patients not meeting the criteria to reside

Variation

H	L	H	L		H	L
Special Cause Concerning variation		Special Cause Improving variation		Common Cause	Monitor Trend High	Monitor Trend Low

Assurance

P	?	F
Consistently hit target	Hit and miss target subject to random	Consistently fail target

TREND

Patient not meeting CTR by Trust and Pathway

Planned Discharge Pathway

Legend: THH, LNWH, ICHT, CWFT

CURRENT PERFORMANCE

Local Authority	CWFT	ICHT	LNW	THH	Total	List Size	Rate r per 10,000
Brent	0	34	60	1	95	470,344	2.02
Ealing	5	42	66	4	117	433,987	2.70
H&F	14	37	3	0	54	296,710	1.82
Harrow	0	5	49	0	54	260,337	2.07
Hillingdon	0	6	11	36	53	324,843	1.63
Hounslow	41	24	2	1	68	338,787	2.01
Kensington & Chelse	19	26	2	0	47	268,576	1.75
Westminister	1	39	1	0	41	253,186	1.62
Out of area	49	48	8	3	108		
Total	129	261	202	45	637		

STRATIFICATION

NARRATIVE

Performance: There has been an overall decrease in the number of patients not meeting CTR in the sector from 688, since last reported, to 637. This decrease is noted in both P0 and P1 pathways at the end of May 2024 with week-on-week variation expected during the month. All patients are input into the Optica system, not just pathway 1-3. Improvements are noted in CWFT and LNW while ICT and THH remain fairly static.

Recovery: All sites have additional beds open to manage the overall volume of patients. These beds are in essence unfunded for M1-6 of this year.

Improvement: Ongoing work with each local authority to improve P1 discharges.

Forecast risks: Ongoing pressure on G&A bed occupancy, continued delays for patients waiting for admission to mental health beds and all escalation beds across the APC remain open.
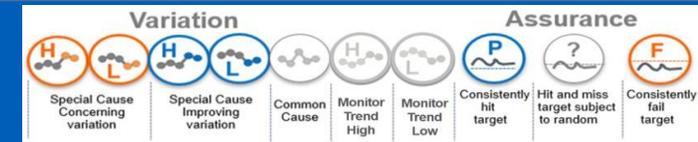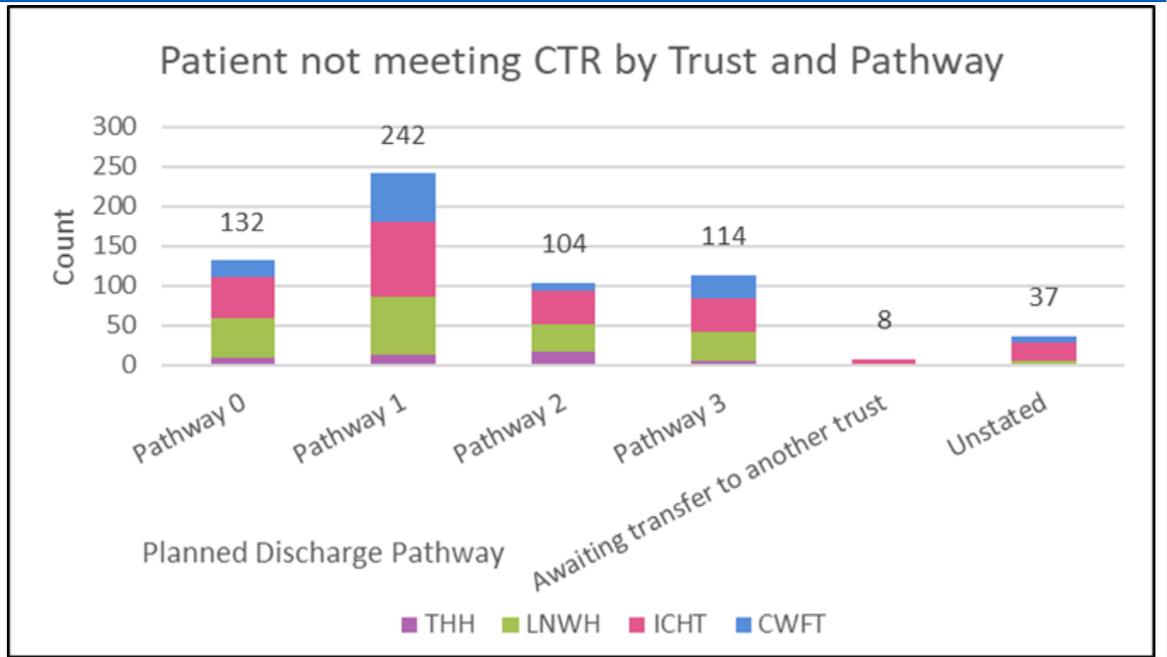
GOVERNANCE

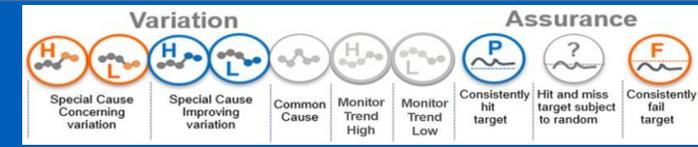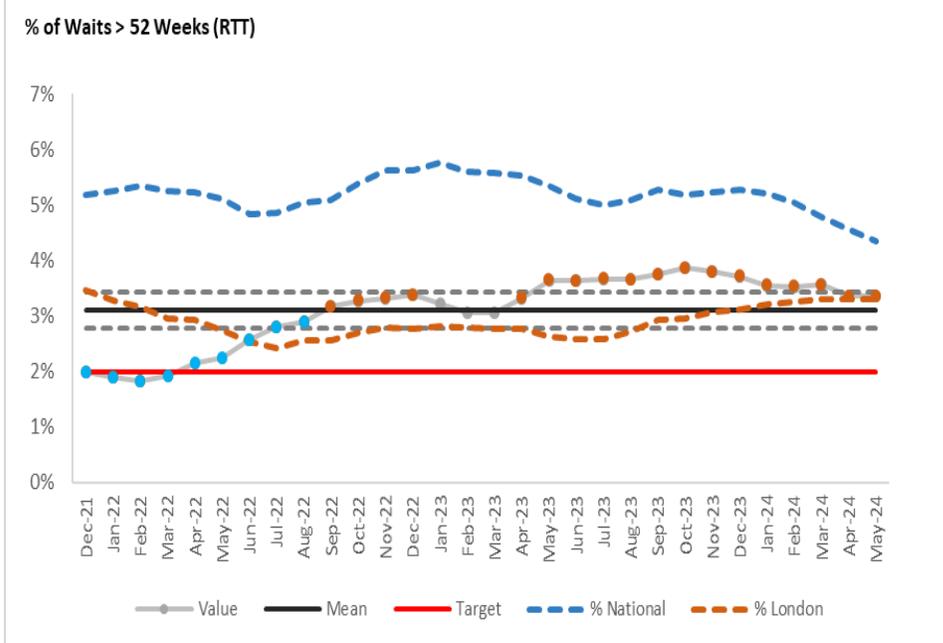**Senior Responsible Owner:** Sheena Basnayake, Deputy Chief Operating Officer
Committee: APC EMB (Chair: Tim Orchard); NWL UEC Board (Chair: Rob Hurd)
Data Assurance: These figures come for the FDP via the ICB

38

Referral to Treatment Waits

Variation / Assurance legend

TREND

% of Waits > 52 Weeks (RTT)

Legend: Value, Mean, Target, % National, % London

2.0%

ALLOWANCE

3.4%

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

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

	Total Waiting List	Waits > 52 weeks	Difference from target	52 + weeks	Of which		Impacted by	Impacts on	
					65 + Weeks	78 + weeks	104 + weeks	OTDCs not booked < 28 days	Average wait (weeks)
CWFT	61549	2.6%	-0.6%	1576	348	28	0	1	16.66
ICHT	98453	3.6%	-1.6%	3535	694	40	0	23	19.40
LNW	103991	4.1%	-2.1%	4263	952	85	0	0	21.54
THH	29510	1.8%		520	38	0	0	0	19.22
APC	**293503**	**3.4%**	**-1.4%**	**9894**	**2032**	**153**	**0**	**24**	**19.57**

STRATIFICATION

Pie chart: CWFT 16%, ICHT 36%, LNW 43%

Trust share of APC waits longer than standard

NARRATIVE

Performance: The Trusts have conducted extensive validation to stabilize and reduce the overall PTL size. Long waits are being monitored at the patient level, with a continued downward trend in 52-week waits. All Trusts are committed to the operating plan targets, aiming to treat all patients waiting over 65 weeks by the end of September 2024. Mutual aid is being provided where needed in the most challenged specialties.

Recovery: Trusts are enhancing productivity alongside insourcing efforts. The most challenged specialties in NWL remain Trauma & Orthopaedics (CWFT), ENT (ICHT), General Surgery and Urology (THH), and Gynaecology (LNW).

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

Forecast Risks: There is a significant risk of increased waits of 65 weeks and above due to industrial action.

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

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Access to Diagnostics

Variation · Assurance

H L	H L		H	L	P	?	F
Special Cause Concerning variation	Special Cause Improving variation	Common Cause	Monitor Trend High	Monitor Trend Low	Consistently hit target	Hit and miss target subject to random	Consistently fail target

TREND

% of Breaches > 6 Weeks (Diagnostics)

Legend: Value — Mean — Target — % National — % London

5.0% ALLOWANCE

17.1% PERFORMANCE

TREND

F ASSURANCE

CURRENT PERFORMANCE

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

	Total Waiting List	Waits > 6 weeks	Difference from target	6 + weeks	Of which 13 + weeks
CWFT	13879	22.7%	-17.7%	3151	822
ICHT	18815	14.2%	-9.2%	2679	1034
LNW	17104	19.3%	-14.3%	3298	1367
THH	7071	8.8%	-3.8%	619	210
APC	**56869**	**17.1%**	**-12.1%**	**9747**	**3433**

STRATIFICATION

THH 6%
LNW 34%
ICHT 28%
CWFT 32%

Trust share of APC waits longer than standard

NARRATIVE

Performance: Overall delivery remains below target. Performance at CWFT, LNW and ICHT has deteriorated whilst THH is on an improvement trajectory. Recovery plans for the DM01 target for all specialties not meeting the target are in place and monitored on a weekly basis through the Planned Care Board. ICHT recovery plan is delayed due to ageing equipment.

Recovery Plan: The target is to recover overall delivery by the end of Q2 2024/25. Risks include ageing equipment and potential failures, mitigated by increased activity through CDCs.

Improvements: Minor improvements in delivery over the APC.

Forecast Risks: MRI and Neurophysiology face capacity challenges due to staffing shortages and ageing equipment replacement programs.
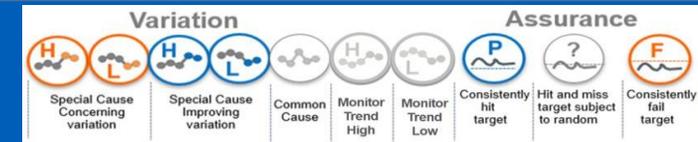
GOVERNANCE

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

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Roger Chinn);
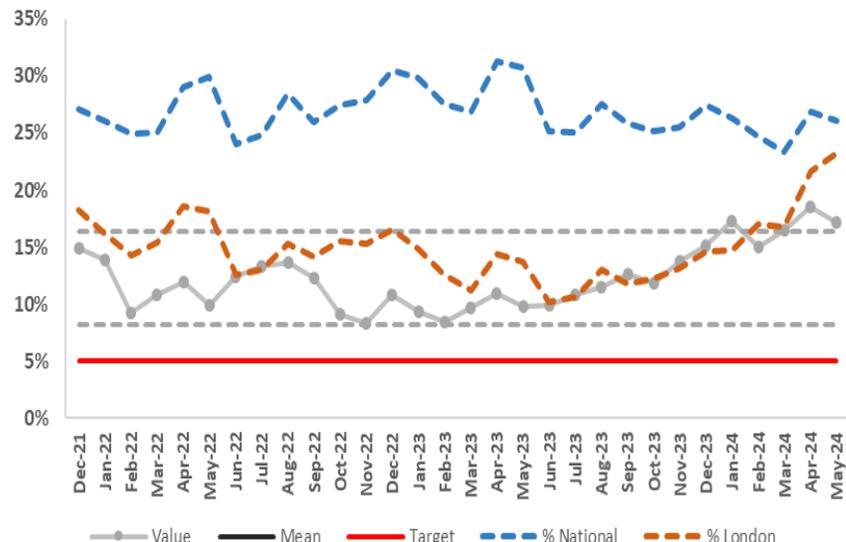
Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

40

Access to Cancer Specialist

Variation | Assurance

TREND

% Seen within 14 Day Cancer standard

Legend: Value — Mean — Target — % National — % London
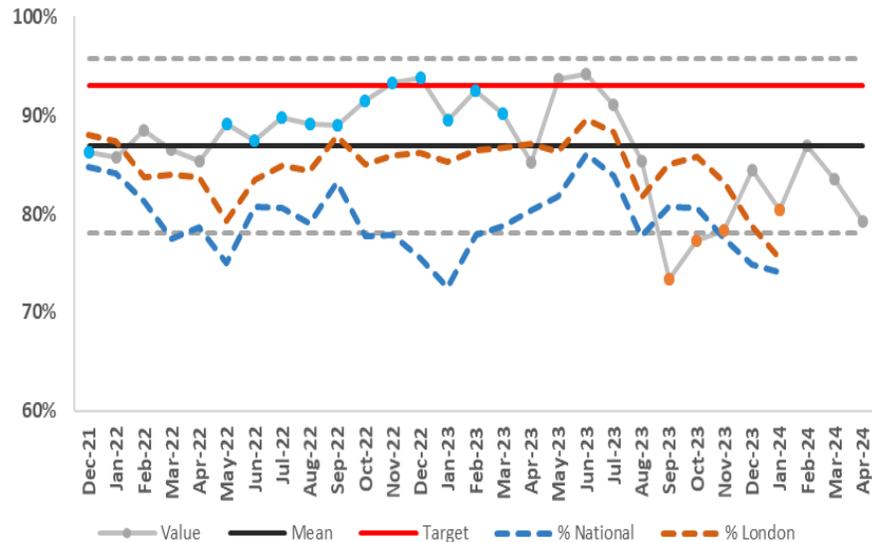
93%
STANDARD

79.2%
PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

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

	Total Seen	Two-week wait performance	Difference from target	14 + days	Of which	
					28 + days	Breast referrals
CWFT	2647	97.5%		67	5	62
ICHT	2700	91.4%	-0.6%	231	0	55
LNW	3132	49.4%	-42.6%	1585	260	3
THH	1221	88.9%	-3.1%	136	12	107
APC	**9700**	**79.2%**	**-12.8%**	**2019**	**277**	**227**

STRATIFICATION

CWFT 3%
ICHT 11%
THH 7%
LNW 79%
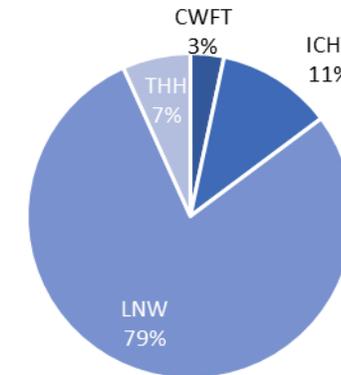
Trust share of APC waits longer than standard

NARRATIVE

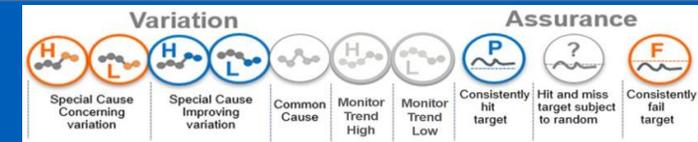**Performance:** 2WW performance standard is challenged with NWL not meeting the 93% standard mainly due to challenges post Cerner go live at LNW and THH but in key specialties such as Dermatology and Urology.

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.

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

41

Access to Cancer Care (Faster Diagnosis)

Variation | **Assurance**

TREND

% Contacted within FDS Cancer standard

Legend: Value — Mean — Target — % National — % London
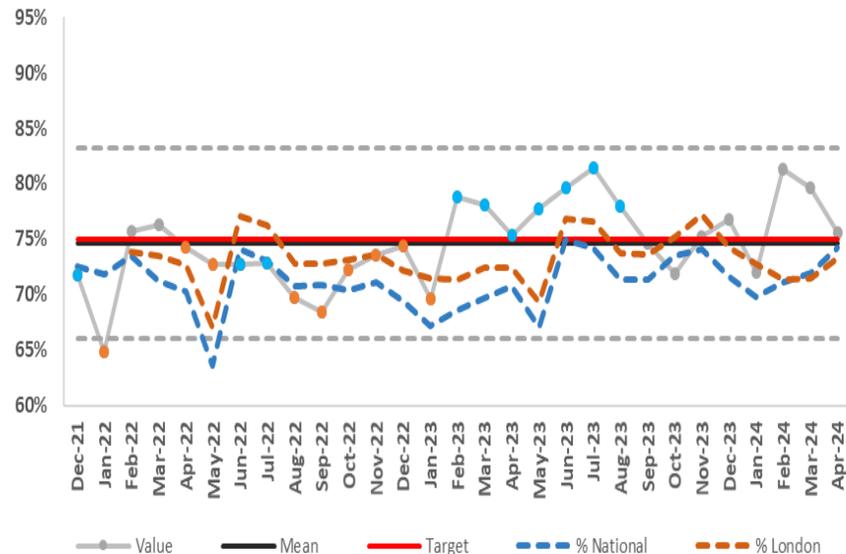
75%
STANDARD

75.5%
PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Access to Cancer Care (Faster Diagnosis) Apr-24

	Total Contacts	Faster Diagnosis performance	Difference from target	28 + days	Of which
					62 + days
CWFT	2611	76.8%		607	85
ICHT	2938	77.8%		652	0
LNW	3299	72.1%	-2.9%	921	117
THH	1339	76.8%		311	80
APC	**10187**	**75.5%**		**2491**	**282**

STRATIFICATION

Pie chart: THH 13%, CWFT 24%, ICHT 26%, LNW 37%
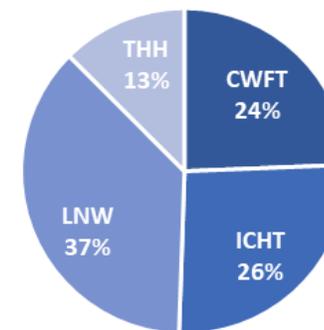
Trust share of APC waits longer than standard

NARRATIVE

Performance: FDS was met as a whole system, including THH which met FDS for the third rolling month in April – with a whole provider position being posted of 75.5% against 75% target.

Recovery Plan: Continue to work with all trusts to resiliently deliver 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 pinch points in pathways to protect cancer delivery as much as possible. Plan for seasonality and on-going impact of any additional industrial action.

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

42

TREND

% Treated within 31 Day Cancer standard

96%

STANDARD

93.1%

PERFORMANCE

TREND

F

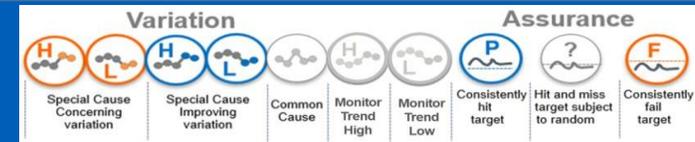ASSURANCE

CURRENT PERFORMANCE

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

	Total Treated	31 day performance	Difference from target	31 + days	Of which 62 + days
CWFT	148	97.3%		4	1
ICHT	742	90.3%	-5.7%	72	0
LNW	180	99.4%		1	0
THH	97	95.9%	-0.1%	4	0
APC	**1167**	**93.1%**	**-2.9%**	**81**	**1**

STRATIFICATION
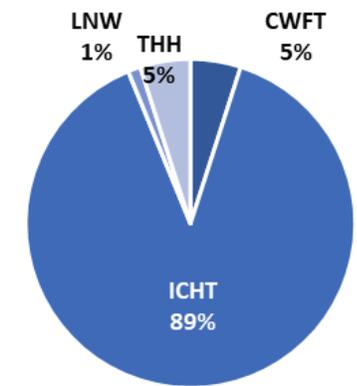
Trust share of APC waits longer than standard

NARRATIVE

Performance: 31-day standard remains challenged in April due to ICHT reduction in treatment delivery this month. There remains on-going challenges particularly at ICHT for available capacity for treatments that is continually being monitored.

Recovery Plan: The Trusts are actively collaborating with RM Partners to conduct audits and create tumour-specific targeted action plans, particularly in urological pathways.

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

Forecast Risks: As referral rates continue to stay high, there is a growing risk of a significant gap between demand and capacity due to workforce challenges.

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

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Variation

| Special Cause Concerning variation | Special Cause Improving variation | Common Cause | Monitor Trend High | Monitor Trend Low |

Assurance

| Consistently hit target | Hit and miss target subject to random | Consistently fail target |
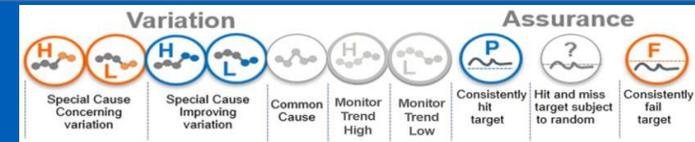
TREND

% Treated within 62 Day Cancer standard

| Value | Mean | Target | % National | % London |

85%

STANDARD

74.2%

PERFORMANCE

H — TREND

F — ASSURANCE

CURRENT PERFORMANCE

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

	Total Treated	62 day performance	Difference from target	62 + days	Of which	Impacts on
					104 + days	Backlog 104 + days
CWFT	144.5	82.4%	-2.6%	25.5	12	16
ICHT	204.5	73.3%	-11.7%	54.5	0	52
LNW	172	76.5%	-8.5%	40.5	12	20
THH	71.5	60.6%	-24.4%	40	6.5	11
APC	**592.5**	**74.2%**	**-10.8%**	**160.5**	**30.5**	**99**

STRATIFICATION
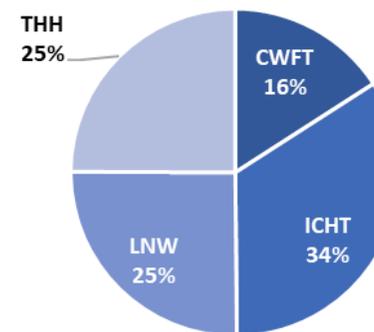
THH 25%

CWFT 16%

ICHT 34%

LNW 25%

Trust share of APC waits longer than standard

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.
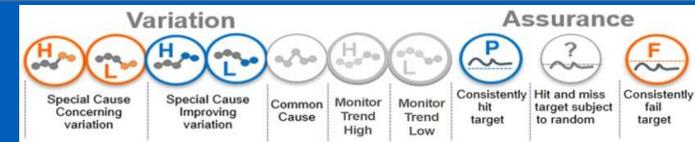
GOVERNANCE

Senior Responsible Owner: James Walters, Chief Operating Officer, LNW
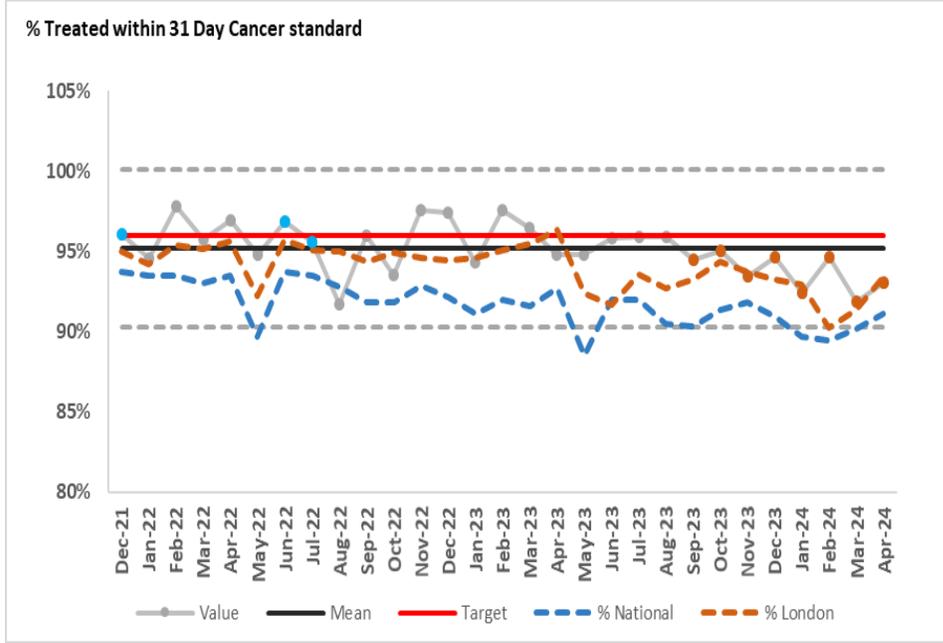
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board:(Chair: Roger Chinn)

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

Demand and Capacity Measures

Theatre Utilisation *(Uncapped)*

TREND

Theatre Utilisation

85%

STANDARD

83.6%

PERFORMANCE

TREND

ASSURANCE
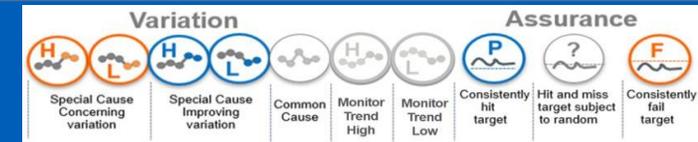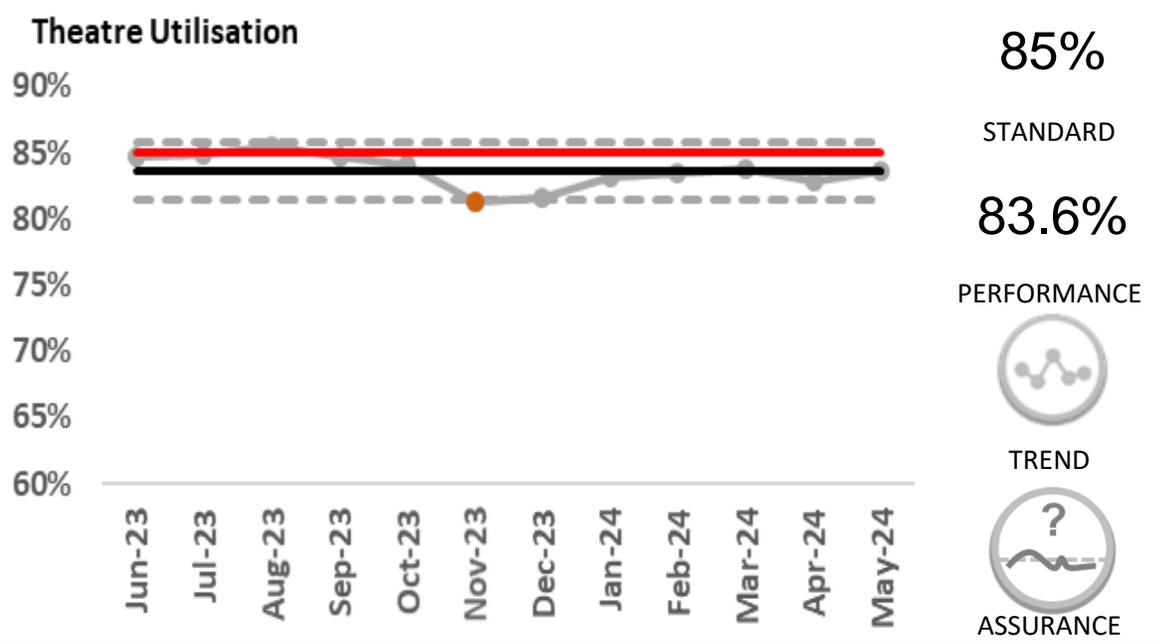
NARRATIVE

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.

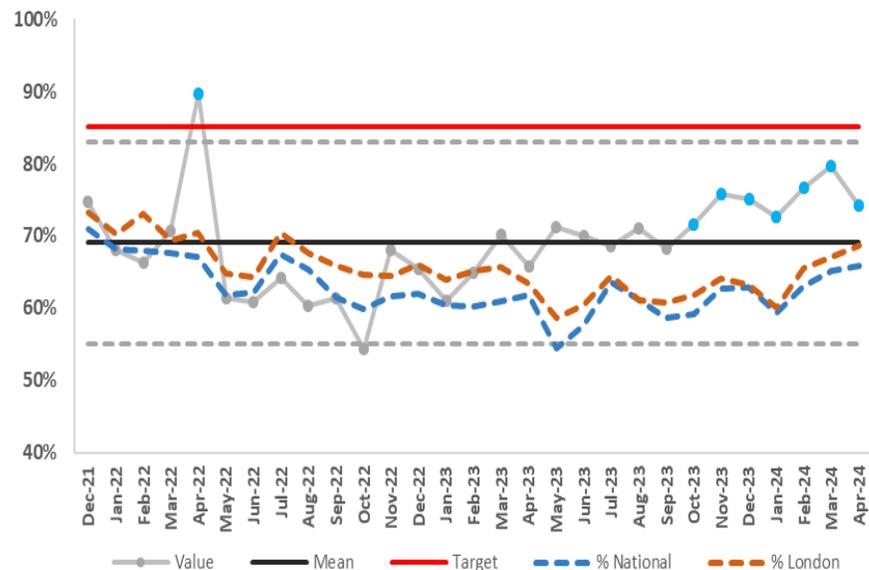**Recovery plan:**. LNW have recovered post Cerner go live.

Improvement: Recovery noted post Cerner implementation for LNW and THH, with on-going 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 May-24

	Planned operating time (hours)	Theatre utilisation	Difference from target	Unused time (hours)
CWFT	3100	82.1%	-2.9%	556
ICHT	4942	83.1%	-1.9%	837
LNW	3375	85.2%		500
THH	1173	84.9%	-0.1%	177
APC	**12590**	**83.6%**	**-1.4%**	**2070**

STRATIFICATION
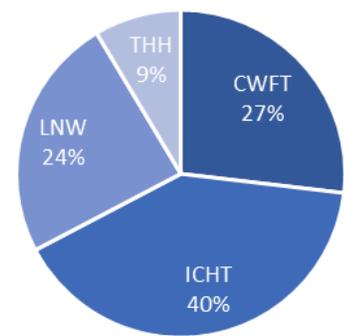
GOVERNANCE

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

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Outpatient Transformation

Variation / Assurance

H L	H L	Common Cause	H Monitor Trend High	L Monitor Trend Low	P Consistently hit target	? Hit and miss target subject to random	F Consistently fail target
Special Cause Concerning variation	Special Cause Improving variation						

TREND

Discharged to PIFU

5%
STANDARD

3.5%
PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Outpatient Transformation May-24

	Total OP contacts	Discharged to PIFU	Difference from target	Moved / Discharged to PIFU	Impacts on		
					OPFA DNAs	OPFU DNAs	Virtual contacts
CWFT	73606	7.3%		5379	10.1%	8.1%	7935
ICHT	72615	1.2%	-3.8%	860	11.8%	10.0%	19058
LNW	55213	1.9%	-3.1%	1073	9.8%	9.6%	9730
THH	34825	2.9%	-2.1%	1011	8.5%	9.6%	2753
APC	**236259**	**3.5%**	**-1.5%**	**8323**	**10.4%**	**9.4%**	**39476**

STRATIFICATION

THH 12%
LNW 13%
ICHT 10%
CWFT 65%
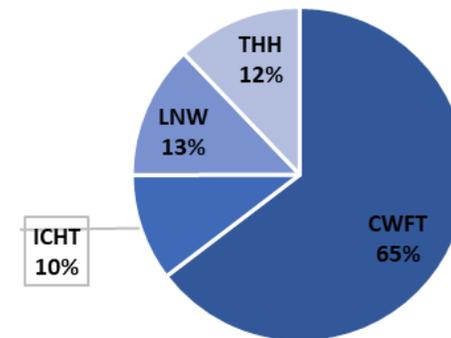
Trust share of APC discharges lower than standard

NARRATIVE

Performance: Pathways discharged to PIFU have stabilised under target. A programme of work looking at those services with the greatest opportunity to utilise PIFU has started looking at Rheumatology and Therapies. A Cerner flow meeting to improve the usability of PIFU and standardisation is being held late July 2024 with the need to change the current workflow to support clinical decisions.

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% although this is largely driven by performance at CWFT.

Future risks: Stability, usability and interoperability of digital infrastructure

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

Variation | **Assurance**

(legend: Special Cause Concerning variation; Special Cause Improving variation; Common Cause; Monitor Trend High; Monitor Trend Low; Consistently hit target; Hit and miss target subject to random; Consistently fail target)

TREND

Critical Care Bed Occupancy

<85%
STANDARD

92.9%
PERFORMANCE

TREND

?
ASSURANCE

CURRENT PERFORMANCE

Critical Care May-24

	Available critical care beds	Bed occupancy	Difference from target	Unoccupied critical care beds
CWFT	19	93.2%	8.2%	1.3
ICHT	94	100.0%	15.0%	0.0
LNW	56	82.2%		10.0
THH	12	87.1%	2.1%	1.5
APC	**181**	**92.9%**	**7.9%**	**12.8**

STRATIFICATION

CWFT 10%
THH 12%
ICHT 0%
LNW 78%

NARRATIVE

Performance: Bed occupancy has remained high overall since October 23, although there is considerable variability between sites.

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

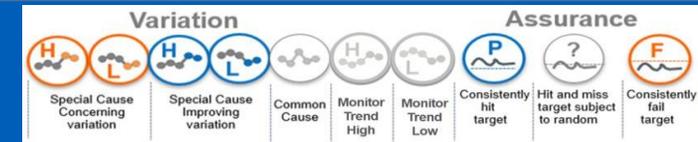## GOVERNANCE

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

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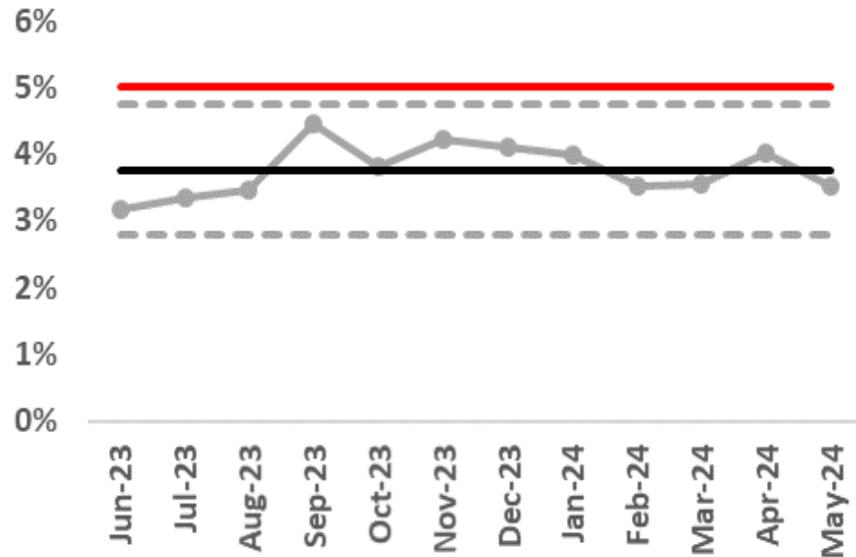
Data Assurance: tbc

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Operating Plan Performance

Operating Plan Performance: Elective Inpatient

TREND

Elective Inpatients variance from Plan
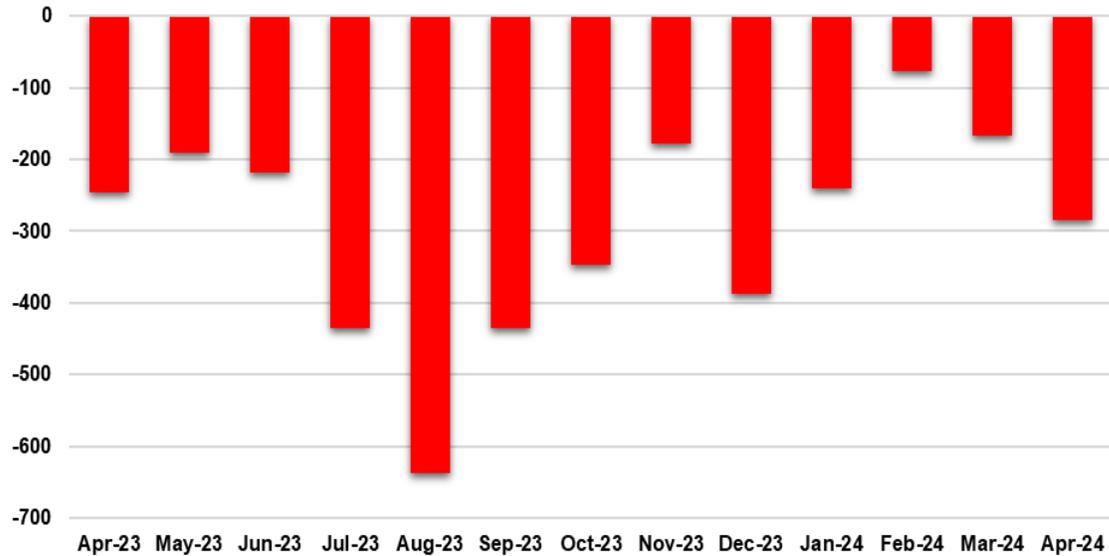
NARRATIVE

Performance: Elective activity improved following industrial action earlier in the year.

Recovery Plan: Additional insourcing was sourced for Quarter 4 and into the new financial year providing this is below tariff and elective funding remains available.

Improvements: CWFT, ICHT and THH are over-delivering on ERF overall.

Forecast Risks: Further junior doctor industrial action

CURRENT PERFORMANCE

	Current Month - Apr-24				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	489	577	88	18.0%	489	577	88	18.0%	489	577	88	18.0%
ICHT	1,233	1,155	-78	-6.3%	1,233	1,155	-78	-6.3%	1,233	1,155	-78	-6.3%
LNW	970	701	-269	-27.7%	970	701	-269	-27.7%	970	701	-269	-27.7%
THH	211	185	-26	-12.3%	211	185	-26	-12.3%	211	185	-26	-12.3%
APC	**2,903**	**2,618**	**-285**	**-9.8%**	**2,903**	**2,618**	**-285**	**-9.8%**	**2,903**	**2,618**	**-285**	**-9.8%**

STRATIFICATION
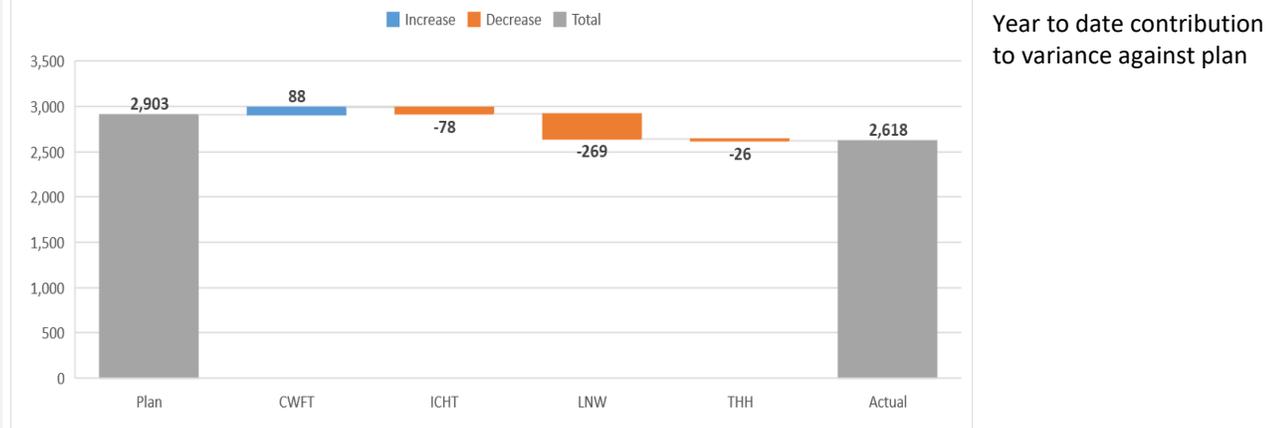
Year to date contribution to variance against plan

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

Elective Daycase variance from Plan
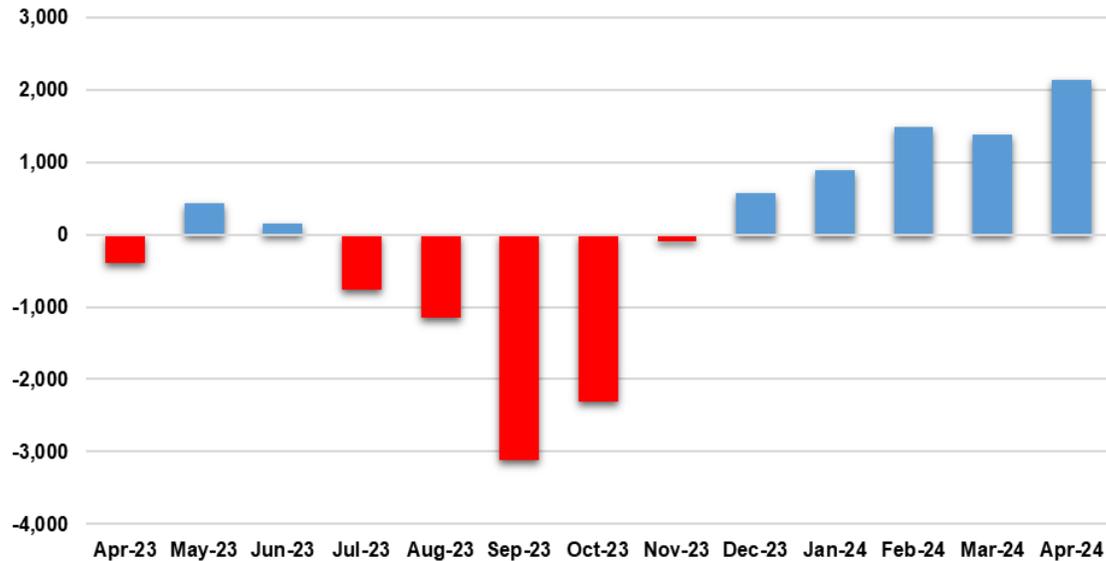
NARRATIVE

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. LNW are still in a recovery process with weekly oversight meetings.

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

CURRENT PERFORMANCE

	Current Month - Apr-24				Quarter to Date				Year to Date			
	Plan	**Actual**	**Var**	**% Var**	**Plan**	**Actual**	**Var**	**% Var**	**Plan**	**Actual**	**Var**	**% Var**
CWFT	4,816	5,831	1,015	21.1%	4,816	5,831	1,015	21.1%	4,816	5,831	1,015	21.1%
ICHT	8,800	9,231	431	4.9%	8,800	9,231	431	4.9%	8,800	9,231	431	4.9%
LNW	6,856	6,623	-233	-3.4%	6,856	6,623	-233	-3.4%	6,856	6,623	-233	-3.4%
THH	1,937	2,848	911	47.0%	1,937	2,848	911	47.0%	1,937	2,848	911	47.0%
APC	**22,409**	**24,533**	**2,124**	**9.5%**	**22,409**	**24,533**	**2,124**	**9.5%**	**22,409**	**24,533**	**2,124**	**9.5%**

STRATIFICATION

Year to date contribution to variance against plan

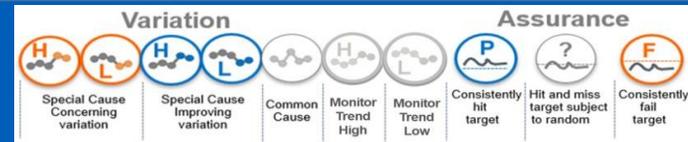## GOVERNANCE
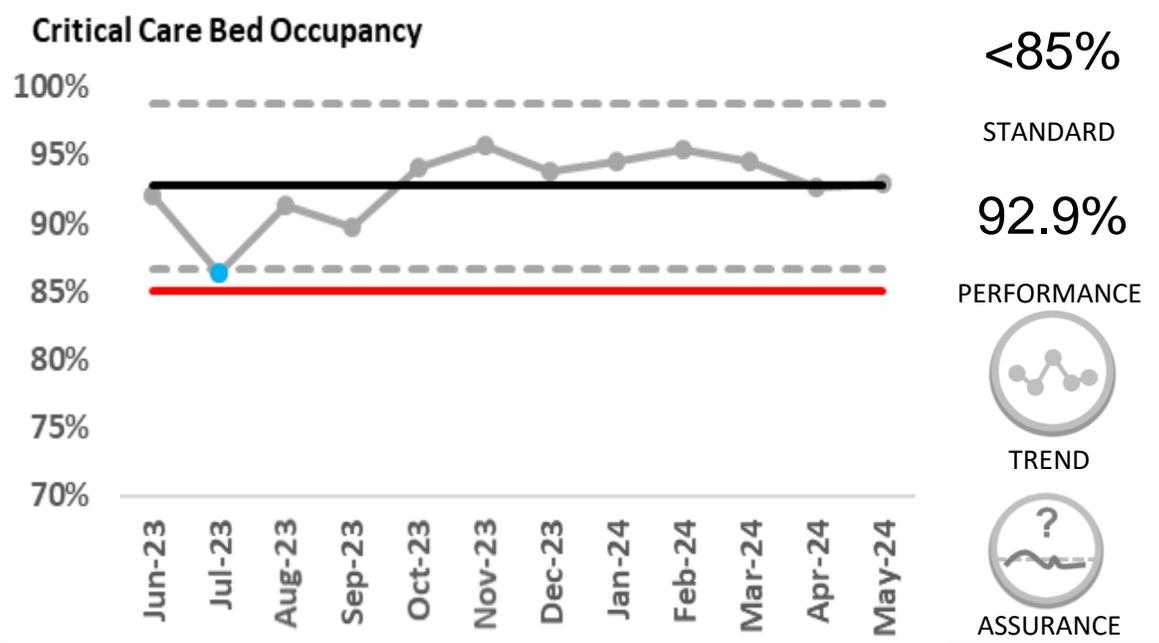
Senior Responsible Owner: Tina Benson, COO, THH

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

Data Assurance: tbc

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Operating Plan Performance: Outpatient New

TREND

Outpatient New variance from Plan
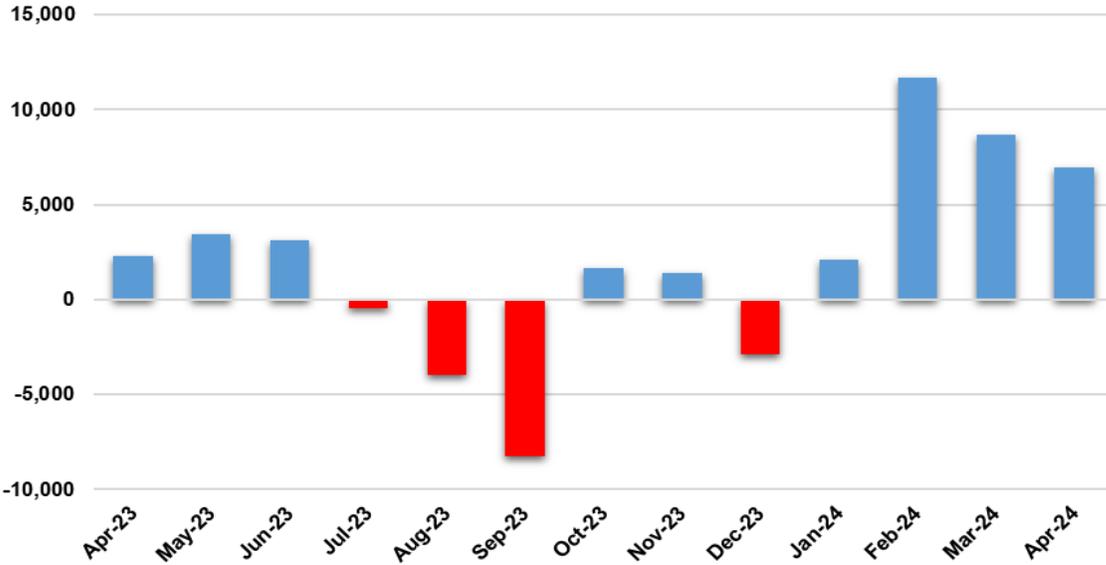
NARRATIVE

Performance: Outpatient New activity across the sector is above plan in-month and is on plan for 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. THH are investigating a reporting/mapping issue affecting both outpatient new and procedures

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.

CURRENT PERFORMANCE

	Current Month - Apr-24				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	16,377	21,600	5,223	31.9%	16,377	21,600	5,223	31.9%	16,377	21,600	5,223	31.9%
ICHT	19,493	22,434	2,941	15.1%	19,493	22,434	2,941	15.1%	19,493	22,434	2,941	15.1%
LNW	24,385	23,548	-837	-3.4%	24,385	23,548	-837	-3.4%	24,385	23,548	-837	-3.4%
THH	8,342	7,978	-364	-4.4%	8,342	7,978	-364	-4.4%	8,342	7,978	-364	-4.4%
APC	**68,597**	**75,560**	**6,963**	**10.2%**	**68,597**	**75,560**	**6,963**	**10.2%**	**68,597**	**75,560**	**6,963**	**10.2%**

STRATIFICATION
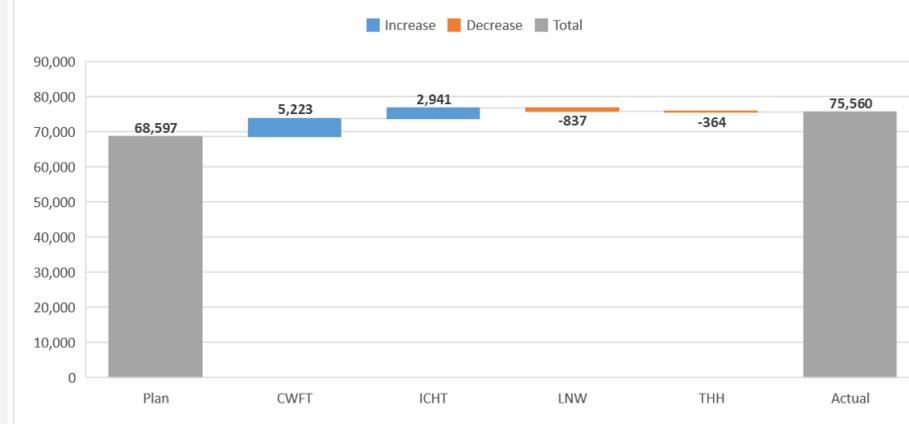
Year to date contribution to variance against plan

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

Workforce Performance

An overview of performance against all indicators, is shown in the balanced scorecard, using statistical process control variation assurance. In summary, there are no workforce metrics currently performing as special cause concerning variation with all four Trusts meeting the Acute Provider Collaborate agreed targets; (vacancy, sickness, turnover & core skills).

Vacancy rates at collaborative level are consistently hitting target and show common cause variation. Since August 2023, the collaborative vacancy level has maintained below the agreed target of 10.0% and in May 2024 was 9.4%. This performance 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 10.6% 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.

Sickness levels are within seasonal normal range and for May 2024 are collectively at 4.0%; meeting the agreed 4.0% target and a common cause variation. 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 May 2024 was 2.5% 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 twelve months with the metric continuing as 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 62% of total workforce. To enable the ACP to achieve its 2025 MEG goals, each senior pay band needs to reflect 62% 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.
• Industrial action planning and preparedness.

Workforce Vacancies

Variation: Special Cause Concerning variation | Special Cause Improving variation | Common Cause | Monitor Trend High | Monitor Trend Low

Assurance: Consistently hit target | Hit and miss target subject to random | Consistently fail target

TREND

Acute Collaborative - Vacancy Rate %

=/<10%

STANDARD

9.4%

PERFORMANCE

TREND

ASSURANCE (P)

CURRENT PERFORMANCE

Vacancies

	Target %	Month 02 Vacancy Rate %	Variance to Target %	Vacancy WTE
CWFT	10%	6.8%	3.2%	500
ICHT	10%	10.3%	-0.3%	1,602
LNW	10%	10.5%	-0.5%	1,016
THH	10%	7.5%	2.5%	281
APC	**10%**	**9.4%**	**0.6%**	**3,398**

STRATIFICATION

Trust proportion of vacant WTE across the APC Month 02

THH, 8%
CWFT, 15%
LNW, 30%
ICHT, 47%

NARRATIVE

Performance: Vacancy rates at collaborative level are consistently hitting target and are common cause variation. Since August 2023, the collaborative vacancy level has maintained below the agreed target of 10.0% and in May 2024 was 9.4%. This performance 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.

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

GOVERNANCE

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

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Workforce Vacancies by Staff Group

Acute Trusts Staffing Group Vacancies - May 2024	Post WTE	Staff Inpost WTE	Vacant WTE	Vacancy Rate %
Admin & Clerical (bands 1/2/3/4/5/6)	4,936	4,479	457	9.3%
Allied Health Professional (Qualified bands 5+)	2,095	1,857	238	11.4%
Allied Health Professional (Unqualified bands 2/3/4)	367	295	72	19.6%
Ancillary	1,582	1,377	205	12.9%
Doctor (Career Grade)	252	216	36	14.3%
Doctor (Consultant)	2,329	2,185	143	6.2%
Doctor (Training & Trust Grade)	3,529	3,325	204	5.8%
Nursing & Midwifery (Qualified bands 5+)	12,178	10,997	1,181	9.7%
Nursing & Midwifery (Unqualified bands 2/3/4)	3,830	3,452	378	9.9%
Pharmacist	471	483	-12	-2.6%
Physician Associate	45	49	-4	-8.9%
Scientific & Technical (Qualified bands 5+)	1,517	1,392	125	8.2%
Scientific & Technical (Unqualified bands 2/3/4)	883	778	105	11.9%
Senior Manager (non-clinical bands 7/8/9/VSM)	2,225	1,954	272	12.2%
Other Staff	4	4	0	0.0%
Totals	36,242	32,844	3,398	9.4%

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 9.4% which has reduced by 0.5 percentage points over the past twelve months; in May 2023 the collective vacancy rate was 9.9%.

Qualified nursing and midwifery roles have a 9.7% vacancy rate representative of 1,181 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 19.5% of current vacancies are non-clinical roles below band 7; 457 WTE admin & clerical and 205 WTE ancillary roles.

Qualified scientific & therapeutic (125 WTE) account for 3.7% of the current vacancies.

Clinical support roles at bands 2, 3 & 4 total 446 WTE / 13.1% of current vacancies.

Medical vacancies totalled 383 WTE at the end of May 2024.

56

Variation

Special Cause Concerning variation	Special Cause Improving variation	Common Cause	Monitor Trend High	Monitor Trend Low

Assurance

Consistently hit target	Hit and miss target subject to random	Consistently fail target

TREND

Acute Collaborative - Turnover Rate %

=/<12%

STANDARD

10.6%

PERFORMANCE

(L) TREND

(P) ASSURANCE

CURRENT PERFORMANCE

Voluntary Turnover

	Target %	Month 02 Turnover Rate %	Variance to Target %	Voluntary Leavers WTE (rolling 12 months)
CWFT	12%	11.8%	0.2%	642
ICHT	12%	10.1%	1.9%	1,186
LNW	12%	11.1%	0.9%	642
THH	12%	9.6%	2.4%	244
APC	**12%**	**10.6%**	**1.4%**	**2,714**

STRATIFICATION

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

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 10.6% which is below the APC target of 12.0%.

All Trusts are currently tracking below the 12.0% target and 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. The development of a careers hub is underway.

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

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

57

Workforce Sickness Absence
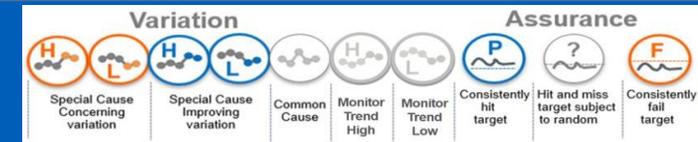
TREND

Acute Collaborative - Rolling Sickness Rate %

=/<4%

STANDARD

4.0%

PERFORMANCE

TREND

ASSURANCE
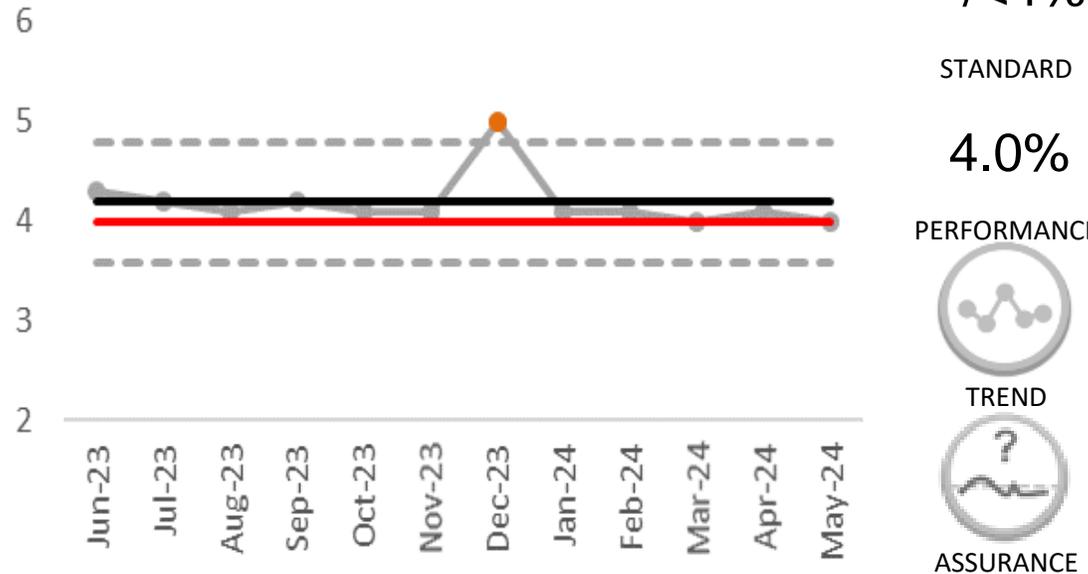
CURRENT PERFORMANCE

Rolling Sickness Absence

	Target %	Month 02 12 Month Rolling Sickness Absence Rate %	Variance to Target %	Month 02 In-Month Sickness Absence Rate %
CWFT	4%	3.9%	0.1%	3.7%
ICHT	4%	4.0%	0.0%	3.6%
LNW	4%	4.2%	-0.2%	4.0%
THH	4%	4.9%	-0.9%	4.8%
APC	**4%**	**4.0%**	**0.0%**	**3.7%**

STRATIFICATION

12 Month Rolling Sickness Absence Rate % across the ACC Month 02
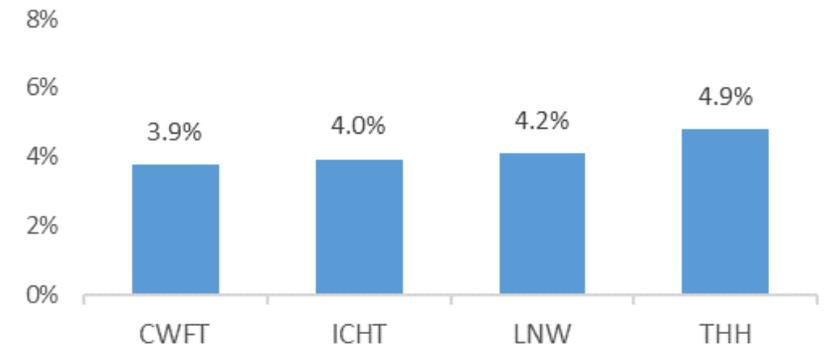
NARRATIVE

Performance: Within seasonal normal range and for May 2024 are collectively at 4.0%; meeting the agreed 4.0% target and a common cause variation. 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 seasonal illness waves.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

Productivity - Agency Spend

Variation

H L	H L		Monitor Trend High	Monitor Trend Low
Special Cause Concerning variation	Special Cause Improving variation	Common Cause	Monitor Trend High	Monitor Trend Low

Assurance

P	?	F
Consistently hit target	Hit and miss target subject to random	Consistently fail target
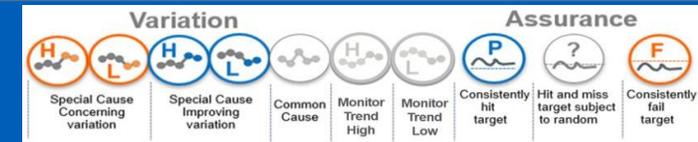
TREND

Acute Collaborative - Agency Spend % of Paybill
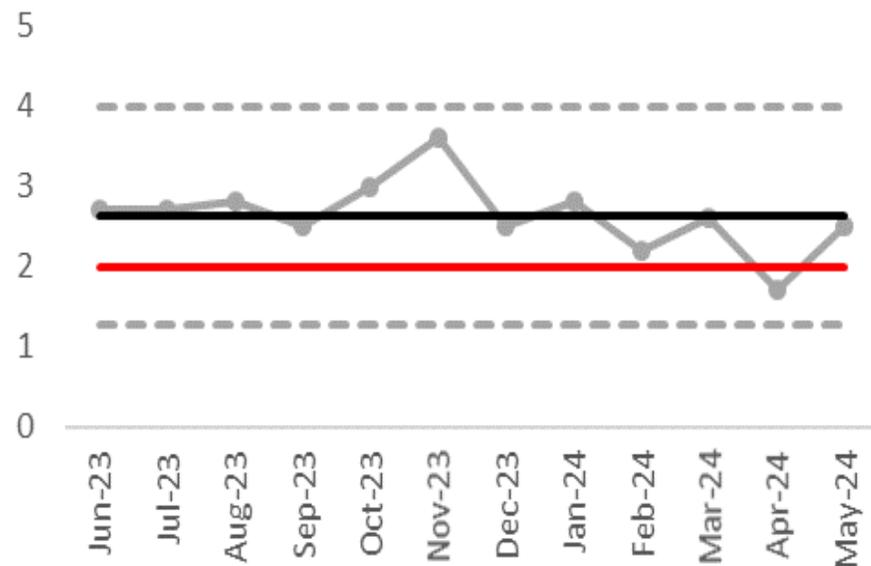
=/<2%

STANDARD

2.5%

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Productivity - Agency Spend

	Target %	Month 02 Agency Spend Rate %	Variance to Target %	Agency Spend £ (in Month)
CWFT	2%	2.0%	0.0%	899,595
ICHT	2%	1.5%	0.5%	1,373,476
LNW	2%	2.1%	-0.1%	1,127,111
THH	2%	8.5%	-6.5%	1,856,115
APC	**2%**	**2.5%**	**-0.5%**	**5,256,297**

STRATIFICATION

Proportion of agency spend (£) by Trust across the APC For Month 02

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 May 2024 was 2.5% and is a common cause variation; however this masks a significant spend on agency at THH which is being actively tackled.

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 and industrial action.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

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Variation

Assurance

TREND

Acute Collaborative - PDR Completion Rate %

=/<95%

STANDARD

89.9%

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Non Medical PDR

	Target %	Month 02 PDR / Appraisal Rate %	Variance to Target %
CWFT	95%	84.6%	-10.4%
ICHT	95%	96.7%	1.7%
LNW	95%	86.5%	-8.5%
THH	95%	80.0%	-15.0%
APC	**95%**	**89.9%**	**-5.1%**

STRATIFICATION

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

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 and potential further industrial action.

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

Workforce Core Skills Compliance
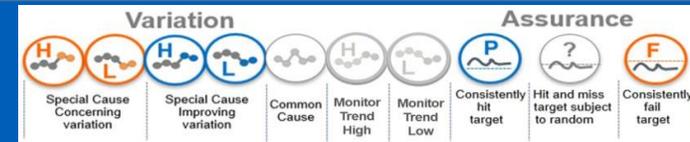
TREND

Acute Collaborative - Core Skills Rate %
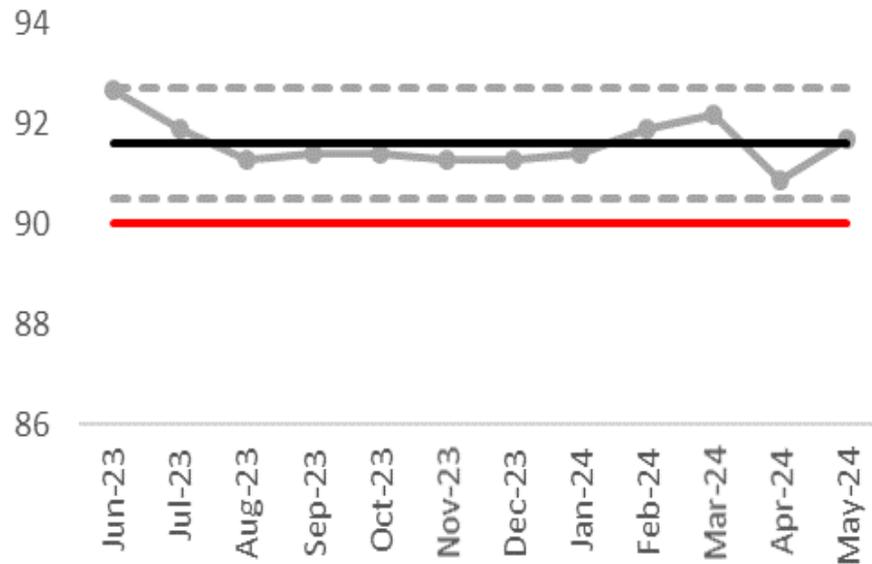
=/<90%

STANDARD

91.7%

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Core Skills Compliance

	Target %	Month 02 Core Skills Compliance Rate %	Variance to Target %
CWFT	90%	90.9%	0.9%
ICHT	90%	94.6%	4.6%
LNW	90%	88.8%	-1.2%
THH	90%	92.1%	2.1%
APC	**90%**	**91.7%**	**1.7%**

STRATIFICATION

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

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

Forecast Risks: None

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

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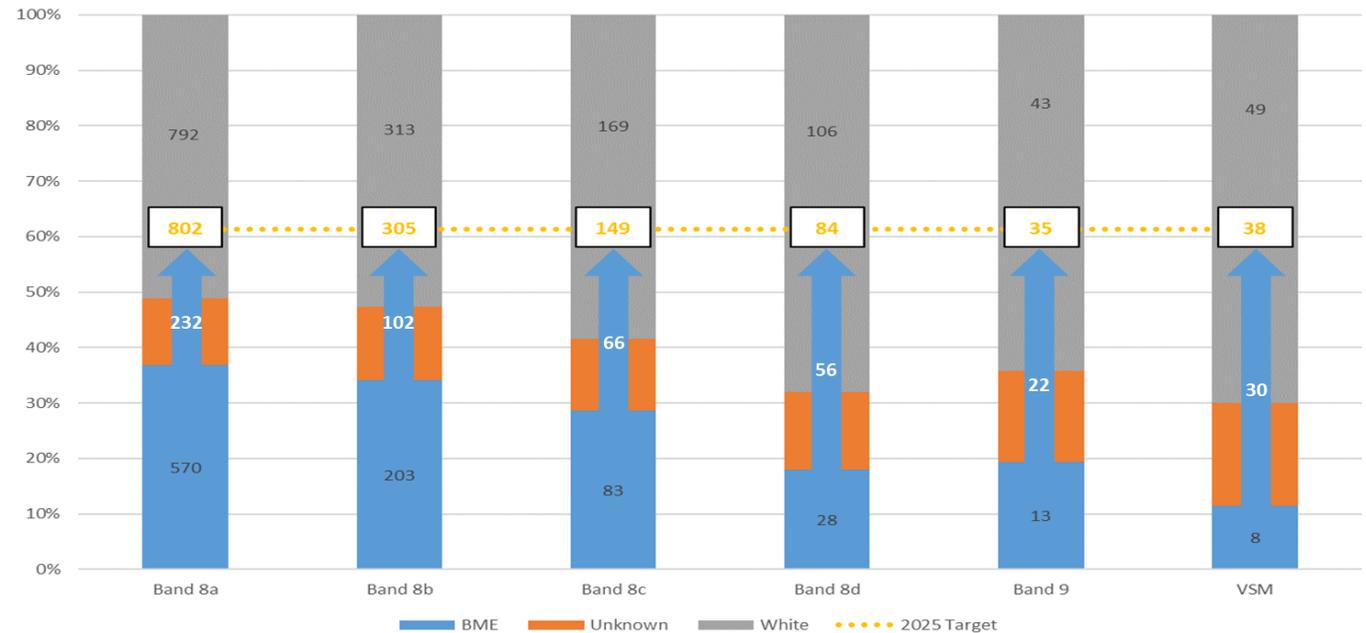
Actions being taken and developed to support MEG goals across the ACP at trust level are as follows (but not limited to);

- 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

62
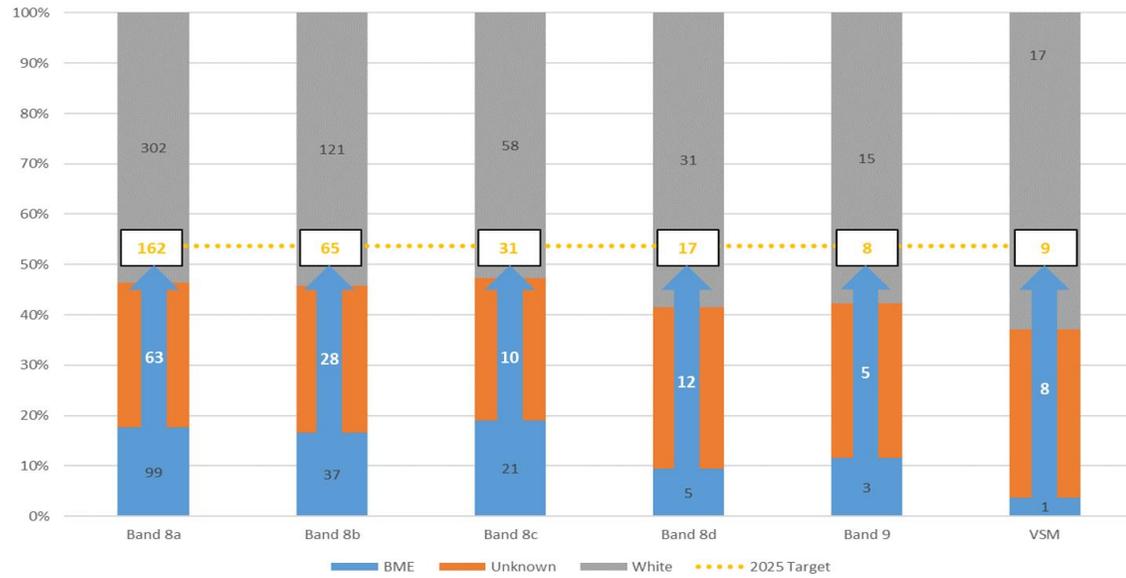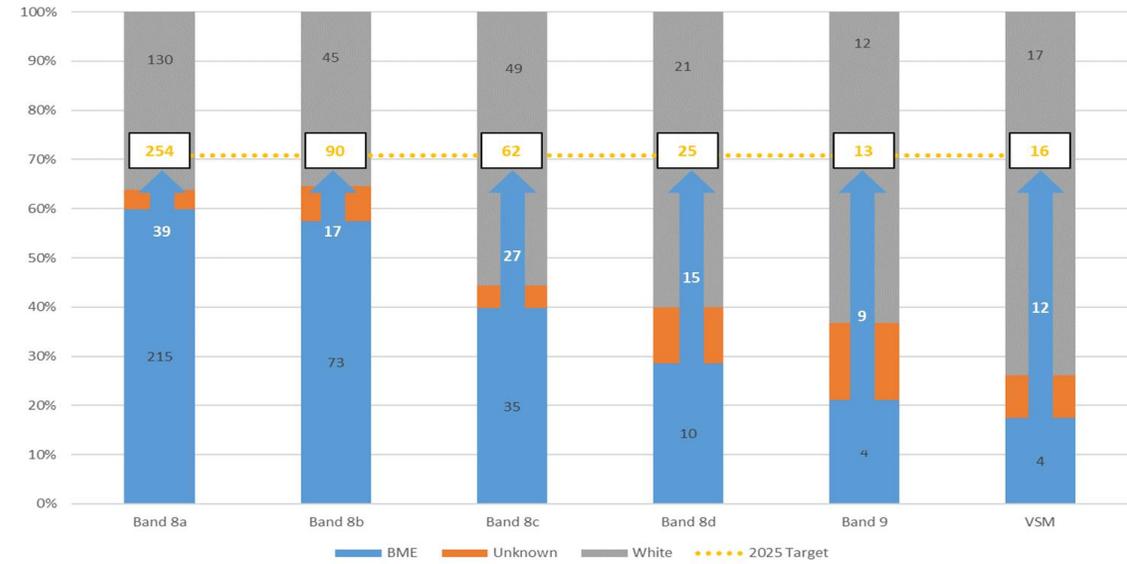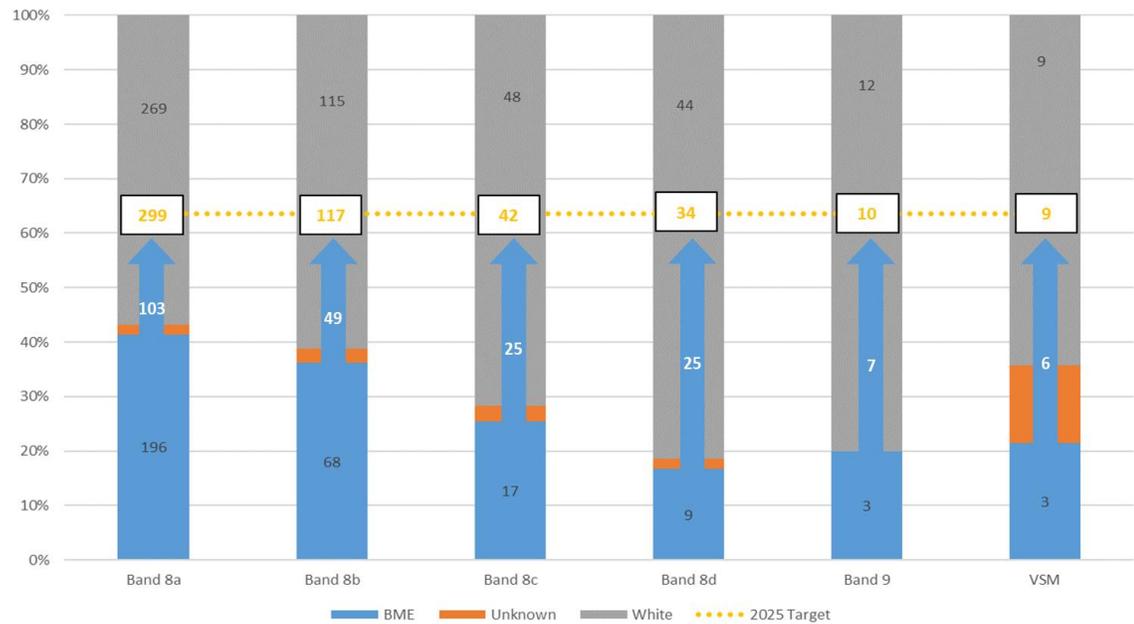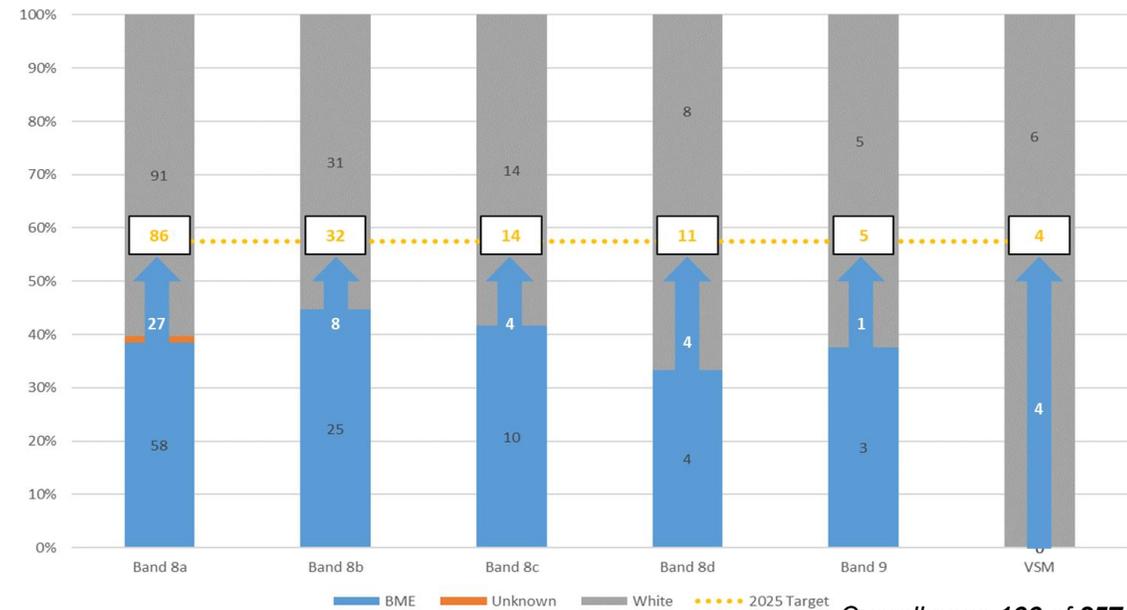
Finance

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 2 (May).

Performance:

- At Month 2, the APC reported a deficit of £23.9m against a year-to-date plan of £6.1m, a £17.8m adverse variance to plan. All four trusts report adverse variances to plan.

- The main drivers of the adverse variance are:
  - Undelivered CIPs : CIP delivery in the month is £11.7m against a plan of £20.7m YTD, thus reporting a £9.1m adverse variance in the month. 56% of the YTD plan is reported as delivered with 8% (£1.6m) via non recurrent means. The rate of CIP delivery improved in month 2 at £7.7m delivered compared to £4m in month 1.
  - Mitigations included in the financial plan which have not commenced as at month 2, such as the System Optimisation Proposal and the Business Case Review project.
    - The System Optimisation Proposal is in progress. A meeting was held with Mental Health partner organisations on 20 June 24 to formalise the workstreams including identification of leads and agreement of task and finish groups. There are two work programmes : Focus on discharges & medically optimised patients and Mental Health models of care.
    - The outcome of the business case review has been presented by Hunter Healthcare and the APC is working through the proposals, many of them overlap with the current workstreams in the APC Business Plan.
  - Operational pressures: all trusts have winter beds open in the first two months of the year and report continuing pressure on supporting mental health patients.
  - Excess inflation : inflation over funded levels contributes to the overall adverse variance. Teams are confirming the values

Financial Performance Escalation :

- A Peer to Peer CFO meeting was held on 14th June 24 to check and challenge Month 2 financial performance whereby several actions were agreed, including the strengthening of grip and control measures in all organisations. It has been agreed a further Peer Review session to be held in July to review Q1 performance which will include the preparation and discussion of forecast recovery plans

TREND

Financial Delivery YTD (I&E)

(£6.1m)
STANDARD

(£23.9m)
PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Financial Delivery (I&E)

	Financial Delivery I&E YTD £'000	Variance from target	
		YTD £'000	FOT £'000
CWFT	(2348)	(1958)	-
ICHT	(4085)	(1500)	-
LNW	(8532)	(6292)	-
THH	(8961)	(8064)	-
APC	**(23,926)**	**(17814)**	**-**

STRATIFICATION
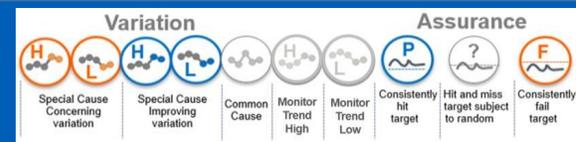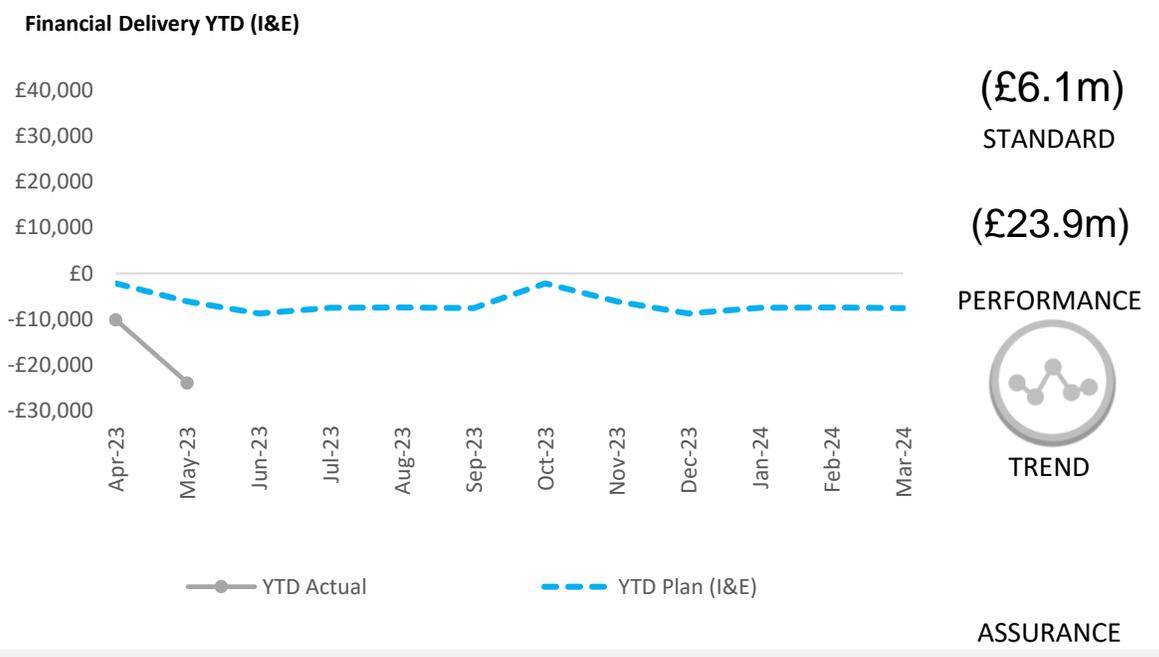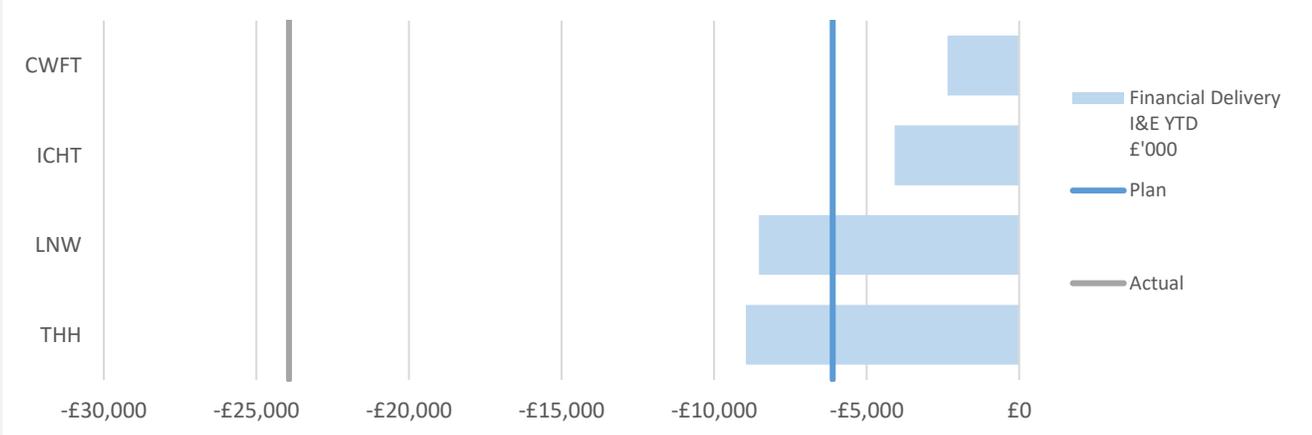
NARRATIVE

Performance: YTD deficit of £23.9m, against a YTD plan deficit of £6.1m, reporting a £17.8 adverse variance to plan.

Recovery plan: Mitigations in the financial plan being in progress : System Optimisation proposal. Business case review work ongoing.

Financial escalation in place with Peer to Peer CFO meeting on 14.o6 and further one in Q1 to review financial recovery plans.

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.

TREND

Financial Delivery YTD (CIP)

Legend: YTD Actual, YTD Plan
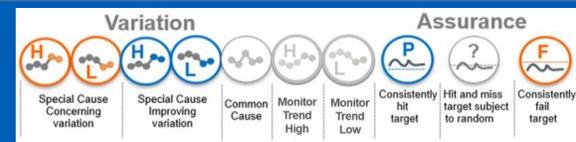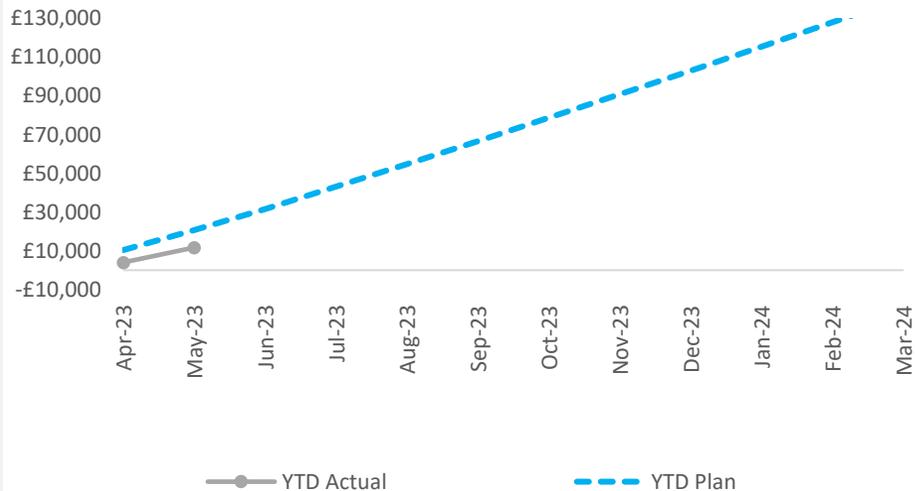
£20.7m
STANDARD

£11.7m
PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Financial Delivery (CIP)

	CIP YTD £'000	CIP Variance YTD £'000	FOT £'000
CWFT	2681	(442)	-
ICHT	5936	(4523)	-
LNW	2472	(2724)	-
THH	612	(1374)	-
APC	**11701**	**(9063)**	**-**

STRATIFICATION

Legend: CIP YTD £'000, Plan, Actual

NARRATIVE

Performance: YTD M2 delivery is £11.7m (56% of M2 YTD plan), split 49% recurrent and 8% non-recurrent schemes. CIP is under delivered by £9.1m YTD. In month delivery is £7.7m, with two trusts CWFT & ICHT meeting CIP plans in the month.

Recovery Plan: Financial escalation in place with Peer to Peer CFO meeting on 14 June 24 and a further meeting in July review financial recovery plans and grip and control measures.

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.

Variation | Assurance

H L Special Cause Concerning variation | H L Special Cause Improving variation | Common Cause | H Monitor Trend High | L Monitor Trend Low | Consistently hit target | ? Hit and miss target subject to random | F Consistently fail target

TREND

Capital Spend YTD

- YTD Actual
- YTD Plan
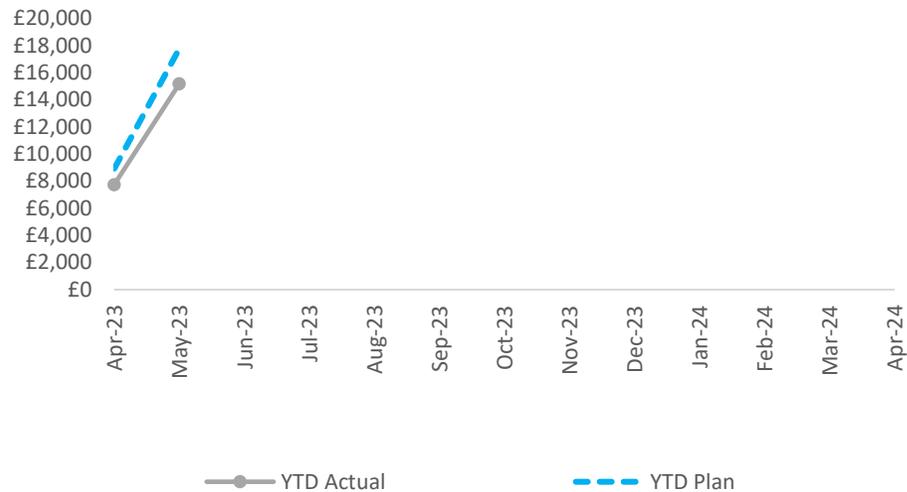
£17.7m

STANDARD

£15.2m

PERFORMANCE

TREND

ASSURANCE

CURRENT PERFORMANCE

Capital Spend

	YTD Spend £'000	YTD Variance £'000	Forecast Spend £'000
CWFT	5228	432	-
ICHT	8534	(2493)	-
LNW	1367	1285	-
THH	60	3372	-
APC	**15189**	**2596**	**-**

STRATIFICATION
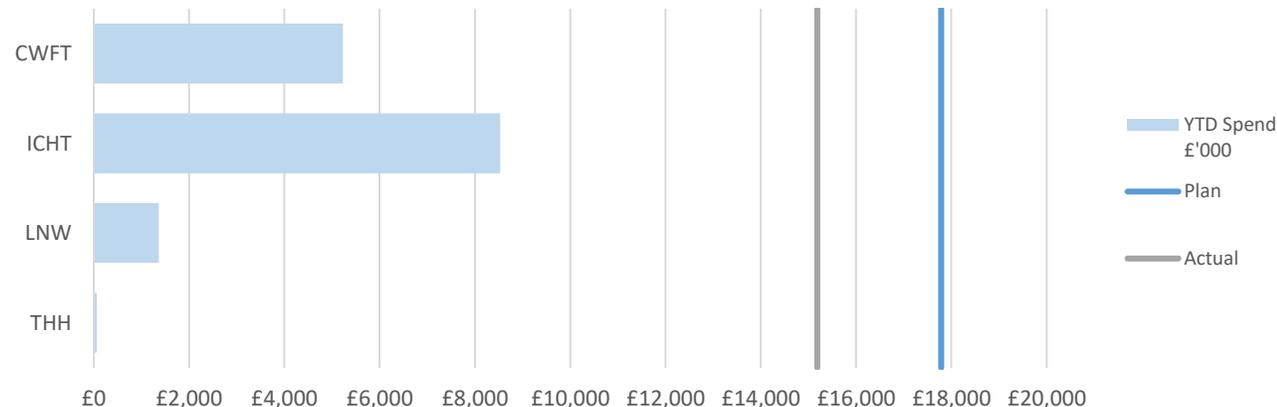
- YTD Spend £'000
- Plan
- Actual

NARRATIVE

Performance: Capital spend is £15.2m, against a YTD plan of £17.8m, therefore a £2.6m underspend reported. There is an overspend at ICHT (due to the acceleration of backlog maintenance programme) and underspends at the other three APC trusts.

The full year capital plan is £239.4.4m of which £52.8m is national capital schemes funded by PDC. The capital plan was increased by £39m in June to account for additional capital funding granted from NHSE.

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.

5.1 COLLABORATIVE QUALITY COMMITTEE CHAIR REPORT

● Discussion Item   👤 Steve Gill   🕐 10.30

REFERENCES

Only PDFs are attached

📄 5.1 Collaborative Quality Committee Chair's Report - June 2024 final.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
June 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.   NWL APC Strategy
2.1.1.   The Committee discussed the draft strategy and were pleased with the excellent work that had taken place so far.

2.1.2.   The Committee agreed that more should be done to strengthen the quality aspects of the strategy together with the key enablers to support implementation. The Committee agreed that the document correctly captures the mechanism for redesigning the clinical pathways, but the quality aspects need to be strengthened, which will be supported by the right narrative. The Committee agreed that the team should accelerate this work so there can be move to actual reporting via the APC dashboard.

2.2.   APC Quality Priorities 2024/25
2.2.1   The Committee received the proposed APC Quality Priorities for 2024/25. Themes for the priorities have arisen from quality insights, including patient safety incident response plans (PSIRPs), and the review of Never Events and Serious Incidents (SIs).

2.2.2   Several priorities will continue from the current year, with the only addition being the introduction of the new national safety standards for invasive procedures (NatSSIPs2). A project group is being set up to deliver the NatSSIPs2 work stream.

2.2.3   The 6 quality priorities for 2024/25 are:

      i.   The implementation of the national patient safety strategy with a focus on procuring and implementing the joint Risk Management System (RMS)
     ii.   Mental health in an acute setting
   iii.   Infection prevention and control
   iv.   Maternity and neonatal standards

<div style="margin-left:2em">

v.   Care of the deteriorating patients

vi.   The implementation of the new NatSSIPs2

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2.2.4   Sufficient time is required to embed the new initiatives and implementation is likely to be a two-year process.

2.2.5   **End of Life Care**: The Committee noted that the work stream has focused on strengthening the priorities around Cerner and streamlining workflows. The key performance indicators have been adjusted due to the data difficulties with the Universal Care Plan (UCP). There has been a change to how the National Audit of End of Life Care (NACEL) is constructed, and efforts have been made to ensure that data input across NWL is consistent to allow for more comparable results when they are released in July.

2.2.6   **Deteriorating Patients**: The Committee noted that three of the four NWL APC trusts have adopted the deteriorating patient CQUIN and achieved their target for Q4. All four trusts have been successful in their bids to join the national pilot for Martha's rule; there have been just under 40 calls and about a third have been relevant calls for help. It was noted that all four trusts will receive some funding as part of this pilot.

2.2.7   **Infection Prevention and Control**: The Committee noted that Hospital Acquired Infections thresholds have not yet been published, but all Trusts continue to work on internal benchmarking. There has been an increase in gram negatives and c difficile. The work stream is keen to compare performance not only in London, but also nationally where the rates of c difficile and gram negatives have increased by 20-30%. A deep dive was undertaken into this increase and it was found that the complexity of cases has increased, as have recurrent admissions. There remains a real appetite to improve access to information and beta lactam antibiotics. However, there are restrictions with resources and funding, and the work stream continues to focus on standardising where possible.

2.2.8   **Mental Health in Acute Trusts**: The Committee noted that a deep dive will be undertaken on the training around de-escalation and restraint to ensure that staff feel safe in all situations. A mental health strategy for the NWL APC is in development.

2.2.9   The Committee noted ongoing concern over the decreasing number of employees in mental health trusts and the significant pressure being applied in the acute sector. Assurance was received that discussions are taking place at ICS level who are looking at the workforce and clinical pathways across the whole system. The Committee requested an update at the September meeting.

2.3   **Learning from Never Events**

2.3.1   A review of all SIs and Never Events was undertaken and the overarching finding was that themes aligned to the Trusts' newly agreed PSIRPs. The local themes not included in 2024/25 APC Quality Priorities, include the safe transfers of patients, medication safety, falls, and pressure ulcers. Thirteen Never Events were recorded across the APC last year.

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. Focus has been given to implementing Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events (LFPSE) and all trusts went live in April as planned. The aims and objectives of the original task and finish group have now been

achieved and there is a plan to formally close this group and move focus to the procurement and transition to the APC wide reporting and learning system, which is planned for full launch by April 2025.

2.5.   APC EDI Improvement Plan 2024 to 2026

2.5.1.   The Committee received the APC EDI Improvement Plan. Following wide engagement, the EDI Steering Group has produced draft recommendations on how to improve the equity of outcomes for patients, communities, and staff.   The recommendations are separated between actions to be done once across the APC and best practices to be implemented consistently within each Trust. The final Action Plan will be recommended to the Board in Common in July.

2.5.2.   The Committee commended the good work that has been undertaken through engagement to formulate a people focussed action plan, but raised concerns that the plan does not sufficiently capture actions from a quality perspective.

2.5.3.   The Committee suggested that the plan includes key areas with known disproportionality of outcomes in relation to ethnicity, focuses on health inequalities and outcomes for specific communities and demonstrates more ambition from a quality perspective. The Committee also discussed the need to agree clear equity metrics which is a work in progress.

2.6.   Learning from Deaths quarterly report

2.6.1.   The Committee reviewed the combined NWL APC Q4 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.   Trust Quality – Function Reports

2.7.1.   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.

2.7.2.   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.

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

2.8.   Collaborative Quality Committee Terms of Reference

2.8.1.   The Committee received the revised terms of reference further to the recent review of APC governance for approval. Changes include references to the delivery of the Collaborative Quality Strategy and associated Strategic Priorities, the reduction of health inequalities, and the Chair of the APC Executive Management Board as an attendee of the meeting. The former assurance role associated with the functioning and effectiveness of local Trust Quality Committees has been removed as this is now a role of the local Trust Standing Committees.

2.8.2.   The Committee agreed that work should be done to map the items that must be formally reported to the public board because this is key to driving the forward plan for the collaborative and standing committees. The Committee noted the

importance of maintaining a collaborative view, internal benchmarking and comparison.

2.8.3. Approval of the terms of reference was deferred so the necessarily updates can be made, but it was agreed that they should be approved ahead of the next meeting.

2.9. Acute Collaborative Quality Performance Report
2.9.1. The Committee received the collaborative quality performance reports. Four SIs were reported at CWFT and ICHT, two were reported at LNWH and one at THHT. The overall upward trend for hospital acquired infections continue, with the exception of MRSA, for which there have been no reported cases across the four trusts in the past month. E. coli was highlighted as a particular concern due to a recent national outbreak. Both ICHT and LNWH have had patients hospitalised as a result of this outbreak. The Venous Thromboembolism (VTE) data for all four trusts is available for the first time via Cerner and does not show any major outliers.

2.9.2. The Committee received the neonatal and maternity performance report. All Trusts are recording below the national average stillbirth rate, with the exception of THHT. Each Trust is undertaking a stillbirth review and will report on key findings to facilitate shared learning. There will also be a review of the 38 suspected brain injury cases. The preterm birth rate is below target for all Trusts with the exception of ICHT which is slightly higher due to the nature of the unit at Queen Charlotte Hospital. One maternal death was reported at LNWH and the incident is being investigated.

2.10. Maternity Quarterly Report Acute Collaborative Themes and Actions including compliance with Saving Babies Lives
2.11.1 The Committee received the quarterly report. The submission date for Year 6 of the Maternity Incentive Scheme has changed to 3 March 2025. All trusts are on track to demonstrate compliance by the deadline, but there is a risk that LNWH and THHT will be unable to submit their national maternity data set due to an issue with the build in Cerner. The teams are working to fix this within a tight timeframe.

2.11.2 The Committee received an update on 'Saving Babies Lives Version 3' and noted that all trusts are above 80% compliance across all elements.

2.12 Maternity Staffing Report
2.12.1 The Committee received the maternity staffing report and noted that each Trust has plans in place to undertake a further Birthrate Plus Workforce Planning review this year. CWFT is the only provider using off-framework agencies at less than 1% and this will cease from July. Significant recruitment has taken place around maternity, with 47 international educated midwives in the pipeline for LNWH and 25 currently undergoing their Observed Structured Clinical Examinations (OSCEs). Three of the trusts have joined the capital midwife wellbeing pilot, as sickness rates are high in all providers and higher than the individual trust targets. The Committee requested that future reports include information on student midwives, medical staffing, allied health professionals, plus actions on retention.

2.12.2 From a neonatal perspective, other than CWFT, all trusts are compliant with qualified in speciality (QIS). CWFT have a plan in place to address this by recruiting at Band 5, with an accelerated development plan in place.

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.
  - 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.

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

- Assurance of the maternity safe staffing paper
- Agreed quality priorities for 24/25
- Recognition that further work needs to be undertaken in the patient inequality agenda outside of the EDI staff action plan
- Concern over the decreasing number of employees in mental health trusts and the significant pressure being applied in the acute sector.

5. Concerns outstanding

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

6. Key actions commissioned

- Initial work will be undertaken to review whether each Trust is providing best practice maternity care in line with published guidance, followed by a separate piece of work on how research and innovation can help to lower the still birthrate across NWL.

- Future maternity staffing reports to include the wider workforce, including student midwives, consultants on the labour ward, junior doctors, and allied health professionals.

7. Decisions made

- The Committee approved the APC quality priorities for 2024/25.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	APC Strategy	To approve	10.	Collaborative Quality Committee Terms of Reference	To approve
2.	APC Quality Priorities 2024/25	To approve	11.	Learning from deaths quarterly reports – Quarter four 2023/24	To discuss
3.	Acute Collaborative Quality Performance Report	To discuss	12.	Agree APC Quality Committee function moving forward	To approve
4.	Work Stream PIDs and Project Updates:	To discuss	13.	Any Other Business	To discuss
5.	National Patient Safety Strategy and Quality System Standardisation	To discuss	14.	Committee forward planner	To note
6.	Maternity Quarterly Report Acute Collaborative Themes	To discuss			

	and Actions including compliance with Saving Babies Lives				
7.	Learning from Never Events	To discuss			
8.	APC EDI Action Plan 2024 to 2026 input	To discuss			
9.	Trust Quality Committee – Function reports	To discuss			

9. Attendance

Members	June 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)	Y
Raymond Anakwe, Medical director (ICHT)	Y
Roger Chinn, Medical director (CWFT)	Y
Alan McGlennan, Chief Medical Officer (THHT)	N
Jon Baker, Medical director (LNWH)	Y
Sarah Burton, Chief nurse (THHT)	Y
Robert Bleasdale, Chief nurse (CWFT)	Y
Janice Sigsworth, Chief nurse (ICHT)	Y
Lisa Knight, Chief nurse (LNWH)	N

5.2 LEARNING FROM DEATHS REPORT

● Discussion Item   ● Jon Baker

REFERENCES
Only PDFs are attached

📕 5.2 Learning from Deaths Q4 Report BiC.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

NHS

NWL Acute Provider Collaborative Board in Common (Public)

16/07/2024

Item number: 5.2

This report is: Public

Acute provider collaborative Learning from Deaths quarter four 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	**Acute Provider Collaborative mortality surveillance meeting**	**Acute Provider Collaborative Quality Committee**
Various	07/06/2024	18/06/2024
Individual trust reports were reviewed at each quality committee and approved for onward submission.	Trust reports were reviewed and the contents of this paper discussed and agreed.	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.

NHS

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 four 2023/24 reports.

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

1.3. Our mortality rates continue to be lower than, or as expected, when compared nationally, with regular review of these occurring both internally and through the APC quality committee. All Trusts have a "lower than expected" hospital standardised mortality ratio (HSMR) for the period January to December 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, although there was an increase in instances of sub-optimal care where different care might have made a difference (ten cases in quarter four compared to one in quarter three). Mortality rates remain consistently low and there are small numbers of incidents reported overall where harm to patients is confirmed as severe or extreme/death. ICHT have identified a theme around patient transfers from cases in this quarter; this has been confirmed as safety improvement priority for 2024/25.

1.5. 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. There were no new common improvement themes identified this quarter although each Trust has identified new areas of local improvement work.

1.6. All Trusts are investigating variations between observed and expected deaths by diagnostic group on an on-going basis. Reviews undertaken in quarter four were presented to the APC mortality surveillance group in June. No new risks or themes were identified.

1.7. Trusts continue to use standardised Level 2 mortality review triggers and outcomes to support improved comparison of outcomes and identification of cross-trust learning. The APC mortality surveillance group has reviewed how each Trust screens, refers, and completes these reviews and identified some variation across our organisations. The group agreed to accept these differences as reporting and outcomes have now been aligned.

1.8. The APC mortality surveillance group continues to review variation in palliative care clinical coding processes across our organisations. Local improvement work is underway at LNW to improve accuracy of coding and to ensure it reflects the palliative care support the patients were receiving, which has resulted in an initial increase in their rate, in line with national average.

Strategic priorities

Tick all that apply

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

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

Impact assessment

Tick all that apply

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

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

Main report

2.   **Learning and Improvements**

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

2.2.   There are no issues for escalation to this committee.

2.3.   The key theme for improvement from reviews undertaken in this quarter relates to care at the end of life, including recognition and timely referral to palliative care, agreement and documentation of advanced care planning/treatment escalation plans and the involvement of patients and families in these processes. This is a consistent theme 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 continue to 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 continue to identify the importance of recognising and responding to patients who deteriorate. As trust wide safety improvement programme is in place; learning and improvements identified through these reviews have been fed into that programme. An additional theme has been identified involving patients when they are being transferred internally or between different sites/trusts. This has also been picked up through incidents. A review of the trust transfer policy is underway, and this has been confirmed as a safety improvement programme priority for 2024/25.
- **LNW:** reviews have identified good communication between teams, patients and families and the need for timely MDT reviews to make decisions on ceilings of care when patients are recognised as being in the last days of life. Trust guidelines, patient information and local inductions have been updated to reflect the learning from mortality reviews.
- **THH:** reviews identified evidence of prompt assessment and management of patients and good MDT team working and discussions with families around end-of-life care and ceilings of treatment.

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 these mortality rates at Trust and APC level are included in the clinical outcomes performance report and in the appendix of this report.
3.2.3   HSMR and SHMI diagnostic group data is reviewed by the APC mortality surveillance group, with variation noted. Trusts are now regularly reviewing diagnostic groups with a score above 100, or increasing, to understand the differences. Reviews undertaken in quarter four include:
3.2.4   **ICHT:** Multiple myeloma, Leukaemia, and Other lower respiratory diseases. No new clinical concerns identified and assurance provided that learning from death processes were followed in all cases. A review of Acute Myocardial Infarction is underway and will be summarised in the quarter one report.
3.2.5   **LNW:** Cardiac arrest and ventricular fibrillation, and Other psychoses. Reviews did not identify any new issues or emerging risks.
3.2.6   **THH** are reviewing the following groups: Other Perinatal Conditions, Hypertension complicating pregnancy, childbirth and the puerperium, Poisoning by other medications and drugs, and Gastroduodenal ulcer (except haemorrhage). Outcomes will be summarised in the quarter one report.
3.2.7   There were no diagnostic groups requiring further review at CWFT.

3.2.8 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	Jan 23 to Dec 23
ICH (St Mary's)	67.7
ICH (Charing Cross)	72.7
ICH (Hammersmith)	78.0
CWFT (ChelWest)	64.7
CWFT (West Middx)	74.1
HH (Hillingdon)	88.0
LNW (Northwick)	88.6
LNW (Ealing)	80.2
LNW (St Mark's)	72.3
National Benchmark	100.0

3.2.9 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 four.

3.3.2 Trusts continue to work collaboratively via a NWL task and finish group to expand medical examiner scrutiny to all non-coronial deaths occurring in NWL boroughs ahead of this becoming statutory in September 2024 (delayed from 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, both Trusts have received similar levels of referrals from non-acute sector compared to Q3.

3.3.4 All four Trusts have started to provide weekend ME scrutiny, prioritising urgent cases i.e. faith deaths requiring urgent body release.

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 four varies across each Trust, from 11% at LNW, 5% at THH, 16% at ICHT and 37% at CWFT.

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 local triggers to be used where potential learning was identified at initial screening by consultants (36% of cases) or for other local reasons such as requests from divisional mortality review groups (6% of cases), this explains the higher percentage referral data.

3.4.3 'Unexpected deaths' was the most frequently used trigger at ICHT (54% of referrals). A review of the use of this trigger was completed during the quarter by end of life and palliative

care lead which found that 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   Concerns raised by family or carers was the highest trigger in LNW and THH in this quarter, accounting for 35% of LNW cases and 64% of THH cases in the period. Referrals made by the Medical Examiner is the most frequently used trigger at CWFT (50% of cases referred).

3.4.5   The APC mortality surveillance group has reviewed how each Trust screens, refers, and completes these reviews and identified areas of convergence and divergence. Outcomes and reports are aligned which ensures Trusts can compare data and identify shared learning and opportunities stemming from mortality reviews and learning from deaths processes. The group agreed to work together to collaborate and share information from local processes to drive improvements rather than attempt to align internal processes at this stage. All Trusts have implemented the CESDI scoring system to identify whether a death was avoidable to produce standard outputs from Level 2 reviews. Ten cases where sub-optimal care might have contributed to the patient's outcome have been identified from completed reviews in this quarter which is an increase from one in the previous quarter.

3.4.6   Despite this increase, overall outcomes continue to show low numbers of cases where definite issues are confirmed through Level 2 review which is reassuring. For quarter four:

- **CWFT**: 82 completed with one case of sub-optimal care that might have made a difference to the patient's outcome.
- **ICHT**: 70 completed with six cases of sub-optimal care that might have made a difference to the patient's outcome, three of which related to patient transfers as described above.
- **LNW**: 50 completed with three cases of sub-optimal care that might have made a difference to the patient's outcome.
- **THH**: 14 reviews have been completed with no cases of sub-optimal care that might have made a difference to the patient's 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   THH have identified several improvements based on outcomes from PMRT reviews that are being taken forward, including changes to patient information and communication. Work is also underway with local partners to improve liaison around LeDeR reviews and outcomes.

3.5.3   ICHT have aligned PMRT and CDOP reviews with adult death review processes for cases where sub-optimal care that could have affected the patient outcome has been identified. Recent PMRT reviews have identified required improvements around bereavement support for parents and actions are underway in the service to produce a

checklist to ensure all families are offered the same opportunities to spend time with their baby and make memories.

3.5.4   Work is underway in LNW to ensure all deaths of patients with learning disability or autism are referred through the LeDeR process. This includes training and educating staff on the role of the Learning Disability Clinical Nurse Specialists.

4.   Areas of focus

4.1.   All Trusts have started work to review ethnicity data relating to deceased patients and now include this data in their quarterly reports.

4.2.   The APC mortality surveillance group reviewed ethnicity data from all four Trusts in June 2024. THH, LNW and ICHT data shows that the same ethnicity categories are in use, with some minor differences in terminology used which could be aligned. CWFT will update systems to report the same going forward.

4.3.   The group discussed the high numbers of deceased patients where ethnicity is not known at ICHT and LNW, which could be issues in clerking or because patients who are acutely unwell on emergency arrival do not have the capacity to provide these details. The group will review ways to increase data accuracy to make analysis more meaningful.

4.4.   Work continues to analyse ethnicity data. All Trusts will include further analysis of ethnicity data and mortality outcomes in Q1 reports.

4.5.   The APC mortality surveillance group continues to review variation in palliative care clinical coding processes across our organisations. There has been an increase in palliative care coding rates in LNW following work to improve accuracy of coding and to ensure it reflects the palliative care support the patients were receiving. All Trusts are now either in line with or above the national rate for HSMR palliative care coding rates, as shown below.

Provider	Dec-23
Imperial	61.16
Hillingdon	50.00
Chelsea & Westminster	53.33
London NWUH	43.53
National Rate	43.87

4.6.   LNW have completed a palliative care coding audit and have identified several 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.

4.7.   Local areas of focus include:

•   ICHT continue to implement standardised Speciality M&M guidance across the Trust so that these reviews are carried out consistently. Specialty teams have identified leads in each area and system training has started for them.

•   THH have continued to adapt mortality surveillance reporting and processes following the implementation of Cerner. Work continues to align Specialty M&M meetings across the Trust and to improve the timeliness of Level 2 review completion.

- LNW recruited two Consultant Mortality Validators in the previous quarter to undertake mortality reviews and completion rates of Level 2 reviews have continued to increase significantly in this quarter.
- All Trusts continue to work together to review current use of our mortality surveillance systems to identify areas of divergence and 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.

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

5.3.   Local reviews into HSMR and SHMI diagnostic groups 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.

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

NHS

Appendix – Clinical outcomes performance report mortality data

(Patient) **Summary Hospital-level Mortality Index**

TREND

100
England Average
STANDARD

n/a
PERFORMANCE

n/a
TREND

n/a
ASSURANCE

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'.

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

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

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

National baseline = 1

Hillingdon

ChelWest

Imperial

London NWH

SHMI

Expected number of deaths

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(Patient) Hospital Standardised Mortality Ratio

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 APCQC.

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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NWL Acute Collaborative committee cover note
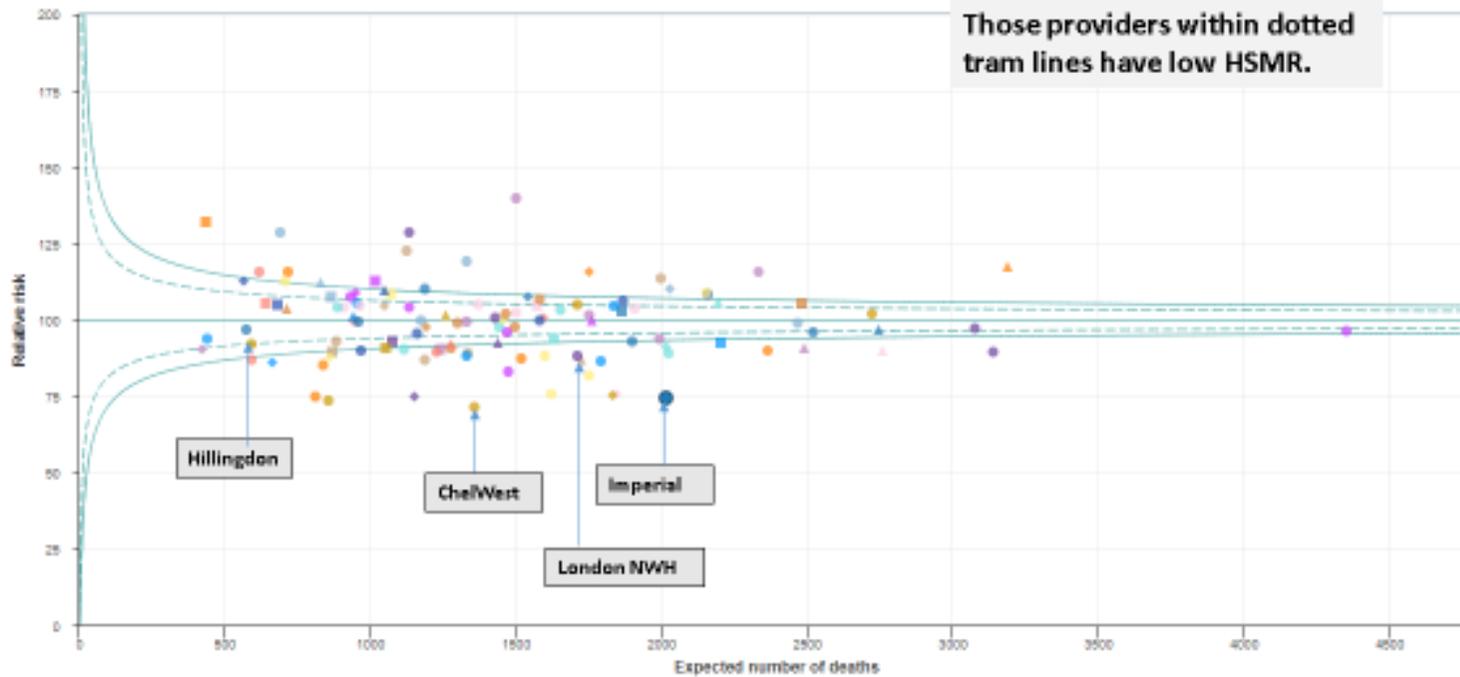
6.1 COLLABORATIVE PEOPLE COMMITTEE CHAIR REPORT

● Discussion Item   👤 David Moss   🕐 10.45

REFERENCES

Only PDFs are attached

📕 6.1 Collaborative People Committee Chair's Report June 24.pdf

North West London Acute Provider Collaborative
Collaborative People Committee Chair's Highlight Report to the Board in Common – for noting
June 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
The Committee received an update on the following points:

- **The Non-Medical Professional Development Review**. CWFT have a focussed programme reviewing their PDR approach and a deep dive was undertaken at their June meeting. Managers have been trained and upskilled and stakeholders are being engaged. THH undertook a deep dive at their local committee in May with divisions agreeing plans to meet targets by the end of June. LNW has implemented a new learning management system with a view to include on-line appraisal system which can be monitored and easily administered. The Committee recognised that a standardised process and format was needed across the collaborative, with a recording process in place and to look at adopting Imperial's approach particularly the operational and quality aspect of it.
- **NWL Workforce Risk Register**: Work is underway around the risk management arrangements for the collaborative. There will be a defined approach to risk management for the collaborative and to ensure that the strategic people risks is aligned to the new approach.

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

- **Reduce premium rate temporary staffing expenditure**: Collective agency spend as a proportion of overall pay bill was 2.6% at the end of the year for 23-24. In month 1 the collaborative agency spend was 1.7% of pay bill against the 2% target. However, there is a variation across the different trusts. Work included looking at rostering system tender as it is relevant to temporary staffing as well as looking at the leavers process.

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- **Elective Orthopaedic Centre workforce transition**: This is now live and is business as usual. Lessons learnt plan is in progress.
- **Recruitment hub for hard to fill vacancies:** There are ongoing initiatives and there was emphasis on the necessity to enhance efforts around international recruitment. The Committee discussed the use of digital AI to help those individual radiographers work more efficiently but recognised that they are not hard to recruit but want to work in a different way. It is about learning from the EOC and the CDC.
- **Careers hub and staff transfer scheme**: The procurement issues are now resolved. There is work to model against another Trust who had an internal transfer scheme. The Non-Executive Directors had established the need to have a centralised defined talent pool to recognise people ready for promotion and to have a more equitable understanding of talent at a higher level.
- **Increase apprenticeship levy uptake:** The utilisation is increasing albeit a different approach is needed. There is borough-based work to try to get around the way that the education is provided to help minimise the backfill issue. The Committee talked the national apprenticeship schemes being utilised by refugees and volunteers which are being run as pilots. As such, a deep dive was proposed for the next meeting around the anchor institution. A few points were raised about the potential income and payment into the national levy, and the national apprenticeship levy being underspent. Income missing
- **Reduce violence, aggression, bullying and discrimination:** These two distinct areas of work will be separated to ensure clearer focus and action going forward. In terms of violence and aggression (V&A), The V&A group with collaborative leads will be reformed. The positive media campaigns across each trusts was noted. The Security Group addresses how to manage incidents for staff, and Imperial are leading on inclusion of data in datix. Hillingdon's CPO will establish a group on learning from each trust. In terms of bullying and discrimination (B&D), the aim is to implement best practices across the Collaborative. The Committee noted that the EDI Summits are looking at tackling leadership diversity in addition to a consistent approach to improve staff experiences. The barriers and leadership report will be shared with the Committee.

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

2.3   The Committee discussed the number of strategies in the Trust and emphasised the need for adequately engaging staff, having a cultural approach and not being at risk of becoming uncontrollable.

3. Positive Assurances Received

3.1   The Committee received positive assurance in the following areas:

1. The People Services Improvement Programme, previously referred to as scaling, was well received. There was significant engagement from staff and the four People Services teams were mapped into 12 functions producing an improvement programme for each. The programme focuses on eliminating waste, simplifying processes, and supporting strategic priorities through digital and data enablers.

2. The Committee was reassured that steps will be taken to address violence and aggression within initiatives such as media campaigns, through various groups such as the Security Group and a group sharing learning from each Trust. Bullying and discrimination best practices will be implemented across the collaborative. There will be a consistent approach in these areas.

3. The APC Strategy will foster a performance-driven culture and will to ensue strategic priorities are met.

4. Key Risks to Escalate

There were no escalation of high level risks from the local people committee.

5. Concerns Outstanding

5.1   The need for a focused discussion on workforce productivity, particularly in relation to pre-covid levels, and to understand the reasons behind productivity changes and to ensure actions are taken to address any declines.

6. Key Actions Commissioned

- The Workforce Risk Report is to be updated and shared with the committee electronically within a week of the meeting, and in time for the next Board in Common. The risks will be at APC level not at the individual trust level.
- A focused piece on productivity analysis is to be prepared for discussion at the next meeting.
- An operational HR report, focusing on employee relations metrics, for discussion twice a year.
- To introduce a staff story section on the agenda focusing on personal safety at work for discussion four times a year.
- The Collaborative Freedom to Speak up Report to be completed once all four trusts have taken their annual report through their respective local committees.

7. Decisions Made

- The Committee approved the revised terms of reference which focused on strategic priorities and roles.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	NWL APC People Priorities 23/24	Information /Noting	6.	NWL Workforce Risk Report	Veral update
2.	People Services Improvement Programme	Information /Noting	7.	Collaborative People Workforce Performance Report	Assurance

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3.	People Strategy, priorities and programmes: up update and way forward	Decision/ Approval	8.	Escalation of high-level risks from local People Committee	Noting
4.	APC Strategy Priorities	Information /Noting	9.	NWL APC Collaborative People Committee Term of Reference	Decision/ Approval
5.	APC EDI Improvement Plan for 2024 to 2026 – draft recommendations	Decision / Approval	10.	Committee Forward Thinking	Discussion

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)	N
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	N

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6.2 APC IMPROVEMENT PLAN ? EDI ACTION PLAN

● Discussion Item   👤 Pippa Nightingale

REFERENCES

Only PDFs are attached

📄 6.2 APC EDI action plan - our people vF 20240701.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)

16/07/2024

Item number: 6.2

This report is: Confidential

APC Equity, Diversity and Inclusion Action Plan 2024 to 2026: Phase 1 - People

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

Accountable director: Pippa Nightingale
Job title: Chief Executive Officer, LNWH

Purpose of report

Purpose: Decision or approval

Approve the recommended actions to promote equity, diversity and inclusion for our people.

Approve establishment of a steering group to investigate, consider and recommend actions for Phase 2 – Patients and communities.

Report history

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

NWL APC Quality Committee	**NWL APC People Committee**	**APC Executive Management Board**
18/06/2024	25/06/2024	05/07/2024
Considered	Considered	Approved

Executive summary and key messages

Our NWL APC hospitals have the most diverse staff in the NHS and we provide care to some of England's most diverse communities. Our statement of intent when forming the NWL Acute Provider Collaborative included our commitments to "continuously work to improve EDI within our workforce".

In 2023 the Board-in-Common agreed immediate actions within the board and its committees to mainstream equity, diversity and inclusion within its discussions and agree metrics to track and prioritise improvements. Alongside this an Action Plan Steering Group was established with representatives drawn from across our organisations and patients to recommend priority interventions to accelerate our progress.

The Group recommends actions we should assure and apply once across our collaborative, including the creation of an Equitable Employer Dashboard, transparency and standardisation across job evaluation and pay awards between our organisations, shared online hub to support international staff, common approach, and training to tackle bullying and harassment, and standardised approaches to making reasonable adjustments. The Group also recommends actions expected to be implemented locally within each trust.

These recommendations are "Phase 1" and focused on our people. We recommend an equivalent group is established for "Phase 2" to focus on the actions our APC should pursue to support higher-quality, equitable patient care and additional contributions we should make in addressing health inequalities amongst our communities. This group should report back before March 2025.

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

Inclusion supports progress on health inequalities that are impacted by discriminatory systems, create a positive environment that attracts and retains the best staff, and addresses unwarranted variation in quality outcomes

Impact assessment

Tick all that apply

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

Promoting equity, diversity and inclusion impacts equity of outcomes, improved quality by addressing unwarranted variation, belonging amongst our workforce and communications and engagement with our communities

Reason for private submission

Tick all that apply

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

Introduction

Our NWL APC hospitals have the most diverse staff in the NHS and we provide care to some of England's most diverse communities. We are committed to lead the NHS in achieving equity and justice. Our statement of intent when forming the NWL Acute Provider Collaborative included our commitments to "continuously work to improve EDI within our workforce".

In 2023 the Board-in-Common agreed immediate actions within the board and its committees to mainstream equity, diversity and inclusion within its discussions and agree metrics to track and prioritise improvements. Alongside this an Action Plan Steering Group ("the Group") was established with representatives drawn from across our organisations and patients to recommend priority interventions to accelerate our progress. The Group was tasked with considering actions to support patients, communities and staff including our collaborative response to the NHSE EDI Improvement Plan.

The Group has met monthly since January. It was co-chaired by two Non-Executive Directors and its membership encompassed executives, EDI experts from each trust and a service user. Between meetings, members have engaged colleagues and stakeholders across our organisations, researched good practice beyond North West London and sought feedback from national experts. Engagement on its recommendations has included the APC Executive Management Board, APC People Committee and APC Quality Committee.

As Phase 1, this action plan sets out the Groups further recommendations on how to improve the equity of outcomes for our people. These recommendations incorporate NHS EDI High Impact Actions. The recommendations are separated between (i) actions which we recommend are done once across our collaborative and (ii) best practices which we recommend are implemented consistently within each organisation. This approach follows our APC strategy to align with best practice, starting with consistently implementing the approach that achieves the best outcomes for our patients and staff in North West London, then continuously improving and innovating together beyond this.

For each action, we have set out the recommended success measure(s), timelines, responsible leads for delivering and board committee accountable for assurance. Following approval of the plan, updates on the progress of milestones, measures, and individual trust actions through to APC committees and the APC EMB will be coordinated using the same best practice approaches we adopt for our wider APC strategy.

The dedicated group with broad membership has been a successful model in considering and developing recommended actions. We recommend establishing an equivalent "Phase 2" group focused on the actions our APC should pursue to support higher-quality, equitable patient care and additional contributions we should make in addressing health inequalities amongst our communities. This group should report back before March 2025.

NWL Acute Collaborative committee cover note

NHS

PRINCIPLES RUNNING THROUGH OUR ACTION PLAN

We want our action plan to make practical, recognised differences to our staff. Our outcomes need to be measurable so that we can ensure out interventions are evidence based and not just performative actions. Across our collaborative, and in line with our APC strategy, we will ensure there is consistency in how we collect and analyse data on important outcomes to help learn, share, and scale good practice. We will have a shared methodology and align our efforts to evidence-based best practices in order to consistency match the best in North West London, then the NHS and then globally.

We will use this evidence and shared learning to support us make proactive interventions. We will be curious and transparent about our outcomes to support continuous improvement, not reliant on having compliant policies, procedures or training programmes. We will share good practice and expertise in making improvements. This will help us prevent inequity and intervene earlier, instead of watching structural inequalities persist and deepen with the negative impact this has on our staff's lives and opportunities.

We are committed across our board in personal learning, development and building confidence to talk about race, diversity, inclusion, and equity. Our board and senior leaders of our organisation will role model the behaviours expected of others, be comfortable with uncomfortable challenge, and listen with attention to the experiences of individuals and the local circumstances in which interventions are implemented.

RECOMMENDATIONS: COLLABORATIVE ACTIONS

Action	What will we do?	What are the benefits of doing this?	What issues and High Impact Actions	How we will know changes are an improvement	What timeline is expected to implement?	Roles/Teams responsible for implementing and

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			does this help us respond to?	(and are then sustained)?		collaborative committee assuring progress
**Actions predominantly impacting our board**
1. Incorporate EDI objectives into 2024/25 board member and executive team appraisals	• All non-executive directors, executive directors and trust executive team members will have two objectives focused on equity, diversity and inclusion • One objective will be an acute collaborative common objective to support changes in how we have conversations about equity and to support system learning and development • The other will be specific to NEDs or Executive Director/Executive team member roles, focused on seeking measurable improvements on a specific, relevant metric at an individual level.	• 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 with respect to EDI.	High Impact Action 1	Track progress against consolidated list of metrics agreed across objectives. Agreed priority outcomes across appraisals will be aggregated into a single list so progress can be tracked by the APC Executive Management Board and updates provided to the Board-in-Common	**By July 2024:** Objectives agreed for 2024/25 and recorded in annual appraisal. Leadership Competency Framework completed by all board members. **By December 2024:** Board discussion held on lessons learnt and refinements of board objective setting process to incorporate into next financial year **By April 2025:** Annual Appraisal review on progress conducted and updated objectives agreed	**Responsibility:** All board members as part of their annual appraisal conversations **Assuring progress:** Collaborative Board-in-Common

2. Strengthen the links between the board and our staff networks	• Add a standing agenda item to the agendas of individual trust People Committees and APC People and Inclusion Committees for reports from Staff Networks	• Creates regular opportunity for standing consideration and feedback from staff networks into board consideration, including sharing good practice on the support offered to staff networks • Promotes learning and sharing across the APC networks	Contributes towards all high impact actions	Feedback from staff networks on the benefits of discussions with board committees	**By October 2024:** Standing agendas are updated	**Responsibility:** EDI leads reporting to the Chief People Officers **Assuring progress:** Collaborative People Committee

<div align="center" style="color:blue">**Actions predominantly impacting our staff**</div>

3. Create an Equitable Employer Dashboard for measuring employment outcomes across the APC and agree targets to track progress	• Create one dashboard shared across the APC on the equity of staff outcomes broken down by race, gender, age and disability. • Indicators disaggregated to include staff at each band, professional group and directorate/division and Trust. • Metrics will include applications for a post, shortlisting success rate,	• Promote transparency of the recruitment pipeline and progress on outcomes and leading indicators for leadership diversity that reflects the	High Impact Actions 2, 4 and 6	Improvements in equity of staff in all senior band, VSM and consultant medical roles that reflects the diversity of our local community *Although progress should*	**By September 2024:** Pilot version with metrics available shared for input and feedback **By January 2025:** Automated dashboard finalised	**Responsibility:** Chief People Officers working with Business Intelligence Teams to ensure data and dashboards incorporated

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	interview success rate, pay gaps, time spent in current band/level, training participation, "stretch opportunities" access (e.g., acting up, secondments, significant projects), sickness rates, access to wellbeing support (e.g., employee assistance programme psychological support), disciplinary processes, reported bullying, harassment, discrimination, and annual turnover. • Dashboard available online and also shared within local People committees, Trust Executive Groups and Board in Common People Committee. All individual Trusts would have access to their information and be able to compare across Acute Provider Collaborative partners. • Include information in the dashboard about data completeness of protected characteristic information in ESR and support communication and campaigns to improve this.	community we serve • Enables sharing and learning of best practice across the APC • Enabler for improvement and progress on other actions and recommendations in this report		*be seen on a number of measures, this has been recommended as the priority because it requires progress on all measures leading up to it including progression in other roles*	**By March 2025:** Agree targets and trajectories of the proportion of Black, Asian and Ethnic Minority staff at AfC Band 7 and above	within analytical portals **Assuring progress:** Collaborative People Committee

	• Use the creation of the dashboard and supporting analysis to set targets and trajectories of the proportion of Black, Asian and Ethnic Minority staff at AfC Band 7 and above to track progress and test whether supportive interventions are having intended effects.					
4. Promote transparency and standardis-ation across job evaluation and pay awards to support pay gap elimination	• Agree a reporting metric across the APC to identify pay gaps reflecting gender, ethnicity and disability and include this in the Diversity Dashboard • Agree a standard methodology for Consultants Excellence Awards • Conduct review into the consistent application of job evaluation criteria and assuring appropriate banding for equivalent roles across the APC, with special consideration of AfC Bands 2-5 where pay is lower and a higher proportion of global majority colleagues are employed	• Ensures awards including temporary or extra payments from acting up are reflected and consistent across the APC. • Improves robustness of area management understanding of the commitment	High Impact 3	Reduction in pay gaps across disability, gender and race	**By September 2024:** Agreed APC reporting metric on pay gaps **By November 2024:** Agreed standard methodology for Consultants Excellence Awards to use for 2025-2026 financial year **2025-2026:** Conduct consistent application of job evaluation criteria review	**Responsibility:** Chief People Officers **Assuring progress:** Collaborative People Committee
5. Develop and implement a digital overseas staff	• Establish an APC-wide international staff network,	• Create a greater sense of belonging and	High Impact 5	Reduction in bullying, harassment, discrimination	**By October 2024:** Launch APC-wide international staff network	**Responsibility:** Chief Nursing Officers

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| "app" and/or online hub that supports their induction, captures overseas staff experience to support improvements and provides on-going support | open to international staff and allies
• Supported by the APC International Staff Network to inform co-design, then create a digital, dedicated environment across the APC that provides information prior to induction (e.g., common FAQs, accommodation, life in the UK), captures information on their experience to support improvements and on-going networks to support wellbeing (e.g., social and community groups, wellbeing resources, training opportunities, explaining policies/practices).
• Implement the Overseas Medical Training Hub
• Tailor exit interviews to have targeted questions to better understand, measure and act upon the experience of international recruits
• Create training programme for managers on supporting international recruits, including adopting proactive behaviours in seeking feedback and understanding of recruits experiences, and increasing their awareness to | acceptance as equal colleagues
• Ensure dedicated, consistent resources and information provided to colleagues recruited internationally
• Promote connections across APC organisations, where greater scale means more potential for tailored and localised international communities and connections | | and disciplinary and grievances related to international staff and Black, Asian and Minority Ethnicity Staff

Improvement in Staff Survey question: "My organisation takes a positive interest in my health and wellbeing" when filtered just for staff who were recruited internationally | **By December 2024:** Implement the Overseas Medical Training Hub

By December 2024: Updated Exit Interviews to incorporate bespoke feedback from international colleagues

By April 2025: Launch digital platform for international colleagues | **Assuring progress:** Collaborative People Committee |

			High Impact 6			
	• discriminatory behaviours including "othering" • Use insights from the App/digital platform and APC-wide network to support future initiatives and on-going improvements					
6. Implement a common approach in supporting colleagues across the APC in tackling bullying, discrimination, harassment and physical violence, with a specific focus on addressing the worse experiences of Black, Asian and Ethnic Minority colleagues	• Implement common, zero tolerance policies on defining and responding to bullying, discrimination, harassment and physical violence from patients, staff and managers. • Create training, steps and interventions with specific focus on the worse experiences of our teams, especially bullying and harassment of Black, Asian and Ethnic Minority staff, bullying and harassment of staff with disabilities, bullying and harassment of LGBTQ+ colleagues and sexual harassment. This training will be compulsory for managers, demonstrated by passing assessment every two years. Manager training will include acting decisively and effectively on issues, and how to create inclusive cultures, such as how to be proactive, preventative and to sense	• Demonstrate consistent curiosity, commitment and culture against tackling negative experiences. This curiosity and consistency is very important as staff will work across and between our organisations in the future • Active allyship training offers valuable life skills beyond work, and will support just and constructive resolutions • Freedom to speak up will support safe and supportive	High Impact 6	Number of staff who have undertaken active bystander training Reduction in NHS Staff Survey scores on experiences of bullying, harassment, discrimination and physical violence whether from patients, other staff or managers for Black, Asian and Minority Ethnicity Staff, staff with disabilities, and LGBTQ+ staff	**By October 2024:** Recruit APC Freedom to Speak up and Race Ambassadors **By December 2024:** Complete "active bystander" procurement and make recommendations for incorporation into budgets and planning for 2025/2026 **November 2024 to March 2025:** Conduct review on bullying, discrimination, harassment and physical violence policies to standardise to best practice and then	**Responsibility:** EDI leads reporting to the Chief People Officers **Assuring progress:** Collaborative People Committee

	problems using data and lived experience, rather than being dependent on staff to raise concerns. • Investigate potential APC reporting systems on incidents akin to DATIX, and including monitoring and tracking on whether reports have been followed-up. Use this shared data to support learning and improvement across the APC. Procure "active bystander" training to be made available across the APC • Implement an APC-wide freedom to speak up channel	sharing, experiences and learning across our organisations			support references to this in Active Bystander training **2024/2025:** Launch "Active Allyship" training and conduct review of policies	
7. Create APC director pairing programme	• Establish pairing between Black, Asian and Minority Ethnicity staff and directors across the APC, to provide jointing mentoring, personal development and advice • This should complement pairing programmes within each trust between other senior leaders and staff to be implemented locally • Establish common processes and approach across the APC to share the outcomes and learning of director pairing and local organisation pairing schemes	• Supports implementation of the Executive Director EDI objectives • Build connections and understanding between APC organisations about different experiences, which will also help share best practice • Sharing different perspectives and	High Impact Action 1 and 2	Feedback from participations in pairing scheme on whether they would recommend others should participate	**By September 2024:** Invitation sent out for colleagues who would like to be paired **By October 2024:** Pairing connections made **By December 2024:** Local trust pairing schemes launched when not already in place	**Responsibility:** EDI leads reporting to the Chief People Officers **Assuring progress:** Collaborative People Committee

		experiences will support leadership development of all participants, benefiting inclusive leadership of directors and career development of paired staff					
8. Standardise how Reasonable Adjustments terminology is applied to support workforce health, wellbeing and equity and track timeliness of support	• Review and agree consistent policy and understanding of the Reasonable Adjustments (RA) terminology and how this is used to support staff wellbeing. Investigate and align to best practices, such as centralising budgets for reasonable adjustment support • Provide training materials for staff, managers and specialist functions (e.g., OH), and shared communications • Create a performance metric to track the timeline for implementation of reasonable adjustments for disabled staff and staff with hidden disabilities and agree a target performance level for this	• Promote inclusion and equity across our workforce, positively emphasising support available	High Impact 4	Improvement in Staff Survey question: "My organisation takes a positive interest in my health and wellbeing" Increase in staff declaring their disability (WDES)	**By December 2024:** Agreed consistent policy on Reasonable Adjustments for the APC, performance metric and target **By March 2025:** APC performance metric and training materials shared and implemented within each trust	**Responsibility:** Occupational Health leads reporting to Chief People Officers **Assuring progress:** Collaborative People Committee

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RECOMMENDATIONS: CONSISTENT ACTIONS EXPECTED LOCALLY WITHIN EACH TRUST

Action	What will we do?	What are the benefits of doing this?	What issues and High Impact Actions does this help us respond to?	How we will know changes are an improvement (and are then sustained)?	What timeline is expected to implement?	Roles/Teams responsible for implementing and collaborative committee assuring progress
9. Implement the NHSE Inclusive Recruitment Framework	• Ensure all recommendation from the NHSE Inclusive recruitment framework (NHS-People-Plan-Inclusive-Recruitment_0.pdf (nhsemployers.org)) are implemented including diversity of	• Promotes inclusive panels for interviewees • Provision of best practice feedback from diversity and inclusion champions to help support candidate development	High Impact Action 2	Increasing proportions of Black, Asian and Minority Ethnicity staff in Agenda for Change Bands 7 and above	**By December 2024:** Confirmation that all actions within NHSE Framework implemented within each trust	**Responsibility:** Trust People functions **Assuring progress:** People Committee

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	interview panels, diversity inclusion champions and offering feedback on all interviews					
10. Implement inclusive talent management initiatives within each trust	• Offer career development coaching, sponsorship training and programmes within each trust to promote the diversity of colleagues in senior leadership positions • Implement standard that all "step-up", "acting up", "special project" and similar opportunities are advertised openly with at least expressions of interest sought and record kept of who applied, who was successful and rationale • Link monitoring of "step up", "acting up" and "special project" access to the Equitable Employer Dashboard (Action 3)	• Address inequitable and biased access to opportunities that could further career progression • Encourage greater diversity of viewpoints within senior leadership	High Impact Action 2	Increasing proportions of Black, Asian and Minority Ethnicity staff in Agenda for Change Bands 7 and above	**By March 2025:** Confirmation that coaching programmes and standards on temporary opportunities have been communicated	**Responsibility:** Trust People functions **Assuring progress:** People Committee

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| 11. Conduct local review of health inequalities within trust workforce and implement local interventions to support their health and wellbeing | • Establish local task and finish groups including staff representatives to review health needs and inequalities within each trust, with specific focuses on structural drivers of inequity including disability and race and how work pressures and behaviours can cause ill health
• Agree and implement priority interventions and initiatives and support, targeted at areas of greatest inequity (e.g., smoking cessation, encouraging exercise, diet advice, mental health support, MSK support)
• Apply learning from previously successful wellbeing campaigns conducted within the APC that addressed inequity of access and outcomes (e.g., | • Healthier staff reduces overall sickness rates across the trust
• Equitable approach to health and wellbeing underpin inclusive access to career development and improved performance | High Impact 4 | Improvement in Staff Survey question: "My organisation takes a positive interest in my health and wellbeing" with particular focus on improvements for Black, Asian and Ethnic Minority staff or staff who declare a disability | **By March 2025:** Health inequality reviews finalised with initiatives recommended for 2025/2026

2025/2026: Implementation of prioritised initiatives | **Responsibility:** Trust People functions

Assuring progress: People Committee |

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			High Impact 5			
	vaccines) to support the design of interventions, such as community advocates					
12. Reinforce local systems for inducting and onboarding internationally recruited staff	• Ensure standardised training modules and good practice for local Trust induction programmes which should be offered to all overseas staff • Establish if it does not already exist local Trust International Staff networks • Implement other supportive progression pathways and initiatives, such as buddying, accelerated experienced nurse leadership development programmes and preceptorship packages	• Support the wellbeing, progression and retention of international staff • Inclusion, psychological safety and improved representation support improved decision making, connections with our diverse patient communities and their needs, which in turn supports higher quality of care and patient experience	High Impact 5	Improvement in Staff Survey question: "My organisation takes a positive interest in my health and wellbeing" when filtered just for staff who were recruited internationally	**By March 2025:** Implemented standardised induction and established International Staff networks **2025/2026:** Implementation of other prioritised local initiatives	**Responsibility:** Trust People functions **Assuring progress:** People Committee
13. Address unconscious bias and promote inclusive environments in local areas	• Ensure availability of innovative Virtual Reality (VR) training on unconscious bias • Promote diversity of art, people in pictures	• Signal inclusive environment that where patients and staff can see community diversity represented in	High Impact 6	Improvement in Staff Survey question: "I think that my organisation respects individual differences (e.g., cultures, working	**By March 2025:** Establish access to local VR training opportunities	**Responsibility:** Trust People functions **Assuring progress:**

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| | | | | styles)" with particular focus on improvements for Black, Asian and Ethnic Minority staff or staff who declare a disability | **2025/2026:** Updated communications, art and visual media policies that encourage greater diversity and inclusive information | People Committee |

and major languages used in public facing areas
- Create good practice guidance and review printed medical materials, including posters and post-operative materials, for inclusion such as references to different skin tones

range of visual media and decoration
- Provide engaging and novel training opportunities that support inclusive behaviours and mindsets

Appendix - Other ideas and practices identified for future consideration

This appendix summarises the good practices and ideas shared during the development process. These examples of good practices could be considered locally within each trust depending on local circumstances and needs and revisited for future action plans.

Focus area	Potential actions

High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	• Positive action leadership development schemes and pairing, including access to apprenticeships promoted and available
	• All professional networks and opportunities to participate advertised across APC.
	  o Includes external networks and opportunities (e.g., NHS Providers)
	  o Individuals can participate in any APC group
	• APC-wide career progression and applying for NHS jobs training, including:
	  o How to complete application forms
	  o Interviews advice
	  o Career development advice
	  o Sponsorship
	  o Raising your profile and getting noticed for future opportunities
	  o Access to interview practice sessions

	• Cultural Intelligence Training

High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps	• Focus on data quality in ESR:
	    o Communication campaign to staff to promote ESR local completion of ESR for protected characteristics
	    o Data quality monitoring at team level to support managers discuss with staff

High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce.	• Manager training on promoting and supporting health and wellbeing • APC Wellbeing Hub including support available, such as access to recommend apps, 24/7 contact advice • Monitoring and reporting by race and other protected characteristics of reasonable adjustment requests and outcomes • Use collective weight of APC to negotiate/promote local health promotion schemes and discounts, e.g., negotiate discounts at local gyms or exercise groups, promotion of local activities including Park Run, walking groups, etc
High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.	• Establish post-6 week support package to international staff to support on-going development, with links to any wellbeing offers
High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	• Civility and respectful resolution training to help everyone have a common understanding of and tools to address • Visible signage across sites about how we view violence/aggressive behaviour (e.g., TfL posters) and public communication campaign • Visible accountability on addressing bullying/harassment, e.g., bi-annual or annual report sharing statistics on incidents raised, those that led to investigation, actions taken and anonymised examples of issues and consequences

NWL Acute Collaborative committee cover note

7.1 COLLABORATIVE DATA AND DIGITAL COMMITTEE REPORT

● Discussion Item　　　　👤 Steve Gill　　　　🕐 11.00

REFERENCES

Only PDFs are attached

📕 7.1 BIC Collaborative Digital and Data Chair's Report FINAL 25.06.24.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
June 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   Cerner Programme Update and Benefits Realisation Piece

2.1.1   The Committee received an update on the Cerner stabilisation programme following the implementation of the Cerner EPR at LNWH and THHFT.

2.1.2   A Joint Cerner Benefits realisation and finance group has been formed with terms of reference and key areas of focus agreed. This group will work with other groups across the APC in relation to Cerner EPR benefits identification and realisation.

2.1.3   The oversight of the ongoing development of the Cerner system across the APC will be delivered through the Cerner Enhancement Programme.

2.1.4   The Committee was advised that an enhanced programme group to specifically review concerns around the use of Cerner in Maternity has been set up.

2.2   The APC Digital and Data Strategy – Priorities for 2024/25

2.2.1   The top five Digital and Data priorities are supported by six prioritisation themes which are closely aligned with Trust and APC priorities. These priorities and themes translate into a total of 65 APC digital and data projects which are all fully funded and resourced.

2.2.2   The Committee discussed the work required re the implementation of the Strategic Management Information Reporting system including the provision of data to

complete the NWL APC board pack. The Committee noted that the technology exists within the Federated Data Platform (FDP) to provide this but it would be an additional programme as this is not one of the current NHSE FDP use cases. A small working group will be set up to discuss options and to make recommendations ASAP to the NWL APC Executive Management Board (EMB) for approval; an update to be provided to the September APC D&D Committee.

2.3   ICT Capital Programme 2024/25

2.3.1   The Committee received an update on the internal IT capital investment plan for the NWL APC and was advised that there is sufficient IT capital in year with a small manageable gap. . Work has been undertaken to align the capital plans across the APC and a 5-year overall plan has been produced.

2.4   Equality, Diversity & Inclusion (EDI) Update

2.4.1   The Committee received an update on the progress of the three EDI priority areas for digital and data 2023/24 and draft EDI objectives for the Digital and Data Committee for 2024/25.

2.4.2   Since the last committee meeting further work has been undertaken to establish the completeness of data on equality and diversity for staff and patients. Draft EDI objectives for 2024-25 were outlined with the proviso that once the EDI objectives for each sub-committee have been agreed and the APC EDI objectives are agreed at the Board in Common on 16 July 2024 a final set of EDI objectives for the Digital and Data committee will be presented at the September 2024 meeting.

The suggested priorities include.
1. The roll forward of the % of patients where there is a complete record of their EDI characteristics (target 90%) for all four Trusts and will be using data extract from WSIC. This will be worked through by the Inequalities data working group and will enable pieces of work to be undertaken to look at the differences in ethnic group in specific areas to aid sensible discussions on providing care.

2. WRES and WDES - more work to ensure that the recording of these characteristics is promoted through staff networks.

3. Ensure process for procurement of hardware and software considers patient and staff accessibility and there is a review of existing hardware and software

4. Accessible information standard; recording people requirements and digital flags.

5. NHS England Statement of Information on health inequalities

2.5   APC Strategy

2.5.1   The committee discussed the APC Strategy and gap analysis to the Digital and Data Strategy. It was agreed that there is substantial alignment and previously fed back comments will be added to the next iteration.

2.5.2 The Committee also noted the commitment to transparency and that data would be need to be available for information sharing with clinical teams to enable the benchmarking and transformation programmes at the heart of the APC strategy. This capability and capacity is not currently available to provide an agile service and the creation of dedicated capacity to develop shared dashboards on common infrastructure will need to be prioritised.

2.5.3 The Committee noted that greater emphasis on the Culture change required and detail on the enablers to ensure implementation would be helpful.

2.6   ICT Risk Register

2.6.1 The committee was provided with an update on the highest scoring risks in relation to NWL APC digital and data. The risk log contains 68 risks identified through a process of reviewing 'risks in common' across the 4 Trusts. The paper provided a summary of mitigations, controls and assurances of the 8 highest scoring risks on the register. Cyber Security has the highest current score (20) with also the highest target score (15).

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 Cerner stabilisation programme following the implementation of the Cerner EPR at LNWH and THHFT. The programme is on track to complete at the end of June 2024 after which time any issues with Cerner at each Trust will be managed through the Digital & Data Technology Steering Group.

4.   Key Risks to Escalate

4.1   A specific targeted piece of work will be undertaken re single point of failure to ensure a comprehensive understanding of where the Cyber risks are currently. It was suggested that the top suppliers should be identified and tested for their cyber risk along with financial risk, and that the work included updates to the Trust and APC Business Continuity Plans (BCPs).

5.   Key Actions Commissioned

5.1   Work on inconsistencies and discrepancies in maternity data provided to boards to be shared with the NWL APC Quality Committee.

5.2   A small working group will be set up to discuss options and to make recommendations ASAP to the NWL APC Executive Management Board (EMB) for approval re the implementation of the Strategic Management Information Reporting system including the provision of data to complete the NWL APC board pack.

5.3   A specific targeted piece of work will be undertaken re single point of failure to ensure a comprehensive understanding of where the Cyber risks are currently. It was suggested that the top suppliers should be identified and tested for their cyber

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risk along with financial risk, and that the work included updates to the Trust and APC Business Continuity Plans (BCPs).

5.4   Further work on governance of common risks across the four Trusts will be undertaken.

6.   Decisions Made
None

7.   Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Cerner Programme Update and Benefits Realisation piece	For Information	6.	ICT Risk Register	For Discussion
2.	APC Digital and Data Strategy - Priorities for 2024/5	For Discussion	7.	Forward Plan 2024/25	Verbal Update
3.	ICT Capital Programme 2024/25 Update	For Discussion	8.		For Information
4.	Equality & Diversity Update	For Discussion	9.		For Information
5.	APC Strategy	For Discussion	10.		

8.   Attendance

Members	June attendance
Steve Gill (D&D Chair; Vice Chair CWFT/NED THHT)	Y
Nick Gash (NED - ICHT/THHT)	Y
Neena Modi (NED – ICHT/CWFT)	Y
Loy Lobo (NED ICHT/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)	Y
In Attendance	
Matthew Swindells (NWL APC Chair in Common)	Y
Janet Campbell (Associate NED THHT)	Y
Peter Jenkinson (Director of Corporate Governance)	Y
James Biggin-Lamming (Director of Strategy and Transformation) – Item 9	Y
John Keen (Deputy CIO LNWH & THHFT - Item 7 & Item 10)	Y
Tim Orchard (CEO ICHT) Part	Y
Leigh Franklin (Assistant Trust Secretary - THHFT (minutes)	Y

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8.1 COLLABORATIVE STRATEGIC ESTATES AND SUSTAINABILITY COMMITTEE REPORT

● Discussion Item   👤 Bob Alexander   🕐 11.10

REFERENCES

Only PDFs are attached

📄 8.1 Collaborative Strategic Estates and Sustainability Committee - June 2024 final draft.pdf

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

Highlight Report

1.   Purpose and Introduction

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

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

2.   Key highlights

2.1   The Strategic Estates and Sustainability Collaborative Committee was held via e-governance in June 2024, with papers circulated for comment via email.

2.2   In place of the meeting, Committee members attended a meeting where they reviewed the Acute Provider Collaborative (APC) draft strategy and provided input on estates enablers.

2.3   The following papers were circulated vie e-governance.

2.4   Acute Provider Collaborative (APC) Strategy – Draft for input and review
2.4.1   The APC strategy had been in development since the end of 2023. The key question was "How can the APC most effectively use our collective resources to provider better, more equitable care for the population of north west London, over the next three years".
2.4.2   A number of colleagues from each organisation had supported analysis, wide ranging engagement with staff, patients and partners, and supported discussions at APC groups including the Board in Common development sessions. These discussions informed the draft strategy, which was shared with all APC Collaborative Committees to gather input and feedback and consider its area of responsibility. The APC Strategy was also being shared with Executive Teams for their feedback.
2.4.3   The final strategy would incorporate the input of the Collaborative Committees and Executive Teams, for recommendation to the Board in Common in July 2024.
2.4.4   In place of the Strategy Estates and Sustainability Collaborative Committee, Non-Executive Directors Committee members met with the Director of Strategy and

Transformation (LNWH) to input and review the APC Strategy, with particular thought to estates enablers.

2.5   Terms of Reference and Forward Plan for the Strategic Estates and Sustainability Collaborative Committee

2.5.1   The updated terms of reference for the Strategic Estates and Sustainability Collaborative Committee were reviewed in December 2023. No amendments were proposed, however the terms of reference and forward plan were circulated to ensure these were aligned to the delivery of the APC strategy.

2.5.2   No comments were received on the terms of reference or forward plan.

2.6   Update on Sustainability / Green Plans

2.6.1   The paper provided an update on the Green Plans of the four Trusts within the North West London APC, with a specific focus on updating the committee on progress around standardisation of data collection and analysis relating to the NHS carbon footprint.

2.6.2   The paper also described work that is underway across the Trusts to:
- develop a shared approach for our NHS carbon footprint data and measurement
- share and spread initiatives that have shown demonstrable benefit to carbon and financial savings
- share learning of approach and to build multi-agency partnerships.

2.6.3   In response to a previous committee action, the annex included the Green Plans (shortened versions) from each of the Trusts and a summary slide pack that showed the latest iteration of collaborative work undertaken and led by the Trusts' Green Teams to develop carbon footprint summary data tables and trajectories.

2.6.4   This work continues and the Committee will review progress again at the next meeting.

2.7   Benchmarking the APC Estates

2.7.1   The paper outlined a number of opportunities for further collaboration, following the Estates Returns Information Collection (ERIC) 2022/23 data benchmarking exercise.

2.7.2   This will be discussed in more detail at the next meeting.

2.8   Equality, Diversity and Inclusion (EDI) Benchmarking – Accessibility

2.8.1   Trusts have a duty to consider and support people with a disability who access our buildings, use our services, or work for us. Each Trust delivers this duty in different ways, but all have a similar approach, including staff networks established to share lived experiences to drive improvement and to support staff with disability, consideration of accessibility in planning new projects, and use of data to improve existing access to services.

2.8.2   The paper included a brief summary of the approaches being taken by each of the four Trusts in the North West London APC, and started to explore some of the potential initiatives to pursue collaboratively, to ensure we learn from each other and implement best practice.

2.9   Update on redevelopment plans

2.9.1   The papers outlined confidential briefings on the redevelopment plans for The Hillingdon Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Trust respectively.

2.10   Summary report from the Estates and Sustainability Executive Group

2.10.1   The paper provided a summary of the Estates and Sustainability Executive Group discussions which took place between 27 March and 28 May 2024.

3. Positive assurances received

3.1   The Committee took place via e-governance on this occasion, nothing to note.

4. Key risks to escalate

4.1   The Committee took place via e-governance on this occasion, with no new risks escalated. 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 took place via e-governance on this occasion, nothing to note.

6. Decisions made

6.1   N/A

7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	APC Strategy – reflections from the Board in Common Development Session	To consider	5.	EDI Benchmarking – accessibility	To consider
2.	Terms of Reference and forward plan	To consider	6.	Update on redevelopment programmes - THHFT - ICHT	To receive
3.	Update on green plan and sustainability plans, including decarbonisation	To receive	7.	Summary report from the Estates and Sustainability Executive Group	To note
4.	Benchmarking the APC Estate	To note			

8. Attendance Matrix

N/A

9.1 COLLABORATIVE FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT

● Discussion Item   👤 Catherine Jervis   🕐 11.15

REFERENCES   Only PDFs are attached

📄 9.1 Collaborative Finance and Performance Committee Chair's Report June 24 - FINAL.pdf

North West London Acute Provider Collaborative

Collaborative Finance and Performance Committee Chair's Highlight Report to the Board in Common – for discussion

June 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 20 June 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, which has changed in light of the recent governance developments and establishment of Board Standing Committees, is:

- To identify, prioritise, oversee and assure strategic change programmes to support the delivery of the Acute Provider Collaborative (APC) strategy and to drive collaborative-wide and Integrated Care System (ICS) integrated improvements,
- To identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements

2.0 Key Highlights

2.1 APC Strategy

The Committee considered the latest draft of the APC strategy, which has been discussed at a number of workshops and committees, with many opportunities to input through its development. The Committee was encouraged to provide feedback specifically regarding elements of the strategy relating to finance and performance, and to consider the role and remit of the FPC in relation to the strategy.

A range of comments were fed back:

- To provide more context in terms of the constraints, so while the focus is on patient experience and quality, it must be clear that this is within a limited financial envelope.
- To be clear on the metrics and measures of success, including how progress will be monitored.
- To be realistic on what is within the APC's gift to improve given the rise in co-morbidities and expectations on preventative and care outside of hospital.
- Ensure the rationale for coming together is articulated, including the potential for more efficient use of resources and medium term financial recovery for the constituent Trusts.
- Be explicit on ensuring best value for money and the importance of care being provided in the best way for patients – the right care, in the right location, by the right person.

Further comments included reference to the increasing impact of mental health patients in acute hospital settings, with assurance provided that ICS discussions take place regularly on this. In addition there are regular conversations with local authorities on wider flow issues with a common theme of patients ready to be discharged without the appropriate care packages in place.

A further discussion took place on how the strategy should enable bottom up and top-down approaches (with the wider clinical workforce) in terms of the selection of pathways to focus on and what the methodology for determining these should be, along with dashboards to measure productivity and quality.

The Committee was advised that the final strategy will be updated following input from executive teams and each collaborative committee, after when it will be recommended to the Board in Common meeting on 16 July 2024.

2.2 Operational performance

The Committee considered March and April data. Overall the Collaborative continues to perform well, with achievement above local and national targets for the majority of metrics. It was noted however that close scrutiny will be required on urgent and emergency care (UEC) and elective performance to ensure national targets are met.

2.2.1 Urgent and Emergency Care (UEC): All Trusts maintained 76% performance against the 4 hour UEC target in April, with actions in place to sustain this and then meet 78% by March 2025. Performance has been maintained by keeping open winter beds, which is not sustainable. Amalgamated action plans for sustaining and improving performance will come to the next Committee meeting for assurance in advance of winter. The Committee heard about the system wide discussions, including with all local directors of adult social care, regarding the continued high numbers of patients in beds who do not meet the criteria to reside. Additional community and mental health impacts also feature in the discussions with partners and the ICB, recognising the financial challenges within local government.

2.2.2 Elective care: the Committee heard that the number of long-waiting patients has decreased again with consistent high levels of activity and London North West (LNW) largely recovering post the Cerner go-live. The Collaborative 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 including for religious celebrations, meaning that there were a small number of 78 week waiters (ww) at the end of April, with Hillingdon at zero reported 78ww. The Committee heard about the focus now on 65ww and 52ww. Teams are working hard to ensure this performance is sustained.

2.2.3 Cancer: Cancer performance was maintained in March 2024 with the APC meeting the 28-Day Faster Diagnosis Standard (FDS). The focus continues in order to sustain the FDS performance for cancer patients. The Committee heard that this was strong performance that was not replicated regionally or nationally, so was welcomed, but risks were noted in terms of planned industrial action.

2.2.4 Diagnostics Focus: The Committee heard in greater detail following the request at the last meeting regarding diagnostics. Members were updated about the workshops that had taken place over the past quarter to focus on improving performance. Initial diagnostic recovery was good and NWL was the top performing sector in London. There have been a range of challenges which has seen a deterioration in diagnostic performance despite the opening of the community diagnostics centres. The

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implementation of Cerner impacted on endoscopy and echo (cardiology) at LNW and Hillingdon.

Hillingdon, Chelsea and Westminster (CWT) and LNW have recovery trajectories for each speciality not delivering the required standard, with Imperial working on their trajectories. The latter are particularly challenged due to ageing imaging equipment and reliability. Overall there is a risk to delivery across the APC but trajectories are monitored weekly through the Elective Care Board

The Committee discussed the recent cyber-attacks and any impact locally. It was confirmed that there was none for NWL APC Trusts. The Committee was also reminded of the plans for the diagnostic centre at CWT's West Middlesex site. The Committee discussed how diagnostics nationally is a challenged area, where investment is required. The collaboration and mutual aid across the APC was welcomed, noting that each organisation has equipment that ages at different times, so providing alternative provision across the APC supported maintenance of standards. The plans for a single patient list (PTL) across the Collaborative will provide additional agility and flexibility into the future.

2.3   Financial report, including CIP delivery
The Committee noted and discussed the month two position, which shows an overall £17.8m adverse variance to plan. Each Trust provided a summary of their position, noting that the greatest risk is for Hillingdon and LNW, but that each of the Trusts faced significant financial challenges. Each CFO provided a summary of the mitigations in place to recover, which included further restrictions on bank and agency staffing in line with national guidelines and a continued focus on elective recovery and maximising income. Hillingdon and LNWH are developing detailed financial recovery plans, reflecting the scale of the adverse position at Month 2. CWT are reporting a smaller adverse variance to plan, however a range of mitigating actions to address the position have been put in place by the organisation's leadership and communicated widely throughout the organisation. Imperial are also reporting an adverse position, albeit with mitigations to ease the position in the first two months. Under delivery of CIPs was offset through the recognition of additional income including from overseas and private patients

The Committee heard how the main drivers of the adverse variance are undelivered cost improvement plans (CIPs) and the mitigations included in the financial plan which have not commenced as at month one. These include the system optimisation proposal and the business case review project.

It was agreed that the Chief Finance Officers (CFOs) and Chief Operating Officers (COOs) will work together to share learning and support recovery actions, and ensure plans are in place to get each Trust and the APC back on track. It was noted that this would be discussed at the next BiC meeting.

2.4   Finance Plan 2024/25
The Committee was reminded that the draft financial plans were presented to the BiC meeting on 16 April with agreement that final plans be signed off by local Trust Finance and Performance Committees ahead of submission to NHS England and NWL ICB on 2 May. This deadline was met, with all Trusts submitting breakeven financial plans after agreeing a series of mitigations, noting an overall CIP of £140.7m, £21m higher than 2023/24.

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It was noted that there was significant risk in terms of the plans submitted, but recognised and acknowledged that there must be a complete focus on delivery, particularly given some of the risks were materialising in months one and two. In response to questions about the consequences of non-delivery and how the local committees can be assured of delivery against the plan, it was confirmed that focused action was required and that there would be regular reporting through the current local and collaborative governance structures to ensure delivery. Committee members were advised on the likely process of escalation through regulators should the position not improve.

2.5   Underlying position and run-rate
This Committee discussed the report which set out the overall APC and individual Trust underlying financial position as at the end of 2023/24. The report included the planned underlying position at the end of the 2024/25 financial year and underlying run rate for month one in 2024/25.

There is significant non recurrent income included in the plan including elective recovery fund (ERF) over-performance, critical care and 'true-up' funding. Throughout the year a programme will be developed to agree the unearned and earned income in the NWL contract with the ICB which is turn will confirm income streams as recurrent and non-recurrent and the underlying position will be amended accordingly. This will support future forward planning and a move to sustainability.

The Committee discussed the importance of each local Finance and Performance Committee being clear and agreed on their underlying position, and for the matter more generally regarding non-recurrent funding to be resolved with the ICB.

2.6   Productivity and efficiency update
The report summarised the overall APC plans to deliver £140.6m of efficiencies in 2024/25, with £130m (93%) of plans identified. Of the overall £140.6m schemes, 92.8% are forecast as recurrent. At month one, £3.9m of efficiencies have been delivered, £6.4m below plan. The Committee heard about the key areas of focus across the four trusts, beginning with outpatients and a focus on embedding digital tools, accurately recording activity and delivering the PIFU (patient initiated follow-up) target and theatre productivity – using collective capacity. Mental health remains a focus including reducing the usage of registered mental health burses (RMN) and on corporate efficiencies across the collaborative. Each workstream has a plan with a CFO aligned to each and wider teams supporting as appropriate.

2.7   APC Business Planning – Progress and Monitoring Report
The Committee heard a brief update on the above, noting how last year's business plan was tracked monthly through the Finance and Performance Working Group. For 2024/25, the BiC agreed that there would be a 'light touch' refresh of the Business Plan priorities for 2024-25, recognising that the 2023-24 priorities had taken some time to implement. IN addition the APC Strategy due to be agreed in July will lead to a full and formal refresh of the Business Plan. In the meantime there were two additions, the first to include the work of the clinical reference groups (CRGs) in the delivery of activity targets, the second to implement the Business Case Review Programme agreed with the ICB. The CFOs and COOs will include health inequalities as a theme in all business plan priorities, while also agreeing overall executive leads for each element, along with key performance indicators and metrics.

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2.8   Equality, Diversity and Inclusion (EDI)
The Committee discussed the report which set out the work by the COOs to date on EDI, hearing that this was linked in with what was happening across the wider system in relation to health inequalities, with the APC represented at the ICB group. The data presented was broken down across 15 specialities, and included information on impacts by gender and ethnicity. A rise in people not attending appointments (DNAs) linked to deprivation and ethnicity was noted. The Committee discussed the potential drivers for this, and looked at whether training for staff, a multi-lingual appointments hub and/or other interventions would help bring the rate of DNAs down. The work underway through one pilot scheme utilising volunteers was highlighted. This is currently within one borough with positive results, which if maintained will be spread across the whole of NWL.

It was agreed that this was interesting work but that tracking DNAs in one borough did not meet the collaborative EDI strategy expectations that each collaborative committee would have a number of metrics to track EDI across the range of services that they were responsible for, in this case access. It was suggested that in addition to tracking DNA by ethnicity in a quarterly report to the committee and the board there needed to be a number of other metrics such as "Wait for first outpatient appointment", "time from referral to addition to waiting list", "time from addition to waiting list to treatment" and "4 and 12 hour waiting times in A&E".   Recommended metrics should come back to the next Finance and Performance Committee.

2.9   Terms of Reference Update
The proposed amendments to the terms of reference (ToR) for the Committee, drafted in response to the governance review and implementation of the recommendations, were approved. With the introduction of Trust Standing Committees the focus of APC committees is now the development and delivery of collaborative strategy priorities. This is informed by escalation and identification of common risks across the four trusts, or within strategic initiatives.

It was also suggested to reference the financial approval limits for this Committee and reflect in the ToRs.

2.10   Forward Plan for the Committee
This was noted, however once the strategy is approved, it was agreed to schedule the forward plan of items this Committee would want to receive reports for and subject matter for 'deep dives'. It was agreed that the COOs and CFOs would work together on this, with the focus on strategic priorities and collaborative schemes.

3.0   Positive Assurances Received
3.1   The Committee was assured regarding current performance against many of the constitutional standards and the initial work on EDI.

4.0   Key Risks to Escalate
4.1   The key risks noted were the financial position given where each Trust was at month two, with a need to understand the drivers and rapidly put in place mitigations, along with a sensible trajectory to year end. Challenges on discharge and continued use of winter beds was noted, including the impact of the forthcoming junior doctor industrial action.

5.0   Concerns Outstanding
5.1   The financial position and focus on flow through hospital as mentioned above.

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6.0 Key Actions Commissioned

6.1 **Financial plans:** the CFOs and COOs to meet to refresh the forward plan in line with the APC strategy once adopted.

6.2 **EDI:** continue the positive work begun, and produce quarterly reports for this Committee

6.3 **Financial shared services:** to provide an update in relation to the planned procurement, addressing the issues raised by the Committee. To do this rapidly and before the next meeting.

6.4 **Winter planning:** amalgamated plans will come to the next Committee meeting

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.	APC Strategy	To note	**6.**	Underlying Position and Run Rate	To note
2.	Integrated Performance Report and operational performance updates on UEC, elective care, cancer	To note	**7.**	Productivity and Efficiency Update	To note
3.	Diagnostics	To note	**8.**	APC Business Planning – Progress and Monitoring report	To note
4.	Finance Report including CIP Delivery	To note	**9.**	Review of Terms of Reference	To approve
5.	Financial Plan	To note	**10.**	Draft Forward Agenda Planner	

9.0 Attendance

Members:	Attendance
Catherine Jervis, Non- executive director (NED) - (Chair)	Y
Patricia Gallan, NED, Chair of CWT F&PC*	N
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
Tina Benson, Chief Operating Officer – Hillingdon	Y
Jon Bell, Chief Financial Officer - Hillingdon	Y
Claire Hook, Chief Operating Officer - Imperial	Y
Jazz Thind, Chief Financial Officer - Imperial	Y
Virginia Massaro, Chief Finance Officer - CWT	Y
Laura Bewick, Hospital Director - CWT	Y
James Walters, Chief Operating Officer - LNW	Y
Jonathan Reid, Chief Financial Officer - LNW	Y

Helen Berry, Associate Director of Finance, NWL APC	Y
Peter Jenkinson, Director of Corporate Governance	Y
Marie Price, Deputy Director Corporate Governance - CWT	Y
Alexia Pipe, Chief of Staff to the Chair	Y

*Carolyn Downs, NED and member of CWT F&PC attended in PG's absence.

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9.2 FINANCIAL PERFORMANCE REPORT

● Discussion Item   👤 Jon Bell

REFERENCES   Only PDFs are attached

📄 9.2a NWL APC Month 2 financial performance 202425.pdf

📄 9.2b NWL APC M2 financial performance v2.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

NHS

NWL Acute Provider Collaborative Board in Common (Public)

16/07/2024

Item number: 9.2

This report is: Confidential

2024/25 Month 2 Financial Performance

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

Accountable director: Acute CFOs & Lesley Watts
Job title: Chief Financial Officers and Chief Executive CWFT, Finance & Performance Lead CEO

Purpose of report

Purpose: Assurance

The Committee is asked to note the month 2 financial performance of the APC: income and expenditure, CIP, capital and cash

Report history

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

APC CFO Meeting	**APC Business Plan Finance & Performance Workstream Meeting**
28/06/2024	28/06/2024
Agreed	Agreed

Executive summary and key messages

- The paper presents the NWL APC Month 2 (May) financial position including income and expenditure, capital and cash.

- At Month 2, the APC reported a deficit of £23.9m against a year-to-date deficit plan of £6.1m, a £17.8m adverse variance to plan. All four trusts report adverse variances to plan.

- The main drivers of the adverse variance are:

    - Undelivered CIPs.

NWL Acute Collaborative committee cover note

- Mitigations included in the financial plan which have not commenced as at month 2, such as the System Optimisation Proposal and the Business Case Review project.

- Operational pressures: all trusts have winter beds open in the first two months of the year, and report continuing pressure on supporting mental health patients.

- Excess inflation: inflation over funded levels contributes to the overall adverse variance.

- An assessment of ERF income performance is made up to the end of May, based on information available from local systems. Overall ERF performance reports a favourable variance of £6.6m.

- Capital plans were updated in Month 2 to account for additional capital allocation granted by NHSE. This increased the capital plan from £200.3m to £239.4m, encompassing trust CRL and national programmes funding. To month 2 the capital plan is underspent by £2.6m or 15%

- The APC combined cash balance at the end of May is £279m, a decrease of £59.5m since the end of the financial year and lower than the planned cash balance at the end of the month by £45.3m.

Financial Performance Escalation and Recovery:

- A Peer to Peer CFO meeting was held on 14th June to check and challenge Month 2 financial performance whereby several actions were agreed, including the strengthening of grip and control measures in all organisations. It has been agreed a further Peer Review session to be held in July to review Q1 performance.

- Trust recovery plans were tabled and discussed at the Peer Review meeting and following the reporting of month 3's performance these will be updated, and peer reviewed at the next meeting including presentation to local trust executive / finance and performance 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

This supports the delivery of the collaborative partners duty to deliver it's financial and plans.

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

2024/25
NWL APC Financial Performance
May (Month 2)

Helen Berry, Associate Director of Finance

24th June 2024

Executive Summary

- This paper presents the NWL APC Month 2 (May) financial position including income and expenditure, capital and cash.

- At Month 2, the APC reported a deficit of £23.9m against a year-to-date deficit plan of £6.1m, a £17.8m adverse variance to plan. All four trusts report adverse variances to plan.

- The main drivers of the adverse variance are:
  - Undelivered CIPs : CIP delivery in the month is £11.7m against a plan of £20.7m YTD, thus reporting a £9.1m adverse variance in the month. 56% of the YTD plan is reported as delivered with 8% (£1.6m) via non recurrent means. The rate of CIP delivery improved in month 2 at £7.7m delivered compared to £4m in month 1.

  - Mitigations included in the financial plan which have not commenced as at month 2, such as the System Optimisation Proposal and the Business Case Review project.
    - The System Optimisation Proposal is in progress. A meeting was held with Mental Health partner organisations on 20.06 to formalise the workstreams including identification of leads and agreement of task and finish groups. There are two work programmes : Focus on discharges & medically optimised patients and Mental Health Models of Care.
    - The outcome of the business case review has been presented by Hunter Healthcare including organisation specific reports. The APC is working through the proposals, many of them overlap with the current workstreams in the APC Business Plan.

  - Operational pressures: all trusts have winter beds open in the first two months of the year, the ICHT and LNWH positions include the allocation of winter funding in the contract envelope to mitigate the YTD cost. All trusts report continuing pressure on supporting mental health patients.

  - Excess inflation : inflation over funded levels contributes to the overall adverse variance. Teams are confirming the values.

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Executive Summary - continued

- An assessment of ERF income performance is made up to the end of May, based on information available from local systems. Overall ERF performance reports a favourable variance of £6.6m .Trusts have assumed additional ERF income (more than contract funded values) in plans.

- Capital plans were updated in Month 2 to account for additional capital allocation granted by NHSE. This increased the capital plan from £200.3m to £239.4m, encompassing trust CRL and national programmes funding. To month 2 the capital plan is underspent by £2.6m or 15%

- The APC combined cash balance at the end of May is £279m, a decrease of £59.5m since the end of the financial year and lower than the planned cash balance at the end of the month by £45.3m.

Financial Performance Escalation and Recovery :

- The financial performance escalation process implemented in 2023/24 is in place in 2024/25 due to the high risk in the financial plan. A set of escalation metrics are in place whereby a breach enacts escalation. This tests the variation from YTD plan, CIP delivery, ERF performance and annual plan. At Month 2, all trusts breached all or some of the escalation metrics. Appendix 3 details the escalation metrics.

- A Peer to Peer CFO meeting was held on 14th June to check and challenge Month 2 financial performance whereby several actions were agreed, including the strengthening of grip and control measures in all organisations. It has been agreed a further Peer Review session to be held in July to review Q1 performance.

- Trust recovery plans were tabled and discussed at the Peer Review meeting and following the reporting of month 3's performance these will be updated, and peer reviewed at the next meeting including presentation to local trust executive / finance and performance committees.

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I&E Performance tables

NWL Acute Collaborative (Month 2 Financial Performance)

2024/25	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	321,666	338,746	17,080	643,141	669,861	26,720	4.2%	3,884,684	3,884,684	0
Pay	(199,417)	(210,445)	(11,028)	(398,340)	(414,532)	(16,192)	-4.1%	(2,388,839)	(2,388,839)	0
Non-Pay	(121,971)	(137,970)	(15,999)	(242,597)	(271,346)	(28,749)	-11.9%	(1,449,419)	(1,449,419)	0
Non Operating Items	(4,219)	(4,154)	65	(8,316)	(7,909)	407	4.9%	(46,426)	(46,426)	0
Total	**(3,941)**	**(13,823)**	**(9,882)**	**(6,112)**	**(23,926)**	**(17,814)**			0	0	**0**

NWL Acute Collaborative (Month 2 Financial Performance by Trust)

2024/25	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	Year to date (deficit) / surplus as a % of YTD income %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
CWFT	(195)	(680)	(485)	(390)	(2,348)	(1,958)	-1%	0	0	0
ICHT	(1,819)	(3,319)	(1,500)	(2,585)	(4,085)	(1,500)	-1%	0	0	0
LNWH	(1,471)	(4,230)	(2,759)	(2,240)	(8,532)	(6,292)	-5%	0	0	0
THH	(456)	(5,594)	(5,138)	(897)	(8,961)	(8,064)	-15%	0	0	0
Total	**(3,941)**	**(13,823)**	**(9,882)**	**(6,112)**	**(23,926)**	**(17,814)**	**-4%**	**0**	**0**	**0**

Key messages:

- YTD plan of £6.1m deficit, actual YTD of £23.9m deficit, a £17.8m adverse variance to plan at M2.
- Income is favourable : variable ERF and other variable income (some pass-through items compensated by expenditure); additional funding to account for consultant pay award (not in plan)l; some non-clinical income over plan.
- Pay adverse variance: undelivered CIP, consultant pay award accrual, operational pressures (escalation beds remain open) and RMN pressure.
- Non pay adverse variance: undelivered CIP; excess inflation, escalation beds, marginal cost of ERF over performance.

- All Trusts report adverse variances to plan YTD and in the month.
- Further detail of the drivers of I&E variances at each trust are in Appendix 1.
- CFO Peer Review meeting held on 14.06.
- Recovery plans (monthly forecast) to be prepared by each trust at month 3.

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M2 CIP Performance

Month 2

Efficiency Month 2	YTD plan			YTD actuals			YTD Var	In Month Plan	In Month Actuals	in Month Variance	Annual Plan			Annual Forecast			Fcast Variance
	R	NR	Total	R	NR	Total		Total	Total	Total	R	NR	Total	R	NR	Total	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	2,617	506	3,123	1,778	903	2,681	(442)	1,522	1,625	0	17,926	5,594	23,520	12,951	10,569	23,520	0
ICHT	10,459	0	10,459	5,386	550	5,936	(4,523)	5,265	4,506	103	63,400	0	63,400	62,850	550	63,400	0
LNWH	4,162	1034	5,196	2,328	143	2,472	(2,724)	2,614	1,305	(759)	28,494	6,352	34,846	32,583	2,263	34,846	0
THH	1,986	0	1,986	612	0	612	(1,374)	993	292	(1,309)	18,900	0	18,900	18,900	0	18,900	0
Total	**19,224**	**1,540**	**20,764**	**10,104**	**1,597**	**11,701**	**(9,063)**	**10,394**	**7,728**	**(1,965)**	**128,720**	**11,946**	**140,666**	**127,284**	**13,382**	**140,666**	**0**
% delivery of plan				49%	8%	56%								90%	10%	100%	

- The APC CIP plan is £140.7m FY, an increase of £21.2m or 18% compared to 2023/24 CIP plan.
- YTD M2 delivery is £11.7m (56% of M2 YTD plan), split 49% recurrent and 8% non-recurrent schemes.
- CIP is under delivered by £9.1m YTD.
- In month delivery is £7.7m, with two trusts CWFT & ICHT meeting CIP plans in the month.
- Overall, the rate of delivery has improved in the month from £4m in month 1 to £7.7m in month 2.
- CIP plans are profiled fairly evenly across the year according to plan profile agreed by the APC CFOs.
- Specific CIP definitions have been agreed in 24/25 by all APC trusts to ensure all teams are measuring and reporting CIP using a unified approach.

M2 ERF Performance

NWL APC ERF Income Performance to M2

Month 2	All Commissioners					
	Annual Contract income ERF £'000	Additional ERF income in plan £'000	Total ERF income in Provider plan £'000	YTD ERF plan £'000	YTD ERF actual (estimate) £'000	ERF over/under performance in M2 I&E £'000
CWFT	140,437	7,358	147,795	23,222	28,662	5,440
ICHT	254,845	20,431	275,275	43,087	44,128	1,041
LNWH	171,996	37,898	209,894	34,707	34,707	0
THH	66,000	3,700	69,700	10,897	11,029	132
APC	**633,278**	**69,387**	**702,665**	**111,913**	**118,526**	**6,613**

- ERF income in the financial plan is £702.7m across the APC, comprising baseline income in contracts at £633.3m and additional income assumed of £69.3m to account for planned overperformance over baseline values, in line with the operating plan submission.
- At month 2 an assessment of ERF performance has been made by each trust using data on local systems. There is a fair degree of estimation due to the early month in the financial year and relying of "flex" activity reported which will include an element of uncoded and therefore estimated values.
- ERF income reports a favourable variance against the year-to-date plan of 6.6m to month 2.
- To note LNWH has been estimated as breakeven due to the implementation of a new SLAM reporting system and actual performance will be updated at month 3.

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APC Month 2 Capital Summary

The APC's Capital Plan for 2023/24 is £239.4m, comprising schemes funded from trust capital and national funding. The capital plan increased in June from £200.4m, due to additional capital funding notified from NHSE. Most of the increase (£28.3m) is allocated to CWFT to be held as a reserve for the ICB providers pending bids. £5m was allocated each to ICHT & CWFT under UEC schemes.

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 breakdown of the capital plan is per the table below which includes detail on national schemes funded from the DHSC national capital programme:

APC Capital Plan 2024/25 (refreshed June)	CWFT £'000	ICHT £'000	LNWH £'000	THH £'000	Total £'000
CRL (excluding IFRS 16)	64,836	70,785	21,873	14,636	172,130
Impact of IFRS 16	95	11,573	1,500	1,197	14,365
Total CRL (including IFRS)	64,931	82,358	23,373	15,833	186,495
PDC : National Schemes					-
Diagnostic Digital Capability Programme	-	810	500	-	1,310
Elective Recovery/Targeted Investment Fund	20,206	-	-	-	20,206
Front Line Digitisation	-	-	780	-	780
New Hospital Programme (NHP)	-	1,281	-	26,100	27,381
PFI capital charges (e.g. residual interest)	2,126	-	1,032	1	3,159
					-
Total National Schemes	22,332	2,091	2,312	26,101	52,836
Total Capital Plan (Net CDEL)	87,263	84,449	25,685	40,934	239,331

At Month 2, the APC's capital spend is £15.2m against an £17.8m plan, a £2.6m underspend to date.

The overspend at ICHT is primarily due to the acceleration of the backlog maintenance programmes to the start of the year and is expected to balance out across the year.

Note : £28.3m of capital is held at CWFT on behalf of the ICB, pending bids.

Capital	M2 2024/25			Annual 2024/25		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	5,660	5,228	432	87,263	87,263	0
ICHT	6,041	8,534	(2,493)	84,449	84,449	0
LNWHT	2,652	1,367	1,285	25,685	25,685	0
THH	3,432	60	3,372	41,934	41,934	0
Total	17,785	15,189	2,596	239,331	239,331	0

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APC Month 2 Cash

The APC combined cash balance stood at £279m at the end of May, a decrease of £59.5m since the end of the previous financial year; and £45.3m lower than the May cash plan. All trust report lower balances than planned. The difference is driven by I&E deficits partially compensated by capital underspend.

Cash flow plan per trust for 2024/25 and cash Vs plan for the APC are shown in the graphs:

NWL APC Cash Balance					
Trust	31-Mar-24	31-May-24	Movement to YTD	31 May 24 Cash Plan	Variance from plan
	£m		£m	£m	£m
CWFT	161.6	145.8	(15.8)	152.9	(7.1)
ICHT	136.7	113.2	(23.5)	141.6	(28.4)
LNWH	19.8	6.5	(13.3)	8.7	(2.2)
THH	20.3	13.4	(6.9)	21.0	(7.6)
Total	338.4	278.9	(59.5)	324.2	(45.3)
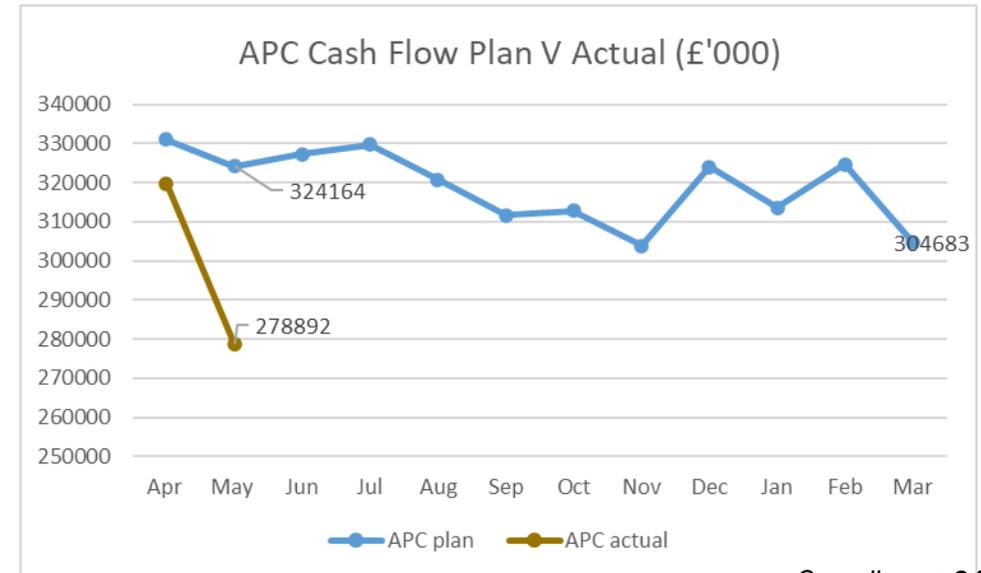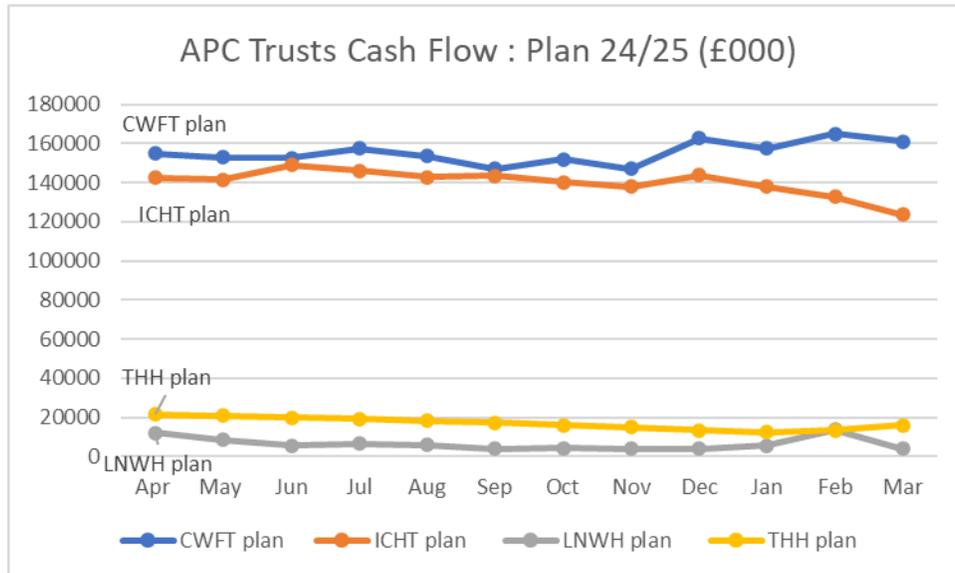
APC Trusts Cash Flow : Plan 24/25 (£000)

CWFT plan, ICHT plan, THH plan, LNWH plan

APC Cash Flow Plan V Actual (£'000)

324164

278892

304683

APC plan — APC actual

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Appendix 1

NWL APC Trust I&E at M2

I&E Performance : CWFT

CWFT

2024/25 M2	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	YTD variance %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	74,808	80,560	5,752	149,616	159,420	9,804	7%	902,003	902,003	0
Pay	(43,318)	(45,403)	(2,085)	(86,636)	(91,026)	(4,390)	-5%	(523,203)	(523,203)	0
Non-Pay	(31,036)	(35,181)	(4,145)	(62,021)	(69,385)	(7,364)	-12%	(369,028)	(369,028)	0
Non Operating Items	(649)	(656)	(7)	(1,349)	(1,357)	(8)	-1%	(9,772)	(9,772)	0
Total	**(195)**	**(680)**	**(485)**	**(390)**	**(2,348)**	**(1,958)**		**0**	**0**	**0**

Key Messages :

The primary drivers of the £2.0m adverse YTD variance are :

- CIPs – (£1.24m) adverse driven by a combination of slippage in schemes and an unidentified gap.
- Provision (£0.15m) – cost pressure relating to a provision made in year.
- CNST: Maternity Incentive Scheme (£0.43m) – incentive benefit relating to 2023/24.
- WM UTC (£0.30m) – cost pressure relating to income generated from the Urgent Care Centre at West Middlesex not covering expenditure incurred to run the service.
- RMN/Specialling (£0.2m) – cost pressure over and above planned levels against 23/24 outturn.
- General Non-pay/Inflation (£0.25m) – non-pay and inflation driving an increase in the run rate, exact inflationary pressure above funded levels to be estimated.

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I&E Performance : ICHT

ICHT

2024/25 M2	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	YTD variance %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	135,760	143,780	8,020	271,520	285,268	13,748	5%	1,639,832	1,639,832	0
Pay	(84,996)	(90,113)	(5,117)	(169,992)	(174,610)	(4,618)	-3%	(1,017,717)	(1,017,717)	0
Non-Pay	(51,657)	(56,091)	(4,434)	(102,261)	(113,212)	(10,951)	-11%	(611,000)	(611,000)	0
Non Operating Items	(926)	(895)	31	(1,852)	(1,531)	321	17%	(11,115)	(11,115)	0
Total	**(1,819)**	**(3,319)**	**(1,500)**	**(2,585)**	**(4,085)**	**(1,500)**		**0**	**0**	**0**

Key Messages :

The main drivers of the £1.5m adverse YTD variance are:

- Income over performance of £15.1m – this includes pass through drugs and devices, CDC income, Road Traffic Accident recovery; overseas visitors and additional 2.6% of VWA ERF delivery.
- Overall pay and non-pay spend is above the YTD plan by £16.8m which the some of this pressure offset by over performance of income and the balance linked to the under delivery of identified efficiencies, RMNs and specials.
- Efficiencies - year to date the Trust is reporting an actual achievement of £5.9m against a plan of £10.2m (£4.3m).
- Core (winter) beds remain open with 24/25 winter funding brought forward to offset these costs.
- The position does not include:- the additional income anticipated against the UTC cost pressure (£0.3m) or the cost benefit assumed from system optimisation programmes for . the RMNs and A&E/Flow/CtR.

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I&E Performance : LNWH

LNWH

2024/25 M2	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	YTD variance %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	81,323	84,681	3,358	162,454	166,422	3,968	2%	985,540	985,540	0
Pay	(51,854)	(53,112)	(1,258)	(103,214)	(106,192)	(2,978)	-3%	(617,024)	(617,024)	0
Non-Pay	(28,977)	(33,883)	(4,906)	(57,712)	(65,047)	(7,335)	-13%	(345,904)	(345,904)	0
Non Operating Items	(1,963)	(1,916)	47	(3,768)	(3,715)	53	1%	(22,612)	(22,612)	0
Total	**(1,471)**	**(4,230)**	**(2,759)**	**(2,240)**	**(8,532)**	**(6,292)**		**0**	**0**	**0**

Key Messages

The primary drivers of the £6.3m adverse variance to plan are:

- Income is favourable £4m due to : Overperformance on pass through drugs and devices £1.5m (compensated by same level of spend); Medical pay awards £0.7m; PFI central funding £0.7m; rephasing of winter income to match spend £1m.

Expenditure adverse variance of £10.3m is due to :

- Pay costs overspend of £0.7m in relation to the payment of the revised 2023/24 Consultant pay uplift;
- CIP is £2.7m behind plan. At the time of the plan submission the unidentified element of the efficiency programme was profiled evenly throughout the year, YTD shortfall includes c. £2m of this unidentified target.
- Additional capacity put in place for Winter continued into the April & May, due to services pressures, accounting for c £0.9m of the YTD pay overspend; Waiting List Initiative costs of c.£1.4m are included in the YTD position.
- The non-pay position includes c. £0.5m of excess inflationary costs above plan levels. Drugs spend above planned levels c £2m, offset in part by funding for pass through drugs.

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I&E Performance : THH

THH

2024/25 M2	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	YTD variance %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	29,775	29,725	(50)	59,551	58,751	(800)	-1%	357,309	357,309	0
Pay	(19,249)	(21,817)	(2,568)	(38,498)	(42,704)	(4,206)	-11%	(230,895)	(230,895)	0
Non-Pay	(10,301)	(12,815)	(2,514)	(20,603)	(23,702)	(3,099)	-15%	(123,487)	(123,487)	0
Non Operating Items	(681)	(687)	(6)	(1,347)	(1,306)	41	3%	(2,927)	(2,927)	0
Total	**(456)**	**(5,594)**	**(5,138)**	**(897)**	**(8,961)**	**(8,064)**		**0**	**0**	**0**

Key Messages:

The primary drivers for the £8m adverse YTD variance are :

- Income : adverse due to unresolved dispute on NHS Income for environmental controls (£0.4m) and £0.6m on cross border activity underperformance. Non elective activity is overperforming however this is under a block arrangement.
- CIP under delivery by £1.3m.
- Pay is adverse due to operational pressures - including use of escalation beds, ED & UTC medical staffing & RMNs cost pressure.
- Non pay adverse due to prior year cost (insourcing), pathology excess inflation, an increase drugs and clinical supplies.

Appendix 2

NWL APC Run Rates

Run Rates

- This appendix shows the monthly run rates of income, pay and non-pay for the APC and trusts 23/24 to 24/25.

- Non pay excludes non-operating items.

- The spike in M12 March 24 in pay and income relates primarily to the accrual for additional employer's pension costs. To note in 2024/25 the pay uplift is accounted for in line with national planning assumptions, including the agreed consultants' pay award.

- Comparing YTD 24/25 with the average of M7-M11 23/24:

  - For the APC, Income is 1% lower, expenditure is 3.8% higher (pay 2.8% higher; non-pay 5.3% higher)
  - For CWFT, Income is 0.3% higher, expenditure is 3.2% higher (pay 3.3% higher, non-pay 0.5% higher)
  - For ICHT, Income is 0.9% higher, expenditure is 3.2% higher (pay 3.5% higher; non–pay 2.8% higher)
  - For LNWH, Income is 2.7% lower, expenditure is 6% higher (pay 1.7% higher; non-pay 13.8% higher)
  - For THH, Income is 11% lower, expenditure is 4.6% higher (pay 1.6% higher; non-pay 10.5% higher)

Run rate - APC

NWL APC £'000			23/24 M1	23/24 M2	23/24 M3	23/24 M4	23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2
	Income	Plan	293,602	294,894	306,159	299,699	303,520	306,236	308,438	303,436	301,481	303,602	302,955	302,293	321,475	321,666
		Actual	290,660	308,697	308,647	316,242	327,853	314,565	325,571	355,041	321,160	326,872	367,546	451,692	331,115	338,746
	Pay	Plan	178,110	178,254	189,177	180,989	184,188	187,129	187,596	183,686	184,110	184,002	183,632	183,778	198,923	199,417
		Actual	188,795	196,489	188,999	193,304	207,265	200,358	198,686	199,395	200,686	206,006	203,442	291,212	204,087	210,445
	Non-pay	Plan	116,842	116,638	114,709	116,059	115,999	115,922	117,704	116,905	116,902	116,924	116,913	117,366	120,626	121,971
		Actual	119,225	117,060	125,938	129,151	120,994	120,155	132,394	133,934	117,693	128,490	131,876	140,753	133,376	137,970

Acute Providers Income Run Rate vs Plan
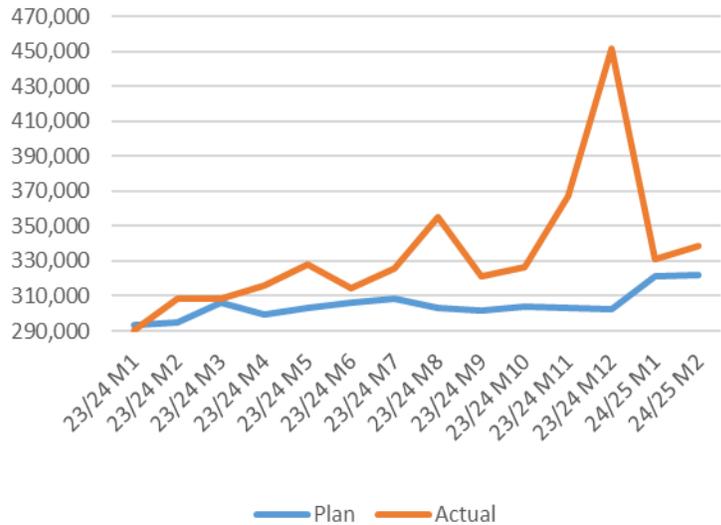
Aute Providers Pay Run Rate vs Plan

Acute Providers Non Pay Run Rate vs Plan
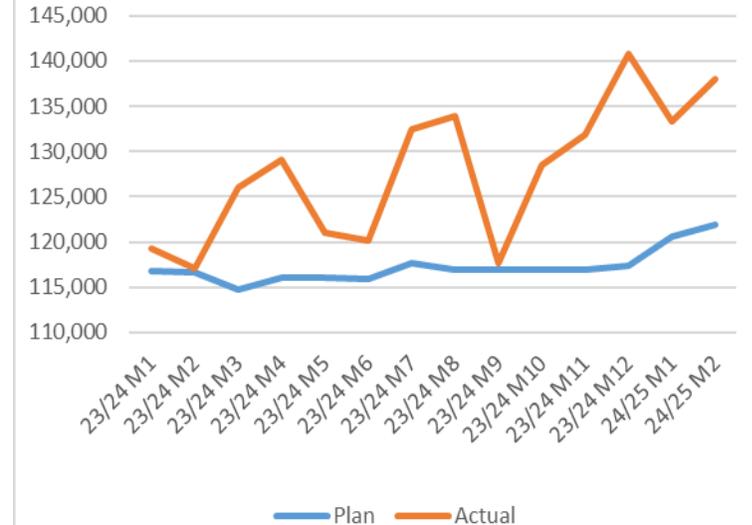
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Acute Provider Collaborative

Run rate - CWFT

CWFT £000			23/24 M1	23/24 M2	23/24 M3	23/24 M4	23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2
	Income	Plan	68,851	68,851	72,948	70,217	70,217	72,604	75,414	71,978	71,978	71,978	71,978	71,974	74,808	74,808
		Actual	70,186	72,005	70,875	76,888	80,474	76,438	78,497	79,753	75,742	78,892	84,282	94,262	78,860	80,560
	Pay	Plan	38,787	38,787	42,672	40,084	40,084	42,471	43,629	41,001	41,001	41,001	41,001	40,948	43,318	43,318
		Actual	41,643	42,191	42,085	42,122	45,487	42,712	43,759	43,167	43,700	46,134	43,431	62,931	45,623	45,403
	Non-pay	Plan	29,096	29,091	29,301	29,203	29,203	29,187	30,893	30,083	30,079	30,100	30,102	30,156	30,985	31,036
		Actual	29,288	28,918	29,186	35,617	33,828	30,278	33,791	36,003	29,685	35,948	37,171	27,887	34,204	35,181
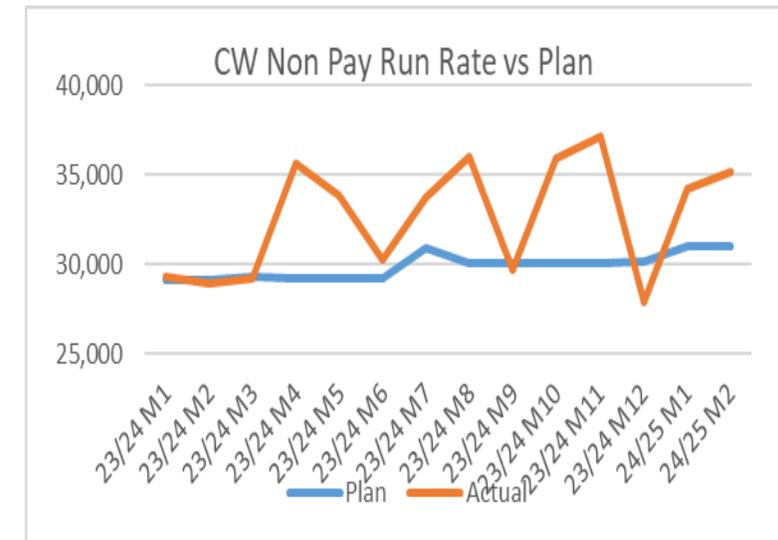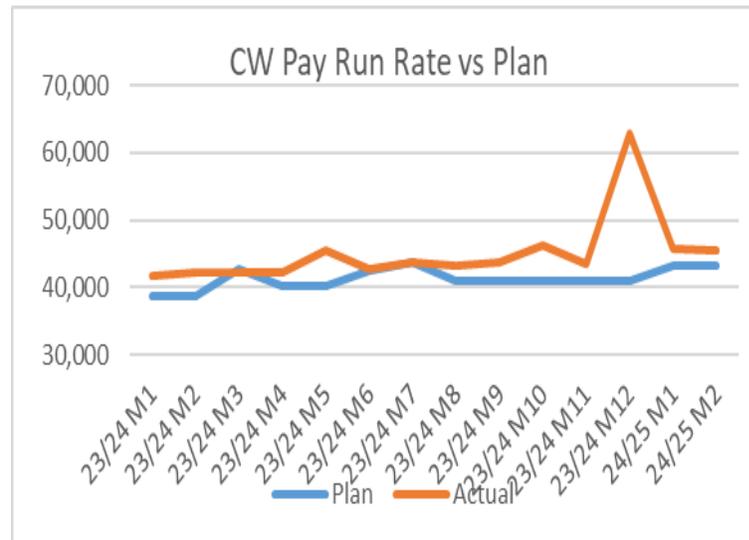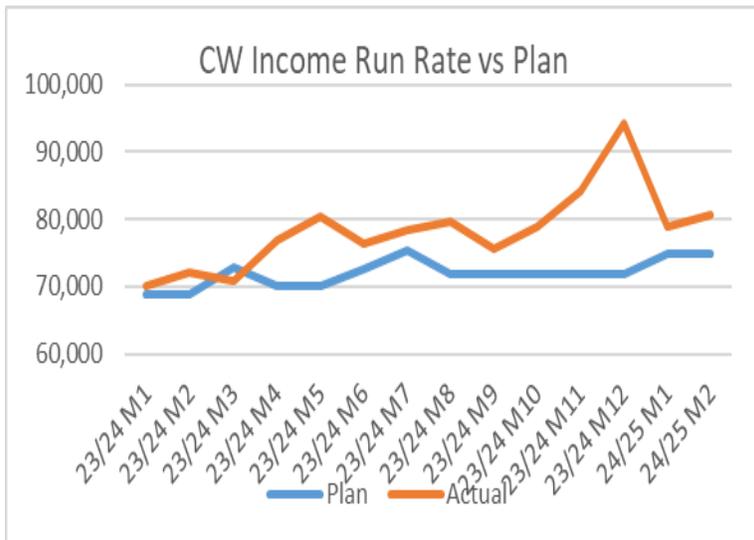
Run rate - ICHT

ICHT £000			23/24 M1	23/24 M2	23/24 M3	23/24 M4	23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2
	Income	Plan	127,148	127,148	129,289	127,886	131,067	128,526	128,530	128,530	128,508	128,530	128,526	128,506	135,760	135,760
		Actual	123,370	132,382	134,011	134,039	134,704	135,016	136,803	150,589	140,630	136,304	142,143	199,604	141,488	143,780
	Pay	Plan	76,069	76,068	80,376	77,528	80,709	78,168	78,172	78,173	78,149	78,173	78,168	78,158	84,996	84,996
		Actual	79,586	84,999	79,325	81,683	86,677	87,010	83,311	83,728	84,330	85,005	85,558	120,712	84,497	90,113
	Non-pay	Plan	50,321	50,322	48,155	49,600	49,600	49,600	49,600	49,599	49,601	49,599	49,600	49,582	50,604	51,657
		Actual	53,537	51,396	55,706	53,176	48,910	50,919	57,223	56,855	51,116	55,055	54,960	64,683	57,121	56,091

ICHT Income Run Rate vs Plan

ICHT Pay Run Rate vs Plan

ICHT CW Non Pay Run Rate vs Plan

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Run rate - LNWH

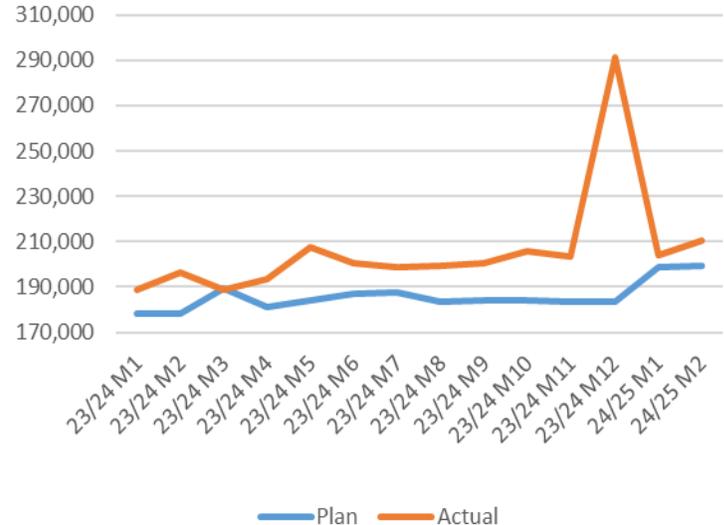| LNWH £000			23/24 M1	23/24 M2	23/24 M3	23/24 M4	23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2
	Income	Plan	70,632	71,923	76,095	74,335	74,980	77,845	75,407	75,407	73,471	75,406	74,762	74,116	81,131	81,323
		Actual	70,106	75,985	76,559	77,472	81,261	74,473	79,784	89,703	74,786	80,717	102,490	114,750	81,741	84,681
	Pay	Plan	44,358	44,502	46,383	44,462	44,624	47,854	45,330	45,755	46,202	46,070	45,705	45,914	51,360	51,854
		Actual	48,231	49,559	49,011	50,193	54,268	50,366	50,335	51,548	52,167	53,644	53,339	75,502	53,080	53,112
	Non-pay	Plan	28,061	27,893	27,904	28,028	28,028	28,028	28,104	28,175	28,174	28,177	28,162	28,175	28,735	28,977
		Actual	26,653	28,048	27,705	29,032	26,917	27,367	30,673	29,830	27,260	26,019	29,168	31,722	31,164	33,883
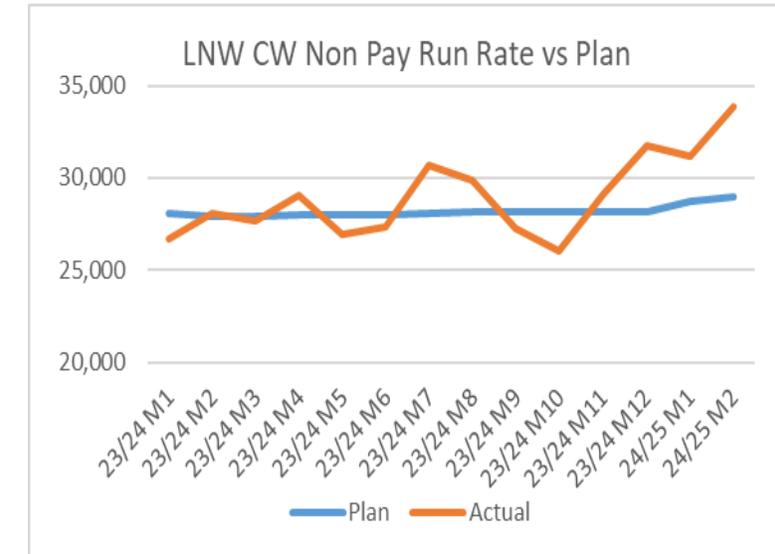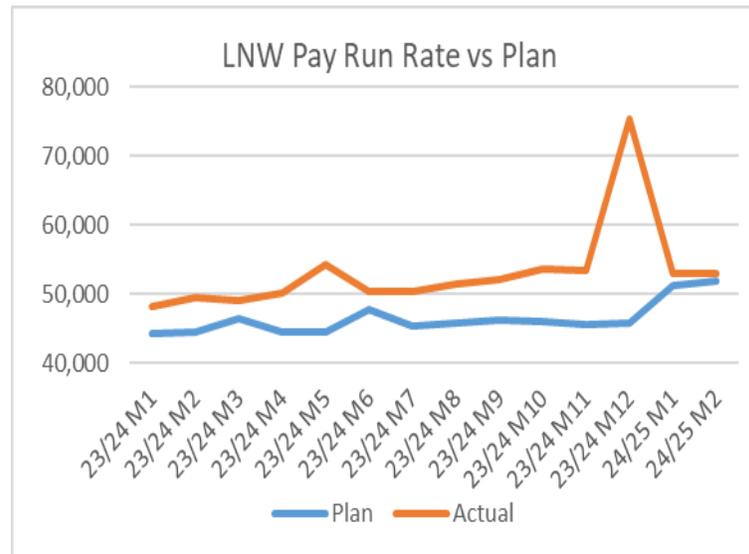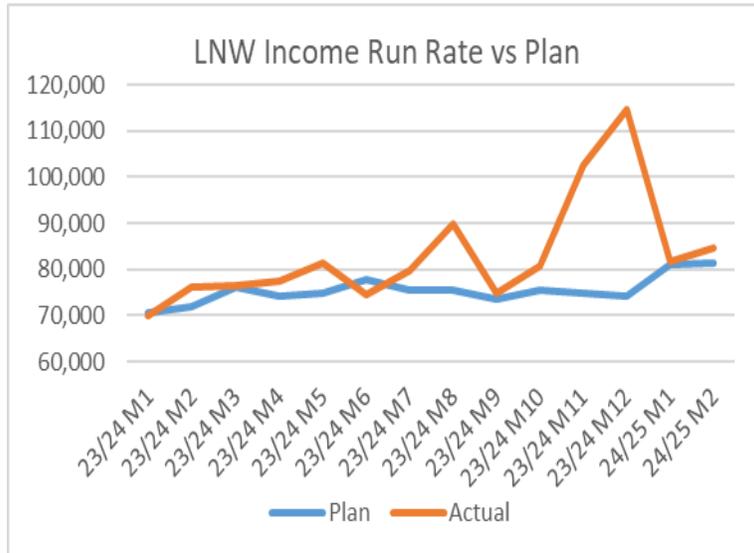
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Run rate - THH

THH £000			23/24 M1	23/24 M2	23/24 M3	23/24 M4	23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2
	Income	Plan	26,971	26,972	27,827	27,261	27,256	27,261	29,087	27,521	27,524	27,689	27,689	27,698	29,776	29,775
		Actual	26,998	28,326	27,202	27,843	31,414	28,637	30,487	34,996	30,002	30,959	38,631	43,076	29,026	29,725
	Pay	Plan	18,896	18,897	19,746	18,915	18,771	18,636	20,465	18,757	18,758	18,758	18,758	18,758	19,249	19,249
		Actual	19,335	19,741	18,578	19,306	20,833	20,269	21,281	20,952	20,489	21,223	21,114	32,067	20,887	21,817
	Non-pay	Plan	9,364	9,332	9,349	9,228	9,168	9,107	9,107	9,048	9,048	9,048	9,049	9,453	10,302	10,301
		Actual	9,747	8,698	13,341	11,326	11,339	11,592	10,707	11,246	9,632	11,468	10,576	16,461	10,887	12,815
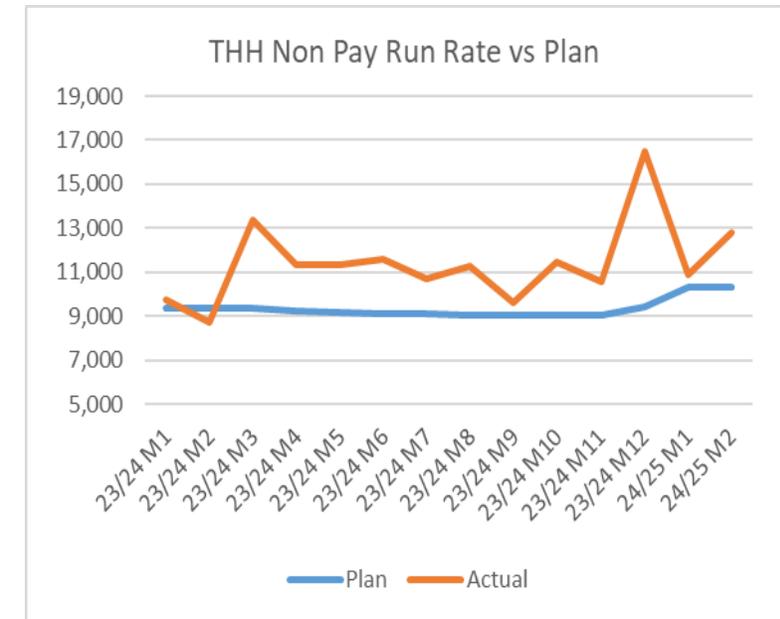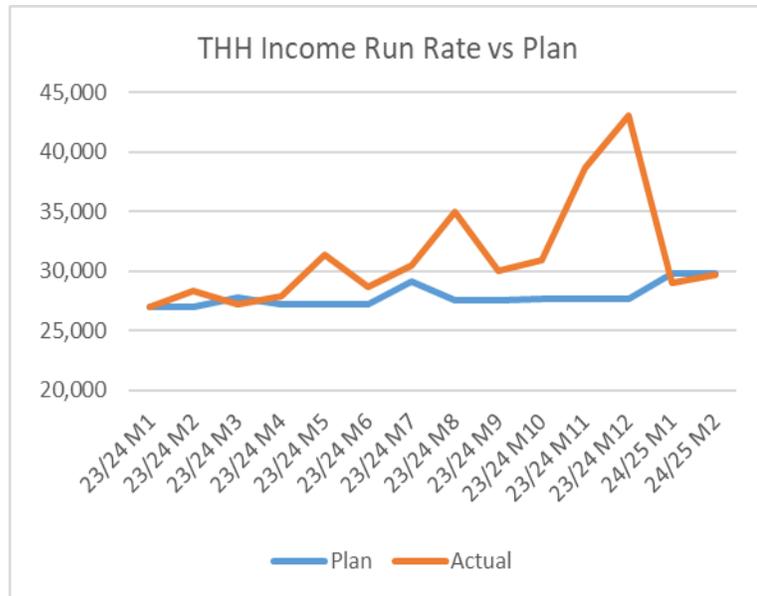
THH Income Run Rate vs Plan

THH Pay Run Rate vs Plan

THH Non Pay Run Rate vs Plan
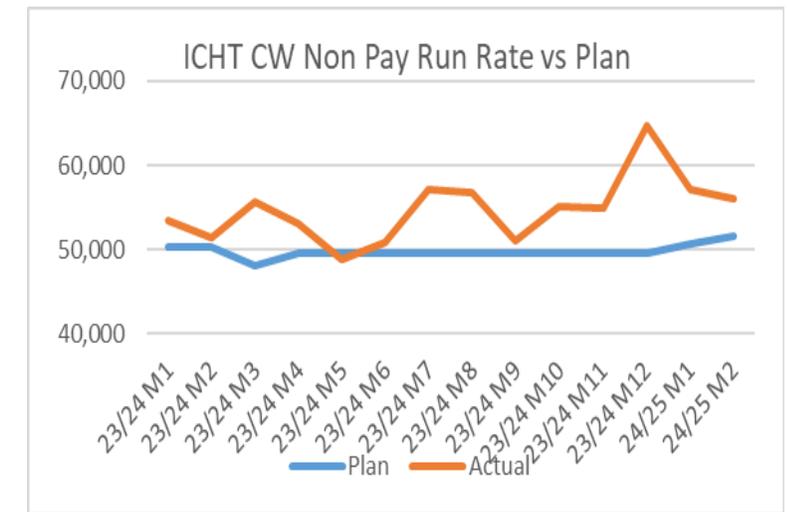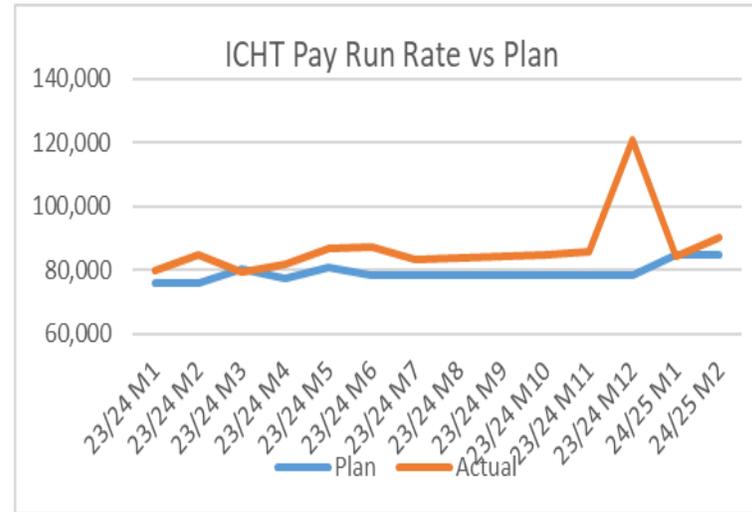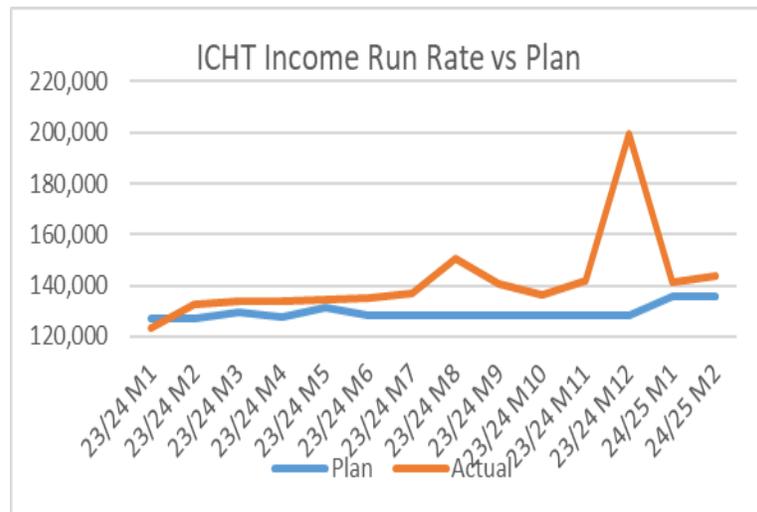
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Appendix 3

Financial Performance Escalation

Financial Performance Escalation - 1

- The financial performance escalation process implemented in 2023/24 will be followed in 2024/25 due to the high risk in the financial plan.
- A set of escalation metrics are in place whereby a breach enacts escalation. This tests the variation from YTD plan, CIP delivery, ERF performance and annual plan, .
- Once a trust moves into escalation, formal peer review and reporting is initiated including testing grip and control measures, reviewing forecasts and run rates and developing financial recovery plans.
- Escalation metric scores are shown in the table below. All trusts score 4 (the highest) for at least two metrics. On average, CWFT has the lowest score and LNWH & THH the highest.
- The escalation process commenced during June (for month 2 reporting). A CFO Peer Review session was held on 14.06, a series of actions were noted. A further meeting to be held in July to Peer review trust financial recovery plans.

M2 Escalation Trigger Summary													
Measure	Basis	Level 1	Level 2	Level 3	Level 4	CW	ICHT	LNW	THH	CW	ICHT	LNW	THH
Year to Date deterioration against plan	T/over	0-0.5%	0.5-1%	0-1%	>1%	4	3	4	4	-1.3%	-0.6%	-3.9%	-13.5%
Year to Date Run Rate - deficit	T/over	0-0.75%	0.75-1%	0-1%	>1%	4	4	4	4	-1.6%	-1.5%	-5.3%	-15.0%
CIP non-delivery against plan	CIP Value	0-10%	20-30%	30-40%	>30%	2	4	4	4	-14%	-43%	-52%	-69%
ERF activity delivery	ERF %	0-2.5%	2.5-5%	5-10%	>10%	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Forecast Outturn	T/over	0	0-0.5%	0.5-0.75%	>0.75%	1	1	1	1	0	0	0	0
Ave score						2.8	3.0	3.3	3.3				

Financial Performance Escalation - 2

Level	Escalation Process	ICB
1	Peer review by peer CFO to challenge recovery and support identification of mitigations	N/A
	Notification to CEOs	
2	As 1 above	Inform (i.e. advise of proposals)
	Turnaround plan developed and presented to CEOs	
	Implementation of turnaround controls e.g. vacancy review, discretionary spend review	
	Report to Trust F&P	
3	As 1 & 2 above	Engage (discuss and agree proposals)
	Trust in formal turnaround requiring APC led SOM style meeting to agree recovery plan and actions	
	Turnaround controls reviewed by multi-trust panel (double lock)	
	Report to CIC F&P	
	Release of support from APC to mitigate the financial position *	
4	As 1-3 above	Involve (likely to be part of wider escalation process)
	Turnaround controls reviewed by ICS panel (triple lock)	
	Report to CIC Board	

- Upon breaching the metrics, the levels of escalation are shown in the table.
- This is the 2023/24 process which has agreed to be followed in 2024/25.
- * to note for 2024/25 there is no risk pool support funding.

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9.3 ACUTE PROVIDER COLLABORATIVE AND TRUST BUSINESS PLANS ?

PRIORITIES, OPERATING AND FINANCIAL

● Discussion Item   👤 Lesley Watts

REFERENCES   Only PDFs are attached

📄 9.3a APC Board Operating and Financial Plan.pdf

📄 9.3b APC Finalised Financial and Business Plans 2024-25 v1.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

NHS

NWL Acute Provider Collaborative Board in Common (Public)

16/07/2024

Item number: 9.3

This report is: Public

2024/25 Operating and Financial Plans

Author:	Helen Berry
Job title:	Associate Director of Finance, NWL Acute Provider Collaborative
Accountable director:	Jonathan Reid
Job title:	Chief Financial Officer, London North West University HC NHS Trust

Purpose of report

Purpose: Information or for noting only

The Board is asked to note the confirmed submission of the financial, operating and workforce plans for 2024/25 in May 2024, alongside the reconfirmation of the Business Plan priorities in advance of the Strategy approval. Submitted plans are in line with the Board discussion in April 2024.

Report history

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

APC Trust Finance & Performance Committees held in April & May 2024 01/05/2024 Key Elements Agreed	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 report summarises the 2024/25 plans which were submitted to NHS England and NWL ICB on 2nd May 2024. Draft plans were presented to the Board in Common Meeting on 16th April with agreement that final plans be signed off by local Trust Finance and Performance Committees ahead of the submission deadline on 2nd May.

APC and all trusts submitted breakeven financial plans in line with the Board discussions. These plans included Cost Improvement Targets of £140m and sit alongside ambitious activity, workforce and operating plans for the coming year. Plans were discussed and agreed at Trust

Committees in advance of submission. Progress on each of these plans is discussed on a monthly basis at the Executive Management Board, and at Board sub-Committees as appropriate, with an update on the agenda for today's meeting.

Alongside these plans, Executive Management Board continues to receive quarterly updates on the Business Plan priorities for the Collaborative which were rolled forward into 2024/25 in advance of the formulation of the Collaborative Strategy. Lead CEOs and the relevant sub-Committees have already commenced the process of refreshing priorities in the context of the new Strategy and it is anticipated that a full refresh of the Business Plan will be presented to the next meeting of the Collaborative Board.

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

Delivery of our Collaborative plans will explicitly support delivery of our Strategy Priorities.

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

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

2024/25 Plans

Summary of Confirmed Submissions

Jonathan Reid

CFO, LNWH

9 July 2024

Executive Summary

- In April, the Collaborative Board-in-Common considered the draft financial and operational plans for the Collaborative. Trust Finance and Performance Committees were given delegated authority to sign off the final plans, and these were signed off and submitted on 2nd May. Although the national planning process has continued for systems and Trusts not at breakeven, the Collaborative and ICB plans have remained substantially unchanged since the submission on 2nd May, allowing the whole system to focus on delivery.

- The Collaborative Financial Plan is break-even. This plan assumes a significant and continued increase in elective activity, and a combined Cost Improvement ask of £140m across the Trusts. In addition, the Trusts are working with the wider system on a broader System Optimisation Plan, with a combined value for the Acute Provider Collaborative of £12.5m. This latter element of the plan will be challenging and represents an opportunity to progress a new approach to delivering financial improvement. The capital plans were supplemented at Month 2 with further capital allocations and now stand at £239m for the year. The finalised plan is included in this pack.

- The Collaborative submitted operating plan trajectories in line with discussions at both the Collaborative Board-in-Common and Finance and Performance Committee in June 2024. Overall compliance with the requirements of the national planning process, as well as the NWL priorities, is high – reflecting strong performance over the last year – but there are some areas where local circumstances create challenges in delivery, or in timing. These are summarised and included in this pack.

- The Collaborative also confirmed a collective workforce plan submission, in line with discussions at the People Committee, and at individual Trusts. This is summarised within this pack, with monthly reviews by the Executive Management Board, and supported by a detailed and innovative set of dashboards on workforce productivity.

- The Collaborative Business Plan priorities for 2023/24 were rolled over, with minor clarifications and amendments, into 2024/25 with a commitment to review these in full once the Collaborative Strategy is finalised. These are also included in this pack, noting that Chief Executive Leads and the relevant Board sub-Committees have started the process of refresh and refinement as the Strategy takes shape.

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Final Collaborative Financial Plan

- The table below sets out the combined Collaborative Financial Plan for 2024/25, showing that all Trusts within the Collaborative and the Collaborative as a whole have submitted break-even plans. There are a series of assumptions within each plan, tested and agreed at each Finance Committee and considered as part of the Collaborative Finance and Performance Committee, and the table also shows the headline Cost Improvement Values for the Trusts. There is some variation in CIP target, recognising past achievement and underlying deficits. All Trusts have now identified 100% of their required CIP schemes, with the focus now shifting to delivery of these schemes.

APC Trust Plans 24/25 02.05 submission	CWFT £'000	ICHT £'000	LNWH £'000	THH £'000	Total APC £'000
Income	912,794	1,639,832	985,540	357,309	3,538,166
Pay	(523,203)	(1,017,717)	(617,024)	(230,895)	(2,157,944)
Non pay	(370,673)	(613,343)	(346,849)	(123,736)	(1,330,865)
Non Operating Exp	(12,410)	(11,115)	(21,469)	(2,930)	(44,994)
Other adjustments	(6,508)	2,343	(198)	252	(4,363)
Total	**0**	**0**	**0**	**0**	**0**
CIP in Plan (02.05):					
Recurrent	17,926	63,400	28,494	18,900	128,720
Non Recurrent	5,594	0	6,352	0	11,946
Total CIP	**23,520**	**63,400**	**34,846**	**18,900**	**140,666**
% of Operating Exp	2.6%	3.9%	3.6%	5.3%	4.0%

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Final Collaborative Capital Plan

- The Collaborative Capital Plan is, partly by necessity, iterative, and developed over time. Each Trust developed its own capital plan, reflecting their own internal capital planning frameworks and aligned with the allocation from NWL ICB. However, the Trusts also received additional allocations of capital from the NHS England based on their performance against certain urgent care standards at the end of the financial year. In addition, the ICB received a significant allocation of capital based on the submission of a breakeven plan and the delivery of a breakeven plan in 2023/24. At Month 2, £28.3m of capital is held by CWFT on behalf of the ICB for the wider system.

APC Capital Plan 2024/25 (refreshed June)	CWFT £'000	ICHT £'000	LNWH £'000	THH £'000	Total £'000
CRL (excluding IFRS 16)	64,836	70,785	21,873	14,636	172,130
Impact of IFRS 16	95	11,573	1,500	1,197	14,365
Total CRL (including IFRS)	64,931	82,358	23,373	15,833	186,495
PDC : National Schemes					-
Diagnostic Digital Capability Programme	-	810	500	-	1,310
Elective Recovery/Targeted Investment Fund	20,206	-	-	-	20,206
Front Line Digitisation	-	-	780	-	780
New Hospital Programme (NHP)	-	1,281	-	26,100	27,381
PFI capital charges (e.g. residual interest)	2,126	-	1,032	1	3,159
					-
Total National Schemes	22,332	2,091	2,312	26,101	52,836
Total Capital Plan (Net CDEL)	87,263	84,449	25,685	40,934	239,331

Operational Performance Headlines

Area	Objective	Current performance (May 2024)	2024/25 delivery plan meets objective	Notes
Urgent and emergency care	Improve A&E waiting times, compared to 2023/24, with a minimum of **78% of patients seen within 4 hours in March 2025**	76.7%	✓ CWFT ✓ ICHT ✓ LNWUH ✓ THH	
Elective care	**Eliminate waits of over 65 weeks** for elective care as soon as possible and **by September 2024** at the latest (*except where patients choose to wait longer or in specific specialties*)	2032	✗ CWFT ✓ ICHT ✓ LNWUH ✓ THH	No waits over 65 weeks at CWFT by October 2024
Cancer	Improve performance against the headline **62-day standard to 70% by March 2025**	74.2% (April 2024)	✓ CWFT ✓ ICHT ✓ LNWUH ✓ THH	APC commitment to achieving 85% by February 2025
Cancer	Improve performance against the **28 day FDS to 77% by March 2025** towards the 80% ambition by March 2026	75.5% (April 2024)	✓ CWFT ✓ ICHT ✓ LNWUH ✓ THH	
Diagnostics	Increase the percentage of patients that receive a **diagnostic test within 6 weeks to 95% by March 2025**	82.9%	✓ CWFT ✓ ICHT ✓ LNWUH ✓ THH	

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Workforce Plan

- The table below sets out the combined final submission of the workforce plan for the Collaborative. The plans for each Trust were reviewed by the respective Trust Workforce Committees, and then considered by the Collaborative People Committee. On a monthly basis, progress against the plan is reviewed by the Chief People Officers, the Executive Management Board and, where appropriate, the workforce Committee. The plan is supported by a detailed series of metrics contained within the workforce productivity dashboard, which is also reported on a monthly basis.

2024/25 WF PLAN	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	WTE CHANGE	% CHANGE
CWFT	7,569	7,455	7,460	7,459	7,461	7,457	7,465	7,460	7,456	7,454	7,451	7,450	7,331	-238	-3.1%
ICHT	15,733	15,663	15,702	15,640	15,763	15,725	15,773	15,670	15,708	15,670	15,708	15,670	15,670	-63	-0.4%
LNW	9,658	9,701	9,573	9,584	9,584	9,584	9,584	9,651	9,622	9,637	9,631	9,617	9,603	-55	-0.6%
THH	3,930	3,894	3,894	3,894	3,854	3,854	3,854	3,774	3,774	3,774	3,774	3,774	3,774	-157	-4.0%
APC	36,890	36,714	36,628	36,577	36,663	36,620	36,676	36,554	36,560	36,534	36,564	36,511	36,377	-513	-1.4%

NHS
Acute Provider Collaborative

Business Plan Priorities

- The Business Plan for the Collaborative was rolled over into 2024/25 with some minor refresh as the Collaborative Strategy is finalised. On a monthly basis, Executive Management Board receives an update on the progress against the priority programmes within the plan, as shown below at the end of Q1. On approval of the Strategy for the Collaborative, a formal refresh will take place – but Chief Executive Leads and relevant Board sub-Committees have already started this work, so that the full programme of work for 2024/25 can be confirmed at the earliest opportunity.

Quality Priorities - 2024/25	Q1
Priority	Rating
Clinical harm review, access and inequality	A
Infection prevention and control	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	A
Implement new national patient safety strategy	G
Incident and risk management system	A

Workforce Priorities - 2024/25	
Priority	Q3
Reduce premium rate staffing expenditure	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	Q1
Finalise the APC Digital and Data Strategy	G
Implementation and Optimisation of Cerner system	G
Federated Data Platform	A

Finance & Performance Priorities - 2024/25	Q1
Priority	
Delivery of the activity targets in the 24/25 operational plan, including ERF	G
Support Services Consolidation	G
Implementation of Collaborative and ICB Programme 'System Optimisation'	A
Develop a clear financial model for a move to sustainability within a 3-5 year period, including rebalancing of earned/unearned income and reduction in ICB support	A
Outpatient Transformation	A
Implementation of ICB/Trust Business Case Review Outcomes	A

- Sitting alongside these programmes of work are priority Collaborative Productivity and Efficiency Schemes. An initial 13 schemes were identified earlier in the planning cycle – four have now been prioritised and are being supported by Directors of Transformation as well as Chief Financial Officers and Chief Operating Officers.

10.1 ACUTE PROVIDER COLLABORATIVE GOVERNANCE MODEL AND SCHEME OF DELEGATION

● Decision Item   👤 Peter Jenkinson   🕐 11.35

REFERENCES

Only PDFs are attached

📕 10.1a Revised scheme of delegated authority v1.3 BiC - July 2024.pdf

📕 10.1b Appendix 1 - Scheme of Delegated Authority revised July 2024 v2.pdf

📕 10.1c Appendix 2 - Trust Standing Committees TOR.pdf

NWL Acute Provider Collaborative Board in Common
16 July 2024
Item number: 10.1
This report is: Public

Implementing revision to the Collaborative governance arrangements – Scheme of Delegated Authority

Author: Peter Jenkinson
Job title: Director of Corporate Governance

Accountable director: Tim Orchard, Chief Executive Officer
Pippa Nightingale, Chief Executive Officer
Lesley Watts, Chief Executive Officer
Patricia Wright, Chief Executive Officer

Purpose of report

Purpose: Decision or approval

The purpose of this paper is to set out the revised governance process and amendments to the Scheme of Delegated Authority for the four Trusts within the North West London Acute Provider Collaborative, in order to implement decisions made at the previous Board in Common meeting.

Report history

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

Board in Common Cabinet 14 May 2024	**Board in Common development session** 21 May 2024

The Board in Common agreed proposed amendments to the governance arrangements for the Acute Provider Collaborative (the 'Collaborative') in April 2024, to strengthen the level of Trust-level engagement and oversight by establishing Trust-level Standing Committees, and to maximise the effectiveness of the Collaborative governance arrangements by clarifying the relationship between Trust-level and Collaborative-level committees. These revised arrangements will ensure appropriate oversight of delivery of trust-level strategic priorities and performance by each Trust Board and a focus on development and delivery of the Collaborative strategy and strategic priorities by the Collaborative-level committees.

The purpose of this paper is to confirm the revised governance arrangements and to present amended Scheme of Delegated Authority for the Collaborative to reflect these changes.

At the April Board in Common meeting, the four Trust Boards agreed that each Trust Board should delegate authority for the establishment of a Standing Committee as a sub-committee of the Trust Board. While it is for each Trust Board to agree their own governance arrangements, including the terms of reference for their respective committees of the Trust Board, there are some common standards to be applied across all four that ensure triangulation of assurance across Trust-level board committees, and assurance that local issues and risks are being addressed.

These common standards include each Standing Committee reporting to their respective Trust Board, meeting as part of the Board in Common, and publication of papers for the Standing Committee on the respective Trust website.

As part of this review, we have also reviewed the terms of reference for Collaborative-level committees, to clarify their role in developing and delivering Collaborative-level strategy and strategic priorities and their relationship with board committees. Collaborative committees will continue to focus on the development and delivery of strategic priorities that support the delivery of the Collaborative strategy and to manage Collaborative risks. To this end, while Collaborative-level committees will no longer have oversight of the effectiveness of trust-level committees, there will be appropriate identification of common issues and escalation of risks from board committees to inform Collaborative-level priorities.

We have also reviewed the terms of reference, including frequency and purpose, of other existing meetings, including board committees, to remove duplication and minimise the number of meetings while ensuring effective governance arrangements. It is for each Trust Board to determine the most appropriate governance for the Trust, including frequency of board committee meetings.

These proposed changes have been discussed at the Board in Common Cabinet meeting and the Board in Common development session in May 2024.

These arrangements will provide a governance structure to develop and deliver the strategic priorities that will enable the delivery of the Collaborative strategy, while providing the governance structure to enable individual Trust Boards to receive

assurance regarding delivery of their Trust strategy, business plans and management of Trust risks and issues. These arrangements are reflected in the amended Scheme of Delegated Authority, attached as Appendix 1 to this paper.

These arrangements will be kept under review and evaluated again, as part of the annual review of effectiveness of board governance.

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 (where applicable)

Click to describe impact

1.   Background / purpose

1.1   At the last meeting of the Board in Common, in April 2024, the Trust Boards considered options for the revision of governance arrangements across the NW London Acute Provider Collaborative (the 'Collaborative'), following the review of the effectiveness of the current governance arrangements completed in November 2023.

1.2   The four Trust Boards agreed to delegate authority to establish Standing Committees of the Trust Board, with detailed terms of reference to be agreed by each Standing Committee and Trust Board. The Boards also agreed 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.

1.3   The purpose of this paper is to confirm the outcome of this review, to confirm the revised governance arrangements, and to present an amended Scheme of Delegated Authority for the Collaborative to reflect these changes, and to present the terms of reference for the Trust Standing Committee for approval.

2.   Amendments to the Collaborative governance arrangements

Trust Standing Committees

2.1   At the April Board in Common meeting, the four Trust Boards agreed that each Trust Board should remove the existing NED triangulation meetings and approved the delegation of authority for the establishment of a Standing Committee as a sub-committee of the Trust Board.

2.2   The first meetings of the Trust Standing Committees will take place in June / July 2024.

2.3   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 and to triangulate across the various domains, to provide an integrated view of performance and risk across the Trust.

2.4   While it is for each Trust Board to agree their own governance arrangements, including the terms of reference for committees of the Trust Board, some common standards are being applied across all four trusts for the Standing Committee.

        •   The purpose of the meeting is to oversee the delivery of the Trust strategy and strategic priorities, and the achievement of constitutional and

regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

- They will receive reports from the Board committees to provide a holistic view of performance across the Trust, and to consider trust-specific issues prior to the Board in Common.
- Decision-making will remain the remit of the Trust Boards in the Board in Common, unless explicit delegation of authority.
- Membership will include all non-executive directors (including designate and associate) and executive (voting) board members of that Board. Meetings will be chaired by the Trust Vice-Chair.
- Frequency will be at least quarterly.
- Formal reporting, via a summary report, to the Trust Board which meets quarterly in public as part of the Board in Common.

2.5   The Scheme of Delegated Authority (Appendix 1) has been amended to include the delegated authority from Trust Boards to their respective Standing Committees, and terms of reference for the Standing Committee is included (Appendix 2) for Trust Boards to approve.

2.6   There are some duties that remain reserved for the Trust Board. Decision-making will remain the remit of the Trust Board, in the Board in Common meeting, unless Trust Boards agree to delegate authority to their respective Standing Committee. The Standing Committee will oversee the development of the Trust strategy, in the context of the Collaborative strategy, and oversee the delivery of Trust-specific strategic priorities. The Committee will also have the delegated authority to approve Trust-only business cases in line with the delegated authority limits of the Trust Board.

2.7   There are several reports that must be received by the Board, in public, for example annual reports for infection, prevention & control, safeguarding, learning from deaths, seven day service, complaints, and health & safety. Previously these reports have been presented to the relevant board committees, Collaborative committee and the Trust Boards via the Board in Common. With the establishment of the Standing Committees, each Trust will receive such reports via the relevant board committee, and the Standing Committee, and will then publish on the Trust website. A summary of the common issues arising from such reports across the Collaborative will also be presented to the relevant Collaborative committee, to inform any Collaborative programme of work that would add value to the individual trusts.

2.8   Trust Standing Committees are sub-committees of the Trust Board, and will therefore meet *in camera* as per other committees of the Trust Board. However, to ensure public transparency and to allow each Board to be held to account by stakeholders, including members of the public, the papers for Standing Committee meetings, including agendas and minutes, will be published on Trust websites, unless they are confidential due to personal data or commercially sensitive.

2.7   The revised reporting arrangements across the Collaborative governance structure is shown in the structure below.
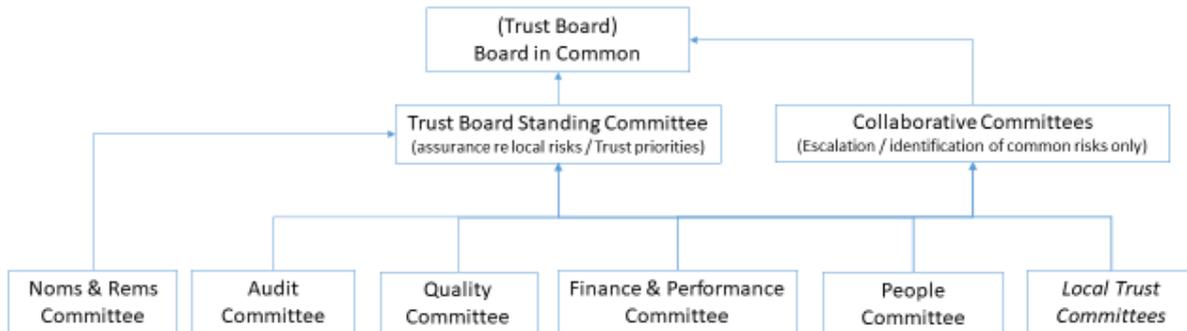
Figure 1 – reporting lines for Trust Standing Committees

Collaborative committees

2.7   With the establishment of the Trust Standing Committees, there is a need to minimise any duplication in the governance structure. To date, Collaborative-level committees have played a dual role:

   • Overseeing the effectiveness of Trust board committees in the management of local issues
   • Overseeing the development and delivery of strategic priorities at APC level.

2.8   While it will remain important for board committees to escalate risks appropriately to Collaborative-level committees, so that we can identify common themes and risks across the Collaborative and to derive value from the Collaborative by developing programmes at Collaborative level to address key common risks, we need to address the balance of Collaborative versus Trust level focus.

2.9   With the introduction of Trust Standing Committees the focus of Collaborative committees will become the development and delivery of Collaborative strategy and the strategic priorities and programmes that will enable the delivery of the strategy. These priorities will be informed by escalation and identification of common risks across the four trusts, or strategic initiatives agreed by the Collaborative committee and Board in Common. Revisions to the terms of reference and forward plans for the respective committees have been revised accordingly.

2.10 The frequency of collaborative level committee remains as quarterly, and they will continue to report to the Board in Common on the development and delivery of appropriate aspects of the APC strategy and strategic priorities.

Board committees

2.11 The establishment of Trust Standing Committees will add 32 hours per year to meeting time across the Collaborative. To mitigate this increase in time commitment for board members, options have been considered to reduce other meetings. These include removal of the quarterly 'NED triangulation meetings', as agreed at the last Board in Common meeting, and the frequency of other informal NED meetings.

2.12 Options were also considered around the frequency of Board-level committees. It is for each Trust Board to determine the frequency of their respective board-level committees, taking into account local circumstances and assurance requirements.

2.13 Taking into account the benefits of aligning to a quarterly meeting cycle for board committees, Standing Committees and the Board in Common, while ensuring that Trust-level governance arrangements are appropriately effective, Trust Boards have reviewed the frequency of their Board committees and agreed, where appropriate, for those meetings to move from every two months to every quarter, with local variation as appropriate.

3.0 Conclusion

3.1 Following the decision by the four Trust Boards at the last Board in Common meeting, to delegate authority to establish Trust Standing Committees for each Trust, and to review other elements of the Collaborative governance arrangements, amendments have been to such arrangements including:
- Establishing Trust Standing Committees for each Trust
- Revising the terms of reference for Collaborative level
- Reviewing the frequency of Board committee arrangements in each Trust.

3.2 These amendments have been reflected in the revised Scheme of Delegated Authority for the Collaborative, attached at Appendix 1 to this paper for the four Trust Boards to approve.

4.0 Recommendations

4.1 Trust Boards are asked to approve the revised Scheme of Delegated Authority for the Collaborative, attached at Appendix 1, and the draft Terms of Reference for the Trust Standing Committees, attached at Appendix 2, to approve the establishment of the revised governance arrangements at Trust and Collaborative level.

4.2 Next steps include:
- Development and implementation of the Collaborative approach to risk management, including identification and appropriate escalation of risks from Trust Board committees to Collaborative level committees.

NORTH WEST LONDON ACUTE PROVIDER COLLABORATIVE

SCHEME OF RESERVED AND DELEGATED POWERS

VERSION 2.0 - REVISED JULY 2024

Purpose

The purpose of this document is to identify those powers which will be reserved to the Trust Board and those which shall be delegated by the Trust Board to a committee-in-common to be discharged as part of the north west London acute provider collaborative Board in Common, a trust level committee or a collaborative level committee, or to the Chair or a director or an officer of the Trust.

The individual Trust Board statutorily remains ultimately accountable for all of the functions of the Trust, even those delegated by the Chair, individual directors or officers and therefore expects to receive information about the exercise of delegated functions on an annual basis, to enable it to maintain an appropriate overall monitoring role, or on an exceptional basis if required.

This scheme will be reviewed and approved by the four trust boards on an annual basis.

Scheme of Delegated Financial Authorities

The financial value of delegated authorities is described in the Scheme of Delegated Financial Authorities, aligned with, but separate from this document

Contents
The Scheme of reserved and delegated powers is in four sections:
Section 1 – Decisions reserved for the Trust Board
Section 2 – Decisions delegated to the Trust Board Committee in Common (to be discharged via the Board in Common)
Section 3 – Decisions / duties delegated to Trust level committees
Section 4 – Decisions / duties delegated to Collaborative level committees
Section 5 – Decisions delegated to Board in Common Cabinet

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SECTION 1 – DECISIONS RESERVED TO THE TRUST BOARD

DUTIES RESERVED TO THE TRUST BOARD
General Enabling Provision   The Board may determine any matter, for which it has delegated or statutory authority, in full session.
Decisions reserved for the Trust Board are delegated to the Committee in Common of the Trust Board (the 'Board in Common'), detailed below.

SECTION 2 – DECISIONS DELEGATED TO THE COMMITTEE IN COMMON OF THE TRUST BOARD (BOARD IN COMMON)

The Trust Board may determine that certain of its powers shall be exercised by Committee in Common of the Trust Board, that meets and operates as part of the north west London acute provider collaborative <u>Board in Common</u>. The terms of reference of this committee and the Board in Common shall be that determined by the Trust Board, including the reporting requirements in respect of these committees.

DUTIES RESERVED TO THE TRUST BOARD COMMITTEE IN COMMON
General Enabling Provision   The Board may determine any matter, for which it has delegated or statutory authority, in full session.
Regulations and Control   • Ratify any urgent decisions taken by the Chair and Chief Executive Officer (CEO)   • Ratify any urgent decisions taken by the Trust Board in Common Cabinet   • Initial approval of a scheme of delegation of powers from the acute provider trust boards to collaborative committees and local Trust Committees, then two-yearly review or earlier as required.   • Require and receive the declaration of Board members' interests that may conflict with those of the board in common, and determine the extent to which that member may remain involved with the matter under consideration.   • Receive reports from committees including those that the Trust is required to produce by the Secretary of State or other regulation to establish and to take appropriate action on.   • Confirm the recommendations of the Trust's committees where the committees do not have executive powers.   • Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Trust Board Committee in Common   • Ratify use of the use of the seal, receiving an annual report of its use.   • Initial approval of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business, then two-yearly review by Audit, Risk and Governance Committee on behalf of the Trust Board or earlier, as required.   • Suspend or vary Standing Orders on recommendation by Audit, Risk and Governance Committee.   • Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trusts within the Collaborative and to agree modifications thereto.   • Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property across the Collaborative.

- Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive Officer's attention, on recommendation by the Audit, Risk and Governance Committee.

Appointments/ Dismissal
- Establish and dismiss committees that are directly accountable to the Trust Board in Common.
- Appoint the chief executive officer.

Strategy, Plans and Budgets
- Define the strategic aims and objectives of the Trust and the North West London acute provider collaborative.
- Approve proposals for ensuring quality and developing clinical governance in services provided by the Trusts within the Collaborative, having regard to any guidance issued by the Secretary of State.
- Approve business cases for investment with a value in excess of £5M where the business case is specific to one Trust within the Collaborative.
- Approve Business Cases for Investment over £5m, where the business case affects more than one of the Trusts within the Collaborative
- Approve Private Finance Initiative (PFI) proposals.
- Approve proposals to award contracts (other than as part of the annual NHS commissioning round) of a capital or revenue nature amounting to, or likely to amount to, over £5m.
- Approve annually Trust's business / operational plans within the Collaborative
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings.
- Approve the opening of bank accounts across the Collaborative.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive Officer and Chief Financial Officer (for losses and special payments) previously approved by the Boards within the Collaborative.
- Approve individual compensation payments (where permissible by Secretary of State).
- Approve proposals for action on litigation against or on behalf of the Trust within the Collaborative

Policy Determination
- Approve the Trust's policies and procedures for the management of risk.

Monitoring
1. Receive such reports as the Trust board sees fit from committees, including Collaborative and standing committees, in respect of their exercise of powers delegated.
2. Continuous appraisal of the affairs of the Trust by means of the provision of reports as may be required from directors, committees, and officers of the Trust. All monitoring returns required by the Department of Health and Social Care (DHSC) shall be reported, at least in summary, to the Trust board.
3. Receive reports from CFO on financial performance against budget and Annual Operating Plan, and on actual and forecast income.
.

Direct Operational Decisions
- The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £5 million or where there is potential for significant media interest.
- Approval of individual contracts (other than as part of the annual NHS commissioning round) of a capital or revenue nature amounting to, or likely to amount to over £5m (capital) or £5m per annum (where total exceeds £10m).

	DUTIES RESERVED TO THE TRUST BOARD COMMITTEE IN COMMON

Financial and Performance Reporting Arrangements
- Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Directors and committees. All monitoring returns required by NHS England, shall be reported at least in summary, to the Trust Board.

Audit
- Ratify the appointment (and where necessary dismissal) of External Auditors (by the Audit Risk and Governance Committee acting as the Audit Panel)

SECTION 3 – DECISIONS /DUTIES DELEGATED BY THE TRUST BOARD TO TRUST COMMITTEES

The Trust board may determine that certain of its powers shall be exercised by a Committee of the Trust Board. The composition and terms of reference of such committees shall be that determined by the Trust Board from time to time taking into account where necessary the requirements of the Secretary of State (including the need to appoint an Audit and Risk Committee and a Remuneration and Appointments Committee). The Trust board shall determine the reporting requirements in respect of these committees. Committees may not delegate such powers to sub-committees unless expressly authorised by the Trust board.

In addition to these committees of the Trust Board, the Trust Board may determine the need for additional 'local' committees. The duties and authority delegated to those committees will be documented in the respective terms of reference.

TRUST STANDING COMMITTEE	The Committee will:
	1. Oversee the delivery of the Trust strategy and strategic priorities, and the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.
	2. Approve business cases for investment with a value in excess of £5M where the business case is specific to one Trust within the Collaborative.
	3. Receive and provide assurance to the Trust Board on the following areas:
	    • Integrated Quality and Performance Reports (Operational performance, Finance, Quality and Workforce)
	    • Board Committee chairs' reports
	    • Board Assurance Framework
	    • Corporate Risk Register
	    • Sustainability and net zero ambitions
	    • Reduction of health inequalities
	    • Essential assurance / reporting requirements, including the following annual reports:
	        a. Infection Prevention & Control
	        b. Safeguarding Adults & Children
	        c. 7 Day services
	        d. Learning from Deaths
	        e. Complaints
	        f. Health & Safety

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AUDIT RISK AND GOVERNANCE COMMITTEE	The Committee will: 1. Monitor the integrity of the financial statements of the Trust, including its annual report and any formal announcements relating to the Trust's financial performance and review and report to the board on significant financial reporting issues and judgements which those statements contain having regard to matters communicated to it by the auditor. 2. Review the annual report and financial statements before recommending them to the Trust board, in particular, the Committee shall review and challenge where necessary. 3. Ensure that the systems for financial reporting to the board of directors, including those of budgetary control, are subject to review as to completeness, integrity and accuracy of the information provided to the Trust board. 4. Review any other statements requiring board approval which contain financial information first, where to carry out a review prior to board approval would be practicable and consistent with any prompt reporting requirements under any law or regulation including the Listing Rules, Prospectus Rules and Disclosure Guidance and Transparency Rules sourcebook. 5. Where the Committee is not satisfied with any aspect of the proposed financial reporting by the Trust, it shall report its views to the board 6. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the Trust's goals. 7. Seek assurance that the Trust board's oversight and management of the delivery of the strategic objectives and in managing strategic, financial and operational risks, is effective, via implementation of the Board Assurance Framework. 8. Seek assurance that the monitoring of due diligence on any integration or partnership arrangement is appropriate. 9. Seek assurance on behalf of the Trust board that the design and application of the control environment in core financial processes are fit for purpose and reflect both public and commercial sector best practice 10. Utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it. 11. Ensure that there is an effective Internal Audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the chief executive and board of directors. 12. Review the work and findings of the external auditor and consider the implications and management's responses to their work. 13. Review any proposal considered for commissioning work outside the annual audit plan (in its role as the Audit Panel) prior to approval. 14. NHS trusts are required to appoint their own external auditors and directly manage the resulting contract and the relationship; trusts are required to have an auditor panel to advise on the selection, appointment and removal of external auditors and on maintaining an independent relationship with them. The Trust has nominated the Committee (Part I) as the Auditor Panel for the Trust. 15. The Auditor Panel will advise the Trust board on the selection and appointment of the external auditor. The Trust board must consult and take account of the Auditor Panel's advice on the selection and appointment of the Trust board on the appointment of external auditors, and publish a notice on the website within 28 days of appointing the auditor providing details of appointment, and noting auditor panel advice. 16. Request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. 17. Request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements. 18. Where requested by the board, the Committee should review the content of the annual report and accounts and advise the board on whether, taken as a whole, it is fair, balanced and understandable and provides the information necessary for stakeholder to assess

NORTH WEST LONDON ACUTE PROVIDER COLLABORATIVE
SCHEME OF RESERVED AND DELEGATED POWERS (SoRDP)   Version 2.0   July 2024

the Trust's performance, business model and strategy and whether it informs the board's statement in the annual report on these matters that is required under the Code.

19. Review the work of the Local Counter Fraud Specialists, including any allegations of possible wrongdoing in financial reporting or other matters of concern including patient care, safety, staff and bullying.
20. Review on behalf of the Trust board any proposed changes to the Standing Orders and Standing Financial Instructions.
21. Examine the circumstances of any departure from the requirements of Standing Orders and Standing Financial Instructions.
22. Monitor the Declarations of Interest & Hospitality policy with reference to the codes of conduct and accountability thereby providing assurance to the board of probity in the conduct of business.
23. Review schedules of losses and compensations annually.
24. Ensure that other board committees receive findings of other significant assurance functions as appropriate, both internal and external to the organisation, including the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors, and professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges and accreditation bodies).
25. Work and liaise as necessary with all other board committees ensuring interaction between committees and with the board is reviewed regularly, taking particular account of the impact of risk management and internal controls being delegated to different committees.
26. Review single tender waivers
27. Review schedules of debtor/creditor balances over 6 months old and over £50,000 and explanations/action plans
28. The Committee will work and liaise as necessary with all other board committees ensuring interaction between committees and with the board is reviewed regularly, taking particular account of the impact of risk management and internal controls being delegated to different committees.
29. Maintain oversight of the effectiveness of Information Governance, including annual submission of the Information Governance Toolkit and the Trust approach to cyber security.
30. Review the effectiveness of other board committees in ensuring that risk and assurance mechanisms are maintained, issues are identified and action and assurance requested on performance outside expected parameters.

Annual Reports and Accounts
31. Receive and approve the Trust's Annual Report, Annual Governance Statement and Annual Accounts.
32. Receive and approve the Charitable funds – annual accounts and report (annual) (where applicable)
33. Receive the annual management letter from external auditor (annual)
34. Receive the Head of Internal Audit Opinion (annual)

| REMUNERATION AND APPOINTMENTS COMMITTEE | The Committee will:
1. Trust board composition
• Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust board and make recommendations to the Trust board with regard to any changes.
• Give full consideration to and make plans for succession planning for the chief executive officer and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the board in future.
• Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
• Be responsible for identifying and nominating a candidate, for approval by the Trust board, to fill the position of chief executive officer.
• Before an appointment is made evaluate the balance of skills, knowledge and experience on the Trust board, and, in the light of |

this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

2. Appointment of executive directors
   - Nominate one or more members to be actively involved with the chief executive officer in the appointment of executive director and executive team member posts, and in the design of the selection process on behalf of the Committee.
   - Ensure that the selection process is based on: an agreed role and person specification; the use or other involvement of any third party recruitment professionals; an interview panel to include the chief executive officer, an agreed non-executive director or directors, an external assessor representing NHS England / DHSC or successor bodies and such other persons as may be agreed to be helpful.
   - Ensure that posts are openly advertised and that the appointment procedure at all times complies with the Trust's policies, standards and general procedures on recruitment and selection. This will include the Trust's inclusive recruitment standards and ensuring compliance with fit and proper person regulations (FPP).
   - Keep the Trust board informed of the process, procedures and timetable to which it is working, as appropriate.

3. Remuneration of executive directors
   - Agree on behalf of the Trust board the remuneration and terms of service of the executive directors and that the executive directors are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance, and to the provision of any national arrangements or directives for such staff where relevant. Approve the remuneration policy for executive directors and executive team members, including approving the performance criteria for bonuses where appropriate and agreed. For the Chief executive, the Committee will advise the Chair regarding the framework for bonuses, in accordance with contract of employment.
   - Agree and review annually the remuneration policy framework for very senior managers (VSM) not on national contracts, including executive directors. Determination of the salaries of very senior managers, other than executive directors, is delegated to the chief executive officer or relevant executive director, advised by the director of people & OD and working within the agreed policy framework. The committee will review annually the earnings of such managers including senior clinicians and clinical managers.
   - Establish the parameters for the remuneration and terms of service for the appointment of executive directors, with delegated authority of the chief executive officer to agree starting salaries within the agreed parameters.
   - Agree the termination of contract of executive directors and the payment of any redundancy or severance packages in line with prevailing national guidance.

4. Performance and Succession Planning
   - Receive assurance that appropriate annual appraisals have been completed by the Chief executive for executive directors and that development plans are agreed with individuals.
   - Ensure the capability of potential or nominated deputies for executive directors to effectively deputise during periods of extended absence on the part of the Executive directors.
   - oversee an assessment of the capability and succession potential of the Trust leaders in order to identify any strategic gaps requiring appropriate intervention and to receive assurance regarding the succession plans for directors and talent management; including assurance regarding equality in the succession planning

FINANCE AND PERFORMANCE COMMITTEE	The Committee will: 1. Advise the Trust board on financial policies; 2. Recommend to the Trust board, the Trust's medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used, ahead of review and approval by the Trust board; 3. Review the Business Plan including the annual revenue and capital budget prior to submission to the Trust board for approval; 4. Review the Trust's financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust board; 5. Review compliance with the self-assessment quality checklist for the annual national cost collection or other equivalent submission; 6. Review, at the request of the Trust board, specific aspects of financial performance where the Trust board requires additional scrutiny and assurance; 7. Review the Trust's projected and actual cash and working capital; 8. Approve and keep under review, on behalf of the Trust board, the Trust's investment and borrowing strategies and policies; 9. Ensure the Trust operates a comprehensive budgetary control and reporting framework (but acknowledging that the Audit, Risk & Governance committee is responsible for systems of financial control); 10. Review the financial risks; 11. Establish the overall methodology, processes and controls which govern the Trust's investments; 12. Evaluate, scrutinise and monitor costs and funding relating to investments (such as Redevelopment and any major pandemic or other incident requiring additional scrutiny of costs)), including regular review of the capital programme ensuring value for money; 13. Review, and recommend to Trust board, the Trust's treasury management and working capital and estates strategies; 14. Review and recommend to Trust board, the Trust's estates strategies and ensure the associated funding arrangements are in place. 15. Review post project evaluations for capital and revenue projects (above £5million) approximately 12 months after go live of project to review whether anticipated outcomes/savings had been achieved; 16. Evaluate and scrutinise the financial and commercial validity of individual investment decisions over £5m recommended for approval by the executive management board, including the review of outline and final business cases, and service development tenders and procurement contracts, for onward recommendation for approval by the Trust board. The current delegated limit for the Trust is £15 million; 17. Approve all business cases up to a maximum value of £5M where the business case is specific to the Trust and is within the Trust plan; 18. Review and make recommendations to the Collaborative Finance and Performance Committee on all business cases with a value above £5M where the business case affects at least 2 acute Trusts within the Collaborative 19. Consider quality implications for all financial cases and escalate to the Quality Committee as appropriate. 20. Review operational planning and performance for the Trust, including activity, capacity and winter planning, identifying the key issues and risks requiring discussion or decision by the Trust board where these issues and risks impact on financial performance and planning; 21. Review performance against such plans and identify the key issues and risks requiring discussion or decision by the Trust board where these issues and risks impact on financial performance and planning; 22. Review the Transformation programme and receive progress reports on key projects within that programme. 23. Refer other matters to other Committees as appropriate. 24. To receive updates and understand emerging system level risks and the strategic and financial impacts on the Trust and consider how collaboration with the ICS can help in managing financial risks.

PEOPLE COMMITTEE	The Committee will: 1. Review the development and delivery of the Trust's sustainable workforce strategy. 2. Provide assurance that the Trust's People Strategy and policies effectively respond to national and regional people strategies and policies. 3. Review strategic intelligence and research evidence on people and work, and distil their relevance to the Trust's strategic priorities. 4. Oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback. 5. Oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications to the Board. This includes raising concerns and freedom to speak up reports to the People Committee and Board. 6. Oversee the development and delivery of the Trust's strategy and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area. 7. Oversee the development and delivery of a strategy regarding a sustainable workforce (more generally). That would include development of new roles, recruitment and retention etc. The safe staffing report would be an example of a source of assurance. 8. Assess the workforce strategies and plans to support transformational change, service redesign and pathways of care that make best use of new technologies, the use of apprenticeships, introduction of new roles and innovative working across traditional professional and organisational boundaries. 9. Review plans for ensuring the development of leadership and management capability, including the Trust's approach to succession planning and talent management. 10. Review the Trust's strategy and performance as a provider and enabler of health and care education. 11. Review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system, including risk training. 12. Review the Trust's strategic contribution to the development of the health and care workforce. 13. Secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff. 14. Oversee the development and delivery of a Trust Staff Health and Well-being Strategy 15. Review the accessibility and impact of the health and well-being strategy and improvement programmes, in particular, for staff with protected characteristics. 16. Establish a succinct set of key performance and progress measures relating to the full purpose and function of the Committee. 17. Review progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions. 18. Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these. 19. Ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board in relation to the Committee's purpose and function. 20. Ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit, Quality and Finance & Performance Committees. 21. Review and shape the quality-related content of periodic workforce reports to the Board.
QUALITY COMMITTEE	The Committee will:

	1. Obtain assurance that the Trust has effective mechanisms for managing clinical risk, including clinical risk associated with clinical trials and improving service user safety, learning from incidents and taking action to reduce risks and improve clinical quality; 2. Receive and review a thematic summary of the lessons learned from serious adverse incidents; individual 'never' events; coroners' post-mortem reports; medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning; 3. Receive and review quality implications of business cases, as appropriate. 4. Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults; 5. Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act; 6. The Committee will review the quality-related risks and will identify emerging quality risks. 7. Receive assurance that all cost improvement programmes (CIPs) have been quality impact assessed and measures taken to mitigate risk and protect quality of care. 8. Establish and oversee the Quality Strategy and priorities underpinned by the Trust's strategic goals. 9. Approve and assure delivery of the annual programme of Trust-wide clinical audits. 10. Obtain assurance that NICE Guidelines and Technology Appraisals are implemented. 11. Obtain assurance that all requirements as set by the Maternity Incentive Scheme / CNST are achieved. 12. Obtain assurance that there are robust systems for undertaking nationally mandated audits, receive summary results and monitor the implementation of recommendations. 13. Oversee the Trust's work to meet the Care Quality Commission's (CQC) quality standards and ensure the Trust learns from national reviews by organisations such as the Care Quality Commission improvement reviews and implements all necessary recommendations to improve the safety and quality of care 14. Work with partners to agree a consistent approach to defining and measuring quality, collecting information from providers, and delivering a single vision of high-quality care. 15. Determine whether the Trust is maintaining and improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan. 16. Obtain assurance that robust quality governance structures, systems, and processes, including those for clinical risk management and service user safety, are in place across all services, and developed in line with national, regional and commissioning requirements. 17. Nurture a quality improvement culture across the Trust and celebrate achievement in quality improvement. 18. Obtain assurance that the divisional quality groups are effectively coordinating quality and clinical governance activity within the Trust. 19. Ensure that board assurance framework reflects the assurances for which the Committee has oversight, and that risks highlighted are appropriately reflected on the risk registers. 20. Approve and assure delivery of the Trust's patient and public engagement plans, and the patient experience plans/strategy, and obtain assurance that these plans are a key element of the work of quality and clinical governance teams across the Trust. 21. Receive and review a thematic summary of patient experience and feedback including Friends and Family Test, formal complaints and Patient & Advice and Liaison concerns. 22. To be assured that lessons are learned and that actions/improvements are implemented to ensure that patients' experience of care is improved. 23. Obtain assurance that patient access targets are being delivered. 24. Obtain assurance that effective channels are in operation for communicating and managing issues of clinical governance to relevant managers, staff and external stakeholders.

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	25. Obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented.
	26. Review the aggregated analysis of adverse events, complaints, claims and litigation to identify common themes or trends to take forward as improvement projects, as sponsored by the Committee
	27. Review and approve the annual Quality Account

SECTION 4 – DECISIONS /DUTIES DELEGATED BY THE TRUST BOARDS TO COLLABORATIVE COMMITTEES

As part of the governance model for the north west London acute provider collaborative, the trust boards of the four acute provider trusts have agreed to establish some collaborative level committees. The purpose of these committees is to support the Board in Common (the four Trust committees in common) exercise their powers by taking a collaborative view of risk and assurance, identifying and addressing key themes across the four trusts.

The composition and terms of reference of such committees shall be that determined by the Board in Common from time to time, taking into account where necessary the requirements of the Secretary of State. The Board in Common shall determine the reporting requirements in respect of these committees. Collaborative committees may not delegate such powers to sub-committees unless expressly authorised by the Board in Common.

COLLABORATIVE FINANCE AND PERFORMANCE COMMITTEE	The Committee will:
	• Identify, prioritise, oversee and assure strategic change programmes to support the delivery of the APC strategy and to drive collaborative-wide and ICS integrated improvements,
	• Oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
	• Identify areas of risk where collaborative-wide interventions would speed and improve the response.
	• Approve all business cases with a value between £1M and £5M where the business case impacts on more than one of the acute providers in the collaborative, taking advice from the Infrastructure Collaborative Committee where that business case applies to estate and digital infrastructure;
	• Review and make recommendations to the Board in Common, taking advice from the Collaborative Estates & Sustainability Committee where that business case applies to estate and digital infrastructure, on all business cases with a value in excess of £5M
	• Review operational planning and performance across the collaborative, including activity, capacity and winter planning, identifying the key issues and risks requiring discussion or decision by the Board in Common;
	• Review performance against such plans and identify the key issues and risks requiring discussion or decision by the Board in Common;
	• Oversee the development and delivery of Collaborative strategies and improvement programmes on Equality, Diversity and Inclusion in relation to operational activity.
	• To receive updates and understand emerging system level risks and the strategic and financial impacts on the Collaborative, and consider how collaboration with the ICS can help in managing collaborative level financial risks.
COLLABORATIVE	The Committee will:
	• Oversee the development and delivery of the Collaborative People Strategy and priorities.

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PEOPLE COMMITTEE	- Consider Trusts' People Strategy and policies to respond to national and regional people strategies and policies, and agree any improvement actions. - Review strategic intelligence and research evidence on people and work, and distil their relevance to the people related strategic priorities. - Oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback. - Oversee the development and delivery of the Trusts' strategies and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area. - Oversee the development and delivery of strategies regarding a sustainable workforce, including development of new roles, recruitment and retention. - Review plans for ensuring the development of leadership and management capability, including the Collaborative approach to succession planning and talent management. - Review the Collaborative strategy and performance as a provider and enabler of health and care education. - Review the accessibility and impact of health and well-being strategies and improvement programmes across the Collaborative, in particular, for staff with protected characteristics. - Review progress against workforce performance metrics and seek assurance around any performance issues identified, including proposed corrective actions. - Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these. - Ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee. - Oversee the development and delivery of Collaborative strategies and improvement programmes on Equality, Diversity and Inclusion in relation to People.
COLLABORATIVE QUALITY COMMITTEE	The Committee will: - Establish and oversee the delivery of Collaborative quality strategy and priorities, informed by the trusts' quality priorities. - Consider any Collaborative actions to ensure robust quality governance structures, systems, and processes, including those for clinical risk management and service user safety, are in place across all services in the Collaborative, and developed in line with national, regional and commissioning requirements. - Consider any risks to trusts maintaining effective mechanisms for managing clinical risk, including improving service user safety, learning from incidents and taking action to reduce risks and improve clinical quality; - Develop Collaborative level patient and public engagement plans, and the patient experience plans/strategy, and obtain assurance that these plans are a key element of the work of quality and clinical governance teams across trusts. - Ensure that lessons are learned across the Collaborative from serious adverse incidents, including 'never' events, coroners' post-mortem reports, medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning across the Collaborative; - Review quality related performance metrics across the Collaborative and agree collaborative level actions where appropriate - Identify common themes, and agree Collaborative level improvement actions regarding compliance with statutory and mandatory quality related requirements, including: - Safeguarding children and young people and vulnerable adults; - Compliance with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act;

	- o NHS Resolution requirements regarding CNST; - o CQC fundamental standards of care; - o Infection control - o Learning from deaths - o Complaints & patient experience - Consider Collaborative level quality-related risks and identify emerging quality risks; - Oversee the development and delivery of Collaborative strategies and improvement programmes on Equality, Diversity and Inclusion in relation to quality. - Nurture a quality improvement culture across the Collaborative and celebrate achievement in quality improvement.
COLLABORATIVE STRATEGIC ESTATES AND SUSTAINABILITY COMMITTEE	The Committee will - Provide assurance on the development and implementation of estate and sustainability strategies across the Collaborative within defined and prioritised capital funding resources. - Identify areas of risk where collaborative-wide interventions would speed and improve the response - Oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term estate and improvements - Prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements in the management of estate - Provide assurance on the development and implementation of the Sustainability Strategy at Collaborative level - Provide assurance on the development and implementation of the Estate Strategy at Collaborative level - Provide advice to the Finance and Performance Collaborative Committee on draft business cases. - Oversee the development and delivery of Collaborative strategies and improvement programmes on Equality, Diversity and Inclusion in relation to estates and sustainability. - Draw to the Board in Common's attention matters they need to agree or note.
COLLABORATIVE DIGITAL AND DATA COMMITTEE	The Committee will - Provide assurance on the development and implementation of digital infrastructure strategies across the Collaborative within defined and prioritised capital funding resources. - Identify areas of risk where collaborative-wide interventions would speed and improve the response - Oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term digital infrastructure improvements - Prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements in the management of digital infrastructure - Provide assurance on the development and implementation of the Information and IT Strategy at Collaborative level - Provide advice to the Finance and Performance Collaborative Committee on any digital infrastructure business cases that come to that committee. - Oversee the development and delivery of Collaborative strategies and improvement programmes on Equality, Diversity and Inclusion in relation to use of digital and data.

	• <mark>Draw to the Board in Common's attention matters they need to agree or note.</mark>

SECTION 5 – DECISIONS /DUTIES DELEGATED BY THE TRUST BOARDS TO THE BOARD IN COMMON CABINET

To ensure agility in decision making and to maintain oversight, the board in common will delegate some specific responsibilities to a board in common cabinet, comprising the chair, vice chairs and chief executives, meeting in the months when the board in common is not meeting. The Board in Common Cabinet will report on any action it has taken to the next meeting of the Board in Common. Delegated responsibilities include:-

- Discussing operational planning and performance across the collaborative, including activity, capacity, finance, quality and workforce related issues, identifying the key issues and risks;
- Review performance against such plans and identify the key issues and risks requiring discussion or decision by the Board in Common;
- Refer other matters to other Committees as appropriate.

Appendix 2 – Template terms of reference – Trust Standing Committee

Trust Standing Committee
Terms of Reference

1. Overarching Purpose

1.1 The purpose of the Trust Standing Committee will be to receive assurance around the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

2. Specific Duties and Responsibilities

2.1 The Trust Standing Committee shall oversee and provide assurance to the Trust Board on the following areas:

- Integrated Quality and Performance Reports (Operational performance, Finance, Quality and Workforce)
- Board Committee chairs' reports
- Board Assurance Framework
- Corporate Risk Register
- Statutory reporting requirements including the following annual reports which will be reported at the Board in Common
  - Infection Prevention & Control
  - Safeguarding Adults & Children
  - 7 Day services
  - Learning from Deaths

2.2 The Committee will oversee the development of the Trust strategy, in the context of the Collaborative strategy, and oversee the delivery of Trust-specific strategic priorities.

2.3 The Committee will also have the delegated authority to approve Trust-only business cases in line with the delegated authority limits of the Trust Board.

2.4 The Committee will undertake 'deep dives' as part of the meeting using the Board Assurance Framework to identify areas of risk to the achievement of the strategic priorities as well as any area of concern escalated to the Trust Standing Committee by the Board Committees.

2.5 They will also receive reports from the Chief Executive.

3. Composition
Membership

3.1 Membership of the Trust Standing Committee is made up of the Trust Board members:
- all non-executive directors (voting & designate)

Trust Standing Committee Draft Terms of Reference May 2024 v1

- voting executive directors of the board

3.2   Other executive directors and programme leads will attend as appropriate to provide updates on their respective work.

3.3   The Trust Standing Committee will be chaired by the Vice Chair.

4. Meeting arrangements

Attendance

4.1   Members of the Trust Standing Committee are expected to attend meetings wherever possible. In exceptional circumstances and subject to prior approval from the Chair, a deputy can attend.

4.2   The Chair may ask any person in attendance who is not a member of the Trust Standing Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

Quorum

4.3   The quorum requires the presence of at least four Directors who are eligible to vote (including at least one Executive Director and one Non-Executive Director). A duly convened meeting of the Trust Standing Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Trust Standing Committee.

Meetings

4.4   The Trust Standing Committee will meet (including by telephone or video conferencing) quarterly, or as determined by the Chair. Any member of the Trust Standing Committee can ask for a meeting to be convened in person, by video conference or by telephone, or for a matter to be considered in correspondence/e governance.

4.5   Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed shall be circulated to each member of the Trust Standing Committee and any //other person required to attend, five working days before the date of the meeting. Supporting papers will be sent to members, and to other attendees as appropriate, five working days before the date of the meeting.

4.6   Papers, including agendas and minutes will be published on the Trust website.

4.7   The secretary will minute the proceedings and decisions of all meetings, including recording the names of those present and in attendance.

4.8   Draft minutes shall be sent to the Chair of the Trust Standing Committee within ten business days of the meeting and submitted for formal agreement at the next meeting.

5. Declarations of Interest

5.1   All members and attendees of the Trust Standing Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting.

6. Reporting Responsibilities

6.1   Formal reporting will be via a summary report, to the Trust Board which meets quarterly in public as part of the Board in Common.

7. Other Matters

7.1   The Trust Standing Committee will:
- have access to sufficient resources to carry out its duties,
- consider any other matters where requested to do so by the Board in Common
- review on an annual basis its own performance and terms of reference to ensure that it is operating effectively as part of the Board's effectiveness review.

8. Authority

8.1   The Trust Standing Committee is authorised:
- to seek any information it requires, or request attendance at a meeting, from any employee or any other person in order to perform its duties;
- to obtain, legal or other professional advice on any matter within its terms of reference.

8.2   The Trust Standing Committee is established as a Committee of the Board and therefore has delegated authority from the Trust Board as per the Scheme of Delegated Authority.

11.1 EXECUTIVE MANAGEMENT BOARD (EMB) SUMMARY

⬤ Discussion Item   👤 Tim Orchard   🕐 11.40

REFERENCES   Only PDFs are attached

📕 11.1 APC EMB Chair's Report - July 2024 FINAL.pdf

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

July 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 10 April 2024, 8 May 2024, 5 June 2024 and 5 July 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 APC EMB also discussed potential changes to the format of the performance reporting to make it easier to use. The latest version of the performance report is presented at this meeting.

2.2. APC Strategy
2.2.1. The APC EMB discussed the APC strategy development, approving the guiding policy for the strategy and the draft text that is presented at this meeting. The APC EMB also supported and gave advice on the engagement approach throughout the strategy development.
2.2.2. The APC EMB also discussed the clinical pathways paper which is shared for noting at the Board in Common, which aims to operationalise a key strand of the APC strategy. The APC EMB approved the proposed approach to aligning priority pathways to best practice in the first year of the APC strategy.

2.3. APC governance
2.3.1. The APC EMB discussed amendments to the scheme of delegated authority for the four Trusts within the APC, to strengthen the level of Trust-level engagement and oversight which was a recommendation arising from the

internal audit into collaborative governance. The EMB noted and approved the recommended approach to develop Trust standing committees. The scheme of delegated authorities is presented to this meeting for Board approval.

2.3.2.   The APC EMB agreed a new process for business cases for capital investment. This will ensure collaborative business cases are sighted at the APC EMB and the Collaborative Strategic Estates and Sustainability Committee before they are presented to the Collaborative Finance & Performance Committee for approval. This will ensure the business cases have been suitably considered from a Collaborative estates perspective and are aligned with the Collaborative strategy.

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 infection, prevention and control. The APC EMB noted the four agreed priorities which included standardised winter planning, HAI reduction through education, benchmarking and shared practice, the implementation of a shared antimicrobial and IPC surveillance system and a Penicillin de-labelling programme. EMB members noted the good and steady progress of the work streams.

2.4.3.   The APC EMB also undertook a deep dive on maternity improvement at THHFT noting the high level actions in place and were assured around the formal reporting from the Maternity Neonatal Improvement Programme to the Trust Executive Board and to the Maternity Neonatal Assurance Group (attended by NEDs and maternity safety champions) and then into the Quality and Safety Committee of the Board. It was also noted that Hillingdon had joined the maternity safety support programme (MSSP) from 13 May 2024 and the CEO and Chair had agreed a process of oversight from Lesley Watts as Board Advisor from late May 2024.

2.4.4.   The APC EMB also undertook a deep dive on discharge noting the metrics across the collaborative which were overseen by the urgent and emergency care recovery board. The performance of each trust was noted and APC EMB members reflected on the risks and the current progress against each of the actions in place.

2.4.5.   The APC EMB received monthly updates and assurance on the corporate programme board and clinical pathways board. The APC EMB noted the closure report for the clinical pathways programme board and ensured that the lessons from this are taken into the new clinical pathways work as part of the APC strategy.

2.4.6.   The APC EMB received an update on sector priorities, including Urgent and Emergency Care (UEC), diagnostics and planned care.

2.4.7. 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 the EOC reached full capacity in April and continues to operate effectively. The APC EMB were pleased to note that patient and staff feedback on the EOC has been extremely positive. The APC EMB also discussed options to manage activity levels, including consideration of patient eligibility and potential pooling of operating lists, and agreed it would continue to monitor operational performance of the EOC.

- **EDI action plan:** APC EMB received updates on progress with phase 1 of the EDI Action Plan Steering Group actions to support patients, communities and staff including our collaborative response to the NHSE EDI improvement plan. At the July meeting, it was agreed that there would be an establishment of an equivalent group to move to phase 2 of this work which would include a focus on the actions the APC would pursue to support higher quality, equitable patient care and additional contributions we should make to address health inequalities amongst our communities.

- **Ophthalmology**: APC EMB received regular updates on ophthalmology in NWL. APC EMB agreed with the recommendation to scope potential options and route map to develop a NWL APC ophthalmology referral and advice process for elective and urgent care.

- **Estates**: The APC EMB received an update on the work undertaken to benchmark the APC estate and determine the areas of estates and facilities where we can collaborate to add most value.

- **Data strategy**: The APC EMB noted the work in progress to develop the APC data strategy. They noted the successful implementation of Cerner and that the data strategy would seek to standardise the reporting capabilities and infrastructure across the collaborative.

- **Ethnicity coding for patient data**: the APC EMB requested information on how to ensure wider collection of patient ethnicity data. The APC EMB noted the work to ensure this data is available by the end of quarter 2.

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

11.2 REPORTS FROM THE CHIEF EXECUTIVE OFFICERS AND TRUST

STANDING COMMITTEES

To note the reports:

REFERENCES   Only PDFs are attached

📕 11.2a LNWH CEO report to BIC July 2024.pdf

📕 11.2b LNWH Trust Standing Committee Chair's Report - June 2024 FINAL.pdf

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   On Wednesday 3 April LNWH moved to level 4 of the operational pressures escalation levels (OPEL) framework. This is the highest escalation level in the framework, and was in response to a massive rise in demand for emergency care after the Easter bank holiday.

    We worked extremely closely with local authority partners on putting additional measures in place so that all patients could leave hospital as soon as they were ready to do so.

    Staff worked hard to ensure that all patients who needed care received it as swiftly as possible in the most appropriate place. In some cases, this meant transferring patients to other hospitals which had more capacity. I am grateful to colleagues across the Acute Provider Collaborative (APC) for their support in this regard.

    This was a challenging and stressful situation for staff across LNWH, and I remain grateful for their professionalism, focus and dedication whilst working under great pressure. Thanks to the efforts of staff and partners we were able to step down to OPEL Level 3 on Friday 5 April.

1.2   In June we began preparation for industrial action planned by the GMB union for July. Industrial action will affect Medirest services and cause disruption to catering, cleaning and portering services at Northwick Park Hospital. Strikes began on Friday 12 July and will continue through July.

    The strikes are scheduled for:

- Friday 12 July 6am to Saturday 13 July 5:59am
- Monday 15 July 6am to Wednesday 17 July 5:59am
- Friday 19 July 6am to Saturday 20 July 5:59am
- Monday 22 July 6am to Tuesday 23 July 5:59am

We will continue to provide patient care during these times, however alternative arrangements to the services provided by Medirest will be made. These could include slight changes to lunch and dinner times when safe to do so, and where possible patients may be asked to make their menu choices a day in advance.

There may be some changes to cleaning rotas, but we will continue to ensure the hospital is clean and safe prioritising the most 'at risk' areas.

Security will continue to operate 24/7, and patients who need assistance from porters to move across the hospital will continue to be supported.

Most public food and drink facilities will continue to function as normal.

1.3   The North West London Elective Orthopaedic Centre (EOC) held its official opening event on the 23 May at Central Middlesex Hospital.

Barry Gardiner MP, Dawn Butler MP and Cllr Ketan Sheth were joined by guests from across the APC, wider NHS, local government, patient working groups and the voluntary sector. Guests were invited on a tour of the facilities and heard from staff and patients about the EOC's first few months of operation.

The EOC is the great result of the APC's four trusts working together, across geographical boundaries, for the benefit of people right across north west London.

1.4   In May our new acute medical unit opened at Northwick Park Hospital. The £20m unit is designed to provide excellent acute medical care in the most clinically appropriate setting.

The unit includes 32 beds in eight side rooms and six four-bedded bays. These additional new beds will help improve the flow of patients through our emergency pathways. This will reduce the pressure on our emergency department and mean that we're able to admit patients for assessment more quickly, improving their experience and waiting times.

Staff on our new acute medical unit will medically assess patients who may need a stay of up to 48 hours. If they need to stay longer or need care from one of our specialties, they'll be moved to the most appropriate ward.

The unit is staffed by our acute medical and nursing team, with support from occupational therapy, physiotherapy and pharmacy.

2.   Quality and safety

2.1   In May the CQC requested that all trusts consider the assurance they have about the safety, quality, and accessibility of their paediatric hearing services and requested a report confirming:

- Whether we have achieved Improving Quality in Physiological Services accreditation (IQIPS), including whether there were any improvement recommendations made.
- Whether we are working towards IQIPS accreditation.
- What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.

LNWH was awarded IQIPS accreditation in August 2023 following an assessment which took place in the previous month. Improvement recommendations at the time related to:

- Surveillance (local policy template ID)
- Quality objectives (required measurable elements of quality policy – evidence)
- The need for an audit/re-audit policy
- The requirement for a COSHH update
- Additions to the risk assessment policy including panic alarm testing, paediatric competency assessments.

We have responded to all recommendations and IQIPS have confirmed that they are satisfied with the progress made by LNWH and that no further feedback is required at this stage.

In accordance with most paediatric hearing services across the country, IQIPs continue to monitor our waiting times in relation to access to services and we continue to take forward our demand and capacity work in this regard.

Our next IQIPS assessment is in July 2024 (documentation review only), with an on-site review scheduled for July 2025.

Regarding incidents, there has been one incident of Cytomegalovirus (CMV) which has been fully investigated. This identified a missed diagnosis at another Trust.

We continue to use the UKAS benchmarking tool as a source of ongoing assurance as to the quality and safety of care delivery.

2.2   On the 1 May we launched our new call for concern helplines at Ealing and Northwick Park Hospitals.

The helplines allow inpatients, friends and family to call our critical care outreach teams

at Ealing and Northwick Park Hospitals if they are concerned that the patient's condition is acutely deteriorating and do not feel that the ward or area looking after the patient is addressing their clinical concern.

The service is open 24 hours a day, seven days a week. It's a national requirement that's designed to add a safety net for patients and relatives by adding an extra review from a fresh pair of eyes.

3.   Operational performance

3.1   Emergency department performance reported 76.9% for April 2024 against the 4-hour standard. This is the sixth highest performance in London for the 18 acute trusts reporting against this standard. 93.1% of patients were treated within 12 hours against the 98% standard.

Key actions underway include:

- Divisions are discussing ways to improve internal flow.
- Bed capacity will be reassessed in spring 2024 to balance current demand with the closure of the winter plan.
- The new acute medical unit at Northwick Park Hospital opened in May 2024, adding 32 short-stay inpatient beds.
- The 45-minute ambulance handover process in London improves handover times but increases acute flow due to higher patient volumes.
- Efforts to increase daily discharges and use of discharge lounges are ongoing.

3.2   Cancer waiting times: LNWH has successfully reduced the number of patients waiting over 62 days for diagnosis and treatment and remains on trajectory. The Trust also met the Faster Diagnosis Standard in April.

The final position for March 2024 (reporting a month in arrears) was:

- 2-week wait for suspected cancer: reported 65.7% against the 93% standard.
- 28-day faster diagnosis: reported 77.9% against the 75% standard.
- 62-day wait for treatment following GP referral: reported 69.3% against the 85% national standard.

Key priorities for 24/25 include:

- Continuing to focus on reducing the number of patients on the 62-day backlog who are awaiting diagnosis and treatment, with a special emphasis on those who have been waiting for more than 104 days.
- Continue to manage demand and capacity while prioritising timely access to diagnostics and histology through initiatives like waitlist management, recruitment efforts, and collaborations with external teams.

- Ongoing capacity planning to try to protect cancer pathways from being impacted by any future strikes as well as upcoming known seasonal holidays.

3.3 18 weeks referral to treatment: As per the national ask LNWH has been focussed on reducing the number of patients waiting over 78 weeks. The number waiting in April did increase to 94 however a significant number of these were a result of patient choice.

We aim to clear all patients waiting over 78 weeks by the end of July (excluding any patient choice delays).

In line with the national operational plan, the Trust is focussing on reducing all patients waiting over 65 weeks by the end of September.

Data quality issues 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.

Finance and estates

4.1 Finance: The Trust ended the 2023/24 financial year at breakeven, balancing our income and expenditure. This was the result of hard work by colleagues across the organisation, with support from across the APC, and support from the NWL ICB – it was a truly collaborative effort.

I would like to highlight the hard work of colleagues across LNWH in addressing the income and activity challenges arising from the Cerner implementation. Many staff spent long hours working on counting and coding activity and supporting our clinical colleagues and Cerner implementation team on getting the processes right after such a significant change to our systems.

There is more to do to realise the benefits of the new system – and to make sure we are capturing and recording all the hard work our teams put in across the Trust – but we have really moved the dial on the implementation of the new systems.

LNWH also delivered on its capital targets and budgets for the year, ensuring that capital is spent in line with our overall plan and the requirements of the Capital Review Group.

Our external auditors, KPMG, are reviewing the annual report and accounts, and will be reporting to the Audit Committee on 21st June. We are set to meet the national deadlines for completion of the audit and submission of the completed documents to the Department of Health in line with the national timetable of 28 June. My thanks to all colleagues involved in this process.

For 2024/25 the LNWH finance team worked closely with colleagues across the organisation, the APC and the NWL ICB to develop and agree a balanced financial plan for the coming year.

This will be another challenging year, but we start from a solid foundation and a good track record of delivery. We have set ourselves an ambitious £34.8m cost improvement/transformation plan – and we have identified £37m of savings and productivity improvements which we will be seeking to implement in the coming year.

We are also working with colleagues across the ICB, the wider NHS system and the APC to identify and deliver a further £10m of financial improvements, through reviewing pressures at the front door and wider urgent and emergency care system, as well as reviewing all the business cases we have agreed in the last three years.

Our Divisional leadership teams have agreed stretching and ambitious activity targets, building on the solid progress we have made since the implementation of Cerner. At the end of Month 2, we are not yet where we need to be in delivering this plan, but we can see the actions that we need to take, and we will continue to monitor and support delivery through our Grip & Control framework and our Financial Delivery Group.

4.2 Estates and Facilities: At the start of the financial year, we opened our new Acute Medical Unit at Northwick Park Hospital, and we fully opened the North West London Elective Orthopaedic Centre at Central Middlesex Hospital. Our Community Diagnostic Centre at Ealing Hospital is progressing well, and we expect this to open during the summer.

These developments are significant both for LNWH and for the wider north west London system. The hard work of colleagues across the Trust in getting us to this point is very much appreciated.

Our challenge for 2024/25 is to make the best use of these excellent new facilities and to integrate them into our broader service offer.

In 2024/25 our estates and facilities team will focus on implementing our programme of backlog maintenance and site service development and improvement. They are already working hard on the endoscopy suite refurbishment at Northwick Park Hospital.

Our capital budget is a little smaller this year, as the strategic funding envelope has been utilised, and we will focus through the Capital Review Group on maximising the value from our operational capital budget. We will continue to develop further strategic capital cases, working in partnership with staff across the Trust, the Collaborative and the ICB.

5. People

5.1 Linda Dyson has joined LNWH as Interim Deputy Chief People Officer, replacing Phil Spivey

5.2   In May we were delighted to welcome our 11 new nursing associate students. Our new colleagues started their exciting development role as nursing associates at the University of West London.

5.3   Heidi Mulhall has joined the Communications team as interim Deputy Director of Communications. Heidi is covering for Rivka Lewis while she is on maternity leave.

4.   Equity, diversity and inclusion

6.1   LNWH has become the first trust in the country to develop a 'compound equity index' which ensures the quality of care offered is consistent regardless of factors such as gender, ethnicity, disability or social and economic circumstances.

The strategic tool monitors LNWH's progress towards equity by highlighting both progress and areas requiring attention. The methodology is supported by thorough statistical analysis, ensuring that the index reflects genuine and significant disparities in equity.

There can be a multitude of reasons behind disparities in care, and the new indicator allows us to clearly see the how, where, when and who.

6.2   LNWH now has the 60th most accessible NHS website nationwide according to the Silktide Index which ranks public sector sites based on their level of compliance a globally recognised standard for web accessibility.

High compliance means more people with accessibility needs - which could range from wearing reading glasses to profound physical disabilities - can easily use our website.

LNWH now has the fourth most accessible NHS website in London, only behind The Royal National Orthopaedic Hospital, GOSH, and Guy's.

6.3   We're delighted to announce that LNWH have a place at this year's Pride Parade in London. Our Rainbow network will be marching at Pride London on 29 June this year and invited colleagues to join them.

7.   LNWH updates

7.1   On the 30 May we experienced issues accessing our electronic patient records system (Cerner EPR). The issue was raised with our suppliers as soon as we became aware, and the problem was quickly fixed.

Due to the downtime we had to reschedule some appointments, where it was safe to do so. Most patients were seen as usual, but there was a slight delay to appointments and procedures that lasted through the day.

7.2   The update to Cerner on the 4 June went smoothly, and now LNWH along with other trusts in the APC is on the latest version of the electronic patient record system.

7.3   We are hoping to save hundreds of thousands of pounds a year by reducing unnecessary glove use on our hospital wards. This is part of a wider NHS campaign to help save money and be more environmentally friendly.

More than 1.4 billion gloves are used by the NHS every year with staff often wearing them for tasks that don't require their use, such as taking patients' vitals, tidying bedspaces, helping a patient with food and drink.

The campaign has initially been introduced across six wards including both intensive care units at Ealing and Northwick Park hospitals.

7.5   Garden TV will be filming a six-part series about the London Major Trauma System at Northwick Park Hospital between 3 June and 23 June

7.4   We've made some changes to our Covid-19 testing processes. At Northwick Park Hospital on Drake ward (haematology and haema-oncology) we continue to test patients each week using lateral flow tests.

On other wards we perform PCR tests for diagnosis if a senior clinician suspects a patient has Covid-19. Patients who test positive are isolated for a minimum of five days and must have no fever before they can be discharged to a care home or hospice.

8.   Research and innovation

8.1   We have launched a new 'satellite' pharmacy at Northwick Park Hospital's maternity unit to help mothers and their newborns get home quicker. The new initiative has helped cut discharge times from half-a-day to half-an-hour.

The satellite pharmacy allows patients to be quickly seen by a pharmacy technician who checks their allergies, medication history and any prescription items that they have brought into hospital with them.

The initiative has been a huge success with the midwives requesting the same level of service at weekends. LNWH has a further two satellite pharmacies set up in Acute and Medicine to improve the flow of patients leaving hospital with minimal delay.

8.2   Ealing Hospital has teamed up with the charity Supporting Children with Diabetes to provide financially challenged families with free mobile phones to help manage their children's condition.

Continuous Glucose Monitoring is achieved through an app the connect via Bluetooth to a small patch which is applied to the patient where a small cannula inserts just under the

skin. The app automatically monitors blood sugar levels telling the child if their glucose level is rising or falling, while a sister app allows parents to monitor their children's use of the device.

We have more than 100 children on our books ranging from five months to 19 years-old but we do have families among them who can't afford a phone allowing them to access this technology.

8.3   We have reduced the amount of time patients with liver conditions spend in hospital by introducing a twice weekly 'hot clinic'.

Whilst there is a two week pathway for cancer patients, it is difficult to see a liver outpatient in that timeframe. The hot clinic is a step to address the gap by providing better monitoring of their health, and early interventions to reduce the need for admission.

Length of stay has now been halved from 10.5 to 4.5 days with fewer hospital stays, which were costing the trust an average of £3,000 per patient.

The project was submitted to British Society of Gastroenterology to be considered for the clinical service development prize and received a commendation.

8.4   Our research and innovation team have celebrated their thirteenth annual conference, which was attended by over 90 commercial, academic, and clinical research network partners. LNWH presented some brilliant and innovative research.

Our Chair in common Mr Matthew Swindells gave a key note lecture, and internationally renowned Professor Ailsa Hart was invited to present a named lecture on her contribution to research since joining LNWH as a junior doctor.

I was delighted to present the best poster and best presentation awards. Congratulations to all the presenters and our research and innovation team for another excellent event.

9.   Stakeholder engagement

9.1   On the 15 May we welcomed a delegation from the Royal College of Surgeons of England who visited the Trust to see at first hand the daily surgical challenges facing teams.

This included visits to the newly opened Elective Orthopaedic Centre at Central Middlesex Hospital, St. Mark's Hospital and the new North West London Breast and Urology centres at Northwick Park Hospital.

President Tim Mitchell also met with maxillofacial and ENT teams and trainees. The visit was a great opportunity to showcase the progress LNWH is making in surgery, critical care, training, and robotics.

9.2   Kim Wright, CEO of Brent Council visited Northwick Park Hospital on the 9 May. Ms Wright visited the Maternity department, Emergency Department and the new Acute Medical Unit.

10.   Recognition and celebrating success.

10.1   Dr Shriti Pattani was recently presented with an OBE by Princess Anne at a ceremony at Windsor Castle. Dr Pattani is LNWH's clinical lead for occupational health as well as the national lead on health and wellbeing for NHS England.

Dr Pattani was included in the New Year's Honours List for her contribution to occupational health and is recognised as a leading authority by the World Health Organisation who have invited her to speak at several global events.

10.3   Senior pharmacist Cecilia Tse has won the excellence in hospital pharmacy practice award at this year's Clinical Pharmacy Congress (CPC).

The CPC recognises outstanding individuals and teams who have been recognised for their exceptional contributions to clinical pharmacy practice in the UK.

10.4   Clinical nurse specialist Babitha Joseph was awarded runner's up prize for her paper on the inflammatory bowel disease dysplasia surveillance pathway at the inaugural Kerala Nurses UK conference.

11.   Two current members of staff and one retired member have been shortlisted for a Black Healthcare Award.

Sala Abdalla, Consultant General and Upper GI Surgeon, has been shortlisted for the Clinical Excellence Award for Consultants. Ben Jackson, Cardiac Cath lab Superintendent Radiographer, made the shortlist for the Allied Health Professionals' Award. And finally Rose Amankwaah, former Theatre Matron, who retired earlier this year after 49 years' service, has been nominated for the Long Service Recognition Award.

The Black Healthcare Awards are for Black healthcare professionals of the Caribbean or African diaspora. They recognise individuals who have established themselves as outstanding in their practice, with unrivalled determination to make a difference to all as they fulfil their vocation.

Sala, Ben and Rose will be joined by members of the LNWH executive team at an event in Central London on the 27 July, attendance at which has been kindly sponsored by the LNWH Charity.

London North West University Healthcare NHS Trust (LNWH) Trust Standing Committee Chair's Highlight Report to the North West London Acute Provider Collaborative Board in Common (BiC) – for discussion

June 2024

Highlight Report

1.   Purpose and Introduction

The role of the LNWH Trust Standing Committee is:-

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

2.   Key highlights

2.1.   Assuring ourselves against the findings of the Fuller Enquiry

2.1.1.   The Committee received assurance that the Trust's self-assessment indicates that strong controls are in place in its mortuary services. As part of the second phase of the inquiry, a questionnaire has been sent to providers of mortuary services, and no material concerns have been identified. However, it was noted that whilst the average length of stay in the mortuaries is 7 days, there have been some exceptions. The Trust Executive Group discussed this issue, and it has been agreed that there will be an escalation point within the formal governance for length of stay beyond 7 days.

2.1.2.   The Committee noted that the self-assessment process highlighted good practice and governance but also identified a single point of failure with the Mortuary Manager. It also brought attention to the challenges in recruiting to specialised roles, and the team are working on apprenticeships and career progression opportunities to mitigate this.

2.1.3.   The Committee discussed how they can anticipate and prevent such unexpected events and were assured that the Executive team have visibility into all services within the Trust.

2.2.   LNWH Strategy: Our Way Forward Year One Review

2.2.1   The Committee received the year one review of the LNWH Strategy: *Our Way Forward*. Engagement with staff and patients have helped assess the progress made so far and identified areas for improvement.   Challenges were acknowledged around timely care impacted by industrial action and the impact of the implementation of Cerner.

2.2.2   Looking ahead, the focus will be on making the most of Cerner, improving elective performance, and fostering innovation.

2.2.3   Two KPIs have been amended since the first publication. The first change is the adoption of the cancer faster diagnosis standard, which better reflects patient experience. The second change is the use of turnover rather than staff duration to enable benchmarking against other organisations.

2.2.4   The Committee agreed to include benchmarking data against international healthcare organisations. There were also suggestions to increase focus on staff health and safety and to include the LNWH Charity.

2.3   Annual Report and Accounts 2023/24
2.3.1   The Committee received the 2023/24 Annual Report and Accounts for noting. The report was approved by the Audit and Risk Committee at the meeting held on 21 June 2024. The report will be presented in public at the Annual General Meeting on 26 September 2024.

2.4.   Chief Executive's report
2.4.1. The Committee discussed the Chief Executive's report. An enquiry was received from the CQC on paediatric audiology. The Trust has full accreditation in Improving Quality in Physiological Services (IQIPS), but it was noted that there are access issues into the service due to difficulties in recruiting paediatric audiologists.

2.4.2. The Committee discussed the research and innovation work across the Trust. A successful research day was held with a focus on health inequalities. The Trust has been successful in its bid for three large research projects.

2.5.   Board Assurance Framework
2.5.1. The Committee received the Board Assurance Framework. During Q1, each of the board committees reviewed their principal risks and a further iteration will be produced for Q2 to provide continued assurance.

2.5.2. The Committee agreed that work should be done to refresh and update the Board's risk appetite.

2.6.   Integrated Performance report
2.6.1. The Committee received the M1 report. There has been a 16% year-on-year growth in ambulance arrivals at Northwick Park Hospital which has had financial implications. There is a need to deliver the operating plan this year in accordance with the Elective Recovery Fund, and to ensure that patients waiting do not extend beyond an acceptable tolerance. There will be an in-depth look at the diagnostic six week wait, which has struggled to recover following the Cerner implementation.

2.7.   Finance report
2.7.1. The Committee received the M2 report and noted the focus on recovery. Despite a slippage on the Cost Improvement Programme, there is an ambitious programme in place and confidence that it will be delivered.

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

2.8.2. The Committee received assurance that key risks raised by each Committee were being managed appropriately.

3.   Positive assurances received
- The Trust's external auditors issued their final unqualified opinions on the accounts, annual report and arrangements for economy, efficiency and

effectiveness.

- No significant weaknesses were identified in the Trust's value for money assessment.

- The Trust's self-assessment indicates that strong controls are in place in its mortuary services,

4. Key risks / topics to escalate to the NWL APC BiC
- The significant pressures on the emergency pathways at the Trust.

5. Concerns outstanding
- There are no significant additional concerns outstanding which require escalation to the Board.

6. Key actions commissioned
- Future meetings will receive a staff story about their personal safety experience at the Trust.

7. Decisions made
- The Committee approved the Trust Standing Committee terms of reference in principle.

- The Committee approved the revised Health and Safety policy.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Terms of Reference	To approve	9.	Board committee report – Appointments & Remuneration	To discuss
2.	Health and Safety Policy	To approve	10.	Board committee report – Audit & Risk	To discuss
3.	Assuring ourselves against the findings of the Fuller Enquiry	To discuss	11.	Board committee report and Director's report – Charitable Funds	To discuss
4.	Our Way Forward Year One Review	To discuss	12.	Chief Executive's report	To discuss
5.	Annual Report and Accounts 2023/24	To discuss	13.	Board assurance framework	To discuss
6.	Board committee report – Quality & Safety	To discuss	14.	Integrated performance report	To discuss
7.	Board committee report – Finance & Performance	To discuss	15.	Finance report	To discuss
8.	Board committee report – People, Equity & Inclusion	To discuss			

9. Attendance

Members	June attendance
David Moss, Vice Chair (Chair)	Y
Matthew Swindells, Chair, Board in Common	Y
Bob Alexander, Non-Executive Director	Y
Huda Asad, Associate Non-Executive Director	Y
Loy Lobo, Non-Executive Director	Y

Martin Lupton, Non-Executive Director	Y
Ajay Mehta, Non-Executive Director	Y
Simon Morris, Non-Executive Director	Y
Sim Scavazza, Non-Executive Director	Y
Syed Mohinuddin, Non-Executive Director	Y
Baljit Ubhey, Non-Executive Director	Y
Pippa Nightingale, Chief Executive Officer	Y
Simon Crawford, Deputy Chief Executive	Y
Jonathan Reid, Chief Financial Officer	N
Jon Baker, Chief Medical Officer	Y
Lisa Knight, Chief Nursing Officer	Y
James Walters, Chief Operating Officer	Y
Tracey Connage, Chief People Officer	N
Dawn Clift, Director of Corporate Affairs	Y
Shekh Motin, Deputy Chief Financial Officer	Y
David Jenkins, Joint Director of Charities	Y
James Biggin-Lamming, Director of Strategy and Transformation	Y
Tracey Beck, Director of Communications	Y
Nikki Walcott, Head of Corporate Governance / Assistant Trust Secretary (minutes)	Y

REFERENCES

Only PDFs are attached

📄 11.2c THH CEO Public Report BiC- 3 Jul 2024 v2FINAL.pdf

📄 11.2d THH SC July 2024 VSCJPWTBMSAT FINAL.pdf

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 is moving at pace to address the concerns raised by the CQC following their inspection of Maternity services in August 2023 (reported on 14 February 2024). We have established a Maternity and Neonatal Improvement Programme and strengthened oversight and governance, with support from the national team to support our improvement journey (further described in section 2.1).

1.2. The Trust is developing a financial recovery plan and trajectory to get back to a breakeven financial position (further described in section 4).

1.3. We are now in year four of the comprehensive five-year enabling and decant programme to get the west of the Hillingdon site ready for construction of the new hospital. Recently this has included preparing several wards along the annexe corridor for demolition, progressing work to bring in the power supply for the new hospital and developing business cases for the next projects to start this year.

2.   Quality and Safety

2.1. The trust is addressing concerns raised by the CQC with the Maternity and Neonatal Improvement Programme (MNIP) and Maternity and Neonatal Assurance Group (MNAG).

The MNIP has been established, and its aims and key milestones have been shared with the board and sector colleagues. Our programme is now supported by a programme director and two project management support officers. NHSE Maternity Safety Support Programme has allocated two Maternity Improvement Advisers (one midwife and one obstetrician) as external advisers. The monthly programme board has met twice, agreed governance and workstreams. and reports through the Quality and Safety Committee line.   MNAG is a revised assurance group which now meets monthly with more executive and non-executive attendance. The format now matches that advised by the MSSP. Both groups report to the Quality and Safety Committee.

2.2. Martha's Rule is an NHS patient safety initiative which gives patients the right to an urgent review if they are showing signs of rapid deterioration. Our Trust is launching 'Call 4 Concern' a new phoneline enabling patients and their families to trigger an urgent clinical review if the patient is in hospital, is deteriorating rapidly, and the family or the patient feels they are not getting the care they need.

3.   Operational performance (Month 2, 2024/25)

3.1. Referral To Treatment (RTT) 52 week waiters (ww), 65ww and 78ww remained special cause improvements for the Trust and elective activity outperformed planned targets (111.4% against a target of 110.4% (as at 25/6/24 unvalidated)).

3.2. Trust wide focus on monitoring and supporting Emergency Department Performance remains a key pritority. All types performance remains a special cause improvement for the Trust but is below target at 75.8% for May against a target of 78%.

4.   Financial performance (Month 2, 2024/25)

4.1. At M2, the Trust is reporting a year to date deficit of £8.9m, which is £8.0m worse than plan, and £5.8m worse than Trusts expectations.

4.2. The Trust is developing a financial recovery plan and trajectory to get back towards breakeven. Immediate actions have been put in place to improve grip and control on bank and agency spend and early data is showing a reduction in agency hours in nursing during June. Further actions to reduce spend are being considered by the Executive with a full assessment of the risks.

5.   People

5.1. A new Health Care Support Workers Forum has been set up to support our colleagues in those roles. The purpose of the forum is to enable open discussion, network, share learning, ideas and concerns, and opinions to support colleagues.

5.2. Our nurses and midwives were recognised and honoured at a very well supported day of celebration for International Nurses' Day and International Day of the Midwife. The event included an awards ceremony, where individual nurses and midwives, plus teams working in both disciplines, were recognised for their work by their contemporaries.

5.3. The Trust also celebrated with out Estates and Facilities staff on Estates and Facilities Day on 19 June 2024, recognising they key role non-clinical staff play in the delivery of care and the significant digital innovation being used to deliver more efficient care support such as ward to kitchen ordering of patient food.

5.4. Two of our Health Care Support Workers - Simon Odegah and Lynn Connell – have been honoured with a Chief Nursing Officer Support Worker Excellence Award. These national awards recognise the vital contribution of the role and our colleagues' exceptional support of nursing practice.

6. Hillingdon Hospital Redevelopment

6.1. We have continued to make good progress with our plans to deliver a new Hillingdon Hospital, which will be a world-class facility providing first-rate care for our patients and the best place to work for our people.

6.2. We are now in year four of the comprehensive five-year enabling and decant programme to get the west of the site ready for construction of the new hospital. Recently this has included preparing several wards along the annexe corridor for demolition, progressing work to bring in the power supply for the new hospital and developing business cases for the next projects to start this year, including:

- Modernisation of the Furze building to prepare it for the provision of Adult Audiology, Haematology, the Education and Training Library and office accommodation
- Extension and refurbishment of the Tudor Centre to accommodate the Trust's new Education and Training Centre and
- Creation of a temporary offsite car park

6.3. Whilst we continue to prepare the new hospital site for construction, we are working closely with the national New Hospital Programme (NHP) team on progressing the Outline Business Case for the new Hillingdon Hospital.

7. Updates from the Council of Governors (CoG)

7.1. The Trust held a briefing session for our governors on 23rd May 2024. The session was designed to provide the governors with a greater understanding and insight of the People Priority within the Trusts Strategy, highlight what was delivered in 2023/24 and what we plan to deliver in 2024/25, and how the Trust People Committee will gain assurance that the plan is being delivered against agreed targets.

7.2. The CoG met at an extraordinary meeting on 28th May 2024, where the CoG approved the recommendation from the COG Nominations and Remuneration Committee to appoint Carolyn Downs as the next THHFT Vice Chair and Senior Independent Director for a three year term when Catherine Jervis steps down in September 2024.

7.3. The CoG is delighted to welcome Mr Alistair Myers MSc FRCSEd, Consultant Colorectal Surgeon who was appointed uncontested to vacant Doctors and Dentists role within the council's staff constituency.

8. Research and innovation

8.1. The Trust is moving to a new online appointment letter system – DrDoctor. This is the same service currently in use across the APC for video appointments. Once the system is live, all four trusts in the North West London APC will be using the same platform for appointment letters and reminders. This will help us provide a more consistent patient experience across north-west London, especially for anyone who needs to access treatment at more than one trust, or from a collaborative service like the Elective Orthopaedic Centre.

8.2. The Trust has joined an important clinical trial project - Cancer Vaccine Launchpad Platform (CVLP) which will enable NHS cancer patients to get the earliest possible access to personalised cancer vaccine trials.

We were particularly pleased to be immediately singled out by the organisers for successfully gaining consent then referring a patient in the quickest time, from our Trust being activated as a participant to referral - a process which took less than a week.

9.   Stakeholder engagement

9.1. The Trust has signed the Armed Forces Covenant and is aiming to complete the first stage of accreditation by the end of June. Accreditation was received on 8 July 2024. Once stage one has been completed, staff will be asked to record if a patient has served in the armed forces or reserves. This will help us ensure they can access the additional support and benefits available to veterans in the community.

9.2. Teams from redevelopment, our charity and the hospital radio station, Radio Hillingdon, were at the annual Hillingdon Business Expo at Brunel University London in May, organised by Hillingdon Chamber of Commerce. It offered a great opportunity to make contacts, get feedback on our new hospital plans and raise the profile of our Trust.

10.   Recognition and celebrating success

10.1. The Paediatric Oncology Shared Care Unit (POSCU) was highly commended in the Team of the Year category at the national Children's Cancer and Leukaemia Group (CCLG) conference.

10.2. The new Rehabilitation Garden at Hillingdon Hospital has now been planted – funded by Hillingdon Hospitals Charity.

10.3. Our Estates and Facilities Team has once again beaten national competition across the NHS to win both the coveted Team of the Year Award and also bag a runner-up spot in the Efficiency and Innovation Award category in the HEFMA (Health Estates and Facilities Management Association) NHS Awards. The Team of the Year' Award was in recognition of our Estates and Facilities senior leadership team, for the success of the restructured team working both as individual subject matter experts, and as a cohesive unit delivering high performing operational services and championing sustainability.

The Hillingdon Hospitals NHS Foundation Trust

Trust Standing Committee report to the North West London Acute Provider Collaborative Board in Common (BiC) – for discussion 16th July 2024

Highlight Report

1.   Purpose and Introduction

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

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

2.   Key highlights from the Trust Standing Committee

2.1   **Terms of Reference**

2.1.2   The committee agreed to approve the draft Standing Committee Terms of reference subject to inclusion of the Deputy CEO as a member of the committee, and triangulating comments from fellow APC inaugural Standing Committees.

2.2   **CEO Report**

2.2.1   The Committee noted the CEO report, key highlights and messages included:

- The Trust Annual Staff Awards planning is underway and will be held on 5th September 2024, as an opportunity to celebrate the dedication and excellence of our staff. Nominations are open throughout June and early July, inviting recognition of outstanding contributions within out Trust.

- The Trust has continued to work hard to address the concerns raised by the CQC in respect of their inspection of our Maternity services as I mentioned in my previous report. We have established a Maternity and Neonatal Improvement Programme and strengthened oversight and governance, with support from the national team to support our improvement journey.

- Martha's Rule is an NHS patient safety initiative which would give patients the right to an urgent review if they were showing signs of rapid deterioration. Our Trust is launching 'Call 4 Concern' a new phoneline enabling patients and their families to trigger an urgent clinical review if the patient is in hospital, is deteriorating rapidly, and the family or the patient

feels they are not getting the care they need.

- Our Patient Safety Team carried out an unannounced inspection of areas at Mount Vernon, using the ward accreditation framework. The exercise was useful for sharing learning and highlighting issues that need to be resolved before the expected CQC inspection at the hospital.

- A new Health Care Support Workers Forum has been set up to support our colleagues in those roles. The purpose of the forum is to enable open discussion, network, share learning, ideas and concerns, and opinions to support colleagues.

- We have continued to make good progress with our plans to deliver a new Hillingdon Hospital, which will be a world-class facility providing first-rate care for our patients and the best place to work for our people. We are now in year four of the comprehensive five-year enabling and decant programme to get the west of the site ready for construction of the new hospital. Recently this has included preparing several wards along the annexe corridor for demolition, progressing work to bring in the power supply for the new hospital and developing business cases for the next projects to start this year. The Committee noted the level of disruption, impact on staff and received assurance that appropriate communication and engagement was in place to manage this.

- The Trust moved to a new online appointment letter system – DrDoctor. This is the same service we currently use across the APC for video appointments. Once the system is live, all four trusts in the North West London APC will be using the same platform for appointment letters and reminders. This will help us provide a more consistent patient experience across north-west London, especially for anyone who needs to access treatment at more than one trust, or from a collaborative service like the Elective Orthopaedic Centre.

- The Trust has joined an important clinical trial project - Cancer Vaccine Launchpad Platform (CVLP) which will enable NHS cancer patients to get the earliest possible access to personalised cancer vaccine trials.

- The new Rehabilitation Garden at Hillingdon Hospital has now been planted – funded by Hillingdon Hospitals Charity.

- Our Estates and Facilities Team has once again beaten national competition across the NHS to win both the coveted Team of the Year Award and also runner-up spot in the Efficiency and Innovation Award category in the HEFMA (Health Estates and Facilities Management Association) NHS Awards.

2.3 **Integrated Quality and Performance Report (IQPR) - (M2)**

2.3.1 The Committee discussed the IQPR noting:

- Continuing strong performance around long-waiters, and good movement around cancer diagnostics. Referral To Treatment (RTT) 52 week waiters (ww), 65ww and 78ww all remaining special cause improvements and elective activity outperforming planned targets.

- All types Emergency Department performance remains a special cause improvement for the Trust but is below target at 75.8% for May, this is a challenging area, the current flow is still reliant on the additional 30 beds currently open, which are unfunded. There are actions in place to ensure there is sustainable improvements to A&E Performance.

- Quality and Safety indicators remain stable, and the committee noted assurances in this area, with additional assurance and movement needed with regards to serious incidents management.

- Turnover and Substantive Vacancies remain special cause improvements for the Trust outperforming targets while PDR's remain an areas of focus with a 2 month improvement trajectory for the Trust at 80% compliance and In-Month Sickness Absence is at 4.8% - both below Trust targets.

- 30 winter beds remain open and reman unfunded. Work is progressing with Hillingdon Health and Care Partners (HHCP) to look at discharge and the Trust are reviewing options to close as many beds as possible.

2.4. **Maternity and Neonates Improvement Plan Update**

2.4.1 The Committee received and discussed the Maternity and Neonates Improvement Programme. The programme was set up to achieve the trust elements of the National Three-Year Delivery Plan for Maternity and Neonatal services, and to respond to actions and improvement recommendations received by the service in recent months, including from the February 2024 CQC report. The plan consists of 5 workstreams, Engagement with service users, Workforce, Safety Culture, Clinical Standards and the CQC action plan.

2.4.2 The noted good progress and momentum with important activities being completed and positive engagement of teams across all workstreams. The committee emphasised the need to maintain momentum and focus with clear and smart objectives. The committee also noted work progressing to improve maternity data accuracy and commissioning our Internal Auditors (BDO) to audit this area.

2.5. **Finance Report (M2)**

2.5.1 The Committee received and discussed the Finance Report. the Trust is reporting a year to date deficit of £8.9m, which is £8.0m worse than plan, and £5.8m worse than Trusts expectations following review of savings monthly profile. The Trusts financial performance for month 2 is driven by a reduction in income versus our plan relating to a dispute on contractual income levels with NHS England, reduced chargeable activities outside of North West London and increased run rate in costs over various services including bed

pressures within planned care, medical pay costs and pathology services.

2.5.2   The Committee were taken through the proposed recovery plan and trajectory and discussed the inherent risks to achieve this as well as financial sustainability.

2.5.3   The Committee noted that there were additional savings programmes being developed to bridge the gap and that these would be presented to July Finance and Performance Committee. The Standing Committee thanked the executive for developing further plans to mitigate the risk and reasserted the need for the Trust to get back to sustainable break even this year.

2.6.   **Board Committee Reports**
2.6.1   The Committee received reports from the Finance and Performance, Quality and Safety, People, Redevelopment, and the Audit and Risk Committees, noting exceptions against key performance indicators and measures being taken to address areas of variance against target and received assurance that key risks raised by each Committee were being managed appropriately.

2.7.   **Board Assurance Framework Q4 2023/24**
2.7.1   The Committee received the Board Assurance Framework (BAF) and noted work underway to refresh the BAF for 2024/25.

3.   Positive assurances received
3.1   Good progress being made in delivering the Maternity Improvement Plan

3.2   Good performance across a number of areas within the IQPR as per section 2.3, with actions in place to ensure sustainable improvements in A&E Performance.

3.3   Good progress continues with the Trust Redevelopment programme.

3.4   The committee noted the Board Nominations and Remunerations Committee have approved an options appraisal for the replacement of the Trusts CFO role. The Trust will appoint an interim CFO for the remainder of 2024/25 and explore options to strengthen its finance function generally reporting back to the Nominations and Remuneration Committee in September 2024, as summarised below:

- CFO for ChelWest to work with the CEO group and CFO colleagues to explore the three options:
    o   Like for Like replacement of CFO;
    o   Shared CFO between Hillingdon and ChelWest with separate finance teams;
    o   Single Finance Service out of ChelWest delivering a service to Hillingdon, ensuring that we continue to meet our obligations around the statutory function of a CFO.

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

4.1 The Trust is reporting a year-to-date deficit of £8.9m, which is £8.0m worse than plan, and £5.8m worse than Trusts expectations.

4.2 Winter Beds remain open and continue to be unfunded.

4.3 The Trust submitted it Audited Accounts on 2nd July 2024, against the deadline of 28th June 2024. The Trust will undertake a post audit learning exercise which will be overseen by the Audit and Risk Committee.

5. Concerns outstanding

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

6. Key actions commissioned

6.1 None

7. Decisions made

7.1 The Committee approved the Trust Standing Committee terms of reference in principle subject to the amendments as per section 2.1.

8. Summary Agenda 3rd July 2024

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Terms of Reference	To approve	6.	Board committee report – Finance & Performance	To note
2.	Chief Executives Report	To note	7.	Board committee report – Quality & Safety	To note
3.	Integrated Quality and Performance Report (M2)	To discuss	8.	Board committee report – People	To note
4.	Maternity Improvement Plan Update	To discuss	9.	Board committee report - Redevelopment	To note
5.	Finance Report (M2)	To discuss	10.	Board committee report – Audit and Risk	To note
			11.	Board Assurance Framework	To note

9. Attendance

Members	3rd July 2024 attendance
Catherine Jervis, Vice Chair (Standing Committee Chair)	Y
Matthew Swindells, Chair – North West London Acute Provider Collaborative	Y
Baljit Ubhey, Non-Executive Director	N
Linda Burke, Non-Executive Director	N
Martin Lupton, Non-Executive Director	Y
Nick Gash, Non-Executive Director	Y
Patricia Gallan, Non-Executive Director	Y

Simon Morris, Non-Executive Director	**Y**
Steve Gill, Non-Executive Director	**Y**
Vineeta Manchanda, Non-Executive Director	**Y**
Patricia Wright, Chief Executive Officer	**Y**
Jason Seez, Deputy Chief Executive Officer, SRO New Hillingdon Hospital Programme	**Y**
Alan McGlennan, Chief Medical Officer	**Y**
Jon Bell, Chief Finance Officer	**N**
Sarah Burton, Chief Nursing Officer	**Y**
Tina Benson, Chief Operating Officer	**Y**
In attendance	
Janet Campbell, Associate Non-Executive Director	**N**
Philip Spivey, Chief People Officer	**Y**
Steve Wedgwood, Director of Operational Estates and Facilities	**N**
Gavin Newby, Deputy Chief Finance Officer	**N**
Carolyn Downs, APC NED Observer	**Y**
Lesley Watts, CEO Chelsea and Westminster Hospital NHS Foundation Trust	**Y**
Vikas Sharma, Trust Secretary	**Y**

REFERENCES

📄 11.2e ICHT CEO Public Report - July 2024 FINAL.pdf

📄 11.2f ICHT Standing Committee report to BiC - Final.pdf

Chief Executive Officer's Report – Imperial College Healthcare NHS Trust

Accountable director: Professor Tim Orchard
Job title: Chief Executive Officer

1   Key messages

1.1   In terms of our operational performance, we continue to have some of the fastest ambulance handover times in London (97.3 per cent within 30 minutes in May 2024), though we are below the national target for at least 78 per cent of A&E patients to be treated and discharged or admitted within four hour waits (76.2 per cent in May 2024). We are meeting our planning trajectories for reducing long waits for planned care, though the number of patients waiting for over 65 weeks and over 52 weeks has increased.

1.2   Financially, at the end of May, we reported a year-to-date deficit of £4.1m which is £1.5m adverse to plan, primarily due to lower than planned delivery of efficiencies. We have plans in place to recover our delivery of efficiencies and so continue to forecast that we will deliver our break even plan for the end of the financial year.

1.3   A new eye care centre run by the Trust has opened in north Paddington, providing an additional 10,000 appointments to support patients with their eye conditions each year. The Stowe Eyecare Centre will provide extra capacity for diagnosing, monitoring and treating eye conditions. This increased capacity will reduce patient waiting times and help respond to increases in demand. The centre will work alongside our established eye care services at the Western Eye Hospital and will use the same state of the art equipment. Based on Harrow Road, the eye care centre will provide a range of tests for regular monitoring and treatment of long-term conditions, such as glaucoma, diabetic eye checks and other retinal conditions.

1.4   Our hospitals are included in the first 143 sites that will test and roll out Martha's Rule, a national initiative to provide a consistent and understandable way for patients and families to get immediate help and advice if they are concerned that their local health care team has not recognised their own or their loved one's deteriorating clinical condition. We launched our 24/7 telephone 'Call for concern' service earlier this year and are now working on the next phase of implementation which is to record daily feedback about a patient's health from the patient and their family as part of regular clinical assessment.

1.5   In May, it was announced that GSK will become the first founding partner of the Fleming Initiative, a new global approach to tackling anti-microbial resistance (AMR) spearheaded by Professor the Lord Darzi of Denham on behalf of the Trust and Imperial College London. It includes the Fleming Centre set to open at St Mary's Hospital in 2028, marking the centenary of the discovery of penicillin by Sir Alexander Fleming. The centre will work closely with networks around the world to catalyse action while also forming a key part of our Paddington Life Sciences cluster of organisations driving wider life sciences research and innovation.

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 a positive reflection of our safety culture and our focus on encouraging colleagues to speak up, and harm levels are well below national averages. Themes from incidents and mortality reviews are consistent with previous months and have been used to inform our final quality and safety improvement priorities for 2024/25. These are set out in our annual quality account which is due to be published on our website at the end of June 2024. One of our medical directors will lead a quality review meeting whenever a clinical directorate has a sustained increase in incidents with moderate and above harm - we are reviewing three directorates under this process currently.

2.2 We fully transitioned to the patient safety incident response framework (PSIRF) as planned from 1 April. Teams are engaging well and good progress is being made to embed the new processes and ensure meaningful, compassionate engagement with those involved (patients, families, and staff). We are experiencing some delays, both in completing PSIRF investigations and closing off investigations declared under the previous SI framework. This is driven by the time required to undertake the work, particularly for senior clinical staff who lead the investigations, and learning about the new processes. We are keeping this under review. We also transitioned to the new national system for recording incidents, Learn From Patient Safety Events (LFPSE), in April with no issues to report.

2.3 Concerns remain about the experience and educational opportunities for doctors in training in neurosurgery. After January's Learner and Educator visit, our intensive support framework (ISF) level was escalated from ISF2 to ISF3 which means this specialty is falling below the education standards expected. We moved the specialty into the Surgery & Cancer Division in April to sit alongside other surgical specialties and have taken additional steps to ensure the mandatory requirements are going to be met, including enhanced oversight of outpatient clinic attendance and capacity, in response to continuing mixed feedback from trainees. We will also be implementing further actions based on feedback, including protected theatre sessions and a full workforce model review. A review of the culture in the team is nearing completion which will better inform actions going forward.

2.4 Our maternity and neonatal services continue to be very busy, with activity consistently above plan. Recruitment plans are in place to increase staffing levels and in the interim, staffing levels have been maintained bank and agency, and additional Saturday clinics at Queen Charlotte's and Chelsea Hospital are continuing. There have been no occasions where we have not met the requirements for supernumerary staffing. We are continuing to focus on a number of national and local schemes to improve patient safety, quality and experience, including CNST (Clinical Negligence Scheme for Trusts) MIS (maternity incentive scheme) year 6 and the NHS three year delivery plan. We have achieved full compliance with Saving Babies' Lives care bundle 3.

2.5 NHS England has not yet published thresholds for mandatory reportable infections for 2024/25. We exceeded the thresholds for the majority of these in 2023/24. Since the pandemic, there has been rising numbers nationally. NHSE thresholds continue to reduce year on year, meaning we are exceeding thresholds earlier. Despite exceeding the thresholds, in certain areas we perform well in comparison to peers, such as C difficile, E Coli, Klebsiella, MSSA BSI. Good progress continues to be made with the hand hygiene improvement programme, which is our main improvement action.

3   Operational performance

3.1   We continue to have some of the fastest ambulance handover times in London. There is a new London-wide standard for handover within 45 minutes and our May 2024 performance against this was 99.4 per cent. In May 2024, 76.2 per cent of patients were admitted, transferred or discharged from the emergency department within four hours, below our improvement target. We are working to implement various improvements to meet the national target of 78 per cent by March 2025.

3.2   Our overall referral to treatment waiting list was 98,453 at the end of May 2024, a decrease on the previous month. 40 patients had been waiting over 78 weeks, 694 waiting 65 weeks and 3,525 waiting over 52 weeks. This position has been affected by industrial action and we are exploring many solutions to reduce long waits such as additional theatre capacity, mutual aid support from the sector, and weekend lists.

3.3   14.2 per cent of patients were waiting over six weeks for their diagnostic test at the end of May 2024 (against a 5 percent target). There are some specialties with excellent performance such as endoscopy with 0 per cent of patients waiting over 6 weeks and we are focusing on challenged areas including neurophysiology and imaging, where we have issues with aging equipment. We have plans to increase activity in the challenged areas and are developing a longer term plan to manage demand.

3.4   In terms of cancer performance, we are meeting the faster diagnostic standard of at least 77 per cent of patients given a positive or negative cancer diagnosis within 28 days of referral (at 77.8 per cent in April 2024). 73.3 per cent of cancer patients had under 62 days between referral and first treatment, meeting our improvement trajectory target. We are working to meet the national standard for 96 per cent of patients to receive treatment within 31 days of decision to treat (our performance was 90.3 per cent in April 2024), with prostate accounting for most of our delays here.

4   Financial performance

4.1   At the end of May 2024, the Trust was £1.5m adverse to plan with a year-to-date deficit of £4.1m. Overall, there was good performance on income with elective activity equating to 108.1 per cent of pre-pandemic activity. This additional income is offsetting the over spends on pay and non-pay. The over spend includes the marginal costs of delivering the additional elective activity as well as lower than planned delivery of efficiencies (year to day target £10.5m versus actual delivery of £6.1m).

4.2   Clinical divisions are working hard to increase activity as the Trust plan becomes more challenging with effect from June 2024 when the planned level of value weighted elective recovery income needs to stretch to 111.9 per cent for June and 113.9 per cent for July 2024.

4.3   Year to date the Trust has incurred £8.5m of capital spend. This is £2.3m ahead of plan and represents an acceleration of the backlog maintenance planned for the financial year. This is a timing issue only and does not at present alter the full year forecast.

4.4   The cash balance stands at £113.2m; a reduction of £23.4m from the start of the year, the key driver being an increase in supplier payments.

5   Workforce update

5.1   I am chairing a task force made up of staff from across the organisation to develop a more comprehensive action plan to tackle violence and aggression on our sites. It is

building on previous developments, including new training to help spot and de-escalate challenging situations, an expansion of our mental health nursing team and increased use of CCTV and body-worn cameras.

Equality, diversity and inclusion (EDI)

5.2 The second phase of our Engaging for Equity and Inclusion project concluded in June. We have run an additional eight sessions with over 200 staff, patients and community partners to inform our first anti-discrimination and antiracism statements and equity, diversity and inclusion strategy, due to be launched in September.

5.3 We have been nominated for an award for our Healthcare Leaders Fellowship and are planning a graduation ceremony.

5.4 Staff networks have set out a comprehensive programme for increasing visibility of staff concerns. We are running further executive pairings and staff listening sessions and an Imperial College Healthcare group will be attending the London Pride celebration in June.

5.5 The data for our Workforce Race Equality and Workforce Disability Equality Standards have been submitted to NHS England. We have seen improvements in key areas such as career progression, formal disciplinary cases and staff morale although experiences of bullying and harassment remain areas of concern. Our action plans for our Medical and Bank Race Equality Standards will continue from last year.

Update on industrial action

5.6 The consultant BMA members have accepted a revised pay offer which is now being implemented nationally. The SAS doctors have also accepted a revised pay offer. The BMA's junior doctors committee has announced a full walkout by junior doctors beginning at 7am on 27 June and ending at 7am on 2 July 2024. We have a robust plan to ensure patient safety during the strike.

6 Regulatory compliance - Care Quality Commission (CQC) update

6.1 The CQC launched a national review of children's hearing service pathways in April. We have submitted our required return to the CQC, which includes a board assurance review (approved by the Board in Common cabinet) of our oversight of the safety, quality and accessibility of these services and other data. Our review found there is effective oversight of the safety, quality and accessibility of the Trust's children's hearing services across audiology and ENT pathways, at all levels within the Trust and its board committees.

7 Research and innovation

7.1 By the end of the previous financial year (23/24), we had recruited 24,716 participants into NIHR Portfolio studies, with over 1,000 active clinical studies. This was the fourth highest participant recruitment amongst acute Trusts in the country.

7.2 We also continued growth in commercial trials recruitment – 626 participants from 119 separate trials. In addition, NIHR data has demonstrated that the Trust delivered the highest number of 'first European' and 'first Global' recruits to commercial studies in the country (5 out of a total of 51). This is a measure that commercial sponsors take very seriously and reflects well on the new research study set-up processes that were introduced in our Trust just under a year ago. We are actively contributing to work that is sharing best practice in these set-up processes with our colleagues in the other acute Trusts in the sector.

7.3   The Imperial Healthcare Knowledge Bank is a major BRC-funded initiative which is consenting Trust patients 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 analysis and storage for future research. Wider communications and full launch have taken place recently – more than 1,200 patients have already signed up in the first two months, meaning we are on track to recruit our target of 5,000 participants in the current year.

7.4   Paddington Life Sciences Partners continues to go from strength to strength with 13 active industry, academic, GP and business district partners now working together to: provide social value to the communities in the north of Paddington; make improvements to equitable recruitment into research trials; collaborate around data-driven research; and nurture Paddington as a place and space where a life sciences eco-system can grow and thrive alongside St Mary's Hospital.

7.5   Recent research highlights include:
- The first UK patients received an experimental mRNA therapy – a type of immunotherapy treatment called mRNA-4359 – at the Trust as part of a phase 1/2 clinical trial. The trial aims to evaluate its safety and potential for treating melanoma, lung cancer and other 'solid tumour' cancers.
- Pregnancy charity Tommy's has launched a dedicated research centre to reduce the number of babies born prematurely in the UK. The new Tommy's National Centre for Preterm Birth Research will bring together researchers from five leading institutions and is led by Professor Catherine Williamson.
- Remote monitoring of patients at home who had recently had a heart attack was found to have a significant effect on readmissions to hospital, in research carried out by Imperial College London working with patients at Imperial College Healthcare NHS Trust. Half of the group had devices installed at home, allowing them to send their vital signs and call specialist cardiology teams for a remote consultation – known as 'telemedicine' - when they experienced worrying symptoms. The other group of patients followed normal care pathways, taking medicine and consulting their GPs or attending hospital if they had cause for concern. In the study, telemedicine patients were 76 per cent less likely to be readmitted to hospital within six months and 41 per cent less likely to attend A&E, compared to those who followed normal care pathways. Researchers suggest that remote monitoring could help to tackle pressure on health systems worldwide.

8   Estates and redevelopment update

8.1   We opened new Rest Nests for Lewis Lloyd and Charles Pannett wards at St Mary's Hospital and the Labour ward at Queen Charlotte's & Chelsea Hospital. These areas have been fully refurbished and transformed into relaxing sanctuaries of calm for staff on busy shifts, with funding support from Imperial Health Charity.

8.2   I attended the official opening of the St Mary's play and therapy room by Comedian and TV presenter Mo Gilligan on 15 May. The space, benefiting from over £250,000 raised by Imperial Health Charity, will help create a much better hospital experience for patients aged one to 18 and provides our play specialists and therapy teams with a permanent, fun and comfortable environment in which to work.

Redevelopment
8.3   We now expect a formal decision on funding to support the next stage of the St Mary's Hospital design and town planning development after the general election. We are preparing for the next iteration of stakeholder engagement to refresh the design brief.

8.4   We have completed appointments for the design team to support early design and planning stage of both the Hammersmith Hospital and Charing Cross Hospital redevelopment projects and are continuing to work on first-stage business cases.

9   Stakeholder engagement and visits

9.1   Below is a summary of significant meetings I have had with stakeholders. We have been careful to follow the guidance for the pre-election period in our stakeholder engagement and visits.

- Andy Slaughter (MP) and Karen Buck (MP), 30 April 2024
- Cllr Ketan Sheth, London Borough of Brent, 3 April 2024
- Cllr Nafsika Butler-Thalassis, City of Westminster, 9 May 2024
- Ben Coleman, Rachel Blake, Joe Powell, local parliamentary candidates, 30 May 2024
- Greg Hands, local parliamentary candidate, 3 June 2024

9.2   We have also hosted several visits to the Trust, including:

- Lord Victor Adebowale, Chair of the NHS Confederation, visited St Mary's on 29 April for a community walk and a tour of our site to meet staff, see some of our services and discuss our plans for redevelopment.
- Minister for Energy Efficiency, Lord Callanan, visited Hammersmith Hospital on 15 May, aligning with the announcement that we received a further £41 million from the public sector decarbonisation scheme for energy efficient projects across Charing Cross and Hammersmith Hospitals.
- The Times Crime and Justice Commission visited St Mary's in May to hear about our partnership with Redthread, whose youth work and young women's services are embedded in the hospital.
- Local parliamentary candidates Felicity Buchan and Tim Barnes, alongside Victoria Atkins, secretary of state for health and social care, visited St Mary's on 28 May for a tour of our maternity services and wider estate.
- Local parliamentary candidates Rachel Blake and Joe Powell, alongside Wes Streeting, shadow secretary of state for health and social care, visited St Mary's on 4 June for a tour of our emergency services and wider estate.

9.3   We are hosting our 2024 AGM on Tuesday 23 July from 17.45-19.30, at Charing Cross Hospital and online. We will welcome staff, patients and our local communities to hear about our performance in 2023/24 and our plans for the future.

10   Recognition and celebrating success

10.1   I am delighted that in the King's Birthday Honours list Professor Janice Sigsworth CBE, director of nursing at Imperial College Healthcare, has been awarded a damehood for her services to nursing and contribution to embedding genomics into nursing and midwifery practice. Janice is the national professional lead for nursing and midwifery genomics. Janice - who started her nursing training at Charing Cross Hospital in 1980 - has been the Trust's director of nursing since 2008, coming from the Department of Health where she was deputy chief nurse for England. Janice was previously awarded a CBE in the 2018 Queen's Birthday Honours for services to nursing.

10.2   In addition, Professor Anthony Gordon, consultant in critical care at the Trust has been recognised and has been awarded an MBE for his services to critical care. Professor Gordon is also an NIHR senior investigator and chair in anaesthesia and critical care at Imperial College London. His work in critical care focuses largely on sepsis, leading innovative clinical trials to improve care for critically ill patients and developing personalised

treatment approaches, including the use of novel diagnostics and artificial intelligence to adapt treatment strategies.

10.3 Professor Jonathan Weber, director of the Imperial College Academic Health Science Centre and former Trust consultant specialising in HIV, has also been awarded a CBE for services to global medical science. Professor Jonathan Weber is a renowned HIV/AIDS researcher and has been working for over 40 years looking after and researching treatments for patients with HIV and AIDS.

10.4 Congratulations to Emma Spencer, analytics coach, and our Business Intelligence Unit team on winning the Digital Literacy, Education and Upskilling Award at the HSJ digital awards on Thursday. This was for the development of Data Bytes, a data literacy programme, the first of its kind in England. Well done to North West London Pathology who were also shortlisted for digital organisation of the year and for their digital laboratory information management system standardisation and transformation programme.

10.5 Congratulations to Dr Victoria Harmer, consultant nurse in breast care, for being awarded the Global Health Award as part of the King's College London 2024 Distinguished Alumni Awards in recognition of her outstanding work which has had a national and international impact.

10.6 I'm delighted that we have been shortlisted for "Best HR/L&D & OD team of the year – public/third sector" and "Best EDI Initiative" in two awards. These are the 2024 CIPD People Management Awards (ceremony is 19 September in London) and HPMA Excellence in People Awards (ceremony will be held on 3rd October in Belfast).

Imperial College Healthcare NHS Trust (ICHT)
Standing Committee Report to the North West London Acute Provider
Collaborative Board in Common (BiC) – for discussion
2 July 2024

Highlight Report

1.   Purpose and Introduction

The role of the ICHT Standing Committee is:-

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

2.   Key highlights

2.1.   **Chief Executive's Report**
The Committee received and noted the updates within the Chief Executive's report.

2.2.   **Complaints annual report 2023/24**
The Committee noted the annual PALs and Complaints report for 2023/24 noting key themes and trends in the types of complaints received. The Committee was pleased to note that there had been a reduction in the number of complaints received in trauma and acute and specialist medicine following improvement work that had been undertaken to improve communication with patients and their families. The Committee also noted further examples of where learning and improvements had been made following issues raised in complaints.

The Committee reflected on the challenges, opportunities and plans for the year ahead and were pleased to note that feedback from complaints, concerns and other types of user feedback were considered at EMBQ, EMB, Quality Committee and strategic lay forum meetings. Also, complaints with potential patient safety issues were now flagged and reviewed with the medical directors office on receipt and there was greater coordination of cases that involve complaints and safety incidents.

The Committee noted the improvement work for 2024/25 and that the Trust's complaints team were working with complaints teams across the collaborative to align complaints management processes and reporting.

2.3.   **Safeguarding annual report 2023/24**
The Committee received and noted the safeguarding annual report for 2023/24 noting that safeguarding adults, children and maternity referrals overall increased by 20% during 2023/24.   Themes were monitored and shared with partner agencies to inform learning and interventions.

Training compliance was noted and the Committee was pleased to note the positive feedback from board members on the Oliver McGowan training.

The Committee received assurance that the Trust safeguarding team continued to meet the requirements set out in section 11 of the Children Act 2004 and the Care Act 2014. Significant multiagency joint working, including a number of charities, has demonstrated the Trust's commitment to work together to improve the identification of concerns and to protect children and vulnerable adults within the Trust.

The Committee recognised that this would not be possible without the commitment of our front-line staff and the safeguarding team who demonstrate extraordinary professionalism, curiosity, challenge and commitment to safeguarding our patients.

2.4. **Quality Assurance report**

The Committee received and noted the Quality Assurance report which summarised the key quality exceptions, emerging risks and actions/mitigations. It was noted that there were no issues for escalation that required action or support from the Committee and Committee members noted assurance of the work of the internal governance processes; it was noted that the Quality Committee has oversight of the key quality risks and undertake regular deep dives into areas of concern.

Key areas of assurance provided to the Quality Committee related to the implementation of PSIRF, incident reporting, serious incidents and PSIRF learning responses, infection control, mortality, user insights and maternity.

The Committee also noted the quality scorecard and risk register.

2.5. **People Assurance report**

The Committee received and noted the People and Organisational Development (P&OD) Assurance report noting updates against the people priorities, workforce performance, and noting the risks on the P&OD risk register.

The Committee noted the key metrics on the people performance scorecard, the people productivity and efficiency scorecard, vacancies and turnover rates for month 2.

2.6. **Operational performance report**

The Committee noted the operational performance for month 2. Key highlights included the Trust continuing to have some of the shortest ambulance handover times across London, with 97.3% of handovers being achieved within 30 minutes in May 2024. 76.2% of patients attending A&E were admitted, transferred or treated and discharged within four hours which was slightly below our improvement target of 76.7%; our plan to improve and sustain four hour performance continued in order to meet the national NHS objective of a minimum of 78% by March 2025. The Committee also noted the month 2 Referral to Treatment (RTT) performance.

2.7. **Finance report**

The Committee received and noted the financial performance at month 2 noting the emerging developments and risks which included the NHSE proposed timeline for conclusion of 2024/25 contracts for NHS clinical services, income ERF stretch to 111.9% in June and 113.9% in July, industrial action and the continuing cash challenge.

The Committee also noted the resubmission of the financial plan following the NHSE update to the 2024/25 financial framework.

2.8. **Board Assurance Framework**

The Committee received and noted the Board Assurance Framework noting that the Board Committees had risks aligned to them to ensure that they receive the appropriate assurance that the strategic risks are being managed appropriately.

2.9. **Imperial College Healthcare NHS Trust board development improvement**

The Committee noted the development of Improvement for All and to the rationale and content within the Executive Development programme. This would be used as a base from which broader aspects of Board Development can be developed.

2.10. **Board Committee Reports**
The Committee received summary reports from the Quality and Safety, Finance and Performance, People, Audit, Risk and Governance and the Redevelopment Committees that took place in May and June 2024. The Committee received assurance that key risks overseen by each Board Committee were being managed appropriately.

3. Positive assurances received

The Committee received assurance that the Trust was compliant with safeguarding requirements set out in section 11 of the Children Act 2004 and the Care Act 2014.

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

There are no key risks which require escalation to the Board.

5. Concerns outstanding

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

6. Decisions made

The Committee approved the Trust Standing Committee terms of reference in principle noting that minor amendments would likely be made following all four Trust Standing Committees.

7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Terms of Reference	To approve	9.	Board committee report – Finance and Performance	To note
2.	CEO report	To note	10.	People Assurance report	To discuss
3.	Quality Assurance report	To discuss	11.	Boar d committee report – People	To note
4.	Complaints annual report 2023/24	To approve	12.	Board Assurance Framework	To discuss
5.	Safeguarding annual report 2023/24	To approve	13.	Board committee report – Audit, Risk & Governance	To note
6.	Board committee report – Quality & Safety	To note	14.	Board committee report – Redevelopment	To note
7.	Operational performance report	To discuss	15.	Imperial college healthcare NHS Trust - board development improvement	To discuss
8.	Finance report	To discuss			

8. Attendance

Members	July attendance
Bob Alexander, Non-Executive Director (Vice Chair)	Y
Matthew Swindells, Chair, Board in Common	Y
Sim Scavazza, Non-Executive Director	Y
Loy Lobo, Non-Executive Director	N
Nick Gash, Non-Executive Director	Y
Carolyn Downs, Non-Executive Director	Y
Neena Modi, Non-Executive Director	N
Aman Dalvi, Non-Executive Director	N
Tim Orchard, Chief Executive Officer	Y
Jazz Thind, Chief Financial Officer	N
Julian Redhead, Chief Medical Officer	Y
Janice Sigsworth, Chief Nursing Officer	Y
Claire Hook, Chief Operating Officer	Y
Kevin Croft, Chief People Officer	Y
Peter Jenkinson, Director of Corporate Governance	Y

REFERENCES

<div align="right">Only PDFs are attached</div>

📄 11.2g CWFT CEO Public Report July 2024 FINAL1.pdf

📄 11.2h CWFT Agenda - Trust Standing Committee - July 2024.pdf

Chief Executive Officer's Report – Chelsea and Westminster Hospital NHS Foundation Trust

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

1.0   Key messages

1.1   Our hospitals continue to be incredibly busy this summer. Our staff are focussed on ensuring patients have the acute care they need in hospital and are then supported to return home as early as possible. This means planning for their discharge early-on to ensure they receive the ongoing care they need in the most therapeutic setting. We know that patients needing this care and rehabilitation recover better out of the busy acute setting. This allows us to look after those patients who most need acute care, both via our emergency department and through our elective recovery programme. We are working with health and social care system partners to ensure that all parts of the system take responsibility for the seamless care of all our patients.

1.2   Living within our means is central to ensuring we are a well-run organisation. We ended the financial year 2023/24 in a good position and have submitted a plan to break-even this year. This takes effort from every single one of us to deliver. Bank and agency usage is a key focus for the organisation right now, as well as delivering our cost improvement programmes (CIPs), controlling wider expenditure and continuing to treat our long waiting patients, which in turn secures elective recovery fund income. All our divisions and corporate teams are focused on the quality of care we deliver, the timely care we deliver and delivering that care in the most cost effective way.

1.3   Ensuring our staff feel supported and valued is always a priority. We, together with our staff-led networks, have hosted a number of awareness events and exhibitions to highlight Windrush Day, National Reserves Day and Black Leaders Day, as well as attendance at London Pride. We hosted a number of national events to celebrate International Day of the Nurse, Midwife and Operating Department Practitioners (ODP), partnering with NHS England for an NHS Park run. Our midwives at West Middlesex Hospital appeared in a Times feature, where the photographs captured in 2020 will appear as an exhibition at the hospital at the end of this month.

1.4   We collaborated with colleagues at Imperial on proactive messaging to raise awareness of the recent resurgence of measles in London. Working with BBC London and BBC Radio London Nabeela Mughal, Director of Infection Prevention and Control at the Trust, shared key messages including the importance of vaccination, how to spot symptoms of measles and why parents and families need to ensure they are up to date with their jabs. Dr Liz Whittaker, consultant in paediatric infectious diseases at Imperial College Healthcare NHS Trust who shared her concerns about the rise in cases.

1.5   Industrial action by junior doctors took place and we continue to be very grateful to our staff and services for their commitment to patients during these periods. Thanks to our teams, there were good plans in place to mitigate the impact of the planned industrial action, but all recognised the impact on services, patients and finances.

1.6   Our focus on digital inclusion continues and we were delighted that a digital inclusion project, funded by the Health Foundation, led by colleagues at West Middlesex University Hospital, the London Borough or Hounslow, our official charity CW+ and Imperial College Health Partners has won a national Municipal Journal Award. The team at West Middlesex have won an award for a whole council approach to tackling health inequalities, a fantastic achievement to have taken home the prize, among many successful local initiatives.

1.7   The Trust's Annual Report and Accounts 2023/24 were approved by the Trust's Audit and Risk Committee in June. The Annual Report highlights our achievements over the past year, and we look forward to sharing this with everyone who attends our forthcoming Annual Members' Meeting on 18 July.

2.0   Quality and safety

2.1   The Trust's Quality Account for 2023/24 has been approved by the Quality Committee following discussion and input by the Council of Governors. The report, which was shared with local Healthwatch organisations, the NWL Integrated Care Board (ICB) and NHS England, is published on the Trust's website. The Report showcases the positive work we have undertaken at the Trust, including progress against last year's quality priorities.

2.2   This year the focus is on the following agreed priorities: Transitional Care, Deteriorating Patients (PEWS), Deteriorating Patients (Call 4 Concern), Improving care for our Frail Patients, Tobacco and smoking reduction, Patient experience (Nutrition and Hydration) and continued implementation of the Patient Safety Incident Framework (PSIRF).

2.3   Infections are running above thresholds locally, which is consistent with the sector, regional and national picture. It is however a focus for all staff, and additional communications have been cascaded to ensure best practice in terms of infection prevention and control.

2.4   The level of Never Events remained at five at end of year. A full review and learning from these, including barriers, is being completed.

3.0   Operational performance

3.1   Overall, performance remains good in the Trust, which is testament to the hard work of our staff. A&E four-hour performance in May was compliant at 80.68%, which remains above the national target of 78%. Flow remains a challenge, impacting on performance at the Chelsea site over the past two months.

3.2   The 31-day and 28-day faster diagnostics standard (FDS) national targets were met in April. The 62-day combined target delivery was 82.47% against the 85% standard with specific challenges in urology and colorectal surgery. There are plans in place to reduce

the backlog and return to compliance. May saw improvement in the number of patients waiting less than six weeks for diagnostics, however there is particular pressure at West Middlesex in terms of MRI and colonoscopy. An additional MRI scanner has been provided to support clearing the backlog to return to a compliant position.

3.3   The elective referral to treatment (RTT) 18-week wait performance remains challenging but improved in May, standing at 63.97% with elective admitted and outpatient activity levels in May above operational plans. The last month's ED 4-hour performance remained challenging due to demand, but remains above the national target.

3.4   For elective referral to treatment, performance remained challenged but improved. Operational teams are focused on reducing delays, with targeted interventions for specialties including Trauma & Orthopaedics, Colorectal Surgery, Plastic Surgery and General Surgery.

4.0   Finance and estates

4.1   **Finance:**
        As mentioned in the introduction, the financial picture is challenging. At month two, the Trust is seeing £1.96m adverse variance to plan, largely driven by cost improvement plan (CIP) slippage, with additional impact from registered mental health nurse (RMN) spend, the West Middlesex Urgent Treatment Centre and general non-pay increases/inflationary pressures. Elective recovery fund (ERF) performance is over-performing (124% delivery vs 117% planned), the funding for which will be offset against additional costs.

4.2   **Treatment Centre at Chelsea and Westminster**
        Works have now started to redevelop the Treatment Centre and the Therapies outpatient department at Chelsea and Westminster Hospital, with completion due in spring 2025. Since the opening of the hospital more than 30 years ago, the Treatment Centre has supported high quality care for thousands of patients undergoing day case and short stay procedures. With the generous support of our official charity CW+, our aim is to: create modern and welcoming facilities which support the latest surgical innovation and more complex procedures; ensure the highest possible quality of care for our patients; offer a better working environment for staff; treat more patients year-on-year; improve patient aftercare;and improve efficiency through treating more patients at a lower cost.

4.3   **Ambulatory Diagnostic Centre (ADC) at West Middlesex**
        Preparation to clear the ADC site is now fully underway at West Middlesex Hospital, the demolition of the MRI building based at the back of Marjory Warren has been completed which is a significant step in gearing up for construction. We continue to have a regular monthly engagement forum with local residents sharing the progress and developments of the construction. We are planning for our ground breaking event on 23 July to officially start construction, this will be a key milestone moment for the Hospital and an opportunity to thank everyone who has supported us in getting to this point.

5.0   People

5.1   We have had a busy period of staff events, including the upcoming launch of the staff forum. Staff-led network events including Windrush, South Asian Heritage, Reserves

Day, and London Pride were followed by a number of events to mark the NHS's 76th Birthday.

5.2 Cyber security – we have stepped up wider awareness to all staff on being cyber secure further to the cyber-attack across the NHS in South East London.

5.3 Leadership Summit – plans are underway to host a summit on 24 September at Brentford Football Club for all leadership. This event will be an important date to reflect and focus on our priorities as we head in to winter, and there will also be a focus on our strategic priorities aligned to our revised Clinical Services Strategy, alongside the wider Acute Provider Collaborative strategy.

6.0 Equity, diversity and inclusion

6.1 We are taking positive steps to ensure that we are continually creating a more diverse workplace. Recently, the Trust completed the face to face modules for the Diversity in Health and Care Partners Programme 2023/2024. The programme which is run annually, is a comprehensive organisational development programme which helps organisations advance equality, diversity and inclusion (EDI) in the workplace. The programme provides thought leadership, tools and tips which will positively help our organisation be at the forefront of EDI. This important certification will help to ensure that the care we provide is reflective of the diverse communities we serve.

6.2 Pride month is a key month for our services and our staff, and this year we led a number of talks and events, partnered with Soul Cycle in Soho for a charity fundraising event for our LGBTQ+ network and had a great representation at the London Pride parade. For the third year in a row, there was an incredible turn out from Trust colleagues for London Pride 2024, with over 60 members of staff proudly flying the Chelwest flag on our Trust-wide float and marching in the parade. Colleagues at 56 Dean Street also marched in this year's parade, proudly flying the 56 Dean Street. We echoed this year's theme #WeAreEverywhere with our own #WeAreProudToCare message.

7.0 Chelsea and Westminster NHS Trust updates

7.1 We opened the new stroke unit at West Mid in early July. The new ward, situated in the basement of Marjory Warren and opposite Kew ward, represents a vital lifeline to our community, ensuring that our patients get the most appropriate care as quickly and efficiently as possible. The opening of this dedicated stroke ward signifies a critical step forward in providing high-quality care for the people and communities we serve at West Mid.

7.2 Our team of 12 surgical staff on our Chelsea site, led by surgeons James Smellie and Oliver Warren, performed an impressive 11 robotic hernia operations in the first general surgery 'super Saturday'. This was made possible by using two high tech robots in side-by-side theatres, allowing the team to perform more operations than would normally be done on a standard day – helping us to see more patients on the waiting list. Patients recovered well from the robotic procedure, with 8 of the 11 patients going home that same day and the rest leaving the next morning. This would not have been possible without the dedication of our staff working on Saturday and the meticulous planning from all involved.

8.0   Research and innovation

8.1   Our annual Research, Innovation and Quality Improvement (RIQI) event at the West Middlesex site on 17 July focuses on 'curiosity, creativity, and change'. All staff are invited to attend and can explore research, innovation, quality improvement and audit through a range of presentations and networking opportunities.

9.0   Recognition and celebrating success.

9.1   We were pleased to announce that we have signed the Business in the Community (BITC) Race at Work Charter. This significant step demonstrates our commitment to promoting equality and addressing the disparities that Black, Asian, Mixed-Race and other ethnically diverse individuals face in the workplace. By signing the Race at Work Charter, we are taking concrete actions to eliminate these barriers and ensure that our organisation is representative of British society today.

9.2   Our maternity team at West Middlesex University Hospital featured in a photography editorial in the Times on International Day of the Midwife. The award winning photographer James Kent shared the moments of his daughter's birth at West Middlesex Hospital in 2020. The article titled 'It takes a village' highlights the multi-disciplinary team of healthcare professionals, including midwives, Operating Department Practitioners (ODPs), anaesthetists, obstetric surgeons and nurses who work together to bring life into the world, and shares some of their own personal stories. These photos will soon be on display in an exhibition at West Middlesex hospital, thanks to a grant funded by CW+.

9.3   To mark our celebrations for International Day of the Midwife, International Nurses Day and National ODP Day we hosted a taking over of the Fulham Palace parkrun. Over 150 of our staff completed parkrun to celebrate our Midwives, Nurses and ODPs. Leaders from NHS England and the London Region also supported on the day, including Chief Nursing Officer, Ruth May, Deputy Chief Nursing Officer, Duncan Burton, London Regional Chief Nurse, Jane Clegg and London Regional Chief Midwife, Nina Khazaezadeh. Thank you to everyone who put on their running shoes and took part.

9.4   A collaborative digital inclusion project, funded by the Health Foundation, led by colleagues at West Middlesex University Hospital, the London Borough or Hounslow, our official charity CW+ and Imperial College Health Partners has won an MJ Award. The team at West Middlesex, have won an award for a whole council approach to tackling health inequalities, a fantastic achievement to have taken home the prize, among many successful local initiatives.

9.5   On Armed Forces Reserves Day, we paid tribute to our Reservists for their dedication, professionalism and commitment to serving our country and our Trust. We will also raised money for two Armed Forces charities - Combat Stress and SSAFA - in memory of and in tribute to our friend, colleague and veteran Trevor Post who sadly passed away in April.

9.6   Catherine Sands, Head of Emergency Preparedness, Resilience and Response and Business Continuity at the Trust recently received a coronation medal for her contribution in the planning and delivery of the city wide effort to coordinate King Charles' coronation.

Catherine was nominated by NHS England (London) and received one of 29 medals which was awarded by Amanda Pritchard, Chief Executive of NHS England.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chelsea and Westminster NHS Foundation Trust
Trust Standing Committee
18 July 2024 – 10:00 – 12:00
Main Boardroom, LG Floor, Lift Bank B

AGENDA

Item	Item description	Lead	Presentation
1.	Welcome and introductions	Vice Chair	Oral
2.	Apologies	Vice Chair	Oral
3.	Declarations of interest *To note any changes in previously declared interests and any interests related to agenda items*	Vice Chair	Oral
Items for decision			
4.	Terms of Reference *To approve the terms of reference for the Trust Standing Committee*	Vice Chair	Paper
5.	Trust Clinical Strategy *To approve the Trust's refreshed Clinical Strategy*	Director of Strategy/ Chief Medical Officer	Paper
Items for discussion			
6.	Chief Executive's report *To receive the Chief Executive's report*	Chief Executive	Paper
7.	Integrated Quality and Performance Report *To review the monthly integrated quality and performance report for month 2*	Hospital Directors	Paper
8.	Quality Quality Report • *To review the latest quality update* • *To receive a report from the Board quality committee meeting held on 9 July 2024* Infection, Prevention and Control Annual Report 2023/24	Chief Nursing Officer Committee Chair Director of Infection, Prevention and Control	Paper Paper
9.	Finance Report • *To review the monthly finance performance report for month 2* • *To receive a report from the Board finance and performance committee meeting held on 20 May 2024*	Chief Financial Officer Committee Chair	Paper

10.	People and Workforce Report • *To review the latest people update* • *To receive a report from the Board people and workforce committee meeting held on 20 June 2024*	Chief People Officer Committee Chair	Paper
Items for assurance			
11.	Audit and Risk - Board Committee Report – *To receive a report from the Board audit and risk committee meeting held on 21 June 2024*	Committee Chair	Paper
12.	Board Assurance Framework *To review the board assurance framework*	Director of Governance	Paper
Other items for discussion			
13.	Any other business	Vice Chair	Oral
14.	Next meeting: 10:00 – 12:00, 2 October 2024		Oral

12.1. REPORTS FOR INFORMATION ONLY - NIL ADVISED

13.1 ANY OTHER BUSINESS - NIL ADVISED

14. QUESTIONS FROM THE MEMBERS OF THE PUBLIC

14.1 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.

⬤ Discussion Item   👤 Matthew Swindells