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

North West London Acute Provider Collaborative
Board in Common - Public
Tuesday 18 April 2023, 9.00am – 12:00noon

Conference Hall, 3rd Floor, Brent Civic Centre,
Engineers Way, Wembley, HA9 0FJ

Members of the public are welcome to join this meeting in person or by Microsoft Teams, via the following link: Here

The Chair will invite questions at the end of the meeting. It would help us to provide a full answer if you could forward your questions in advance to thh-tr.foundation@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's 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	Matthew Swindells Chair in Common	Verbal
	1.1	Declarations of Interest	Matthew Swindells Chair in Common	Verbal
	1.2	Minutes of the previous NWL Acute Provider Collaborative Board Meeting held on 17 January 2023	Matthew Swindells Chair in Common	1.2
	1.3	Matters Arising and Action Log	Matthew Swindells Chair in Common	1.3
09:05	1.4	Patient Story – Discharge planning *To note the patient story*	Melanie Van Limborgh Director of Nursing (THH)	1.4
Delivery and Assurance				
09:20	2.1	Report from the Chair in Common *To note the report*	Chair in Common, Matthew Swindells	2.1
	2.2	Reports from the Chief Executive Officers *To note the reports* • Chelsea and Westminster Hospital NHS Foundation Trust • Imperial College Healthcare NHS Trust • London North West University Healthcare NHS Trust • The Hillingdon Hospitals NHS Foundation Trust	 Lesley Watts Tim Orchard Pippa Nightingale Patricia Wright	2.2 2.2a 2.2b 2.2c 2.2d

Decision Making and Approvals				
9.45	3.1	Business, Finance and Operational Plans 2023/24	Lesley Watts	3.1, 3.1a, 3.1b, 3.1c
	3.2	Elective Orthopaedic Centre Full Business Case (LNW)	Pippa Nightingale	3.2, 3.2a, 3.2b (Appendix 1 -14)
	3.3	Delegated Authorities to Provider Trust Committees 2022/23 *To approve the recommended delegated authorities to provider Trust committees for the financial year ending 2022/23.* • *Annual Report and Accounts* • *Quality Account* • *Self-certifications for Non Foundation Trusts* • *Self-certifications for Foundation Trusts* • *Modern Slavery Act Statement*	Peter Jenkinson, Director of Corporate Governance (ICHT & CWFT) David Searle, Director of Corporate Affairs (THH & LNWH)	3.3
Integrated Quality, Workforce, Performance and Finance				
10.30	4.1	Integrated Quality, Workforce, Performance and Finance Report *To receive the integrated performance report*	CEO Workstream Leads	4.1, 4.1a
	4.2	Financial performance report *To receive the financial performance report*	Lesley Watts, Chief Executive (C&W)	4.2, 4.2a
	4.3	Reports from Collaborative Committees: *To receive functional reports from the collaborative committees, to note progress in key workstreams and to note risks and assurances* • Collaborative Finance and Performance Committee Chair • Collaborative Quality Committee Chair • Collaborative People Committee Chair • Collaborative Infrastructure and Capital Committee Chair	 Lesley Watts / Catherine Jervis Tim Orchard / Steve Gill Pippa Nightingale / Janet Rubin Patricia Wright / Bob Alexander	4.3 4.3a 4.3b 4.3c 4.3d
	4.4	Learning from deaths *To receive a summary of learning from deaths across the four acute trusts* • Chelsea and Westminster Hospital NHS Foundation Trust • Imperial College Healthcare NHS Trust	Medical Directors	4.4 4.4a 4.4b

		• London North West University Healthcare NHS Trust • The Hillingdon Hospitals NHS Foundation Trust		4.4c 4.4d
Governance and Risk				
11.15	5.1	Reports from Trust Audit Committees *To note the reports* • Chelsea and Westminster Hospital NHS Foundation Trust • Imperial College Healthcare NHS Trust • London North West University Healthcare NHS Trust • The Hillingdon Hospitals NHS Foundation Trust	Audit Chairs	5.1 5.1a 5.1b 5.1c 5.1d
	5.2	Report on items discussed at the Board in Common Cabinet meetings held in November and December *To note any items discussed at the Board in Common Cabinet meetings*	Matthew Swindells, Chair	5.2
Reports for Information Only				
11.30	6.1	Use of the Trust Seal	Peter Jenkinson, Director of Corporate Governance (ICHT & CWFT) David Searle, Director of Corporate Affairs (THH & LNWH)	6.1
Any Other Business				
11.35	7.0	Nil Advised		
Questions from Members of the Public				
11:40	8.0	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.		
Close of the Meeting				
Date and Time of the Next Meeting				
18 July 2023 – 09:00 Conference Hall, 3rd Floor, Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ				
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)				

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North West London Acute Provider Collaborative Board in Common Public Meeting

Tuesday 17 January 2023, 9.00am – 12noon

Conference Hall, 3rd Floor, Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Members Present

Mr Matthew Swindells	Chair in Common
Mr Robert Alexander	Vice Chair (ICHT) & Non-Executive Director (LNWH)
Mr Stephen Gill	Vice Chair (CWFT) & Non-Executive Director (THHFT)
Ms Catherine Jervis	Vice Chair (THHFT) & Non-Executive Director (CWFT)
Ms Janet Rubin	Vice Chair (LNWH) & Non-Executive Director (ICHT)
Dr Vineta Bhalla	Non-Executive Director (LNWH & THHFT)
Ms Linda Burke	Non-Executive Director (THHFT & ICHT)
Professor Andrew Bush	Non-Executive Director (ICHT & CWFT)
Mr Aman Dalvi	Non-Executive Director (CWFT & ICHT)
Mr Nilkunj Dodhia	Non-Executive Director (CWFT & THHFT)
Mr Nick Gash	Non-Executive Director (ICHT & THHFT)
Mr Peter Goldsbrough	Non-Executive Director (ICHT & CWFT)
Professor Desmond Johnston	Non-Executive Director (LNWH & THHFT)
Mr Neville Manuel	Non-Executive Director (THHFT & CWFT)
Mr Ajay Mehta	Non-Executive Director (CWFT & LNWH)
Dr Syed Mohinuddin	Non-Executive Director (LNWH & CWFT)
Mr Simon Morris	Non-Executive Director (THHFT & LNWH)
Mr David Moss	Non-Executive Director (LNWH & ICHT)
Ms Gubby Ayida	Chief Medical Officer (THHFT)
Dr Jon Baker	Chief Medical Officer (LNWH)
Mr Jon Bell	Chief Financial Officer (THHFT)
Ms Tina Benson	Chief Operating Officer (THHFT)
Dr Robert Bleasdale	Chief Nursing Officer (CWFT)
Dr Roger Chinn	Chief Medical Officer (CWFT)
Mr Robert Hodgkiss	Deputy CEO & Chief Operating Officer (CWFT)
Ms Claire Hook	Chief Operating Officer (ICHT)
Ms Lisa Knight	Chief Nursing Officer (LNWH)
Ms Virginia Massaro	Chief Financial Officer (CWFT)
Ms Pippa Nightingale	Chief Executive Officer (LNWH)
Professor Tim Orchard	Chief Executive Officer (ICHT)
Professor Julian Redhead	Chief Medical Officer (ICHT)
Mr Jonathan Reid	Chief Financial Officer (LNWH)
Mr Jason Seez	Deputy Chief Executive Officer/Director of Strategy (THHFT)
Professor Janice Sigsworth	Chief Nursing Officer (ICHT)
Ms Jazz Thind	Chief Financial Officer (ICHT)
Ms Melanie Van Limborgh	Chief Nursing Officer (THHFT)
Mr James Walters	Chief Operating Officer (LNWH)
Ms Lesley Watts	Chief Executive Officer (CWFT)
Ms Patricia Wright	Chief Executive Officer (THHFT)

In Attendance

Ms Victoria Cochrane	Director of maternity and midwifery (CWFT) – for item 2.1
Dr Muna Noori	Consultant Obstetrician and Maternity Clinical Director (ICHT) – for item 2.1
Ms Joy Fashade	Head of Project Finance (ICHT) – for item 3.2
Dr Amrish Mehta	Divisional Director of Women's and Clinical Support (ICHT) – for item 3.2
Ms Tracey Beck	Head of Communication (LNWH)
Ms Tracey Connage	Chief People Officer (LNWH)
Mr Simon Crawford	Deputy Chief Executive Officer (LNWH)
Mr Kevin Croft	Chief People Officer (ICHT)
Ms Emer Delaney	Director of Communications (CWFT)
Ms Michelle Dixon	Directors of Communications (ICHT)
Mr Peter Jenkinson	Director of Corporate Governance (ICHT & CWFT)
Ms Alexia Pipe	Chief of Staff to Chair in Common
Mr David Searle	Director of Corporate Affairs (LNWH & THHFT)
Ms Jessica Hargreaves	Deputy Director of Corporate Governance (ICHT) (minutes)

Apologies for Absence

Ms Sim Scavazza	Non-Executive Director (ICHT & LNWH)
Ms Justine McGuiness	Head of communications and engagement (THHFT)

Minute Reference		Action
1.0	**Welcome and Apologies for Absence**	
1.0.1	Mr Swindells, Chair in Common (the Chair) of the North West London Acute Provider Collaborative Board welcomed members of the Board, attendees, staff and members of the public (attending both in person and virtually) to the meeting. Apologies were noted from Ms Scavazza and Ms McGuinness.	
1.1	**Declarations of Interest**	
1.1.1	There were no new declarations of interest to those already published.	
1.2	**Meetings of the Previous Provider Board Meetings**	
1.2.1	The Board in Common **approved** the minutes of the Board in Common meeting held on 18th October 2022.	
1.3	**Patient /Staff/Stakeholder Story**	
1.3.1	Mr Swindells introduced the patient story relating to maternity and neonatal care which involved a patient, Ms Bowers, whose waters broke whilst working away from home in Bristol and who, after being assessed at hospital and confirming that she was not in active labour, was transferred to Northwick Park Hospital where she delivered her son, who was then admitted into the special care baby unit due to being premature.	
1.3.2	Dr Baker highlighted the seamless care across the sector, noting that the patient had received her antenatal care at Hillingdon and was then transferred back to the care of Hillingdon once her son had been discharged home, for her follow up care with the health visiting team.	

1.3.3	**The Board in Common noted the patient story.**	
2.1	**Maternity services – reflections from external reports**	
2.1.1	Prof Sigsworth introduced the maternity services report highlighting the work being undertaken across the collaborative which sought to address the failings highlighted in the East Kent and Ockenden reports.	
2.1.2	Prof Sigsworth noted that assessments had been undertaken both locally and across the sector against the reports, with actions being put in place which would form a single action plan for maternity services across the collaborative.	
2.1.3	Some of the main themes in terms of lessons learned included not listening to women and families and the importance of multidisciplinary team working.	
2.1.4	Prof Sigsworth noted that both she and Mr Bleasdale were working together on forming and integrating the local ICS maternity services network (LMNS) so that governance and oversight across the collaborative could provide assurance to the Board in Common in regards to maternity services.	
2.1.5	Ms Cochrane reflected that it had been a challenging time over the past few years in maternity services but noted the importance of moving at pace to make the improvements that these reports had brought to light; these included having the right staff in the right place, noting that there were 500 midwives less this year than previous years and therefore recruitment was a key priority to reduce the vacancy rates. Listening to the women and their families was also a hugely important area of focus and there had been a lot of work across the collaborative to ensure that voices are heard and that services reflect the needs of its users. The Board in Common noted the work streams in place to drive improvement across the collaborative.	
2.1.6	Dr Muna Noori added that themes around collaborative working and consultant engagement, supporting teams and driving a good workplace culture were important to enable safe care; this was also a key area of focus for the collaborative and robust governance processes, where all learning is shared across the teams, were driving improvements in care across the collaborative.	
2.1.7	Prof Sigsworth added that working as a collaborative across North West London had been very helpful in terms of providing fresh eyes and challenge which would help to drive improvements across all of the services and specialties which would enable a transparent and open culture.	
2.1.8	Mr Gill confirmed that each trust had presented to the Collaborative Quality Committee where they were in regards to the seven key actions and assured Board members that scrutiny was being applied at the local trust Quality Committees as well, and was pleased to note that whilst challenging, progress was being made.	

2.1.9	Responding to a query from Ms Burke around how culture was assessed, Prof Sigsworth noted that a couple of specific areas of focus included the outcomes of both patient and staff surveys. Mr Bleasdale added that visibility of the board safety champions was also incredibly important and would continue to be worked on in the collaborative.	
2.1.10	Mr Bleasdale reflected that the work in developing new roles was also an important benefit of working as a collaborative and there was national team involvement. Ms Cochrane added that a collaborative approach to recruitment was taking place looking across the service, which would help releasing midwife time to care.	
2.1.11	**The Board in Common noted the report.**	
2.2	**Clinical Negligence Scheme for Trusts (CNST) – Maternity Incentive Scheme – Year 4**	
2.2.1	Mr Bleasdale introduced the maternity incentive scheme report which summarised the position of the four trusts against the 10 safety actions, which aim to improve maternity services and maternity safety. There was also a financial incentive – a rebate in the CNST fees – available to trusts if all ten standards were achieved.	
2.2.2	Board members noted that the scheme was in year 4 and had been paused in December 2020 in recognition of the operational pressures in maternity and the broader NHS, and had been relaunched in May 2022. This included several revisions to the standards, leading to challenges for maternity services to provide the evidence of compliance. Mr Bleasdale noted that a key benefit of the collaborative had been the peer reviews that had been completed which provided support and challenge to teams across the trusts.	
2.2.3	Board members noted that all Trusts were declaring compliance with all ten of the safety standards, apart from London North West Hospitals (LNWH) where safety action 1 had not been fully met; Mr Bleasdale assured the board that actions were immediately put in place to address this.	
2.2.4	It was noted that a standard 'at risk' was action 5, relating to ensuring a labour ward coordinator was in place as a supervisory role. All four Trusts had this in place but it was noted that this was not always a supernumerary role due to pressures on the service. This was being worked on as part of the collaborative work and Mr Bleasdale assured the Board in Common that maternity services were safe on a day to day basis. Prof Redhead noted that if the labour ward coordinator wasn't able to be supernumerary most of the time, then we needed to ensure the staffing ratio was correct. Mr Bleasdale noted that this was being actively reviewed across the four Trusts.	
2.2.5	Responding to a query from Mr Moss regarding whether the self-assessments were scrutinised, Mr Bleasdale responded that peer reviews were undertaken prior to submission, including board maternity safety champions as well as noting that both NHS Resolution and the Care	

	Quality Commission (CQC) could select trusts and review their evidence of compliance. Ms Nightingale added that at LNWH, auditors had also reviewed their data.	
2.2.6	Noting the requirement to submit the declarations of compliance by 2nd February, the Board in Common was asked to delegate authority to the local Quality Committees to monitor and approve the submissions.	
2.2.7	**The Board in Common noted the report and approved the proposed process that the individual Trust Quality Committees would monitor and approve the final submissions.**	
2.3	**Report from the Chair in Common**	
2.3.1	Mr Swindells presented his report and highlighted the tough operational winter pressures across the collaborative, and extended thanks on behalf of the board to all teams involved in managing this across North West London.	
2.3.2	Noting that three non-executive directors would be coming to the end of their terms of office between April and August 2023, Mr Swindells confirmed that the recruitment process was now confirmed and it was hoped that first appointments would be in April.	
2.3.3	Noting that it was her last Board meeting, Mr Swindells extended thanks to Dr Bhalla for her work at LNWH and more recently at The Hillingdon Hospitals NHS Foundation Trust (THHFT).	
2.3.4	It was also noted that Ms Van Limborgh was moving back to Chelsea and Westminster Foundation Trust (CWFT) and Mr Swindells thanked her for all of the support provided to THHFT.	
2.3.5	**The Board in Common noted the report.**	
2.4	**Reports from the Chief Executive Officers**	
2.4.1	<u>Chelsea and Westminster NHS Foundation Trust (CWFT)</u> Ms Watts highlighted the pressures across the sector but noted the focus on elective recovery and the wellbeing of staff, as well as the restoration of the standards of work pre-pandemic, noting that this was a cultural, long term piece of work.	
2.4.2	Ms Watts asked for delegated authority to approve the business case for the Ambulatory Diagnostic Centre from the Board in Common to the CWFT Finance and Performance Committee. The planning had been approved by the Local Authority and the delegated authority was for this work to continue.	
2.4.3	**Chelsea and Westminster Board members approved the delegated authority request.**	
2.4.4	<u>Imperial College Healthcare NHS Trust (ICHT)</u> Prof Orchard highlighted the operational pressures as well as the added pressures of industrial action and noted that the Trust had worked well to	

	ensure cancer and lifesaving operations took place on the nursing strike days with over 400 members of staff participating in the strike. Focus on ensuring the level of rigour operationally continued.	
2.4.5	Prof Orchard advised there was a slight delay in the capital programme relating to the community diagnostic development in Wembley; this would go ahead but there would be a slight delay into next year's capital plan.	
2.4.6	Research networks, now called regional research delivery networks, had changed borders and there was now a North London one with an arrangement in place with Barts Health NHS Trust who will submit a bid on behalf of the north London sector.	
2.4.7	Prof Orchard extended thanks to all staff that helped deal with an estates issue at the St Mary's site that led to the temporary closure of the Paterson centre the day before.	
	<u>London Northwest University Healthcare NHS Trust (LNWH)</u>	
2.4.8	Ms Nightingale was pleased to highlight that the Trust had moved from an enhanced National Oversight Framework (NOF) level 3, which had been in place since 2018, to level 2, reflecting great progress for the Trust.	
2.4.9	Ms Nightingale highlighted the focus on staff wellbeing, noting that there had been great engagement from the team and the investment in wellbeing was working well and would continue to be a key focus.	
2.4.10	It was noted that the Trust had turned on the Energy Centre which was a positive step in the Trust's sustainability work.	
2.4.11	Ms Nightingale extended thanks to all stakeholders for all of the work over the past 3 months, which would also continue going forward.	
	<u>The Hillingdon Hospitals NHS Foundation Trust (THHFT)</u>	
2.4.12	Ms Wright highlighted that the Trust remained in National Oversight Framework (NOF) level 4, but was working with the national intensive support team to move to level 3. Despite the pressures the services had been dealing with the Trust remained hopeful to achieve level 3 in 2023/24. Ms Wright confirmed that this process had been really helpful in understanding the issues driving quality, performance and financial positions.	
2.4.13	Ms Wright noted that the Trust had undergone a number of external inspections including Health & Safety Executive (HSE), and CQC inspections. The Trust had received a compliance notice relating to radiology and safer sharps; these concerns had been resolved quickly with the HSE. It was noted that the draft CQC report had been received by the executive team, this would be reported to the Board in due course.	
2.4.14	Responding to a query from Mr Goldsbrough regarding the number of safety incidents increasing where capacity was an issue at ICHT, Prof Orchard advised that the emergency departments were full and additional patients were 'on boarded' onto the wards rather than waiting in the	

	emergency department. Every incident where patients were 'on boarded' was reported on Datix which was increasing the number of incidents but allowed for a great level of focus on the patients and their pathways. It was noted that there had not been any increase in any harm coming to patients and Prof Orchard added that the focus was on safety but accepted that there was potential for a negative impact on patient experience.	
2.4.15	Mr Moss asked Ms Wright how learning was shared across the collaborative following visits from the HSE for example. Ms Wright noted that there was not yet a process in place; it was currently reported through Quality Committees and Audit Committees, but agreed there was some important learning to share. Ms Wright added that inspections seemed to be much more focused on a suitable working environment and the impact on staff.	
2.4.16	**The Board in Common noted the updates.**	
3.1	**Elective Orthopaedic Centre update**	
3.1.1	Dr Chinn presented the elective orthopaedic centre update highlighting the timeline for the programme which was currently in the consultation period. Once the public consultation closed, it would be published and would inform the decision making business case to the local borough and NHS North West London ICB. Noting these would take place in early and late March, delegated authority was requested to the Board in Common Cabinet to develop the cases as described.	
3.1.2	The tender process was due to commence for the capital developments for the final business case; this would proceed at risk given the public consultation had not yet closed but given the timeline it was felt that proceeding with the tender process was appropriate.	
3.1.3	Responding to a query from Mr Morris, Dr Chinn confirmed that patient transport was one of the most significant issues raised by the consultation along with ensuring that there is no inequity to access wherever possible when moving to a pathway that is more streamlined; work to address both of these issues was underway.	
3.1.4	Responding to a query from Mr Dodhia, Dr Chinn confirmed that the financing model was being looked at in specific detail by a work stream under the programme board, which was being led by Mr Reid. Mr Reid confirmed that the four CFO's met regularly and received regular updates and had agreed a set of risk sharing principles to improve productivity and efficiency and share benefits across the four organisations.	
3.1.5	**The Board in Common noted the update and agreed to delegate authority to the Board in Common Cabinet in order to develop the business case as required.**	
3.2	**Strategic Imaging Asset Management (SIAM) strategic outline case**	
3.2.1	Mr Mehta and his team introduced the strategic outline business case for the strategic imaging asset management for North West London, noting	

	in particular the six areas of challenge, the options that had been considered and the qualitative benefits highlighting the preferred way forward in terms of the financial case which was option 4 (imaging partnership). Mr Alexander assured Board colleagues that this was an outline case and would continue to be reviewed and scrutinised at the ICHT Finance, Investment and Operations Committee in the first instance, and would then be shared at the collaborative finance and performance committee to consider opportunities for other trusts.	
3.2.2	Dr Bhalla queried where the diagnostic gap and capacity would sit going forwards in North West London and noted the importance of understanding this as new diagnostic pathways were developed in the sector. Prof Orchard noted that Dr Mehta had good oversight as regional director for imaging and added that as part of the imaging board across the sector there were many discussions regarding whether the other trusts wanted to be a part of this work or not; at the time they didn't but ICHT felt that it had been important to still progress this due to the aged infrastructure, but to do it in a way that would allow other Trusts to on-board going forward.	
3.2.3	**Imperial College Healthcare NHS Trust board members approved the strategic outline case and agreed that it could proceed to the next stage.**	
3.3	**London North West University Healthcare Trust Strategy**	
3.3.1	Mr Crawford presented the London North West University Healthcare Trust (LNWH) strategy highlighting the broad stakeholder input which had helped shape the four objectives which included high quality care, being a high quality employer, being a high quality non-clinical function and support and having positive provider relationships. Noting it had been developed before the collaborative, Mr Crawford highlighted the need to refine the strategy as the collaborative develops.	
3.3.2	Ms Rubin confirmed that the LNWH non-executive and executive colleagues had all discussed and supported the strategy.	
3.3.3	Responding to a query from Mr Mehta regarding stakeholder engagement, Mr Crawford responded that the Trust were heavily engaged with its stakeholders and were much more active with the Local Authority than previously. It was also confirmed that this engagement would continue.	
3.3.4	**The LNWH Board members approved the strategy.**	
4.1	**Integrated Quality, Workforce, Performance and Finance report**	
4.1.1	Ms Wright presented the collaborative performance report noting that it aimed to bring together key performance indicators across the collaborative, highlighting the trend graphs that pull out key collaborative indicators which are felt to be of importance to board members.	
4.1.2	Prof Orchard presented the quality section of the report, noting that work was in progress to ensure metrics were recorded consistently across the	

	collaborative. It was noted that these metrics were monitored through the local and collaborative quality committees.	
4.1.3	Mr Goldsbrough asked where harm or lack of harm was assessed of those waiting long times for their appointments. Prof Orchard confirmed that harm was analysed at a number of points including, periodic reviews of the patient tracking list (PTL), an assessment is taken when the patient is added to the waiting list, and teams were trialling different ways of contacting patients on the waiting list and asking how they are and at the point when they come into hospital. Prof Redhead added that there was a clinical harm review group in the collaborative considering how to prevent harm before it occurs.	
4.1.4	Ms Wright asked the nurse directors whether better patient engagement surveys would be useful. Ms Dixon noted that local workshops with stakeholders were in train and agreed to bring a further update to a future board in common meeting.	MD
4.1.5	Ms Watts introduced the operational section of the report noting that more indicators would be included going forward.	
4.1.6	Mr Walters highlighted that waiting times for cancer diagnostics and treatment across the collaborative were currently above NHS England targets for all cancer metrics. GP two week wait referrals were rising and were 15% above pre Covid levels which impacted diagnostic capacity and work to improve this was in place. Following the pandemic there had been a focus on the 62 day long wait, performance was on plan against the trajectory.	
4.1.7	Ms Hook highlighted the challenges over the winter, noting that before Christmas the demand was as forecast, all winter beds were opened across the four Trusts, but following this there appeared to be a step change in terms of the capacity with a peak in admissions for Covid, flu and other respiratory illness. Ms Hook noted that in terms of key metrics the collaborative were the highest receiver of ambulances in London and had the best handover times although there was still work to do on this. There had been good collaborative working to spread demand across the sector and trusts were determined to deliver improvement in waiting times.	
4.1.8	Ms Benson reflected that the collaborative had delivered high activity and noted the key challenges included workforce hotspots where recruitment was difficult and all services heavily reliant on specialist workforce which means the diagnostics workforce, for example was particularly fragile. Work to increase MRI capacity was in progress.	
4.1.9	Mr Hodgkiss reflected that North West London was the best performing sector in London. Theatre utilisation was a key area of focus with every Trust above 80% and each Trust was working to get to above 85%.	
4.1.10	Responding to a query from Mr Morris, Ms Watts agreed to put patient flow data in the pack going forwards.	PW

4.1.11	Responding to Mr Gill, Mr Hodgkiss noted that 52 week wait data had increased slightly but that this was due to focusing on reducing the 78 week waiting lists and confirmed that once this had been addressed the 52 week waiting lists would start to reduce again.	
4.1.12	**The Board in Common noted the report.** **Action: An update on patient engagement surveys to be presented to a future Board in Common.** **Action: Patient flow data to be included in the performance report going forwards.**	
4.2	**Financial performance report**	
4.2.1	Ms Watts introduced the financial performance report noting that the financial plan was aligned to the operational plan.	
4.2.2	The Board in Common noted the individual Trust updates provided by the chief finance officers on their financial positions.	
4.3	**Reports from collaborative committees**	
4.3.1	<u>Report from Collaborative Quality Committee Chair</u> Mr Gill presented a summary of the discussions at the previous collaborative committee meeting, highlighting the clinical impact of winter pressures, the peer review of the emergency pathway, maternity and CNST noting the approved funding for birth rate plus. User insight had been added as one of the work streams for the Committee.	
4.3.2	Prof Redhead highlighted the peer review work in the emergency departments, with the learning separated into seven themes which had been brought together into work streams for the Trusts to work on. The next phase of this would be to focus on discharge. Mr Swindells noted the benefit of having these peer reviews as a collaborative and thanked Prof Redhead for leading this work. Mr Gill noted that three-four of these peer reviews would be completed each year. No issues were escalated to the Board in Common.	
4.3.3	<u>Report from Collaborative People Committee Chair</u> Ms Rubin presented a summary of the discussions at the previous collaborative committee meeting and highlighted the establishment of an international recruitment programme for junior doctors, making better use of the apprenticeship levy for filling allied health roles and thirdly growing more of our own in terms of practitioners. In terms of EDI, there were a number of people on the People Committee that ensured EDI was mainstream in terms of the committees work. Ms Rubin noted that there had been some improvements in this area, the number of BAME staff going through disciplinary proceedings had reduced and the number of BAME staff getting senior roles had increased. Ms Rubin highlighted that exit interview analysis had been completed by one trust which highlighted three reasons people leave: career progression, training and development, and work life balance and workload. Ms	

	Rubin noted that as leaders it was important to lead on the improvement in all three of these areas. <u>Report from Collaborative Finance and Performance Committee Chair</u>	
4.3.4	Ms Jervis presented a summary of the discussions at the previous collaborative committee meeting, noting that the continuing challenges around capacity and demand would continue in the year ahead and the challenged position financially. <u>Report from Collaborative Infrastructure and Capital Committee Chair</u>	
4.3.5	Mr Alexander presented a summary of the discussions at the previous collaborative committee meeting and highlighted the focus on sustainability and green planning, and the hard tangible objectives that Trusts were required to meet.	
4.4	**Medical examiner service community pathway implementation**	
4.4.1	Mr Chinn presented the report outlining the roll out of the community pathway of the medical examiner service across the collaborative, noting that each Trust was on track to initiate this service from April. Responding to a query from Mr Dalvi regarding 24 hour burials for deaths that occur on weekends or during public holidays, Mr Chinn noted there would be good cover over 7 days.	
4.4.2	**The Board in Common received and noted the report.**	
4.5	**Learning from deaths**	
4.5.1	Mr Chinn presented the report highlighting that bringing the reporting together which would provide a more thematic review across the collaborative.	
4.5.2	**The Board in Common received and noted the report.**	
6.1	**Reports from Trust Audit Committees**	
6.1.1	**The reports from the Trust Audit Committees were received and noted by the Board in Common.**	
6.2	**Report on items discussed at the Board in Common Cabinet meetings held in November and December 2022**	
6.2.1	Mr Swindells highlighted the business discussed at the Board in Common Cabinet, noting in particular the approval of the incinerator business case for Hillingdon Hospital at the Board in Common Cabinet in November 2022.	
6.2.2	The full business case was available to all board members in the private section of the Board in Common due to commercial sensitivities.	
6.2.3	**The Board in Common noted the report and ratified the incinerator business case.**	
6.2.4	**The Board in Common ratified the stakeholder engagement plan.**	

7.1	**Any other business**	
7.1.1	On behalf of the Board in Common, Mr Gill congratulated Ms Watts for being awarded a CBE in the New Year's honours.	
8.1	**Questions from the Public**	
8.1.1	The Board in Common noted that questions were received in advance of the meeting. Mr Swindells summarised the questions and asked members of the Board to provide answers, noting that written responses would be provided on the website.	
9.1	**Date of the Next Meeting**	
9.1.1	The next meeting would take place on 18 April 2023 at 9.00am until 12 noon	

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

North West London Acute Provider Collaborative

Board in Common (public) Action Log

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

Meeting Date: 18 April 2023 **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
4.1.4 (January 2023)	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.	April 2023

4.1.10 (January 2023)	Integrated Quality, Workforce and Performance Report	Patient flow data to be included in the report going forwards.	Patricia Wright	Request with the operations team, not yet resolved.	July 2023

Part 2: Actions previously outstanding but now completed

Meeting Date	Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes & Status

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)
18/04/2023
Item number: 1.4
This report is: Public

Patient Story – Pathway 2 discharge from THH to Hawthorn Intermediate Care Unit (HICU)

Author: Jen King
Job title: Head of Discharge, The Hillingdon Hospitals NHS Foundation Trust

Accountable director: Melanie Van Limborgh
Job title: Director of Nursing, The Hillingdon Hospitals NHS Foundation Trust

Purpose of report

Patient Story – Video documentation from a patient about their Experience of at the Hillingdon Hospitals with experience of Northwick Park Hospital and the Hawthorn Intermediate Care Unit (CNWL service on the Hillingdon site).

Purpose: Information or for noting only

Report history

Executive summary and key messages

Patient Story

After previous hospital stays, our patient was repatriated to Hillingdon Hospital from Northwick Park Hospital following a below knee amputation. The patient was admitted to Bevan Ward (General Medicine/Endocrinology Ward) on 20.01.23 requiring antibiotics and identified for requiring rehabilitation. In the ward he was reviewed by a specialised amputee physiotherapist and a member of the Tissue Viability team. A referral was made to the Hawthorn Intermediate Care Unit (HICU) on 01.02.23, admitted to the HICU 07.02.23.

On the 14.02.23 in the early hours of the morning, the patient required re-admission to Hillingdon Hospital via the Emergency Department due to chest pain. He was admitted to the Acute Medical Unit for treatment. Later that day the medical team assessed the patient to be medically stable for transfer back to HICU. The patient was discharged via the Departure Lounge at 15:00hrs arriving back to HICU at 16:30hrs.

The key messages from the patient highlighted positive feedback over his care.

One item that would have supported the patient was the provision of the Trusts Discharge Booklet for his hospital stay into discharge. The learning from this patient story highlighted if the discharge summary completion was at the same time as the referral, this would have allowed HICU to complete the full screening process resulting in a reduced length of stay at the hospital.

The patient also provided feedback regarding the meal services at Hillingdon particularly in relation to his diabetes. The clinical team will be working with the Housekeeping team on this item.

The patient story will be discussed with senior representatives from the Hillingdon Hospitals and Northwick Park Hospital. To cascade the key message of providing patient information booklets to patients on all pathways and earlier discharge planning on the wards to support an improved patient experience. Hillingdon Hospital will be promoting the new NWL patient discharge information booklets and have recently launched a trust discharge study day which will support these actions.

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

Reason for private submission

Tick all that apply

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

If other, explain why

Chelsea and Westminster Hospital NHS 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)

18/04/23

Item number: 2.1

This report is: Public

NWL Acute Collaborative Chairs Report

Author: Matthew Swindells
Job title: Chair in Common

Accountable director: Matthew Swindells
Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

The Board in Common is asked to note the report.

Report history

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

N/A

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

Executive summary and key messages

This report provides an update from the Chair in Common across the Acute Collaborative.

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

- ☐ Commercial confidence
- ☐ Patient confidentiality
- ☐ Staff confidentiality
- ☐ Other exceptional circumstances If other, explain why

North West London Acute Trusts – Chair's Report to the Board in Common, Tuesday 18 April

1. **The Acute Collaborative**

2. As I end my first year as Chair of the acute collaborative and we move into a new financial year, I would like to extend my thanks to my NED and Executive colleagues who have engaged in such a positive way in creating a new approach to delivering acute services to the people of north west London, and particularly to the four Vice Chairs and four Chief Executives who have made the vision a reality with determination and purpose.

3. The benefits of working together in the collaborative whilst maintaining the local leadership and individual personalities of our four Trusts can be seen in the performance of our organisations who have collectively delivered their financial plans for the past year, a historic rarity in north west London. This is particularly impressive given the significant disruption providers have had to deal with, indeed at this month's NHS England briefing for Chairs on the NHS's financial position, north west London was held up as an example for the rest of the country to learn from.

4. We have delivered more elective activity compared to pre-COVID levels faster than any other sector in London; improved our A&E performance across the board and in some Trusts delivered amongst the best performance in London; and we continue to provide the safest acute hospital care, as measured by the Summary Hospital-level Mortality Indicator, of any ICS in England. The Trusts have increasingly supported each other to optimise acute care across north west London, and worked together to spread best practice.

5. Our capital planning is being coordinated in order to make the best use of the facilities at our disposal, as evidenced by the development of the Elective Orthopaedic Centre (EOC) at the Central Middlesex and the Community Diagnostic Centre (CDC) at Ealing Hospital both shared facilities for all the residents of north west London. We expect to enhance this joint planning in the coming years.

6. Our clinicians are increasingly working together under the guidance of the collaborative quality committee to support the spread of best practice, with shared analysis of data and joint service reviews, such as the peer review of all our A&E services by our senior clinicians across all 7 A&E departments. This will develop into one of the primary ways in which we ensure that we deliver our dual ambition of equity of access to top quality care across north west London, whilst reduction variation.

7. The Board in Common held its second development session in February to discuss the Collaborative priorities, which has been used to input into the work for the 2023/24 operational, financial and business plans which has been developed over the last quarter. We have had a third round of Collaborative Committees which are part of the infrastructure we have developed to drive the priorities and monitor the 2023/24 plans.

8. With three of our NEDs having either reached the end of their term of office or approaching the end, we are currently in the process of recruiting to replace them. This affects all four of the Trusts in the acute collaborative. We have had a great response to the advert and were able to put together a diverse shortlist of people with strong links to North West London who are passionate about improving our organisations and patient outcomes.

Each of the shortlisted candidates participated in a stakeholder engagement session and a full interview yesterday (17 April). The interview panel included both external advisors and the lead governors from our two Foundation Trusts. The panel recommendations now need to be approved by London Region for the two acute Trusts and the Councils of Governors for the two FTs before we can make an announcement, which will hopefully be soon.

9. Industrial action

10. In March and last week Junior Doctors across the four Trusts took part in a three day and four day strike, I know that the decision to take action would not have been taken lightly by any healthcare staff and it is important that we respect one another's decisions and views. As with other Trusts across the country, we had to reschedule a high number of planned appointments so that urgent and emergency treatment was prioritised but we did manage to keep a significant proportion of our elective activity going.

11. The level of commitment and teamwork shown in the lead up and during the strike by our medical leaders, nursing and other clinical staff and operational managers demonstrates the exemplar leadership of our entire workforce. Not only did this support our junior doctor colleagues who were taking strike action, but also served to protect our patients and ensured safe staffing for essential services across north west London. I want to thank all staff on the efforts during the strike.

12. Meeting Staff

13. I have been on a number of visits across the four Trusts, below is round up of some of the visits I have been on.

14. At **Hillingdon** I have met with the Diversity and Inclusions leads where I heard the tremendous amount of work which is taking place across the Trust to engage staff in the different staff networks we have across Hillingdon. I met with a large group from our Estates and Facilities team who gave me an overview of the work that the teams are involved in across the Trust. I also had a session with two trainers from the Clinical Education team where I heard what training happens for nurses across the Trust. I recently also did a question and answer session with Consultants across the Trust with Gubby Ayida, Chief Medical Officer.

15. At **West Middlesex**, I went on the Kew ward which houses the specialist stroke team led by Ravneeta Singh, Care of the Elderly and Stroke Consultant and Brian Drumm, Stroke Consultant, I talked through with the team their multi-disciplinary approach to working with long term stroke patients. I also had a tour of the Acute Medicine Unit with Gwen Whatley, Head Physiotherapist.

16. At **St Mary's** I had a tour of the emergency theatres and obstetrics across the whole site by Sarah McNeilly, Head of Specialty, Theatres and Anaesthetics and Consultant in Anaesthesia and Intensive Care Medicine at Imperial. It was interesting to see these areas through the lens of anaesthetics and how integral the equipment and estate is in providing the best care for our patients.

17. At **Northwick Park** Pippa and I met with Patrick Flaherty, Chief Executive and Senel Arkut, Corporate Director for People's services from Harrow Council. We had a tour of the Accident and Emergency department and the Maternity Unit together.

18. Elective Orthopaedic Centre (EOC)

19. Our Acute Provider Collaborative's proposal to bring together most routine inpatient orthopaedic surgery in north west London in a new 'elective orthopaedic centre' at Central Middlesex Hospital was approved by our Integrated Care Board last month. The proposal incorporates feedback from a 13-week public consultation that closed earlier this year involving almost 2,000 people.

20. Drawing on evidence from similar centres in other areas, the expectation is that this new approach will improve quality and reduce long waiting times. The plan is to open the centre later this year, with the

project expected to pass additional gateways over the coming months, including approval of a full business case and implementation plan.

21. End-to-end care for patients who have their operation at the new centre will continue to be the responsibility of the surgical team at their 'home orthopaedic hospital', with outpatient care provided locally or online. For our Trusts, that means patients' 'home orthopaedic hospital' surgeons will carry out the operation at the elective orthopaedic centre with the support of a permanent, specialist team. Care pathways for orthopaedic patients with complex health needs and day-case patients are unchanged and surgery will be provided, as now, at a range of North West London hospitals. Detailed workforce plans will now be developed with staff.

22. **Community Diagnostic Centres (CDCs)**

23. New NHS Community Diagnostic Centres are a national initiative to build additional diagnostic capacity for planned care, based in the community and separated from urgent and emergency pathways. This 'one stop' approach for checks, scans and tests will be more convenient for patients and help to improve outcomes for patients with cancer and other serious conditions.

24. We are creating three new CDCs on existing NHS sites situated in two areas of north west London where there are significant clusters of deprivation, the area of Hanwell, Southall and Greenford; and the area of Neasden, Stonebridge, Harlesden, North Hammersmith and Fulham, North Kensington, Queen's Park and Church Street in North Westminster. An additional 300,000 diagnostic tests per year will be provided across the three new Community Diagnostic Centres by 2024/25.

25. Future Capital Plans

26. Proposals for the new **Hillingdon Hospital** got a significant boost at the Hillingdon Council's Major Applications Planning Committee on 18 January 2023, when they resolved to grant approval for the plans. Following the Council's decision to grant resolution for approval, the planning application is now being prepared for referral to the Mayor of London for final sign-off, which is standard practice for a project of this size. Most of all, we are also waiting for confirmation of funding for the plans and permissions to move developing the full business case from central government. This has been "any day now" for several months. As I have said previously, I am confident that our team has done a brilliant job drawing up the plans and engaging with the national "New Hospitals Programme" to ensure that our proposal both meets the needs of local people and what the government is looking for, but in the end this is a ministerial decision and we can only wait.

27. Intensive planning is in train at **Central Middlesex Hospital** to support the planned Endoscopy Unit and the Elective Orthopaedic Centre which have required significant enabling works relocating some existing services in advance of the building works which are on-going.

28. At **Ealing Hospital**, work continues on the Community Diagnostic Centre which will open near the end of this year, as well as ongoing repairs and improvements to the core infrastructure on the site. Our teams at Ealing have also been working with architects and healthcare planners to start the Ealing Hospital Site Development Control Plan – and we will be working with key local stakeholders to shape and refine the medium-term plans for the site over the next few months.

29. At **Northwick Park Hospital**, the new Energy Centre 'officially' launched on 1 April with practical completion and handover of the project to the Trust team. This starts a long period of guaranteed financial savings for the Trust at a time of rising energy costs, but perhaps more importantly it also marks a significant milestone in our plans for carbon reduction, and in moving towards greater resilience and stability in energy supply. The major works around the hospital to build the new road and access points, being undertaken by the local authority as part of the One Public Estate initiative are moving along, and these are anticipated to be completed later in the autumn. Looking forward to later in the year, our teams at Northwick are planning for a modern 'modular' bedded extension to the emergency department – subject to finalising the funding – to support patient flow and increases in capacity during the winter months. This marks phase 1 of our plans to increase capacity by around 60 beds on the site – and work continues on our business case for the new

Critical Care unit which will enable phase 2 of the plan, and which will over time create the capacity needed to meet the growing demands on the urgent and emergency care service at Northwick.

30. **Imperial College Healthcare NHS Trust** continues to progress its redevelopment plans across all it sites, which are all in Cohort 4 of the New Hospital Programme. At **St Mary's Hospital** the first-stage business case for a full redevelopment of the site was submitted in September 2021 and the case for change has been accepted by the government. We set out the need for a new, 840-bed, research-led, major trauma, and acute teaching hospital which would release around five acres of surplus land for wider site regeneration. Our vision puts life sciences at the heart of the mixed-use masterplan to boost the health, wealth and wellbeing of our local communities, as well as creating a new community-led neighbourhood and vastly improved public spaces. Following feedback from the New Hospital Programme, we have worked on phasing the scheme to speed up delivery, spread the costs and be ready to start building work in 2025. And we are continuing to explore options for maximising the benefits of this once-in-a-generation opportunity. We are planning to step up community engagement too, especially for the more advanced St Mary's scheme.

31. **Charing Cross** and **Hammersmith hospitals** are planning significant refurbishment and some new buildings at both sites. We are currently working on first stage business cases for both sites and hope to submit them later this year. We need an indication from the New Hospital Programme on the funding envelopes for both schemes to help ensure our plans are deliverable.

32. The Ambulatory Diagnostic Centre (ADC) at **West Middlesex Hospital** continues to progress. Hounslow Borough Planning Committee approved planning permission on 12 January and NHSE has confirmed the scheme will also receive an allocation from the national Targeted Investment Fund (TIF). The plan is the centrepiece of the Trust's 5 year capital plan and develops additional Cancer/Haem-Oncology, Renal and Imaging capacity, as well as Clinical Education & Training facilities. Transition plans to maintain capacity while construction takes place are in place and the Trust is about to launch formal procurement processes and the programme plan assumes that on site work will start in the autumn

33. Other plans in **Chelsea and Westminster Foundation Trust's** capital programme include:

    - Redevelopment of Treatment Centre (Daycase Unit) at Chelsea & Westminster (also a NHS England TIF scheme)
    - Additional ward development to support surge capacity pressures at West Middlesex
    - Key estate maintenance and sustainability developments

NWL Acute Provider Collaborative Board in Common (Public)
18/04/2023
Item number: 2.2
This report is: Public

Chief Executive Officer's Reports

Authors: Lesley Watts, CEO – Chelsea and Westminster NHS Foundation Trust
Tim Orchard, CEO - Imperial College Healthcare NHS Trust
Pippa Nightingale, CEO – London North West University Healthcare NHS Trust
Patricia Wright, CEO – The Hillingdon Hospitals NHS Foundation Trust

Purpose of report

Purpose: Information or for noting only

The Board in Common is asked to note the reports.

Report history

N/A

Executive summary and key messages

This report provides an update from the Chief Executive Officers of each of the four Trusts in the North West London Acute Provider Collaborative (Chelsea and Westminster NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundation Trust) on key issues relating to each respective Trust.

The reports include a summary of trust operational and financial performance, workforce issues, regulatory compliance, strategic priorities, stakeholder engagement and events, and successes to celebrate.

Strategic priorities

Tick all that apply

☒ Achieve recovery of our elective care, emergency care, and diagnostic capacity

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

Chief Executive Officer's Report – Chelsea and Westminster Hospital NHS Foundation Trust

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

1.1. **Industrial Action Disruption**- Winter coinciding with a period of service disruption has placed increased demand on our services locally, across the wider North West London Integrated Care System (NWL ICS) and the NHS over the last couple of months. This level of disruption has required a stepped up approach to managing our services. I am incredibly grateful to all my colleagues for their commitment and support during this difficult period.

Over 90% of our Junior Doctor workforce took part in the recent Industrial Action in March, requiring weeks of planning and preparation leading up to the strike days. Thanks to the team work of our entire workforce, we delivered 75% of our normal services across outpatients, diagnostics and same day cases, our Trust A&E performance reported 90% with the Chelsea site delivering above 95%.

1.2. **Emergency services supporting patient flow**
Despite the challenges managing through winter and service disruption, I am proud of the proactive work of our Emergency Department to supporting our patients and communities.

Our team piloted interventions Fit to Sit, Navigation at Triage and Emergency Department led Same Day Emergency Care (SDEC) service. This was part of our wider work aligned with the national Delivery Plan for Recovering Urgent and Emergency Care Services, which set out a number of schemes that our Trust are adopting to improve patient flow and patient experience. The SDEC and other pilots have demonstrated several benefits to our staff and the patients already. The ultimate goal at our Trust was to run a hybrid model where there is joint working between Emergency Medicine and Acute medicine—together they will deliver same day emergency care to our patients.

2. Quality and Safety

2.1. CQC inspection. The Trust underwent a short noticed risk based inspection as part of the national maternity inspection programme. We received notification of the intention to inspect both our sites on Monday 30 January 2023. The onsite inspection took place on Wednesday 1 February and Thursday 2 February, with supplementary interviews on Friday and Monday 6 February 2023. The inspection only focused on the safe and well led domains.

In addition to observing clinical interactions and care across the patient pathway, notes reviews were completed in addition to extensive interviews with staff, across a range of specialist areas.

The inspection team provided initial feedback commented that staff were highly engaged, with evidence of multi-professional working and good visible leadership at all levels. the Trust had a good developed relationship with the MVP, and the team witnessed evidence of changes in practice as a result, and feedback was really valued by the service, with a strong focus on equality diversity and inclusion, and commitment to reducing inequalities for the communities we serve.

The Trust is awaiting the formal report which is scheduled within 10 weeks following completion of the inspection.

2.2. Maternity oversight and Maternity Incentive Scheme - year 4 (CNST)

The Trust provides oversight of quality assurance within the maternity service via a Maternity quality oversight assurance report to each Quality Committee meeting. This is also summarised in the quality function report to the Acute Provider Collaborative Quality Committee. Following review at the Board in Common in January 2023, and sign off through the agreed internal process, we submitted our declaration of compliance with the 10 requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme year 4 by the deadline of 2 February 2023. We declared full compliance following completion of a comprehensive action plan. The focus will now be on embedding the progress made to ensure the improvements are sustained.

As part of the Acute Provider Collaborative maternity work stream, the quality committee received a new quality and safety report which standardises reporting across the collaborative and reports the quality, safety and patient experience elements in one report, alongside the national requirements of the interim Ockenden report and Maternity Incentive Scheme. We await the publication of the National Maternity Single Delivery Plan, completing a self-assessment against this and developing an associated action plan which will be monitored through this reporting framework.

2.3. Infection Control

The Trust reported a case of MRSA blood steam infection in January, bringing the Trust total to 7 for the year. This infection control teams on our sites are continuing with a programme of infection prevention and control training, and reviews of clinical practice focusing on the care of invasive devices. We remain below the Trust threshold for clostridium difficile (C. diff) cases, with the Trust having 22 cases against a threshold of 25. Rates of MRSA and E.coli have also increased within the community and our infection control team is working with NWL ICS to establish improvement work streams with primary care, an example being the implementation of a standard catheter passport given the number of cases that are linked to catheters.

2.4 Quality Priorities

Our proposed quality priorities for 2023/24 are currently being consulted on, and in addition to the priorities of the Trust, reflect collaboration across the collaborative. Following approval these will be published within the Trusts Quality Account. They have been developed following review of quality insight data, including incidents, complaints, patient feedback, claims and inquests, audit, mortality data including structured judgement reviews (SJRs), outcomes from the ward accreditation programme, risks and emerging issues, as well as national, acute collaborative, local priorities and planned

improvement work. They include a continued focus on improving the care for patents at the end of their life, improving the discharge processes and use of digital technology, improving the care for the frail patient and preventing deterioration; and implementation of the new patient safety incident response framework.

3. Operational performance

3.1. January elective activity levels recovered from planned seasonal reductions and remained resilient in the face of non-elective winter pressures and industrial action. The Trust retained strong performance positions across Urgent and Emergency Care, Cancer and Diagnostic pathways, benchmarking well nationally against the Cancer Faster Diagnosis Standard (FDS), 2-Week Wait and 31-Day targets.

3.2. Our total Referral to Treatment Patient Tracking List (RTT PTL), reduced in month by -2% to c. 55,000 referrals. We reduced the number of patients waiting more than 52 weeks to be seen by 190, resulting in 1,432 patients waiting more than 52 weeks at the end of January 2023.This level of performance compares strongly with the relative position across London.

3.3. At the end of January, we had circa 400 patients on our referral list who will have been waiting more than 78 weeks to be seen by the end of March. This position has improved but remains challenged. Operational, Performance and Clinical teams have developed targeted interventions and retain absolute operational grip through daily and weekly assurance and oversight meetings. Vascular, General Surgery, Urology, Colorectal, and Plastic services remain at risk.

3.4. A&E. A&E 4-hr performance improved in January to 78%, driven by an improvement in performance in paediatric ED and the Urgent Treatment Centre at West Middlesex. Focus remains on improving Type 1 performance across both departments, including increased utilisation of Same Day Emergency Care.

4. Finance performance

4.1. We are reporting a breakeven position for the year to date as at the end of February 2023 and are forecasting to deliver our breakeven plan for the financial year 2022/23 (April 2022 - March 2023). The expenditure position includes the reversal of impairments of £7.3m arising from the annual valuation exercise of the Trust's estate that was undertaken at the end of December 2022. Although the impairment movement has a favourable effect on the gross expenditure variance, it does not impact the adjusted total.

4.2. As at the end of February 2023, the year to date capital expenditure is £23.9m, which is £0.7m lower than the year to date plan due to timing differences on the programme. The forecast capital spend for 2022/23 is £35.4m and is on track to be delivered. The Trust had a higher than planned cash balance of £179.6m at the end of February 2023 (£26.7m above planned levels).

4.3. The Trust will be submitting a breakeven plan for 2023/24, which includes an efficiency programme of £23.5m and achievement of elective recovery funding (ERF) for meeting 112% of 2019/20 activity on a value weighted basis.

5. People

5.1. Laura Bewick, the current DDO for Emergency and Integrated Care, has been appointed as the Hospital Director/Deputy COO for the Chelsea hospital site. Sheena Basnayake, the current DDO for Women, Neonatal, HIV/GUM and Dermatology, has accepted a one year secondment to the role of Hospital Director/Deputy COO for the West Middlesex hospital site.

5.2. Both will be responsible for managing the Trust's relationship day-to-day with our partners across the North West London (NWL) Integrated Care System (ICS) and local borough partnerships for commissioned services delivered from their site and the surrounding community

6. Equality, Diversity and Inclusion (EDI) update

6.1. Produced and published our WRES, WDES (National publication deadlines 31st October 2022) and Gender Pay Gap (National publication deadlines 31st March 2023) reports each showing our progress against the indicators. Each report contains an action plan how we plan continue improving.

6.2. We are proud to have recognised Trans Day of Visibility and the contribution of our trans and non-binary staff with an event on Friday 31 March as part of a wider programme of trans awareness training. Members of our staff shared stories and experiences from their lives, their experience of transition, and of their time in the Trust.

6.3. Maternity Cultural Safety Champions- This group of staff have all have anti-racism training, LGBTQ+ birthing training. We have in place a Maternity Cultural Safety lead midwife that provides training to all maternity staff in cultural safety. This service is for staff, patients and partners who can contact a Maternity Cultural Safety champion. They have become the first Trust to apply for the Capital Midwives Anti-Racism Bronze award.

6.4. Commencing an Accessible Working Group in April to review Trust premises for all groups, (patients and staff) in terms of physical access, hearing and visual support and review recommendations and a way forward.

7. Trust highlights

7.1. State of the art diagnostic centre approved for West Middlesex University Hospital. We are pleased to announce that planning approval has been granted for a brand new Ambulatory Diagnostic Centre (ADC) at the West Middlesex University Hospital site. This marks a major step forward for the development of patient care in our local community

7.2. Chelsea at 30. We are fast approaching the 30th birthday of Chelsea and Westminster Hospital, which opened in May 1993. On 3 May we will be marking our 30 years at the Chelsea Hospital site to celebrate our achievements and say thank you to the staff, volunteers, patients and communities that have supported us over the past three decades.

On the day, our Charity CW+ we will be launching a major 30 million fundraiser campaign with a series of events and fundraising activities over the next year.

7.3. French Deputy Health Secretary visit. In February we welcomed the French deputy health secretary who visited our Chelsea site. Colleagues discussed our innovations in palliative and end of life care and the continual improvements we are making as a trust.

8. Council of Governors

8.1. Welcome to our recently Elected Governors

Elections for seats on our Council of Governors completed in January 2023 and I am delighted to welcome:-

- Caroline Boulliat Moulle, Patient Governor – Patient Constituency;
- Nigel Clarke, Public Governor – London Borough of Hammersmith and Fulham;
- Dr Nara Daubeney, Public Governor - London Borough of Wandsworth;
- Nina Littler, Public Governor – Royal Borough of Kensington and Chelsea;
- Ras. I Martin, Public Governor – Rest of England; and
- Joanne (Jo) Winterbottom, Public Governor - the City of Westminster.

Cass J Cass-Horne was re-elected for a second term as Public Governor for the City of Westminster.

8.2 Membership Survey

We are keen to ensure that our membership scheme is more engaging and over the past month have issued an electronic survey to our 18,000 strong membership to understand how we can further improve our membership offer and levels of engagement. Our Membership Communications and Engagement Group chaired by Governor David Phillips will be reviewing the findings of the survey to inform a new and refreshed approach for 2023.

9. Research and innovation

9.1. Newborn Genomes Programme
In February we were announced as one of the first Trusts in the UK, further to approval from Genomics England and NHS England to be in wave one of opening the Newborn Genomes programme. The Programme will co-design and run an ethics approved research pilot embedded in the NHS to explore the benefits, challenges, and practicalities of offering whole genome sequencing (WGS) to all newborns to accelerate diagnosis and access to treatments for rare genetic conditions.

9.2. Our health researchers at West Middlesex are leading on clinical trials with the University of Edinburgh to develop the first non-hormonal, non-surgical treatment for endometriosis, which affects roughly one in 10 women of reproductive age. If successful, it will be the first new class of drug for the condition in 40 years. Along with our gynaecology surgeons on surgical treatment and innovation in this area, I'm delighted that our trust is making such significant advancements in supporting women.

9.3. Engaging our workforce - Innovation for everyone

This year we launched a series of staff focused CW Innovation events which aims to support staff with innovative ideas through our CW Innovation programme. We are encouraging staff to come forward with ideas, no matter how big or small, that support better patient care and outcomes. On the day, staff attend drop-in sessions on funding, business support and proven ‘test and scale’ environments to get their ideas off the ground quickly.

10. Stakeholder engagement

10.1. Below is a summary of significant meetings and communications with key stakeholders:

- Integrated Care Partnership Strategy Forum – Ealing Town Hall 20 January
- Winter improvement UEC Community Forum NHS event
- RBKC Adult Social Care and Health Committee- 27 February
- Greg Hands MP visit to Trust – 10 March

11. Recognition and celebrating success

11.1. Kamila Soltysik, staff nurse in the plastics dressing clinic, who led on national research published in a dermatological journal. Kamila’s work covers the importance of dermatology professionals being increasingly aware of differences in the anatomy of ethnic skin, manifestation of symptoms and cultural practices in skin care.

11.2. Our ‘one stop obstetric ambulatory service’ has been shortlisted as a best-practice case study for the forthcoming National Maternity and Neonatal Delivery Plan. The team identified common themes in complaints which they felt could improve the triage, experience, and care of pregnant women through a truly multidisciplinary approach.

11.3. Our volunteering services have been working with HR and clinical colleagues to pilot a new 'Volunteer to Career' programme - supporting our volunteers into paid employment at the trust.

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 This period has been another particularly difficult one for the Trust operationally, with intense pressure across the Trust, North West London Integrated Care System (NWL ICS) and the wider national healthcare service. Several factors are driving this pressure: increased demand on Urgent and Emergency Care (UEC) services; some staffing shortages and higher levels of sickness; increased transmission of seasonal Influenza and other respiratory diseases, and indeed Covid-19 infections; the cold weather; and episodes of industrial action.

1.2 Since January, there have been a series of unions undertaking industrial action encompassing a range of staff groups, including nurses, physiotherapists, junior doctors and London Ambulance Service workers. Throughout, we have prioritised the safety of our patients and staff, supported those who took the difficult decision to participate in the industrial action, and worked incredibly hard to achieve the delicate balance of cancelling patients where necessary and treating those with the most critical and time-dependant needs. During the recent period of junior doctors' industrial action, the Trust cancelled almost all of our planned elective procedures and about 70% of our planned outpatient appointments.

1.3 The increased demand on UEC services has been noticeable, and we continue to see higher A&E attendances than pre-pandemic. A number of schemes have been introduced to help respond to these pressures and ensure safe care for patients. Most recently, we have created extra capacity by opening an additional ward at the Hammersmith Hospital. This has contributed to improved operational performance, providing a small number of beds for patients who are medically fit to be discharged but whose packages of care are not yet finalised.

1.4 As of January 2023, we had returned to 91.2% of our overall pre-pandemic planned admitted care activity; 109.2% of our pre-pandemic outpatient activity; and 100.6% of our total pre-pandemic diagnostic testing. We remain absolutely committed to delivering more than 100% of overall pre-pandemic planned care in order to help us achieve a sustainable reduction in waiting times.

1.5 I remain incredibly grateful to all of our staff for their dedication and flexibility, especially during this very demanding winter period. Our aim, as always, continues to be to provide the best possible care for our patients and local communities.

2. Quality and safety

2.1 Despite the operational pressures we have faced, we are maintaining very good performance against key quality measures. Mortality rates are consistently, significantly low, incident reporting rates are increasing and harm levels are well below national averages. This is a testament to the hard work of our teams.

2.2 Through monthly thematic analysis of all incidents causing moderate or above harm we continue to see a potential correlation between areas with staffing and operational

pressures and incidents causing harm. Enhanced clinical harm review processes have been implemented on key points of the patient pathway in response. These are identifying a small number of cases where harm has occurred which were not recorded on our incident management system at the time. These are now being investigated and the learning will be used to inform our on-going harm review processes, real-time risk management response and our new clinical outcome dashboards.

2.3 A new dashboard for patients delayed in our emergency departments is currently being tested. Other dashboards - for patients 'boarded' on wards and patients who are medically fit to be discharged - will be ready for testing by the end of March. Weekly reporting to the Clinical Harm Assurance Group is in place while we continue to test, learn and assess the impact of this work. It is important to identify any potential harm to allow us to identify increasing risk in real-time, put additional support in place and track improvement over time.

2.4 Our proposed quality priorities for 2023/24 are being consulted on with key stakeholders internally and externally before approval in April and published in our quality account. They have been developed following review of quality insight data, including incidents, complaints, patient feedback, claims and inquests, audit, mortality data including structured judgement reviews (SJRs), outcomes from the ward accreditation programme, risks and emerging issues, as well as national, acute collaborative, local priorities and planned improvement work. They include a continued focus on existing safety risks through our safety improvement programme; an improvement programme focusing on the treatment of patients with deterioration in their mental health; improving our responsiveness to the needs and views of our patients and local communities; and implementation of the new patient safety incident response framework.

2.5 Thresholds have been exceeded for 2022/23 for Escherichia coli (E.coli) bloodstream infections (BSIs) and clostridium difficile (C. diff) cases, and in January we reported our first MRSA BSI since April 2022. Our key action is the continued roll-out of our improvement programme to support staff with infection prevention control practice; this will remain a safety improvement priority for 2023/24.

2.6 The Trust provides oversight of quality assurance within the maternity service via a maternity quality oversight assurance report to each Quality Committee meeting. This is also summarised in the quality function report to the Acute Provider Collaborative Quality Committee. Following review at the Board in Common in January 2023, and sign off through the agreed internal process, we submitted our declaration of compliance with the 10 requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme year 4 by the deadline of 2 February 2023. We declared full compliance following completion of a comprehensive action plan. The focus will now be on embedding the progress made to ensure the improvements are sustained.

2.7 The Trust has recently undergone its CQC inspection of maternity services, as part of the national maternity inspection programme. The inspection took place on 8 and 9 March and included maternity services at Queen Charlotte's and Chelsea Hospital and St. Mary's, including the Lindo Wing. Initial feedback has been broadly positive, and the Trust awaits the draft report in around 8 weeks.

3 Operational performance

3.1 We have maintained our excellent ambulance handover performance, with our Charing Cross and St Mary's sites continuing to achieve some of the shortest handover times within London. We are working to improve our handover performance further in order to

consistently meet the national standard of handing over 95% of ambulance attendances within 30 minutes. Significantly, we returned to reporting performance against the 4 hour standard from 1 March 2023, with the national expectation that all Trusts will achieve 75% by the end of March 2024. We have been improving since January of this year, and are committed to ensuring that far more than 75% of our patients are seen and admitted or discharged within 4 hours of arriving at our A&E departments.

3.2 We have been focused on improving performance against the 62-day cancer waiting time standard and continue to make good progress. Since September 2022, the number of people on a cancer pathway for more than 62 days has reduced by 291, and this continues to decrease ahead of trajectory. Imperial has been one of the most improved Trusts nationally, and contributed to NWL being one of only four ICSs across the country to meet its backlog target. Equally, we have made progress in achieving the Faster Diagnostic Standard, which requires 75% of patients to be diagnosed or have cancer ruled out within 28 days of referral.

3.3 We have continued to improve our 78 week waiting position as prioritised by NHS England in January 2023. Unfortunately, and as a consequence of both the ongoing industrial action and shortage of anaesthetic staff, a number of theatre list cancellations have impacted on our capacity to see these patients, and we will not meet our trajectory of zero waits over 78 weeks at the end of March 2023. Instead we will achieve this in early 2023/24. We remain committed to ensuring that our long wait patients are rebooked and treated as quickly as possible.

4. Covid-19 and flu vaccination programme

4.1 The 2022/23 seasonal Covid-19 and flu booster vaccination programme was launched on 12 September 2022 and the Trust's vaccination centres closed on 28 February 2023. Since we first opened our Covid-19 vaccination centre in December 2020, it has administered 99,028 vaccinations in total.

4.2 49% of staff in post received their flu vaccinations this campaign and 52.6% of eligible staff received their Covid-19 booster vaccinations. This is above the uptake rate across London, but not where we wanted it to be, despite a comprehensive plan in place to encourage vaccination including extended access overnight, roaming vaccinators and a flu specific focus week in January. Alongside the other trusts in London, we are currently undertaking a lessons learnt exercise, which will be shared with the NHSE London vaccination programme team.

5. Financial performance

5.1 The Trust has set a breakeven plan for the year which is dependent on the delivery of elective activity levels 4% above 2019/20 and achieving £37m of efficiency.

5.2 At month 10, the Trust has reported a £16.5m deficit position, driven by under-delivery of the efficiency programme and additional costs within a number of areas where staffing is above plan, including ICU, theatres and opening of escalation beds in some areas. The Trust has established sufficient mitigations to deliver a breakeven position at year end.

5.3 The Trust's estimated Capital Resource Limit (CRL) funding for the year is £103.4m. Expenditure of £42.5m (57% of year to date (YTD) plan) has been incurred to the end of month 10 (£74.7m including grant-funded schemes). The underspend is driven by the delay in commencing the Wembley Community Diagnostic Centre (CDC) programme whilst the land required for the project was secured from NHS Property Services. However, both the cost and funding will be re-profiled into 2023/24, thereby removing the current

underspend. The Trust is closely managing the capital programme and remains confident that it can achieve its expected CRL.

5.4 The Trust has a cash balance of £167.6m at 31 January 2023; a reduction of £69.8m from the start of the year. The cash balance is forecast to decrease through the year but is expected to remain higher than historic levels.

6. Business planning update

6.1 The Trust is in the process of finalising its financial plan for 2023/24 and this will form part of the Acute Provider Collaborative position. The Trust's final financial plan submission forecasts to deliver a breakeven position for 2023/24. This takes account of national guidance, the adoption of the North West London Integrated Care Board (NWL ICB) set of assumptions, the Trusts' share of the NWL ICB non-recurrent support made available to the Acute Provider Collaborative, and triangulates with both the activity and workforce assumptions (including the delivery of the 104% elective services value weighted activity target for the Trust).

6.2 The plan is underpinned by the delivery of a £53m savings target (3.6% of turnover) and currently excludes (as requested across the NWL ICB) any excess inflation above funded levels which is estimated to be at least £12m as a starting position. This and the delivery of the savings target remain key financial risks to the plan.

7. Workforce update

7.1 National staff survey

7.1.1 Our 2022 NHS staff survey results showed continued progress across a range of measures. We had our highest ever overall response rate at 56%, up from 42% in 2021. We saw increased scores for the themes, 'we are compassionate and inclusive', 'we are always learning' and 'we are a team', and we achieved above average scores, compared with other acute trusts, in 5 out of 9 categories, up from 3 out of 9 categories in 2021. We had the third highest score of all trusts in London for staff who agreed or strongly agreed that they would recommend the trust as a place to work, with the joint highest year-on-year increase.

7.1.2 However, while our score for the theme 'we work flexibly' stayed the same as in 2021, this is the one area where are we are now below the average for acute trusts. We also have much further to go to improve equality and diversity – despite an increase in our score for this specific set of questions within the theme 'we are compassionate and inclusive', we remain below average for acute trusts.

7.2 Senior management changes

7.2.1 Professor Katie Urch, Divisional Director of Surgery, Cancer and Cardiovascular left the Trust in March 2023 to take on a new role as Chief Medical Officer for University Hospitals Sussex. On behalf of the Board, I would like to thank Katie for the passion and commitment she has brought to the role over the past six years. An internal process is underway to appoint an interim divisional director as soon as possible who will cover the role until the permanent recruitment process is completed.

7.3 Equality, diversity and inclusion

7.3.1 Our race equity training for managers, developed and delivered in collaboration with SEA-Change Consultancy, ran between November 2021 and October 2022. Our evaluation indicates a correlation between the training and an increase in open conversations between team members, more managers reporting a better understanding of race and their own self-awareness, and more managers seeking to provide equal opportunities of access

to roles and stretch projects. We will therefore look to extend the training into the 2023/24 work programme.

7.3.2 Additionally, we are seeking to expand the approach of our anti-racist and anti-discrimination statements to build upon the work started with our refreshed values in 2016/17 and our behavioural framework in 2018/19, creating open conversation and greater understanding of the topic and the role everyone has to play.

7.3.3 We have completed an evaluation of the impact on the two cohorts of Calibre at the Trust in September 2021 and September 2022. There is a clear correlation with the Calibre programme supporting improvement 6 of the 9 indicators of the Workforce Disability Equality Standard. We will be proposing a third cohort of Calibre runs in September 2023 at the next EDI Committee.

7.3.4 We are also submitting the review of our centralised reasonable adjustment budget to the EDI committee proposing the funding is adopted as standard practice. The budget is designed to improve user experience, provide a cost benefit to the Trust, as well as ensure an efficient and joined-up approach.

7.3.5 In February and March 2023, we ran several engagement events with Trust executives; Janice Sigsworth, Director of Nursing, joined a panel to reflect on LGBTQ+ experience over the years to mark LGBT+ History Month, and Michelle Dixon, Director of Engagement and Experience, and Jazz Thind, Chief Finance Officer, opened an afternoon of empowering and engaging activities for International Women's Day on 8 March.

8. Regulatory compliance Care Quality Commission (CQC) Update

8.1 I am pleased to report the Trust has received confirmation from the CQC that it has closed its investigation into an incident that occurred in the St Mary's Hospital emergency department in September 2020. No further action will be taken by the CQC in relation to this matter.

8.2 The Board will recall that the CQC expected to publish its new regulatory framework and methodology for NHS Trusts in October 2022. This work has now been further delayed and it is currently anticipated this will begin to be implemented towards the end of 2023. In the meantime, CQC activities for NHS Trusts will follow existing methodology. At present, no routine inspection activity is expected to take place at NHS trusts but, as always, if there are serious concerns about a service - a focused inspection may take place.

8.3 As part of the Improving Care Programme Group's (ICPG) planned activities, a further peer review was undertaken in March 2023, looking at medical areas. Directorate level self-assessments and 'CQC readiness' action plans are currently being prepared by directorates and delivery of related improvement activities will be the ICPG's focus during 2023/24.

9. Research and innovation

9.1 As well as the successful outcome of the National Institute for Health and Care Research (NIHR) Imperial Biomedical Centre (BRC), which launched on 1 December 2022, we have recently been notified of the renewal of our NIHR Patient Safety Research Centre (PSRC). The PSRC is 5-year infrastructure funding (£2.6m) awarded competitively by the Department of Health and Social Care (DHSC). The PSRC seeks to address patient safety challenges now and in the future, by driving uptake of innovations and service

transformation by patients, health and social care workers, health systems, policymakers and regulators. It supports the development, validation and testing of such interventions.

9.2 The Trust is on course to recruit our highest numbers of patients into NIHR portfolio studies for four years (more than 400 individual studies) demonstrating a robust recovery of research activity following the pandemic-associated disruptions. Research activity is at least back up to pre-pandemic levels. This is the case across both commercial and non-commercially sponsored trials.

9.3 We are awaiting announcements from DHSC on the next steps in the NIHR North London Regional Research Delivery Network (RRDN) process. We have established a constructive collaboration with Barts Health NHS Trust in relation to the RRDN hosting application process for North London, on arrangements for Partnership Board and Executive Committee governance, and on the transition process. The outcome of the process should be known soon and the new network will be up and running by 1 April 2024.

9.4 As part of Paddington Life Sciences, the Digital Collaboration Space recently held its formal launch. The space, next to St Mary's Hospital, houses the digital health team from the NIHR Imperial BRC. It provides state-of-the-art management and analysis of the huge amount of health data routinely collected across the Trust's five hospitals and collaborates with the wider North West London Integrated Care System (ICS) on a complementary data set from our diverse population of 2.4 million people. The facility is also used to encourage and host research collaborations between clinicians, academics, data scientists and partners from industry and local communities.

9.5 I am delighted to report that Rachael Lear, iCARE Research Fellow in Digital Health and Care Innovation, was recently awarded a Health Education England Topol Digital Fellowship. These Fellowships provide health and social care professionals with time, support and training to lead digital health transformations and innovations in their organisations. Rachael's 12-month fellowship programme will provide her with time and support to design and deliver a digital health project at the Trust where she will be exploring video-based patient records as a strategy to improve communication of older people's individual support needs. This will involve working closely with the medicine for the elderly team, patient and carer representatives, and technology company Isla, a visual medical record platform provider.

9.6 A BRC study led by researchers from Imperial and published in The Lancet, has found that children who had a lower respiratory tract infection (LRTI), such as bronchitis or pneumonia, by the age of two were almost twice as likely to die prematurely in adulthood from respiratory diseases. The research showed the rate of premature death from respiratory disease was about 2% for those who had an LRTI in early childhood, compared to around 1% for those who did not. The findings remained unchanged after adjusting for socioeconomic factors and smoking status.

9.7 Another study, partially funded by the NIHR Imperial BRC, suggests that loyalty card data on over-the-counter medicine purchases could help spot ovarian cancer cases earlier. The study of almost 300 women found that pain and indigestion medication purchases were higher in women who were subsequently diagnosed with ovarian cancer, compared to women who did not have ovarian cancer. This change in purchases could be seen eight months before diagnosis. The first-of-its-kind study for cancer, published in Journal of Medical Internet Research (JMIR) Public Health and Surveillance, looked at whether there is a link between a diagnosis of ovarian cancer and a history of buying over-the-counter pain and indigestion medications, such as painkillers and digestive aids like antacids.

9.8 The NIHR has appointed 3 new Senior Investigators from Imperial as part of their most recent competition. NIHR Senior Investigators are among the most prominent and prestigious researchers funded by the NIHR. They are outstanding leaders of patient and people-based research within the NIHR research community. The new appointments are:

- Professor Adnan Custovic, Professor of Paediatric Allergy at Imperial College London and Honorary Consultant in Paediatric Allergy at ICHT
- Professor Anthony Gordon, Professor of Critical Care at Imperial College London and Consultant in Intensive Care Medicine at ICHT
- Professor Sonia Saxena, Professor of Primary Care at Imperial College London

Three further Imperial NIHR Senior Investigators were re-appointed for a second term:

- Professor Mark Thursz, Director of the NIHR Imperial BRC, Professor of Hepatology at Imperial College London and Consultant in Hepatology at ICHT
- Professor Mike Crawford, Professor of Mental Health Research at Imperial College London
- Professor Alison Holmes, Professor of Infectious Diseases at Imperial College London.

10. Redevelopment update

10.1 The Trust has continued to develop plans for its three sites in the New Hospital Programme (NHP). In February 2023, we hosted visits of the NHP team to St Mary's, Charing Cross and Hammersmith Hospitals, where we focused on the day to day operational impact of the estate. An announcement on NHS funding is expected shortly, with follow-up discussion anticipated for specific schemes.

10.2 I am pleased to report the Western Eye Hospital will be ready to fully re-open in June 2023, after undergoing 18 months of repairs and improvements. The re-opening of the hospital includes an additional operating theatre to help address long waits caused by the pandemic as well as refurbished pre-assessment and pre and post operation areas. The works address the fire safety issues that led us to take the step of closing some parts of the hospital last year. Services that were relocated temporarily to Charing Cross will continue there until the works are completed with a phased return back to Western Eye starting from late spring.

11. Stakeholder engagement

11.1 Below is a summary of significant meetings and communications with key stakeholders:

- Cllr Ketan Sheth, London Borough of Brent, 4 January, 7 February and 1 March 2023
- Cllr Neil Nerva, London Borough of Brent, 7 February 2023
- Cllr Nafsika Butler-Thalassis, City of Westminster, 23 February 2023
- Cllr Angela Piddock, City of Westminster, 7 March 2023

11.2 Our AGM will be held on Wednesday 19 July – more details to follow and will be published on our website.

12. Recognition and celebrating success

12.1 I am delighted to report that Carys Barton, a consultant nurse in heart failure at Imperial College Healthcare NHS Trust, has won a Roy Award from the Pumping Marvellous Foundation in recognition of her outstanding contribution to heart failure services. The Roy Award is an annual award presented to an individual who has demonstrated excellence in heart failure care, producing the highest standards of care for their patients. The award also reflects the direct impact the person has had on the heart failure community.

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 At the end of February, we launched our new strategy, Our Way Forward, after its approval at our last meeting of the board in common.

The publication sets out our new vision, **Quality at our HEART**, as well as our four new objectives, each with a core focus on quality.

We were proud that launch events both online and in person at each of our hospitals were so well attended, both by employees and patients. We are grateful to Councillor Ketan Sheth, Neha Unadkat and Lisa Henschen, who joined us from partner organisations to celebrate and share Our Way Forward.

We also remain immensely grateful to the more than 3000 people within LNWH and our wider communities who contributed to the strategy. In recognition of the strength this collaborative approach has offered us, we have committed to continuing to work in partnership with employees, patients, partners and communities as we realise our ambitions.

1.2 Many NHS unions have taken industrial action this quarter.

While nurses did not take industrial action at LNWH, we nonetheless put in rigorous planning processes for both nursing and ambulance strikes in case of increased operational demand, with notable success.

Recent BMA industrial action among junior doctors did have a considerable operational impact on our performance, especially in relation to planned care, where we rescheduled a high proportion of operations and outpatient clinics to maintain safe emergency pathways. I would like to thank our patients for their understanding as we work to manage the impact on our planned care.

We are currently in the planning process for safely managing the next planned strike action, which is scheduled to take place immediately after the Easter bank holiday period between Tuesday 11 and Friday 14 April.

Our priorities throughout this period of industrial action remain two-fold: to keep our services safe for our patients and communities, and to respect our colleagues' right to take industrial action.

We are enormously grateful to all our teams, who have worked so hard to maintain a safe service for patients through this challenging period.

2. Quality and safety

2.1 We continue to focus on improving access to care from home through virtual wards. We now offer five virtual wards, covering heart failure, respiratory, infectious diseases and diabetes. The wards allow patients to be monitored by a specialist team in the comfort of their own home and are proving very popular with patients as a result. Several patients have recently praised their care through virtual wards publicly, and our teams at both Ealing and Northwick Park have appeared on TV news in the last few months explaining more about the initiative.

The Department of Health and Social Care also recently released a video explaining virtual wards to the public which was filmed with LNWH employees and patients, while the Secretary of State was interested in our progress during his visit earlier this year (see section 9).

We are now working on plans to introduce virtual wards for surgery and end of life care.

2.2 With the introduction of the national Patient Safety Incident Response Framework (PSIRF), we are undertaking extensive training and education with colleagues and teams across the organisation. Mandatory training is now available online, while education for managers has been made available at one of our monthly team brief session. A wider communications campaign will follow soon.

2.3 Ealing and Northwick Park hospitals are piloting the use of 13 youth buddies to help connect with young patients being treated in A&E.

Young people may find it difficult to engage with staff, so the pilot provides volunteers who can chat with young patients about anything troubling them such as bullying, trouble at home, relationship problems, gang activity or mental health problems.

2.4 Patients at Central Middlesex Hospital diagnosed with sight loss can now benefit from professional support. An Eye Care Liaison Officer (ECLO) will be on hand five days a week to help offer emotional support and vital information to patients who have just received a sight loss diagnosis.

3. Operational performance

3.1 Emergency department performance: reported 72.5% for February 2023. The Trust is now ranked as one of the busiest emergency departments in London receiving the most conveyances with Northwick Park site being the single busiest site in London.

On Thursday 26 January, at the request of the North West London Integrated Care Board, we took over the running of the Urgent Treatment Centres (UTCs) at Central Middlesex, Ealing and Northwick Park Hospitals. That means colleagues working in the UTCs are now a part of our LNWH team.

I am enormously grateful to colleagues for their amazing commitment in putting patients first at a time when their service has been going through such a big change. I'd also like to thank our emergency and ambulatory care teams, who worked so hard to manage the change as smoothly as possible and who have been so enthusiastic in welcoming their new colleagues.

To support winter demand, we have the following in place:

- Full mobilisation of the winter plan was delivered in January 2023 to support flow (escalation beds and staffing)
- Continued use of the new Flow Standard Operating Procedures to support ambulance handover and site flow.
- Daily discharge planning with community partners
- Daily communications continue with Mental Health Trusts and Social Care to support assessment and transfer of adults and children into the right location for their on-going needs.
- Continued mobilisation of the UTC step in contract.
- Continued focus of repatriations to and from local hospitals for stroke, speciality and trauma.

3.2 Cancer waiting times: we continue to work to our operating plan in improving our position regarding the 62-day waiting list backlog created by the Covid-19 pandemic. Our position continues to track positively against our planned trajectory to reduce the waiting list in line with national expectations. We continue our aim to over-deliver and reduce waiting lists ahead of our year-end plan. The final position for January 2023 (reporting a month in arrears) was:

- 2 week wait for suspected cancer reported 91.6% against the 93% standard
- 28 Day Faster Diagnosis reported 72.0% against the 75% standard

- 62 Day wait for treatment following GP referral reported 67.9% against the 85% national standard

3.3 18 weeks referral to treatment: We continue our recovery effort both internally and in conjunction with the North West London Integrated Care System. In line with our operating plan, we have already returned to pre-Covid-19 levels of delivered activity and continue to focus on increasing activity levels. This allows us to continue treating our most clinically urgent and longest-waiting patients. The final position for February 2023 reported 59.1%, with 1,972 patients waiting 52 weeks, of which 59 were waiting over 78 weeks. There are no patients waiting over 104 weeks.

4. Finance and estates

4.1 As we move towards the end of the financial year, we are forecasting full delivery of the financial plan for the year – at breakeven, with income matching expenditure and with full delivery of the cost improvement target. This is a considerable achievement in the challenging financial and operational circumstances that we face, and it reflects the good work of colleagues across the whole organisation in managing complex budgets as well as securing improved elective recovery and managing challenging pressures on emergency care. Teams across LNWH have also been focused on ensuring we meet our capital investment plans for the year, and the Trust is forecasting meeting these targets as well – but, more importantly, we continue to secure additional capital with the support of stakeholders and partners to improve the quality of our estate, our infrastructure and our digital services.

4.2 LNWH has made strong progress in developing and agreeing a financial plan for the coming 2023-24 financial year. Our financial plan sits within the overall collaborative financial plan, and with the support of colleagues across the ICB and the Collaborative, the four trusts have been able to develop a robust and deliverable balanced plan. Within this, they have been working hard to agree a set of rules and principles on supporting and challenging one other to deliver the best performance in a complex operating environment. The LNWH plan itself is robust and supported by budgets agreed with divisional and leadership teams across the whole organisation. It reflects sensible and fair allocations of funding both from the NWL ICB and from within the acute provide collaborative. There are risks and challenges in the coming year: the two which will impact most directly on finance are the implementation of our new Cerner electronic patient record and the delivery of our cost Improvement programme. However, our teams have been working hard on mitigations to manage these risks.

5. People

5.1 Our flu and Covid-19 vaccination programme came to an end in February, in accordance with the national programme. Like trusts across the country, we saw lower levels of take-

up this year, despite extensive focus on ease of access to the vaccine and a comprehensive communications programme. However, both flu and Covid vaccination rates remained approximately in line with the London average.

5.2 National staff survey results were also published earlier this month. Once again, we saw a high completion rate of 51%, which is very encouraging. LNWH also saw strong scores for motivation, enthusiasm, and the quality of appraisals, while fewer colleagues report working additional hours or pressure to come to work when unwell. More colleagues feel that their teams are effective and that they have control over their work.

However, other aspects of the survey were disappointing. Equality, diversity and inclusion scores have remained fairly static, and are lower than average, with fair career progression and discrimination from managers, leaders and colleagues highlighted as particular areas for focus. The data also shows that we must do more on recognition and retaining staff.

Work will now begin on a combination of LNWH-wide and divisional-specific actions, including a focus on refreshing our culture and welcoming new starters, a clear focus on reward and recognition, and developing greater flexibility for our workforce. Our actions will be linked to Our Way Forward, LNWH's new strategy, which sets out an overarching objective to become a high-quality employer.

5.3 At the end of March, Deputy Chief Executive Simon Crawford, Chief People Officer Tracey Connage and Chief Financial Officer Jonathan Reid met with Citizens UK to discuss our commitment to the London Living Wage. We continue to work closely with organisations with whom we hold contracts on this issue.

5.5 We were pleased to host a Health Education England visit to our obstetrics and gynaecology department this quarter. The visit was very positive and I am delighted to report that HEE have ceased enhanced monitoring as a result.

5.4 The Trust has been awarded the NHS Pastoral Care Quality Award in recognition of our work in international recruitment and our commitment to providing high-quality pastoral care to internationally educated nurses and midwives during recruitment processes and their employment.

6. Equity, diversity and inclusion

6.1 Colleagues within LNWH have launched a new international staff support network, which seeks to offer greater support to employees who have joined us from outside the UK. The network helps people access existing resources, supports them to move into the NHS more smoothly, and offers them the opportunity to meet colleagues with similar experiences.

6.2 We recognised LGBT History Month this February, in a campaign featuring the lived experiences of colleagues from across LNWH. Public and internal facing messaging acknowledged the challenges that still face LGBT+ members of our communities and reflected on the importance of small steps in making change.

6.3 I was delighted to attend our event to mark International Women's Day in March, where I was joined by Orleen Hylton, Deputy Mayor of Brent, and our own Chief People Officer, Tracey Connage. Volunteer Beryl Carr also shared reflections via video. The event was full of vibrant conversation and represents the start of what I hope will be many constructive conversations about women in the workplace.

7. Electronic patient record

7.1 We continue our work to launch our new electronic patient record this August. This quarter saw a number of key milestones, with employee training programmes published at the end of March, and an end to regular changes in our existing systems.

8. Research and innovation

8.1 The North West London Clinical Trials Alliance (NWLCTA) were finalists at the New Statesman Positive Impact Awards, in recognition of its contribution to healthcare research. The alliance, whose partners include LNWH, first came together in response to Covid-19, using their collective expertise and resources to conduct trials that helped inform national guidelines and policy.

9. Stakeholder engagement

9.1 The Secretary of State for Health and Social Care Steve Barclay visited Northwick Park Hospital on 18 January. The visit was requested by the DHSC after Mr Barclay expressed a wish to see first-hand the pressures frontline hospital staff were under, especially given additional winter pressures and the impact of industrial action.

Mr Barclay visited several areas including the Emergency Department, Same Day Emergency Care, and Single Point of Access. He spoke with several members of staff including senior nurse Alicia Borja who highlighted how hard staff were working against a backdrop of rising admissions and staff shortages. The visit received coverage on the ITV evening news.

9.2 On 31 January, Simon Crawford and I joined Chair in Common Matthew Swindells for an introductory meeting with Patrick Flaherty, the Chief Executive of Harrow Council and Senel Arkut, Corporate Director for People's Services. The meeting included a short tour of our emergency and maternity departments at Northwick Park Hospital.

9.3 On 9 February, Dr Rupa Huq, MP for Ealing Central and Acton, visited Central Middlesex Hospital where she was given a tour of the Macular and Research service and the main Eye department. The visit followed a parliamentary event to raise the profile of eye health, which was attended by Christina Dinah**,** Director, Research and Development, and Macula Service and Ophthalmology Research Lead.

9.4 On 23 February, members of the NW London Joint Health Overview Scrutiny Committee visited Central Middlesex Hospital. The visit was at the request of the committee and was designed to help inform their decision on the proposed Elective Orthopaedic Centre at the site. I was joined on the visit and tour by Mark Titcomb, Managing Director EOC, Central Middlesex and Ealing Hospitals.

9.5 James Murray, MP for Ealing North visited Ealing Hospital on 2 March. Mr Murray visited the ED and SDEC where he met with several frontline staff. I was joined on the visit by Mark Titcomb, Managing Director EOC, Central Middlesex and Ealing Hospitals, and Norrita Labastide, Divisional Director of Operations Emergency and Ambulatory Care. Mr Murray requested the visit to learn more about the pressures faced by our frontline staff.

I also met with the Chief Executive of Ealing Council at the end of March.

9.6 On 8 March, I joined Matthew again for an online introductory meeting with Cllr Muhammed Butt, Leader of Brent Council, Chief Executive Carolyn Downs, Director for Adult Social Care Phil Porter, and Cllr Neil Nerva, Cabinet Member for Public Health & Adult Social Care.

10 Recognition and celebrating success

10.1 Volunteer Beryl Carr celebrated her 101st birthday shortly before receiving a British Empire Medal in the New Year Honours list, having been nominated by the Prime Minister after receiving his Points of Light award last year.

10.2 Consultant neurologist and co-lead of the Doctors' Association UK Dr Jenny Vaughn was awarded an OBE in the New Year Honours list, in recognition of her campaign to develop a just culture in the NHS.

10.3 Consultant cardiologist and director of echocardiography Professor Roxy Senior received a Lifetime Achievement Award at the annual meeting of the British Society of Echocardiography (BSE) in January.

10.4 Cardiologist Dr Harmandeep Singh was one of the winners in the Education, Science and Innovation category of the India-UK Awards this year.

10.5 Reporting radiographer Radha Rai received the InHealth Prize for Academic Excellence in Clinical Reporting in February.

10.6 Our intensive care teams were shortlisted for this year's Nursing Times Student Awards in five categories: Nurse Education Provider of the Year, Best Student Experience, Student Placement of the Year, Teaching Innovation of the Year, and Practice Supervisor of the Year for Magnolia Pinga. We wish them the best of luck for the awards night.

10.7 Our annual Staff Excellence Awards are now open for nominations. We ask colleagues, patients and members of the public to share their LNWH healthcare hero with us at lnwh.nhs.uk/awards. There are thirteen categories available this year.

Our winners will be chosen from a panel of judges and will be announced at a special ceremony at Wembley Stadium in September.

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 last quarter of the 22/23 financial year has seen unprecedented operational challenges for the Trust including severe winter pressures, increased numbers of Covid-19 positive patients and industrial action. Despite these challenges the Trust has shown sustained improvement in elective recovery performance. The Trust achieved total elective activity of 111.6% (un-validated) in February 2023, its highest levels of activity for the financial year to date. Key measures of quality and safety such have remained stable or continued an improving trend throughout the period.

1.2 Industrial action undertaken by Junior Doctors in March created challenges for the Trust, and the need to prioritise patient safety and emergency care requirements during the Junior Doctor strike resulted in the redeployment of consultants to critical care and the cancellation of elective activity. Whilst data has not been finalised for March, the industrial action will likely negatively impact our overall elective activity as well as impacting Referral To Treatment (RTT) reduction targets.

1.3 The provision of services from the Urgent Treatment Centre at Hillingdon Hospital was transferred to the Trust on Thursday 26th January 2023. We worked very closely with colleagues in the Urgent Treatment Centre to make the transition as smooth as possible.

1.4 Urgent and Emergency Care (UEC) services are showing signs of early improvements in some key metrics but there remains a significant concern for the Trust relating to the Type 1 performance 4 hour standard in the Emergency Department (ED). The Senior Leadership Team is working closely with the ED Leadership Team to mitigate areas of UEC under performance.

1.5 The Trust has made significant progress with addressing the exit criteria which will allow a move from the National Oversight Framework (NOF) category 4 to NOF category 3. A verbal report on the outcome of a review meeting with the National executive on 3 April 2023 will be provided.

2. Quality and Safety

2.1 Key measures of quality and safety such as inpatient falls and pressure ulcers remain stable or continued an improving trend.

2.1 'Frailty Hospital @ Home' (H@H), a new service from the Care of the Elderly (COTE) Team, in collaboration with colleagues at Central and North West London Foundation Trust was piloted in the early part of 2023. The service aims to improve the care of

elderly, frail patients and avoid hospital admission where possible. The benefits of the service have been evaluated with a proposal to introduce early in 2023-24 as part of a suite of services for elderly patients presenting to the Trust.

2.2 An incident learning event took place at the Trust on Thursday 2 February 2023 which received positive feedback from attendees. The drop-in event allowed staff to learn about the incident reporting system, how to report and investigate incidents and support around the duty of candour. After the success of this event a following one took place on Thursday 2 March 2023, focussing on the Trust's Risk Register. These events are part of a wider focus on improving learning and skills across the Trust.

2.3 The Trust announced on 14th February 2023 that surgical face masks were no longer mandatory in non-clinical areas in both our hospitals. However, they are still required in clinical areas.

2.4 The Trust received notification from The Health and Safety Executive on 28 March 2023 that the Trust has complied with the requirements of the Notification of Contravention Letter in relation to sharps.

3. Operational performance (including winter planning)

3.1 January 2023 saw improved performance across all five domains as the Trust recovered from the downturn in performance in December 2022 resulting from severe winter pressures. A rebound in activity in January 2023 has had a positive effect on the Trust's Patient Treatment List (PTL) and a reduction in Referral to Treatment (RTT) 78 and 52 week waiting patients.

3.2 The reduction of RTT 78 week wait patients to zero has been a major focus of the Trust's elective recovery programme leading to 31st March 2023.

3.3 Urgent and Emergency care performance is below the national standard but remains in line with performance across London.

3.4 The trust is pleased to report steady improvement in productivity across the year and examples of exemplar performance in areas such as theatre utilisation, Advice and Guidance and discharge.

4. Finance performance

4.1 The in-month (month 10) position was an adverse variance of £1.60m, giving a year-to-date (YTD) adverse variance of £7.32m. Compared to the forecast prepared in month 5, the in-month adverse variance is £0.62m, giving a YTD adverse variance of £0.82m.

4.2 The Trust remains on target to deliver the full year forecast agreed at month 5 although there are a number of risks that are being managed, including:

- Delivery of the revised elective activity plan
- Delivery of the revised Cost Improvement Plan
- Delivery of the gain on revaluation of the incinerator
- Divisional delivery of agreed forecast improvements, including assumptions on utility costs

- Potential impairments

4.3 National Oversight Framework (NOF), recovery support programme
The Trust has made significant progress with addressing the exit criteria which will allow a move from NOF category 4 to NOF category 3. A verbal report on the outcome of a review meeting with the National executive on 3 April 2023 will be provided.

5. **People**

5.1 The Trust is planning a new 'transition to work' programme for young people with autism or learning disabilities, which will commence in September 2023, partnering with DFN Project SEARCH, Hillingdon Autistic Care & Support (HACS) and Orchard Hill College. The programme will offer up to 12 interns a year of work placements within the hospital, helping them to build confidence and learn new skills, with the aim of securing competitive paid employment.

5.2 To recognise and thank staff for their hard work over the past 12 months members of staff were sent an e-voucher worth £45.

5.3 The results of the NHS Staff Survey were released on Thursday 9th March 2023. From these results, as a Trust, we can see increases in three of the seven People Promise elements compared to 2021, with improvements made in key areas such as autonomy and control, development and appraisals and support for work-life balance. This suggests that the improvements we are making across the Trust, such as the review and relaunch of the appraisal process, are felt across the organisation. For the remaining four of the seven People Promise elements, together with the scores for staff engagement and morale, the Trust did not see a change from the 2021 results. While this is disappointing, this is within the context of the national results where there were improvements in 2 elements, decline in 2 elements and stabilisation in all others. We are carrying out a full analysis of the results to help us refine our People Strategy actions for the coming year. A key area of focus will be to consider our results on the question of whether staff would recommend the Trust as a place to work. In line with the national picture we saw a 2% decrease in positive responses to this question and this follows a declining position since 2019. We will be holding a series of engagement sessions again this year to break down the results and hear from staff on how we can make improvements to their experience.

5.4 Sickness absence improved in January 2023 after a sharp increase in December 2022. Vacancies and turnover both increased in January 2023 and sickness absence and appraisals remain key areas of concern. Mitigations are in place to support operational management with initiatives to address both turnover and sickness absence.

5.5 Our Director of Nursing, Melanie Van-Limborgh will be leaving the Trust at the end of April 2023, returning to Chelsea and Westminster Foundation Trust. She is being replaced by Sarah Burton who has been appointed as our Trust Chief Nurse. She will take up the role on 1 May 2023. Sarah has worked in the NHS for the past 30 years, holding a range of senior leadership roles and is currently deputy chief nurse at University College London hospitals and previously worked in senior roles at Ashford and St Peter's hospitals.

5.7 Our Medical Director, Gubby Ayida will be leaving the Trust in May 2023. Gubby has been appointment as the Chief Executive Officer at the Evelina London, part of Guy's

and St Thomas' NHS Foundation Trust. The Trust is currently recruiting to the role of Chief Medical Officer with interviews taking place on 21 April 2023.

5.8 Non-Executive Vineta Bhalla, left the Trust in February 2023 following the end of her term of appointment. Recruitment for Non-Executive Director vacancies is underway across the Acute Provider Collaborative.

5.9 I would like to thank Melanie, Gubby and Vineta on behalf of the Board for the significant contribution they have made to our Trust and across the Acute Provider Collaborative.

6. Equality, Diversity and Inclusion (EDI) update

6.1 In February, our Trust joined over 90 NHS Trusts to partner with AccessAble; the UK's leading provider of detailed disabled access information. Detailed access guides aim to help patients, visitors and staff plan their journeys to, and around, the hospital sites, covering everything from parking facilities and hearing loops, to walking distances and accessible toilets.

6.2 The Trust continues to hold monthly 'Proud to…' events to showcase different cultures within the Trust. In March 2023 we celebrated Ireland.

6.3 The Trust celebrated LGBT+ History Month - Behind The Lens, celebrating LGBT+ peoples' contribution to cinema and film from behind the lens. Resources were made available to staff as well as a programme of events which included Trust-held webinars, external webinars and training sessions and an event in Choices restaurant at Hillingdon Hospital with live music.

6.4 After the success of the first Let's Talk session on 'Autism and patients' in December 2022 the Disability and Wellbeing Network held another session on Thursday 26th January 2023, this time focussing on 'Autism in the workplace' which was delivered by Hillingdon Autistic Care and Support (HACS).

7. Hillingdon Hospital redevelopment

7.1 Proposals for the new Hillingdon Hospital got a massive boost at Hillingdon Council's Major Planning Committee on 18th January 2023 following the resolution to approve the planning application.

7.2 Local MP Boris Johnson visited Hillingdon Hospital on Tuesday 7th March for an update on the new hospital plans following the successful planning application decision by Hillingdon Council.

8. Updates from Council of Governors (CoG)

8.1 The CoGs met on Tuesday 4th April 2023.

8.2 The CoGs congratulated Ian Bendall on his appointment as the Lead Governor and recognised/celebrated the departing Lead Governor Tony Ellis following 12 years of leadership to the council. On behalf of the Board I would like to thank Tony for his dedicated service to the Trust.

8.3 The CoGs received a presentation on the Trust Quality Priorities for 2023/24, an update on Quality and Operational performance, the Staff Survey results, a summary from the

Chair of the Audit and Risk Committee on the work and priorities of the committee and how these are being strengthened.

8.4 The CoGs received the indicative timetable for Governor Elections in 2023.

8.5 The Trust re-launched briefing sessions for the CoGs in March 2023 the first of which was focused on Finance. The briefing sessions will cycle through the Trusts strategic priorities and aim to be developmental, informative and provide the Governors with opportunity to engage with the lead Executives and Non-Executive Directors, and gain insight into the work of their committees and how the Trust is performing against its strategic objectives.

8.6 The Trusts Annual Members Meeting will be held on Tuesday 26th September 2023, 5pm – 6.30pm.

9. Research and innovation

9.1 Our Trust has joined the North West London Clinical Trials Alliance, alongside Central and North West London NHS Foundation Trust and West London NHS Trust, giving the Alliance full coverage across the North West London Integrated Care System (ICS). The alliance is dedicated to delivering commercial and non-commercial sponsored clinical trials - improving the ease and speed of research delivery, patient access to clinical research and patient opportunities for early access to cutting-edge treatment and therapies that are not yet widely available to patients.

10. Stakeholder engagement

10.1 Dr Chris Streather, regional Medical Director for NHSE (London) visited Hillingdon Hospital on Friday 10th March for an informal visit with the opportunity to visit several ward areas and meet the staff. He received a tour of Bumblebee Ward, the Emergency Department, Intensive Therapy Unit and Jersey Ward with Dr Gubby Ayida, Trust Medical Director.

10.2 Almost 2,000 patients and local people took part in a 14-week public consultation on the proposed central Elective Orthopaedic Centre. The report following the consultation, is available online or, on request from the trusts, in a range of accessible formats.

11. Recognition and celebrating success

11.1 The Trust's library services manager, Adam Tocock, has led a working group of librarians from all over the country on a project backed by Health Education England to produce The National Searching Guidance, a document meant for all librarians and information professionals tasked with searching the evidence on behalf of busy NHS staff.

11.2 Hillingdon Health and Care Partners has launched a new wellbeing support service to improve outcomes for patients being discharged from the Alderbourne and Daniels neuro-rehabilitation units at our Trust. The pilot programme has been introduced as part of system-wide improvement plan, which identified the potential benefit of providing very early, proactive wellbeing support for patients who need neurological rehabilitation.

11.3 The Trust was awarded the national Carbon Reducer of the year award (2023) from Metsa. We are the only NHS Trust to have received this ward and this equates to the seventh sustainability related award the Estates and Facilities team have won in the last three years.

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)
18/04/2023
Item number: 3.1
This report is: Public

Business, Finance and Operational Plans 2023/24

Author: Jonathan Reid
Job title: CFO, LNWH

Accountable director: Lesley Watts
Job title: Chief Executive Lead, Finance and Performance

Purpose of report

Purpose: Decision or approval

There are three papers in this agenda item pack. First, the Operating Plan for the Collaborative, which sets out the collective ambitions for delivery against the national and local ambitions for NHS Trusts across activity, performance and workforce. Second, the Financial Plan for the Collaborative, which sets out the financial plan for the Trusts. And third, the Business Plan for the Collaborative. The Operating and Financial Plans were submitted, in line with national timetables, to NHS England and the NWL ICB.

Report history

The Operating Plan has been drafted and developed by bringing together the components of each Trust's plan – themselves developed by Trust Executive teams and supported by the COO, CPO and CFO groups. The Financial Plan has been developed through the CFO Group, led by the Chief Executive lead, Lesley Watts, working with colleagues across the Trust. The Business Plan has been developed by a small working group (Peter Jenkinson, Jonathan Reid and Bob Klaber), reporting through the Joint Executive Group and with Board Workshops to support development of the objectives for the coming year. The package of plans has been reviewed twice in March by the Collaborative Finance and Performance Committee.

Joint Executive Group – Jan/March – ongoing review Chief Executives Group – Jan/March – ongoing review	**Collaborative FPC** 04/03/2023 Approved the Collaborative Plan, noted the Trust FPCs to approve Trust Plans	**Collaborative FPC** 23/03/2023 Approved the Collaborative Plan, noted the Trust FPCs to approve Trust Plans

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

Executive summary and key messages

The NHS receives an annual set of operating plan requirements in December each year, used to prepare an Annual Operating Plan. Each of the four Trusts has developed detailed activity, performance, workforce and financial plans, working in partnership with the ICB and across the Collaborative. The Annual Operating Plan for the Collaborative brings these four plans together into a single document, which sets out the delivery against these national and regional targets.

The Trusts build on a strong history of delivery in recent years and have developed a plan which meets substantially all of the operating plan requirements, but with some areas of risk and ongoing work. The Trusts have differential Value-Weighted Activity targets, set nationally, which determines the level of Elective Recovery Funding to be achieved. All are planning to meet this target – although the plan flags risk for LNWH in respect of the Cerner Implementation. There is work to do to reduce outpatient follow-ups and to strengthen Patient Initiated Follow-Ups and, to a lesser degree, Advice and Guidance, but the elective ambition in the plan is in line with regional and national aspirations.

The Collaborative has strong plans on access and diagnostics, collectively meeting RTT long-wait and cancer standards. Urgent Care waiting time standards are met, but with an ambition to go further – and the Collaborative is working closely with the ICB on capacity plans and funding to reduce bed utilisation to 92% and support improved ambulance turnaround times. There is further work to do on diagnostic targets, with good progress on waiting times but challenges in consistently getting to the 120% activity level (other than at Chelsea and Westminster). However, this area was challenged by the Collaborative FPC, and has seen improvement as the plan has evolved, with collective action mitigating some of the constraints at Trusts.

The workforce plans have been triangulated by the Collaborative, the ICB and the region and these now align with activity and financial plans – recognising that any impact of cost improvements will need to be taken through a Quality Impact Assessment at each Trust as appropriate.

The Financial Plan sets out the results of the collective work to get to breakeven. Following the application of shared assumptions with the ICB CFO and on agreement on Trust-specific CIP targets, an initial financial gap was identified. The ICB provided non-recurrent funding to support a move to breakeven and the CFOs have worked through an intensive process of reviewing cost, income, CIP levels and risks. A breakeven plan has been agreed, with a fair allocation of risk across the Trusts. Following this work, CFOs are now leading their teams in work to ensure that the CIP programme has reached at least 50% by the end of March – a stretching challenge.

The Collaborative Business Plan has benefited from suggestions across a range of key stakeholders. The Joint Executive Group, supported by the Directors of Strategy and

Transformation, has developed a series of strategic priorities, a prioritisation framework, and a long-list of projects. This has been refined into a initial list of priority projects, and has now been turned into a planned programme of delivery for 2023/24, supported and led by the Chief Executives. The priority projects for quality and workforce have also been reviewed by the Quality and Safety Committee and the Workforce Committee, and the overall plan has been considered by the Finance and Performance Committee.

There remains more work to do to refine and calibrate the projects, but a series of deliverables across each of the four strategic priorities has been identified with an indicative analysis of the benefit and the resource requirements. At this early stage of the Collaborative, this is not yet pulled together as part of an overarching strategy. However, it does have a coherence in coming from debate and dialogue across the Joint Executive Group and Board – and taken together, delivery would represent a significant and demonstrable benefit for and from the Collaborative.

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

N/A

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Acute Collaborative Operating Plan

2023/24

30 March 2023

Executive Summary #1

- This paper presents the NWL Acute Collaborative Operating Plan for 2023/24. It sits alongside the NWL Acute Collaborative Business Plan for 2023/24, which aims to deliver a series of priority programmes developing the Collaborative at the same time as ensuring delivery of the national and regional priorities for 2023/24. It also sits alongside the Acute Collaborative Financial Plan for 2023/24.

- This is the first time the Collaborative has described the Operating Plan in this way – but it is not the first time that the Trusts have worked collaboratively. For the past three years, the Trusts have been working in an aligned and effective way, particularly in ensuring quality and safety, in delivering operating and performance standards, providing considerable mutual aid, and bringing together a series of interventions to address the challenges facing our workforce. Finance has been delivered collectively, but not yet collaboratively, and this will be one of the key developments for this year.

- The Operating Plan targets are set nationally, and translated by London and NWL ICB into priorities and requirements for the Trusts. As the pack shows, the Collaborative has put in place plans to deliver the majority of the key Operating Plan requirements – in some cases going further than the minimum ask – but there will are risks and challenges to delivery. Further work, in particular, is required with the ICB to finalise the plans and implementation arrangements for the increases in capacity envisaged in the national planning guidance – increasing the bed base, and reducing occupancy towards the required 92% across the Board, and at the same time increasing flow and improving ambulance handovers. This work is in hand, with a collective 'bid' being considered by the local and regional teams, and an update will be provided to the Collaborative Board & Cabinet as this capacity plan is finalised. Funding for seven months at current levels of additional capacity has been included in the latest submission of the plans.

- Our workforce plans are well developed with a series of planned interventions at the Collaborative level aimed at improving alignment across the teams, addressing the challenges of recruitment across all professional groups, and supporting Trusts in addressing key issues identified within and across the organisations.

Executive Summary #2

- The NWL Collaborative Financial Plan sits alongside and supports the operational plan and the workforce plans. The Trusts, with CFOs supporting Executive teams to identify opportunities for delivery, have agreed a breakeven plan – but have identified a number of significant risks to delivery, described in a separate paper. Crucially, the ICB has provided non-recurrent support of £40-50m, and has allocated the ICB growth funding reserve of £66m to the Collaborative to support a move to a breakeven plan. We will need to agree a programme of work with the ICB to move to financial sustainability, and this is reflected in the Business Plan for the coming year.

- There are a number of major projects landing in the NWL Collaborative during 2023/24 – the finalisation of the public consultation on the Elective Orthopaedic Centre, and delivery of the build and the initial service change, the implementation of the Community Diagnostics Centres programme, the launch of Digital Care Records at two Trusts and the alignment of the system across all four Trusts. Significant progress on the implementation of the Endoscopy and Digital Diagnostics programmes are expected – and in the background, major cases in respect of SIAM and redevelopment continue to work through refinement and approval processes. These will all impact on the operating plan to a greater or lesser degree, and the draft plan describes how these will be managed during the year. The pipeline of future cases is also healthy, with work in hand on the new ophthalmology service model, critical care and urgent care – the draft Collaborative Business Plan for the coming year helpfully sets out how the emerging strategic priorities for the Collaborative are being translated into priority programmes.

- Finally, there are material risks to the delivery of the plan, and this pack articulates the key risks and the actions to mitigate and manage these. NWL Acute Collaborative, and the ICB, has a strong track record in delivery, and this is anticipated to continue into 2023/24 – but careful management of risk and early responses to variations against planned delivery will be key in maintaining this record of achievement.

Operational Planning – Elective Activity Levels (VWA)

- VWA is the key driver of elective recovery activity levels. The four Trusts within the Collaborative have been given differential value weighted activity (VWA) targets, averaging to differential targets for ICS's. The VWA targets are based on 0.75% improvement in activity each month in 2023/24 over and above the 2022/23 exit run rate.

- The ICB planned value weighted activity is currently **111.8%** against a target for NWL 109% and NWL providers of 107.4% - the ICB must meet the target to secure baseline and additional funding. Trusts have been allocated ERF funding by agreement with the ICB - but it is important to note that the calculation rules for ERF funding has changed, and a new tariff has been applied, so Trusts are working with the ICB to understand whether further funding will become available if the target is delivered. This is covered in the financial plan.

- All Trusts are now planning to meet the VWA target for the year, but there is a significant risk to delivery at LNWHT. This is as a result of a higher target and Cerner Implementation Plans (Cerner is also being implemented at THH, but there is a lower VWA target for the year). LNWH and the ICB are discussing the target with the NHS London team (and have included THH in this) and are seeking an appropriate adjustment for Cerner.

Trust	NWL ICS VWA Target	Trust VWA Target for NWL Activity	Trust VWA Target for All ICS's Activity
CWFT	109%	115.08%	112.68%
ICHT		103.82%	104.29%
LNWHT		107.23%	108.50%
THHT		104.23%	104.52%
Out Of Sector		114.30%	114.30%
Independent Sector		116.12%	116.12%

- Trust by Trust performance plans are shown overleaf - Planned elective activity is 109.5% of 19/20 first outpatient first attendances and 109.2% of 19/20 elective admissions.

- NWL PIFU is non compliant at 1.9% against a target of 5.0%. CWFT is compliant, but ICHT, LNWT and THHT are not compliant.

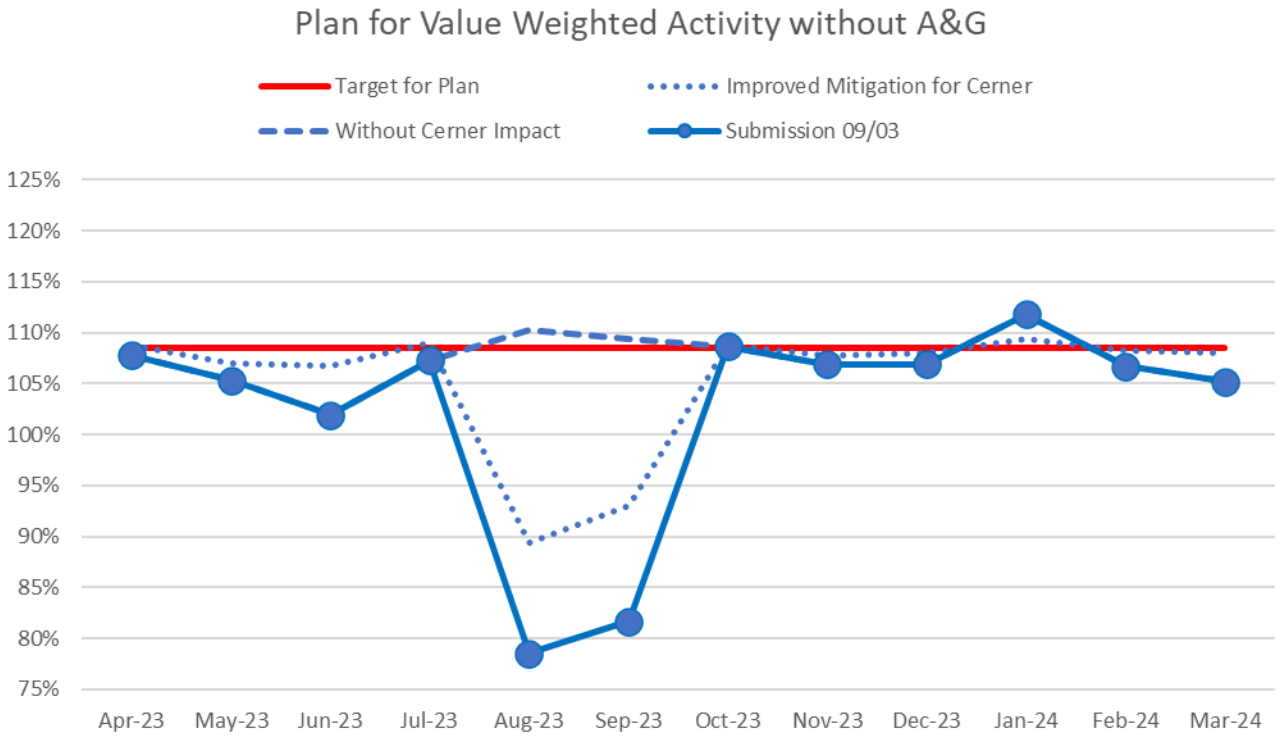
- Outpatient follow up ambition to reduce to 75% is not achieved with 100.2% activity levels currently in plans.

Value Weighted Activity (Plans for 2023/24)

Value Weighted Activity an estimated view based on local logic that is subject to change. Approach has been agreed by the CFOs and COOs.

NWL In Sector Providers VWA	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	2023-24	Target
Elective day case spells	112.5%	113.3%	107.3%	111.2%	107.4%	107.8%	109.3%	111.8%	119.5%	113.0%	110.8%	110.6%	111.0%	107.4%
Elective ordinary spells	102.6%	97.4%	95.1%	101.9%	97.6%	101.1%	99.1%	100.4%	109.3%	104.1%	97.8%	95.9%	99.9%	107.4%
Total OP 1st	115.7%	114.7%	110.1%	113.3%	112.7%	104.3%	108.2%	102.8%	112.3%	107.2%	107.9%	113.2%	110.0%	107.4%
1st OP with proc	111.9%	107.9%	96.9%	102.6%	102.7%	99.8%	106.5%	102.5%	115.1%	103.2%	112.4%	118.4%	106.0%	107.4%
FU OP with proc	105.4%	105.7%	99.3%	100.3%	98.7%	98.2%	105.0%	96.4%	109.8%	97.6%	100.0%	99.5%	101.0%	107.4%
Total incl. A&G	115.1%	113.6%	108.5%	113.2%	110.4%	108.7%	110.6%	109.5%	118.8%	112.5%	110.7%	111.7%	111.8%	107.4%
LNWHT VWA	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**2023-24**	**Target**
Elective day case spells	110.0%	110.0%	110.0%	115.9%	94.2%	94.1%	114.4%	112.6%	111.7%	112.5%	110.5%	111.9%	108.9%	108.5%
Elective ordinary spells	106.6%	100.6%	100.0%	100.1%	82.7%	98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	108.5%
Total OP 1st	109.8%	108.6%	108.6%	108.6%	89.4%	89.7%	109.4%	108.6%	110.7%	113.1%	113.0%	113.2%	106.8%	108.5%
1st OP with proc	112.0%	111.0%	110.0%	110.0%	93.2%	95.1%	110.0%	110.0%	110.0%	110.0%	110.1%	110.5%	107.6%	108.5%
FU OP with proc	100.0%	100.0%	100.0%	100.0%	82.6%	81.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	108.5%
Total incl. A&G	112.0%	110.2%	109.9%	112.2%	92.6%	96.2%	112.0%	111.0%	111.2%	112.7%	111.4%	111.9%	108.5%	108.5%
THH VWA	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**2023-24**	**Target**
Elective day case spells	104.1%	104.1%	104.1%	104.1%	104.1%	104.1%	104.1%	65.1%	93.7%	104.1%	104.1%	104.1%	100.1%	104.5%
Elective ordinary spells	106.8%	106.6%	106.7%	106.6%	106.7%	106.5%	106.6%	66.7%	95.8%	106.6%	106.9%	106.4%	102.2%	104.5%
Total OP 1st	104.5%	104.5%	104.5%	104.5%	104.5%	104.5%	104.5%	65.3%	94.1%	104.5%	104.5%	104.5%	100.2%	104.5%
1st OP with proc	98.9%	98.9%	98.9%	98.9%	98.9%	98.8%	98.9%	61.8%	89.0%	98.9%	98.9%	99.0%	94.5%	104.5%
FU OP with proc	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	63.2%	90.9%	101.0%	101.0%	101.1%	96.7%	104.5%
Total incl. A&G	112.9%	112.3%	112.3%	112.7%	112.8%	112.6%	113.1%	73.6%	103.0%	112.9%	113.2%	113.1%	108.6%	104.5%
ChelWest VWA	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**2023-24**	**Target**
Elective day case spells	120.8%	125.0%	106.3%	115.7%	117.9%	125.9%	114.4%	178.1%	163.1%	154.0%	141.8%	132.6%	130.1%	112.7%
Elective ordinary spells	105.5%	98.8%	83.4%	91.1%	101.1%	106.8%	93.5%	145.1%	146.1%	103.2%	101.2%	102.8%	104.6%	112.7%
Total OP 1st	109.1%	112.0%	94.5%	100.9%	105.1%	105.4%	99.8%	113.4%	107.1%	97.6%	101.0%	113.4%	104.6%	112.7%
1st OP with proc	118.1%	121.2%	91.0%	111.9%	114.3%	108.3%	123.0%	176.3%	175.3%	133.7%	141.8%	190.1%	127.0%	112.7%
FU OP with proc	122.7%	116.1%	98.5%	106.7%	115.2%	112.4%	119.1%	156.2%	166.5%	117.1%	125.8%	114.2%	120.2%	112.7%
Total incl. A&G	119.2%	119.8%	101.8%	110.5%	115.5%	119.0%	110.8%	150.5%	144.5%	124.5%	122.9%	126.1%	120.9%	112.7%
ICHT VWA	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**2023-24**	**Target**
Elective day case spells	112.1%	112.3%	106.9%	108.3%	111.6%	109.5%	105.6%	103.0%	115.1%	103.4%	102.5%	103.3%	107.5%	104.3%
Elective ordinary spells	98.8%	93.3%	94.2%	106.4%	102.9%	99.5%	99.6%	95.4%	105.6%	106.1%	93.9%	89.6%	98.5%	104.3%
Total OP 1st	129.9%	126.2%	124.9%	130.2%	142.1%	114.1%	114.0%	106.7%	124.0%	110.1%	109.9%	116.2%	119.7%	104.3%
1st OP with proc	112.7%	100.0%	89.0%	92.1%	105.1%	98.5%	96.6%	85.4%	103.3%	87.5%	104.4%	104.8%	97.3%	104.3%
FU OP with proc	104.1%	107.6%	98.3%	97.7%	102.5%	103.7%	105.4%	94.5%	110.5%	89.4%	92.6%	93.7%	99.4%	104.3%
Total incl. A&G	115.7%	113.0%	109.9%	115.2%	118.9%	110.6%	109.0%	104.0%	117.7%	107.6%	104.7%	105.3%	110.6%	104.3%

Note: LNWH Impact of Cerner Implementation



23/24 VWA

108.5%

Target

102.3%

Plan scenario **for** Cerner Impact (9th Mar)

105.4%

Improved Mitigation for Cerner impact (23rd Mar)

108.5%

Planned delivery **including** A&G

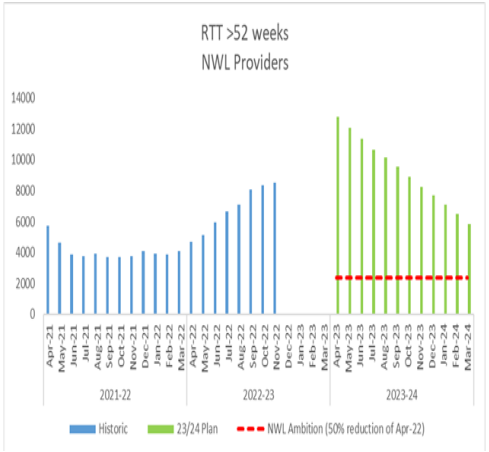
Value Weighted Activity (VWA) consists of elective day case and inpatient admissions, consultant-led and non-consultant-led first outpatient attendances, procedures or tests carried out in an outpatient clinic and advice and guidance which supports patients to be cared for in primary care setting. This volume and value of this activity is measured against the baseline year of 2019/20 with an expectation that LNW achieves 108.5% of the equivalent value of that activity. The original draft submission assumed a negative impact of **3.7%** to the full year plan attributed to the planned reduction in elective activity around the time of the Cerner EPR deployment in August and further time for embedding new work practices. The impact has been mitigated to within **0.7%** through a plans to reduce the immediate deployment impact and by improving the run-rate position through the year.

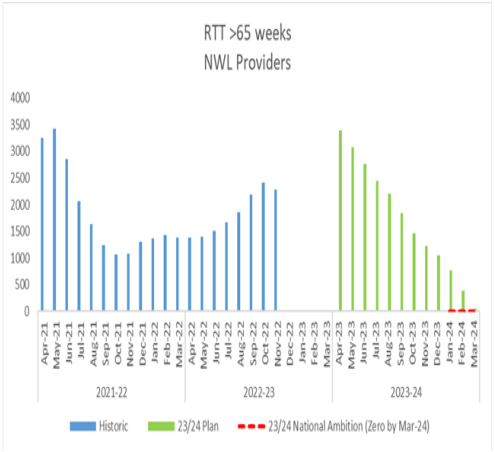
Collaborative Operational Plan – Access and Cancer Standards

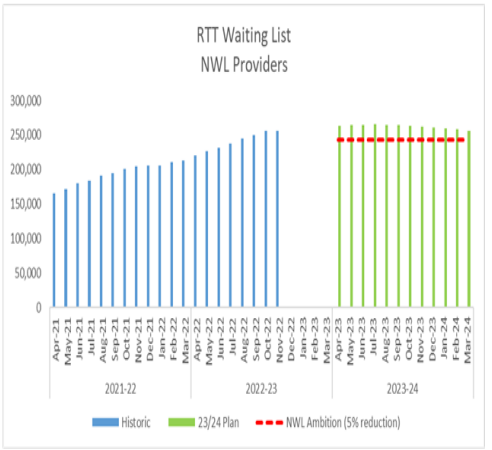
Referral to Treatment Times

- There is a national target to eliminate all 65 week waits by Mar 24. The Collaborative is planning to meet this target and reaching zero by March 24.

- 52 week waits - NWL has a collective ambition to reduce the waiting list by 50% from Apr 2023 - and this has been achieved in the plan, with anticipated levels of 5,812.

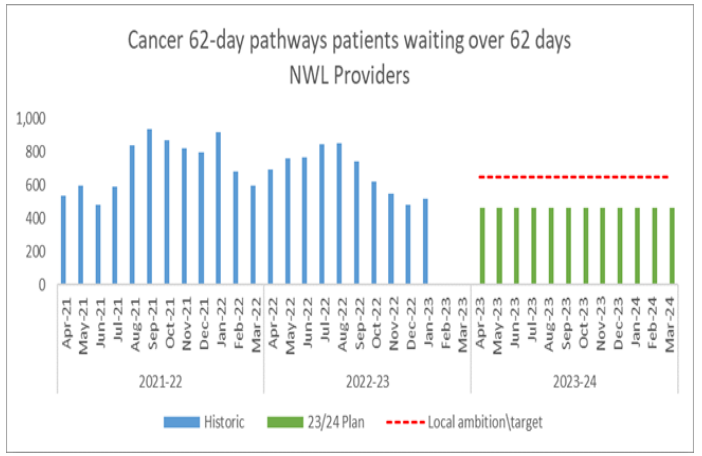


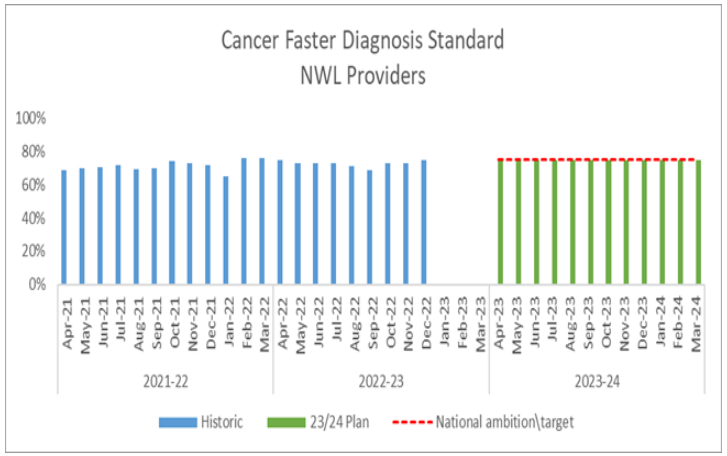




Cancer

- The Trusts are planning to overachieve against the Cancer 62 day plus waits target, with a plan of 460 in March 2024 meeting the national ambition of 645.
- Cancer 28 day waits (faster diagnosis standard) meets the target of 75% from April 2023.





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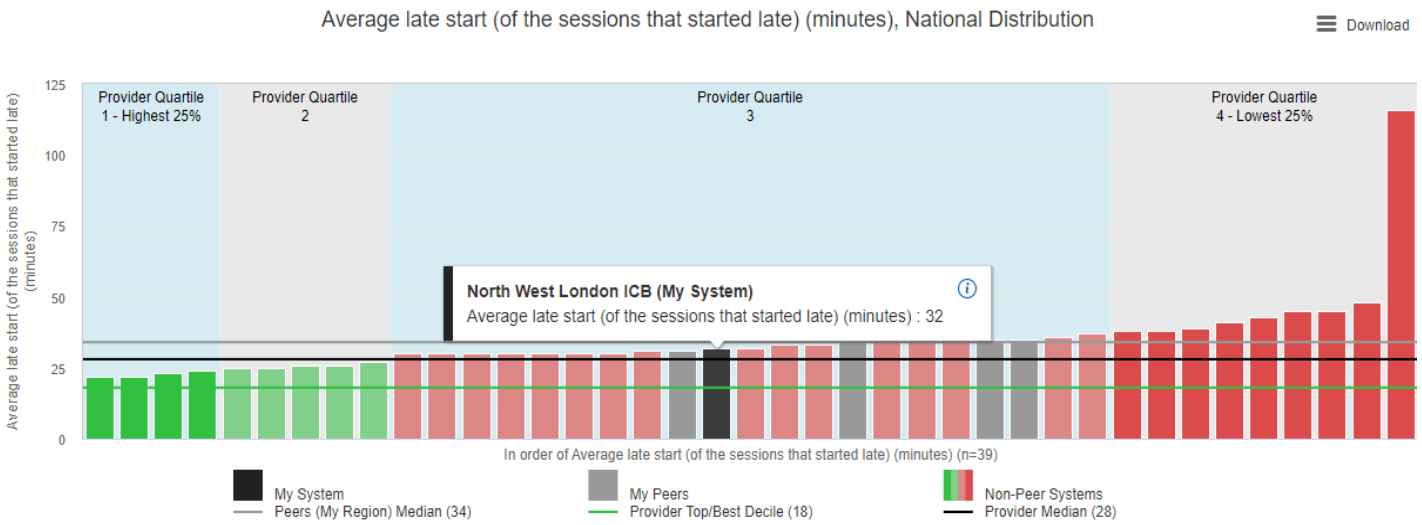
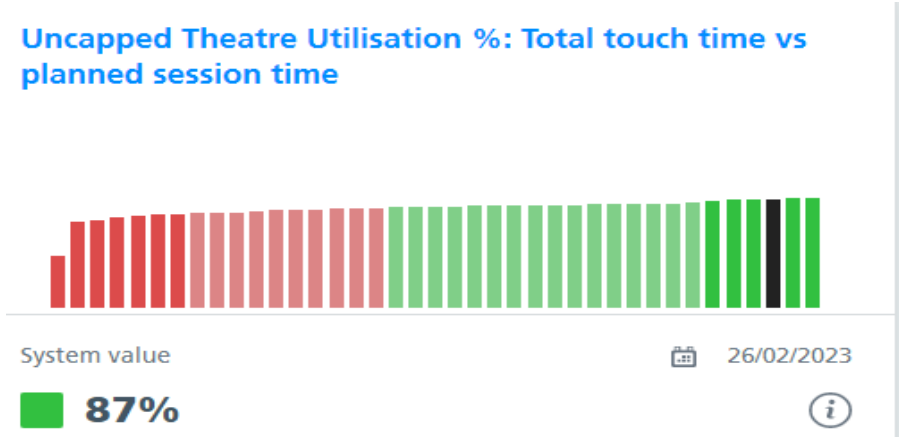
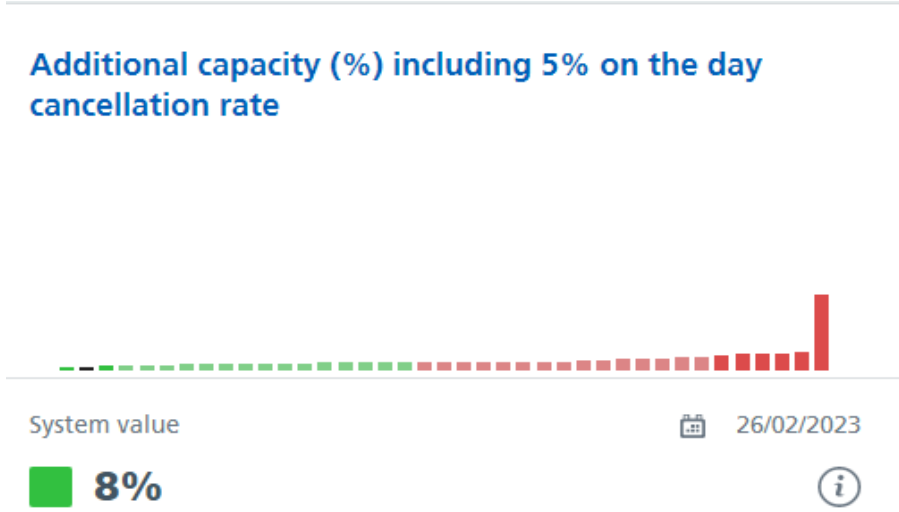
Operational Planning – Elective Activity Levels & Theatre Productivity

- Through the Elective Care Board, the Collaborative has seen a significant increase in the productivity and efficiency of theatres across the past year. But, there remains work to do on late starts and in aligning activity, staffing and the cost of the staffing levels.

- The Collaborative is working in partnership with the ICB on a significant theatres productivity programme across the four Trusts, which will support continued improvement in the overall productivity.







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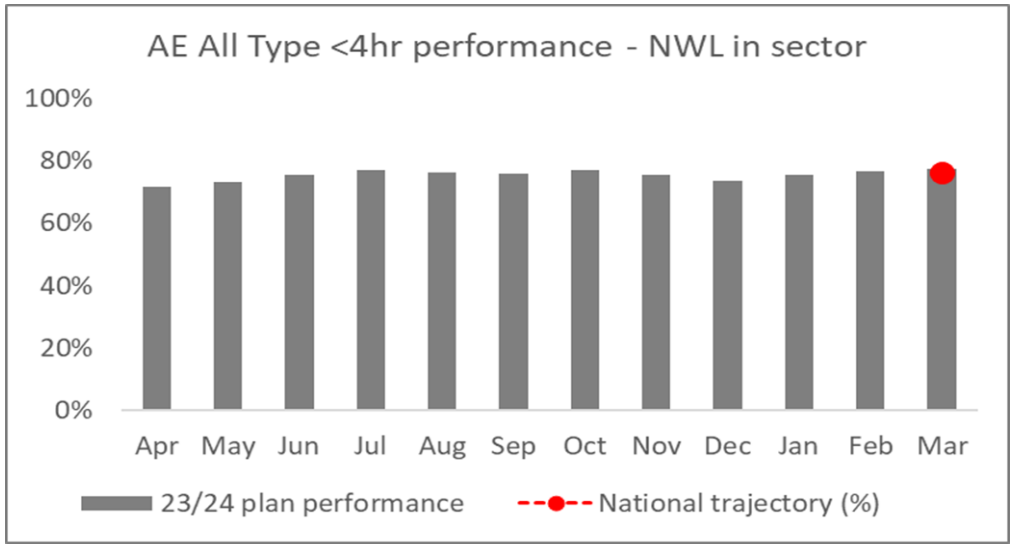
Urgent and Emergency Care

- The Collaborative UEC plan shows the beneficial impact of SDEC and work by the COOs to standardise models and delivery across the four Trusts – but also recognises the significant capacity constraints faced by all providers.

- A&E All Types Performance is planned to be **78.5%.** This is above the national target, but our local ambition is to be higher than the national standard.

- The planned A&E Type 1 performance at March 2024 for CWFT is 66.4%, LNWHT – 56.0%, ICHT – 68.3% and THHT – 53.9%, with further detail in the appendices.

- G&A bed occupancy is expected at **94.4%** compared with a national target of 92%, even with NEL activity planned at 97.4% across 2023-24 against a 100% local target. This assumes existing additional beds remain in place whilst the final NWL capacity plan is being agreed.



- Securing the capacity plan and agreeing funding is key to improving delivery. £47m revenue funding has been allocated to London ICS's to increase UEC bed bases.

- Plans have been developed to bid for funding to open 272 beds in 2023/24. Indicative allocations and bed numbers were included in the 30 March plan submission.

Collaborative Operational Plan – Diagnostics

Diagnostic Test Activity Levels

- The targets for 120% of diagnostic test activity (120%) are not met, reflecting both some capacity challenges and complexity in demand.

Patients Waiting Less than 6 Weeks

- All providers meet the targets set for Echo. CWFT and ICHT are compliant for all test and exam types. LNW is compliant bar CT, and is looking at all options to improve performance. Through the Diagnostic Network and the ICB, actions are in hand to support the THH position, and to seek to strengthen overall compliance.

23/24 Full Year Plan against Adj Baseline	LNW	THH	CW	ICHT	NWL Providers	NWL ICB
Diagnostic Tests - Magnetic Resonance Imaging	120%	100%	120%	127%	121%	117%
Diagnostic Tests - Computed Tomography	120%	127%	120%	133%	126%	122%
Diagnostic Tests - Non-Obstetric Ultrasound	120%	101%	120%	126%	120%	118%
Diagnostic Tests - Colonoscopy	100%	65%	120%	114%	103%	103%
Diagnostic Tests - Flexi Sigmoidoscopy	100%	76%	120%	87%	99%	82%
Diagnostic Tests - Gastroscopy	100%	83%	120%	103%	103%	105%
Diagnostic Tests - Echocardiography	120%	103%	120%	79%	98%	107%

Mar-24 Plan	LNW	THH	CW	ICHT	NWL	NWL ICB
Diagnostic test waiting list - Magnetic Resonance Imagi	3.0%	27.1%	3.0%	3.0%	8.0%	9.0%
Diagnostic test waiting list - Computed Tomography	10.0%	0.0%	3.0%	1.0%	4.5%	5.3%
Diagnostic test waiting list - Non-Obstetric Ultrasound	1.9%	14.0%	2.2%	5.0%	5.3%	8.8%
Diagnostic test waiting list - Colonoscopy	5.0%	25.0%	3.1%	1.0%	6.9%	9.3%
Diagnostic test waiting list - Flexi Sigmoidoscopy	4.7%	31.0%	3.0%	0.9%	6.1%	6.9%
Diagnostic test waiting list - Gastroscopy	4.8%	25.4%	3.0%	1.0%	6.9%	8.3%
Diagnostic test waiting list - Cardiology - Echocardiogra	3.0%	0.0%	2.4%	5.0%	3.1%	1.3%

Workforce Planning

- The core principle for the workforce plans is that the existing staff base will deliver activity for 23/24 with no growth planned. The exception to this is establishment and staffing growth relating to agreed and funded service changes which, for Chelsea & Westminster, relates to approved and funded maternity services improvement investment (41 WTE).

- Whilst recruitment into established vacancies will see the overall substantive staff in post numbers rise by 279 WTE for the four Acute Trusts collectively, these are off-set by commensurate reductions in bank and agency usage as the vacancies are filled.

- In addition, the impact of pay cost improvement opportunities, primarily across the temporary staffing groups (bank and agency), further reduces the overall planned total staffing numbers.

- In summary, there is a planned establishment growth of 41 WTE and an overall staffing reduction of 902 WTE. As the CIP schemes are finalised and signed off, all staffing consequences will pass through the appropriate QIA process.

NWL Acute Trusts	22/23 out-turn	23/24 out-turn	change +/-
Establishment (WTE)	35,067	34,828	-239
Total Staffing (WTE)	35,251	34,350	-902

Chelsea & Westminster	22/23 out-turn	23/24 out-turn	change +/-
Establishment (WTE)	6,930	6,971	41
Total Staffing (WTE)	7,242	6,970	-272

Imperial College	22/23 out-turn	23/24 out-turn	change +/-
Establishment (WTE)	15,320	15,260	-60
Total Staffing (WTE)	15,167	14,819	-348

Hillingdon	22/23 out-turn	23/24 out-turn	change +/-
Establishment (WTE)	3,775	3,746	-29
Total Staffing (WTE)	3,800	3,712	-88

London North West	22/23 out-turn	23/24 out-turn	change +/-
Establishment (WTE)	9,042	8,851	-190
Total Staffing (WTE)	9,042	8,848	-194

Financial Planning for the Collaborative – 2023/24

- The Trusts have worked with the ICB and with Clinical, Operational and Workforce teams to develop the Collaborative Financial Plan for 2023/24. The Trusts have developed and agree a break-even financial plan across the Collaborative, which aligns with the ICB and wider system plans.

- The Trusts have followed a standard set of assumptions, agreed with the ICB, to agree the key elements of the plan. This means standard assumptions have been applied across pay and non-pay uplifts and tariff impacts. Non-recurrent delivery of CIPs has been reversed out for individual Trusts. The impact of non-recurrent delivery in 2022/23 has impacted on each Trust's carried forward position, making 2023/24 a challenging ask.

- ERF and FRF have been treated as in 2022/23, with the same values allocated to Trusts – and the overall quantum of ERF has been marginally increased to reflect changes in activity targets. COVID funding has been issued in line with a set of common principles. ERF represents both an opportunity and a risk, as Trusts will have to 'earn' the ERF values from 2022/23 with a new set of tariff and rules. No growth has been allocated to providers, given activity levels in 2022/23. CIP levels, but all remain below the 4% level.

- The ICB has offered an overall package of support to help support the Collaborative in moving to a breakeven plan, based on non-recurrent allocation of growth in 2023/24. We will need to agree a programme of work (akin to the Theatres Productivity Programme) with the ICB to support the release of this non-recurrent funding, and to look to reduce the deficit by £66m in future years – and this is included in the draft Collaborative Business Plan for the coming year.

Monitoring Delivery of the Financial Plan

- Now that a breakeven plan has been secured, greater focus is now on the work to develop the CIP programme for 2023/24. CFOs and their teams are working intensively on their CIP programme, with an ambition of a minimum of 50% of the required schemes signed off before the start of the financial year.

- CFOs, with support from key stakeholders, are also working during March and April to agree rules and principles for risk sharing for 2023/24, recognising that each Trust has a separate financial plan, but these are woven together to form the Collaborative financial plan. This will support management of financial performance within and across the Trusts.

- The level of ERF risk remains high, given the implementation of Cerner and the impact of industrial action and the challenges facing the clinical and operational teams in continuing to deliver a step increase in activity. The financial risks associated with ERF in the short-term have been marginally reduced through recent agreements with the ICB, which has shifted the amount of income 'at risk' down from the full ERF amount, and has in consequence, provided an increase allocation of funding towards diagnostics and critical care in seeking to deliver the full activity target. The level of focus and engagement on delivering elective targets through the ERF is rigorous and CFOs consider the overall level of risk to financial plans has reduced.

- It is important to highlight the overall risk to the financial plan of inflationary pressures. The Trusts plans, as with all Trusts in the ICB, do not include the additional pressures driven by hyper-inflation. CFOs are working together to identify the full level of risk to the financial plan, and are working in partnership with the ICB, to ensure a consistent approach and dialogue with NHS London and from there into national dialogues.

Financial Plan 2023/24

- The Trusts within the Collaborative have agreed an aligned and balanced financial plan.
- A separate paper to the Collaborative Board sets out the key elements of the plan, the key risks and assumptions and the approach to delivery.
- The Collaborative financial plan also includes a capital plan, building on the core allocation and national/regional funding streams across the Trusts.
- On a monthly basis, a combined Collaborative Finance Report is prepared, showing performance against the plan.
- The key risks for 2023/24 are ERF and CIP, both the subject of intense work during April/May.

NWL APC Financial Plan 2023/24	LNWH Plan 23/24 £000	CWFT Plan 23/24 £000	ICHT Plan 23/24 £000	THH Plan 23/24 £000	Total APC Plan 23/24 £000
Patient Care Income	787,023	754,469	1,363,904	295,932	3,201,328
Operating Income	71,547	71,733	162,988	28,290	334,558
Total Income	**858,570**	**826,202**	**1,526,892**	**324,222**	**3,535,886**
Pay	(535,584)	(465,431)	(912,813)	(221,581)	(2,135,409)
Non pay	(307,194)	(350,713)	(606,263)	(110,514)	(1,374,684)
Total expenses	**(842,778)**	**(816,144)**	**(1,519,076)**	**(332,095)**	**(3,510,093)**
Operating surplus/deficit	**15,792**	**10,058**	**7,816**	**(7,873)**	**25,793**
Finance costs & Income	(5,809)	1,589	5,300	(1,478)	(398)
PDC	(11,200)	(12,570)	(14,404)	(7,612)	(45,786)
Net surplus / deficit	**(1,217)**	**(923)**	**(1,288)**	**(16,963)**	**(20,391)**
Other non operating costs/income	1,217	923	1,288	16,963	20,391
23/24 Financial plan	**0**	**0**	**0**	**0**	**0**

NWL APC Financial Plan 2023/24	LNWH Plan 23/24 £000	CWFT Plan 23/24 £000	ICHT Plan 23/24 £000	THH Plan 23/24 £000	Total APC Plan 23/24 £000
Cost Improvement Programme	31800	23520	53427	10757	119504
% of turnover	3.7%	2.8%	3.5%	3.3%	3.4%

Next Steps, Key Risks and Challenges in Delivery

- This paper presents the NWL Acute Collaborative Operating Plan for 2023/24. It sits alongside the NWL Acute Collaborative Business Plan for 2023/24, and the NWL Acute Collaborative Financial Plan.

- There are also number of major projects landing in the NWL Collaborative during 2023/24 – the finalisation of the public consultation on the Elective Orthopaedic Centre, and delivery of the build and the initial service change, the implementation of the Community Diagnostics Centres programme, the launch of Digital Care Records at two Trusts and the alignment of the Cerner system across all four Trusts. Significant progress on the implementation of the Endoscopy and Digital Diagnostics programmes are expected – and in the background, major cases in respect of SIAM and redevelopment continue to work through refinement and approval processes. These will all impact on the operating plan to a greater or lesser degree, and the final plan will include each of these service developments where appropriate. The pipeline of future cases is also healthy, with work in hand on the new ophthalmology service model, critical care and urgent care – the draft Collaborative Business Plan for the coming year helpfully sets out how the emerging strategic priorities for the Collaborative are being translated into priority programmes.

- Finally, there are material risks to the delivery of the plan. NWL Acute Collaborative, and the ICB, has a strong track record in delivery, and this is anticipated to continue into 2023/24 – but careful management of risk and early responses to variations against planned delivery will be key in maintaining this record of achievement.

- The most significant risks for the Operating Plan are (i). activity levels (ERF funding) which are being managed through the Elective Care Board, which has a strong track record of delivery, (ii). Capacity plan requirements, which are managed through the UEC Board and the COOs, and again where there is a strong track record of delivery, (iii). CIP programme delivery – where the CFOs are working intensively during March to strengthen arrangements to secure delivery, (iv). continued industrial action which will impact both cost and delivery, and (v). Implementation of Cerner at THH and LNWH. Mitigation plans are in place, or under development, for these risks.

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Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Appendices

30 March 2023

Acute Activity – NWL Collaborative

Total In Sector Providers - Planned activity / performance as % of 2019-20 baseline		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP - 1st	114.6%	113.9%	108.8%	111.9%	110.5%	103.5%	107.6%	102.9%	111.4%	106.8%	107.7%	113.0%	109.2%	107.4% of 19/20	National
OP	Total OP - FU	104.7%	104.1%	99.4%	103.2%	102.0%	97.1%	101.2%	96.2%	102.8%	95.6%	98.4%	98.8%	100.2%	<=75% of 19/20 by Mar-24	National
OP	Total OP	107.8%	107.3%	102.5%	106.0%	104.7%	99.2%	103.3%	98.4%	105.5%	99.2%	101.4%	103.3%	103.1%		
PIFU	OP Transformation	3,928	4,409	4,293	4,314	4,353	4,436	4,483	4,426	4,241	5,350	5,183	5,075	54,491		
OP	Consultant-led 1st OP	114.5%	114.2%	108.6%	110.6%	109.4%	100.8%	106.4%	103.9%	111.9%	106.4%	110.7%	115.5%	109.1%	107.4% of 19/20	National
OP	Consultant-led 1st OP with proc	111.8%	108.0%	97.2%	103.0%	102.5%	99.8%	106.8%	102.8%	115.4%	103.9%	112.6%	118.8%	106.2%		
OP	Consultant-led FU OP	102.4%	102.7%	97.2%	100.9%	102.0%	95.1%	97.3%	95.9%	104.2%	95.8%	98.1%	98.1%	99.0%	<=75% of 19/20 by Mar-24	National
OP	Consultant-led FU OP with proc	105.4%	105.7%	99.3%	100.3%	98.7%	98.2%	105.0%	96.4%	109.8%	97.6%	100.0%	99.5%	101.0%	107.4% of 19/20	National
OP	OPFU without procedure	105.3%	104.5%	98.8%	103.1%	105.7%	98.7%	100.3%	96.4%	103.1%	95.2%	97.9%	98.7%	100.5%		
Elective	Total elective spells	111.1%	111.1%	105.8%	110.1%	105.7%	106.5%	108.2%	110.2%	117.8%	111.8%	109.1%	108.6%	109.5%	107.4% of 19/20 baseline (113% exit run rate)	National
Elective	Elective day case spells	112.3%	113.1%	107.4%	111.3%	106.9%	107.2%	109.5%	111.4%	119.0%	112.9%	110.7%	110.5%	110.8%		
Elective	Elective ordinary spells	102.6%	97.3%	94.6%	101.6%	97.4%	101.2%	98.9%	101.7%	110.1%	104.1%	97.7%	95.9%	100.0%		
Elective	Elective day case spells - Children under 18 years of age	68.1%	69.1%	67.7%	74.7%	69.1%	67.0%	69.2%	79.7%	71.8%	70.1%	76.4%	76.9%	71.4%		
Elective	Elective ordinary spells - Children under 18 years of age	51.9%	56.0%	49.1%	52.9%	58.6%	53.9%	52.5%	66.7%	67.6%	63.2%	63.2%	59.6%	57.3%		

Total Electives (incl. A&G):	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
	116.2%	113.0%	113.8%	114.3%

Total Electives (incl. A&G) cumulative:	Q1 23/24	Q1-Q2 23/24	Q1-Q3 23/24	Q1-Q4 23/24
	116.2%	114.6%	114.3%	114.3%

A&E	AE All Type <4hr performance	72.0%	73.7%	75.5%	76.9%	76.4%	75.7%	77.0%	76.4%	74.4%	76.3%	77.8%	78.5%	75.9%	>=76% performance	National
A&E	AE Type 1 <4hr performance	60.5%	63.1%	64.1%	65.2%	67.4%	64.9%	65.8%	65.4%	63.5%	65.8%	65.9%	66.4%	64.8%		
A&E	AE Type 2&3 <4hr performance	87.6%	87.5%	90.2%	92.1%	89.0%	90.2%	91.9%	91.2%	89.0%	91.8%	93.7%	94.6%	90.7%		
NEL	Non-elective spells	95.9%	96.6%	97.2%	95.8%	97.7%	97.1%	99.5%	99.4%	100.0%	96.9%	96.7%	96.3%	97.4%	<=100% of 19/20 (0 LoS adjusted baseline for Type 5 ECDS)	NWL
NEL	Non-elective spells with a length of stay of zero days	98.5%	100.7%	100.5%	99.7%	100.5%	99.4%	100.0%	100.8%	103.2%	96.4%	94.5%	93.3%	98.9%		
NEL	Non-elective spells with a length of stay of 1 or more days	94.1%	93.8%	95.0%	93.2%	95.9%	95.5%	99.2%	98.4%	98.0%	97.2%	98.3%	98.4%	96.4%		

Acute Activity – NWL Acute Collaborative (2)

Total In Sector Providers - Planned activity / performance as % of 2019-20 baseline

		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	12,500	11,865	11,205	10,455	9,902	9,375	8,780	8,172	7,703	7,071	6,472	5,812	5,812	50% reduction by Mar-24 (Baseline = Apr-22)	NWL
RTT	Number of 65+ week RTT waits	3,319	2,986	2,677	2,346	2,073	1,791	1,472	1,218	1,056	762	392	-	-	Zero by Mar-24	National
RTT	RTT waiting list	263,622	264,425	265,066	265,278	264,728	264,376	263,225	262,412	261,321	260,048	258,095	256,167	256,167		
RTT	RTT completed admitted pathways	131.5%	125.3%	111.4%	118.1%	131.8%	129.4%	125.6%	121.8%	121.1%	115.2%	117.0%	134.8%	123.2%	> 22/23	NWL
RTT	RTT completed non-admitted pathways	115.4%	112.4%	93.6%	101.6%	95.4%	100.9%	110.9%	110.8%	115.9%	103.8%	108.6%	122.8%	107.2%		
RTT	New RTT pathways (clock starts)	109.3%	103.1%	95.0%	99.8%	106.7%	103.0%	123.8%	109.4%	117.8%	107.2%	101.1%	118.0%	107.4%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	125.8%	120.2%	112.8%	125.0%	121.4%	120.3%	123.3%	115.6%	120.7%	121.4%	124.0%	128.9%	121.4%	Activity at 120% of 19/20	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	127.6%	124.1%	114.7%	127.5%	120.2%	120.6%	132.6%	123.3%	129.9%	128.1%	131.8%	134.6%	125.9%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	126.6%	116.9%	109.0%	116.8%	117.6%	126.5%	121.3%	116.1%	116.0%	119.8%	124.8%	129.4%	119.8%		
Diagnostics	Diagnostic Tests - Colonoscopy	109.8%	109.8%	101.1%	108.7%	101.9%	101.6%	102.8%	98.1%	114.2%	101.2%	96.7%	95.8%	102.9%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	91.9%	108.6%	76.7%	107.9%	106.8%	100.6%	111.3%	95.3%	101.6%	104.6%	98.1%	91.3%	99.0%		
Diagnostics	Diagnostic Tests - Gastroscopy	101.5%	104.1%	100.6%	106.7%	98.8%	102.2%	104.6%	99.2%	105.9%	109.2%	100.8%	99.8%	102.7%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	99.1%	93.1%	88.1%	95.4%	90.5%	93.7%	102.8%	95.2%	104.6%	125.8%	96.2%	95.4%	97.7%		
ACC	Adult Critical Care Bed occupancy %	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	>= Mar-23	NWL
G&A	Average number of overnight G&A beds occupied - Total	2,982	2,956	2,839	2,842	2,831	2,856	2,879	3,029	3,032	3,062	3,062	3,057	3,057	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds available - Total	3,172	3,172	3,001	3,002	3,002	3,002	3,011	3,207	3,213	3,237	3,240	3,237	3,237		
G&A	Average number of overnight G&A beds occupancy - Total	94.0%	93.2%	94.6%	94.7%	94.3%	95.1%	95.6%	94.4%	94.4%	94.6%	94.5%	94.4%	94.4%		
G&A	Average number of overnight G&A beds occupied - adult	2,857	2,826	2,711	2,716	2,705	2,728	2,749	2,899	2,904	2,935	2,935	2,930	2,930		
G&A	Average number of overnight G&A beds available - adult	3,025	3,025	2,854	2,855	2,855	2,855	2,864	3,060	3,066	3,090	3,093	3,090	3,090		
G&A	Average number of overnight G&A beds occupancy - adult	94.4%	93.4%	95.0%	95.1%	94.7%	95.6%	96.0%	94.7%	94.7%	95.0%	94.9%	94.8%	94.8%		
G&A	Average number of overnight G&A beds occupied - paediatric	125	130	128	126	126	128	130	130	128	127	127	127	127		
G&A	Average number of overnight G&A beds available - paediatric	147	147	147	147	147	147	147	147	147	147	147	147	147		
G&A	Average number of overnight G&A beds occupancy - paediatric	85.0%	88.4%	87.1%	85.7%	85.7%	87.1%	88.4%	88.4%	87.1%	86.4%	86.4%	86.4%	86.4%		
G&A	Average number of overnight G&A beds occupied - adult elective	290	288	279	279	279	281	282	297	298	299	299	298	298		
G&A	Average number of overnight G&A beds occupied - paediatric elective	8	9	9	9	10	9	9	9	9	9	9	9	9		
G&A	Average number of overnight G&A beds occupied - adult non-elective	2,567	2,538	2,432	2,437	2,426	2,447	2,467	2,602	2,606	2,636	2,636	2,632	2,632		
G&A	Average number of overnight G&A beds occupied - paediatric non-electi	117	121	119	117	116	119	121	121	119	118	118	118	118		
LoS	LoS - reducing 21 days LoS and over	683	671	657	658	669	681	669	663	653	652	644	639	639	5% reduction in YoY position	NWL
Discharges	% beds occupied by patients not meeting criteria to reside	12.4%	12.2%	12.4%	12.1%	11.9%	11.8%	11.8%	11.3%	11.4%	11.3%	11.4%	11.5%	11.5%	5% reduction in YoY position	NWL
Cancer	Cancer 63+ days wait	460	460	460	460	460	460	460	460	460	460	460	460	460	Nationally Set	NWL
Cancer	People referred onto a non-specific symptoms pathway	185	220	210	230	185	235	230	240	175	245	230	255	2,640		
Cancer	Cancer 28 day waits (faster diagnosis standard)	74.6%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	FDD standard of 75% by Mar-24	National

Summary – LNWHT

LNWHT - Planned activity / performance as % of 2019-20 baseline		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP - 1st	109.8%	108.6%	108.6%	108.6%	89.4%	89.7%	109.4%	108.6%	110.7%	113.1%	113.0%	113.2%	106.8%	108.5% of 19/20	National
OP	Total OP - FU	103.3%	99.7%	99.5%	102.2%	82.2%	78.0%	100.7%	92.7%	96.8%	92.7%	92.8%	91.3%	94.3%	<=75% of 19/20 by Mar-24	National
OP	Total OP	105.7%	103.1%	103.0%	104.7%	84.9%	82.4%	104.0%	98.5%	102.0%	100.1%	100.3%	99.4%	99.0%		
PIFU	OP Transformation	321	357	392	374	374	374	392	392	672	1,198	1,129	1,061	7,036		
OP	Consultant-led 1st OP	108.8%	108.0%	108.0%	108.0%	87.8%	88.8%	108.4%	108.0%	109.7%	111.7%	111.8%	111.7%	105.8%	108.5% of 19/20	National
OP	Consultant-led 1st OP with proc	112.0%	111.0%	110.0%	110.0%	93.2%	95.1%	110.0%	110.0%	110.0%	110.0%	110.1%	110.5%	107.6%		
OP	Consultant-led FU OP	97.5%	93.6%	93.4%	96.3%	85.2%	80.9%	94.3%	86.9%	90.6%	86.2%	86.3%	84.9%	89.6%	<=75% of 19/20 by Mar-24	National
OP	Consultant-led FU OP with proc	100.0%	100.0%	100.0%	100.0%	82.6%	81.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	108.5% of 19/20	National
OP	OPFU without procedure	92.5%	88.4%	87.7%	90.9%	82.1%	77.3%	89.0%	80.6%	85.2%	79.8%	80.1%	78.6%	84.3%		
Elective	Total elective spells	109.6%	108.9%	108.9%	114.1%	92.8%	94.5%	112.7%	111.2%	110.3%	111.2%	109.3%	110.5%	107.8%	108.5% of 19/20 baseline (113% exit run rate)	National
Elective	Elective day case spells	110.0%	110.0%	110.0%	115.9%	94.2%	94.1%	114.4%	112.6%	111.7%	112.5%	110.5%	111.9%	108.9%		
Elective	Elective ordinary spells	106.6%	100.6%	100.0%	100.1%	82.7%	98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%		
Elective	Elective day case spells - Children under 18 years of age	98.0%	101.6%	99.3%	104.7%	79.3%	79.8%	109.6%	108.0%	112.0%	107.9%	105.8%	105.1%	100.3%		
Elective	Elective ordinary spells - Children under 18 years of age	106.7%	100.0%	97.0%	100.0%	70.3%	83.3%	90.9%	100.0%	95.0%	111.5%	92.3%	100.0%	94.1%		

Total Electives (incl. A&G):	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
	112.3%	100.4%	113.0%	115.1%

Total Electives (incl. A&G) cumulative:	Q1 23/24	Q1-Q2 23/24	Q1-Q3 23/24	Q1-Q4 23/24
	112.3%	106.3%	108.5%	110.1%

A&E	AE All Type <4hr performance	63.9%	65.7%	71.2%	75.0%	71.4%	70.5%	74.9%	73.2%	68.3%	70.6%	75.6%	77.5%	71.5%	>=76% performance	National
A&E	AE Type 1 <4hr performance	45.5%	48.5%	51.0%	54.0%	51.0%	51.0%	54.0%	55.0%	49.0%	52.2%	54.0%	56.0%	51.8%		
A&E	AE Type 2&3 <4hr performance	77.9%	77.9%	85.0%	90.0%	85.0%	85.0%	90.0%	86.6%	81.6%	86.9%	91.7%	93.9%	85.9%		
NEL	Non-elective spells	94.2%	96.1%	97.6%	93.6%	98.6%	97.1%	103.7%	103.5%	105.3%	96.6%	96.1%	94.9%	98.0%	<=100% of 19/20 (0 LoS adjusted baseline for SDEC)	NWL
NEL	Non-elective spells with a length of stay of zero days	99.4%	105.0%	103.8%	101.6%	103.1%	101.0%	102.6%	104.6%	110.2%	94.4%	90.4%	88.0%	100.0%		
NEL	Non-elective spells with a length of stay of 1 or more days	89.6%	88.7%	92.2%	86.9%	94.6%	93.5%	104.8%	102.5%	101.4%	98.6%	101.6%	102.1%	96.3%		

Summary – LNWHT 2

LNWHT - Planned activity / performance as % of 2019-20 baseline		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	5,600	5,211	4,823	4,429	4,141	3,813	3,433	3,053	2,653	2,253	1,873	1,493	1,493	50% reduction by Mar-24 (Baseline = Apr-22)	NWL
RTT	Number of 65+ week RTT waits	1,300	1,210	1,068	978	892	793	651	509	419	329	187	-	-	Zero by Mar-24	National
RTT	RTT waiting list	79,000	79,500	80,000	80,500	80,000	80,000	79,000	78,000	77,000	76,000	75,000	74,000	74,000		
RTT	RTT completed admitted pathways	97.9%	86.8%	75.2%	70.9%	61.7%	96.5%	95.1%	92.3%	100.0%	83.2%	96.3%	104.0%	87.4%	> 22/23	NWL
RTT	RTT completed non-admitted pathways	108.7%	94.5%	86.3%	92.2%	68.0%	74.9%	115.3%	114.1%	104.3%	106.6%	126.8%	134.1%	101.7%		
RTT	New RTT pathways (clock starts)	113.3%	102.2%	97.2%	104.5%	116.4%	112.3%	114.7%	120.1%	126.6%	113.2%	113.0%	116.6%	112.0%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	130.0%	118.2%	112.8%	122.5%	111.8%	109.0%	118.1%	105.5%	110.4%	113.2%	135.8%	159.3%	120.2%	Activity at 120% of 19/20	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	116.8%	110.2%	105.1%	117.0%	115.3%	113.9%	122.3%	111.6%	127.4%	132.3%	137.7%	136.5%	120.3%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	130.3%	108.4%	103.1%	114.3%	125.9%	121.5%	119.3%	101.4%	106.2%	111.5%	146.6%	169.0%	120.3%		
Diagnostics	Diagnostic Tests - Colonoscopy	102.2%	106.1%	92.2%	109.2%	87.6%	83.3%	98.3%	111.6%	119.8%	94.1%	104.5%	103.3%	100.2%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	82.2%	129.5%	67.3%	99.5%	94.6%	88.4%	100.0%	122.2%	104.3%	131.1%	127.7%	96.3%	100.0%		
Diagnostics	Diagnostic Tests - Gastroscopy	96.7%	99.3%	91.6%	100.4%	79.3%	89.5%	105.7%	110.9%	106.5%	123.1%	104.5%	102.8%	100.2%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	114.7%	104.5%	106.1%	114.6%	82.5%	88.3%	128.5%	134.2%	170.0%	140.3%	146.6%	145.5%	120.4%		
ACC	Adult Critical Care Bed occupancy %	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	>= Mar-23	NWL
G&A	Average number of overnight G&A beds occupied - Total	1,001	976	912	911	904	904	904	991	996	1,028	1,028	1,023	1,023	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds available - Total	1,015	1,015	929	930	930	930	939	1,047	1,053	1,077	1,080	1,077	1,077		
G&A	Average number of overnight G&A beds occupancy - Total	98.6%	96.2%	98.2%	98.0%	97.2%	97.2%	96.3%	94.7%	94.6%	95.5%	95.2%	95.0%	95.0%		
G&A	Average number of overnight G&A beds occupied - adult	976	951	887	886	879	879	879	966	971	1,003	1,003	998	998		
G&A	Average number of overnight G&A beds available - adult	988	988	902	903	903	903	912	1,020	1,026	1,050	1,053	1,050	1,050		
G&A	Average number of overnight G&A beds occupancy - adult	98.8%	96.3%	98.3%	98.1%	97.3%	97.3%	96.4%	94.7%	94.6%	95.5%	95.3%	95.0%	95.0%		
G&A	Average number of overnight G&A beds occupied - paediatric	25	25	25	25	25	25	25	25	25	25	25	25	25		
G&A	Average number of overnight G&A beds available - paediatric	27	27	27	27	27	27	27	27	27	27	27	27	27		
G&A	Average number of overnight G&A beds occupancy - paediatric	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%		
G&A	Average number of overnight G&A beds occupied - adult elective	69	68	64	64	64	64	64	71	71	73	73	73	73		
G&A	Average number of overnight G&A beds occupied - paediatric elective	1	1	1	1	1	1	1	1	1	1	1	1	1		
G&A	Average number of overnight G&A beds occupied - adult non-elective	907	883	823	822	815	815	815	895	900	930	930	925	925		
G&A	Average number of overnight G&A beds occupied - paediatric non-electiv	24	24	24	24	24	24	24	24	24	24	24	24	24		
LoS	LoS - reducing 21 days LoS and over	220	219	218	217	216	215	214	213	212	211	210	209	209	5% reduction in YoY position	NWL
Discharges	% beds occupied by patients not meeting criteria to reside	9.2%	9.5%	10.0%	10.0%	10.0%	10.0%	9.9%	9.0%	8.9%	8.6%	8.5%	8.5%	8.5%	5% reduction in YoY position	NWL
Cancer	Cancer 63+ days wait	150	150	150	150	150	150	150	150	150	150	150	150	150	Nationally Set	NWL
Cancer	People referred onto a non-specific symptoms pathway	45	55	55	60	50	60	65	60	50	65	65	70	700		
Cancer	Cancer 28 day waits (faster diagnosis standard)	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	FDD standard of 75% by Mar-24	National

Summary – THH 1

THH - Planned activity / performance as % of 2019-20 baseline		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP - 1st	104.5%	104.5%	104.5%	104.5%	104.5%	104.5%	104.5%	65.3%	94.1%	104.5%	104.5%	104.5%	100.2%	104.5% of 19/20	National
OP	Total OP - FU	93.1%	93.1%	93.1%	93.1%	93.1%	93.1%	93.1%	58.2%	83.8%	93.1%	93.1%	93.1%	89.3%	<=75% of 19/20 by Mar-24	National
OP	Total OP	97.0%	97.2%	97.3%	97.2%	97.0%	97.3%	97.1%	60.7%	87.3%	97.1%	97.0%	97.0%	93.1%		
PIFU	OP Transformation	416	506	590	592	606	667	707	481	585	823	782	772	7,527		
OP	Consultant-led 1st OP	110.2%	110.2%	110.2%	110.2%	110.2%	110.2%	110.2%	68.9%	99.2%	110.2%	110.2%	110.2%	105.6%	104.5% of 19/20	National
OP	Consultant-led 1st OP with proc	98.9%	98.9%	98.9%	98.9%	98.9%	98.8%	98.9%	61.8%	89.0%	98.9%	98.9%	99.0%	94.5%		
OP	Consultant-led FU OP	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	58.1%	83.7%	93.0%	93.0%	93.0%	89.0%	<=75% of 19/20 by Mar-24	National
OP	Consultant-led FU OP with proc	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%	63.2%	90.9%	101.0%	101.0%	101.1%	96.7%	104.5% of 19/20	National
OP	OPFU without procedure	92.7%	92.7%	92.7%	92.7%	92.7%	92.7%	92.7%	57.9%	83.4%	92.7%	92.7%	92.7%	88.8%		
Elective	Total elective spells	104.4%	104.4%	104.4%	104.3%	104.4%	104.3%	104.3%	65.2%	94.0%	104.3%	104.4%	104.3%	100.3%	104.5% of 19/20 baseline (113% exit run rate)	National
Elective	Elective day case spells	104.1%	104.1%	104.1%	104.1%	104.1%	104.1%	104.1%	65.1%	93.7%	104.1%	104.1%	104.1%	100.1%		
Elective	Elective ordinary spells	106.8%	106.6%	106.7%	106.6%	106.7%	106.5%	106.6%	66.7%	95.8%	106.6%	106.9%	106.4%	102.2%		
Elective	Elective day case spells - Children under 18 years of age	84.7%	84.3%	84.4%	84.4%	85.0%	84.5%	84.9%	52.8%	77.2%	84.8%	84.9%	85.1%	81.4%		
Elective	Elective ordinary spells - Children under 18 years of age	133.3%	120.0%	150.0%	150.0%	125.0%	133.3%	133.3%	100.0%	116.7%	120.0%	133.3%		126.3%		

	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Total Electives (incl. A&G):	113.8%	113.9%	97.0%	114.5%
Total Electives (incl. A&G) cumulative:	Q1 23/24	Q1-Q2 23/24	Q1-Q3 23/24	Q1-Q4 23/24
	113.8%	113.9%	108.3%	109.8%

A&E	AE All Type <4hr performance	78.7%	79.6%	78.7%	78.8%	81.5%	81.6%	80.1%	77.7%	74.9%	78.7%	79.7%	79.6%	79.1%	>=76% performance	National
A&E	AE Type 1 <4hr performance	53.9%	54.9%	55.0%	55.0%	60.0%	60.0%	60.0%	55.9%	50.9%	56.0%	53.9%	53.9%	55.7%		
A&E	AE Type 2&3 <4hr performance	99.2%	99.2%	97.5%	97.5%	99.0%	99.0%	97.5%	98.1%	97.7%	99.2%	99.2%	99.2%	98.5%		
NEL	Non-elective spells	87.8%	88.1%	87.9%	87.7%	87.5%	87.8%	87.9%	87.8%	87.8%	87.8%	88.0%	88.1%	87.8%	<=100% of 19/20 (0 LoS adjusted baseline for SDEC)	NWL
NEL	Non-elective spells with a length of stay of zero days	91.8%	91.9%	91.9%	91.9%	91.9%	91.9%	91.9%	91.8%	91.8%	91.8%	91.9%	91.8%	91.8%		
NEL	Non-elective spells with a length of stay of 1 or more days	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.6%	85.7%	85.7%	85.7%	85.7%	85.7%		

Summary – THH 2

THH - Planned activity / performance as % of 2019-20 baseline		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	2,532	2,392	2,256	2,123	1,993	1,866	1,742	1,702	1,663	1,543	1,426	1,308	1,308	50% reduction by Mar-24 (Baseline = Apr-22)	NWL
RTT	Number of 65+ week RTT waits	742	660	578	496	414	332	250	250	250	168	86	-	-	Zero by Mar-24	National
RTT	RTT waiting list	32,359	32,716	32,973	32,879	32,894	32,773	32,806	33,151	33,151	33,056	32,268	31,576	31,576		
RTT	RTT completed admitted pathways	110.2%	110.1%	110.1%	110.1%	110.1%	110.2%	110.2%	68.8%	99.2%	110.1%	110.1%	110.1%	105.5%	> 22/23	NWL
RTT	RTT completed non-admitted pathways	111.0%	111.0%	111.0%	111.0%	111.0%	111.0%	111.0%	69.4%	99.9%	111.0%	111.0%	111.4%	105.5%		
RTT	New RTT pathways (clock starts)	87.0%	87.0%	87.0%	87.0%	87.0%	87.0%	87.0%	54.4%	78.3%	87.0%	87.0%	86.7%	82.7%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	102.2%	102.2%	102.1%	102.1%	102.2%	99.8%	99.8%	94.8%	94.8%	99.8%	99.8%	99.6%	100.0%	Activity at 120% of 19/20	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	108.5%	107.8%	102.2%	110.5%	111.7%	105.4%	156.9%	148.1%	146.9%	154.8%	159.8%	154.7%	126.5%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	102.2%	102.2%	102.2%	102.2%	102.2%	102.2%	102.2%	97.1%	97.1%	102.2%	102.2%	102.0%	101.3%		
Diagnostics	Diagnostic Tests - Colonoscopy	63.2%	63.8%	64.5%	65.4%	65.9%	66.9%	67.6%	42.6%	62.3%	69.6%	70.3%	71.3%	64.5%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	75.0%	75.9%	77.8%	78.7%	79.2%	80.0%	80.7%	50.6%	73.3%	81.8%	82.5%	83.6%	76.0%		
Diagnostics	Diagnostic Tests - Gastroscopy	82.5%	82.9%	83.9%	84.6%	85.1%	86.1%	86.7%	54.6%	79.3%	88.7%	89.7%	90.5%	82.6%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	107.9%	107.9%	107.9%	107.9%	107.8%	107.8%	107.8%	67.4%	97.1%	107.8%	107.8%	107.9%	103.5%		
ACC	Adult Critical Care Bed occupancy %	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	>= Mar-23	NWL
G&A	Average number of overnight G&A beds occupied - Total	335	334	303	301	297	302	313	333	331	329	329	329	329	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds available - Total	370	370	328	328	328	328	328	358	358	358	358	358	358		
G&A	Average number of overnight G&A beds occupancy - Total	90.5%	90.3%	92.4%	91.8%	90.5%	92.1%	95.4%	93.0%	92.5%	91.9%	91.9%	91.9%	91.9%		
G&A	Average number of overnight G&A beds occupied - adult	319	313	283	283	279	282	291	311	311	310	310	310	310		
G&A	Average number of overnight G&A beds available - adult	346	346	304	304	304	304	304	334	334	334	334	334	334		
G&A	Average number of overnight G&A beds occupancy - adult	92.2%	90.5%	93.1%	93.1%	91.8%	92.8%	95.7%	93.1%	93.1%	92.8%	92.8%	92.8%	92.8%		
G&A	Average number of overnight G&A beds occupied - paediatric	16	21	20	18	18	20	22	22	20	19	19	19	19		
G&A	Average number of overnight G&A beds available - paediatric	24	24	24	24	24	24	24	24	24	24	24	24	24		
G&A	Average number of overnight G&A beds occupancy - paediatric	66.7%	87.5%	83.3%	75.0%	75.0%	83.3%	91.7%	91.7%	83.3%	79.2%	79.2%	79.2%	79.2%		
G&A	Average number of overnight G&A beds occupied - adult elective	39	38	34	34	34	34	35	39	39	38	38	38	38		
G&A	Average number of overnight G&A beds occupied - paediatric elective	1	1	1	1	1	1	1	1	1	1	1	1	1		
G&A	Average number of overnight G&A beds occupied - adult non-elective	280	275	249	249	245	248	256	272	272	272	272	272	272		
G&A	Average number of overnight G&A beds occupied - paediatric non-electi	15	20	19	17	17	19	21	21	19	18	18	18	18		
LoS	LoS - reducing 21 days LoS and over	54	54	54	54	54	54	54	54	54	54	54	54	54	5% reduction in YoY position	NWL
Discharges	% beds occupied by patients not meeting criteria to reside	20.7%	21.1%	23.3%	23.3%	23.7%	23.4%	22.7%	21.2%	21.2%	21.3%	21.3%	21.3%	21.3%	5% reduction in YoY position	NWL
Cancer	Cancer 63+ days wait	60	60	60	60	60	60	60	60	60	60	60	60	60	Nationally Set	NWL
Cancer	People referred onto a non-specific symptoms pathway	-	-	-	-	-	-	-	-	-	-	-	-	-		
Cancer	Cancer 28 day waits (faster diagnosis standard)	72.1%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	FDD standard of 75% by Mar-24	National

Summary – CWFT 1

ChelWest - Planned activity / performance as % of 2019-20 baseline		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP - 1st	109.1%	112.0%	94.5%	100.9%	105.1%	105.4%	99.8%	113.4%	107.1%	97.6%	101.0%	113.4%	104.6%	112.7% of 19/20	National
OP	Total OP - FU	108.1%	107.1%	91.9%	99.1%	102.4%	101.9%	96.8%	106.8%	101.2%	93.3%	97.0%	100.1%	100.3%	<=75% of 19/20 by Mar-24	National
OP	Total OP	108.4%	108.7%	92.8%	99.7%	103.3%	103.0%	97.8%	108.9%	103.1%	94.7%	98.3%	104.2%	101.7%		
PIFU	OP Transformation	2,991	3,346	3,111	3,148	3,173	3,195	3,184	3,353	2,784	3,129	3,072	3,042	37,528		
OP	Consultant-led 1st OP	107.3%	110.4%	92.5%	95.8%	102.8%	100.3%	92.4%	110.9%	103.7%	93.6%	96.4%	106.5%	100.6%	112.7% of 19/20	National
OP	Consultant-led 1st OP with proc	118.1%	121.2%	91.0%	111.9%	114.3%	108.3%	123.0%	176.3%	175.3%	133.7%	141.8%	190.1%	127.0%		
OP	Consultant-led FU OP	103.7%	106.4%	88.7%	95.5%	98.5%	95.3%	86.0%	111.9%	108.2%	98.4%	101.6%	103.4%	99.3%	<=75% of 19/20 by Mar-24	National
OP	Consultant-led FU OP with proc	122.7%	116.1%	98.5%	106.7%	115.2%	112.4%	119.1%	156.2%	166.5%	117.1%	125.8%	114.2%	120.2%	112.7% of 19/20	National
OP	OPFU without procedure	116.0%	115.4%	96.8%	103.8%	108.9%	107.6%	100.5%	111.5%	103.2%	94.9%	96.9%	100.6%	104.3%		
Elective	Total elective spells	119.0%	121.3%	103.2%	112.4%	115.5%	123.3%	111.4%	173.4%	160.7%	146.0%	135.6%	128.3%	126.5%	112.7% of 19/20 baseline (113% exit run rate)	National
Elective	Elective day case spells	120.8%	125.0%	106.3%	115.7%	117.9%	125.9%	114.4%	178.1%	163.1%	154.0%	141.8%	132.6%	130.1%		
Elective	Elective ordinary spells	105.5%	98.8%	83.4%	91.1%	101.1%	106.8%	93.5%	145.1%	146.1%	103.2%	101.2%	102.8%	104.6%		
Elective	Elective day case spells - Children under 18 years of age	8.2%	6.9%	4.7%	4.7%	6.9%	5.7%	5.6%	7.2%	7.2%	5.1%	6.4%	6.0%	6.1%		
Elective	Elective ordinary spells - Children under 18 years of age	5.6%	8.2%	0.8%	6.7%	6.0%	1.0%	0.9%	7.0%	7.9%	2.7%	2.5%	2.5%	4.1%		

Total Electives (incl. A&G):	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
	114.0%	114.2%	124.8%	119.2%
Total Electives (incl. A&G) cumulative:	Q1 23/24	Q1-Q2 23/24	Q1-Q3 23/24	Q1-Q4 23/24
	114.0%	114.1%	117.5%	117.9%

A&E	AE All Type <4hr performance	80.6%	82.5%	82.0%	82.0%	82.0%	80.0%	80.0%	80.8%	80.8%	80.8%	80.9%	80.9%	81.1%	>=76% performance	National
A&E	AE Type 1 <4hr performance	75.6%	78.5%	78.0%	78.1%	78.1%	75.2%	75.1%	75.9%	75.8%	75.8%	76.0%	75.9%	76.5%		
A&E	AE Type 2&3 <4hr performance	90.7%	90.6%	90.0%	90.0%	90.0%	90.0%	90.0%	90.9%	90.9%	90.9%	91.0%	91.0%	90.5%		
NEL	Non-elective spells	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	<=100% of 19/20 (0 LoS adjusted baseline for SDEC)	NWL
NEL	Non-elective spells with a length of stay of zero days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
NEL	Non-elective spells with a length of stay of 1 or more days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

Summary – CWFT 2

ChelWest - Planned activity / performance as % of 2019-20 baseline		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	1,250	1,236	1,194	1,019	933	874	821	764	721	643	599	500	500	50% reduction by Mar-24 (Baseline = Apr-22)	NWL
RTT	Number of 65+ week RTT waits	360	301	276	195	147	135	112	89	65	52	23	-	-	Zero by Mar-24	National
RTT	RTT waiting list	54,255	54,211	54,145	54,001	53,986	53,855	53,791	53,753	53,722	53,644	53,599	53,513	53,513		
RTT	RTT completed admitted pathways	109.6%	110.5%	103.6%	104.0%	139.9%	113.9%	111.4%	117.4%	107.0%	93.5%	97.7%	113.5%	109.7%	> 22/23	NWL
RTT	RTT completed non-admitted pathways	112.7%	112.0%	83.3%	97.5%	91.5%	102.3%	95.3%	113.4%	109.5%	101.4%	86.4%	113.6%	100.8%		
RTT	New RTT pathways (clock starts)	108.3%	106.9%	86.0%	93.4%	95.3%	83.9%	130.8%	125.5%	123.5%	114.2%	88.2%	132.1%	106.5%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	120.0%	119.9%	120.0%	120.0%	120.1%	120.0%	120.1%	120.0%	119.9%	120.0%	120.0%	117.3%	119.8%	Activity at 120% of 19/20	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	120.0%	120.0%	120.0%	120.0%	120.1%	120.0%	120.1%	120.1%	120.0%	120.0%	120.0%	118.1%	119.9%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	120.0%	119.9%	120.0%	120.0%	120.1%	120.0%	120.1%	120.1%	120.0%	120.0%	120.0%	118.9%	119.9%		
Diagnostics	Diagnostic Tests - Colonoscopy	120.1%	120.1%	120.1%	120.0%	120.0%	120.0%	120.2%	119.9%	120.3%	120.1%	120.1%	118.5%	120.0%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	120.6%	119.9%	119.1%	120.3%	119.5%	120.3%	120.2%	120.6%	119.6%	120.3%	120.5%	117.9%	119.9%		
Diagnostics	Diagnostic Tests - Gastroscopy	120.2%	120.1%	120.0%	120.0%	120.0%	120.0%	120.0%	120.0%	119.9%	119.9%	119.9%	119.7%	120.0%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	120.0%	119.8%	120.1%	119.9%	120.1%	120.0%	120.1%	120.1%	120.0%	120.0%	120.0%	118.4%	119.9%		
ACC	Adult Critical Care Bed occupancy %	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	>= Mar-23	NWL
G&A	Average number of overnight G&A beds occupied - Total	668	668	646	652	652	672	684	716	716	716	716	716	716	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds available - Total	723	723	688	688	688	688	688	731	731	731	731	731	731		
G&A	Average number of overnight G&A beds occupancy - Total	92.4%	92.4%	93.9%	94.8%	94.8%	97.7%	99.4%	97.9%	97.9%	97.9%	97.9%	97.9%	97.9%		
G&A	Average number of overnight G&A beds occupied - adult	615	615	594	600	600	620	632	664	664	664	664	664	664		
G&A	Average number of overnight G&A beds available - adult	667	667	632	632	632	632	632	675	675	675	675	675	675		
G&A	Average number of overnight G&A beds occupancy - adult	92.2%	92.2%	94.0%	94.9%	94.9%	98.1%	100.0%	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%		
G&A	Average number of overnight G&A beds occupied - paediatric	53	53	52	52	52	52	52	52	52	52	52	52	52		
G&A	Average number of overnight G&A beds available - paediatric	56	56	56	56	56	56	56	56	56	56	56	56	56		
G&A	Average number of overnight G&A beds occupancy - paediatric	94.6%	94.6%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%		
G&A	Average number of overnight G&A beds occupied - adult elective	40	40	39	39	39	41	41	43	44	44	44	43	43		
G&A	Average number of overnight G&A beds occupied - paediatric elective	2	3	3	3	4	3	3	3	3	3	3	3	3		
G&A	Average number of overnight G&A beds occupied - adult non-elective	575	575	555	561	561	579	591	621	620	620	620	621	621		
G&A	Average number of overnight G&A beds occupied - paediatric non-electi	51	50	49	49	48	49	49	49	49	49	49	49	49		
LoS	LoS - reducing 21 days LoS and over	129	122	116	125	141	154	146	145	136	136	136	136	136	5% reduction in YoY position	NWL
Discharges	% beds occupied by patients not meeting criteria to reside	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5% reduction in YoY position	NWL
Cancer	Cancer 63+ days wait	100	100	100	100	100	100	100	100	100	100	100	100	100	Nationally Set	NWL
Cancer	People referred onto a non-specific symptoms pathway	100	120	110	120	90	120	110	120	80	120	110	120	1,320		
Cancer	Cancer 28 day waits (faster diagnosis standard)	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	FDD standard of 75% by Mar-24	National

Summary – ICHT 1

ICHT - Planned activity / performance as % of 2019-20 baseline		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
OP	Total OP - 1st	129.9%	126.2%	124.9%	130.2%	142.1%	114.1%	114.0%	106.7%	124.0%	110.1%	109.9%	116.2%	119.7%	104.3% of 19/20	National
OP	Total OP - FU	107.1%	108.6%	106.9%	110.3%	116.7%	106.6%	107.3%	104.4%	114.1%	99.6%	104.3%	104.1%	107.3%	<=75% of 19/20 by Mar-24	National
OP	Total OP	113.0%	113.3%	111.7%	115.6%	123.2%	108.8%	109.2%	105.1%	116.9%	102.5%	105.9%	107.4%	110.7%		
PIFU	OP Transformation	200	200	200	200	200	200	200	200	200	200	200	200	2,400		
OP	Consultant-led 1st OP	131.2%	128.3%	125.6%	130.3%	146.4%	110.2%	116.4%	107.8%	128.0%	111.1%	124.5%	131.7%	123.1%	104.3% of 19/20	National
OP	Consultant-led 1st OP with proc	112.7%	100.0%	89.0%	92.1%	105.1%	98.5%	96.6%	85.4%	103.3%	87.5%	104.4%	104.8%	97.3%		
OP	Consultant-led FU OP	107.7%	110.0%	106.6%	110.3%	118.9%	105.8%	108.1%	104.9%	118.0%	101.7%	105.9%	105.6%	108.3%	<=75% of 19/20 by Mar-24	National
OP	Consultant-led FU OP with proc	104.1%	107.6%	98.3%	97.7%	102.5%	103.7%	105.4%	94.5%	110.5%	89.4%	92.6%	93.7%	99.4%	104.3% of 19/20	National
OP	OPFU without procedure	109.3%	111.0%	109.0%	113.6%	122.2%	108.0%	109.4%	107.8%	120.2%	105.7%	111.5%	111.7%	111.4%		
Elective	Total elective spells	110.2%	109.6%	105.1%	108.1%	110.5%	108.1%	104.8%	102.0%	113.8%	103.8%	101.3%	101.3%	106.3%	104.3% of 19/20 baseline (113% exit run rate)	National
Elective	Elective day case spells	112.1%	112.3%	106.9%	108.3%	111.6%	109.5%	105.6%	103.0%	115.1%	103.4%	102.5%	103.3%	107.5%		
Elective	Elective ordinary spells	98.8%	93.3%	94.2%	106.4%	102.9%	99.5%	99.6%	95.4%	105.6%	106.1%	93.9%	89.6%	98.5%		
Elective	Elective day case spells - Children under 18 years of age	94.5%	103.2%	97.9%	112.2%	106.9%	102.1%	96.2%	105.6%	99.4%	97.4%	109.2%	110.8%	102.7%		
Elective	Elective ordinary spells - Children under 18 years of age	82.2%	93.9%	87.2%	84.3%	124.4%	99.0%	108.5%	91.9%	101.1%	89.5%	111.5%	108.2%	97.2%		

	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Total Electives (incl. A&G):	122.4%	122.8%	114.8%	110.8%
Total Electives (incl. A&G) cumulative:	Q1 23/24	Q1-Q2 23/24	Q1-Q3 23/24	Q1-Q4 23/24
	122.4%	122.6%	119.8%	117.4%

A&E	AE All Type <4hr performance	68.0%	69.6%	70.9%	71.5%	72.8%	73.5%	74.1%	73.8%	73.4%	75.1%	75.7%	76.4%	72.9%	>=76% performance	National
A&E	AE Type 1 <4hr performance	56.7%	58.1%	59.9%	61.4%	69.9%	64.8%	65.6%	63.9%	63.5%	66.6%	67.4%	68.3%	63.8%		
A&E	AE Type 2&3 <4hr performance	94.7%	95.5%	96.6%	94.5%	88.7%	93.8%	93.9%	96.7%	97.1%	96.2%	96.3%	96.5%	95.4%		
NEL	Non-elective spells	97.7%	97.9%	97.9%	97.8%	97.9%	98.0%	97.9%	97.9%	97.9%	97.9%	97.9%	97.8%	97.9%	<=100% of 19/20 (0 LoS adjusted baseline for SDEC)	NWL
NEL	Non-elective spells with a length of stay of zero days	97.7%	97.8%	97.9%	97.8%	97.9%	97.9%	97.9%	97.9%	97.9%	97.9%	97.9%	97.8%	97.9%		
NEL	Non-elective spells with a length of stay of 1 or more days	97.7%	97.9%	97.9%	97.8%	97.9%	98.0%	97.9%	97.9%	97.9%	97.9%	97.9%	97.8%	97.9%		

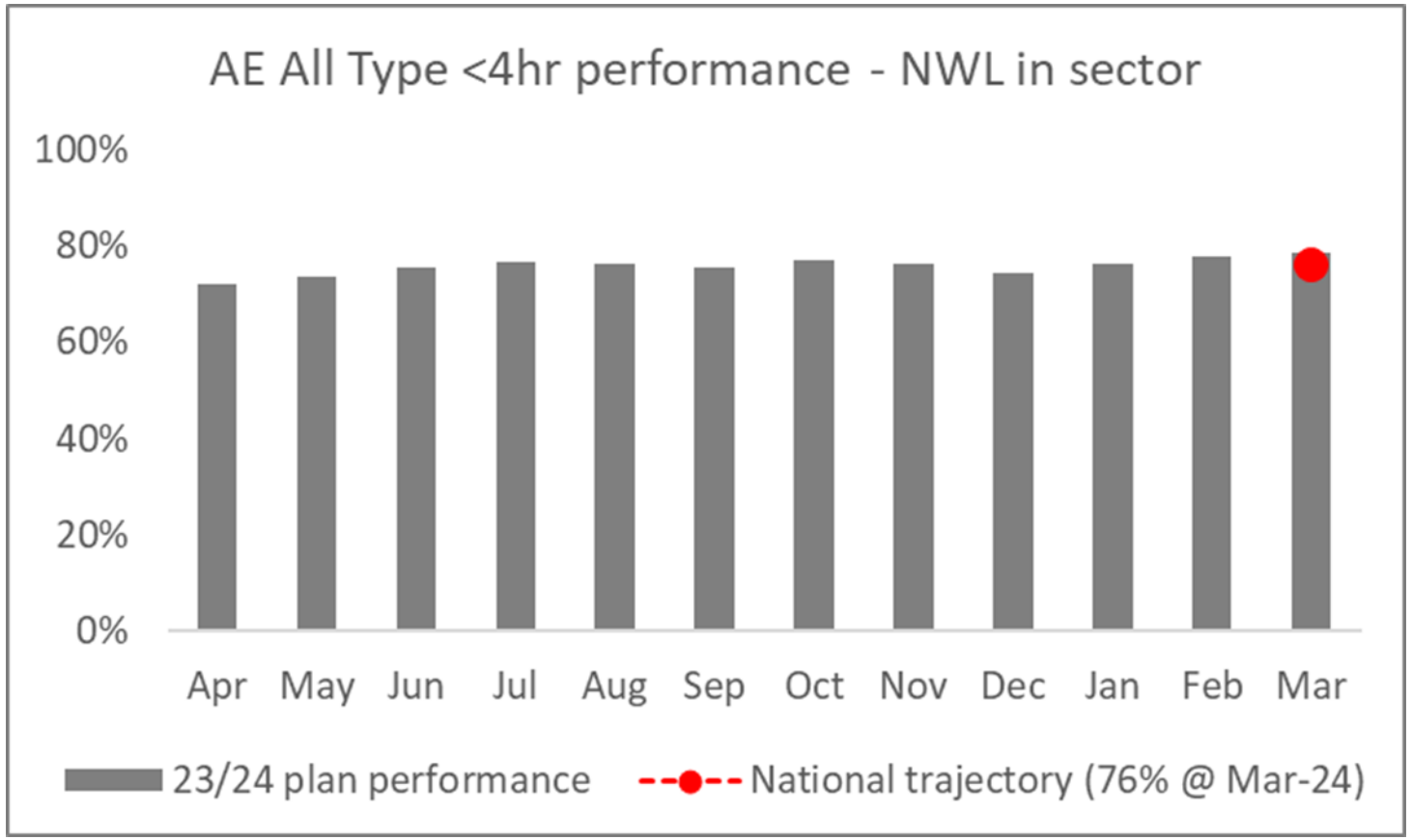
Summary – ICHT 2

ICHT - Planned activity / performance as % of 2019-20 baseline		2023-24														
POD	Measure	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total	Ambition	Ambition Source
RTT	Number of 52+ week RTT waits	3,118	3,026	2,932	2,884	2,835	2,822	2,784	2,653	2,666	2,632	2,574	2,511	2,511	50% reduction by Mar-24 (Baseline = Apr-22)	NWL
RTT	Number of 65+ week RTT waits	917	815	755	677	620	531	459	370	322	213	96	-	-	Zero by Mar-24	National
RTT	RTT waiting list	98,008	97,998	97,948	97,898	97,848	97,748	97,628	97,508	97,448	97,348	97,228	97,078	97,078		
RTT	RTT completed admitted pathways	169.8%	164.2%	138.3%	162.8%	175.4%	160.8%	156.1%	156.8%	149.9%	146.3%	138.1%	172.1%	157.0%	> 22/23	NWL
RTT	RTT completed non-admitted pathways	123.0%	127.2%	100.8%	109.1%	115.1%	118.2%	118.5%	123.6%	135.3%	100.7%	109.4%	123.9%	116.4%		
RTT	New RTT pathways (clock starts)	111.9%	105.8%	100.4%	102.9%	111.1%	110.8%	143.4%	114.8%	122.0%	105.5%	104.6%	122.8%	112.1%		
Diagnostics	Diagnostic Tests - Magnetic Resonance Imaging	130.2%	125.2%	112.3%	133.3%	130.6%	129.8%	131.7%	123.7%	131.6%	129.9%	123.6%	122.6%	126.7%	Activity at 120% of 19/20	NWL
Diagnostics	Diagnostic Tests - Computed Tomography	148.2%	143.8%	124.2%	147.4%	126.9%	131.5%	139.2%	127.6%	131.1%	120.9%	124.1%	133.8%	132.9%		
Diagnostics	Diagnostic Tests - Non-Obstetric Ultrasound	139.0%	126.9%	108.1%	121.4%	117.4%	143.2%	130.4%	131.5%	128.8%	131.0%	120.4%	117.4%	126.1%		
Diagnostics	Diagnostic Tests - Colonoscopy	139.2%	132.4%	111.7%	124.5%	118.2%	126.1%	113.3%	101.1%	131.8%	115.6%	91.3%	90.1%	113.8%		
Diagnostics	Diagnostic Tests - Flexi Sigmoidoscopy	89.3%	89.7%	70.4%	121.4%	119.2%	105.4%	134.9%	73.0%	91.8%	78.1%	65.1%	69.1%	87.4%		
Diagnostics	Diagnostic Tests - Gastroscopy	105.0%	111.1%	106.2%	117.3%	120.3%	114.0%	99.8%	94.9%	108.7%	95.7%	87.9%	86.6%	102.8%		
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	82.0%	78.0%	65.7%	77.0%	79.3%	80.7%	82.1%	78.9%	80.5%	128.9%	69.5%	69.0%	79.0%		
ACC	Adult Critical Care Bed occupancy %	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	>= Mar-23	NWL
G&A	Average number of overnight G&A beds occupied - Total	978	978	978	978	978	978	978	989	989	989	989	989	989	<=92% occupancy rate	National
G&A	Average number of overnight G&A beds available - Total	1,064	1,064	1,056	1,056	1,056	1,056	1,056	1,071	1,071	1,071	1,071	1,071	1,071		
G&A	Average number of overnight G&A beds occupancy - Total	91.9%	91.9%	92.6%	92.6%	92.6%	92.6%	92.6%	92.3%	92.3%	92.3%	92.3%	92.3%	92.3%		
G&A	Average number of overnight G&A beds occupied - adult	947	947	947	947	947	947	947	958	958	958	958	958	958		
G&A	Average number of overnight G&A beds available - adult	1,024	1,024	1,016	1,016	1,016	1,016	1,016	1,031	1,031	1,031	1,031	1,031	1,031		
G&A	Average number of overnight G&A beds occupancy - adult	92.5%	92.5%	93.2%	93.2%	93.2%	93.2%	93.2%	92.9%	92.9%	92.9%	92.9%	92.9%	92.9%		
G&A	Average number of overnight G&A beds occupied - paediatric	31	31	31	31	31	31	31	31	31	31	31	31	31		
G&A	Average number of overnight G&A beds available - paediatric	40	40	40	40	40	40	40	40	40	40	40	40	40		
G&A	Average number of overnight G&A beds occupancy - paediatric	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%	77.5%		
G&A	Average number of overnight G&A beds occupied - adult elective	142	142	142	142	142	142	142	144	144	144	144	144	144		
G&A	Average number of overnight G&A beds occupied - paediatric elective	4	4	4	4	4	4	4	4	4	4	4	4	4		
G&A	Average number of overnight G&A beds occupied - adult non-elective	805	805	805	805	805	805	805	814	814	814	814	814	814		
G&A	Average number of overnight G&A beds occupied - paediatric non-electiv	27	27	27	27	27	27	27	27	27	27	27	27	27		
LoS	LoS - reducing 21 days LoS and over	280	276	269	262	258	258	255	251	251	251	244	240	240	5% reduction in YoY position	NWL
Discharges	% beds occupied by patients not meeting criteria to reside	20.8%	20.0%	19.2%	18.4%	17.6%	17.6%	18.1%	18.2%	18.6%	18.9%	19.3%	19.3%	19.3%	5% reduction in YoY position	NWL
Cancer	Cancer 63+ days wait	150	150	150	150	150	150	150	150	150	150	150	150	150	Nationally Set	NWL
Cancer	People referred onto a non-specific symptoms pathway	40	45	45	50	45	55	55	60	45	60	55	65	620		
Cancer	Cancer 28 day waits (faster diagnosis standard)	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	FDD standard of 75% by Mar-24	National

NWL Advice and Guidance (A&G)

			Pre/Post Ratio Actuals	Pre/Post Ratio Desired	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
LNW	E.M.33	Number of requests for specialist advice, including advice and guidance (A&G) or equivalent via other triage			2,484	2,760	3,036	2,898	2,898	2,898	3,036	3,036	2,484	3,036	2,898	2,760
	E.M.33a	Number of pathways avoided through pre-referral specialist advice	40%	30%	1,093	1,214	1,336	1,275	1,275	1,275	1,336	1,336	1,093	1,336	1,275	1,214
	E.M.33a	Number of requests for pre referral specialist advice (including Advice & Guidance models)			1,987	2,208	2,429	2,318	2,318	2,318	2,429	2,429	1,987	2,429	2,318	2,208
	E.M.33a	Pre referral diversion rate			55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%
	E.M.33b	Number of pathways avoided through post-referral specialist advice	60%	70%	273	304	334	319	319	319	334	334	273	334	319	304
	E.M.33b	Number of requests for post referral specialist advice (including referral triage models)			497	552	607	580	580	580	607	607	497	607	580	552
	E.M.33b	Post referral diversion rate			55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%
THH	E.M.33	Number of requests for specialist advice, including advice and guidance (A&G) or equivalent via other triage			6,034	6,706	7,376	7,040	7,376	7,040	7,376	7,376	6,370	7,376	7,040	6,706
	E.M.33a	Number of pathways avoided through pre-referral specialist advice	47%	50%	1,116	1,241	1,365	1,302	1,365	1,302	1,365	1,365	1,178	1,365	1,302	1,241
	E.M.33a	Number of requests for pre referral specialist advice (including Advice & Guidance models)			3,017	3,353	3,688	3,520	3,688	3,520	3,688	3,688	3,185	3,688	3,520	3,353
	E.M.33a	Pre referral diversion rate			37%	37%	37%	37%	37%	37%	37%	37%	37%	37%	37%	37%
	E.M.33b	Number of pathways avoided through post-referral specialist advice	53%	50%	513	570	627	598	627	598	627	627	541	627	598	570
	E.M.33b	Number of requests for post referral specialist advice (including referral triage models)			3,017	3,353	3,688	3,520	3,688	3,520	3,688	3,688	3,185	3,688	3,520	3,353
	E.M.33b	Post referral diversion rate			17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%
	E.M.33	Number of requests for specialist advice, including advice and guidance (A&G) or equivalent via other triage			7,132	7,925	8,717	8,320	8,717	8,320	8,717	8,717	7,528	8,717	8,320	7,925
	E.M.33a	Number of pathways avoided through pre-referral specialist advice	9%	15%	514	571	628	599	628	599	628	628	542	628	599	571
	E.M.33a	Number of requests for pre referral specialist advice (including Advice & Guidance models)			1,070	1,189	1,308	1,248	1,308	1,248	1,308	1,308	1,129	1,308	1,248	1,189
	E.M.33a	Pre referral diversion rate			48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%
	E.M.33b	Number of pathways avoided through post-referral specialist advice	91%	85%	1,273	1,415	1,556	1,485	1,556	1,485	1,556	1,556	1,344	1,556	1,485	1,415
	E.M.33b	Number of requests for post referral specialist advice (including referral triage models)			6,062	6,736	7,409	7,072	7,409	7,072	7,409	7,409	6,399	7,409	7,072	6,736
	E.M.33b	Post referral diversion rate			21%	21%	21%	21%	21%	21%	21%	21%	21%	21%	21%	21%
ICHT	E.M.33	Number of requests for specialist advice, including advice and guidance (A&G) or equivalent via other triage			9,589	10,655	11,720	11,188	11,720	11,188	11,720	11,720	10,122	11,720	11,188	10,655
	E.M.33a	Number of pathways avoided through pre-referral specialist advice	9%	15%	715	795	874	835	874	835	874	874	755	874	835	795
	E.M.33a	Number of requests for pre referral specialist advice (including Advice & Guidance models)			1,438	1,598	1,758	1,678	1,758	1,678	1,758	1,758	1,518	1,758	1,678	1,598
	E.M.33a	Pre referral diversion rate			50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
	E.M.33b	Number of pathways avoided through post-referral specialist advice	91%	85%	1,399	1,555	1,710	1,632	1,710	1,632	1,710	1,710	1,477	1,710	1,632	1,555
	E.M.33b	Number of requests for post referral specialist advice (including referral triage models)			8,151	9,057	9,962	9,509	9,962	9,509	9,962	9,962	8,604	9,962	9,509	9,057
	E.M.33b	Post referral diversion rate			17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%

A&E – NWL Provider charts



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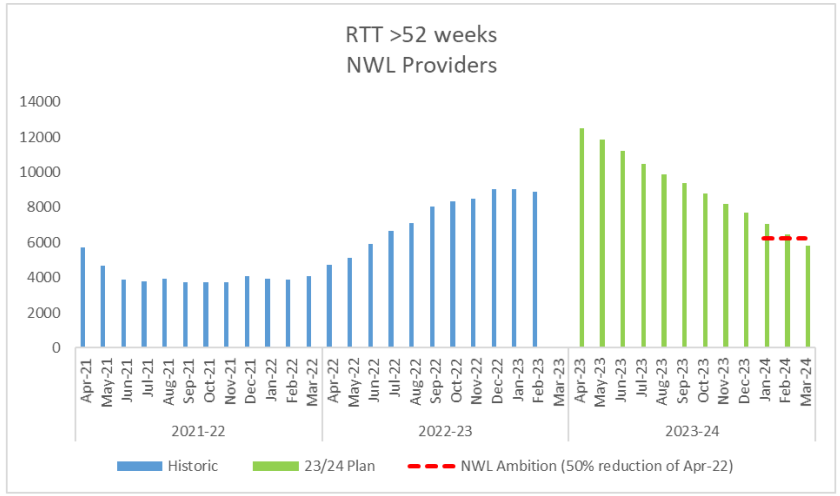
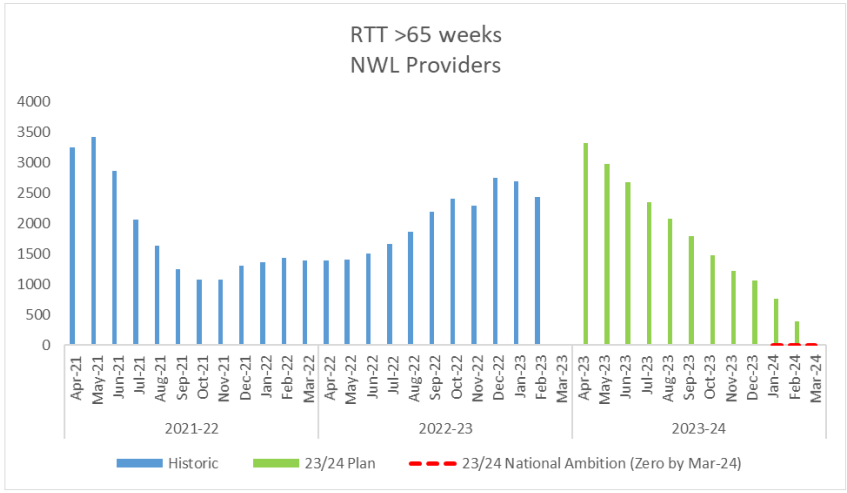
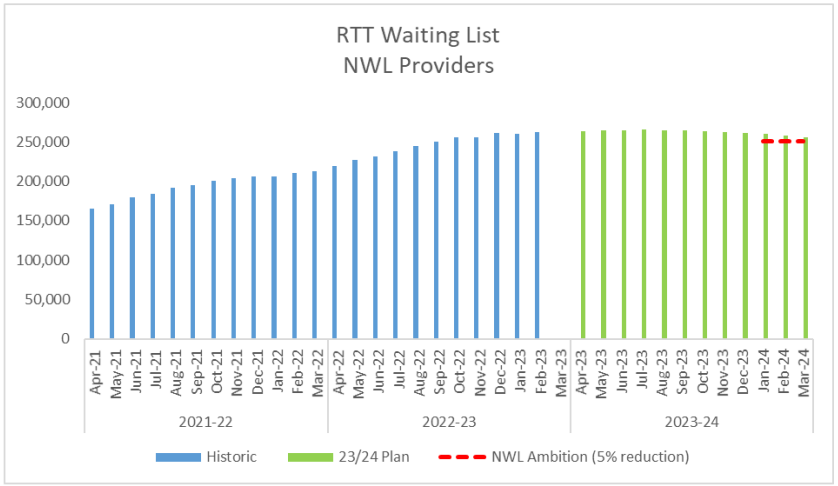
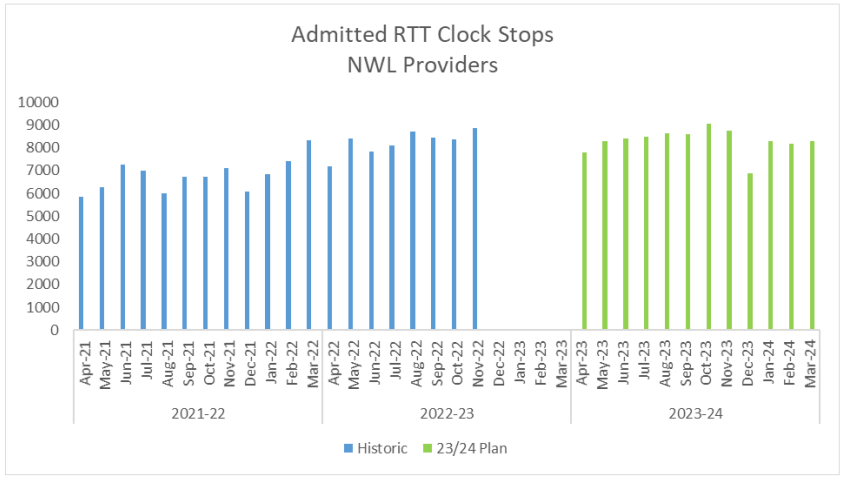
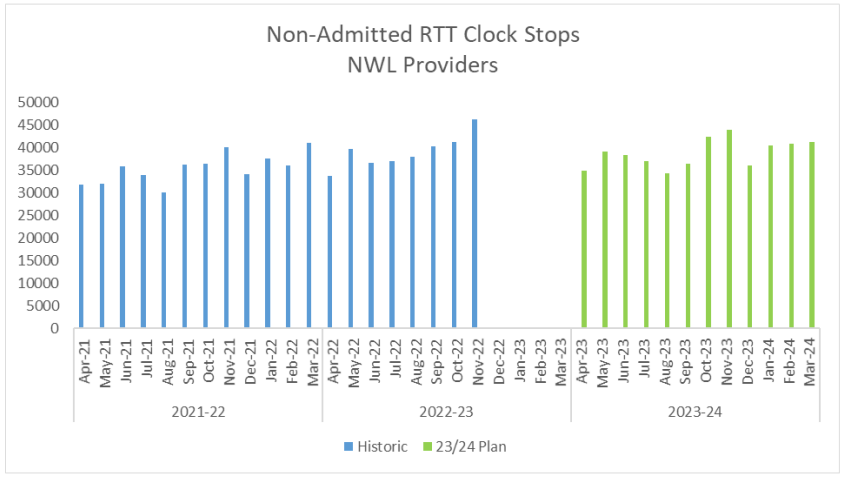
RTT – NWL Provider Summary

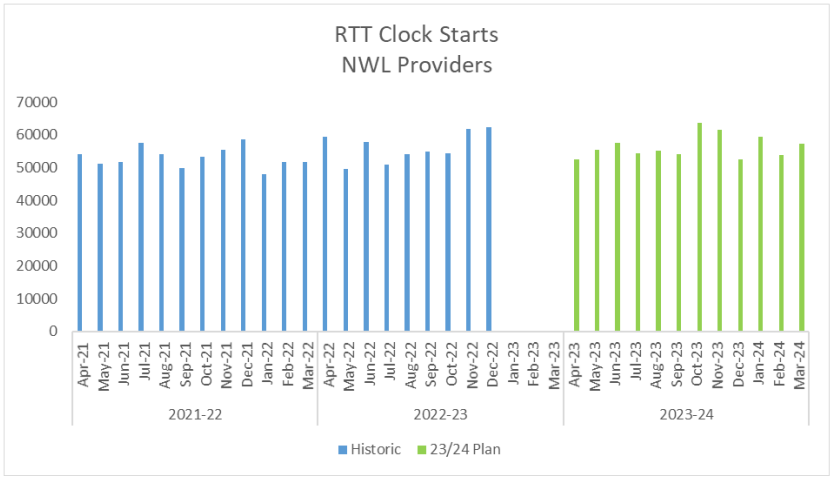












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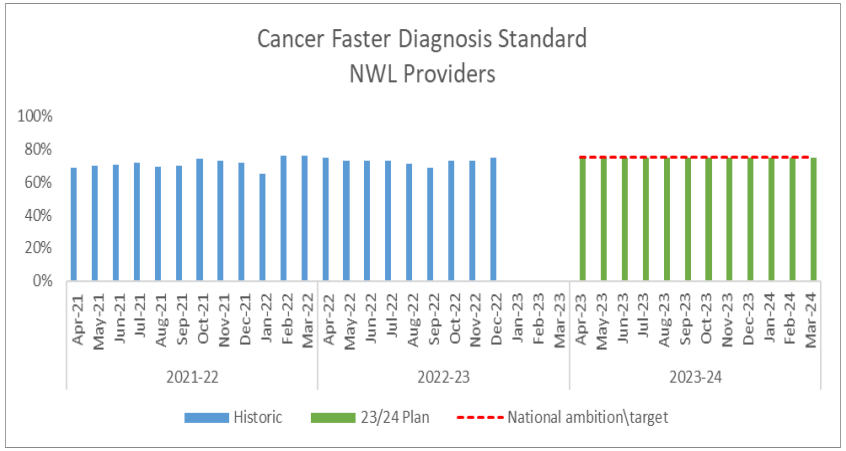
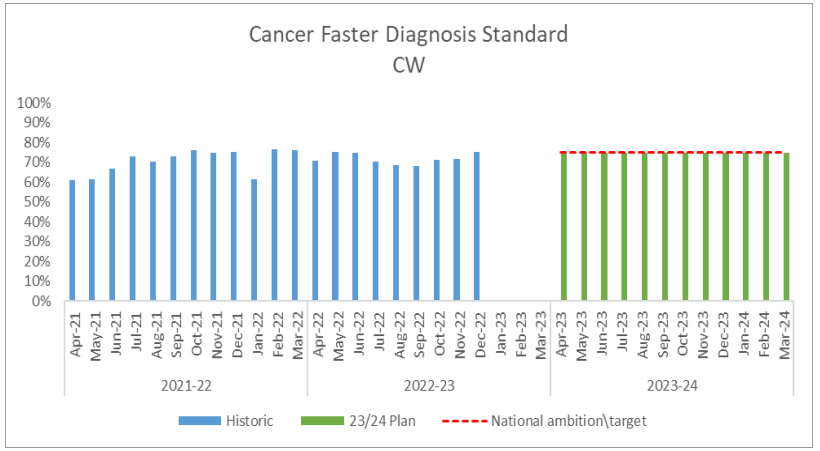
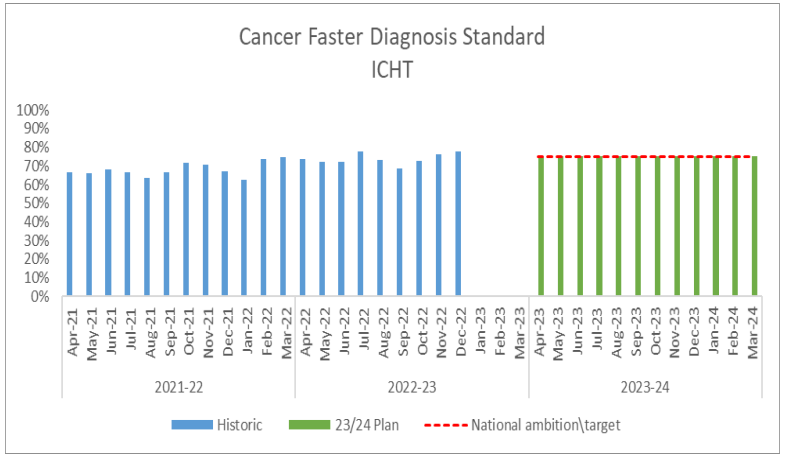
Cancer – Faster Diagnosis (FDS)

Target Performance – The national ambition is to meet the cancer FDS standard of 75% by march 2024

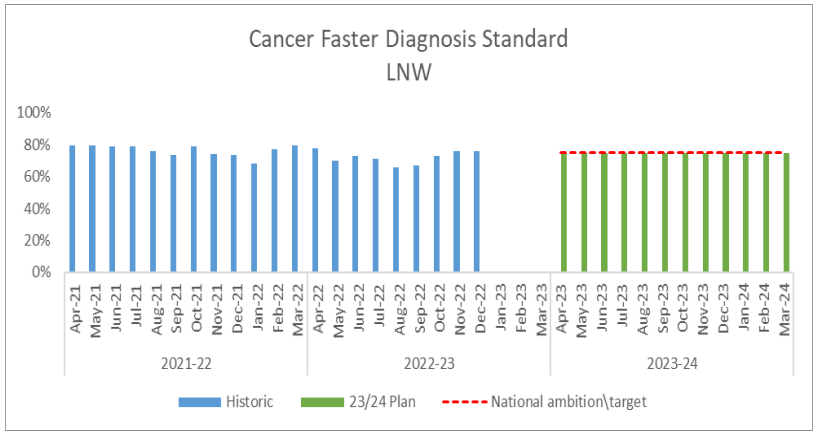


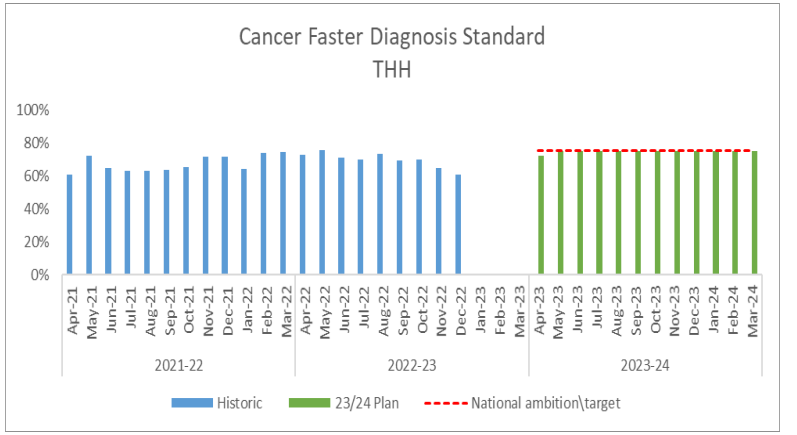




Summary

All NWL providers plan to meet the national ambition of 75% through 2023/24

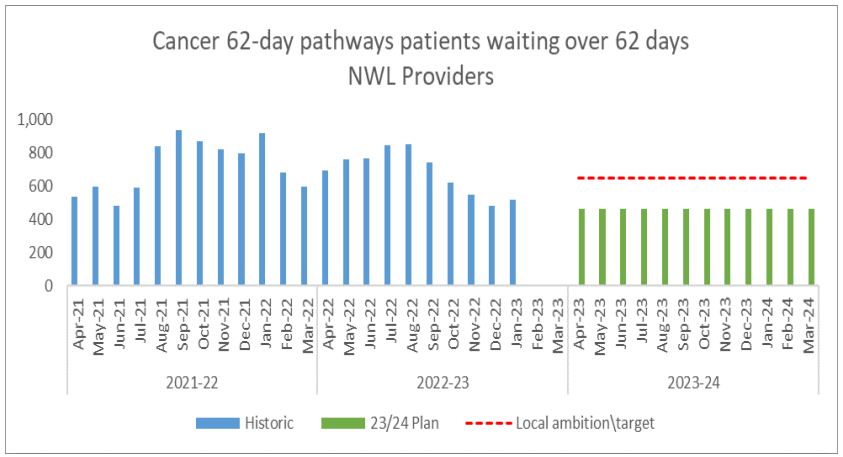


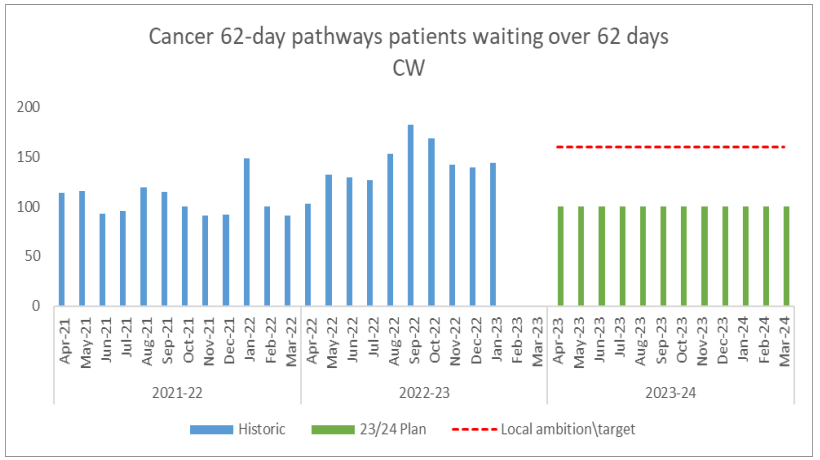


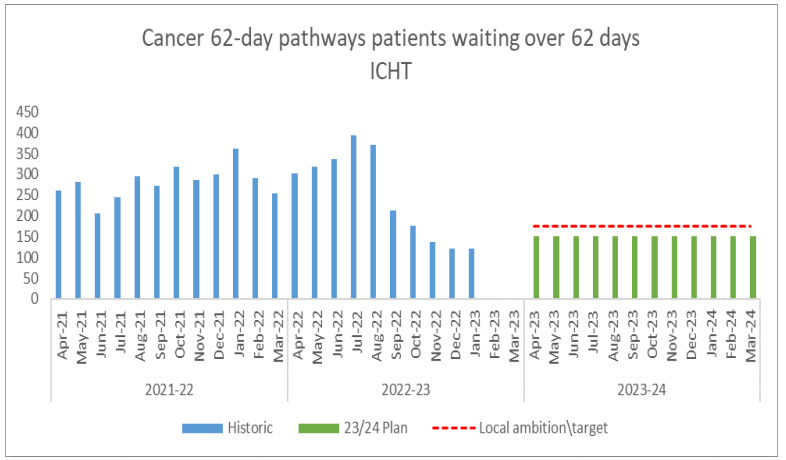
NHS
North West London
Acute Provider Collaborative

Cancer – Patients waiting over 62 days

Target Performance – The national ambition is to continue to reduce the backlog. The local ambition is 5% reduction in backlog size

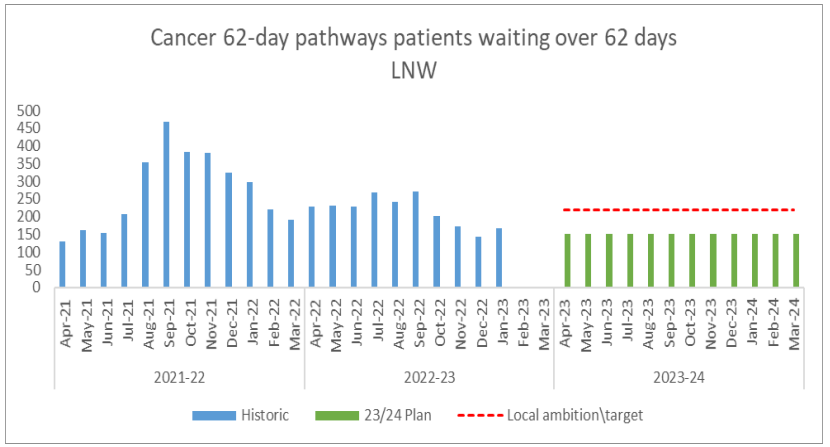


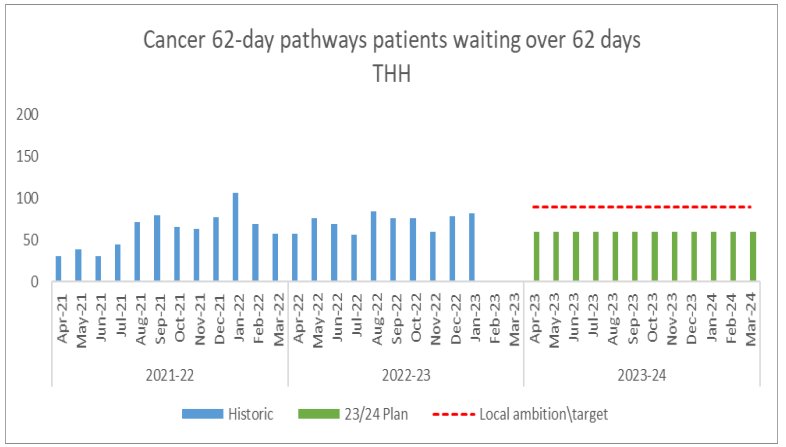




Summary

The NWL planned backlog size at April 2023 is 485, this improves to 460 by March 2024, achieving the ambition to reduce backlog size

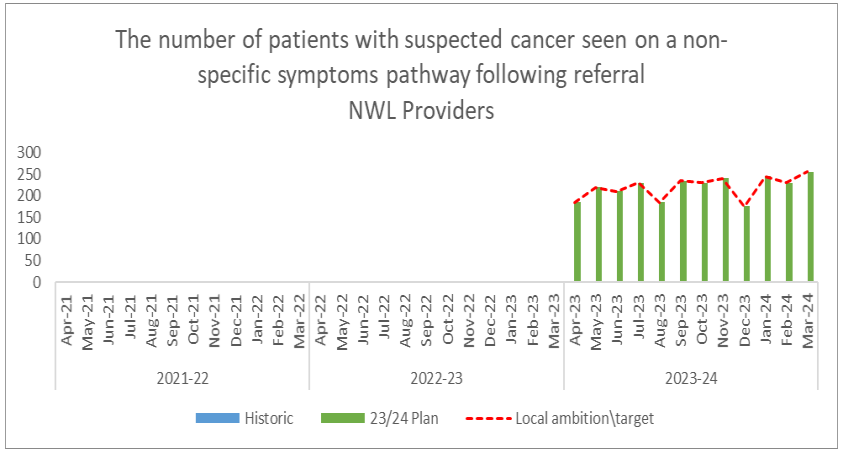


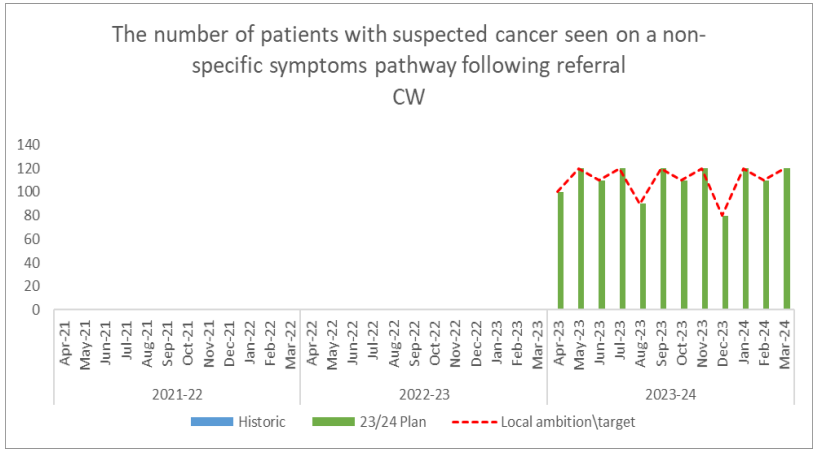


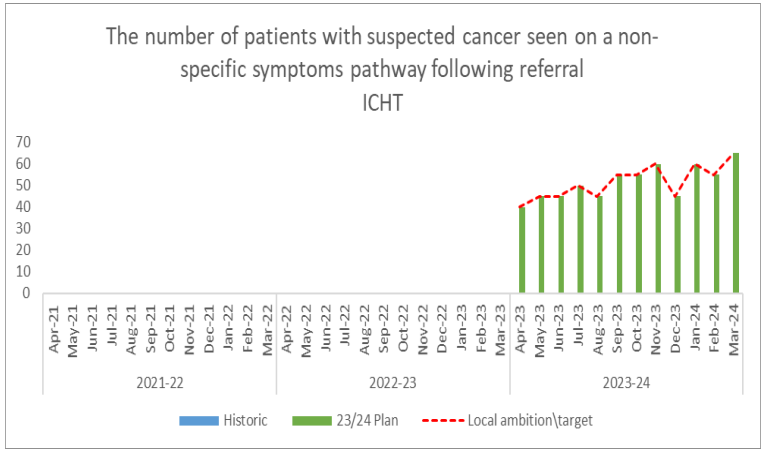
NHS
North West London
Acute Provider Collaborative

Cancer – Number of suspected cancer seen on a non-symptom specific pathway

Target Performance – Local ambition is 5% of all two week wait (2WW) referrals





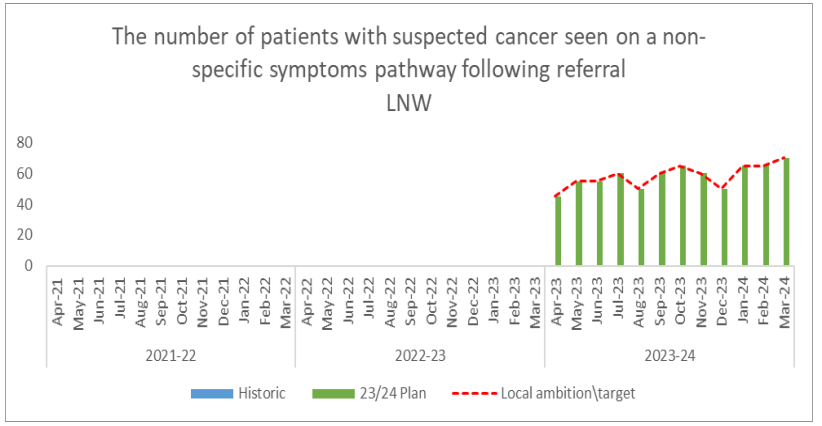


Summary

There is no NSS in THH. THH are not running this service but CW are providing this for Hillingdon borough residents.

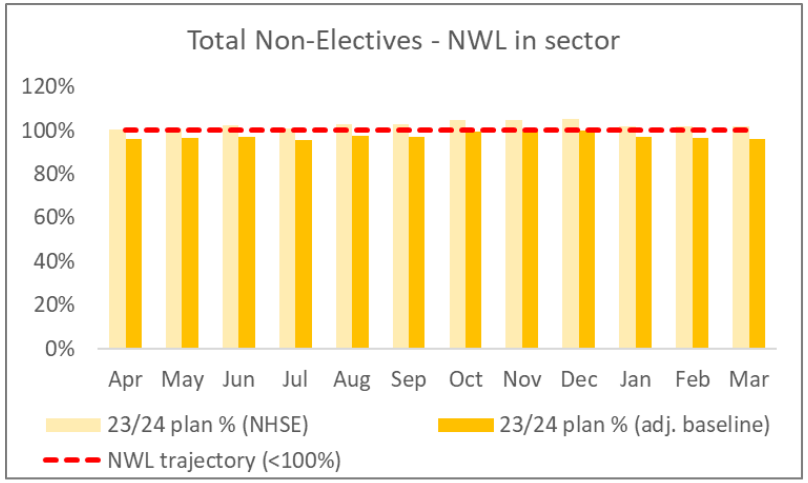
2,640 patients to be seen on NSS are planned for NWL for 2023/2024.

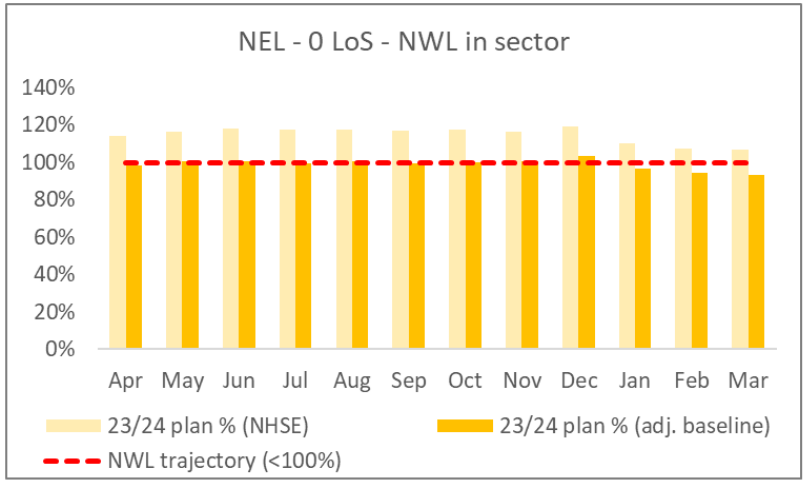
This is a continuing growing service and that there is no expectation that this trajectory will be met in 2023/24.

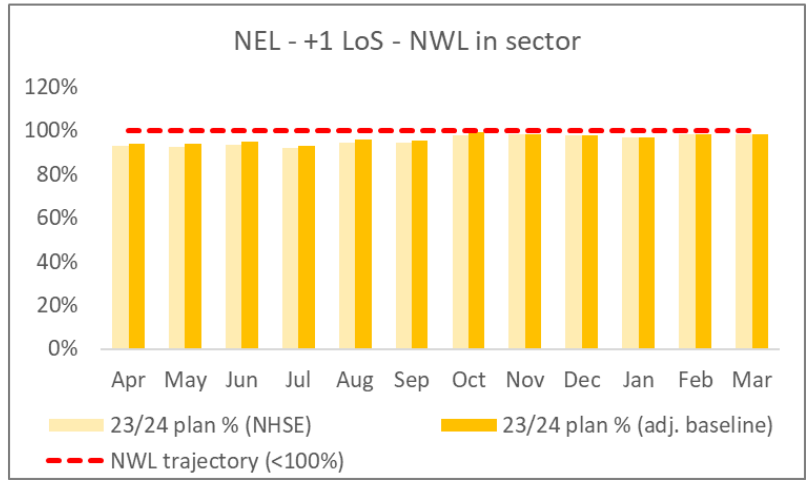


NHS
North West London
Acute Provider Collaborative

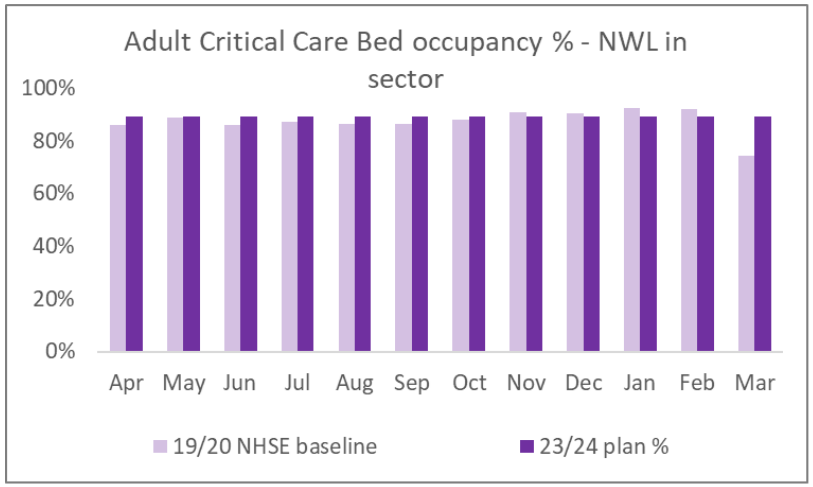
Non-Electives – NWL Provider charts

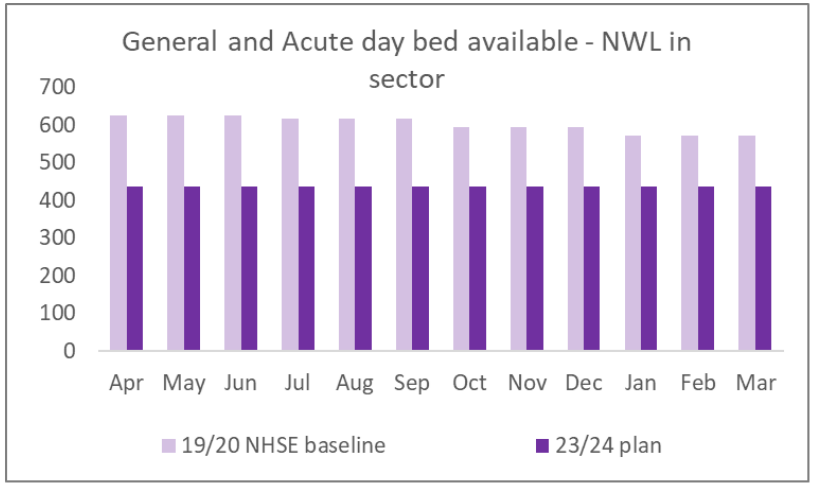


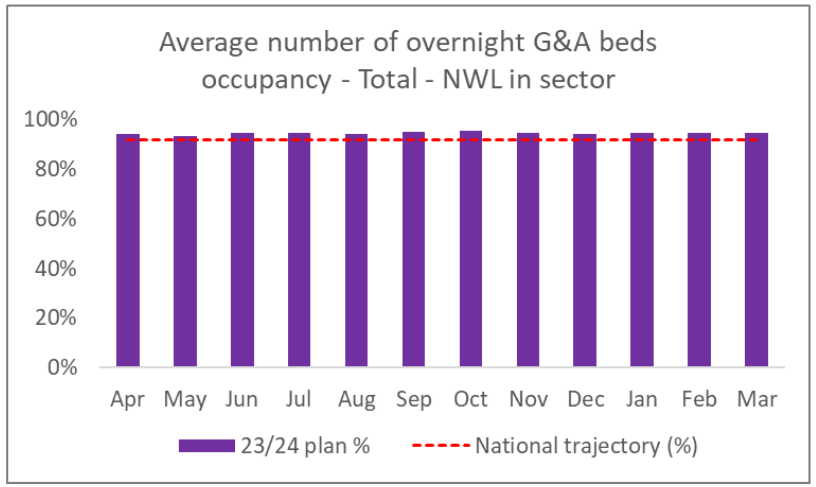


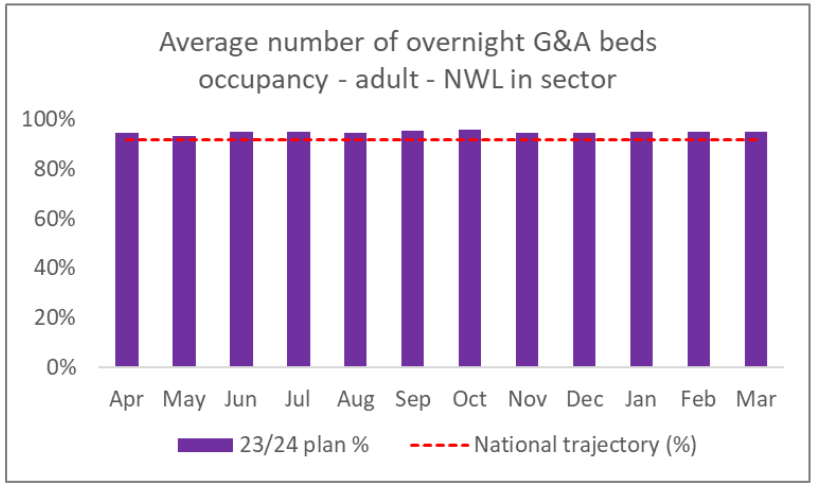


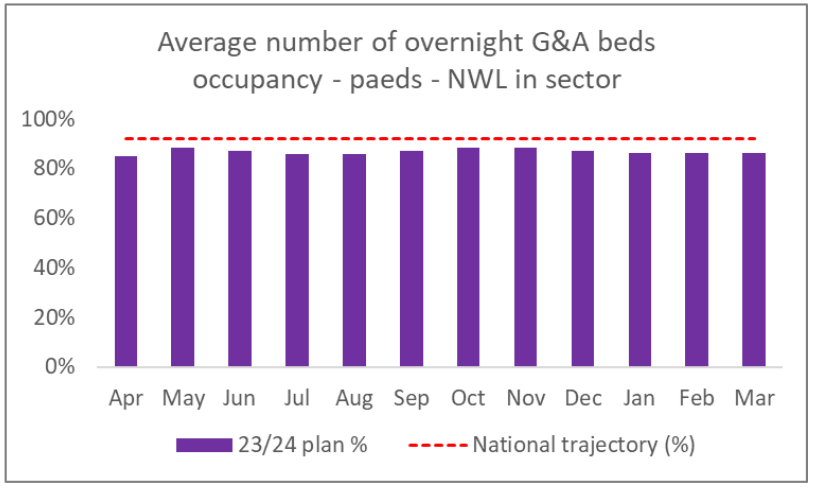
Beds – NWL Provider charts





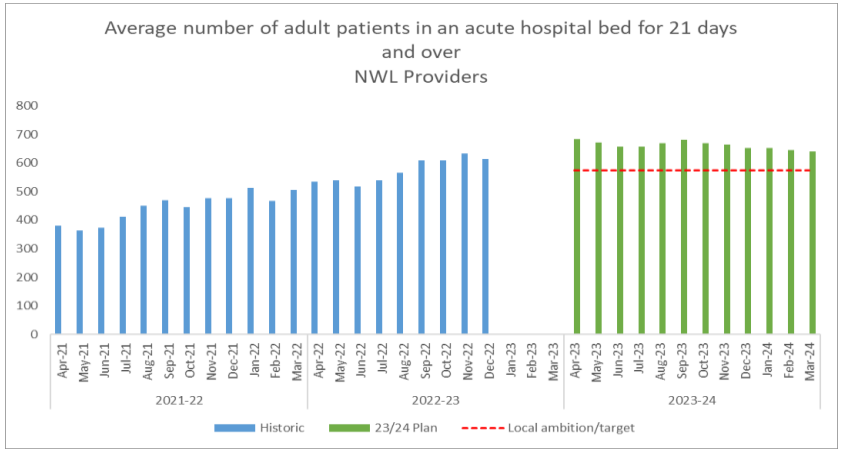


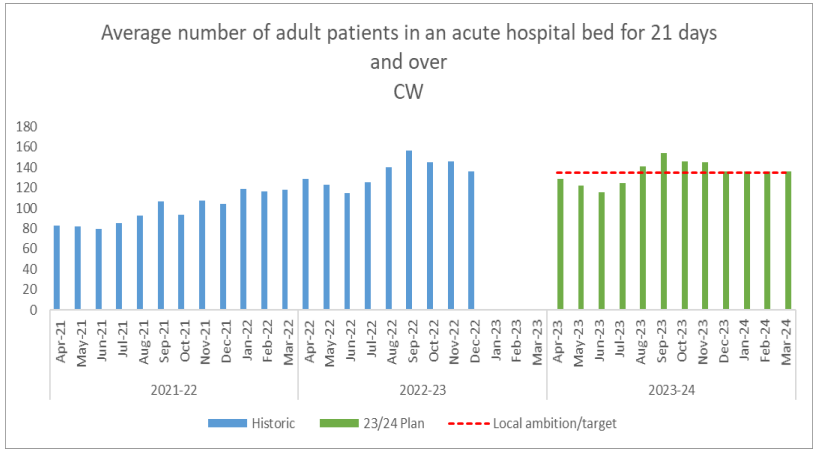


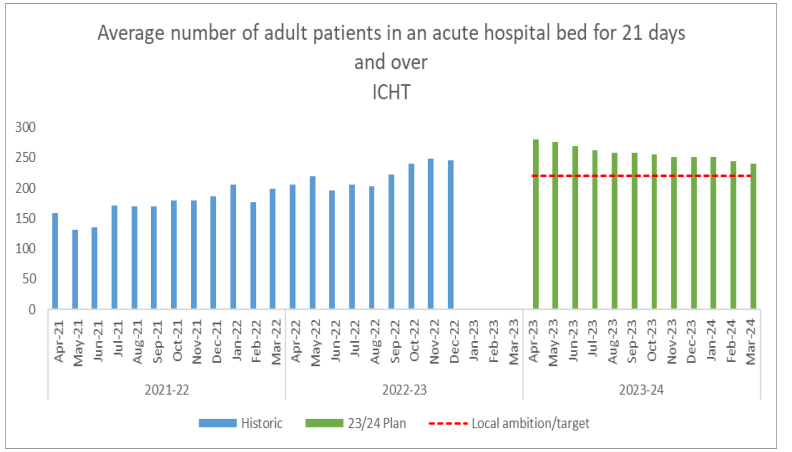


UEC – 21 days length of stay

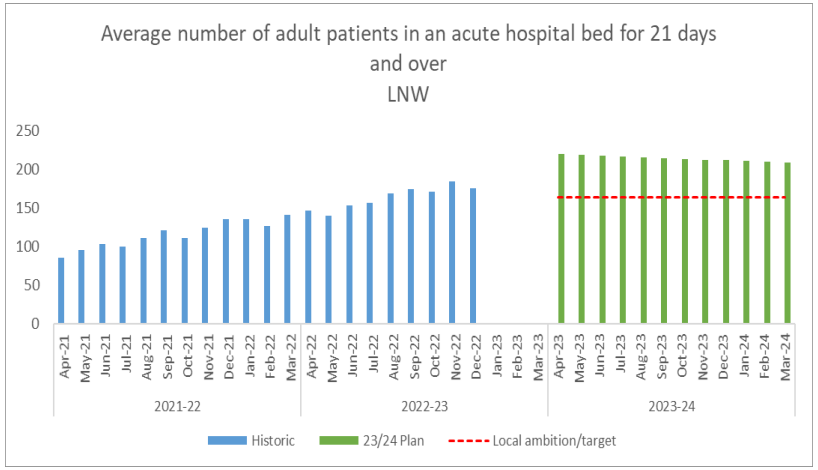
Target Performance – The local ambition is a 5% reduction year on year.

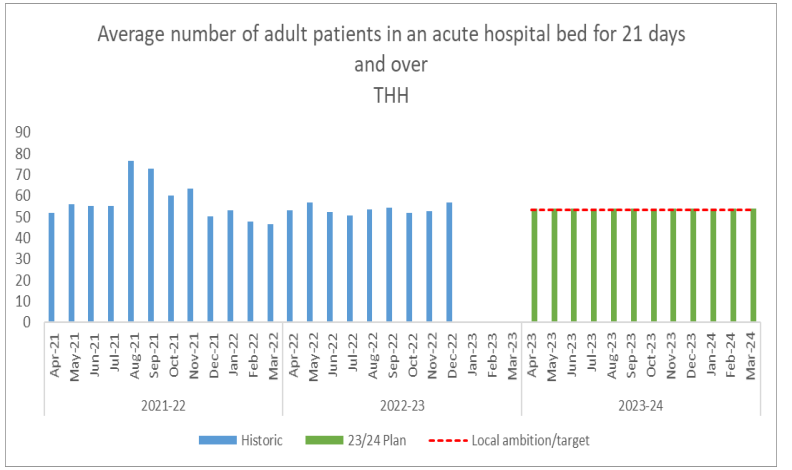






Summary
The ambition for 5% reduction will not be achieved.
Average monthly NWL is 573 April to Dec 2022.
The ambition for 5% reduction is not achieved in 2023/24 with plan set at with plan set at 661.





NHS
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Acute Provider Collaborative

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Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

NWL Acute Collaborative Financial Plan 2023-24

30 March 2023

Executive Summary

- The Trusts have worked with the ICB and with Clinical, Operational and Workforce teams to develop the Collaborative Financial Plan for 2023/24. The four Trusts have each submitted a breakeven plan – and all attention is now focused on firming up the risks within the plan and supporting the identification and delivery of the required Cost Improvement and efficiency savings. As with the business plan, it is important to highlight that there are four separate Trust plans, brought together in a Collaborative Plan.

- The Trusts have followed a standard set of assumptions, agreed with the ICB and across the Acute CFOs, to agree the key elements of the plan. This means standard assumptions have been applied across pay and non-pay uplifts and tariff impacts – included in Appendix 1. Non-recurrent delivery of CIPs has been reversed out for individual Trusts, with some Trusts seeking to address this with an additional efficiency ask. The impact of non-recurrent delivery in 2022/23 has impacted on each Trust's carried forward position, making 2023/24 a challenging ask. CFOs have set the ambition of a minimum of 50% of the required schemes signed off before the start of the financial year, and are working within their Trusts to secure this goal.

- ERF funding has been treated as in 2022/23, with the same values allocated to Trusts (uplifted for tariff inflation) with the exception of CWFT which has been granted an additional £4.8m to support the higher target in 23/24. COVID funding has been issued in line with a set of common principles. ERF represents both an opportunity and a risk, as Trusts will have to 'earn' the ERF values from 2022/23 with a new set of tariffs and rules. No growth has been allocated to providers, given activity levels in 2022/23. CIP levels vary from 2.8% (C&W) to 3.7% (LNWH), but all remain below the 4% level. The combined CIP challenge is £119.5m for the Collaborative and the Trusts.

- The ICB has offered an overall package to help support the Collaborative in moving to a breakeven plan, based on non-recurrent allocation of growth in 2023/24 and a non-recurrent package of support to get to break-even. CFOS are working to agree a programme of work (akin to the Theatres Productivity Programme) with the ICB to support the release of this non-recurrent funding, and to look to reduce the deficit by £66m in future years. This is one of the elements of the Collaborative Business Plan for 2023/24, which is also on the agenda for the Board.

Next Steps – Trust Submissions, Managing Risk & Performance

- The Collaborative Finance and Performance Committee (FPC) signed off the Collaborative Financial Plan on 23rd March, and each of the Trusts reviewed their own plans through the Trust FPCs, with all Trusts submitting plans in line with the national deadline of 30th March.

- During the year, the Trust FPCs will track Trust performance against the Trust financial plan, whilst the Collaborative FPC will support an assessment of performance against the Collaborative financial plan. CFOs are working on a set of principles for the identification and management of risk, as well as for information sharing and analysis, across the Collaborative. The level of risk within the overall financial plan is significant, spread reasonably evenly across the four Trusts, and one key benefit of the Collaborative will be the ability to monitor and manage risk across the four.

- At the same time, CFOs are working closely with the ICB and with the other Collaboratives in an attempt to develop an ongoing programme of work to support an improvement in the underlying financial position of the Collaborative and NWL. The latest ICB financial plan shows that the Trusts have been supported with non-recurrent growth funding (£66m), non-recurrent true-up funding (estimated by the ICB at £70m) and an ERF settlement which may be higher than the estimated costs of delivery for the non-tariff component. The Trusts and the ICB CFO teams will work over the year to move towards a sustainable and robust financial plan – primarily through focusing on improving productivity and efficiency and managing cost. This will also be reported to the NWL Financial Recovery Board, chaired by the ICB Chief Executive.

- An appendix to this pack highlights components of the cash and capital plans. All four Trusts have agreed a capital plan within their FPC meetings, and with the ICB, and the Collaborative Infrastructure Committee has a key role in reviewing and analysing the impact of investment decisions across the four. The Trust cash plans have been finalised, no Trust is signalling a cash flow challenge in the coming year, and all have robust systems in place for the management of cash.

Summary of Financial Plans – NWL Acute Collaborative

NWL APC Financial Plan 2023/24	LNWH Plan 23/24 £000	CWFT Plan 23/24 £000	ICHT Plan 23/24 £000	THH Plan 23/24 £000	Total APC Plan 23/24 £000
Patient Care Income	787,023	754,469	1,363,904	295,932	3,201,328
Operating Income	71,547	71,733	162,988	28,290	334,558
Total Income	**858,570**	**826,202**	**1,526,892**	**324,222**	**3,535,886**
Pay	(535,584)	(465,431)	(912,813)	(221,581)	(2,135,409)
Non pay	(307,194)	(350,713)	(606,263)	(110,514)	(1,374,684)
Total expenses	**(842,778)**	**(816,144)**	**(1,519,076)**	**(332,095)**	**(3,510,093)**
Operating surplus/deficit	**15,792**	**10,058**	**7,816**	**(7,873)**	**25,793**
Finance costs & Income	(5,809)	1,589	5,300	(1,478)	(398)
PDC	(11,200)	(12,570)	(14,404)	(7,612)	(45,786)
Net surplus / deficit	**(1,217)**	**(923)**	**(1,288)**	**(16,963)**	**(20,391)**
Other non operating costs/income	1,217	923	1,288	16,963	20,391
23/24 Financial plan	**0**	**0**	**0**	**0**	**0**

NWL APC Financial Plan 2023/24	LNWH Plan 23/24 £000	CWFT Plan 23/24 £000	ICHT Plan 23/24 £000	THH Plan 23/24 £000	Total APC Plan 23/24 £000
Cost Improvement Programme	31800	23520	53427	10757	119504
% of turnover	3.7%	2.8%	3.5%	3.3%	3.4%

- The table sets out the key elements of the overall plan for the Collaborative, with the combined income estimated at £3.5bn for the 2023/24 financial year.
- Each of the Trusts is expecting to deliver break-even (income and expenditure balanced), with a combined cost improvement plan of £119.5m. By agreement, the Trusts have kept their CIP ask below 4%, which is seen a stretching ambition. To note although the THH CIP is 3.3%, the plan assumes full recurrent delivery of the 22/23 CIP which is a risk. The CFOs are focused on moving towards identification of 50% of the CIP plans by the end of March, with 45% being confirmed. The remainder to be identified by the next FPC meeting in early June.
- All Trusts have used common planning assumptions, and then have agreed an allocation of the additional ICB funding on a consistent basis to support delivery of break-even plans across the Collaborative.

Context: FRF, MRET and Non-Recurrent CIP

FOT Undelivered CIP 2022/23 (at Month 11)	Impact of Non Recurrent CIP				
	CWFT	ICHT	LNWH	THH	Total
	£000	£000	£000	£000	£000
Non Recurrent CIP delivery	(11,246)	(10,417)	(21,189)	(2,444)	(45,296)
FOT Non Delivery of Target		(21,509)		(3,700)	(25,209)
Movement in Non recurrent	**(11,246)**	**(31,926)**	**(21,189)**	**(6,144)**	**(70,505)**

FRF/MRET	ICHT	THH	LNW	CWHT	Total APC
	£000	£000	£000	£000	£000
FRF	510	19,350	55,460	1,200	76,520
MRET	13,423	1,350	7,086	6,326	28,185
Total 22/23	**13,933**	**20,700**	**62,546**	**7,526**	**104,705**
Adjustments for growth					
FRF	16	953	1,761	38	2,768
MRET	427	67	225	201	919
Total	**443**	**1,020**	**1,986**	**239**	**3,687**
Revised FRF/MRET 23/24					
FRF	526	20,303	57,221	1,238	79,288
MRET	13,850	1,417	7,311	6,527	29,104
Total 23/24	**14,376**	**21,720**	**64,532**	**7,765**	**108,392**

- The first table shows the impact of non-recurrent CIP or undelivered CIP in the 2022/23 financial year.
- The net impact into 2023/24 is a pressure of £70.5m – which, taken with the additional funding, explains the increased CIP ask for 2023/24. CFOs are looking at options to make this recurrent where possible. This is particularly important to note for THH, where the plan assumes that recurrent CIPs have been delivered in 2023/24 – a key risk to monitor in 2023/24.
- FRF & MRET funding follows the national and local allocation in the past, with the only change from 22/23 to 23/24 being the tariff inflator. The ICB has agreed that this is recurrent to the Acute Collaborative, and has allocated it in line with historical practice. We will, over time, need to review options for the management of change in the FRF & MRET allocation – likely by linking this to the regular use of the 'true-up' process or similar. The CFOs have committed to review of this process in 2023/24.

Context: Underlying Position and Non-Recurrent Income

- The ICB has been using the 'true-up' approach to review activity levels against funding mechanisms. The ICB has not just been applying this to the Acute Collaborative, but to each of the Collaboratives. This method indicates that the ICB may have funded up to £130m across all providers for which activity has not been fully recorded/delivered, with £74m of this located in the Acute Trusts. The ICB is working with all providers to refine the true-up methodology – for example, it has been doing detailed work on both the counting and coding of elective work at ICHT, and on counting and coding of non-elective work at LNWHT. This work is not yet concluded and will continue into 2023/24 – with an additional focus on critical care counting and coding. Crucially, the ICB is not removing funding for under-delivery.

- If the ICB approach is utilised, then the Trusts have a c£74m underlying activity shortfall – although the operational plan for 2023/24 will in some ways remedy this, given the focus on driving up activity at reduced cost across all four of the Trusts. In addition, the ICB has provided £66m of non-recurrent growth, plus further non-recurrent funding in 2023/24.

- Assuming that the Trusts can achieve break-even plans, this suggests an underlying deficit of c£175m (although this needs a full refresh) – a more realistic figure than previous calculations, but one which requires further review. FRF does not impact on the underlying position of the Collaborative as it has been provided to us recurrently and in line with historical patterns, but we will in due course have to agree a methodology for ensuring that it provides equitable support across all the Trusts.

- The ICB have requested that the Trusts agree a programme of work during 2023/24 – building on the BCG-supported Theatre Productivity work – and the CFOs are working with the ICB CFO and key stakeholders across the Collaborative to develop and agree a programme of work. This is reflected in the Business Plan for the Collaborative, which is also at the Board.

CIP Planning 23/24 – Current Status

All trusts in the collaborative have formal management and governance processes in place to develop CIP plans for 2023/24. The Collaborative Productivity and Efficiency group is working in partnership on those schemes which are common across all trusts. Individual schemes from trusts will be categorised under themes : Procurement; Medicines, Agency (temporary staff); Corporate, Estates, Clinical Improvements. Over the next month the group will focus their efforts on joint working and sharing best practice to assist each other and the Collaborative in developing their schemes that return the maximum benefit.

In addition to this, the group will assist with the estimation of financial benefits and development of schemes within the Business plan mandates, once prioritised.

As part of the financial planning process members of the group regularly feed back on the CIP planning in their respective organisations, including financial target, method of target allocation, work in progress and worked up schemes. The latest position (31/03/23) is shown in the following table:

CIP 23/24 Plan	**CWFT**	**ICHT**	**LNWH**	**THH**	**Total**
31/3/23 update	£000	£000	£000	£000	£000
Trust target 2023/24	**23,520**	**53,427**	**31,800**	**10,757**	**119,504**
WIP schemes	3,734	13,100	9,490	3,696	30,020
Worked up schemes	10,127	5,441	6,450	1,754	23,772
Total	**13,861**	**18,541**	**15,940**	**5,450**	**53,792**
Balance	**(9,659)**	**(34,886)**	**(15,860)**	**(5,307)**	**(65,712)**
% WIP/Worked up	59%	35%	50%	51%	45%

The CFOs recognise the need for increased pace in the development of CIP plans and have identified 45% of the plans as at the end of March.

Key Risks to the Financial Plan for the Collaborative

Key Risk	Risk	Mitigation and Next Steps
ERF – Activity Levels and Calculations	The ERF target for the Collaborative is c109%, which is challenging and may be impacted by Cerner. In addition, the calculations are complex, with a new tariff, and administered centrally. The Cerner is key for LNWHT and THH performance.	Trusts have been prudent in their assessment of ERF income, and have worked closely with the ICB and with COOs on the Operating Plan. The CFOs have agreed an approach with the ICB which reduces risk.
Inflationary Pressures	The plans include the national assumptions on inflation which are likely to understate the true pressures being experienced.	The Trusts are working closely with the ICB to monitor inflation and flag as a regional risk – and are working within their CIP programmes to manage spend.
Delivery of the CIP Programme	Trusts have not delivered strongly on CIP in 2022/23, and have below 100% levels of identified CIP for 2023/24 at the start of the financial year.	Trusts are working with the Strategic Financial Adviser to accelerate CIP delivery, and CFOs will focus on strengthening arrangements in March/April 2023.
Industrial Action	Industrial action will have a significant impact on both ERF activity levels and cost if this continues into 2023/24.	This is a national issue, and the Trusts/ICB will work together to manage the cost impact and report clearly.
Capacity Planning/Winter	The national planning process for the capacity plans and funding is not yet finalised, creating a risk to delivery. However, indicative plans to maintain bed capacity have been included.	Trusts will continue to work closely with the ICB and through the COOs and UEC Group to manage. The current plans include indicative funding allocations.

Next Steps and Securing Delivery of the Plan

- Despite the challenges, the Trusts have made good progress and a balanced plan has been developed. This plan contains significant risk, but if delivered will reduce the underlying deficit and help move the Collaborative towards financial sustainability – both the NWL ICB and the Trusts are strong performers in London on finance.

- The CFOs will work intensively during April 2023 with Trust colleagues and the ICB to reach agreement on risk share and allocation arrangements. At the same time, we will also work with the ICB CFO to agree a programme of work to address the underlying financial position and to work through the eventual removal of the non-recurrent funding position and the activity shortfall.

- The key risk is the level of CIP delivery – the plans are not yet sufficiently robust across the Collaborative. This will be a key focus for the CFO group over the next few weeks, and it is likely that a more challenging approach will be required to support delivery and mitigate risk to the overall Collaborative position. The CFOs continue to meet weekly to review options to accelerate delivery, and to support improved performance by each of the Trusts – as well as options to accelerate delivery of the Collaborative savings opportunities.

- It is important to note that the financial challenges sit alongside a strong Operating Plan for the year. Finance is one of the components of this overall operating plan, and the 2023/24 NWL plans indicate strong performance on activity, access and diagnostics, and urgent care targets. CFOs will work with colleagues across the Collaborative to support delivery of these key standards in the most efficient way possible.

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Appendices

30 March 2023

Appendix 1: Baseline Expenditure Assumptions

Expenditure	
Inflation	Assume (in line with draft national guidance):
	Pay 2.1%
	Drugs 1.3%
	Other non-pay 5.5%
	No hyperinflation values to be included at this point, can be highlighted as a risk when submitting the narrative.
Utility cost	Higher than funding utility cost pressure is kept as a risk as the value is not yet crystallised
Covid Expenditure	Remove any non-recurrent covid expenditure in the 23/24 financial plan
Covid outside envelope	Assume funded flow remains the same as 22/23
Cost pressures and service development	Any internal approved cost pressures and service developments to include sources of funding, need to be cost neutral
	Any service changes that impacts on more then one organisation must be agreed by all parties to reflect the finances into their position
Efficiency programme	Tariff efficiency at 1.1%, plus 22/23 under delivery & non recurrent efficiency
Pay award and inflation (per guidance - does not reflect recent	•Exclude any pay award and inflation funding that is non-recurrent.
	•Apply the FYE of the ENIC reversal (Income and Expenditure)
Cost pressure on 22/23 pay award	Part of underlying deficits
Activity Assumptions	Acute - Minimum at 19/20 level, plus national ERF target. Where NEL is above 19/20 level assume it will continue Mental Health - Assume 19/20 level plus the MHIS for the consecutive years Community - Minimum same as 19/20 level plus service change
Funding	Distribution of funding to be within the ICS allocation. Any gaps in the plan will be covered by increasing efficiency target

Appendix 1: Baseline Income Assumptions #1

Income	
NWL baseline income - recurrent funding	Per schedule from the ICS.
	•Where 22/23 activity is below 19/20 level funding has been adjusted. This is added back in assuming activity is recovered in
	•Baseline adjustments to reflect the movement of top-up funding to other ICS and Spec Com - net neutral to the trust's income
	•22/23 non-recurrent SDF removed
	•Non recurrent funding for additional ICU beds removed
	•Non recurrent funding to support LAS position in 22/23 to remain in 23/24
	•Reflecting the FYE of the community service change between LNW, CNWL and CLCH
Spec Com and other ICS income - recurrent funding	•Baseline adjustments to reflect the movement of top-up funding to other ICS and Spec Com - net neutral to the trust's income
	•Organisations to include local knowledge on issues that impact their income due to service changes
Uplifts from NWL, Spec Com and other ICBs	NWL: Recurrent 22/23 roll forward with net 1.4% inflator (2.9% inflation, 1.1% National efficiency and 0.4% NWL convergence).
	Non-NWL: Recurrent 22/23 roll forward with net 1.8% inflator (2.9% inflation, 1.1% National efficiency).
Covid reduction in funding	NWL and other ICBs will pass their covid funding to the providers at 0.6% of the contract value unless it is an ambulance provider
	For NWL there is a £0.4m gap on the allocation and this will be distributed to the providers on an apportionment bases
Convergence	This will be passed onto all providers based on the ICB's convergence percentage, however this exclude MHIS services.
Capacity Funding	All except NWL ICB will pass on the capacity funding 0.9% of contract value. The capacity funding is for acute and ambulance services only. For spec com to exclude HCD/Devices from the contract when calculating the funding. NWL capacity funding is held back for further discussion.
ERF	NWL ERF assume same as 22/23 plus growth per ICB finance schedule. Other ICBs assume same as 22/23.
Growth funding	Funding agreed with the ICS re: true up exercise
CNST	Funding for the cost pressure will be passed on from NWL ICB
SDF	Exclude 23/24 funding and expenditure.

Appendix 1: Baseline Income Assumptions #2

Income	
Car Park and Catering Income	Increase of 3.8% for inflation 2.18% growth in activity Subject to any known local knowledge on demand or capacity
Local Authority Uplift	LA to fund 22/23 and 23/24 uplift (pay award and non-pay inflation)
Overseas Income	Income to increase at the same rate as current year M1-6
Private Patients Income	Income to increase at the same rate as current year M1-6 Subject to any known local knowledge on demand or capacity
Other non-NHS income	Income to increase at the same rate as current year M1-6 Where applicable apply any local knowledge on the contract value. Any reduction in income the changes must have been confirmed or crystallised.
FRF & MRET	To stay within the current providers, collaborative to review allocation method e.g. per 22/23 method.
Inter-system income, LVA and Spec Comm	•Impact of ENICs for LVA to be reflected in 23/24
	•FYE of ENICs to apply to all inter system contracts
	•Spec Comm services – Trust to work with Spec Comm and use latest finance schedule

Appendix 1: ERF targets (Value Weighted Activity)

		LNWH	CWFT	ICHT	THH	Total
		%	%	%	%	%
VWA target %	NWL activity	107.23	115.08	103.82	104.52	109
	ALL ICS activity	108.5	112.68	104.29	104.52	

Appendix 3: Movement from Draft Plan to Final Plan

Part 1: Starting Plan – Common Assumptions

	LNWH	CWHT	ICHT	THH	NWL Acute
	£000	£000	£000	£000	£000
Financial Planning	**(72,051)**	**(25,426)**	**(96,809)**	**(37,018)**	**(231,304)**
2023/24 Cost Improvement Plan	31,800	23,520	53,427	9,757	118,504
Current Plan 23/24	**(40,251)**	**(1,906)**	**(43,382)**	**(27,261)**	**(112,800)**
Realignment adjustments:					
Deficit adjustment			(3,400)		**(3,400)**
Growth Income reversal		(8,400)			(8,400)
Critical care costs			(27,366)		(27,366)
Inflation assumption			12,000		12,000
Restated current plan	**(40,251)**	**(10,306)**	**(62,148)**	**(27,261)**	**(139,966)**

Part 2: Moving to Breakeven

	LNWH	CWHT	ICHT	THH	NWL Acute
	£000	£000	£000	£000	£000
Restated current plan	**(40,251)**	**(10,306)**	**(62,148)**	**(27,261)**	**(139,966)**
Critical Care Funding	3,184	2,547	7,646	1,191	14,568
Rebasing/True-Up	15,000	8,442			23,442
Central Funding PDC	2,996	0	3,120	640	6,756
Central Funding Other	1,000			0	1,000
CIP Non-Recurrent made Recurrent	9,000				9,000
Other Cost Reduction	1,750				1,750
Other Income Assumptions			17,990	10,000	27,990
Trust Investment	20,000		15,000	10,000	45,000
To 24/25	(9,000)				(9,000)
Collaborative ICB Investment	(3,750)	1,250	1,250	1,250	0
Critical Care Adjustment			11,000		11,000
THH further adjustments as advised by JB				1,390	1,390
THH additional to breakeven as advised by JB				2,790	2,790
C&W additional ERF Income		4,877			4,877
C&W additional ERF cost		(4,877)			(4,877)
C&W cost increase to break even		(1,933)			(1,933)
LNW adjustment	71				71
ICHT - finance income			2,000		2,000
ICHT - addtl b/s review			2,000		2,000
ICHT - utilisation of contingency			2,142		2,142
Plan for Submission	**0**	**0**	**0**	**0**	**0**

Appendix 3: Movement – 2022/23-2023/24 – by Trust

NWL APC Financial Plan 2023/24	LNWH				CWFT				ICHT				THH			
	Forecast 22/23 £000	Plan 23/24 £000	Var £000	%	Forecast 22/23 £000	Plan 23/24 £000	Var £000	%	Forecast 22/23 £000	Plan 23/24 £000	Var £000	%	Forecast 22/23 £000	Plan 23/24 £000	Var £000	%
Patient Care Income	787,023	809,925	22,902	3%	741,248	754,469	13,221	2%	1,305,660	1,363,904	58,244	4%	294,207	295,932	1,725	1%
Operating Income	71,547	65,917	(5,630)	-8%	77,870	71,733	(6,137)	-8%	202,702	162,988	(39,714)	-20%	28,799	28,290	(509)	-2%
Total Income	**858,570**	**875,842**	**17,272**	**2%**	**819,118**	**826,202**	**7,084**	**1%**	**1,508,362**	**1,526,892**	**18,530**	**1%**	**323,006**	**324,222**	**1,216**	**0%**
Pay	(535,584)	(528,622)	6,962	-1%	(467,746)	(465,431)	2,315	0%	(913,670)	(912,813)	857	0%	(213,268)	(221,581)	(8,313)	4%
Non pay	(307,194)	(337,917)	(30,723)	10%	(331,750)	(350,713)	(18,963)	6%	(545,111)	(606,263)	(61,152)	11%	(116,367)	(110,514)	5,853	-5%
Total expenses	(842,778)	(866,539)	(23,761)	3%	(799,496)	(816,144)	(16,648)	2%	(1,458,781)	(1,519,076)	(60,295)	4%	(329,635)	(332,095)	(2,460)	1%
Operating surplus/deficit	**15,792**	**9,303**	**(6,489)**		**19,622**	**10,058**	**(9,564)**		**49,581**	**7,816**	**(41,765)**		**(6,629)**	**(7,873)**	**(1,244)**	
Finance costs & Income	(5,809)	(5,592)	217	-4%	(1,262)	1,589	2,851	-226%	3,334	5,300	1,966	59%	(1,570)	(1,478)	92	-6%
PDC	(11,200)	(13,719)	(2,519)	22%	(11,410)	(12,570)	(1,160)	10%	(13,300)	(14,404)	(1,104)	8%	(7,807)	(7,612)	195	-2%
Net surplus / deficit	**(1,217)**	**(10,008)**	**(8,791)**		**6,950**	**(923)**	**(7,873)**		**(9,966)**	**(9,104)**	**862**		**(16,006)**	**(16,963)**	**(957)**	
Other non operating costs/i	1,217	10,008	8,791		(6,950)	923	7,873		(39,615)	1,288	40,903		10,406	16,963	6,557	
23/24 plan	**0**	**0**	**0**		**0**	**0**	**0**		**0**	**0**	**0**		**(5,600)**	**0**	**5,600**	

Appendix 3: Movement – 2022/23-2023/24, APC Total

NWL APC Financial Plan 2023/24	Total APC			
	Forecast 22/23 £000	Plan 23/24 £000	Var £000	%
Patient Care Income	3,128,138	3,224,230	96,092	3%
Operating Income	380,918	328,928	(51,990)	-14%
Total Income	**3,509,056**	**3,553,158**	**44,102**	**1%**
Pay	(2,130,268)	(2,128,447)	1,822	0%
Non pay	(1,300,422)	(1,405,407)	(104,985)	8%
Total expenses	(3,430,690)	(3,533,854)	(103,164)	3%
Operating surplus/deficit	**78,366**	**19,304**	**(59,062)**	
Finance costs & Income	(5,307)	(181)	5,126	-97%
PDC	(43,717)	(48,305)	(4,588)	10%
Net surplus / deficit	**29,342**	**(29,182)**	**(58,524)**	
Other non operating costs/i	(34,942)	29,182	64,124	
23/24 plan	**(5,600)**	**0**	**5,600**	

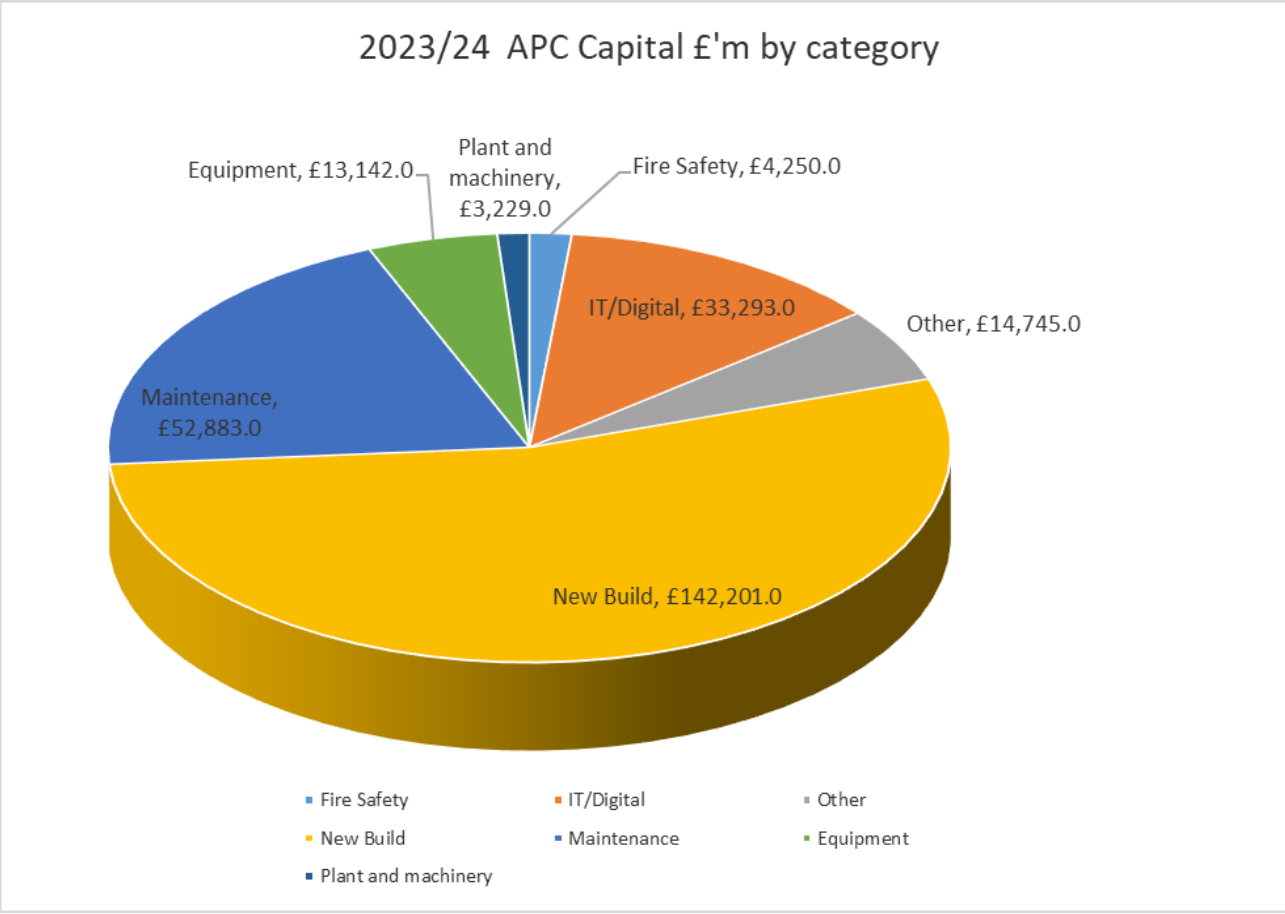
Appendix 4: Capital Plans 23/24 to 28/29 (Category)

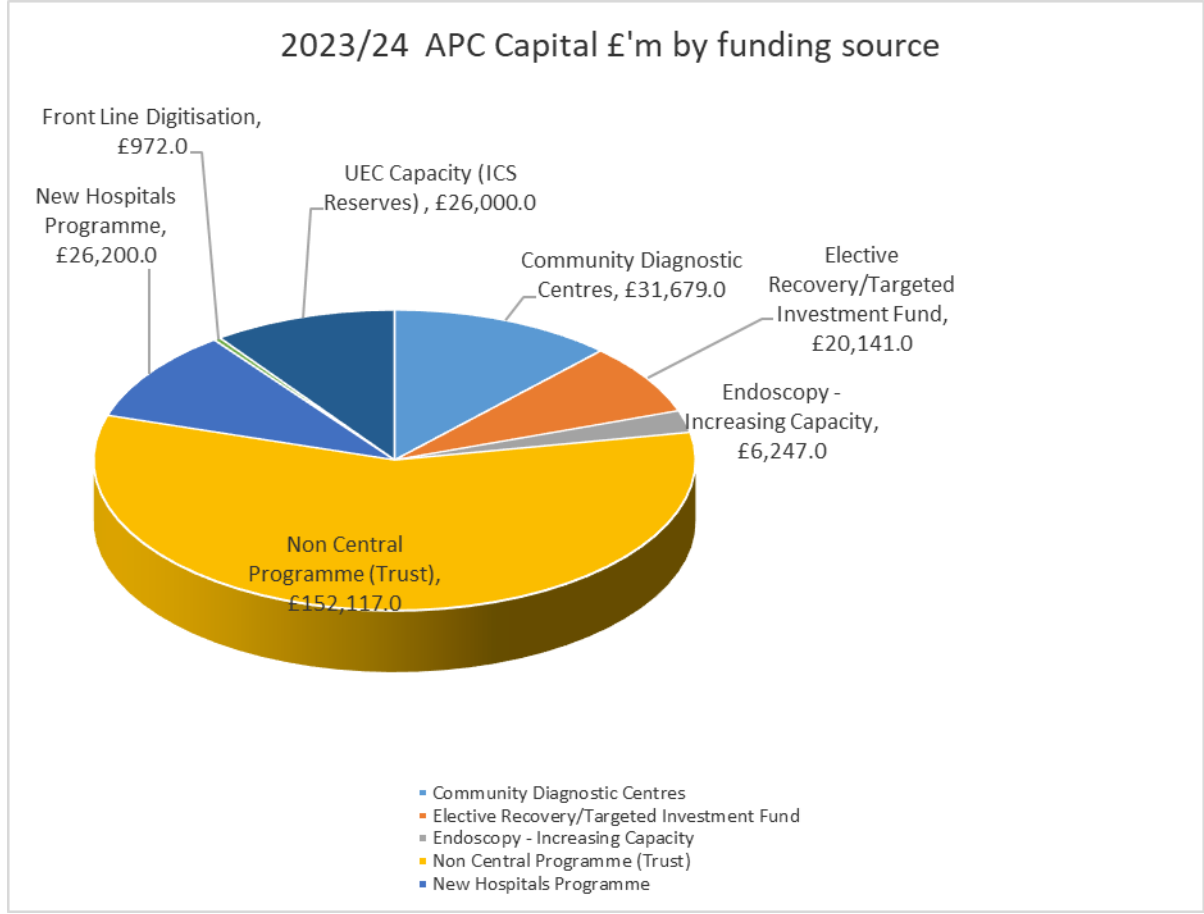
Trust	Category	23/24 £'000	24/25 £'000	25/26 £'000	26/27 £'000	28/29 £'000	Grand Total £'000
ICHT	Fire Safety	4,250	4,250	4,250	4,250	4,250	21,250
	IT/Digital	8,715	11,400	11,500	7,000	7,000	45,615
	Other	6,309	5,807	600	10,722	11,000	34,438
	New Build	13,485	11,000	2,360	-	-	26,845
	Maintenance	36,127	18,690	18,750	18,750	18,750	111,067
	Equipment	7,562	15,448	11,940	8,278	8,000	51,228
ICHT Total		**76,448**	**66,595**	**49,400**	**49,000**	**49,000**	**290,443**
LNWHT	IT/Digital	8,664	2,485	7,000	5,811	3,000	26,960
	New Build	41,821	10,000	25,000	14,000	-	90,821
	Maintenance	1,912	6,588	7,562	6,061	4,106	26,229
	Equipment	3,887	19,888	15,822	19,740	26,506	85,843
LNWHT Total		**56,284**	**38,961**	**55,384**	**45,612**	**33,612**	**229,853**
THH	IT/Digital	9,914	4,636	4,636	4,636	4,636	28,458
	Other	5,700					5,700
	New Build	26,200	11,200	101,200	301,200	301,200	741,000
	Maintenance	4,919	5,000	5,000	5,000	5,000	24,919
	Equipment	1,693	4,000	4,000	4,000	4,000	17,693
THH Total		**48,426**	**24,836**	**114,836**	**314,836**	**314,836**	**817,770**
CWFT	IT/Digital	6,000	6,000	6,000	6,000	6,000	30,000
	Other	2,736					2,736
	Plant and machinery	3,229	2,868	6,392	6,627	7,404	26,520
	New Build	60,695	25,944	9,810	777	-	97,226
	Maintenance	9,925	6,579	6,177	14,815	14,815	52,311
CWFT Total		**82,585**	**41,391**	**28,379**	**28,219**	**28,219**	**208,793**
	Fire Safety	4,250	4,250	4,250	4,250	4,250	21,250
	IT/Digital	33,293	24,521	29,136	23,447	20,636	131,033
	Other	14,745	5,807	600	10,722	11,000	42,874
	New Build	142,201	58,144	138,370	315,977	301,200	955,892
	Maintenance	52,883	36,857	37,489	44,626	42,671	214,526
	Equipment	13,142	39,336	31,762	32,018	38,506	154,764
	Plant and machinery	3,229	2,868	6,392	6,627	7,404	26,520
NWL APC Total		**263,743**	**171,783**	**247,999**	**437,667**	**425,667**	**1,546,859**

Appendix 4: Capital Plans 23/24 to 28/29 (Funding)

Trust	Funding Source	23/24 £'000	24/25 £'000	25/26 £'000	26/27 £'000	28/29 £'000	Grand Total £'000
ICHT	Community Diagnostic Centres	12,485	-	-	-	-	12,485
	Diagnostic Digital Capability Programme	387	810	-	-	-	1,197
	Non Central Programme (Trust)	63,576	65,785	49,400	49,000	49,000	276,761
ICHT Total		**76,448**	**66,595**	**49,400**	**49,000**	**49,000**	**290,443**
LNWHT	Community Diagnostic Centres	19,194	-	-	-	-	19,194
	Elective Recovery/Targeted Investment Fund	-	10,000	25,000	14,000		49,000
	Endoscopy - Increasing Capacity	6,247	-	-	-	-	6,247
	Non Central Programme (Trust)	30,843	28,961	30,384	31,612	33,612	155,412
LNWHT Total		**56,284**	**38,961**	**55,384**	**45,612**	**33,612**	**229,853**
THH	Front Line Digitisation	972					972
	New Hospitals Programme	26,200	11,200	101,200	301,200	301,200	741,000
	Non Central Programme (Trust)	21,254	13,636	13,636	13,636	13,636	75,798
THH Total		**48,426**	**24,836**	**114,836**	**314,836**	**314,836**	**817,770**
CWFT	Elective Recovery/Targeted Investment Fund	20,141	12,696				32,837
	Non Central Programme (Trust)	36,444	28,695	28,379	28,219	28,219	149,956
	UEC Capacity (ICS Reserves)	26,000					26,000
CWFT Total		**82,585**	**41,391**	**28,379**	**28,219**	**28,219**	**208,793**
	Community Diagnostic Centres	31,679	-	-	-	-	31,679
	Elective Recovery/Targeted Investment Fund	20,141	22,696	25,000	14,000	-	81,837
	Endoscopy - Increasing Capacity	6,247	-	-	-	-	6,247
	Non Central Programme (Trust)	152,117	137,077	121,799	122,467	124,467	657,927
	New Hospitals Programme	26,200	11,200	101,200	301,200	301,200	741,000
	Front Line Digitisation	972	-	-	-	-	972
	UEC Capacity (ICS Reserves)	26,000	-	-	-	-	26,000
NWL APC Total		**263,356**	**170,973**	**247,999**	**437,667**	**425,667**	**1,545,662**

Appendix 4 – APC Capital 23/24 pie charts (by Category & funding source)





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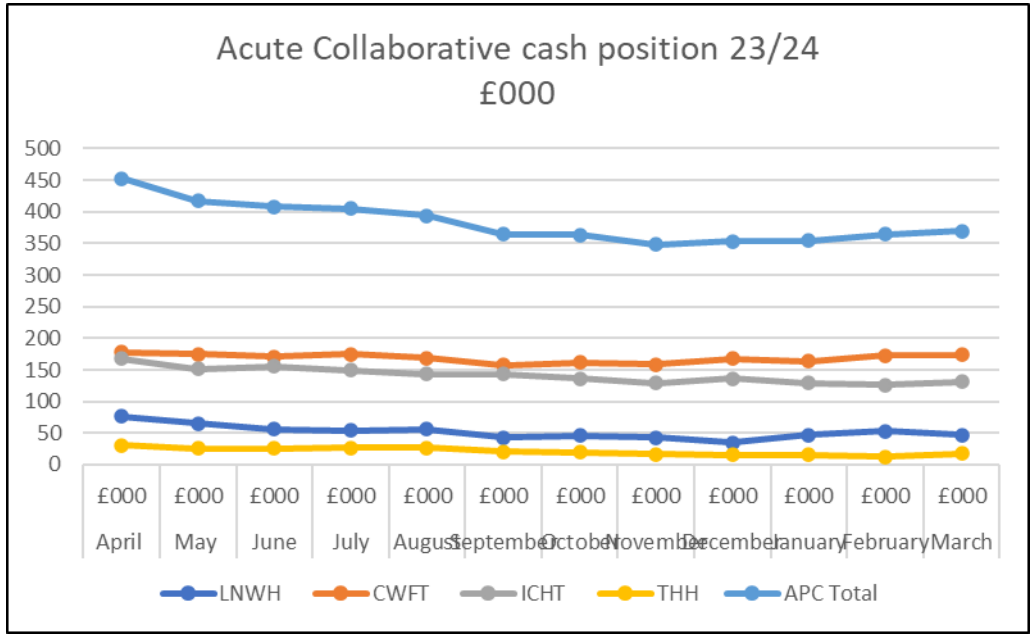
Appendix 5: Indicative Cash Position 2023/24

Cash	April	May	June	July	August	September	October	November	December	January	February	March
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
LNWH	76	65	57	54	56	43	46	43	35	47	53	47
CWFT	178	174	170	174	169	158	162	158	167	164	172	174
ICHT	168	152	156	149	143	143	136	129	136	129	126	131
THH	31	26	25	27	27	20	20	17	15	15	12	17
APC Total	**453**	**417**	**408**	**405**	**394**	**365**	**364**	**348**	**353**	**355**	**364**	**369**

To note :

Cash balances here are representative of the income and expenditure plans per the plan submissions on 30th March, which show all Trusts within the Acute Provider Collaborative planning a breakeven position for the year.



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Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


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London North West University Healthcare NHS Trust

Acute Provider Collaborative Business Plan & Strategic Narrative

2023/24

30/03/23

Executive summary

- This paper presents the draft NWL Acute Provider Collaborative Business Plan for 2023/24. It sits alongside the draft NWL Acute Provider Collaborative Operating Plan and financial plan for 2023/24, which aims to deliver the national & regional planning requirements for 2023/24.

- This is the first time an Acute Provider Collaborative Business Plan has been developed for north west London, and it sets out the results of work across the Collaborative during January-March 2023 to:
  - Establish a strategic narrative for the Collaborative within which to frame the first business plan
  - Agree a portfolio of priority objectives and programmes of work for the Collaborative to support tangible development of the collective programme
  - Agree and implement appropriate vehicles for delivery and support mechanisms across the Collaborative

- Each Trust in the Collaborative, as statutory organisations, have their own priorities and plans, as set out in their respective operating and financial plans, and quality account. This Business Plan adds to those Trust plans, and outlines the portfolio of work programmes where we believe collective effort will lead to greater impact across the Collaborative.

- Delivery of this Business Plan will contribute towards tangible improvements in patient and staff experience across the Trusts – but it will also contribute towards the required move to financial sustainability. The projects identified will – albeit not necessarily in 2023/24 – help reduce cost and drive up productivity and efficiency across the Collaborative, helping to reduce the reliance on non-recurrent funding from the ICB and short-term cost reduction actions. It will help place the Collaborative on a more stable footing.

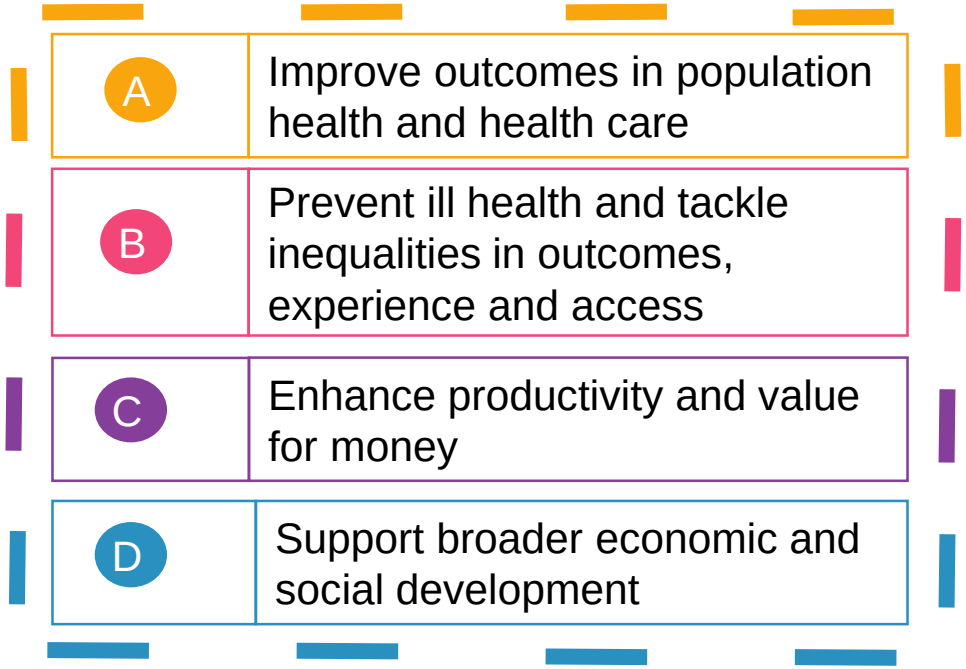
- Delivery of the Business Plan will be monitored and reported on through the Joint Executive Group and the Board in Common. To ensure appropriate resource to support delivery of these objectives, the paper includes a plan to provide some additional support.

Strategic narrative for the acute provider collaborative

- Wider context – including ICS objectives & NHS operating framework
- Why collaborate across our acute providers?
- How we are going about collaboration
- Achievements of the collaborative to date
- Our prioritisation approach
- Plans for 2023/24
- Our approach to transformation and delivery

Wider context: our NWL Integrated Care System has four objectives that cover how we – NHS and local authorities – meet the needs of our residents. The 5-year ICS strategy is currently under development, and we are working with the ICB to ensure we are clear about how the acute providers, working together as a collaborative, can contribute to its delivery

Four objectives of integrated care systems



Within our Integrated Care System the 'acute care programme' – under the leadership of Prof Tim Orchard - is focusing on the priorities below, which were developed in 2021. An updated version of these is informing the acute provider collaborative strategy we are developing:

1) Ensure residents have routine access to specialist expertise
2) Improve access to surgery (in patient and day case) to reduce waiting lists
3) Ensure residents have convenient, effective and timely access to diagnostics
4) Improve urgent and emergency care to reduce delays
5) Ensure residents experience the same quality of care regardless of where they receive it, by identifying and reducing the causes of unwarranted variation and improving equity
6) Provide high quality specialist services to residents
7) Work together to collaborate around key estates and redevelopment issues

This work also has key interdependencies that sit across the priorities (managed within different ICS programmes); these are focused on addressing workforce challenges, driving digital transformation and productivity & efficiency.

This work of the 'acute care programme' has provided a strong base from which we have developed the priorities of the acute provider collaborative, and from that the acute component of the ICS strategy.

NHSE has given us clear guidance within the 23/24 operating framework of the national objectives [listed below] we need to deliver this year. Our portfolio of work across the acute provider collaborative is focused on helping us to achieve these.

Urgent and emergency care

- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
- Reduce adult general and acute (G&A) bed occupancy to 92% or below

Elective care

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
- Deliver the system- specific activity target (agreed through the operational planning process)

Cancer

- Continue to reduce the number of patients waiting over 62 days
- Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028

Diagnostics

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition

Maternity

- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury
- Increase fill rates against funded establishment for maternity staff

Use of resources

- Deliver a balanced net system financial position for 2023/24

Long Term Plan and transformation

- Workforce Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise

Prevention and health inequalities

- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
- Continue to address health inequalities and deliver on the Core20PLUS5 approach

Why collaborate across our acute providers?

- The establishment of our acute provider collaborative across London North West, Chelsea & Westminster, Hillingdon and Imperial College Healthcare gives us an opportunity to build on the foundations of the acute care programme, to work together as the four acute and specialist NHS Trusts in NW London, to improve the health and well-being of the population we collectively serve
- We are working together on the basis that as we go into 2023/24 our acute provider collaborative is not a merger of Trusts, nor a formal 'Group Model', rather a **growing approach to collaboration** across a portfolio of work programmes where we believe collective effort will lead to greater impact. As we build our approach to collaboration, including consolidation of services and reducing unwarranted variation across clinical pathways, this strategy will develop
- We believe that this approach to collaboration will find synergy in our work, enable more scaling of the most impactful interventions, provide opportunities for consolidation of specific corporate services, improve learning across teams and organisations, and reduce unwarranted variation across clinical pathways
- This collaborative working is underpinned by the principles of our acute provider collaborative *[see next slide]* and aims to maximise the benefit of our collective resources to deliver a step change in quality (including safe, equitable, timely, efficient, person-centred care), financial and operational performance across our healthcare system

This collaborative working is underpinned by the principles of our acute provider collaborative

The joint executive group (JEG) and Board-in-Common are working together to utilise seven key principles of collaboration for our NWL Acute Provider Collaborative:

1) A commitment to delivering a step change in quality and financial and operational performance across our system
2) A commitment to treat everyone fairly and inclusively
3) Maximising the benefit of our collective resources by improving coordination and avoiding duplication
4) Collective decision-making for the benefit of our patients, communities and staff
5) Transparency of our data, information and decisions
6) A commitment to join up our strategies and planning
7) Respect for the continuing statutory roles of our respective Trust Boards and Councils of Governors (in the case of Foundation Trusts).

The teams leading our four areas of strategic priority have embedded these principles in the planning and delivery of their work

How we are going about collaboration

- Through the application of these 7 principles we are prioritising a ~~small~~ number of aspirational strategic priorities where we believe collaboration across the acute providers will deliver significant benefits. We are, in particular, looking at opportunities to improve quality, productivity and efficiency through consolidation and reduction of unwarranted variation in the delivery of services. This prioritisation work has utilised our three-level prioritisation framework *[described in the following slide]*
- We recognise the need to implement plans to deliver short/medium term priorities including delivery of the 2023 operating and financial plans while, in parallel, starting scoping and preparatory work for key medium/long term priorities
- We are also cognisant of the balance between being bold, aspirational and ambitious with our planning, while recognising that the starting point for all of this has to be the delivery of high quality care for the patients we serve, and strong operational and financial performance
- For 2023/24 we are focusing on four areas of priority that we believe will have the greatest impact on the quality of care we provide, on reducing unwarranted variation across clinical pathways, on the productivity and efficiency agenda, and in tackling workforce issues. Across the full portfolio of collaborative work we are actively looking for the cross-links that thread through the different areas of work, to ensure we are picking up co-dependencies as well as opportunities for wider measurable impact across a number of domains.
- This portfolio of collaborative work is being designed and delivered by each of our CEO-led work streams (each with focused transformation team support) and overseen by our joint executive group (JEG).

Building on firm foundations…

The Collaborative is building on some firm foundations of collaborative working, developed during the Covid pandemic with the establishment of the Acute Programme and the collaborative work on mutual aid

Coming together as one of the largest collaboratives in the country means we have the resource and expertise to deliver

We are currently the best performing sector in the country, including being one of the safest (based on mortality rates etc)

Between the four trusts we have some of the best research and education in the country, linked to an internationally renowned universities.

over 2 million outpatient appointments

6 Accident & Emergency Department

980,000 Emergency attendees

Over 28,500 babies delivered

5 Maternity units

Over 2.2 million population

32,400 staff and over 80 nationalities

Over £3.5 billion expenditure

Building on firm foundations…

We aim to build on these foundations and resource to:

Create Clinical Alliances to:
- develop joined up care
- develop better care models and care pathways

Create the best place to work:
- attract the best staff
- retain them through a sector wide career strategy

Use our collective resource to:
- deliver consistent high quality care
- address unwarranted variation
- remove healthcare inequalities

Use research to drive better outcomes:
- through partnership with world class academic institutions
- building a culture of research
- riving a rapid and consistent spread of innovation

Some of our early achievements:

- We have created an innovative model for a collaborative that is now becoming a national reference point for acute provider collaboratives
- Plans to establish an Elective Orthopaedic Centre (EOC) for NWL have progressed to enable us to bring together much of the routine, inpatient orthopaedic surgery for the population in a purpose-designed centre of excellence, completely separated from emergency care services.
- In quality, we have used the lessons learnt from peer reviews of A&E visits between sites, and have implemented specialist service improvements including vascular AAA pathway and pouch surgery.
- In digital and estates, we are preparing for the implementation on one domain for Cerner and are scaling IECCP and subsequent analytics enhancements between organisations
- In our people, we have established a joint bank and have implemented Robotic Process Automation pilots and sharing
- In finance and performance, we have developed a joint understanding of financial drivers and capital planning

Agreeing our priority programmes for 2023/24

Our strategy and transformation teams have developed a three-level prioritisation framework to support each Trust's Executive Team, and the Joint Executive Group, in defining our acute provider collaborative's portfolio of strategic priorities for 2023/24. As with any framework priorities may not always fit neatly into one level, but in our work to date it has helped encourage aspiration and provide consistency, focus and prioritisation.

Examples:
Elective orthopaedic centre
Cerner quad-domain

- (A) Priorities we can only deliver by working collaboratively across our 4 Trusts

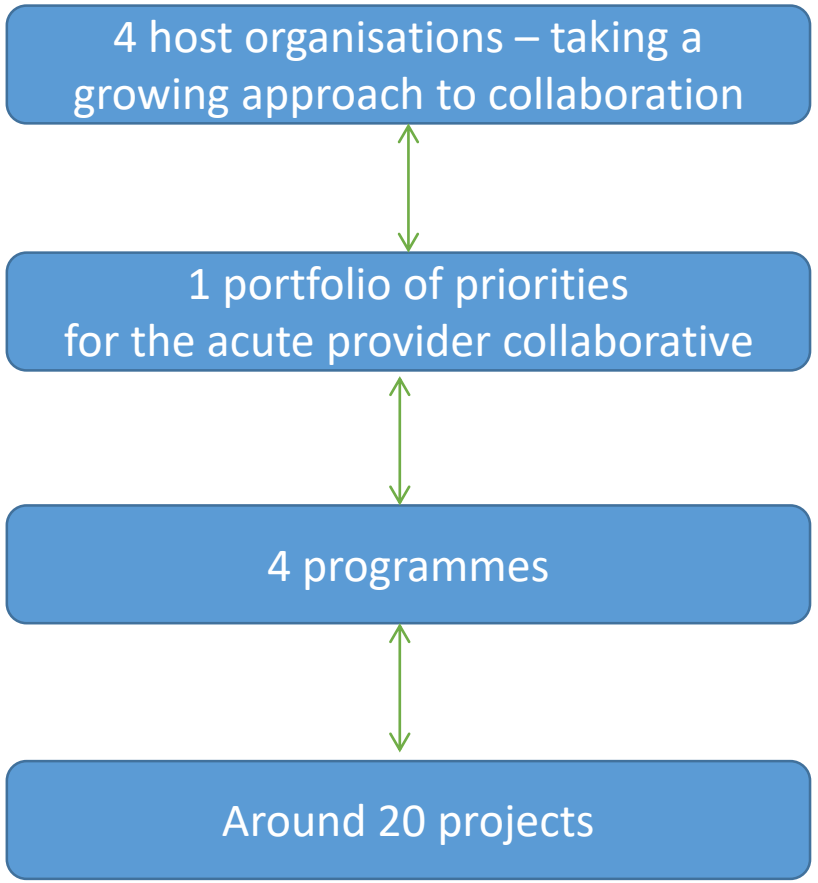
Examples:
Virtual wards
Outpatient transformation
Theatre productivity
Workforce mobility

- (B) Priorities we could chose to deliver as 4 Trusts as it will enhance the efficiency, benefits and/or shared learning

Examples:
Service improvement work
Local cost improvement projects
Site-based estates / redevelopment issues
Research & teaching commitments

- (C) Priorities we need to get on and deliver within each of our individual Trusts, while sharing learning

Consistency of terminology is critical to avoiding unnecessary complexity



One Chair in Common, four Vice Chairs, four CEOs

Joint Board, with the respective four CEO's accountable at the Board in Common for four distinct agendas, with the Board also accountable for steering the programmes as a coordinated portfolio of priorities

Four associated programmes – Finance and Performance, Quality, People, Digital and Infrastructure.
Each programme has a CEO lead, who is the SRO, with clarity on span of control across all four organisations

Each project to have an Executive-level project lead, who is accountable to the programme SRO (one of the CEO leads).

We have worked within four CEO-led workstreams to identify our porfolio of strategic priorities for 23/24, paying close attention to the inter-dependencies that sit between them

Quality: with focus on patient pathway transformation priorities

- One dimension of this is to take forward work across the 4 Trusts to achieve the maternity safety standards, to improve care of the deteriorating patient, to implement standardised processes for clinical harm and mortality reviews, to improve how we drive quality from user insights, and to implement the new National Patient Safety Strategy.
- The second dimension is to prioritise the collaborative transformation of a small number of clinical pathways with the aim of improving reducing unwarranted variation and improving quality (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity); driven by the transformation teams at each organisation working with clinical leaders within respective CRGs across the NWL collaborative. The data-driven prioritisation of which pathways are chosen is being undertaken at the moment.

Infrastructure: with focus on data & digital priorities, but bringing in estates & sustainability

- The collaborative priorities within this workstream are focused on data and digital priorities, noting that they are also a critical inter-dependency with the other three workstreams. Work is underway to complete the collaborative's digital and data strategy. The implementation and optimisation of the Cerner Electronic Health Record is a key priority alongside consolidation of the patient booking administration system, which is an important underpinning of the clinical transformation of outpatients. This work includes embedding elective software modules across all organisations for improved administration, tracking and clinical support across full patient pathways.
- As a collaborative we are also establishing an estates group to explore opportunities for consolidation and/or collaboration. From a Green plan perspective we are also working together as a collaborative to understand our carbon baseline and to co-develop solutions that will help get us towards our 2032 direct emissions target [47% reduction from 19/20].

Finance and performance: productivity & efficiency priorities

- This workstream has placed a major focus on collaboratively working to deliver the activity targets within the 2023/24 operating plan, while also delivering a programme of benefits realisation that will drive up efficiency and productivity across the acute provider collaborative. There is a focus on developing and delivering a programme for consolidation of support services, which includes securing the benefits from a NW London procurement hub. There is also work underway with the ICB and the other collaboratives to develop a proactive programme aimed at improving discharge planning and reducing the length of stay of medically optimised patients.

People: workforce prioritisation plans

- The people workstream has a number of inter-dependencies with other work, and this is recognised with the choice of collaborative priorities. One priority is to establish a recruitment hub to support hard to fill vacancies, and to develop a careers hub and staff transfer scheme. There are plans to increase the utilization of the apprenticeship levy, and there is a specific work programme being developed to support the transition of the workforce related to the Elective Orthopaedic Centre plans. There is work being undertaken to reduce premium rate temporary staffing expenditure. There is also a key priority on reducing violence, aggression, bullying and discrimination.

Programmes and Priority Projects 2023/24

- The table below sets out the four workstreams and the priority projects for the Collaborative in 2023/24. Outcomes and objectives are set out in the next few pages.
- Each Project now has a project mandate, setting out the key deliverables, and work is in hand with project leads to strengthen and refine these project mandates. Alongside this, we are working with the Directors of Transformation to establish appropriate support arrangements to ensure delivery, and to develop a minimalist but effective approach to monitoring performance over the course of the coming year. We anticipate reporting progress to each meeting of the Board-in-Common.
- The Outpatient Transformation project may move to Finance and Performance

Quality Priority Objectives/Projects 2023/24	**CEO Lead**
1. Maternity - Delivery Plan (All Trusts meeting Standards)	Tim Orchard
2. Care of the Deterioriating Patient	Tim Orchard
3. Mortality & Clinical Harm Review - implement standardised process for completing mortality and harm reviews	Tim Orchard
4. User Insights	Tim Orchard
5. Implement the new National Patient Safety Strategy	Tim Orchard
6. Working with GIRFT and the Clinical Reference Groups - reduce unwarranted variation in three clinical pathways	Tim Orchard
Infrastructure & Digital Priority Objectives/Projects 2023/24	**CEO Lead**
1. Finalise the APC Digital and Data Strategy	Patricia Wright
2. Implementation and Optimisation of Cerner system	Patricia Wright
3. Improving Patient Flow and Capacity using Care Co-ordination Solution	Patricia Wright
4. Outpatient Transformation	Patricia Wright
5. Support and Strengthen Delivery of Green Plan	Patricia Wright
6. Survey Estate, set up Estates Group and Develop Plan	Patricia Wright

Finance and Performance Priority Objectives/Projects 2023/24	**CEO Lead**
1. Deliver the activity targets in the 2023/24 operating plan	Lesley Watts
2. Agree a programme of efficiency and productivity for £66m, reducing reliance on ICB support for 2024/24 and improving our financial sustainability	Lesley Watts
3. Jointly develop and support a programme of discharge planning and reducing medically optimised patient LOS with ICB and collaborative partners	Lesley Watts
4. Develop a programme for consolidation of support services, including securing the benefits from the NWL Procurement Hub	Lesley Watts
Workforce Priority Objectives/Projects 2023/24	**CEO Lead**
1. Reduce premium rate temporary staffing expenditure	Pippa Nightingale
2. Elective Orthopaedic Centre workforce transition	Pippa Nightingale
3. Recruitment hub for hard to fill vacancies	Pippa Nightingale
4. Careers hub and staff transfer scheme	Pippa Nightingale
5. Increase apprenticeship levy uptake	Pippa Nightingale
6. Reduce violence, aggression, bullying and discrimination	Pippa Nightingale

Outcomes & Implications: Quality

	Objectives/Projects 2023/24	Key Outcomes	Targets	Financial Impact on the Collaborative	Resourcing Requirement
Quality Projects	1. Maternity Improvement Programme	Collaborative implementation plan for the NHS Maternity Delivery Plan.	The Delivery Plan plan was published in March 2023 and is being reviewed.	The project will drive improvements in quality and hence reduction In cost. In addition, it is likely to support full recovery of NHS Resolution Maternity Premiums	This will be confirmed on review of the implementation requirements of the Delivery Plan - just published in March 2023. Resources will be made available via CFOs.
	2. Care of the Deterioriating Patient and End of Life Care	Standardised methods for both Care of the Deteriorating Patient and End of Life Care, and a consistent monitoring approach across the Collaborative to improve outcomes.	The working group is finalising the targets for these two areas, which will published in Q1 and used to track performance.	The project will drive improvements in quality and hence reduction In cost.	The scope of the project is being confirmed, but an initial review of the mandate suggests no significant additional resource required. Any resource request will be supported by CFOs as a priority project.
	3. Mortality & Clinical Harm Review - implement standardised process for completing mortality and harm reviews	Standardised methods across the Collaborative for Mortality and CH reviews; consistent monitoring and reporting leading to improved learning and outcomes.	The working group is finalising the targets for these two areas, which will published in Q1 and used to track performance.	The project will drive improvements in quality and hence reduction In cost.	The scope of the project is being confirmed, but an initial review of the mandate suggests no significant additional resource required. Any resource request will be supported by CFOs as a priority project.
	4. User Insights	Programme for involving service users in service development n a consistent and truly engaged way.	Scope and targets will be confirmed post the initiation workshop in April 2023.	Unlikely to be an immediate financial impact, but external research indicates that over time, engagement with service users both improves experience and reduces cost.	No resources yet requested for project. Some additional project support likely to be required and will be sourced via CFOs as project scope finalised.
	5. Implement the new National Patient Safety Strategy	A standard methodology and consistent approach to patient safety across the Collaborative, using the new PSIRF model.	Common methodology across Collaborative. Common software/reporting toolkit. Specified impact on patient safety metrics.	Immediate financial impact is unlikely to be material - as the priority is consistent approach and learning - but strengthened learning from incidents will increase quality and reduce cost over time.	Potential impact on NHS Resolution Premiums in future years, but impact more likely to be seen in reduced costs of error and remediation across the Collaborative - to be estimated in Q1.
	6. Reducing Unwarranted Clinical Variation and Improving Quality	An agreed programme of service review, working through the CRGs, and quality improvement, using a standard methodology.	Programme of priority areas of variation to be reduced. Specified targets for improvement.	This project has the potential to be one of the most material drivers of financial improvement, as well as quality improvement. It is still being scoped.	The Model Hospital and Reference Cost Benchmarking Tools suggestion an opportunity of >£50m. No resource yet identified for the programme, but this will be made available as required.

Outcomes & Implications: Infrastructure/Digital

	Objectives/Projects 2023/24	Key Outcomes	Targets	Financial Impact on the Collaborative	Resourcing Requirement
Infrastructure Priorities	1. Finalise the APC Digital and Data Strategy	An agreed Digital and Data Strategy across the Trusts, supported by the appropriate governance and detailed implementation plans.	Strategy confirmed and agreed. Strategy will contain targets for key service areas.	23/24 financial plans include any agreed business cases and delivery models. Further investment derived from the Strategy will require additional funding, and detailed business cases to suport.	Resourcing is already included in the plan to develop the Strategy. Additional resourcing may be required depending on the content of the finalised Strategy.
	2. Implementation and Optimisation of Cerner system	Safe implementation of Cerner at LNWH & THH; Benefits Realisation Plan for Single Instance across Collaborative	Minimal impact on ERF activity. Detailed Benefits Realisation Plans for both LNWH & THH. BRP for single instance to be developed.	The priority in 2023/24 is to ensure a safe implementation, within the available resource envelope, and minimal impact on staff and patients, plus ERF activity per trajectories. For 24/25, benefits realisation plans will deliver financial benefit.	Both LNWH & THH have costs in plan (capital and revenue). Support from ICB on capital should be noted. Further costs likely to emerge in move to go-lives, under review by Cerner Finance Group.
	3. Improving Patient Flow and Capacity using Care Co-ordination Solution	A common - and best in class - platform for supporting the management of patient flow across the Colllaborative, leading to improved flow in all Trusts, and optimised capacity.	Over the course of the year, deployment of key modules across all Trusts, with demonstrable improvement in flow and capacity.	The Operational Plan for 2023/24 contains stretching targets across the Collaborative. Whilst the current infrastructure will support delivery, the roll-out of the CCS modules will secure delivery and potential stretch against targets.	The current plans include the core modules and delivery. Further extensions will require business cases, but will secure an improvement in the underlying financial position and operational delivery across the Collaborative.
	4. Outpatient Transformation - **may be moved to finance and performance**	A clear business case for the Collaborative to move to a common platform and shared support service for Outpatients, delivering specified improvements in both delivery and efficiency.	Business case approved by Trusts and Board-in-Common. Implementation across the Collaborative. Increased delivery against O/P New & Follow-Up, PIFU and A&G, Occupancy targets.	The business case is not included in the current plans, and will need to clearly articulate costs and benefits of the move to the standardised service. An initial investment might be required and will be identified during Q1 as part of the case.	Resourcing for the full case is not yet included in the plans for 2023/24, but will be articulated in the case and secured before implementation. ICHT case indicates £3.4m cost over 3 years, with £15m saving over 5 years TBC.
	5. Support and Strengthen Delivery of Green Plan	Meeting National and NWL Targets for Green Plan; 10% Sustainability Impact in Procurement Plans; Draft Decarbonisation Plan	Nil usage of desflurane by early 2024; Reduction in nitrous oxide usage; switch to <45% MDIs	Focused work on Green Plan will support delivery of savings in the medium-term, but this will need to be balanced with requirement for investment. Nil assumed net impact on finances for 2023/24 at aggregate. Trusts are assuming in CIP plans on case-by-case (e.g. EPC).	Green Plan delivery resources already in place at Trusts. Some business cases may need additional support. ICB Green Plan infrastructure supports delivery, alongside Trust resources. Additional resourcing requirement is unlikely to be extensive.
	6. Survey Estate, set up Estates Group and Develop Plan	Estates Baseline agreed, Indicative Estates Strategy, Succession Plan for Estates Directors, Alignment of Major Projects	To be confirmed after baselining - %age unutilised estate, £av cost/m2, energy and utility costs	Model Hospital analysis & NWL ICB Estates Strategy suggests significant estates opportunity to reduce cost.	Small resource required to support Estates Directors (in plan at LNWH). Analytical resource may be required across Trusts, plus enhancement to Strategy Teams.

Outcomes & Implications: Finance/Performance

	Objectives/Projects 2023/24	Key Outcomes	Targets	Financial Impact on the Collaborative	Resourcing Requirement
Finance and Performance Priorities	1. Deliver the activity targets in the 2023/24 operating plan	Delivery of agreed ERF targets across the Collaborative	108.50%	Securing the ERF funding of £59m (NWL); possible additional ERF funding to mitigate CIP risk through overperformance	Resourcing requirement to be kept under review through COOs & CFOs. Plan for 23/24 includes assumed resources.
	2. Agree a programme of efficiency and productivity for £66m, reducing reliance on ICB support for 2024/24 and improving our financial sustainability	Delivery of agreed £66m improvement in underlying position	£66m reduction in underlying deficit	Plan secures £66m in 2023/24, and supports reduction in ICB support in 2024/25	Resourcing requirement will be reviewed in development of detailed plan in Q1. In principle, funded through ICB 23/24 funds.
	3. Jointly develop and support a programme of discharge planning and reducing medically optimised patient LOS with ICB and collaborative partners	Delivery of agreed interventions to support reduction in >7,14,21 day LOS and reported non-acute delays to discharge	Initial modelling suggested opportunity of up to £14m. No specific element included in CIP plans, but likely to form element.	Trust plans require CIP of £118m - only 50% identified at end of March. This represents significant opoprtunity to support delivery.	Delivery is across Collaboratives, and supported by NWL FRB and Place-Based Boards
	4. Develop a programme for consolidation of support services, including securing the benefits from the NWL Procurement Hub	Delivery of an agreed programme of consolidation of support services within the Collaborative (& ICB as appropriate)	Confirmed Plan with financial estimate of benefits for 24/25	Opportunity to secure Model Hospital/NHSE Benchmarking Benefits of >£5m. Opportunity to drive up service quality.	A small amount of analytical and delivery resource may be required to develop programme, and set up implementation groups.

Outcomes & Implications: Workforce

	Objectives/Projects 2023/24	Key Outcomes	Targets	Financial Impact on the Collaborative	Resourcing Requirement
Workforce Priorities	1. Recruitment hub for hard to fill vacancies	A shared resource to run targeted campaigns for key areas (ED Middle Grades, OTs, ODPs, Sonographers, Pathology Staff) promoting the Acute Collaborative as an employer of choice.	Increased substantive staffing in key areas of shortfall. Reduced temporary staffing expenditure, and a net saving through an overall reduction in 'premium' costs.	The key targets will lead to a new benefit to the Collaborative, with an opportunity for the CPOs and CFOs to include in the CIP programmes for the Trusts.	The project mandate indicates a potential indicative cost of implementation of £184k, being the resources required to run the recruitment programmes.
	2. Elective Orthopaedic Centre workforce transition	Deliver the workforce requirements of the new Elective Orthopaedic Centre, opening in Q3.	Staffing targets in each grouping identified in the FBC, being reviewed by BIC in April.	Non-delivery of the target will increase net cost. Delivery will support the EOC in an initial £700k saving in 23/24, moving to £4m over the following year.	Resourcing requirements have been articulated in the EOC FBC, being reviewed by BIC in April - and included in LNWH plans for 23/24.
	4. Careers hub and staff transfer scheme	Development of a range of interventions that support the four Acute Trusts to retain their own staff via career development advice and guidance and development opportunities.	Reduction in turnover and vacancies in key areas - nursing and midwifery	The financial benefits of the project are still being developed through the CPOs and CFOs, but it is anticipated that this will lead to a reduction in agency/premium costs for temporary staffing.	It is likely that the full impact of this project will be into 24/25, leading to a significant reduction in temporary staffing costs across the Collaborative.
	5. Increase apprenticeship levy uptake	A programme across the Collaborative to increase uptake, and completion, of apprenticeships through a common approach and strengthened visibility/leadership.	Increased number of apprenticeships across the Collaborative. Focused on specific priority areas - HCSW and Senior HCSW.	Improved utilisation of apprenticeship levy, including allocation across the Collaborative to areas where results secured. In 24/25, we can anticipate a reduction in vacancies in some key areas as the project takes effect.	Project is focused on better utilisation of existing resources, and clearer pathways/leadership of apprenticeship work within Trusts.
	6. Reduce violence, aggression, bullying and discrimination	Develop a strengthened and consistent approach to V&A across the Collaborative. Strengthen and align approaches to bullying and discrimination. A common EDI and anti-racist programme.	A clear plan across the four Trusts to strengthen and standardise approaches to V&A. Improvement in staff survey reporting on this issue. A clear plan - and delivery - to reduce instances of bullying and discrimination. Improved staff survey outcomes. An improvement in WRES outcomes as a result of common EDI approach.	The focus of this work is not on securing financial benefits, but on ensuring an improved experience for all staff across our four Trusts, reducing instances of violence and aggression, bullying and discrimination.	Evidence from wider research indicates that delivering improvements in these areas will lead to improved patient care and a reduction in indirect costs to the Collaborative. These may arise - but this project is not focused on financial improvement.

Quarter 1: Objectives for the Projects

Quality Objectives

Maternity – Review of National Delivery Plan & Response
Care of the Deteriorating Patient – Agree Collaborative Methods & Metrics, Working Group in Place
Mortality & Harm Review – Agree Consistent Approach & Metrics
User Insights – Workshop across Collaborative to share learning
Patient Safety – Draft Implementation Plan for PSIF across Collaborative, agree across all Trusts
Unwarranted Variation and Improving Quality – Priority Areas agreed (HVLC included), Standardised Toolkit agreed, Clinical Ref
Groups refreshed as appropriate

Finance and Performance Objectives

Planning and Delivery in Q1

Activity Delivery – Using Elective Care Board, and sub-groups, deliver against Operating Plan targets, bolster Theatres & Outpatient Optimisation Programmes
£66m E&P Programme – agree programme across Collaborative and with ICB CFO. Set up working groups, develop E&P dashboard
LOS Programme – agree metrics and baseline with all Collaboratives, set up working group, agree targets for each partner and Trust
Services Consolidation – agree priority areas, set up working
thin Collaborative for focused plan development

Q1 – Develop Detailed Plans for Delivery

Infrastructure & Digital Objectives

Finalising the Digital Strategy

Digital Strategy – finalise draft of Strategy with stakeholders
Cerner – finalise deployment plans across LNWH and THH
Care Co-ordination – adoption of agreed modules at all sites
Outpatients – Full Business Case complete and approved
Estates – Estates Group set-up; Work Programme agreed
Green Plan – Review of Energy & Transport Contracts; 10% sustainability component of procurement agreed; Plans for NoX, Inhalers, Anasthetic Gas Reduction agreed

Workforce Objectives

Developing Plans for Delivery

Recruitment Hub – confirm plans and implementation across Collab
Careers Hub/Transfer Scheme – adopt 'Itchy Feet' model, set up working group for Hub/Transfer scheme
Increasing Apprenticeships – Set up Apprenticeships Working Group, develop baseline of apprenticeship activity
Reduce Violence & Aggression, Bullying & Discrimination – identify current campaigns across Collaborative, review options for levelling up and joint working

Quarter 2: Objectives for the Projects

Quality Objectives

Maternity – Agreed Maternity Implementation Plan at all Trusts, Targeted response to areas requiring development
Care of the Deteriorating Patient – Standardised approach agreed
Mortality & Harm Review – Std approach implemented at Trusts
User Insights – Implementation Plan agreed across Trusts
Patient Safety – Procurement complete, roll-out commences
Unwarranted Variation and Improving Quality – First round of reviews and plans using methodology and toolkit

Finance and Performance Objectives

Activity Delivery – Support all Trusts, including THH & LNWH, to meet ERF threshold pre- and post-Cerner. Theatres productivity plan.
£66m E&P Programme – delivery of first round of agreed interventions including revised true-up process and CWA improvements, mapping of 33% £66m benefits
LOS Programme – early planning for winter whilst maintaining LOS, implementation of first round of interventions
Support Services Consolidation – clear benefits realisation plan for [illegible]rocurement, agreed plan for financial systems and services, [illegible]e plan for clinical support services and timetable

Q2 – Delivery Commences

Infrastructure & Digital Objectives

Digital Strategy – Strategy passed through each Trust gov[illegible], funding for strategy identified, implementation plans developed
Cerner – deployment at LNWH, planning for THH, single instance benefits realisation plan strengthened and developed
Care Co-ordination – plans for O/Patients, Patient Cohorting, Clinic Management modules developed and agreed
Outpatients – Confirmed business case and delivery plan for Q3
Estates – Succession Plan, NWL Estates Baseline agreed
Green Plan – delivery against targets for projects, decarbonisation plan initial draft developed

Workforce Objectives

[illegible]itment Hub – targeted recruitment for 2/5 targeted groups
Careers Hub/Transfer Scheme – agree approach (MOU0 digital passport, secondment, terms; Transfer Hub set up and operational
Increasing Apprenticeships – agree common operating model and common procurement (lead) approach to secure single model and benefits, implement procurement
Reduce Violence & Aggression, Bullying & Discrimination – agreed consistent minority ethnic career development/offer and EDI and anti-racist training approach across Collaborative, agreed V&A offer

Quarter 3: Objectives for the Projects

Quality Objectives

Maternity – Implementation of Q3 Actions per Plan
Care of the Deteriorating Patient – First round of feedback to Q&S/ BIC
Mortality & Harm Review – First round of feedback to Q&S/ BIC
User Insights – First round of service review/dialogues
Patient Safety – Roll-out of tools and methodology, first review
Unwarranted Variation and Improving Quality – Second wave of service reviews, using toolkit and methodology, outcoming review of first wave

Finance and Performance Objectives

Activity Delivery – Support all Trusts, including THH & LNWH, to meet ERF threshold pre- and post-Cerner,
£66m E&P Programme – delivery of first round of agreed interventions including revised true-up process and CWA improvements, mapping of 33% £66m benefits
LOS Programme – planning for winter whilst maintaining LOS, implementation of first round of interventions
Support Services Consolidation – clear benefits realisation plan for [illegible]rocurement, agreed plan for financial systems and services, [illegible]e plan for clinical support services and timetable

Q3 – Maintaining Delivery

Infrastructure & Digital Objectives

Digital Strategy – Funding for Strategy Delivery secured
Cerner – deployment at THH, PIR at LNWH, finalised BRP for the single instance of Cerner, planning for benefits in 23/24
Care Co-ordination – O/Patients, Patient Cohorting, Clinic Management modules implemented across Trusts
Outpatients – Rollout of standardised model commences, subject to agreement across the Trusts
Estates – Alignment of site strategies, redevelopment reviews
Green Plan – delivery against targets for projects, formal review of decarbonisation plans and cost implications

Workforce Objectives

[illegible]ment Hub – targeted recruitment for 3/5 remaining targeted groups, plus outcoming from first wave recruitments
Careers Hub/Transfer Scheme – operationalisation of agreed protocols for hub, and transfer scheme across four Trusts
Increasing Apprenticeships – roll-out of consistent recruitment and delivery model for apprenticeships, single campaign(tbc)
Reduce Violence & Aggression, Bullying & Discrimination – implement focused EDI and anti-racist training approach across Collaborative, implement agreed V&A campaign across all Trusts

Quarter 4: Objectives for the Projects

Quality Objectives

Maternity – Reporting Progress to Q&S, Board Declarations
Care of the Deteriorating Patient – Implementation of feedback from Round 1 review and analysis, planning for 23/24 actions
Mortality & Harm Review – Implement post BIC feedback, planning for 23/24 interventions and BAU
User Insights – Second review of service dialogues/methods review
Patient Safety – Feedback to Q&S at Trusts, BIC review of progress
Unwarranted Variation and Improving Quality – Alignment of outcomes to 24/25 planning process, reflection on outc

Finance and Performance Objectives

Activity Delivery – Activity performance maintained through winter, target for 24/25 agreed with Trusts and ICB
£66m E&P Programme – final 33% £66m identified, agreed plan for deployment of benefits with ICB, planning for 24/25
LOS Programme – post-implementation review first interventions, stretch for winter, and planning for BAU in 24/25
Support Services Consolidation – Implementation of first support service alignment prior to any formal transfer, review of KPI delivery the four Trusts and target-setting for 24/25

Q4 – Reflection/ Planning for 24/25

Infrastructure & Digital Objectives

Digital Strategy – implementation commences, per Strat
Cerner – BRP for single instance implemented, BRP for THH and LNWH implemented, with net +ve impact on 24/25
Care Co-ordination – Review of outcomes of model roll-out and agreement of priorities for 24/25
Outpatients – Continued rollout of standardised model, PIR review
Estates – Reporting to BIC, indicative Strategy, targets for 24/25
Green Plan – Reporting to BIC, targets for 24/25

Workforce Objectives

Recruitment Hub – Report to BIC on outcomes and Post-Implementation Review
Careers Hub/Transfer Scheme – Report to BIC on outcomes and PIR,
Increasing Apprenticeships – implementation of model continues, allowing time for recruitment of single cohort
Reduce Violence & Aggression, Bullying & Discrimination – Report to BIC on outcomes and post-implementation review. Analysis of WRES/ Staff Survey outcomes and findings and planning for 24/25

Supporting Delivery

- Delivery of the projects within the programmes will be supported by a small delivery group, meeting regularly to track performance of the key programmes against their defined process and outcome measures. This delivery group will include leads from each of the CEO-led workstreams and would be convened/report through the directors of transformation group.
- Project resource can be made available (via ICB funding for programmes of change, held at LNWH) to provide administrative and project support to help CEOs and SROs in delivery. Where a particular programme needs additional dedicated resource, the directors of transformation and CFOs will work to arrange this.
- We are proposing to use the project mandates developed by the HRDs during this prioritisation process, and that all projects are included on our TRAKIT systems.

Next steps

- The Business Plan has been developed through the emergent Joint Executive Group, and reviewed by the CEO Group and the Joint Collaborative Finance and Performance Committee, with individual projects being considered by their relevant Committee.

- Whilst there remains work to do to finalise the project mandates and deliverables, and to agree KPIs across all the projects, the Business Plan represents a coherent body of work for the coming year, sitting alongside the Collaborative Operating Plan and Financial Plan. Delivery of the Business Plan will mark a demonstrable outcome from the four Trusts working together in this new way.

- Key projects within the overall Business Plan move the Collaborative towards systematic and consistent ways of working, towards greater consolidation of support services and infrastructure, and towards a more financially sustainable model of working. During this period, the Directors of Strategy will continue to work on the development of a strategy for the Collaborative.

- Progress will be reported to the Cabinet on a monthly basis, and to the Board-in-Common at each of its meetings over the coming year.

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)
18/04/2023
Item number: 3.2
This report is: Public

North West London Elective Orthopaedic Centre Full Business Case

Author: Mark Titcomb
Job title: Managing Director EOC, CMH & Ealing

Accountable director: Jonathan Reid
Job title: Chief Finance Officer, LNWH

Purpose of report

Purpose: Decision or approval

The board of London North West University Healthcare NHS Trust is asked to **approve** this Full Business Case and to **approve** the capital funding requirement of £9.412m for an elective orthopaedic centre at Central Middlesex Hospital.

The North West London Acute Provider Collaborative Board in Common is asked to **note** that the business case has revenue implications, with a net income and expenditure benefit in the first full year of operation of £3.968m to the NWL system. Other key considerations related to the financial and commercial cases, as well as the fact that the FBC has responded to all assurance feedback and requests for additional information, are also highlighted.

Report history

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

Business Case Review Group 01/04/2023 *Approved*	**Trust Executive Group** 05/04/2023 *Noted for subsequent approval at BiC*	**LNWH F&P** 19/04/2023

Executive summary and key messages

Introduction

The North West London elective orthopaedic centre (NWL EOC) aims to deliver a high volume low complexity (HVLC) surgical hub and a centre of excellence for orthopaedic care in North West London by November 2023. The purpose of this FBC is to offer Value for Money (VfM) and secure capital funding for the proposal. The ambition of the EOC remains the same as the OBC and has been strengthened since the OBC with closer working arrangements via the North West London Acute Provider Collaborative (APC).

An Outline Business Case (OBC) was approved in May 2022, subject to advice and assurance which have been responded to in a Pre-Consultation Business Case (PCBC) published in August 2022 and the Decision-making Business Case (DMBC) was endorsed in March 2023.

What has changed from OBC?

Strategic Case:

- The case for change remains relevant with updated modelling and analysis developing a need to address elective orthopaedic waiting times while aligning with long term strategic models of care as defined by Get It Right First Time (GIRFT), NWL Integrated Care System (ICS) and LNWH Trust strategy.
- The London Clinical Senate said: "*there is a clearly articulated case for change and a background evidence base which supports the quality and outcome improvements anticipated by the changes*".

Economic Case:

- Since the OBC the service selection process was validated and the economic appraisal was refreshed to show option 5 (LNWH DC + IP plus all NWL IP) remains the preferred option, with a NPV of £35.510m over a 25-year period.
- The economic case now includes a summary of the societal benefits, which drive an increase in NPV from £35.510m to £52.771m (driving up the ROI ratio from 3.8:1 to 5.6:1).
- The site selection process was also validated to confirm CMH as the preferred site option. In response to public consultation and assurance feedback, a robust transport solution continues to be designed for the EOC.

Financial Case:

- Capital expenditure is still expected to be £9.412m, and we have confirmed this will come from NHS TIF.
- Refreshed financial modelling shows a net I&E benefit in the first full year of operation of £3.968m to the NWL system.
- The principles underpinning the proposed financial and commercial arrangements between the acute trusts were jointly developed and agreed by the acute trust CFOs in March 2022. This was ratified by NWL APC Collaborative Finance and Performance Committee on 10th March 2023.

Commercial Case:

- The scope of services has not changed since the OBC.
- The physical structure of the centre will comprise of two additional laminar flow theatres, an extended recovery unit and supporting works.
- The design has been created in alignment with LNWH and NWL ICB's Green Plans and Net Zero ambitions and updated to comply with new ventilation requirements.
- The preferred procurement strategy involves a variation to the PFI Project Agreement.

- The tender process commenced in January 2023 for one month. Five tenders were received, and a joint (LNWH/PFI Project Co) recommendation will be made on the preferred Main Contractor and Tender Value to the EOC Programme Board with an intention to award contracts on 20th April 2023.
- A procurement timeline is set out from invitation to tender in January 2023 to the completion of construction works. Enabling works commenced between January and May 2023, in advance of construction commencing.

Management Case:

- The management case has been expanded and revised since the OBC to record the detailed governance model and implementation approach. This includes:
- detailed implementation plan by workstream with four gateways between now and go-live.
- communications and engagement plan that has patients and lay partners as a core component of governance and implementation.
- an ambition to achieve GIRFT accreditation by the end of 2024.
- plan to implement the transport solution through co-design with a working group in response to public consultation, JHOSC and Mayor of London.
- an expanded BRP that measures productivity, cost effectiveness, clinical outcomes, patient access, transport, patient satisfaction and workforce. Clarity on monitoring of in-scope and out-of-scope has been added in response to the London Clinical Senate and Mayor of London.
- a workforce model with individual staff group implementation approach has been developed in response to the Mayor of London, JHSOC and the Public Consultation.
- and articulating which mobilisation functions will be undertaken by whom and by when.

The case concludes with recommendations to the APC Board in Common and a number of appendices including full versions of the refreshed financial tables, BRP and risk register.

Table 1 shows a summary of feedback since the DMBC was published or commitments to additional information to be included in the FBC. A detailed matrix with feedback and how this has been met is included in Appendix 14.

Table 1 – Feedback since the DMBC

Feedback Theme	Source of feedback or request for further information				
	OBC	DMBC	Mayor's Tests	JHOSC	NWL ICB
BRP	✓		✓	✓	
Public engagement and patient involvement	✓	✓	✓	✓	✓
Implementation Plan	✓	✓			
Financial assumptions, updates and value for money		✓			
Workforce model		✓			
Transport solution		✓		✓	✓
Social Care			✓		✓
Enabling works	✓				

Appendices referenced throughout the paper have been made available to Board members separately due to size, and file formats and hence not published on the NWL Acute Provider Collaborative Website. These appendices can be made available to members of the public upon request.

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

NHS
London North West
University Healthcare
NHS Trust

North West London
Elective Orthopaedic Centre
Full Business Case
18th April 2023

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Tender report - not included due to commercial sensitivities

1 Executive Summary

1.1 Introduction

The North West London elective orthopaedic centre (NWL EOC) aims to deliver a high volume low complexity (HVLC) surgical hub and a centre of excellence for orthopaedic care in North West London by November 2023. An Outline Business Case (OBC) was approved in May 2022, subject to advice and assurance which have been responded to in a Pre-Consultation Business Case (PCBC) published in August 2022, the Decision-making Business Case (DMBC) was endorsed in March 2023 and this Full Business Case (FBC) will be presented to the North West London Acute Provider Collaborative Board in Common (NWL APC BiC) on 18th April 2023.

The purpose of this FBC is to offer Value for Money (VfM) and secure capital funding for the proposal. The ambition of the EOC remains the same as the OBC and has been strengthened since the OBC with closer working arrangements via the North West London Acute Provider Collaborative (APC).

1.2 Strategic Case

The case for change focuses on the clear, short-term imperative for addressing elective orthopaedic waiting lists and the longer-term strategic requirement to redefine the model of care whilst delivering a step change in quality and performance as defined by Get It Right First Time (GIRFT) top decile performance.

The case for change continues to be widely accepted since the OBC. The subsequent changes are due to updates in modelling and analysis refreshed since the OBC was published and this chapter sets out the key changes.

Wherever possible, the development of the NWL EOC has been tested against NWL strategies and national best practice. This supports the creation of a new EOC that operates within a system that has broad alignment and stakeholder support. NWL Acute Provider Collaborative (APC) has been fundamental in the development of this proposal. During implementation and opening, the EOC will be accountable to the NWL APC for strategy and business delivery through the EOC Partnership Board.

1.3 Economic Case

Service selection
Since the OBC, the economic appraisal of service options was refreshed to show that option 5 (London North West University Healthcare NHS Trust (LNWH) Orthopaedic day cases and inpatients + all NWL Orthopaedic Inpatients within scope) remains the preferred option.

Using the discounted cashflow over a 25-year period as the measure of return, the return on investment (ROI) is determined by taking the incremental financial cashflow of quantified benefits as a proportion of the initial capital investment made. For the preferred option, this is calculated by taking the return of £35.510m over the initial investment of £9.412m generating a ratio of 3.8:1. This is relatively high and close to the Treasury target ROI for public sector capital investment. This indicates that, over the term of the reported cashflow, the initial investment will be recovered nearly 4 times over. The payback period is 2 years and 357 days from day one of mobilisation.

We have also considered the financially quantified social benefits of the service change, increasing the net present value over a 25-year term of the business case increases from £35.510m to £52.771m. This provides us with an economic ROI ratio of 5.6:1 (in that the net present value covers the £9.412m cost of investment 5.6 times over).

Site Selection
Since the OBC we have reviewed and revised the site selection process to validate Central Middlesex (CMH) as the preferred site option. In response to consultation and assurance feedback, the FBC includes

a transport implementation plan with a working group to develop and deliver an EOC transport solution that works for the population of NWL.

Wider economic benefits

The FBC includes a new piece detailing several societal benefits:

- Positive impact to a patient's long-term quality of life as a consequence of fewer readmissions.
- Positive impact to a patient's long-term quality of life as a consequence of faster access to treatment.
- Reduction in patient sick days from employment as a consequence of faster access to treatment.
- Positive economic impact on local spending as a consequence of increased footfall.
- Negative impact of increased carbon emissions as a consequence of additional average journey distance to travel to care.

1.4 Commercial Case

The commercial case has been developed since the OBC to describe the process and requirements to select a construction partner.

The scope of the services has not changed since the OBC with two additional laminar flow theatres, an extended recovery unit and supporting works. Modern methods of construction will be used where possible while key commercial and design standards complied with. The Design has been created in awareness of LNWH and NWL ICB's Green Plans and Net Zero ambitions and updated to comply with new ventilation requirements.

The preferred procurement strategy for the EOC is to undertake a variation to the PFI Project Agreement (PA). LNWH is experienced in this process and believes it offers the best value for money.

The tender process commenced in January 2023 for one month. Five tenders were received, and a joint (LNWH/PFI Project Co) recommendation will be made on the preferred Main Contractor and Tender Value to the EOC Programme Board with an intention to award contracts on 20th April 2023.

A procurement timeline is set out from invitation to tender in January 2023 to the completion of construction works in November 2023. Enabling works commenced at risk with approval from the LNWH Capital Review Group in advance of the FBC between January and May 2023.

The nature and extent of the construction works are such that there are no material Town Planning considerations.

1.5 Financial Case

The financial case has been refreshed since the OBC, including the income and expenditure position for the first two years as set out below. This shows a net income and expenditure benefit in the first full year of operation of £3.968m to the NWL system.

Table 1 - Income and expenditure summary for years 1 and 2

	Year 1 2023/24	Year 2 2024/25
	£m	£m
Income	18.906	31.613
Expenditure	(18.766)	(27.645)
Surplus/(Deficit)	0.140	3.968

Capital expenditure is still expected to be £9.412m, which will come from NHS Targeted Investment Funding (TIF), following a successful bid. If there is a delay in receipt of TIF funding, the Trust will proceed at risk from its own capital programme whilst seeking capital funding from NWL ICS. It will need to monitor the position on an ongoing basis. The capital is within the NWL ICS capital departmental expenditure limit (CDEL).

The capital spend is profiled £1.3m in 2022/23 and £8.1m in 2023/24. £0.200m of enabling works is being funded in advance of business case authorisation to ensure the critical path for the development and construction of the EOC remains on track.

Taking into account the modelling principles employed and the results of the sensitivity analysis, the financial case demonstrates that the financial modelling assumptions are sufficiently prudent for the model to be able to absorb the most likely outcomes over mobilisation and over the longevity of the case.

The sensitivity and scenario analysis highlights the robustness of the modelling when tested against a number of parameters i.e., rising inflation, impact of inner London weighting from any TUPE staff and cost of temporary staffing for groups with highest vacancies.

The principles underpinning the proposed financial and commercial arrangements between the NWL Acute Trusts have been jointly developed and were agreed by the acute trust Chief Financial Officers (CFOs) on 4th March 2022. This was ratified by NWL APC Collaborative Finance and Performance Committee on 10th March 2023.

The financial model has been developed considering the recurrent investment needs flagged to facilitate a Lead Provider Hosting model. Revenue and capital costs have been captured to facilitate the needed digital infrastructure specific to the EOC development. To support realisation of productivity ambitions, significant investment has been included in new ways of working training.

As part of the governance process, an addendum to the FBC has been produced, setting out the activity and financial implications for each organisation to support decision making on an open and transparent basis.

1.6 Management Case

The management case details the arrangements in place for the management, governance, delivery and monitoring of the development of NWL EOC.

The management case of the FBC been revised and updated from the OBC to record the detailed management arrangements that have been put in place to ensure the successful delivery and evaluation of the project.

Since the OBC, the governance model has been further developed with clearly defined reporting lines to both the LNWH Trust Executive and the NWL APC. The EOC's structure has been created that recognises the EOC as a distinctive partnership clinical service, while also reflecting the structure of a LNWH clinical division to ensure full accountability and governance.

An implementation approach that uses multiple gateways between now and go-live; these serve as assurance checkpoints, with each gateway being overseen by a Gateway Review Panel that draw on internal and external peers for review.

Detailed implementation timelines are split by the four workstreams: Corporate, Clinical Design (including digital), Workforce and Estates to provide a clear critical path which will be reviewed and updated as the project progresses.

Since the OBC, a clinical implementation section has been developed that describes the approach to theatre allocation within the EOC amongst the four trusts and the ambition to achieve GIRFT accreditation by the end of 2024.

In response to public consultation feedback and advice & assurance provided by key stakeholders following publication of the DMBC, the FBC includes a transport implementation plan with a working group to develop and deliver an EOC transport solution that works for the population of NWL. This group's membership will be determined in April and will include patients, carers and staff.

The benefits realisation plan (BRP) has been expanded to include detailed KPIs on productivity, cost effectiveness, clinical outcomes, patient access, transport, patient satisfaction and workforce. It also describes how in-scope and out-of-scope activity will be monitored by the EOC and the wider NWL to ensure parity of access.

Management of any significant barriers and risks to implementation will be undertaken via the Shadow Partnership Board and EOC Management Board, with monthly reports to the APC Board in Common. A comprehensive project risk register was developed for the OBC and has been updated, using qualitative measures to calculate the overall level of risk according to their impact and probability.

1.7 Recommendation

This Full Business Case sets out a vision for a new EOC based on a compelling case for change. When delivered, it will achieve a significant improvement in the quality and access to planned orthopaedic care for the people of NWL.

The business case seeks approval from the board of LNWH for the capital funding requirement of £9.412m for an EOC at Central Middlesex Hospital.

The APC Board-in-Common is asked to note that the business case has revenue implications, with a net income and expenditure benefit in the first full year of operation of £3.968m to the NWL system. Other key considerations related to the financial and commercial cases, as well as the fact that the FBC has responded to all assurance feedback and requests for additional information, are also highlighted.

2 Introduction and Background

Chapter Summary
Chapter 2 sets out the process so far to create an elective orthopaedic centre (EOC) in North West London (NWL) with a preferred option of a single site centre at London North West University Healthcare NHS Trust (LNWH).

Key messages

- The purpose of this Full Business Case (FBC) is to offer Value for Money (VfM) and secure approval for the capital spend.
- Since the OBC was first approved in May 2022, the proposal has gone through several milestones including public consultation, NHS England assurance and Mayor of London advice.
- Following DMBC approval in March 2023, LNWH is the lead provider working in partnership with the NWL Acute Provider Collaborative (NWL APC).
- The vision for a NWL EOC remains consistent with Getting It Right First Time (GIRFT) best practice and British Orthopaedic Association (BOA) recommendations.

2.1 Purpose of the Full Business Case

The NWL EOC aims to deliver a high-volume low complexity (HVLC) surgical hub and a centre of excellence for orthopaedic care in North West London by November 2023. An Outline Business Case (OBC) was approved in May 2022, subject to advice and assurance which have been responded to in a Pre-Consultation Business Case (PCBC) published in August 2022, the Decision-making Business Case (DMBC) was endorsed in March 2023 and this Full Business Case (FBC) will be presented to the North West London Acute Provider Collaborative Board in Common (NWL APC BiC) on 18th April 2023.

The purpose of this FBC is to:

- Record the findings of the procurement phase.
- Identify the option that offers the 'most economically advantageous tender' - identifying the marketplace opportunity which offers optimum Value for Money (VfM) and achieves best public value.
- Set out the commercial and contractual arrangements for the negotiated deal.
- Confirm the deal is still affordable.
- Put in place the agreed management arrangements for successful delivery, monitoring and post-implementation evaluation of the scheme.

Much of the work undertaken in producing this FBC has focused on revisiting, and updating where necessary, the conclusions of the Outline Business Case (OBC), reviewing and refining the new model of care and documenting the outcomes of the procurement. Additionally, this FBC captures and responds to feedback from the various milestones on the assurance and decision-making route that are described in the key messages above.

The FBC follows the recommended Five Case Model as per the UK HM Treasury Business Case Guidance (The Green Book: appraisal and evaluation in central government HM Treasury guidance on how to appraise and evaluate policies, projects and programmes 3 Dec 2020[1]). The five cases are strategic, economic, financial, commercial and management.

This document demonstrates a revisited and compelling case for change and explains how the proposed new care model will address the service requirements and constraints outlined in the case for change and deliver on the investment objectives. The FBC also revisits the affordability, benefit quantification and the funding required, alongside the procurement and management processes put in place to ensure successful delivery of this scheme.

2.2 Approvals and process so far

The proposal for an EOC has met several key stages of endorsement within LNWH and the wider North West London Integrated Care System (NWL ICS):

Table 2 - NWL EOC governance timeline

Date	Milestone	Governance forum
24 May 2022	OBC approved	LNWH Trust Board
27 September 2022	PCBC endorsed	NWL ICB Board
19 October 2023	Start of public consultation	n/a
20 January 2023	End of public consultation	n/a
27 January 2023	Public consultation report published and endorsed	NWL EOC Programme Board NWL ICB Service Change Governance Project Delivery Group Public Consultation Steering Group
16 February 2023	IIA approved	NWL ICB EHIA panel
23 February 2023	Present public consultation report, refreshed IIA and refreshed evidence informing decision making	NWL ICB Strategic Commissioning Committee
8 March 2023	Present public consultation report and update	NWL JHOSC
14 March 2023	Present draft DMBC	NWL APC Board in Common
21 March 2023	DMBC endorsed	NWL ICB Board
5 April 2023	FBC presented	LNWH Trust Executive Group
18 April 2023	FBC presented	NWL ICB APC Board in Common

2.3 Origins of the proposal

The four acute NHS trusts in NWL – Chelsea and Westminster Hospital NHS Foundation Trust (CWHFT), The Hillingdon Hospitals NHS Foundation Trust (THHFT), Imperial College Healthcare NHS Trust (ICHT) and London North West University Healthcare NHS Trust (LNWH) – have been working closely together throughout the response to COVID-19 and in the period since we emerged from the pandemic. This led to the establishment of a formal Acute Provider Collaborative (APC) in July 2022.

The APC forms part of the NWL Integrated Care System (ICS). The provision of healthcare services for the population of NWL is overseen by the NWL Integrated Care Board (ICB) and it is the population's needs that are at the heart of the proposal set out in the PCBC, which aims to improve planned elective orthopaedic care service delivery.

The case to improve planned elective orthopaedic care service delivery remains undiminished. To support collaborative and coordinated working across the acute collaborative providers, a lead provider model was put in place. LNWH is the lead provider for elective orthopaedic care and, again drawing on evidenced best practice, the Trust has led work on exploring the potential for a dedicated EOC for NWL, focused on determining whether greater benefits to patient care in terms of quality, equity, efficiency and sustainability would be achieved by creating an EOC for routine, planned inpatient orthopaedic surgery in NWL.

2.4 Ambition of the EOC

The vision for a NWL EOC is consistent with the model recommended by GIRFT and the British Orthopaedic Association (BOA) and adopted widely in London and nationally.

The intention is to create a centre of excellence for planned orthopaedic care, delivering productivity and quality of care for patients that consistently meets best practice, delivers optimum value and builds on the learning from the South West London Elective Orthopaedic Centre (SWLEOC) model and other EOCs.

The NWL EOC will be fit for the future. It is designed using evidence from a range of sources, in addition to GIRFT and the BOA, including the National Joint Registry and other professional bodies. There will be sufficient capacity to meet current and future demand resulting in timely access to services.

The potential benefits for patients will be:

- faster access (due to sufficient capacity).
- equitable access.
- consistent and best practice care in a centre of excellence.
- better clinical outcomes.
- improved preoperative care.
- shorter length of inpatient stay.
- dedicated facilities and reduced likelihood of cancellation.
- dedicated, specialist post-operative care and service.
- increased investment due to potential savings from repatriation from out of sector.
- a COVID-secure environment.

The GIRFT vision is for 'cold' elective surgical hubs, offering ring-fenced beds and ultra clean air theatres, thus delivering evidence-based best practice in relation to protection against infection. Standardisation of care ensures the highest levels of productivity and value for money. This proposal is compatible with best practice recommendations from GIRFT, as shown table 3, and is supported by the National Director of Clinical Improvement for the NHS.

Table 3 - GIRFT best practice recommendations for elective orthopaedics

Theme	GIRFT comment	Does the EOC meet best practice?
Ring-fenced beds	Best practice is rigidly to enforce ring-fencing of elective orthopaedics minimises infection. Some trusts have achieved this, others have not.	✓
Hot and cold sites	By separating "hot" unplanned emergency work from their "cold" elective work, trusts have seen reductions in average length of stay, reductions in cancellations of surgery and increased elective activity during winter pressures.	✓
Minimum volumes	Surgeons should perform 35 or more total hip replacements per year to avoid increased complication rates. There is still work to be done with providers to achieve this.	✓
Choice of implant	Surgeons should follow the evidence that choice of implant should be tailored to the patient need. Best practice is that 80% of patients over 70 should receive a cemented hip.	✓
Surgical site infection (SSI)	Variation in SSI rates were found when GIRFT started their visits. Ring-fencing, hot/cold sites and laminar flow are key factors in reducing infections.	✓
Rehabilitation services	Particularly relating to increased physiotherapy service for elective and hip fracture patients – 7 days a week in hospital and continuity into the community.	✓
Procurement	Variable implant costs and use of loan kits has been tackled through improved visibility and price negotiations.	✓

3 Strategic Case

Chapter Summary
Chapter 3 sets out how the case for change has been reviewed and re-validated since the Outline Business Case (OBC) with a clear understanding of the changes faced within the system, as well as the rationale, drivers and objectives for the proposal.

Key messages:
The drivers for change remain undiminished:

- North West London (NWL) Orthopaedic waiting lists currently stand at 16,000 patients.
- There is inequality in access to elective orthopaedic services among Black, Asian and minority ethnic (BAME) groups.
- NWL elective orthopaedic care underperforms against key quality indicators.
- Insufficiently joined-up care across primary, community and acute services and care that is not sufficiently focused on the needs of the patient.
- There remains significant unwarranted variation in theatre utilisation and downtime.
- Some healthcare roles are challenging to recruit.

The case for change aligns with national best practice and NWL Integrated Care System (ICS) strategy to move towards high volume, low complexity surgical hubs.

3.1 Case for change

The case for change has been widely accepted through the OBC, PCBC, DMBC and external assurance. The six drivers for change identified remain undiminished:

- Growing demand and increasing waiting times.
- Population health challenges, including large health inequalities.
- Underperformance against key quality indicators, wide variations in quality and disruption to planned care caused by surges in unplanned car.
- Insufficiently joined-up care across primary, community and acute services and care that is not sufficiently focused on the needs of the patient.
- Unwarranted variations in theatre utilisation and downtime.
- Staff recruitment and retention challenges.

Waiting lists and waiting times
The total NWL orthopaedics waiting list for care has been rising with an approximate 30% increase since April 2022 following elective recovery since the disruption caused by COVID-19. Due to winter pressures, this list has grown by about 1,000 additional patients since September 2022. The waiting list, as of January 2023, currently stands at over 16,000 patients.

Waiting times for inpatient surgery from decision to admit (DTA) have improved slightly since 2021/22 from 24 to 22 weeks, although still worse than 2019/20 where it was 15 weeks. This metric is measured from the date the patient is added to the waiting list (once both the patient and clinician decide there is a need for surgery) until completion of the surgery itself.

The number of patients waiting more than a year in NWL for elective orthopaedic surgery specifically has risen by c.200 from 4 patients pre-COVID-19.

As a result of establishing an EOC waiting times between DTA and surgery for inpatients will see a reduction in the region of 3-weeks at Year 1 and 9-weeks at Year 2. This will mean patients waiting times for orthopaedic surgery will halve, in most cases, at year 2, and the number of patients on the waiting list will reduce to pre-COVID levels.

Table 4 - Modelled reduction of DTA to surgery waiting times for day case and inpatients for all NWL elective trauma and orthopaedic care following the opening of the EOC (midpoint (range) in weeks)

	No EOC	EOC opens	
	Current Wait	**Year 1**	**Year 2**
EOC Inpatient	22 (18-29)	19 (15-24)	13 (9-18)
NWL Day case (excluding EOC)	15 (13-16)	11 (8-15)	6 (3-10)

Population health challenges

The projected population for London by 2050 is expected to reach over 10 million people as per 2020 GLA Housing Led Population Growth Projections. Musculoskeletal disorders remain the third leading contributor to the total burden of disease (represented by disability-adjusted life years (DALYs) in Greater London and increased by nine per cent between 2009 and 2019. People aged 65 and over account for a third of elective orthopaedic patients in NWL. These three factors combined show an ageing population with health challenges that will lead to increased demand on MSK services.

Demographic analysis of the historic use of elective orthopaedic services across NWL has shown that some health inequalities exist across deprivation and ethnicity. Addressing these is a priority for NWL ICB, and actions to reduce health inequalities will be incorporated into the design and implementation of the EOC.

The IIA has noted that historic use of elective orthopaedic services is slightly higher in the more deprived areas of NWL. This reflects the higher prevalence of MSK disorders in the more deprived deciles of the population, which the Mayor of London has also noted.

The IIA has also noted that the historic use of elective orthopaedic services is lower in the Black Asian and Minority Ethnic groups, compared to the white population. Research from the 2022 Health Survey of England[1] indicates a similar prevalence of MSK conditions among ethnic minorities compared to the national average. While ethnic minorities have a younger population on average, so you would expect a lower use of elective orthopaedic services, there is still a gap when adjusting for age. This suggests inequalities in access to elective orthopaedic services.

The MSK pathway will be routinely reviewed to identify and resolve bottlenecks to enable a seamless pathway and identify areas which might be driving health inequalities in access or outcomes. The EOC will actively monitor its waiting lists to avoid introducing any further inequalities within any protected characteristics or higher levels of deprivation. These inequalities are likely to arise at different points throughout the MSK pathway, and the EOC can help reduce inequalities within secondary care. However, the new community MSK pathway offers an opportunity to address inequality earlier in the pathway.

Underperformance against key quality indicators

NWL elective orthopaedic care underperforms against key quality indicators (KQI), from model hospital data and patient reported outcome measures (PROMs) across all Trusts.

When refreshed to Q2 2022/23 there has been no improvement in performance against key quality indicators (KQI) when compared to the OBC.

Table 5 - Key quality indicators for NWL

	ICHT	LNWH	CWHFT	THHFT
OBC KQI Average	Q3	Q3	Q2	Q4
FBC KQI Average	Q3	Q3	Q3	Q4

Key	Q1 – Top quartile performance	Q2 – Second quartile performance	Q3 – Third quartile performance	Q4 – Bottom quartile performance

[1] https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england

Estates and efficiencies
There remains significant variation in theatre utilisation and downtime across the NWL acute trusts providing elective orthopaedic surgery since the PCBC.

As part of the HVLC programme, GIRFT has set targets for Integrated Care Systems and providers to achieve the following:

- Cases per session - 2 cases per 4-hour list.
- Theatre utilisation - 85% utilisation by 2024/25.

Table 6 - Theatre efficiency and utilisation across NWL

	OBC (FY 2020/21)		DMBC (FY 2021/22)	
	Average number of orthopaedic cases per operating session	Theatre session utilisation (capped)	Average number of orthopaedic cases per operating session	Theatre session utilisation (capped)
NWL ICB T&O	1.4	70%	1.8	63%

Table 6 shows that while NWL theatre utilisation has not recovered post COVID-19, there have been improvements in the number of patients treated per session for all orthopaedic surgery. This is an average of all simple and complex, elective and trauma, inpatient and day case procedures across the system.

The development of a NWL EOC will enable more transformational change right through the peri-operative orthopaedic surgery pathway that address the barriers to effective and efficient theatre utilisation along with improving outcomes for patients and ensuring nobody is left behind. The development ensures that there is a clear focus and place for longer routine cases and shorter cases (these include day cases to be delivered more locally) both which are commonly referred to as high volume low complexity surgery. Offering high volume low complexity surgery using this model offers proven efficiencies of scale and has been shown to improve quality and patient experience.

Workforce: recruitment and retention
Recruitment and retention of skilled and engaged staff is one of the biggest challenges facing the NHS. The EOC plans to meet these challenges by:

- providing a greater range of training and career development opportunities, including new roles, such as advanced clinical practitioners and care navigators.
- making it easier for staff to move across roles and partner employers, with common approaches to ways of working.
- increasing resilience, including through greater appropriate cover.
- reducing sickness and absence rates.
- increasing more flexible working.
- reducing the use of bank and agency through more effective cover of the rotas with permanent staff.
- ensuring trainees and students have access to the highest quality education and training.

A report published in the British Journal of Healthcare Management in November 2022[2] examined four case studies and outlined how surgical hubs can be harnessed as a tool to improve training, retention, and overall staff experience:

"The volume of activity that takes place in a surgical hub can be an asset to training, as described in the Wrightington Hospital and Croydon and Purley Elective Centres case studies. This was also highlighted in the RCSE report (2022), which cited an example from the hub at the Surgical Treatment Centre in Roehampton, where a urology trainee had been able to perform 297 surgeries in just 5 months. The case studies also indicate that surgical hubs can provide an environment that is more conducive to learning than an acute hospital. Particularly in standalone sites, registrars, fellows, and other trainee staff can be

[2] Optimising surgical hubs for staff: case studies on training, wellbeing and retention, Tim Briggs, Peter Kay, Stella Vig, Alvin Magallanes, Haroon Rehman, Mary Fleming, and Isobel Clough 28:12, 1-9

ringfenced so they can focus on learning without the possibility of being called away. As mentioned in the Wrightington Hospital case study, this creates an environment in which trainees can flourish and lists can be planned in a way that balances efficiency with opportunities for learning."

As an innovative care model, with its potential for a range of new roles and ways of working and an aspiration to embed best clinical practice, the EOC will help us with both staff recruitment and retention. Ensuring the EOC is part of an integrated, end-to-end pathway together with the other NWL hospitals providing orthopaedic surgical care and with primary and community care partners, will help with wider staff recruitment and retention.

Conclusion
The case for change remains true and as relevant as when the OBC was published. The demand for elective orthopaedic care remains high in NWL with over 1,000 people added to the waiting list in less than a year. The mixed use of theatres and beds owing to demands for urgent and emergency care continues to challenge achieving more effective theatre utilisation and quality improvements for more routine, planned inpatient orthopaedic surgery in NWL.

3.2 Alignment with National, ICS and Trust strategy

Orthopaedics is one of the highest volume specialties and has one of the longest waiting lists. It is one of the first specialties to which GIRFT was applied to help drive efficiency, throughput and cost effectiveness. GIRFT first shone the light on areas for focus and improvement in Orthopaedics in March 2015. GIRFT identified three key steps to improve quality and productivity for high volume, low complexity (HVLC) surgery. These are:

1. separating elective and non-elective surgery
2. increasing day case surgery rates
3. improving the utilisation of asset such as operating theatres, x-ray equipment and other complex equipment, increasing theatre productivity and creating more efficient care pathways.

The NHS Elective Recovery Plan also includes surgical hubs as a key measure for focusing on high-volume routine surgery to enable a rapid increase in the number of patients can get seen more quickly, ensuring that emergency cases do not disrupt operations and cause cancellations or delays. Surgical hubs will reduce waiting lists, improve patient outcomes create a centre of excellence for clinical excellence and level up patient access and performance.

The NWL ICS Strategy is currently in development. When published it will also establish the framework for the ICS Estates Strategy. The ICS strategy will highlight a core ambition to improve access to elective surgery by moving to high volume, low complexity centres like the EOC. This draws upon best practice from other parts of England where the establishment of dedicated EOCs has led to improved clinical outcomes and has enabled more orthopaedic activity to be undertaken throughout the year, helping to reduce waiting times for life-changing joint replacements. Dedicated orthopaedic theatres will release capacity in other hospitals, contributing to elective recovery in other specialities. The EOC will bring together patients and specialists from across NWL in a purpose-designed centre with the goal of delivering rapid access and world-class clinical outcomes.

LNWH published its strategy for 2023-2028 in February 2023 called "Our Way Forward". The strategic vision was to place "Quality at our HEART", against which the EOC with its demonstrated quality benefits strongly aligns. The EOC supports each of the strategy's objectives addressing quality of care (including equity, timeliness and sustainability), high-quality employer, improved non-clinical support services and a commitment to partnership working. The strategy included the ambition for CMH to be an EOC.

An Integrated Impact Assessment, Equality Health Impact Assessment and Quality Impact Assessment have been completed, considering impacts on the different groups of the population of NWL, including those in the more deprived areas within NWL, and those with protected characteristics as defined by the UK government[3], and set out the mitigating actions that have be incorporated into the implementation plan of this FBC. This provides evidence and information to NWL ICS decision-makers to enable them to fulfil their duties under section 149 of the Equality Act 220 and section 14z35 of the NHS Act 2006.

[3] https://www.gov.uk/discrimination-your-rights

4 Economic case

Chapter Summary
Chapter 4 identifies and appraises the service and site options for the delivery of the project to recommend what is most likely to offer best value for money, and what aligns most closely with the established investment objectives and critical success factors.

Key Messages

- Following completion of the Public Consultation and DMBC phases of this programme, the recommended option as detailed in the OBC (option 5) has been endorsed as the preferred option.
- The economic appraisal shows the preferred option generates a positive NPV of £35.510m over a 25-year span. This is a result of this option achieving the optimal balance between efficiency gains and activity, income, and use of resources through the optimisation of capacity created.
- Using the discounted cashflow over a 25-year period as the measure of return, the return on investment (ROI) is determined by taking the incremental financial cashflow of quantified benefits as a proportion of the initial capital investment made. This is calculated by taking the return of £35.510m over the initial investment of £9.412m generating a ratio of 3.8:1. This is relatively high and close to the Treasury target ROI for public sector capital investment. This indicates that, over the term of the reported cashflow, the initial investment will be recovered nearly 4 times over. The payback period is 2 year and 357 days from day one of mobilisation.
- When factoring in the societal benefits, the NPV over a 25-year term increases from £35.510m to £52.771m, providing an economic return on investment of 5.6 times (in that the NPV covers the £9.412m cost of investment 5.6 times over).
- Five hurdle tests have been developed and used to assess the NWL sites to determine the optimum location for the NWL EOC. This has identified CMH as the preferred location based on factors which have been used to develop Orthopaedic Centres nationally and tailored for the NWL context.

The Trust has reviewed the options available to establish the model of care for the NWL EOC. The model of care has is evaluated from a non-financial perspective followed by a non-financial assessment of site location options. The economic appraisal is then undertaken based on the model of care options, assuming the preferred site location.

4.1 Service selection – long list appraisal

The following eight options were identified based on delivering the principle of creating an EOC of excellence for NWL, drawing upon the experience of other recently established NHS EOCs. While the Royal National Orthopaedic Hospital is in NWL, it was not considered as an option as it plays a regional role rather than a sector one, and does not carry out the routine, low complexity orthopaedic procedures considered in the business case. Do nothing/ Do minimum options were included in line with NHSE service change guidance and HM Treasury Green Book Guidance:

- Option 0: Do Nothing – Retain the current model of distributed elective Orthopaedic Surgery across the NWL catchment area.
- Option 1: Do Nothing Plus – Option 0 plus Orthopaedic Joint Weeks (based on proof of concept currently being undertaken within LNWH).
- Option 2: Do Minimum – Option 1 plus return to “business as usual” activity levels pre COVID-19.
- Option 3: All NWL Orthopaedic inpatient activity but no day cases.
- Option 4: LNWH Orthopaedic day cases and inpatients + NWL hip and knee joint replacements.
- Option 5: LNWH Orthopaedic day cases and inpatients + all NWL Orthopaedic Inpatients.
- Option 6: LNWH Orthopaedic day cases and inpatients + NWL Orthopaedic day cases and inpatients.
- Option 7: LNWH day cases and inpatients + NWL day cases and inpatients + NHS day cases and inpatients currently outsourced to the private sector (the latter applies to this option only)

4.1.1 Investment objectives and critical success factors

A workshop was held in November 2021 to shortlist the options for the services, with representation from orthopaedic clinicians, therapies, estates, operations, nursing, and finance. The workshop qualitatively assessed each option against the investment objectives (IOs) and critical success factors (CSFs).

Table 7 - NWL EOC Investment Objectives

Investment Objective	Description
a) Improve Outcomes	To deliver improved outcomes without raising costs. To reduce surgical site infections.
b) Improve Equality of Access	To improve equality of access by introducing a single waiting list for inpatient elective orthopaedics across NWL.
c) Reduce Inequalities	To reduce inequalities by delivering accessible elective orthopaedic care to groups within our population who find it harder to access care.
d) Improve Staff and Patient Satisfaction	To recruit, retain and develop staff and achieve high levels of staff satisfaction. To improve patient experience.
e) Improve Productivity and Reduce Variation	To achieve best practice by reducing variation and meeting top decile performance for length of stay and cases per list.

Table 8 - NWL EOC Critical Success Factors

Critical Success Factor	Description
a) **Strategic Fit**	How well the option: • Meets the NW London HVLC strategic aims (i.e., risk mitigation; resilience & recovery; system redesign).
b) **Capacity & Capability**	How well the option: • Can be delivered within a robust sector-wide governance framework. • Appeals to all partner trusts.
c) **Affordability**	How well the option: • Can be financed from available capital funds. • Aligns with ICS investment priorities. • Improves financial sustainability.
d) **Achievability**	How well the option: • Can ensure operational start date in 2022/23 to start improving PTL back to pre-COVID BAU. • Can provide the required staffing numbers. • Can be delivered with appropriately skilled staff.
e) **Value for Money**	How well the option: • Optimises the use of NHS resources (i.e., staff; estate). • Optimises the use of available NWL estate.

From the longlist of the eight service options, five service options were shortlisted during the workshop by assessing each option against the IOs and CSFs.

4.1.2 The services shortlist

The shortlisted options were Options 1, 4, 5, 6 and 7. The rationale for each of the shortlisted options is detailed below:

- **Option 1 –** This option scored low. There is limited evidence currently of the benefits of 'joint weeks', as they tend to have a detrimental effect on productivity in the weeks before and after. It was, however, the most appealing of the 'Do nothing' options as it offered more potential for productivity improvements than returning to business as usual which, even though it received the same score, was less credible as a baseline comparator option.

- **Option 4 –** This option delivers improved clinical outcomes for the patient cohort it serves. It largely meets the objectives of improved access, equality, and productivity for that cohort, and offers an opportunity for staff to work in a centre of excellence. It also largely meets the national and sector strategic agenda. It scores lower than other options because it does not fully meet any IO or CSF, other than improved clinical outcomes, because it benefits a more limited cohort of patients.
- ***Option 5* –** This was the highest scoring option, delivering improved clinical outcomes to the patient cohort it serves. It fully meets all critical success factors, meeting the national and sector strategic agenda while being deliverable within the expected resource. This was the only option that was considered to be value for money given that the projected level of activity within scope of this option is deliverable within the currently available NWL estate.
- **Option 6 –** This option, while fully or largely meeting the objectives and fully meeting the national and sector agenda and being broadly supported by partners, was considered only partially affordable or deliverable given the size of the capacity required. It was considered likely that there is no location that could be identified that could reasonably or affordably provide the capacity required.
- **Option 7 –** The advantages and disadvantages of this option were similar to those of Option 6 but scored lower against two criteria. It was considered unachievable within the required time frame because of the complexity of untangling existing arrangements with providers and was considered more complex in terms of governance and appeal to the four acute trusts. As with Option 6, it was considered likely that there is no location that could be identified that could reasonably or affordably provide the capacity required.

4.2 Service selection - short list appraisal

The scoring of the five shortlisted service options was undertaken by a multidisciplinary group, which included clinical representation, to identify one preferred option for the services. The following evaluation criteria were developed, weighted, and scored to reflect their relative order of importance:

Table 9 - Weighted scores for shortlisted service options

			Option 1	Option 4	Option 5	Option 6	Option 7
Evaluation criteria	Sub-criteria	Criteria weightings	Weighted scores				
1 Quality of Care and Safety	a) Impact on clinical outcomes b) Improved patient safety c) Enhanced infection control	23	46	161	184	161	161
2 Activity and Capacity	a) Can accommodate activity and has capacity to expand to meet demand	10	20	60	70	70	70
3 Patient Pathways, Flow and Access	a) Facilitates more efficient pathways, supporting rapid flow, as reflected in impact on PTL b) Supports more equitable access and patient choice c) Reduces lengths of stay d) Lowers likelihood of cancellation e) Model of care addresses inequalities	20	20	120	140	120	120

4 Workforce	a) Enables improved retention and recruitment b) Staff development – excelling in orthopaedics c) Workforce remains a key consideration in all NWL Trust Board Assurance Frameworks	8	36	108	144	108	108
5 System Wide	a) Achieves centre of excellence for all major joints b) More effective management and use of theatre resources	5	5	30	35	40	40
6 Operational sustainability	a) Services can be maintained in the event of a surge in demand or through subsequent waves of COVID b) Enables separation of elective and emergency activity	17	15	90	105	90	90
7 Ease of Implementation/ Deliverability	a) Requires minimal disruption to services during implementation	12	96	60	60	48	48
8 Teaching and Research	a) The solution supports teaching and research activities by providing an environment of sufficient size which will be attractive to staff.	5	30	40	40	30	30
Total Weightings = 100		100					
TOTAL RAW SCORE			23	50	57	50	50
TOTAL WEIGHTED SCORE			268	669	778	667	667
RANK			5	2	1	3	3

The results of the final service evaluation show that the preferred service option is Option 5 which scored higher than the other options. This is driven by:

1. **Quality of care and safety –** Option 5 is marginally better because there is a wider evidence base of success with other centres of excellence.
2. **Workforce –** recruitment is better with centres of excellence, although there is a tipping point beyond which the benefits of consolidation are eroded because other sites become denuded for example, for trauma.

3. **Operational sustainability –** currently, NWL does not have a fully hypothecated workforce across the system for elective and emergency. There are underlying workforce gaps. A relatively much larger centre would create less flexibility if located in hospitals that have A&E and trauma and which may have to repatriate surgeons to maintain core services in the originating hospitals.

The clinical model for the EOC is based on treatment of all NWL ASA 1 and 2 inpatient cases, excluding spinal and joint revisions. The day case and ASA 3, 4 and 5 cases plus spinal and joint revisions will be treated as currently and are not part of the service change.

4.3 Economic appraisal of service options

At the time of the OBC being drafted (May 2022), economic and financial modelling was carried out using London North West University Healthcare NHS Trust Central Middlesex Hospital. Following conclusion of the public consultation and DMBC, option 5 (LNWH Orthopaedic day cases and inpatients + all NWL Orthopaedic Inpatients) has now been selected as the preferred option. The economic appraisal analysis was refreshed as part of the FBC development, validating this service option selection.

The results of the economic appraisal showed Option 5 has the most positive Net Present Value (NPV) of the shortlisted model of care options, making it the most financially attractive option with the highest cash inflows over time compared to cash outflows. This is a result of this option achieving the optimal balance between efficiency gains and activity, income and costs associated with each incremental increase in activity within the EOC for each shortlisted option.

Capital investment and costs
The appraisal shows a capital requirement of £9.412m for the preferred option.

Table 10 - Capital expenditure by option

Option	Name of option	Total £m
Option One - Base Case	Do Nothing (LNWH)	0
Option Four	LNWH DC & IP + NWL Hips & Knees	(4,995)
Option Five - Preferred Option	LNWH DC & IP + NWL IP	(9,412)
Option Six	LNWH DC & IP + NWL DC & IP	(18,247)
Option Seven	LNWH DC & IP + NWL IP & DC + NHS IP & DC Cases Treated Privately	(22,664)

The cost of capital was treated consistently for all 5 options presented. If considering solely the cost of investment, Option 7 would need the greatest level of capital funding, with Do nothing requiring no investment. This should be looked at in the context of which option could deliver the best ROI.

A provision has been made to cover stranded costs for the three referring entities during the mobilisation year. This was based on a 6-month relief of overhead costs as communicated by the home trusts to allow for a period of adjustment while the space is repurposed.

Stage 4 design plans for the preferred option have now been through the tender process, confirming the £9.412m capital estimate in the OBC is correct. OBC costing included a 23% optimism bias. As LNWH now has a fixed price offer for the construction works needed, this has been reduced to 12% (5% general continency and 7% optimism bias). This is still a heightened provision as c. 5% is usually applied.

Net Present Value calculations
Cashflow calculations using a discount factor of 10% over 25 years show option 5 generates the best increase in discounted cashflow over the appraisal period of £35.510m, with the next best option (option 6) being 45% lower.

Table 11 - Economic appraisal summary for shortlisted service options showing the NPV

Option	Description	NPV (25 yrs.) £m
Option One - Base Case	Do Nothing (LNWH)	(23.474)
Option Four	LNWH DC & IP + NWL Hips & Knees	3.015
Option Five	LNWH DC & IP + NWL IP	35.510
Option Six	LNWH DC & IP + NWL DC & IP	21.531
Option Seven	LNWH DC & IP + NWL IP & DC + NHS IP & DC Cases Treated Privately	19.609

Using the discounted cashflow over a 25-year period as the measure of return, the return on investment (ROI) is determined by taking the incremental financial cashflow of quantified benefits as a proportion of the initial capital investment made. For the preferred option, this is calculated by taking the return of £35.510m over the initial investment of £9.412m generating a ratio of 3.8:1. This is relatively high and close to the Treasury target ROI for public sector capital investment. This indicates that, over the term of the reported cashflow, the initial investment will be recovered nearly 4 times over. The payback period is 2 year and 357 days from day one of mobilisation.

Impact on income and expenditure
The impact of each option on the income and expenditure position is shown below.

Table 12 - Income and expenditure position by year by option

Option	Year 1 (£m)	Year 2 (£m)	Year 3 (£m)	Year 4 (£m)	Year 5 (£m)	Total (£m)
Option one – Base case	(2.047)	(2.111)	(2.209)	(2.327)	(2.449)	(11.143)
Option four	(1.973)	689	709	700	685	810
Option five	140	3.968	4.159	4.323	4.464	17.054
Option six	(2.226)	2.210	2.255	2.250	2.234	6.723
Option seven	(2.105)	1.922	3.066	3.084	3.089	9.057

Over the initial 5-year term, Option 5 presented the most positive improvement in income and expenditure position, contributing £17.054m over a 5-year period with Do nothing representing a future deterioration of £11.143m over the same period (based on London North West existing caseload).

Table 13 - Income and Expenditure position for the preferred option

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	2023/24	2024/25	2025/26	2026/27	2027/28	
	£m	£m	£m	£m	£m	£m
Income	18.906	31.613	32.742	33.917	35.097	152.275
Expenditure	(18.766)	(27.645)	(28.583)	(29.594)	(30.632)	(135.220)
Surplus/(Deficit)	140	3.968	4.159	4.323	4.464	17.054

In conclusion, the economic appraisal showed Option 5 to be the preferred care model option. Of the care model options assessed, Option 5 had the most positive NPV, generated the best increase in discounted cash flow, the most positive improvement in income and expenditure position and the best return on investment.

Identification of the preferred option
The modelling also shows the preferred option enabling a significant increase in the volume of elective orthopaedic surgery undertaken in NWL. For example, for the hospital option modelled, this includes an additional 3,500 procedures annually based on current cases per session.

The starting month is November 2023 and activity has been modelled based on the ramp up over the initial 5 quarters as detailed below (aligned to the NWL Operating Plan principles) with GLA growth modelled between 2025-29. Beyond 2029, growth is capped from 2029 as bed capacity is exhausted.

Table 14 - Activity phasing by quarter

Period	Scenario Description
23/24 – Q1	109% LNWH 2019 (no population growth)
23/24 – Q2	109% LNWH 2019 (no population growth)
23/24 – Q3	109% LNWH (no population growth) + 75% sector 2019 (+ sector target growth of 109%)
23/24 – Q4	109% LNWH (no population growth) + 109% sector 2019
24/25 – Q1	110% LNWH (no population growth) + 110% sector 2019

NHS pay rates have been assumed for the workforce models needed to service the intended activity model and these have been costing including on costs, enhancements with 15% of posts assumed to be filled with temporary staffing (10% Bank and 5% Agency).

For Inpatient cases being referred into the centre, revisions and patients with an ASA score of 3 or above have been excluded from scope.

To gauge the financial reward potential of each of the finance statements, it is important that the three key financial statements are considered as in the Finance Case. Namely, these are the Income and Expenditure Statement, Impact on the Trust's Balance Sheet (Capital ask) and the discounted cash flow position.

More details on the analysis behind the economic appraisal of the service options can be seen in appendix 1.

Risk analysis
As a detailed level of care has been undertaken when financially appraising the case supported by the DMBC approval stage gate, the cost consequences and risk mitigations are balanced out with supporting sensitivity analysis (section 6.7) testing any material areas of risk.

4.4 Wider economic benefits

Societal benefits
Societal benefit is one which is quantifiable in monetary terms, but for which the benefit is realised by society outside of the health economy. For example, helping someone to recover from ill health and return to work earlier than otherwise, increases economic activity but does not impact the health service. Quality adjusted life years (QALYs) are a common example of societal benefits arising from health care investments. One QALY equates to one year in perfect health.

Table 15 - Societal benefits

Benefit description	Calculation of benefit	Assumptions made	Total economic value (Year 1)	Total economic value (Year 2)	Total economic value (Year 3)
Impact to a patient's long term quality of life as a consequence of fewer readmissions	6 months faster recovery (X) The number of patients impacted (X) Quality of Additional Life Years	QALY value - £19,802 Improvement in readmission rate – 3% 6 month delay in recovery if needing readmission	£419,529	£1,066,961	£1,084,033
Impact to a patients long term quality of life as a consequence of faster access to treatment	Predicted fall in Waiting Times (3 - 5 Weeks) (X) The number of patients impacted (X) Quality of	QALY value - £19,802 Reduced waiting list – 3 weeks	£2,603,118	£6,620,342	£6,726,267

	Additional Life Years				
Reduction in patient sick days from employment as a consequence of faster access to treatment	Predicted fall in Waiting Times (3 - 5 Weeks) (X) Employment Rate (NWL Specific Employment Rate) The number of patient impacted (X) Average Salary in NWL (X) MSK Reason - Not Working (X) Proportion of ASA 1 & 2 patients who are aged 16 to 65	Reduced waiting list – 3 weeks NWL Employment Rate – 57.56% Average NWL Salary - £26,113 ASA 1&2 patients – 69.1% % Sickness (London) – 1.40% % Sickness for MSK – 13.40%	£2,562	£6,516	£6,620
Reduction in patients who need unemployment support and can return to economic activity as a consequence of faster access to treatment	Predicted fall in Waiting Times (3 - 5 Weeks) (X) NWL Employment Rate (X) Average Salary in NWL (+) Universal Credit (X) MSK Reason - Not Working (X) Proportion of ASA 1 & 2 patients who are aged 16 to 65	Reduced waiting list – 3 weeks NWL Economic Inactivity – 21.1% Inactivity due to ill health – 28.4% MSK the cause of ill health – 40.6% Average NWL Salary - £26,113 Universal Credit - £4,018 ASA 1&2 patients – 69.1%	£66,509	£169,150	£171,856
Economic impact on local spending	Average price of a hot beverage (X) Number of Patients + 1 Visitor	Average price of a major coffee supplier - £3.69	£16,816	£42,767	£43,451
Increased cost of carbon emissions for increased travel to care	% Patients that use a car (X) Average miles travel increase to EOC (X) Average Car Carbon Emission (X) Carbon Cost per Ton (X) ULEZ impact	Patients that use a car to travel to hospital – 77% Average additional miles – 3.53 Average car carbon emissions – 404g of CO2 per mile Carbon cost per tonne - £83.03	£ (83.17)	£ (211.52)	£ (214.90)

	Reduction in emissions due to ULEZ – 5%			
	Total	£3,108,452	£7,905,525	£8,032,013

The total sum of economic value at Year 3 is c. £8 million.

Table 16 - Activity assumptions to support societal benefits

Year	Activity
1	39.3% during mobilisation
2	100%
3	101.6%

More detail on the quantification of societal benefits can be found in appendices 2 and 3.

4.4.1 Impact of Societal Benefits on Return on Investment

Alongside the traditional financial measures appraised through the development of the financial statements, it is important that we consider the wider economic financial implications that have been tested through the evaluation of the wider societal impacts.

When we consider financially quantified benefits from both these assessments, the net present value over a 25-year term of the business case increases from £35.510m to £52.771m. Based on this assessment, provides us with an economic return on investment of 5.6 times (in that the net present value covers the £9.412m cost of investment 5.6 times over).

4.5 The preferred service option

The evaluation therefore finds care pathway Option 5 to be the preferred option, from both a clinical and economic standpoint, on the basis that:

- the economic evaluation supports care pathway Option 5.
- access options are most optimal of the shortlisted sites, for both private and public transport.
- the expansion of theatres is within the current footprint of the preferred site and does not disrupt current services or create any planning challenges.
- the bed capacity for the EOC is already in situ.
- the EOC ring-fences elective orthopaedic beds throughout the year to create winter resilience, and has suitable infrastructure for orthopaedic surgery, for example, laminar flow theatres.
- PTL is standardised, enabling equitable access and reducing pockets of unwarranted variation.
- GIRFT expectations and targets are met.

4.6 Summary of clinical model

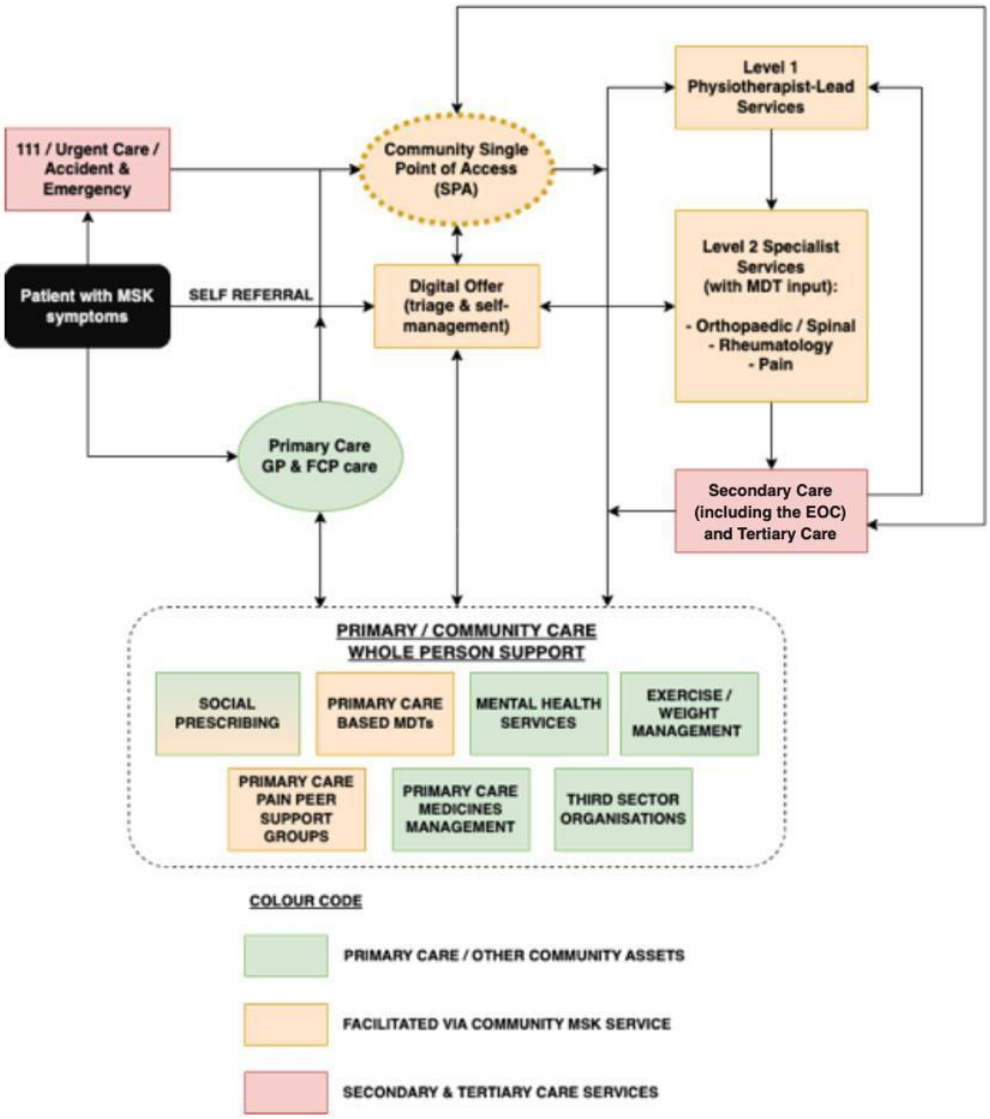
Based on the preferred option, clinical leads from across the NWL acute trusts have worked in collaboration to develop a clinical strategy for elective orthopaedic surgery. This clinical strategy underpins the expected benefits from the MSK pathway and sets out the clinical ambition to provide a centre of excellence for elective orthopaedic surgery (see appendix 4).

4.6.1 The MSK pathway

The MSK pathway will provide the overarching pathway within which the EOC will operate. The MSK pathway will be clinically and digitally integrated service, with strong relationships between primary care, secondary care, community services and third sector voluntary organisations. With a single point of access, the most appropriate community-based treatment to be offered is based on clinical need but, where secondary care intervention is required, onward referral is integrated and seamless to ensure efficient use of secondary care and improved patient experience. There will be outreach to under-served communities to target unmet need and monitor the end-to-end pathway to better understand where patients are hesitant to present or likely to drop out.

This pathway has been developed in line with national guidance including from NICE[4], NHSE BestMSK[5], GIRFT[6] and NHS Evidence Based Interventions[7]. It has also incorporated locally agreed pathways[8] informed by local needs and services. The end-to-end MSK pathway intends to treat a range of MSK conditions with exclusion criteria including under 16s; those not registered with a GP in NWL ICS; non-MSK podiatry; and NHS England specialist commissioning services.

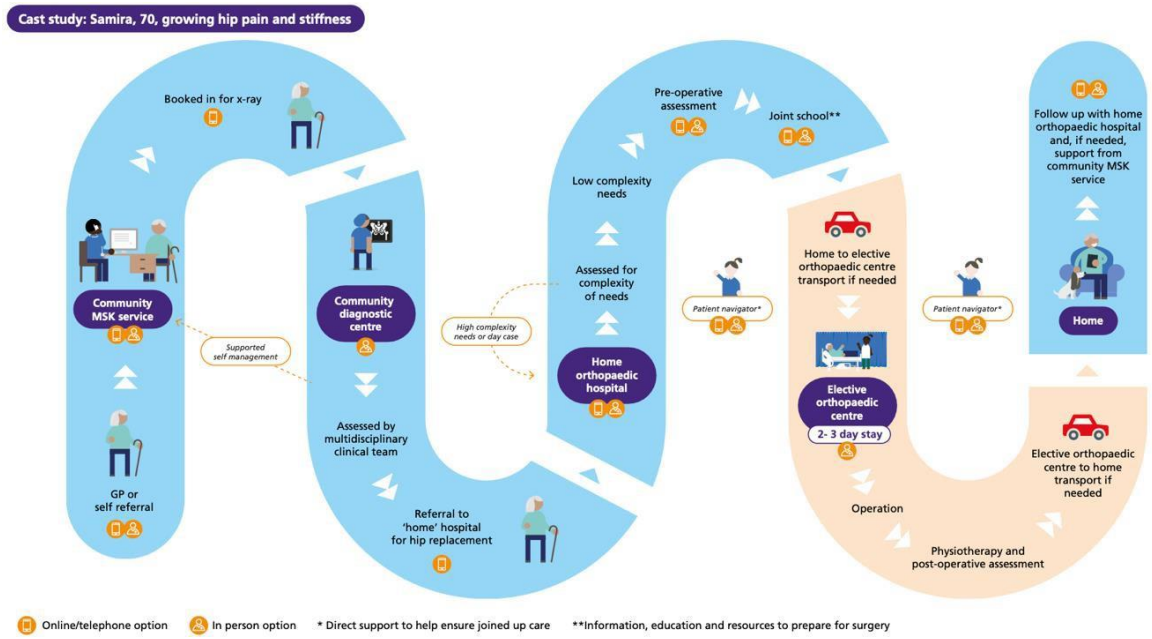
Figure 1 - NWL MSK pathway



To outline how the pathway would work in practice, see Figure 2 for a case study about Samira and her journey through the MSK pathway and the EOC.

[4] https://www.nice.org.uk/guidance/conditions-and-diseases/musculoskeletal-conditions
[5] https://future.nhs.uk/NationalMSKHealth/groupHome
[6] https://gettingitrightfirsttime.co.uk/workstreams/
[7] https://www.england.nhs.uk/evidence-based-interventions/
[8] https://www.nwlondonics.nhs.uk

Figure 2 - Case study of how the EOC will work within an overall improved MSK pathway



4.6.2 The elective orthopaedic clinical model

As a centre of excellence, the NWL EOC will coordinate care planning from local pre-operative care through to local post-discharge rehabilitation and follow-up. Patients will benefit from early assessment of their needs virtually or close to home in the community. If surgery is required, they will be guided to the surgical service that can best meet their needs. If they are broadly well (ASA 1 or 2[9]) and require a routine inpatient procedure (such as a hip replacement), they will be able to have their surgery at the EOC.

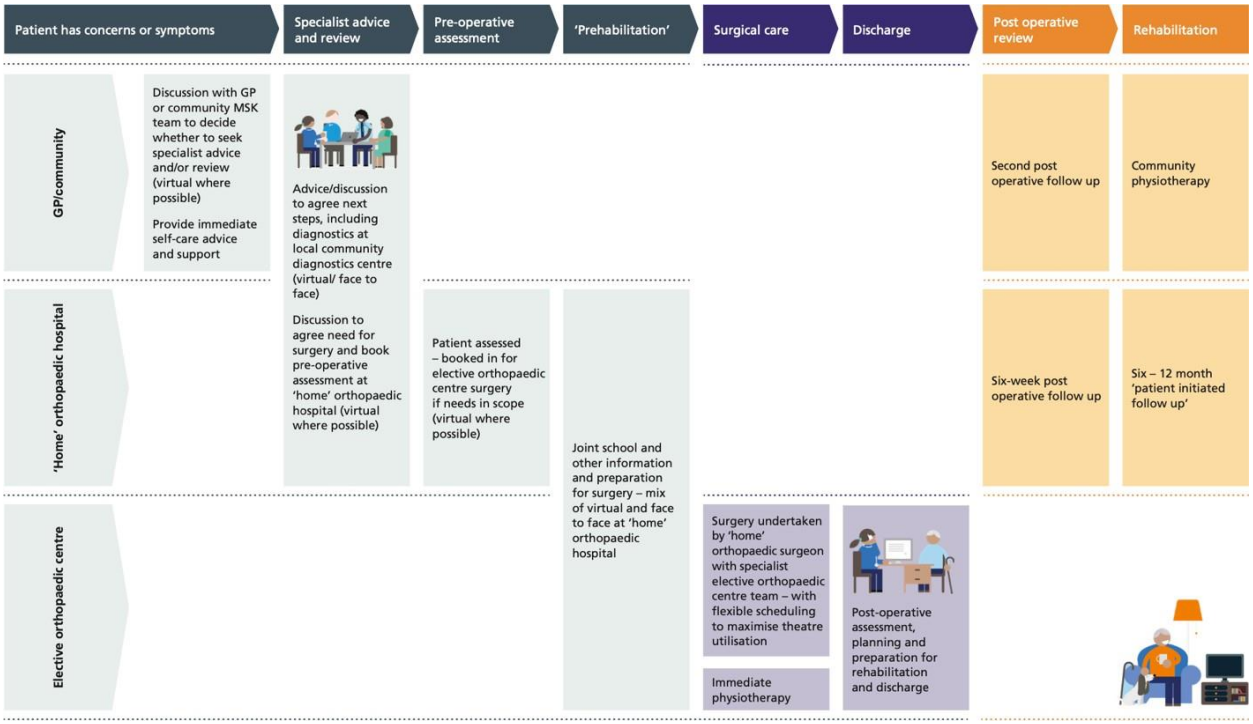
Patients who have additional health risks will be offered surgery in whichever of the NWL hospitals that currently provides orthopaedic surgical care is suitable for their needs, usually their home hospital. Whichever surgical service they access, their end-to-end surgical care will remain under the same surgical team based at their 'home' orthopaedic hospital to help ensure a seamless experience. If they have their surgery at the EOC, their 'home' surgical team will rotate to the new centre as well, supported by the centre's permanent support team.

The EOC will bring together the low complexity, inpatient, orthopaedic surgery for NWL in a purpose-designed centre of excellence, separate from emergency care services. This means that:

- patients will have faster and fairer access to surgery, with less chance of postponement due to emergency care pressures elsewhere.
- the care they have will be of a consistently high quality, benefitting from latest best practice and research insights and a clinical team who are highly skilled in their procedure.
- the centre will be extremely efficient, enabling more patients to be treated at a lower cost per surgery.
- patients will have better outcomes, experience, and follow-up.
- In addition, capacity is created in the 'home' orthopaedic hospitals by the consolidation of low complexity surgery in the EOC and this capacity will be available to be used for surgical patients who have more complex needs and for other specialties.

[9] https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system

Figure 3 - Case study of the NWL EOC clinical model



Further details on pre-operative assessment, managing deteriorating patients, support on discharge from the EOC, multidisciplinary team and clinical support services, equity of care for patients not treated at the EOC, and avoiding digital exclusion can be found in the DMBC[10] (a link to which can be found in the bibliography in appendix 5). Further detail on the clinical model as a whole can be found in the Clinical Strategy drafted by the Clinical Cabinet (appendix 4).

4.7 Site selection – long list appraisal

A clinical workshop was held in August 2022 to define the essential criteria for the location of the EOC (from a clinical perspective) and shortlist the options, as well as to build out the desirable criteria of the centre.

Table 17 - Evaluation criteria developed at clinical workshop

Essential Criteria	Desirable Criteria
• Be accessible to our NWL community and those that need care – with a mix of virtual and face to face depending on need – keep options open for those who are not digitally enabled. • Suitable infrastructure for orthopaedic surgery, for example, laminar flow theatres – needs to also cover workforce, which must be identifiably NWL workforce. • Must cover end-to-end sharing of information, enable good communication and seamless care – for example, pre-op assessment through to post-op pathway – and with robust discharge arrangements. • Deliver a shared care record for our patients.	• Short travel time for patients and staff. • Create a good track record of outcomes to build momentum. • Create an environment and infrastructure for better training and leveraging technology and innovation – for example, robotics. • Be attractive for commercial partners to increase sustainability. • Reduce cost of outsourcing to independent providers. • Good patient transport options, and public transport access for staff and patients.

[10] https://www.nwl-acute-provider-collaborative.nhs.uk/-/media/website/nwl-acute-provider-collaborative/documents/nwl-eoc-consultation/1459-dmbc-report-v19.pdf?rev=aec2c2b4463d40459dc3cd741d8b52d2

- Standardisation of PTL – enables equitable access and reduces pockets of unwarranted variation.
- Must be staffed through local workforce.
- Facilities on-site are interdependent.
- Must be 'neutral territory' – which is seen as a system asset, not part of one of the organisations.
- Ability to ring-fence elective orthopaedic beds throughout the year to create winter resilience.
- Meet the needs of the NWL community and case mix.
- Capacity to expand in future if demand increases.
- Delivers on GIRFT expectations, for example, six day a week access to high quality care.

The following 10 options were identified for the clinical evaluation (that is, the nine hospitals offering orthopaedic inpatient surgery in NWL ICS, and two other hospitals in NWL not offering inpatient surgery – Ealing Hospital and Hammersmith Hospital):

1. Central Middlesex Hospital
2. Charing Cross Hospital
3. Chelsea and Westminster Hospital
4. Ealing Hospital
5. Hammersmith Hospital
6. Hillingdon Hospital
7. Mount Vernon Hospital
8. Northwick Park Hospital
9. St. Mary's Hospital
10. West Middlesex Hospital

NWL is committed to an open and transparent process and has taken a balanced scorecard approach to the requirements for the EOC site or sites in assessing the longlist of potential sites and identify those that are clinically suitable.

We assessed the longlist options, as outlined in the table below. All but two sites (CMH and MVH) were ruled out as they did not meet the clinical criteria, particularly concerning the ability to ring-fence beds for elective capacity. The findings from the shortlisting exercise align with the pre-consultation feedback obtained.

Table 18 - Results of the site option shortlisting process, with scores reached through consensus discussion at the workshop in August 2022

Options	Essential requirements met?	Desirable requirements met?	Align with site strategy?	Level of disruption to create EOC on existing services	Key risks/other considerations
Key	Yes currently / Could be met in future / No		Yes/No	Low/Medium/ High	
Central Middlesex Hospital	✓	✓	✓	Low	Been part of site strategy for a while and disruption will be minimal – formation of an EOC would not displace the current patient flow

Charing Cross Hospital	X (ring-fencing)	Could be met in future	X	High	Not ring-fencing throughout the year – can ring-fence current volume but not EOC volume (as many acute specialties). Co-location with critical care bed base – EOC will have an impact on that bed base
Chelsea and Westminster Hospital	X (ring-fencing)	Could be met in future	X	High (for non-elective services)	
Ealing Hospital	X	X	X	High	
Hammersmith Hospital	Could be met in future	Good geographic location	X	High (due to other spec. services)	The site has lots of specialised services (for example, cardiac and renal) with specific requirements, and not looking to be developed. The site is also not currently suitable (that is, laminar theatres)
Hillingdon Hospital	X	X	X	High	Will be disruption to manage if this is not selected as a key site.
Mount Vernon Hospital	✓	Difficulties with access (travel time)	✓ (for current capacity)	Low (for current capacity)	Cannot take on additional capacity than it is currently handling
Northwick Park Hospital	X	X	X	High	Would have to knock down buildings
St. Mary's Hospital	X	X	X	High	Co-location with critical care bed base – EOC will have an impact on that bed base
West Middlesex Hospital	X (ring-fencing)	Could be met in future – not close to public transport	X	High (for non-elective services)	
Novel site(s) (for example, Westfield Shopping Centre)	Could be met in future	Potentially good transport options	N/A	High	Not many previous NHS sites to use. St Charles – not for this clinical infrastructure

4.7.1 The site shortlist

The site shortlist consisted of CMH and MVH. As shown by the scoring above, both CMH and MVH are already well-established providers of elective orthopaedic care and protected from emergency and urgent care surges. Both sites have laminar flow theatres of high quality. For example, CMH has the BeCAD theatre suite with 3 laminar flow theatres and available beds in situ, and MVH has a modern diagnostic and treatment centre. CMH and MVH both have the requisite clinical and non-clinical adjacencies available for the patient group, with an opportunity to co-locate the theatre suite with the inpatient care.

4.8 Site selection – short list appraisal

As the clinical requirements had identified two appropriate sites for the EOC, a set of non-clinical lenses has been applied to determine which should be taken forward as options for the EOC.

Access to sites

Analysis was conducted on the average time to travel to the hospital sites that currently provide 'routine' orthopaedic surgery and other sites from all parts of the sector. Distances were measured from lower layer super output areas (LSOAs), which are small geographical areas of approximately the same population size to provide a fairer unit of comparison than boroughs which vary in size.

As can be seen from the figures below, MVH has greater mean travel times for both public and private transport, nearly double the average travel time compared to CMH. Analysis also showed that the CMH site provides an improvement in travel times for the most deprived LSOAs. MVH was also scored very poorly for accessibility ratings by TfL, although this area is serviced by other providers. MVH would also mean a higher increase in total carbon dioxide emissions than CMH. Off-peak has been used as the EOC will only provide inpatient elective services to ASA 1 and 2 categories, excluding joint revisions and spinal.

Figure 4 - Off-peak driving travel times (private transport) from every NWL LSOA to each site

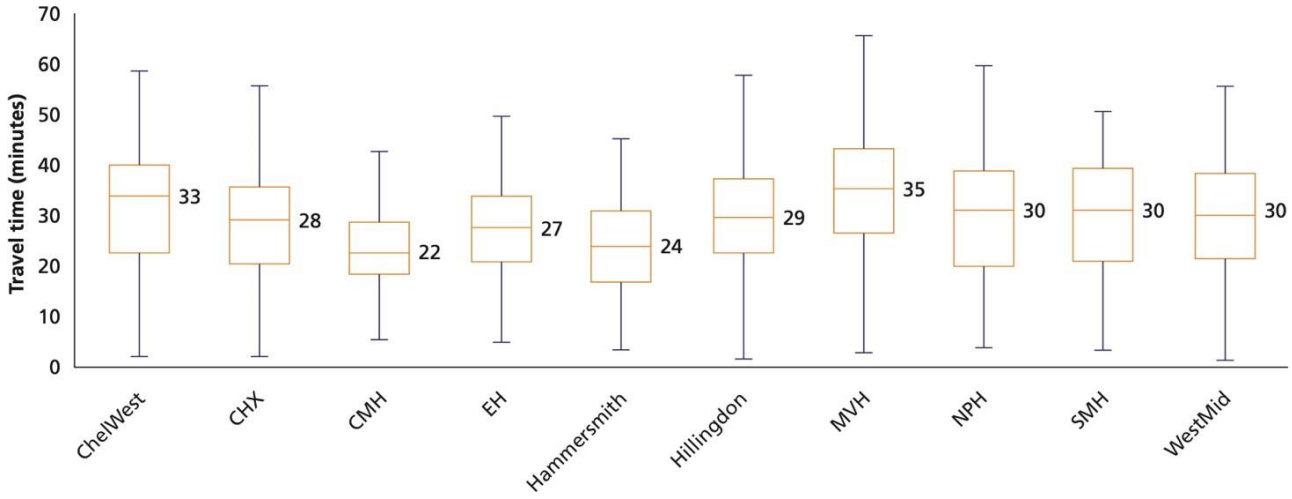
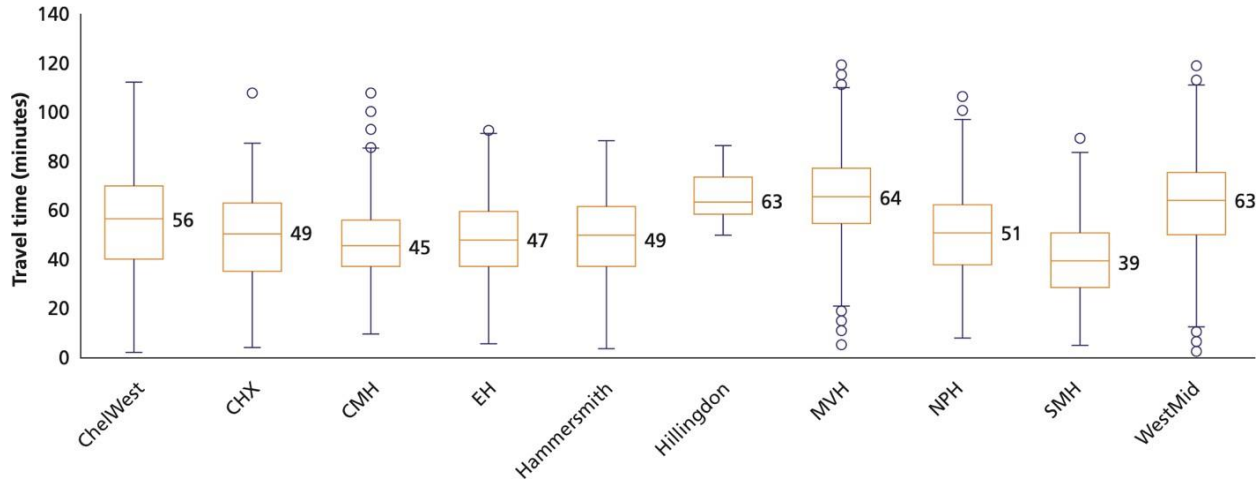


Figure 5 - Off-peak public transport times from NWL LSOA to each site



The CMH site is located in the centre of the NWL ICS. As shown in the analysis above, it offers the shorter travel times relative to other NWL sites.

Capacity

MVH has the capacity to address its current level of activity for ASA 1s and 2s. However, it does not have the infrastructure or the beds to take on the elective orthopaedic activity for all NWL. The Hillingdon

Hospitals NHS Foundation Trust is the only trust in NWL that did not see an increase in admitted waiting lists between April 2022 and August 2022 and is at near maximum capacity, therefore changes to this site would likely result in adverse impacts to waiting times and equality of access and timeliness of treatment.

In contrast, CMH is currently underutilised with 50% bed occupancy, so would not require the same theatre and bed capacity expansion to operate as the EOC.

Estates
CMH is a high-quality clinical estate which has a surplus of bed capacity available for use. It is also anchored within the Old Oak Common Redevelopment area contributing to the socio-economic development of the area. The expansion of theatres is within the current footprint and does not disrupt current services or create any planning challenges and the bed capacity for the EOC is already in situ.

A more extensive expansion would be potentially needed to host the EOC at MVH. As set out in the THHT Estates Strategy[11], planning permission at MVH is likely to be difficult to secure due to the planning designations for the site and the estate has significant challenges, including backlog maintenance and poor condition.

4.8.1 Two-site option

We have explored the feasibility of having two EOCs to respond to the consultation feedback, particularly from Hillingdon. In practice, due to the capacity constraints at MVH, this would mean it would have to maintain its current levels of activity, therefore capacity to cover patients who do not currently use MVH and the scope of the EOC would be reduced.

A dual site option would also make it significantly harder to reduce the unwarranted clinical variation and would make it difficult for MVH to improve its current quality and operational performance levels. For instance, the South West London EOC has more than 40 clinicians from their 4 participating trusts who all work to the same pathways and productivity standards. Additionally, the volume of patients going through the EOC would be lower, which would make it harder to achieve the reduction in the waiting list set out in the case for change.

From a workforce perspective, a two-centre approach would mean duplication of some specialist roles across two sites, meaning it would be harder to achieve safe nursing ratios and there would need to be higher investment in site management. Resilience to absorb vacancies and build a 'surgical hub' identity and culture would also be negatively impacted.

Recent data shows that trainees and training in trauma and orthopaedic surgery have been disproportionately affected by the covid-19 pandemic and reduced elective surgery volume. EOC will offer an important solution for this problem in NWL and will provide future trainees with high volume training in a supervised high volume performance environment. Splitting across two sites would diminish this opportunity for NWL.

4.9 Preferred site option

In the public consultation, there was less support for the EOC to be located at Central Middlesex Hospital, primarily due to travel concerns. Some people, primarily staff and stakeholders in Hillingdon, would prefer the centre to be located at Mount Vernon Hospital.

To respond to this feedback, we reviewed our assumptions for the site options appraisal and check the validity of our preferred location. Central Middlesex continues to score highest against clinical criteria, has the shortest median travel time by car and by public transport and meets a higher number of desirable criteria. This has reconfirmed the assessment that CMH would be the best choice of site to host the EOC.

[11] https://www.thh.nhs.uk/documents/_Publications/strategy-docs/THH_Esates_Strategy_Feb_2022.pdf

We have therefore designed a robust travel solution that will provide support to any patients facing a long, complex, or costly journey to the EOC, detailed in the following section.

4.10 Transport solution to support the preferred option

The concerns raised by patients, staff, and stakeholders over the course of public consultation were considered alongside a review of key recent publications on patient transport (which highlighted that long or costly patient journeys can be a significant barrier to care). The key areas of concern raised within the public consultation were around travel times, journey complexity and costs. These areas correlate closely with the findings of an extensive review completed by Age UK in 2018 which showed older people encountered several challenges when travelling to hospital that included long and uncomfortable public transport journeys and cost[12].

Healthwatch UK also surveyed patients, commissioners, and charity organisations on their experience of patient travel to and from NHS services[13]. The outcomes of this further echoed the concerns raised and provided valuable insight into how patients travel to appointments (although it is important to note that the patients travelling to the EOC are not likely to need to attend repeatedly). Alongside national best practice and recommendations, the arrangements at neighbouring EOCs were also assessed. Feedback from these centres demonstrated that the challenge faced by patients travelling longer distances had been recognised and support had been put in place to help patients travel.

The reviews recommended that best practice was to provide patients with information and assistance on how to plan and book their independent journey, access to healthcare travel cost schemes and local community resources. These recommendations correlated strongly with the feedback received from patients and staff during the public consultation process.

4.10.1 Eligibility Criteria

NHS England and NHS Improvement formally commissioned a national review into non-emergency patient transport services (NEPTS) that concluded in 2021 with an update to patient eligibility criteria and key recommendations published in 2022[14].

This was based on the overarching principle that most people should travel to and from hospital independently by private or public transport, with the help of relatives or friends if necessary, and NHS-funded patient transportation is reserved for when it is considered essential to ensuring an individual's safety, safe mobilisation, condition management or recovery.

Patients should be encouraged to make independent journeys where possible (with the provider informing on local transport options) and be made aware of the existence of and eligibility criteria for other sources of travel support, including Healthcare Travel Costs Scheme (HTCS) and the Disability Living Allowance (DLA) mobility component. Moreover, only patients who have been referred by a doctor, dentist or ophthalmic practitioner for non- primary care NHS-funded healthcare services or are being discharged from NHS-funded treatment are considered for eligibility for NEPTS.

Patients must meet one or more of the following criteria to qualify for NEPTS:

a) Have a medical need for transport support (such as requiring specialised equipment or monitoring during the journey).
b) Have a cognitive or sensory impairment requiring the oversight of a member of a specialist or non-specialist patient transport staff or a suitably trained driver.
c) Have a significant mobility need that means they are unable to make their own way with escorts or carers whether by private transport (including a specially adapted vehicle if appropriate for the journey), public transport or a taxi.
d) Are travelling to or returning from in-centre haemodialysis, in which case specialist transport, non-specialist transport or upfront/reimbursement costs for private travel will be made available.

[12] https://www.ageuk.org.uk/our-impact/campaigning/painful-journeys/
[13] https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/nepts-review/
[14] https://www.england.nhs.uk/wp-content/uploads/2022/05/B1244-nepts-eligibility-criteria.pdf

e) A safeguarding concern has been raised by any relevant professional involved in a patient's life, in relation to the patient travelling independently.
f) Have wider mobility or medical needs that have resulted in treatment or discharge being missed or severely delayed.

Patients are only able to travel with escorts or carers if they are under 16 years of age, need the escort's particular skills or support, cannot be left alone or are under the care of the patient who is eligible for NEPTS.

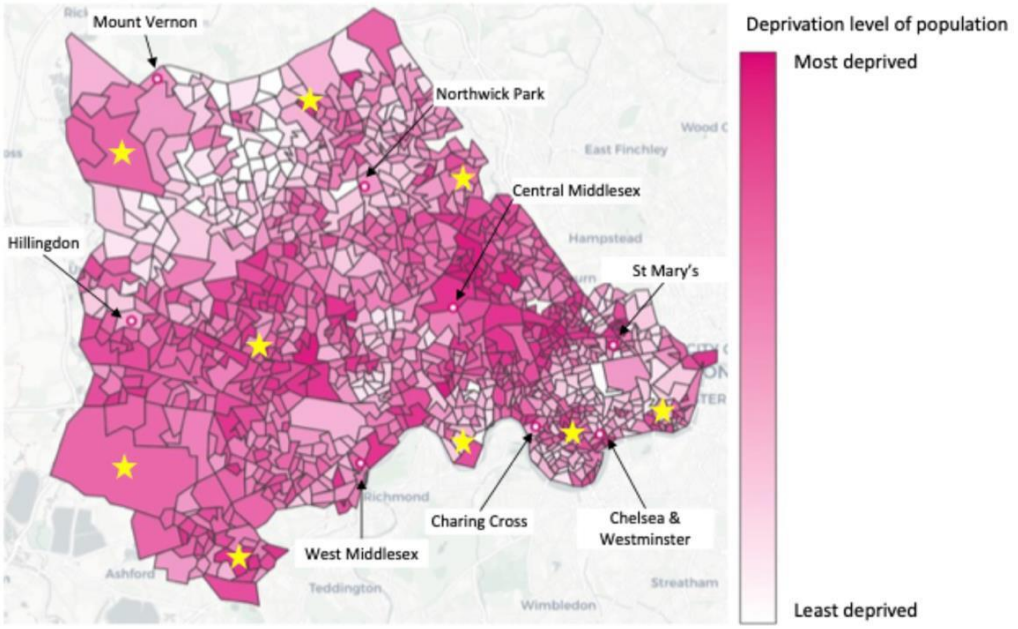
These criteria included consideration of a patient's wider mobility needs and suggested that local systems may wish to add further criteria when determining eligibility for non-emergency patient transport that included consideration of long distances to travel, high cost associated with travel by taxi, and limited or complex public transport options.

An authorised eligibility assessor, whose role will be locally defined, will provide a judgement on whether any other transport is suitable or available. Other transport options, such as the patient's own transport, support from relatives or carers, and transport people are entitled to as part of funded social care provision or a social security benefit, should be exhausted before NEPTS is provided.

4.10.2 New Travel Analysis

The feedback received through public consultation cited that reviewing only median travel times was not a fair measure as there were likely to be cohorts of patients who experienced very long and complex journeys. On this basis, ten archetype journeys were developed that modelled a journey that was over 45 minutes in time and from a lower layer super output area with high level of deprivation. These archetype journeys provide insight into the difference in time, complexity and cost that patients may encounter when travelling to CMH as opposed to their home hospital.

Figure 6 - LSOA map showing the 10 archetypes identified to demonstrate all areas covered LSOA population deprivation level heatmap for all ages (two journeys are mapped for Hammersmith and Fulham)



The analysis showed the current journey to the home hospital and compared this to the journey to CMH for ten different scenarios across NWL.

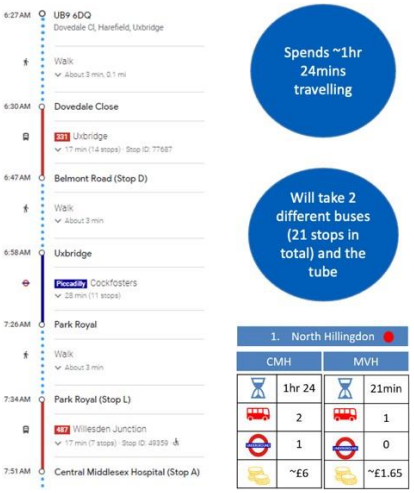
Figure 7 - Patient journey mapping example

Scenario: Jane lives in the north of Hillingdon, she would have previously received treatment at Mount Vernon Hospital. Jane is now required to travel to Central Middlesex Hospital, she will travel on the day of surgery, so will be adhering to pre-surgical fasting requirements.

Jane requires low complexity routine orthopaedic surgery AND:

- Does not meet the eligibility criteria for NHS funded patient transport
- Is not able to arrange private transport for herself such as a taxi or a lift from friends/family
- Does not qualify for or have access to community transport or the health travel reimbursement scheme

Jane plans to travel by public transport to Central Middlesex Hospital, aiming to arrive before 8am, she sets the parameters to include reduced walking times to ease the journey.



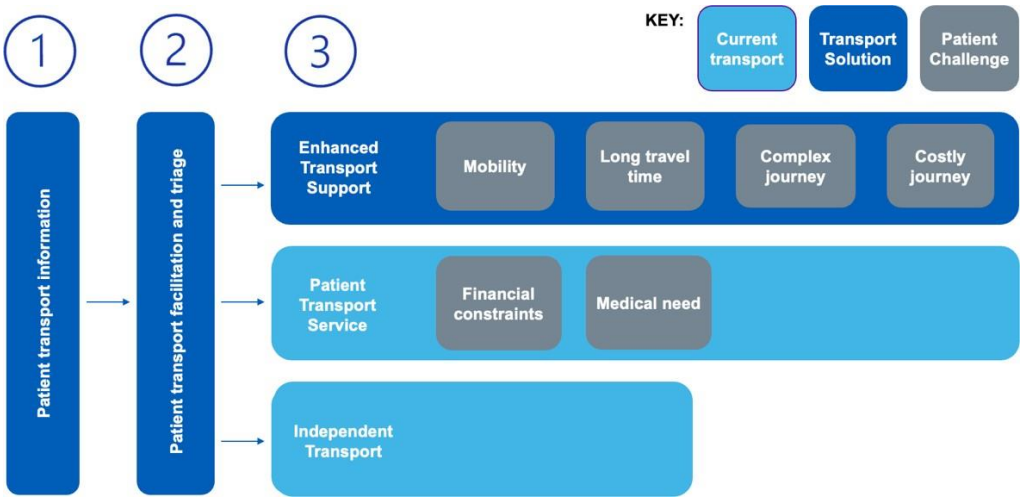
The analysis highlighted the areas in NWL for which a journey to CMH would be considerably longer, more complex and more costly than patients' current journeys. Further analysis of the profile of patients across the sector approximated the number of patients residing in the identified areas who would most likely encounter a complex or costly journey if travelling by public transport.

The analysis showed that following the implementation of a risk assessment and triage process that considered travel time, complexity, and cost, approximately 25% of NWL patients attending the EOC could qualify for support with their travel arrangements, given that approximately 1,300 out of 5,175 patients (instead of the current 240, typically from Ealing, Harrow and Brent) would have to undergo long journeys. Under the revised criteria, a further 5% of patients would incur long, complex, or costly journeys and be eligible for support.

4.10.3 The proposed transport solution

The solution has been designed with best practice recommendations from national reviews and public consultation suggestions as the basis for identifying a resolution. It is best considered as a three-step approach that will provide patients and their families with the level of support that they need to access care effectively at the EOC. The solution includes providing information and signposting to available resources, facilitation for all patients and carers and transport for those who require it. The inclusion of additional eligibility criteria in line with national review outcomes will enable patients who have mobility challenges and have a long, complex journey on public transport or prohibitive costs to access patient transport. The solution is outlined below in more detail.

Figure 8 - The proposed transport approach includes facilitation and triage for patients and carers, with enhanced support when needed



Step 1: Information – all patients

The first step is to provide all patients travelling to the EOC with up-to-date information on transportation to CMH. This will include information for those travelling independently by car or taxi in terms of directions, parking and drop-off locations. There will also be information available that signposts patients to financial resources and support available through national schemes such as the Healthcare Travel Cost Scheme and community services.

Step 2: Facilitation – all patients

The second element of support builds on the information provided and supplements this with facilitation support. This will enable patients to plan their journey effectively with a member of staff who can advise and signpost patients to national and local support schemes and will assess if a patient will encounter a long, complex or costly journey if they are considering travelling by public transport.

Step 3: Patient Transport provision for eligible patients

For patients who are unable to travel to or from the EOC for treatment independently or through support from national schemes and who will encounter a long, complex or costly journey by public transport, typically a car ambulance or taxi will be provided. This will ensure that patients can access care at the EOC from across NWL in a fair and equitable manner.

We aim to offer transport information and facilitation support to all patients attending the EOC. Patients will be able to access information digitally where they prefer to, or their transport support options will be explained to them by the care navigator team. This will include asking patients how they are planning to travel to the EOC and, if required, providing patients and carers with information on where CMH is located, how best to travel there from home, and information on support such as the Healthcare Travel Cost Scheme. If, on assessment, patients can't rely on friends or family for support with getting to their appointment and they have mobility challenges or live at a distance that would require them to navigate a long, complex journey on public transport that may be costly, travel support will be booked to and from the centre at no charge.

The implementation and ongoing co-design of this transport solution including the formation of a transport working group is detailed in section 7.8.

5 Commercial case

Summary
Chapter 5 sets out the commercial case and describes the process followed and the associated requirements to enable selection of the construction partner.

Key messages

- The proposal for a the NWL EOC will make use of high-quality estates at CMH, whilst also achieving compliance with national guidance for NHS hospital developments and aspiring to achieve strong BREEAM performance, contributing to Net Zero Carbon and utilising Modern Methods of Construction where appropriate.
- The preferred procurement strategy is the Variation Process to the CMH PFI Project Agreement.
- The Tender Report, produced by PFI Project Co, recommends the tender submitted by bidder 1 and this is endorsed by both PFI Project Co and LNWH Trust Estates & Facilities team.
- A comprehensive design process has been undertaken and a full set of RIBA Stage 4 drawings have been produced which have been signed off by the Design Team, including clinical representation. These designs align with HBN requirements and were noted and approved in the Schedule of Derogations.
- Enabling works commenced with approval from the Capital Review Group in January at risk to ensure construction can begin in May 2023.
- There is a clear recognition of the challenges within the construction market, with rapidly increasing costs of building materials and timing of the procurement will need to be carefully addressed to mitigate the risks of locking in these high prices.
- Following approval, construction will occur from 26th May to 16th November 2023.
- The proposed location at CMH will benefit from the absence of any planning issues or need for planning approval, given this is refurbishment scheme with no change to the curtilage of the building.

5.1 Scope of services

5.1.1 Scope of services

The new EOC will be located within the BECaD wing at Central Middlesex Hospital. The project will include:

- Two additional laminar flow theatres.
- An extended First Stage Recovery Unit and.
- Associated works to rehouse support facilities to liberate space for the additional clinical spaces.

The EOC will comprise:

- Three existing Laminar Flow Theatres and their supporting facilities.
- Two New Laminar Flow Theatres and associated facilities.
- Extended Ten Bay First Stage Recovery Unit supporting all five Theatres.
- Inpatient and PACU Beds within existing re-purposed in-patient accommodation.
- Various support facilities within existing re-purposed support accommodation.

The design reflects the Productive Theatre ethos, to be as efficient as possible for the patients and staff who use the building. Service redesign and transformation will be undertaken as part of the implementation plan (see section 7.2) in advance of the new building opening to enable GIRFT top decile performance to be achieved. The investment is predicated on the benefits of creating a new EOC for NWL at CMH which is an Elective Orthopaedic Surgical Centre for NWL[15].

[15] "Determining Guidelines for LNWH Site and Service Configurations, report to London North West University Healthcare Trust Executive Group, 17th March 2021.

5.1.2 Modern Methods of Construction

To the extent possible, Modern Methods of Construction (MMC) will be used. Achievement of these requirements will be determined through the procurement process and finalisation of the construction methodology. Being a refurbishment orientated construction project the opportunity for MMC is naturally limited but wherever component systems can be incorporated these are included for their benefit on cost, quality and on-site build time.

A summary of key commercial arrangements and design standards are provided below:

- Procured through ByCentral Ltd, the PFI Project Co, as a direct and documented Deed of Variation to the original Project Agreement (PA) as executed on 6th November 2003 for the CMH PFI under the requirements and obligations of Schedule 22 of the PA.
- Built on Trust land within the BECaD Wing at Central Middlesex Hospital
- Designed to BREEAM Very Good standard
- Compliant with current HBN/HTM guidance, subject to agreed derogations as listed on the Schedule of Derogation (appendix 6)
- Wherever practicable, the works will be undertaken using Modern Methods of Construction i.e. component systems within M&E plant, infrastructure and service delivery modules. In line with the Government Construction Strategy 2016-2020
- 1:200 and 1:50 drawings along with Room Data Sheets have been signed off by clinicians, senior management, infection control and fire safety representatives at the Trust.
- Fully tendered contract package adjudicated and ready to award.

5.1.3 Net Zero

LNWH embraces the obligations set out on PPN 06/021 in taking Carbon Reduction Plans both into day-to-day operations but also more specifically within the Procurement exercise for the new EOC facility. The design will support the Trust's Net Zero plans as described within LNWH's Green Plan and NWL ICB Green Plan. More specifically the design will seek to achieve a minimum of BREEAM Very Good (matching that of the BECaD Wing) and to be designed/constructed to help the Trust work towards achieving a Net Zero Carbon Estate in so far as possible given the limitation of project that re-purposes an existing structure and footprint.

The Trust is working on a number of Net Zero initiatives for the wider CMH site for which the EOC will benefit. These initiatives are wide and (potentially) ground-breaking; including straightforward investment in LED lighting upgrades, solar PV opportunity assessed at 3% of the site demand for electricity and at the more radical level, collaboration with the Old Oak Park Royal Development Corporation (OPDC – the local Planning Authority and business and enterprise development organisation promoting investment in the locality) in the creation of a District Heating Network whereby the hospital would be supplied by heat that is recovered from local data-centres – this initiative has just been successful in securing Mayor of London funding to further develop the feasibility model and LNWH has offered support of CMH being a potential long-term customer of this heat supply. More detail around the implementation of environmental sustainability.

5.2 Procurement strategy and process

5.2.1 Procurement strategy

The construction works form part of CMH's Private Finance Initiative (PFI). Two strategies for delivery were proposed in the OBC and have been further explored and this FBC sets out the chosen strategy:

- Strategy 1 - Agree a variation to the PFI Project Agreement (PA)
- Strategy 2 - Carve the space out of the PFI and LNWH undertake the works directly.

Both procurement strategies (within or outside of the PFI) necessitate formal legal documentation that draws the works output into the PFI. There are differences in regard to the risk profile, the extent of legal documentation and cost, are much similar whatever procurement choice is made; neither is

straightforward and both are influenced by “Lender nervousness” consequential to the Carilion collapse. This does drive a due diligence that serves both parties well in the long-term.

Strategy 1 – Variation Process to the PFI Project Agreement
The PFI Variation Process that was originally envisaged created within the PA the ability to allow for projects such as the EOC to be undertaken. Through the PA, LNWH will have the ability to directly influence the actions of the PFI in delivering the project itself but also in the context of our wider (and significantly greater) relationship over the Operational Phase of the PFI PA to fulfil our partnership responsibilities.

LNWH is experienced in this process, having previously used the PFI Variation Process in the successful delivery of three prior schemes to time and budget:

- GP Practice conversion of former Rainbow Ward space (c£1.5M, 2018),
- Infrastructure changes to allow Land Sale (c£1M, 2019) and,
- Endoscopy Project (c£4M, 2022).

The value of the EOC construction works will not be seen as a material variation of the original PFI Procurement exercise and as such, any risk of procurement challenge is low.

LNWH is subsequently experienced in managing the PFI Variation Process and has confidence in Strategy 1.

Strategy 2 – LNWH undertake works directly outside the PFI
The second strategy is to work outside of the PFI and LNWH undertake these works. There is a high impact but low probability risk that LNWH carrying out work to a PFI Project Co building could be absorbed back into the PFI with no material consequence to risk profile and wider cost base.

This has been assessed as low probability as PFI Project Co are unlikely to absorb the risk of works undertaken by others. The original PA did absorb the existing ACAD wing into the PFI when new and at the outset of the PFI term; the commercial dynamic is far less in the favour of the building being absorbed now.

If taken as a stand-alone Project, the value of works is close to Procurement thresholds and as such any risk of challenge might be elevated should advertisement follow. Mitigating this risk adds time to the process and can also deter bidders. LNWH has previously experienced this with other trust projects. While not a reason alone to reject this approach, the fact that a viable alternative through the PFI PA exists helps support the commercial case, provided that value for money is achieved.

The procurement method of choice for Strategy 2, would be P23 National Framework (About ProCure23 | Procure22). Under P23, if LNWH elected to undertake the works outside of the PFI, it would duplicate the structure of PFI given the similarities of both arrangements during the construction phase of this work.

The key factor of choice between the two strategies therefore becomes that of delivering “value for money” on the EOC Project specifically. Within P23 the supply chain is appointed by the Principal Supply Chain Partner (PSCP) from their declared resource pool. Under the PFI structure, there is a requirement that works (above £75k index-linked) are procured via an open (traditional) tender process.

It is also worth noting that the lowest threshold of P23 is “up to £20M”; the EOC project is significantly below that threshold and as such, it must be questioned that the level of overhead associated with a P23 project could be excessive for the EOC Project; P23 is focused upon the building of hospitals rather than (in relative terms) minor changes to facilities already built.

Conclusion
These two main factors of process and size lead to the conclusion that “value for money” is achieved via Strategy 1 – Variation to the PFI Project Agreement.

5.2.2 Commercial Relationship with the CMH PFI

The Trust has worked very closely with PFI Project Co on developing the procurement process for the NWL EOC works with a specific focus on achieving value for money. Together the parties were keen to ensure that the “Contractor market” were keen and responsive to the prospect of the tender being issued and thereby likely to respond competitively. The parties were equally mindful of the elevated risk of failure within the Construction marketplace and post-Carillion consequences need little emphasis in this sector.

5.2.3 PFI Project Agreement Schedule 22 – Variation to the Agreement

The original PA expected variation across its thirty-year operational phase Term and includes Schedule 22 as the mechanism for management of such variation.

The requirements of Schedule 22 are such that the Trust makes a proposal for a variation (Variation Enquiry) and the PFI Project Co assesses any grounds for rejection within domains cited in the PA. The PFI Project Co equally assesses any Service Variation (operating impact) that might be consequential to the works too.

The governance of the PFI Project Agreement (PA) is via a Liaison Committee of all parties who meet quarterly and with whom any dispute would be referred to, as and when any discord, might arise.

The PA treats variations under the principle of "no worse (or no better) off as a consequence of the change". This applying as much to the apportionment of risk, as it does to financial recovery; any variation should not impart undue risk, nor equally can one party unduly benefit as a consequence of a Variation.

The Trust and the PFI Project co-operate the procurement of works variations in line with the processes of good Estate and Project Management and Schedule 22 requirements.

LNWH is experienced in the process, having previously used the PFI Variation Process in the successful delivery of prior schemes to time and budget:

- GP Practice conversion of former Rainbow Ward space (c£1.5M, 2018),
- Infrastructure changes to allow Land Sale (c£1M, 2019) and,
- Endoscopy Project (c£4M, 2022).

5.2.4 Tender Process

The procurement of the works follows a traditional industry standard approach that seeks to evaluate the qualitative and quantitative aspects of seeking "best bids" from a pool of interested competent Contractors.

The tender process commenced in January 2023 for one month. To ensure that LNWH achieved “value for money”, one of the Contractors invited to tender was a "known party", having recently undertaken the creation of the Intensive Care Unit at Northwick Park Hospital (NPH) and also works to upgrade Theatres at Northwick Park Hospital. This party provided a benchmark mechanism albeit all decisions are subject to the iterative process of the tender exercise and will be influenced by local and timely factors of market influence.

Adjudication of the Tenders has been undertaken by a joint team of PFI Project Co and Trust Client appraisees who will appraise the submitted documentation based upon both qualitative and quantitative criteria. The qualitative criteria being closely defined including an adequate description of "what good looks like" (see tender report). A joint (LNWH/PFI Project Co) recommendation will be made on the preferred Main Contractor and Tender Value to the EOC Programme Board with an intention to award contracts on 20th April 2023.

While not formally obliged to follow the principles of Social Value, the Trust and PFI Project Co has embraced the objectives of PPN 06/20 and incorporate Social Value within the qualitative scoring criteria being allocated to Social Value in line with that set out in the Procurement Note guidance.

5.2.5 Procurement timeline

Table 19 - Procurement timeline

Milestone	Dates
Instruction to proceed to tender	17th January 2023
Tenders issued	23rd January 2023
Enabling works	23rd January 2023 – 25th May 2023
Tender period	24th January 2023 – 23rd February 2023
Tender return date	23rd February 2023
Tender adjudication and report	24th February 2023 – 28th April 2023
Tender validity (90 days)	24th February 2023 – 24th May 2023
Contract Awards	20th April 2023
Contracts Exchanged	21st April 2023 – 27th April 2023
Contracts and CDM planning period	28th April 2023 – 25th May 2023
Construction works	26th May 2023 – 16th November 2023
Handover & Commission	November 2023

5.2.6 Market and Other External Forces

The decisions related to procurement; timing and process carries a number of commercial caveats for consideration. The marketplace is volatile, with the mixed and aggregated product of Brexit, the COVID-19 pandemic and disturbances in Ukraine all having an effect. The Construction Sector is seeing levels of inflation that were only experienced decades ago and the uncertainty over labour and material supplies further adds to the mix that generates any Tender Sum. It is usual for bids to stay open for 90 days but currently, having a period of one-quarter of a year with assumed inflation can lead to an elevated bid that market forces alone may not control. A shorter period might be preferable (to eliminate any risk premium) but this has to be measured against the certainty of outcome in approval, as referring tenders back for uplift will just multiply likely inflation risk premiums and lead to undue elevated cost.

In managing the process with the PFI Project Co, these influences have been monitored and controlled. The need for Public Consultation imparted a significant delay to the original timescale of which prospective tenders were briefed. Consequently, those prospective bidders were kept informed and updated through the Public Consultation exercise and as a consequence only one of the five bidders withdrew from the process (albeit at Tender stage and too late to be effectively replaced).

5.3 Design team

The Trust has previously worked with Project Co on three major variations; the new GP Practice, the Infrastructure works associated with the Land Sales at CMH and the Endoscopy Project. The first and last of these three projects, required extensive architectural design. LNWH is subsequently satisfied that Project Co can deliver high quality designs that deliver quality clinical services.

The design team and Project Management is procured by Bouygues Project Management division who have procured specialist engineering, quantity surveying and structural engineering skills all procured by the Bouygues Project Management division. Project Co team also provide Project Management support.

LNWH has also supplemented its own team with co-ordinating advice from a Healthcare Planning specialist and its own Medical Equipment and Procurement Support Team. All working with the Trust's Operational Divisional Management Team, the Trust's Transformation Team and the Trust's Estates & Facilities Team who manage the PFI Project Co on a day-to-day basis.

The specification of many aspects of the design are pre-dictated by the PA and the materials, equipment and maintenance regimes set out therein. Any derogation due to changes in guidance will only be accepted after co-review by the Trust and PFI Project Co. Those accepted are fully recorded in detail on the schedule of derogation (Appendix 6).

Examples of compliance with guidance include:

- Obligations of the Trust's Green Plan as well as those relevant aspects of the wider Net Zero Carbon agenda and the PFI Project Co's own desires for Carbon Reduction.
- Changes to HTM 03 01 and the requirements for ventilation services within clinical spaces

These have had a direct impact on the design and the Trust and PFI Project Co have worked together in optimising the re-investment of life-cycle programmes with the new specified works.

The design of the facility has followed the industry-standard Royal Institute of British Architects (RIBA) Work stages with formal approval given at Stage 2 (OBC) and Stage 4 (FBC), the latter being the design that has been taken to Tender. The Design Team are engaged by the PFI Project Co based on a fixed-price fee submission with the terms of that engagement (as regard to the Trust) being that captured within the original PA. The full CMH EOC Architectural Derogations can be found in appendix 7.

5.4 Alignment with Trust and ICS Strategy

The Central Middlesex Hospital site has a long history of planned elective care. The Ambulatory Care and Diagnostics Centre (ACAD) was opened by Tony Blair, Prime Minister, in 1999. It was the original "Treatment Centre" that delivered a physical separation between elective and emergency care and was designed and located to serve a wider population which would be incentivised to travel further than might have otherwise been expected in return for the certainty that their care would be provided at a planned point in time without the risk of that care being cancelled due to pressures on the emergency pathway.

Under the previous "Shaping a Healthier Future" Strategy for NWL, CMH was again separated out and allocated as specific location for elective care. The notion of its central location within NWL, the absence of busy emergency centred care and the exceptional quality of the facilities available, again make the CMH site ideal for the notion of being a home for planned healthcare activity.

LNWH published its new strategy for 2023 to 2028 in February 2023 called "Our Way Forward". Within the strategy, it sets out CMH will be an elective care hub and the home for the NWL EOC. Other HVLC specialities will be prioritised at the site encouraging a site culture focused on high quality and highly productive planned care, without risk of disruption from emergency care services. This complements the strategic goal to make best use of each of the trust's sites, with differentiated service offers at Ealing and Northwick Park Hospitals to support high quality of care and meet local population needs.

Given the history of planned care on the CMH site, the protection of the site from the operational pressures of the Emergency Pathway and the continued use of CMH by surgery firms and the associated critical care support that requires, the concept of locating the EOC at CMH is strongly aligned with local and sector strategies.

From an Estates perspective, there is untapped utilisation of modern twenty-first century healthcare facilities. The EOC fits into the footprint of the existing structure and significant modifications are required to less than 20% of that space (by area). A substantial proportion of the EOC will be re-purposed existing space that may require some lifecycle updating as part of the ongoing commitment of the PFI Project Co to maintain the facilities to the condition required by the Project Agreement.

The proposal does displace some Outpatient activity, but the site does hold the capacity to accommodate this displaced activity elsewhere on the site. In fact, the need to review Outpatients acts as a prompt for a much wider capacity and utilisation assessment. The CMH "design" was generally founded on a long association with specialist discipline-led care, derived from "patient focused care" models of the late-20th century. CMH was a small DGH that proved to be sub-scale and unable to operate effectively compared to its larger neighbours, as the population became more mobile and more focused on outcome led care models, then CMH would never have been able to deliver the wide range of services that it was originally designed for.

As a PFI site, exit costs are too high to compete commercially with the alternative of better utilisation. To this effect CMH provides the ideal home for the EOC, with bed spaces that can be occupied and theatre

facilities that can be readily expanded. There is no physical overlap (other than local choices that can be met with minimal impact) and the facilities are readily adaptable to the needs of the EOC.

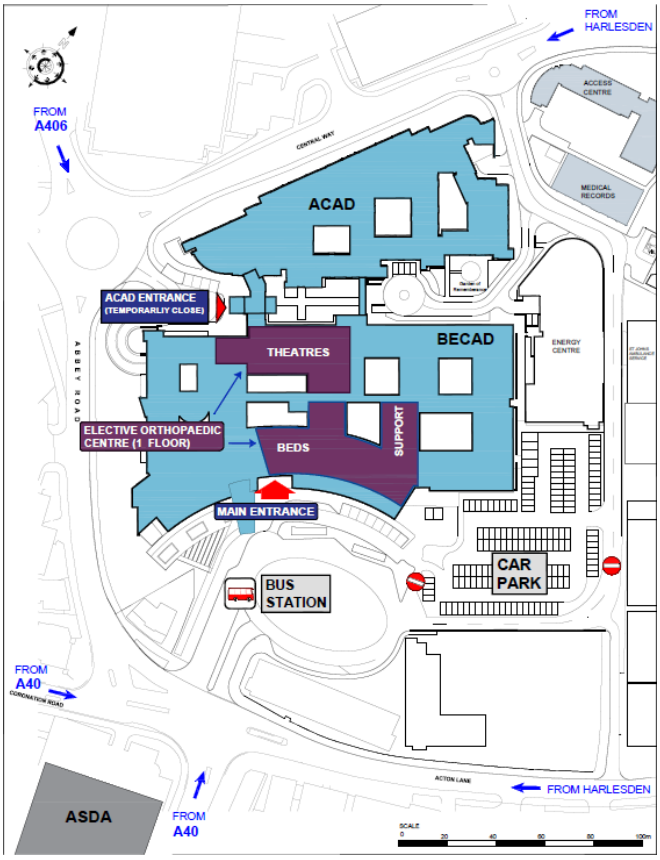
Work is in progress on the development of the ICS Acute Strategy, through the Acute Collaborative. This will establish the framework for the ICS Estates Strategy.

As a Trust, LNWH has established guidelines for LNWH site and service configurations. These guidelines are to be used to determine which services should be delivered from each of LNWH's sites. This is to inform immediate service improvement planning and space prioritisation decisions. Whilst these guidelines can be overridden, the burden of evidence should be higher than decisions that follow them. Within the guidelines, it is stipulated that Central Middlesex Hospital is now the ICS Elective Care Hub, prioritising high volume surgical specialties and should therefore be a key driver for the location of the NWL EOC. These guidelines were incorporated and affirmed within LNWH's 2023-2028 strategy published.

5.5 Site plan and design of preferred option

A site plan for Central Middlesex Hospital showing the proposed location of the EOC (at 1st Floor level) is set out below.

Figure 9 - Site plan



As previously noted, the design of the preferred option sits within the existing Theatres of the BECaD Wing (originally the Emergency Theatres for the CMH site). To these three Theatres will be added two further Theatres generating a total of five for the EOC, along with a ten bay First Stage Recovery unit and associated support facilities. The design of the new facility is shown below:

Figure 10 - Design of the new EOC facility

5.6 Tender exercise and capital costs of the preferred option

An invitation to tender was issued on 23rd January 2023 with a one-month period. Following closure of the tender period on 23rd February, the five tenders received were adjudicated, three shortlisted and a report produced. The full process and detailed assessment of the Tender exercise is captured within the Tender Report by the PFI Project Co.

The conclusion of the formally adjudicated Tender Prices is summarised below:

Table 20 – Tender Prices for Option 5 (Preferred Option)

Contractor	Price	Index	Period
Bidder 1	£3,923,845.61	100	26 Weeks
Bidder 2	£3,964,318.78	101	22 Weeks
Bidder 3	£4,154,195.33	106	25 Weeks

The Tender Report recommends the tender submitted by Bidder 1 and this is endorsed by both the PFI Project Co and LNWH Trust Estates & Facilities team.

Bidder 1 has also been appointed as the Contractor for CMH's Endoscopy Project. This was noted during the tender exercise and in making the recommendation by LNWH Trust & Estates Facilities team. A single contractor offers economies of scale, risk mitigation and improved on-site liaison across operational teams.

While not successful, the addition of the Trust nominated bidder (Bidder 2) has ensured that the Tender exercise is "fresh" and competitive with a positive outcome for the NHS. The closeness of the outcome also supports a robust process with clear content, given the limited extent of queries and uncertainties that the process has generated.

In the Tender Report the Professional Quantity Surveyor has compared to their own original assessment likely cost. This implies an increase of cost of circa £500k; while reflective of actual submitted information, it must be noted that in transferring the original Cost Plan to the OBC, risk elements

identified had been applied to enhance OBC values and a direct comparison, is very much like-for-like; the Tender Exercise has delivered the outcome predicted within the OBC.

The output of the Tender exercise has been taken forward to the FB Forms (appendix 8) and added to other cost lines and risk allowances. Of those cost lines and risk allowances:

- Fees – supplemented with additional Trust Project Management to support the wider interface of the Project with Operational Teams (both delivery and outcome)
- Non-Works Costs – updated to fully incorporate Project Development costs.
- Equipment Costs – costs reviewed and schedules remain as projected at OBC stage.
- General Contingency – a 5% of Works Cost allowance has been retained to cover potential design development through Stage 5 of the Project. While working with a fully approved Stage 4 design, it is felt nonetheless prudent to retain this allowance given the unique operating arrangement for the EOC that might impact on works.
- Optimism Bias (OB) – while mitigated significantly by the move to FBC stage, there remains an element of risk that fall within the remit of OB. This assessment is modelled using a standard appraisal matrix that sets an upper limit of the potential “optimism risk" and this is then mitigated by the specific stage of the Project’s development. This appraisal assesses a 7% allowance of Optimism Bias is retained within overall Project Costs at FBC stage. More detail can be seen in appendix 9.

The FB1 summary of costs is set out in Table 21 with full costs detailed in Appendix 9.

Table 21 - Summary of Capital Costs

Item	Cost inclusive VAT (£)
Work Costs	5,686,453
Fees	628,415
Non-work costs	1,004,400
Equipment costs	1,225,200
Contingency (5%)	284,323
Optimism Bias (7%)	583,114
Total	**9,411,904**

5.7 Construction and works management

Once approval of the FBC is confirmed the works will be managed by the PFI Project Co in line with requirements of Schedule 22 and good industry practice. The Project Manager will meet with the Client Team and the PFI Trust Representative on regular basis to report on progress, variations (if any), a financial standing and cash-flow of the works. Appropriate summary reports will be communicated wider. Variances of any KPI (quality, time and money) will be duly reported based on the context of the same.

The works are planned to be formally instructed on 20 April 2023 (subject to approval on 18 April 2023) such to allow works to construction to commence on 25 May 2023 and complete on-site by 30 November 2023 (see table

5.7.1 Enabling works

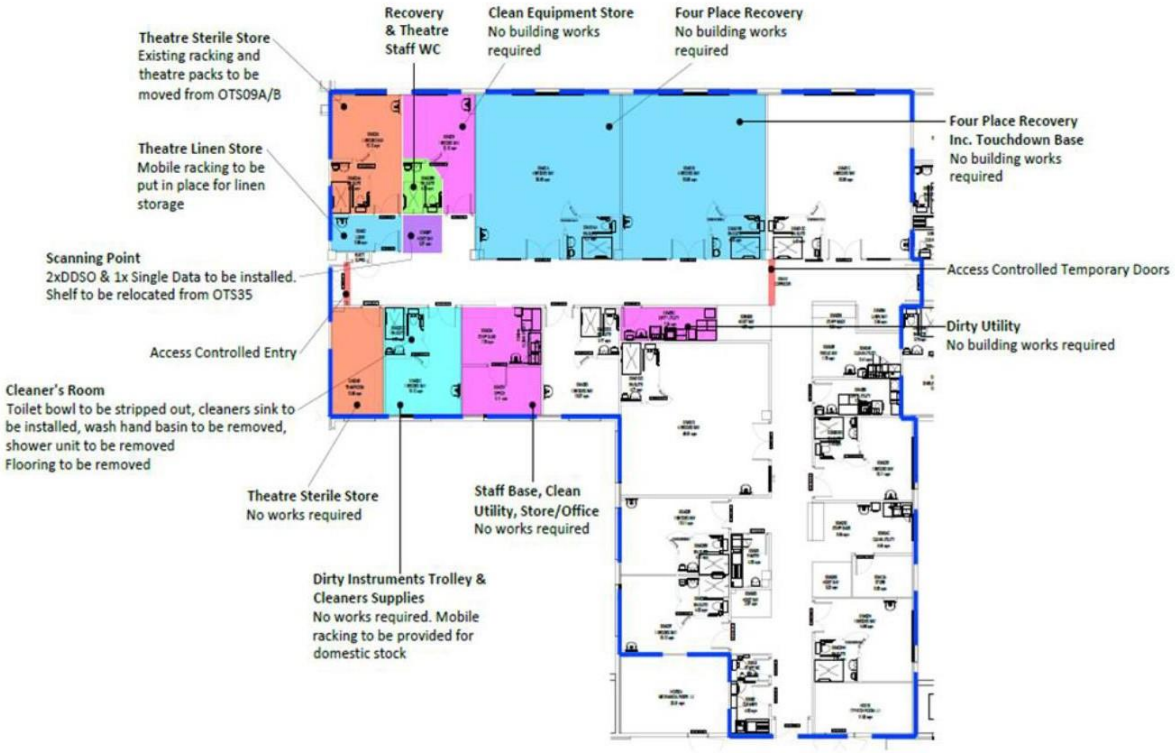
The Trust will have completed a series of relocation and decanting works that are mainly centred upon the re-purposing of existing functions across existing spaces between January and May 2023. The EOC Project coincides with a wider review of functionality across the CMH site and in particular in relation to Outpatient functions.

The one permanent move sees the Neurophysiology Team move to the Second Floor as well a couple of domino moves (TB Clinic moving to the ground floor) to create the necessary void. These works are in hand for timely completion through the Main Contractor lead-in period.

In order to undertake the works within the Theatre complex, yet maintain activity within the three existing Theatres, Recovery and support accommodation relocates to Ward G1. Again, these works are being undertaken in good time for vacant possession handover on 25 May 2023.

The enabling works to relocate to Ward G1 are illustrated below.

Figure 11 - Enabling works to relocate Ward G1



Further to the works set out in the Stage 4 tendered design, the Trust will also utilise the existing Ward G4 space to support the Theatres Team during both the construction and operational phases. These works have been developed in discussion with the clinical and operational management teams and the noted changes will be undertaken partially in advance and partially in parallel with the commissioning of the EOC.

The works to Ward G4 are illustrated below.

Figure 12 - Works to Ward G4

5.7.2 Handover

On completion, the construction works will be tested and commissioned in line with good industry practice, the design requirements and those of the supplier/manufacturer to ensure operation, all in line with the Design. There is a “no-snagging” agreement within the PA, which means all spaces must be operational on handover at day one.

5.7.3 On-going monitoring and maintenance

On-going monitoring and maintenance falls within the Business As Usual (BAU) responsibility of the PFI Project Co, their Hard FM Service Company and the Trust Estates & Facilities Team as client representative.

Soft FM and support services are provided by the Trust under directly managed Trust-wide service contracts; these service arrangements being implemented as part of the Commissioning Phase.

5.8 Planning consent

The nature and extent of the construction works are such that there are no material Town Planning considerations given the proposed works will be entirely undertaken within the curtilage and footprint of the existing BECaD Wing.

Being wholly internal modifications, the construction works are similar to that of both the prior GP Practice and Endoscopy projects, neither of these projects required Planning nor has there been any subsequent challenge to that assessment by the Local Planning Authority. Both Brent Council and OPDC (the organisation charged with Planning powers within the development zone) have been informed and are supportive of the “re-filling” of CMH with further clinical activity. There is no “change of use” and the remit of the original ACAD Planning approval as a Treatment Centre for North West London (dating back to the later 1990’s) supports the site selection of CMH to host the EOC.

5.9 Legal and commercial issues

A formal Deed of Variation to the PFI Project Agreement (PA) is required by the PFI Project C, following standard precedent format. This deed will have legal input from the LNWH's and PFI Project Co's legal advisors (Capsticks and Addleshaw & Goddard, respectively).

Works will be instructed under a Letter of Underwriting issued by LNWH to the PFI Project Co and further supported by a Letter of Indemnity (with both documents reviewed by the Trust's legal advisors). The Letter of Underwriting will move to a Deed of Variations as soon as the process allows.

Engagement of the construction contractor remains part of on-going negotiations within the PFI Project Co. This will occur via a standard form of JCT Contract, likely to be the Intermediate Form, which is familiar to both parties.

Risk allocation is important for the approval process, and PFI lenders are particularly cautious. Trust teams will use the Letters of Underwriting and Indemnity to define risks in a way that avoids undue premiums and allows transfer to the PFI Project Co once adequately appraised.

The project must meet the legal costs of the PFI Project Co as defined in the Deed of Variation and associated documents. These costs are included in the FB forms (appendix 8).

5.10 Key construction risks and mitigations

The main construction risks are summarised below:

Table 22 - Key construction risks for the NWL EOC development

Risk description	Mitigating actions	Mitigated risk rating (likelihood x impact)
There is a risk that storage is insufficient resulting in poor process and delays to care	Redesign storage areas in advance of opening to maximise use of space. Rationalise products Involve clinical teams in solutions	6
There is a risk of delay or cost increase due to PFI Project Co taking longer to make decisions than planned, requiring significant change, or getting lenders approval	Weekly assurance meeting to address issues as they arise Successful track record of working with PFI Project Co Non-adversarial relationship is continued with early engagement	4
There is a risk that the displaced admin space cannot be accommodated in the footprint	Prioritise the need for space and develop a plan in consultation with Programme Board Agreed plan for space on G 4 Utilise unoccupied space elsewhere in CMH where feasible Develop agile working solutions where feasible	3
There is a risk that the extension of the EOC building footprint reach into outpatients will have a detrimental impact on the displaced services	Engagement with affected teams to develop alternative locations Review all outpatient capacity at CMH to identify opportunities for improved utilisation of space Explore alternative outpatient delivery models where feasible	3
Potential risk of delay or cost increases due to availability of	Continuous dialogue with PFI Project Co	6

materials and/or supply chain constraints	Plan for early procurement of materials	
There is no space for bed hold	Review patient flow to identify solutions	3

A risk register for the full business case is described in the Management Case (Chapter 7) and in appendix 10.

6 Financial case

Chapter Summary
Chapter 6 sets out the revenue and capital financial case for the development of the NWL EOC, including the scheme's affordability and impact on the trust's position and balance sheet and income and expenditure.

Key Messages
- The NWL EOC financial analysis includes the income and expenditure position for the first two years as set out below. This shows a net income and expenditure benefit in the first full year of operation of £3.968m to the NWL system.
- Outputs from the public consultation and assurance process have been assessed from a financial standpoint, and the only material change from a financial perspective is the patient transport solution. The proposed transport solution has been costed at £0.106m per year, which will increase the annual running cost of the EOC.
- NHS Targeted Investment Fund (TIF) has been secured to fund the projected £9.412m capital investment to facilitate this development.
- Enabling works are being funded in advance of business case authorisation to ensure the critical path for the development and construction of the EOC remains on track along with needed case development investment.
- Taking into account the modelling principles employed and the results of the sensitivity analysis, the Financial Case demonstrate that the financial modelling assumptions are sufficiently prudent that the model is able to absorb the most likely outcomes over mobilisation and over the longevity of the case.
- The sensitivity and scenario analysis highlights the robustness of the modelling when tested against a number of parameters.
- The principles underpinning the proposed financial and commercial arrangements between the NWL Acute Trusts have been jointly developed and were agreed at the Acute Collaborative Finance and Performance Committee on 10th March 2023.
- The financial model has been developed considering the recurrent investment needs flagged to facilitate a Lead Provider Hosting model. Revenue and capital costs have been captured to facilitate the needed digital infrastructure specific to the EOC development. To support realisation of productivity ambitions, significant training investment has been included to provide new ways of working training.
- As part of the governance process, an addendum to the FBC has been produced setting out the activity and financial implications for each organisation to support decision making on an open and transparent basis.

6.1 Key assumptions in the financial model

The financial model has been developed to reflect with as much precision as possible the likely financial consequence of the new NWL EOC, including LNWH DC and EL case load and taking on the elective activity for the wider NWL Sector (excluding ASA 3 and above and revisions).

The refreshed financial tables can be found in full detail in appendix 3.

Capacity maximisation has been at the centre of the model's development, with the points below demonstrating how this has been captured:
- The £9.412m capital requirement, funded by the NHS Targeted Investment Fund. This scheme is the number one priority for the sector.
- The capital costs include £0.2m relating to enabling works for relocation of the Outpatient area, temporary relocation of Recovery to G1 and relocation of staff/services to accommodate the new theatre footprint including preparation works for G4.
- Capital charges are based on post tender fixed price RIBA Stage 4 design costs, with a 12% contingency (5% general contingency and 7% optimism bias) risk adjustment. This is the unmitigated risk to manage the potential impact of surging supply chain costs as a consequence of the conflict between Ukraine and Russia.
- Collaborative workforce model development with the multidisciplinary service clinical leads.

- Full costing mapped the patient's pathway from point of referral into inpatient case management ending with the patient being discharged back to the community and home trusts for post operative care and rehabilitation.
- Outpatient modelling has been assumed out of scope as the clinical model supports that this activity will be undertaken by the home trust organisations facilitating care closer to home where viable
- Modelling includes various uplifts to mitigate financial risk including optimism bias (as detailed above), impact of indexation (revenue and capital), temporary staffing premium (reflecting current market backfill needs), application of a 10% Discounted Cashflow (DCF) adjustment to account for the time value of money (modelled at a heighted rate due to current rates of inflation) and DNAs.
- The costing model assumes that the service will be hosted by LNWH and assumes that staff will be employed by the host organisation. The sensitivity analysis addresses the impact of different staff deployment options for potential scenarios outside of the modelled case.
- Activity modelling is reflective of the operating plan needs up to the end of 24/25 at which point the cumulative impact of GLA population demand growth beyond 2025 up to 2029 is used as this exceeds the 110% modelled in the operating plan (2029 is the ceiling year in the model as this is when beds become a limiting resource, activity beyond this point plateaus).

- Income has been modelled based on the LNWH average tariff and local MFF (this reflects the costing model deployed also). Detailed in the table below is the year two (first full year) income and activity plan transfers that will be required to wider NWL providers in scope.

Table 23 - Organisational cross charging on a full tariff basis for the preferred option (year 1)

	Elective DC and IP	Full Tariff (£)
ICHT	304	1,955,680
Hillingdon	267	1,725,080
CW	336	2,149,056
		5,829,816

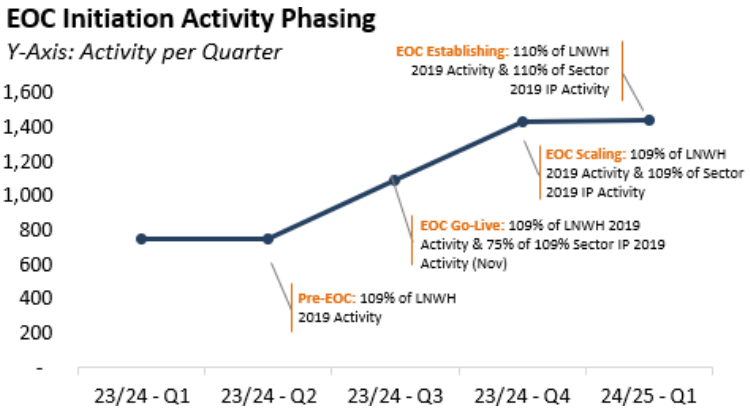
- Sector benefits have been quantified using the 2019/20 National Cost Collection (NCC) inflated to current year prices. This shows an initial NWL £3.673m annual cost saving using this method (based on 23/24 anticipated contracted activity and excluding any additional capacity created through the development of the EOC).
- Through the Finance Workstream, the implications of the development of the EOC have been explored in terms of the impact to the home Trusts. The residual overheads are known with clarity and these valuations have been used to determine a level of financial relief of these standard costs (6 months in year one of the business case). This will allow home organisations a period to stand up replacement services to occupy vacated clinical space.
- Investment in supporting corporate services have been captured with estates charges being costed with the facilities team and with increased investment in other revenue support functions such as ICT, Finance, Insurance being captured based on the % of LNWH existing costs represent of direct clinical spend.

- The appraisal and the approach to the financial assessment has been developed and supported by the NWL CFOs.

6.2 Activity modelling

Activity in year one of the service gradually increases to allow for a manageable pathway transition. Details of the activity ramp up that lead to the recurrent capacity (as detailed above) are shown in the chart below (plan assumes commencement in November 2023):

Figure 13 - NWL EOC Activity phasing



6.3 Impact on the trust's Income and Expenditure position

When reviewing the Income and Expenditure position for the Trust, it is important to consider both the impact for LNWH and also the wider sector Implications. It is vital that this is assessed over year one (implementation year) and year two (recurrent position) of the project.

The recurrent annual sector benefit to I&E is £3.968m (£0.1m in year one due to home trust relief for overheads/stranded costs, phased activity plans and mobilisation investment) is shown below:

Responses from the public consultation and assurance process were assessed from a financial standpoint and the only material change from a financial perspective was the patient transport solution. The proposed transport solution has been costed at £106k per year. Reducing the net surplus of the EOC to £3.968m, starting in the first full year of operation. This is in absolute terms and considers operating at full capacity.

The model takes the detailed patient-level costings from the trusts, which gives an indication of the costs of the work being undertaken within the trusts, drawn directly from the trusts' reporting systems. This analysis shows a recurrent annual benefit to the I&E position of £3.968m. In effect, across the four trusts it costs £3.968m more to treat these patients with the current model than it would within the EOC.

6.4 Impact on the trust's balance sheet

Traditional capital charges calculations have been deployed over the course of the investment. For the preferred option, £9.412m of capital investment has been modelled which included development costs for project management, clinical pathway modelling, activity planning, ICT transformation and legal fees in addition to the development works costs (including design fees) and equipment.

Assets have been depreciated (with respective capital charges costed at 3.5%[16]) over the useful life of the investment. The capital investment plan, with associated capital charges in Year one and Year two of the proposal, is shown below.

Table 24 - Impact of the NWL EOC on the Trust's Balance Sheet

LNWH DC & IP + NWL IP					Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
		Std life		£000	£000	£000	£000	£000	£000	£000	£000	£000
					NBV b/fwd	Depn	NBV cfwd	Cost of cap	NBV b/fwd	Depn	NBV cfwd	Cost of cap
Refurbishment (Aligned to PAC Development) (25 Years useful life)	Wrks	25		7,610	7,610	304	7,305	261	7,305	304	7,001	250
Development Costs (25 Years useful life)	Wrks	25		577	577	23	554	20	554	23	531	19
	Wrks	25			0	0	0	0	0	0	0	0
Equipment (Medium Term Assets) (7 Years useful Life)	Eqpt	7		1,225	1,225	175	1,050	40	1,050	175	875	34
	Eqpt	7			0	0	0	0	0	0	0	0
	Eqpt	7			0	0	0	0	0	0	0	0
	IT	5			0	0	0	0	0	0	0	0
	IT	3			0	0	0	0	0	0	0	0
Total capital investment required				**9,412**	**9,412**	**502**	**8,910**	**321**	**8,910**	**502**	**8,407**	**303**

[16] 3.5% is NHS standard practice based on historically low interest rates. However, the current economic situation is reflected in sensitivity analysis and the risk register.

6.5 Cashflow implications

To determine that impact to LNWH's cashflow, a discounted cashflow forecast has been developed over a 25-year period, based on a discount factor of 10%. A higher discount factor has been applied to the case to reflect growing inflation pressures and in turn the depletion of the value of money over time. Over this period, it is modelled that £35.510m will be the discounted cashflow benefit to the centre over the next 25 years (commencing with effect from Nov 2023).

Table 25 - Impact of the NWL EOC on the Trust's Cashflow

LNWH DC & IP + NWL IP	Year 1 £000	Year 2 £000	Year 3 £000	Year 4 £000	Year 5 £000	Year 6 £000	Year 7 £000	Year 8 £000	Year 9 £000	Year 10 £000	Year 11 £000	Year 12 £000	Year 13 £000	Year 14 £000	Year 15 £000	Year 16 £000	Year 17 £000	Year 18 £000	Year 19 £000	Year 20 £000	Year 21 £000	Year 22 £000	Year 23 £000	Year 24 £000	Year 25 £000	Total £000	
Revenue cash	483	4,774	4,947	5,093	5,217	5,341	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	118,295	figs from Revenue tab
Capital cash	-9,412																									-9,412	figs from Capital tab
Total	-8,929	4,774	4,947	5,093	5,217	5,341	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	4,865	108,883	
Disc Fact 10%	1.000	0.909	0.826	0.751	0.683	0.621	0.565	0.514	0.467	0.425	0.386	0.351	0.319	0.290	0.264	0.240	0.218	0.198	0.180	0.164	0.149	0.135	0.123	0.112	0.102		
NPV	-8,929	4,339	4,086	3,825	3,563	3,317	2,749	2,501	2,272	2,068	1,878	1,708	1,552	1,411	1,284	1,168	1,061	963	876	798	725	657	598	545	496	35,510	

As outlined in the economic case, we have also considered the financially quantified social benefits of the service change, increasing the net present value over a 25-year term of the business case increases from £35.510m to £52.771m, leaving us with an economic ROI ratio of 5.6:1.

6.6 Efficiency savings

Through the development of the Lead Provider Hosting arrangement and also through the continuation of the finance workstream as we lead into mobilisation, the key areas that underpin delivery of the efficiencies outlined in the case will continue to be drawn out.

To this point, National Cost Collection data has been used (inflated to current prices) to determine the cost savings that will be release as a result of the EOC development. Based on the first full year of activity (Year Two of the Model), there is a potential that this model will release £3.673m in efficiencies, primarily from moving to GIRFT standards for LOS and theatre utilisation.

Table 26 - Potential Cash-releasing efficiency gains

NWL Trust	NCC Price	Mobalisation Year Activity	Opening Year Activity (Recurrent)	Mobalisation Year £	Opening Year £ (Recurrent)
ICHT	£ 7,641	304	818	£ 2,322,864	£ 6,253,394
Hillingdon	£ 7,345	653	718	£ 4,796,285	£ 5,275,914
CW	£ 6,557	336	905	£ 2,203,152	£ 5,936,052
LNWH - Inpatients	£ 6,807	611	1,480	£ 4,157,943	£ 10,070,957
LNWH - Daycase	£ 2,411	648	1,569	£ 1,561,123	£ 3,781,895
Grand Total		**2,551**	**5,490**	**£ 15,041,366**	**£ 31,318,211**
				£ 12,847,163	**£ 27,645,235**
				-£ 2,194,203	**-£ 3,672,976**

The benefits realisation plan described in appendix 11 includes an assessment of the impact on unit costs of achieving target improvements in productivity and efficiency. This includes:

1. Weighted activity unit (WAU) all activity – targeting a 5% cost reduction, as there is no change to trauma, which is out of scope.
2. WAU elective activity – 11% cost reduction, as only routine inpatient orthopaedic activity is in scope.

The financial savings will be achieved by delivering a service that is more efficient and in line with GIRFT standards, enabled by a modern facility and centralisation to provide the critical mass and clinical expertise. The EOC will add capacity to the NWL system to treat more patients. This undertaking requires more staff. With the elective-orthopaedic-centre-enabled service transformation, we are able to treat

those additional patients more efficiently. This will reduce the unit cost compared to a 'do nothing' option.

The medical workforce cost will transfer to the EOC via recharges. At present, we have not identified an organised grouping of staff whose principal role is the delivery of the transferring activity. As result, it is anticipated that these staff will remain in the 'home' trusts, strengthening their staffing positions by reducing vacancy rates and being utilised to deliver replacement activity (additional complex activity and repurposed capacity). Plans for the repurposing of capacity have been scoped and are being developed by the three 'home' trusts.

Taking into account the modelling principles employed and the results of the sensitivity, the financial case demonstrates that the financial modelling assumptions are sufficiently prudent that the model is able to absorb the most likely outcomes over mobilisation and over the longevity of the case.

The sensitivity and scenario analysis has been reviewed by the Financial Workstream and revalidated. This analysis highlights the robustness of the modelling when tested against a number of key parameters.

The principles underpinning the proposed financial and commercial arrangements between the NWL acute trusts have been jointly developed and agreed by the chief financial officers of the acute trusts.

Greater work has been undertaken to date reviewing the detail on stranded costs (which has been reflected in the change of methodology in costing marginal relief in Year One). As well as appraising the efficiency opportunities that the EOC will deliver, support has been provided through the Finance Workstream to explore wider savings opportunities from additional contributions from the use of vacant home capacity and also temporary staffing savings from retained staff in difficult to recruit to areas. Neither of these saving themes have been captured within the financial detail of this case.

To test the efficiencies calculated through the national cost collection method above the three core efficiency drivers have been calculated using a bottom-up costing measure to test the reasonableness of the determine value added.

6.6.1 Theatre utilisation savings

Reviewing the analysis through Model Hospital, the level of expected savings can be determined through the expected number of cases to be completed during and standard 4 hours theatre session. There is an opportunity in terms of theatre savings that can be realised from moving to a 2 elective cases per theatre session model versus the individual Trusts' existing performance. Currently, the average number of cases through theatres (based on the case mix in scope) is 1.6 per theatre for the 4 NWL providers. Based on GIRFT standards, the average number of cases through a standard theatre session is expected to be 2.3 (weighted based on the day case activity in scope). This equates to 739 sessions is released capacity which would generate £1.770m in direct clinical theatre costs.

6.6.2 Length of Stay Savings

The GIRFT modelling principles adopted shows that the expected patient LOS would be 2.3 days for the elective patients in scope. The sector's current performance is 2.6 days for elective care and specifically 3.7 days for knee replacements and 3.4 days for hip replacements. This would therefore release 4,165 bed days by delivering this standard. This would realise savings of £1.070m based on a ward direct costing model £257 per bed day.

6.6.3 Site Consolidation Savings

In addition to the above, there will be savings generated from the rationalisation of facilities. The value of these efficiencies can be determined through the calculation of the difference between the marginal rate costs of services delivered and the present income attracted from the delivery of these services. The costing model has assumed that these savings will not be realised in year one during mobilisation to allow for a suitable period of time for vacated theatres and ward domains to be repurposed. Based on the

methodology above, there is a potential saving of £1.900m from the release of premises and support costs.

6.7 Sensitivity Analysis

The sensitivity analysis presented explores a range of financial upsides and downsides that could change the financial modelling presented. The financial model communicates the expected monetary impact of the case as described however it is important that we explore a range of potential scenarios that could influence the financial position.

There are five areas of risk that have been modelled below which the Project Group determines to be the most significant areas that could vary against the modelling assumptions deployed above. These risks are largely a reflection of the current position in terms of expected methods of staff deployment and recruitment and wider price challenges. The analysis below reflects a greater understanding of the recruitment market challenges and communicates a reduction in the overall risk profile of the financial case driven from changes to the finance model. Investments in training and recruitment initiatives have been modelled in the base financial case to support better recruitment outcomes.

Alongside the risks presented there are three potential benefits that have not been captured in the financial case however could improve the overall financial margin. These have also been explored below to inform the assessment of influences to the financial case.

6.7.1 Sensitivity Contingency and Optimism Bias

Due to the risk to current supply change prices, it is necessary to consider various views on the appropriate optimism bias applied to the capital charges assumed within this case. In this scenario, a relatively risk adverse approach has been taken as the unmitigated contingency of 12% has been applied. Responses to the tendering exercise have been received and therefore the prices captured for construction works have been quoted at a fixed price based on the design plans issued. 12% (5% general contingency and 7% optimism bias) is the top estimate that should be consider for a programme at this stage of development.

Considering a mitigated position, taking into the robustness of valuations collated so far, then it is determined that 5% would be sufficient which would reduce capital costs by £0.583m and annual revenue costs by £0.051m against the model presented.

As the final tender costing templates are available, this provides a significant level of assurance regarding the capital valuations included. Considering a maximum exposure rate of 16% above base case costings (2% per remaining active month of the project), this would result in an increase in capital requirements of £0.402m and £0.035m annual revenue implications.

Table 27 - Optimism Bias Sensitivity

	Capital Costs	Movement in Capital Costs	Average Capital Charges (Revenue)	Annual Revenue Impact
Modelled Capital Charges - Contingency and Optimism Bias 12%	£9,411,904		£823,117	
Mitigated Capital Charges - 5%	£8,828,791	-£583,113	£772,121	-£50,996
Hyperinflation (2% per month to completion) - 16% (8 months)	£9,813,783	£401,879	£858,263	£35,146

6.7.2 Sensitivity Impact of Inner London Weighting

As we have developed the full business case there has been an emerging position that TUPE will not apply in the context of the EOC arrangement. Taking this as the most likely scenario this in turn has provided greater clarity on whether Inner London Weighting payments would apply. We can now model with reasonable certainty that staff that have been identified to be cross charged to the host will retain

their home Trust terms and conditions and the exposure to Inner London Weighting payments have been included in the base costings. For all other staff groups, we should consider that individuals have the opportunity to work at the EOC and therefore it would be reasonable to assume a proportion of exposure relating to these employees on costs. To date, the Workforce workstream have not identified a material volume of staff expressing to transfer to the EOC from their home Trusts however, it is important that we model the potential cost implications if this was to occur as conversations with employees mature. The table below communicates that if the full EOC was to full an Inner London payment methodology, this would annually increase the case by £0.562m. If, however, we considered the more likely scenario that a wider proportion of staff express to work as part of the EOC, let's say 10% of the total establishment, this would increase the case cost by £0.067m periodically.

Table 28 - Inner London Weighting Sensitivity

6.7.3 Sensitivity Reliance of Temporary Staffing

In light of the likely outcome that TUPE does not apply to this case (legal advice pending), it is important that we consider a greater reliance on temporary staffing to support the delivery of the detail clinical model. Looking at the current recruitment market as well as the time to recruit 18% during mobilisation year and 15% recurrent of the total establishment has been assumed will be covered by temporary staffing. The projected establishment is currently showing an expectation that 5% of the establishment will be filled with agency and 10% with locum/bank staff recurrently. Due to the significant recruitment effort (albeit this is partially mitigated by the investment in recruitment and training) that will be needed it is important to consider a wider cost exposure for a range of vacancy rates that in turn will increase the cost of temporary staffing premiums. Shown below is the impact if 30%, 25%, 20% or 100% of the remaining vacancies were to be filled with agency which generates an annual cost range of between £0.311m to £2.868m, making this the single biggest financial risk to the model.

Table 29 - Temporary Staffing Sensitivity

6.7.4 Sensitivity Length of Stay (LOS) Reductions

GIRFT principles have been the foundation to calculate the required bed capacity to deliver the projected level of activity. This assumes an average LOS of 2.3 bed days for all inpatient care. Detailed below is the cost impact (based on SLR direct bed day costs) if LOS was to move in 0.2 of a day intervals from 2.3 days to 3.5 days. This would require additional investment of between £0.217m and £1.303m of ward investment.

Table 30 - Length of Stay Sensitivity

		Annual Number of Occupied Bed Days (Modelled Case)	LOS Scenarios					
Average LOS		2.3	2.5	2.7	2.9	3.1	3.3	3.5
Inpatient Activity	4,226	9,721	10,566	11,411	12,257	13,102	13,947	14,792
Excess Bed Days			845	1,691	2,536	3,381	4,226	5,072
Excess Direct Cost @ £257 per Bed Day - £'000*			**£ 217.24**	**£ 434.47**	**£ 651.71**	**£ 868.95**	**£ 1,086.18**	**£ 1,303.42**

* Based on LNWH direct SLR bed day cost

6.7.5 Sensitivity Theatre Utilisation

As part of the development of the clinical model, the number of case per 4 hour theatre session has been based on GIRFT standards of 2 inpatient cases per list of 4 day cases. Based on variability across the sector, two other flow models have been considered (as detailed below) which could result in a cost consequence of between £1.150m and £2.012m, if the capacity needed to be replaced with Waiting List Initiative lists (if the Trust were able to generate capacity within operational hours then the cost of the options modelled would be between £0.455m and £0.797m). It is important to note that there is a high degree of confidence that the model utilisation is possible due the referred elective caseload being below ASA 3.

Table 31 - Theatre Utilisation Sensitivity

				Activity (Year 2)	Equivilent 4 Hour Lists	Additional Above Modelled	WLI Cost for Activity Recovery £'000	Additional Cost for Lost Productivity £'000
5-hour list: Inpatient	2.00	Cases per 5-hour List	Expert Opinion	4,226	2,642	528	1,697	
5-hour list: Day case	4.00	Cases per 5-hour List	Expert Opinion	1,569	490	98	315	**2,012**
4-hour list (High Productivity): Inpatient	2.00	Cases per 4-hour list	Expert Opinion	**Modelled Version**				
4-hour list (High Productivity): Day case	4.00	Cases per 4-hour list	Expert Opinion					
4-hour list (Low Productivity): Inpatient	1.75	Cases per 4-hour list	Expert Opinion	4,226	2,415	302	970	
4-hour list (Low Productivity): Day case	3.50	Cases per 4-hour list	Expert Opinion	1,569	448	56	180	**1,150**

6.7.6 Sensitivity Home Trust Temporary Staffing Reduction

With the considerations made regarding recruitment in the scenarios presented above we should consider the impact of the EOC in the Home trust environments. With a greater proportion of workforce retained there is potential that these individuals will fill vacancies in key services such as Theatres and in

Ward domains preventing the need for temporary staffing. Looking at the proxy workforce supporting activity in the home trusts we have assumed that 10% of the establishments supporting activities in

scope of the EOC could replace the use of agency staff thus releasing the premium cost. This could potentially generate a further £0.385m and up to £0.769m looking at the agency reliance across NWL.

Table 32 - Sensitivity home trust temporary staffing reduction

	Home Trust Establishment	Home Trust Establishment (Weighted Based on LNWH NCC)	Average Agency Premium per Post	5% Fill Home Trust Vacancies (Covered with Agency) £'000	10% Fill Home Trust Vacancies (Covered with Agency) £'000	15% Fill Home Trust Vacancies (Co	20% F
Admin and Clerical	8.27	10.42	12.49	6.51			
Allied Health Professional	9.20	11.60	19.30				
Consultant	15.17	19.11					
Management	0.90	1.					
Medical Other	16.06						
Nursing							
Pharmacist							
Total							

6.7.7 Sensitivity Home Procurement Supply Standardisation

The host providers financial unit costs have been used to inform the cost of clinical consumables and drugs required to treat the case mix in scope of the EOC. Through the normal stages of efficiency planning and in the context of standing up a new a contract, a 3% reduction in spend would be a reasonable expectation. If we explore further product and supply standardisation opportunities then an upper threshold of 5% could be attainable. Playing this through this could deliver a range of between £0.207m and £0.345m of savings annually.

Table 33 - Sensitivity home procurement supply standardisation

	Year Two (FYE) £'000	1%	2%	3%	4%	5%
Clinical Supplies & Services	6,373.92	63.74	127.48	191.22	254.96	318.70
Drugs	530.92	5.31	10.62	15.93	21.24	26.55
	6,904.84	**69.05**	**138.10**	**207.15**	**276.19**	**345.24**

6.7.8 Sensitivity Margin from New Activity

Based on an expected margin from income that could be delivered over and above contribution to overheads from new activity delivered from vacated capacity (as a proportion of lost income from EOC activity). Under this assessment it has been assumed that delivery of a margin would be unlikely from a growth in NHS commissioned activity however savings from private patient or independent sector routes would attract a higher contribution. For this reason, the overall % expected has been captured at the lower end however considered as home Trusts are exploring the expansion of private patient activity.

Table 34 - Sensitivity margin from new activity

		% Margin Above Overheads	
	Local Valued Income for EOC Activities	3%	4%
C&W Year Two (Full Year) £	5,790,2		
Hillingdon Year Two (Full Year) £			
Imperial Year Two (Full Y			

6.8 Scenario Analysis

Based on the sensitivities presented above, it is important to revisit and appraise what the probable

impact of these pressures and benefits would be against the overall revenue and capital models

presented. To distil this, the table below shows the modelled position, the possible position (based on variables not full mitigated in the development of the full business case) and also a highly unlikely (or possible worse case position). These scenarios cover a broad range of eventualities.

Table 35 - Scenario Analysis Summary

Annual Revenue Cost Change £
Capital Costs (One Off) Change £

	Modelled	Possible	Highly Unlikely	Comments
Sensitivity Contingency and Optimism Bias	Unmitigated	Mitigated	Current	5% would be the expected level of contingency built into the capital plan at this stage of the process
		-£50,996	£35,146	
		-£583,113	£401,879	
	12%	15%	30%	
Sensitivity Inner London Weighting	Outer London (Inner London included on Salary Recharge Posts)	Further 10% of Establishment Transfers to EOC	Inner London (All Posts)	Based on TUPE guidance, assumed that a further 10% of establishment could be filled with employees attracting inner London weighting wishing to transfer to the EOC on protected T&Cs. Consultants and Medical Other grades already modelled with Inner London Weighting costs due to salary recharge mechanism.
		£67,081	£562,224	
		N/A	N/A	
	15% Capped			
Sensitivity Temporary Staffing	Market	Pooled	Pooled	Calculated taking the staff group in scope with the highest vacancy rate (Band 5 Nurses - 30%) as the worst case
		£769,405	£384,702	
		N/A	N/A	
	14% (10% Bank 5% Agency)	20% Vacancy (5% Additional Agency)	30% Vacancy (15% Additional Agency)	
Sensitivity Length of Stay	GIRFT	Top Quartile (Worst MH Performer)	Current (NWL ICB Model Hospital)	Data taken from model hospital to provide benchmark (LOS will be slightly distorted as Model Hospital cannot differentiate activity by ASA score)
		£325,855	£868,948	
		N/A	N/A	
	2.3 (Average Top Quartile MH)	2.6	3.1	
Sensitivity Theatre Utilisation	High Productivity (GIRFT)	Low Productivity	Current (NWL ICB Model Hospital)	Possible impact due to patient complexity (longer to treat), planning, infrastructure or practices
		£1,149,598	£1,377,752	
		N/A	N/A	
	2 IP or 4 DC per 4 Hour List	1.75 IP or 3.5 DC per 4 Hour List	1.7 cases per list (EL and DC)	
Sensitivity Temporary Staffing Avoided (Retained Staff @ Home Trusts)	No Benefits Included	Minimum Potential	Stretch Opportunity	Deployment of staff in core services such as theatres and also ward based nursing to fill existing service vacancies releasing temporary staffing premiums
		-£384,702	-£769,405	
		N/A	N/A	
		10%	20%	
Sensitivity Procurement Supply Standardisation	No Benefits Included	Standard Contract Efficiency	Optimal Annual Efficiency	Based on procurement efficiency expectations across clinical supplies and drugs expenditure (based on full year activity Year Two)
		-£207,145	-£345,242	
		N/A	N/A	
		3%	5%	
Sensitivity Margin from New Activity	No Benefits Included	Low Level Margin	Moderate Margin	Based on an expected margin from income that could be delivered over and above contribution to overheads from new activity delivered from vacated capacity (as a
		-£297,039	-£495,065	
		N/A	N/A	
		3%	5%	

				proportion of lost inform from EOC activity) Margin unlikely from NHS commissioned activity however savings from private patient or independent sector routes would attract a higher contribution.
Sensitivity Impact to Revenue		**£1,372,056**	**£1,619,061**	
Sensitivity Impact to Capital		**-£583,113**	**£401,879**	

When considering the financial impact of these possible scenarios, these projections would have the potential to reduce the annual recurrent revenue benefits by £1.372m based on the current financial model. It should be noted that even taking into consideration the possible impact of the sensitivities modelled above, the EOC will still make a healthy contribution when we consider both scenarios presented.

The tables below illustrate the possible impact of these quantified risks and benefits on the financial projections.

Table 36 - Impact of Possible Scenario

	Discounted Cashflow (25 Year) £m	Capital Investment £m
Current Modelled Position	£35.5m	£9.4m
Adjusted Financial Position	£23.2m	£8.8m
(Improvement)/Deterioration of Financial Case	£12.3m	(£0.6m)

Table 37 - Impact of Highly Unlikely Scenario

	Discounted Cashflow (25 Year) £m	Capital Investment £m
Current Modelled Position	£35.5m	£9.4m
Adjusted Financial Position	£19.9m	£9.8m
(Improvement)/Deterioration of Financial Case	£15.6m	£0.4m

6.9 Affordability of the Scheme

The capital development costs are key when appraising the financial viability of this case. The Trust has been working with the NWL Sector to secure the required capital facility is made available through TIF funds. The development of the Elective Orthopaedic Hub is sighted as the number one priority for capital investment for the NWL Sector.

6.10 Financial and Commercial Arrangements between the NWL Providers

Regular briefings have been held with the NWL Chief Financial Officers (CFO) through the NWL CFO meetings on the financial and commercial implications of establishing the EOC on a site managed by London North West University Healthcare NHS Trust. A Hosting and Management Vehicle Workstream has being stood up adopting a lead provider hosting model that will lead into support the eventual mobilisation of the EOC.

Detailed trust addenda can be found in appendix 13.

Hosting arrangements and impact on lead trust and partner trusts

- Given that the preferred model is for the service to be sited at CMH, the costing model assumes that the service will be hosted and assumes that staff will be employed by the host organisation. However, the 'standard costing' approach, coupled with the national pay scales for NHS staff,

means that the 'hosting' costs would be largely undifferentiated if a different trust was the lead provider. Similarly, and provided that the model is based on a single-site delivery approach, the model is largely transferable between different trusts, bar the differentiation in costs for inner and outer London staff weightings and the consequences of fixed Private Finance Initiative costs. The sensitivity analysis addresses the impact of different staff deployment options.

- The EOC will be run as a stand-alone business unit (in financial terms) within the host trust, in line with the approach adopted elsewhere and to provide transparency to all stakeholders on the financial outcomes. In terms of clinical and managerial leadership arrangements, the host trust will have a degree of discretion around inclusion within an existing division, or the creation of a separate division, provided that appropriate and adequate clinical and managerial leadership is in place.
- The EOC business unit will have an 'income budget' of £29.388m and, when operating at full capacity, will be expected to deliver the activity within this budget (the model shows a small surplus, reflecting the improved efficiency benefit to the host trust of the host trust's activity being delivered more efficiently). Patient-level costing data shows that the activity is currently costing the four trusts £33.716m to deliver – and the move to a single EOC will reduce this cost by £3.968m. This provides the collaborative trusts with two challenges.
- The host trust must run at a high level of efficiency to deliver the activity at tariff and the partner trusts must either reduce their costs or redeploy these to activities which are not loss-making, leading to an overall improvement in the collaborative financial position by £3.968m.
- To some degree, given that the trusts are operating as an acute collaborative, it is not material where this operating surplus is located, but the current model assumes that this benefit will be distributed across the four trusts in accordance with their pre-existing levels of 'overspend' against the tariff funding levels, subject to any agreement on reinvestment or service redesign across the acute collaborative. Any resources provided by each trust to the EOC will be reimbursed at full direct cost – for example, clinical staff who work within the trust providing services – with quarterly reimbursement.
- To model the implementation of the EOC, 'income' movements across the four trusts have been modelled based on the Host hospital average tariff and local Market Forces Factor (this aligns with the costing model deployed). Approximately £17m of 'activity' moves from the three partner trusts to the host trust. The key challenge for the trusts as a collaborative is to ensure that the cost associated with this activity either moves across to the lead provider, is used in another way, or is reduced. Each of the finance teams within the collaborative are working on an approach to determine a mutually agreed way forward. The model does not take into account the potential benefits of utilising the additional capacity freed up at each of the partner trusts at this stage, recognising that there will be a combination of opportunity and risk.

- As described above, the four trusts have been working more closely together on a range of joint projects since the formation of the collaborative. To support this, the trusts have signed up to a set of principles – 'the multi-system financial framework' – and these have been adopted. In particular, in year one of the business case this assumes that marginal rate accounting will be reflected for the incoming activity to the lead provider (providing the referring organisation's financial stability over the transition year to cover overheads). As the case has progressed, the trusts have refined this approach and a specific financial framework for the development of the EOC has been developed and agreed. This should not impact on the operation of the EOC but provides for a clear framework for each of the trusts to plan their finances in a time of resource constraint and financial challenge.

Activities following FBC approval:

Following approval of the Full Business Case, the following activities will need to be undertaken to ensure that the necessary contractual rigor is in situ that underpins the modelled case as detailed above:

- Ensure that individuals wishing to Transfer from Home Trusts to the EOC are facilitated to do so and the needed governance is in situ supported collaboratively by the Finance and Workforce workstreams.
- Collaborated plan for the recurrent implications of the EOC with commissioning partners across NWL Trusts and the ICB as the main commissioner (23/24 planning implications are being discussed pending full business case approval).
- Develop the basis of the formal agreements to be put in place between the providers, including whether to adopt the NHS sub-contract, SLA or other form of agreement. This will be needed to facilitate salary recharge agreements for the staff groups as identified in the case.

- Novation, consolidation and termination of necessary procurement contracts primary supporting the provision of clinical consumables are actioned.
- Facilitation through the Lead Provider agreement that efficiencies are released not only through the outputs of Service Line Report directly from the EOC but also ensuring that efficiencies have been realised as intended from Home Trust organisations.
- Revisit the treatment of NWL ICS ASA 3 and Revisions (currently out of scope).

7 Management case

Chapter Summary
Chapter 7 sets out the management case for how the model of care will be delivered, including details of governance approach (comprising a partnership level and an organisation level) and workstreams.

Key Messages

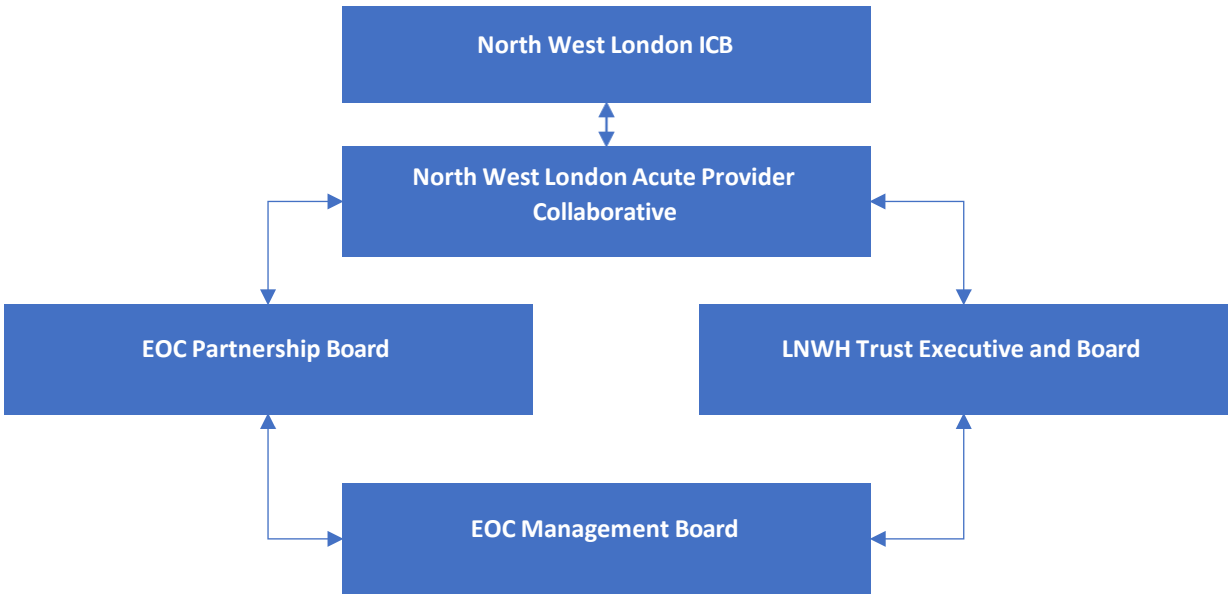
- The implementation model has been developed based on best practice evidence and draws on learning and feedback from the public consultation and external, independent assurance and advice.
- London North West University Healthcare NHS Trust will act as host for the new EOC, managing the new EOC and providing all logistical support for the EOC to operate as a free-standing business division with its own service line reporting.
- A detailed timeline, implementation plan and project plan has been developed for opening in November 2023.
- Continued engagement and involvement with patients, staff and carers is central to the implementation of the new model of care and the development of the NWL EOC.
- An initial model for sharing theatres between home trusts has been proposed with a timeline to approval, to then facilitate the job planning timeline.
- Achieving GIRFT accreditation has been incorporated into the first year of opening.
- The transport solution will be driven and implemented with support of a working group.
- Job planning for consultants will be completed by 31 August 2023.
- An extended BRP to monitor achievement of EOC benefits has been developed with revised and expanded KPI themes and metrics, designated owners and validated trajectories.

7.1 Governance model

The governance approach for the EOC will comprise two elements:

1. Partnership level – Partnership Board
2. Operational level – the EOC will be hosted and run by London North West Healthcare NHS Trust (LNWH) as Lead Provider as a ring-fenced entity aligned and within the Trust's governance structures.

Figure 14 - Governance approach to NWL EOC



The EOC partnership model is entirely consistent with the LNWH Trust vision to place "quality at our heart", by providing high-quality care, underpinned by high-quality support services and partnerships, with its four strategic priorities:

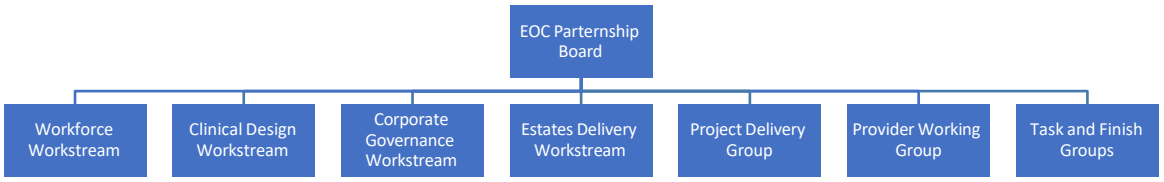
- Provide high-quality, timely and equitable care in a sustainable way.

- Be a high-quality employer where all our people feel they belong and are empowered to provide excellent services and grow their careers.
- Base our care on high-quality, responsive, and seamless non-clinical and administrative services.
- Build high-quality, trusted ways of working with our local people and partners so that together we can improve the health of our communities.

The governance model proposed in this FBC is designed to be agile as it transitions from approval through mobilisation to implementation. It is supported by four workstreams and three delivery groups (see figure 13) that can respond flexibility and make data-driven decisions that encourage system collaboration and robust risk management. While this management case provides detailed implementation plan, these are not set in stone and will be continually iterated through implementation workshops as we move towards our go-live in November 2023. This governance model with then be continually developed through the Partnership Board and post-implementation evaluation reviews.

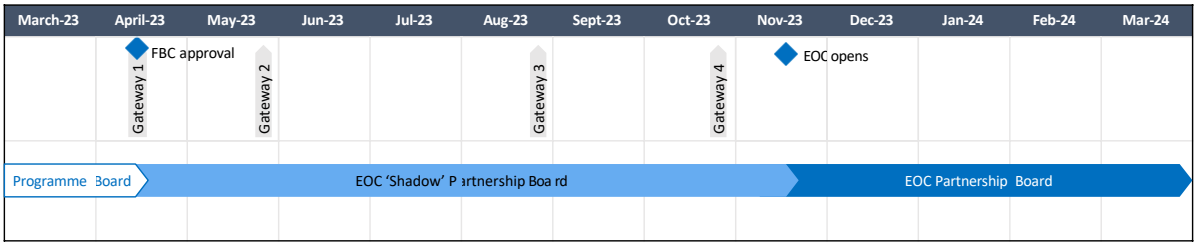
The EOC Partnership Board

Figure 15 - The EOC Partnership Board Governance Framework



The Partnership Board is supported by four workstreams and three delivery group to allow an agile transition from decision-making' & FBC approval, through 'mobilisation', to 'implementation' and opening of the EOC. The Partnership Board will run in 'shadow' form until the EOC goes live and will then formally operate as the Partnership Board (see figure 16).

Figure 16 - Transition process for the EOC governance

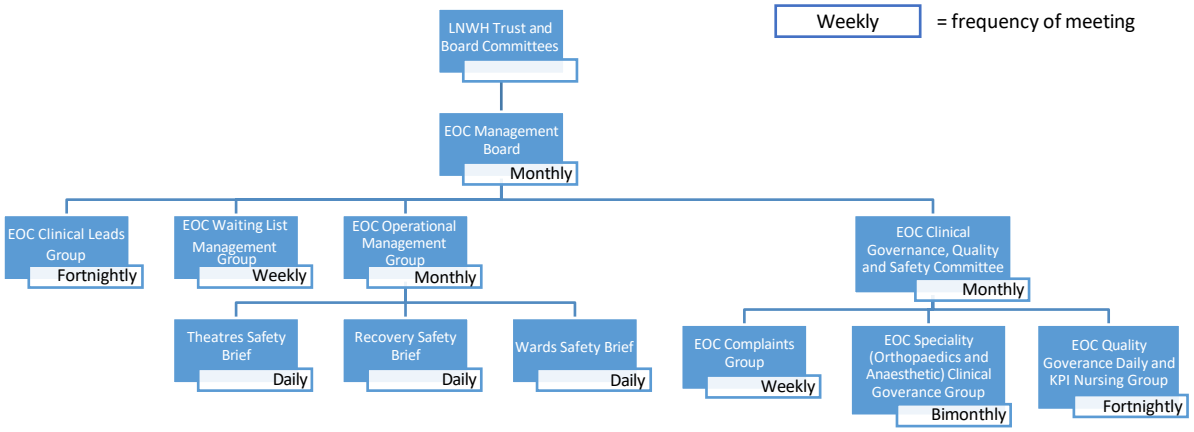


The Partnership Board will meet monthly, will be chaired by the lead provider Senior Responsible Officer (SRO) - the EOC Medical Director. It will include senior clinical representation from each of the four acute providers as well as the delivery workstream leads and will also include lay representation. It has responsibility for performance, clinical leadership, governance and risk, and finance and workforce matters. Terms of Reference for the Partnership Board will be approved by the first NWL EOC programme board that follows FBC approval - and it is expected that the transition to shadow partnership will occur in April/May 2023.

The EOC Management Board

Operationally, the EOC will be run by LNWH as a stand-alone business unit with its distinct budget, cost centre and service line reporting. In a similar fashion to other LNWH clinical divisions, for governance purposes the EOC Management Board will report to the Trust Executive Group and upwards to the Trust Board. The EOC Senior Leadership Team will be members of the Trust Executive Group, and the existing LNWH divisional governance framework will be mirrored by the EOC, and aligned with the surgical division where appropriate, as set out in Figure 15.

Figure 17 - The EOC Management Board Governance Framework



The EOC Management Board will review information reported by operational groups within the centre, the governance team and corporate partners including estates, finance and human resources. This forum will provide the platform for the discussion and communication of key EOC and trust operational, business, performance, quality, safety and governance issues. This meeting will be attended by the EOC leadership triumvirate, clinical leads, the EOC estates, finance and HR business partners, general manager, heads of nursing and therapies and the clinical governance lead.

The EOC Clinical Governance, Quality and Safety Committee maintains oversight of the governance, quality, safety and patient experience activities of the EOC. It will review reports on a variety of incidents, providing the opportunity to share the recommendations and learning derived from incidents. The Committee will review and maintain the EOC risk register, review and ratify SOPs, policies and guidelines, review and monitor key performance and quality indicators and provide a platform for discussing performance and celebrating innovation and success. The attendance will consist of the EOC leadership triumvirate, representation from the medical, nursing, therapies, management and the governance team.

In parallel with the LNWH governance, accountability to the NWL APC for strategy and business delivery will be through the EOC Partnership Board. The specifics of these reporting lines will be set out in the partnership agreement, to be drafted in the period April to May 2023. This will be designed in light of the APC's principles:

- Reduction in unwarranted variation in outcomes and access to services.
- Reduction in health inequalities
- Greater resilience across systems. including mutual aid. better management of system-wide capacity and alleviation of immediate workforce pressures.
- Better recruitment, retention, development of staff and leadership talent, enabling providers to collectively support national and local people plans.
- Consolidation of low-volume or specialised services.
- Efficiencies and economies of scale.

7.2 Implementation approach

The implementation model has been developed based on best practice evidence and draws on learning and feedback from the public consultation and external, independent assurance and advice. Our approach has been designed to mitigate the challenges and risks we have heard during consultation and that we have identified during our own implementation planning. Initial planning has informed the high-level approach and details the system-wide key enablers.

Following a formal decision to implement the proposed model of care, the programme will enter a mobilisation phase. A gateway approach will be taken towards mobilisation, with the programme required to pass criteria successfully at each gateway before proceeding to the next.

Table 38 - Gateway approach to implementation

Key **Function type**

- Partnership function
- LNWH function
- LNWH function with partner agreement

Gateway 1	Gateway 2	Gateway 3	Gateway 4	Post launch review
18th April 2023	30th May 2023	31st August 2023	31st October 2023	24th February 2024
Corporate				
FBC approval Stand up shadow partnership following FBC approval	Mobilisation phase Partnership agreement drafted and feedback sought from all partners		Partnership agreement signed off by all partners	100 day review Benefits realisation monitoring and reporting Future planning
Clinical design				
	Theatre allocation agreed	Clinical strategy agreed	GIRFT accreditation application complete	Decision point for six day working
Workforce				
	Substantial appointment to key EOC posts – Medical Director, Chief Nurse, mobilisation manager	Host and partner consultant job planning complete Recruitment trajectory at 40%	Consultant job plans implemented Recruitment at minimum 70% OD and mandatory training underway	
Estates				
Tender complete Contracts ready to be awarded	Enabling works completed Construction commenced		Construction complete 90%	
Comms and engagement				
Initial employee communication with consistent lines Recruitment campaign Detailed communications plan developed with proactive updates on next stages	Ongoing co-design & involvement to shape implementation plans Develop joint branding and patient communications	Ongoing proactive communications to support workstreams Stakeholder engagement and involvement	Formal launch and opening Ongoing patient messaging through social media and digital channels	Review of patient information process

This gateway implementation approach will undergo internal and external review to provide assurance and continually develop from best practice and subject matter experts. The main focus of this peer review will take place during Gateway 3 and 4 to ensure adequacy of plans and identify areas for further development where required.

Internal assurance will be provided by the LNWH Transformation Team and Patient Experience Team to TEG.

Examples of the external assurers that will be used are:

- delivery assurance from NWL Acute Provider Collaborative Board in Common.
- nominated social care lead from local authorities to review plans around discharge planning.
- external clinical assurance and challenge from the medical director of an established GIRFT accredited elective orthopaedic centre.
- early engagement with the GIRFT Accreditation Team.

A Gateway Review Panel will be established, and its membership agreed in April 2023 at an implementation workshop. However, membership is anticipated to draw from the EOC 'shadow' partnership board, senior leadership in all four trusts, internal and external reviewers (see above) and lay partner.

The Gateway Review Panel will meet at each proposed gateway to assess if:

- Workstream milestones – Have the key gateway criteria for each workstream been achieved?
- Quality – Has the project met required standards and best practice so far?
- Risks – Have any significant risks been identified and mitigated that could impact the success of the EOC?
- Budget – Has the EOC stayed within the approved budget?
- Schedule – Has the EOC met the overall agreed schedule at this stage?
- Stakeholder satisfaction – Have the internal and external assurance from peers expressed satisfaction with the progress so far?

Once progress has been assessed against these criteria, the gateway review panel will make a recommendation to the EOC 'Shadow' Programme Board as to whether it has passed the gateway or not. If project has passed, it can then move on to the next stage of implementation. If it has not passed, the review panel may recommend corrective action that needs to be taken before the plan can proceed to the next stage.

A more detailed timeline and key milestones by workstream is described in section 7.3.

Change Management

Our approach to change management as the EOC is mobilised and implemented is described below.

Table 39 - Change management process

Change	Process approval process
Design proposal/changes potentially impacting the: **1. clinical model** **2. workforce model** **3. digital enablement** **4. financial model**	• Workstream lead to review and assess request and determine impact with the project manager. Engage financial workstream lead to assessment cost impact. • Engage wider stakeholders where broader interdependencies, risks or opportunities are identified with a focus on end-to-end pathway care. • Workstream lead and senior responsible officer to make request or recommendation to NWL EOC Development Programme Board, or its successor Shadow Partnership Board, for decision making. • Clinical proposals can be referred and further tested with NWL Orthopaedic Clinical Reference Group (CRG) and/or NWL Musculoskeletal

	Network and/or NWL Clinical Advisory Group before or after presentation to the NWL EOC Development Programme Board, or its successor Shadow Partnership Board.
Day-to-day decisions and changes	• Mobilisation manager to assess impact and risk to the programme, engaging stakeholders and leads as required. Escalate to Managing Director (the host provider SRO) if time critical or risk is assessed as major or above. • Assess cost impact and act according to delegated financial thresholds.
Significant decisions – such directing major exceptions to the plan, halting or pausing significant elements	• Managing Director to assess impact of material changes and present to Shadow Partnership Board to confirm approach, including escalation route depending on nature of matter. • Comply with NWL EOC Shadow Partnership Board directions. • Present to NWL APC Board in Common or delegated cabinet for approval. • Present to NWL ICB for approval where appropriate or advised. Ensure appropriate action is taken with local authority stakeholders and NHS England.

7.3 Timelines and key milestones by workstream

Table 40 - EOC Milestones by workstream

Key **Function type**

- Partnership function
- LNWH function
- LNWH function with partner agreement

Milestone	Date / Deadline	Function
EOC mobilisation and implementation		
Gateway 1	18th April 2023	●
Gateway 2	31st May 2023	●
Gateway 3	31st August 2023	●
Gateway 4	31st October 2023	●
Post-launch review (100 day review and plan for 6-day working)	24th February 2024	●
Workforce		
Develop OD plan	April 2023	●
Recruitment to key posts including EOC Med director, EOC DDN and EOC mobilisation manager	30th May 2023	●
"Active recruitment" trajectory at 40%	31st August 2023	●
Minimum staffing checkpoint for all staffing groups	31st August 2023	●
"Active recruitment" trajectory at 70%	31st October 2023	●
Clinical Design		
Theatre allocation agreement	31st May 2023	●
Host and partner consultant job planning completed	31st August 2023	●
Orthopaedic and anaesthetic consultant job plans implemented	31st October 2023	●
GIRFT accreditation application complete	31st October 2023	●
Education and training strategy published	1st May – 30th June 2023	●
Training time allocated and agreed	1st – 31st May 2023	●

Contracts with Health Education England in advance of implementation developed	1st August – 30th September 2023	●
Application for contract with Health Education England and GMC site recognition	30th September 2023	●
Produce and test standard operating procedures	1st April – 30th September 2023	●
Develop research strategy for sign off by shadow Partnership Board	1st August – 30th September 2023	●
EOC as a distinct unit on Model Hospital	31st October 2023	●
Develop clinical governance framework and test in shadow form	1st September – 30th November 2023	●
Finance		
Develop a minimum data set for EOC financial report	1st May – 30th June 2023	●
Agree templates and terms for cross charging between the four partner trusts	1st August – 30th September 2023	●
Stand up cross-organisational charging arrangements between the four partner trusts	1st – 31st October 2023	●
Set up service line reporting methodology and system	1st – 31st October 2023	●
Develop recurring financial governance arrangements reporting into EOC Partnership Board	1st September – 31st October 2023	●
Support the workforce workstream with regards to recruitment of staff	1st April – 31st October 2023	●
Comms and Engagement		
Proactive internal staff communications & engagement activities to support transfer of staff	1st April – 31st October 2023	●
Development of detailed communications plan across channels and messaging	1st April – 18th April 2023	●
Develop and launch joint recruitment marketing campaign	18th April – 31st October 2023	●
Further co-design and involvement work with lay partners/interested contacts, community partners and others to shape implementation plans (especially transport)	18th April – 31st October 2023	●
Regular updates on implementation to key stakeholders (JHOSC, Local Authorities, Mayor of London etc)	18th April – 31st October 2023	●
Develop and agree joint approaches on patient information and communications including Letters, PALS, Branding, Service directories and websites	18th April – 31st October 2023	●
Proactive communications with Primary Care, GPs & partners		●
Media – proactive general updates	18th April – 24 February 2024	●
Comms plan to support formal launch & official opening event	1 – 31st October 2023	●
Monitoring of patient information process	31st October 2023 – 24 February 2024	●
Digital		
Finalise ICS pre-operative assessment process	March – 31st August	●
Ensure provision of clinical information to enable safe care	March – 30th September	●
Finalise admin flows including waiting list management	April – 30th June	●
Ensure digital inclusion in all processes	April – 31st October	●
Provide staff system access	1st May – 30th September	●
Roll out IT equipment	1st July – 30th September	●
Data protection checkpoints	1st – 30th September	●
Provide staff training	1st October – 15th November	●
Business continuity planning	1st October – 30th November	●

7.4 Project Plan for Construction

A construction project plan has been developed by the estates workstream for the EOC which shows a planned opening date of November 2023 with the key milestones included in Table 39.

Table 41 - NWL EOC Construction Project Plan

Milestone	Date
FBC approval	18th April 2023
Contracts Awards	20th April 2023
Planning consent	n/a
Main construction period	26th May 2023 to 16th November 2023
Construction completed/handover	November 2023
Building operational	November 2023
Opening date	November 2023
Post Evaluation Review (PER) at six months	May 2024
Post Evaluation Review (PER) at two years	November 2025

7.5 Transition planning and mobilisation structure

The design principles for transition and implementation have been approved by the programme board and LNWH Trust executive group are shown in Table 40.

Table 42 - Design principles for transition and implementation

Structures	• Designed to allow transition from 'decision-making' through 'mobilisation' to 'implementation'. • Proposed structure to be sufficiently agile to accommodate change and EOC transition to implementation. • Partnership board (& shadow board) oversees the EOC as a standalone business unit to provide transparency to all stakeholders.
Processes	• Draws on existing 'host provider', PFI processes, and NWL processes where appropriate. • Mobilisation workstreams may adjust to manage transition, reduce risk of silo working and shape towards EOC launch and benefits realisation.
Resources	• Mobilisation resource must be affordable within the EOC financial envelope. • Where appropriate, roles within EOC may be combined with existing posts – to help embed the EOC within the host provider, provide service resilience and to optimise efficiency.

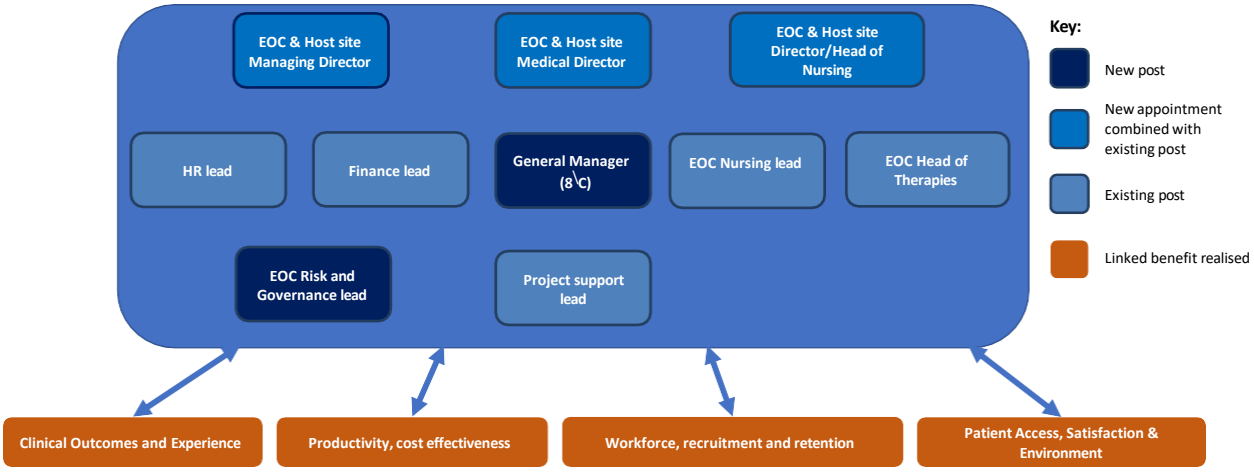
To deliver against the design principles, LNWH has established a fortnightly 'Host Management' workstream that is charged with delivering the transition and implementation plan.

The EOC programme board transitions into a shadow partnership board following FBC approval (Gateway 1) in April 2023 and following the final EOC programme board (April/May 2023), which will approve the TORs for the shadow partnership board.

Proposed mobilisation structure

An EOC mobilisation leadership structure has been developed and approved via the EOC Programme Board and LNWH Trust Executive Board. This structure draws on the above principles and links directly to the four areas of benefits realisation: clinical outcomes, patient access, workforce recruitment & retention and productivity:

Figure 18 - Leadership structure during the mobilisation stage



To provide assurance and drive implementation and delivery, LNWH is proceeding at risk to ensure this structure is in place before the end of April 2023. The managing director, HR lead, finance lead and project support lead are individuals already in post and working within the EOC programme.

The Medical Director and General Manager roles are out to advert, and the recruitment process will continue at risk before the FBC is submitted. Continuity and service resilience is provided by the structure bringing together a mixture of combined, existing and new posts. Agility is a key design principle and as the implementation progresses, this structure will be regularly reviewed at each Shadow Partnership Board to ensure it is sufficiently resourced to deliver against the deliverables and implementation timeline.

7.6 Communications and engagement plan

Continued engagement and involvement with patients, staff and carers is central to implementing the new model of care to better inform development of the EOC and better allow continued improvement.

We have built up a significant volume of insight over the past 18 months about what patients and local communities in NWL want and need from inpatient orthopaedic care and wider MSK services. This has been established through the public and patient involvement activities that informed the development of the initial proposal for an EOC and even more so through the formal public consultation on the proposal and the IIA. We are committed to continuing to build and respond to this insight, to inform both the continued development and implementation of the EOC and supporting inpatient services and the related plans to improve community based MSK services.

It begins with ensuring we communicate proactively and openly with all of our audiences to raise awareness and understanding of what our services offer and what they involve, now and as they change. This will be an integrated approach across the APC hospitals and with community services. Patient information, including patient letters, will have a consistent approach in terms of content, terms, tone and branding, helping patients to experience our care as a joined-up pathway even as they move between their home orthopaedic hospital and the EOC. We will also ensure that information about travel support options, follow-up care and help with queries or concerns as well as feedback prompts are widely publicised and consistent. This will be made accessible to non-English speaking patients through CMH's language services (see section 7.16).

We then see the diverse contacts and relationships we have made through the engagement and consultation work to date as being central to continued engagement and involvement on inpatient orthopaedic services and wider MSK care. We propose doing that in the following ways:

- Inviting the 200 plus people who took part in the consultation and who gave us permission to keep them informed – as well as the community organisations who supported us with particularly in reaching individuals not generally engaged with our services – to take part in involvement activities through a regular email update about the project (and wider MSK service improvements).

- Continuing to include lay partner roles in the governance structure for implementation (including oversight of ongoing involvement plans, Gateway Review panel and patient and community feedback and experience indicators).
- Developing an iterative plan, employing a variety of methods, for expanding our understanding of patient and community needs and views to inform the further development and implementation of the EOC and related care pathways. The iterative plan (plus the insights and responses to those insights) to be overseen as part of the main project governance for implementation and for onward, continuous improvement:
    - ad hoc co-design workshops for specific elements of implementation, for example, transport options
    - patient panels – for feedback via email, for example, on patient information
    - surveys
    - focus groups
    - continuing to triangulate existing sources of patient feedback and insight.

Through developing this implementation plan, we have involved patients including:

- Decision-making – the public consultation allowed us to identify 200 plus individuals to take part in involvement activities as the EOC moves through implementation gateways
- Patient engagement – we plan to involve patients and other stakeholders from diverse backgrounds in our working groups and implementation processes to ensure their perspectives and needs are taken into account.
- Co-production - we will be using co-production methodologies during our implementation workshops and working groups (e.g. transport) to ensure that patients and other stakeholders are actively involved in the design and implementation of our initiatives
- Patient representation – we will be inviting lay partners to sit on the EOC partnership board to ensure that we have a diversity of voices at the highest level of our governance to provide insights and perspectives on the health and care needs of the NWL population
- Patient advocacy – patients will continue to be advocated for through ongoing communication and engagement with the NWL Joint Health Overview & Scrutiny Committee (JHOSC)

This communications and engagement plan will be co-developed further by the corporate workstream at an LNWH implementation workshop in April 2023.

7.7 Clinical implementation

7.7.1 Theatre model and schedule for delivery of care

The chosen option is that the clinical model will be delivered at the Central Middlesex Hospital site which will be expanded to five ‘state of the art’ laminar flow operating theatres with ring-fenced bed capacity. Currently LNWH operates three theatres at CMH to deliver elective orthopaedic surgery including some day surgery cases. This includes patients assessed as ASA 3.

This theatre model should ensure that clinicians from each trust can ensure continuity of care through consistent access to theatres while allowing their teams to manage their respective patient waiting lists to ensure inequalities are not worsened.

The chosen option has been developed to maximise the benefits of the EOC without destabilising LNWH. LNWH will use one theatre at the CMH to provide ASA 3 and day case surgery. Each of the acute providers will assume the running of one of the other four theatres each day to deliver planned ASA 1 and 2 patient activity in the EOC. This will allocate two operating theatres to LNWH each day and one each to Chelsea and Westminster Hospital NHS Foundation Trust, Imperial College Healthcare NHS Trust and Hillingdon Hospital NHS Foundation Trust.

Perioperative care of patients will be the responsibility of the EOC team including nursing staff, junior doctors and therapists. On call and out of hours consultant surgical and medical cover will be provided by the LNWUH rotas supported by SOPs for escalation where necessary.

This allows efficiencies of scale; bringing teams from across NWL on site together as a step to closer working, improved quality and safety outcomes; allowing for the development of regular processes, routines and teams working together.

An SOP for the theatre model and schedule of use will be developed at an Implementation workshop in April by the clinical design workstream with an approach to monitoring and distribution of theatre sessions.

7.7.2 Managing the unwell patient

As a well-established stand-alone elective site, the mechanisms to manage unexpected deterioration are well tested and embedded on the CMH site. Based on this existing approach, a protocol-driven model of peri-operative care will be delivered, with standardised anaesthetic and post-operative analgesia regimes. Post-operative patients will remain the responsibility of orthopaedics with anaesthetics providing advice on pain management and help with the deteriorating patient.

The existing Enhanced Care Unit (ECU) on CMH is led by anaesthetics for patients needing higher levels of care, under an existing standard operating policy (SOP). It is not anticipated that the ECU will be required for EOC patients because of the patient selection criterion (ASA 1 and 2), however all these safety features will be available to all patients having operative procedures at the new centre.

Within the EOC, a Post Anaesthetic Care Unit (PACU) has been developed for patients who require additional monitoring, for example patients with home continuous positive airway pressure (CPAP) machines. The SOPs will be closely based on the pre-existing Abbey Ward PACU SOPs.

7.7.3 GIRFT accreditation

To understand the impact of surgical hubs, Royal College of Surgeons (RCS) England with GIRFT has launched a pilot Elective Hub Accreditation Scheme[17] during the second half of 22/23 with seven pilot hubs. The scheme allows trusts to seek formal assessment of their hub sites and external recognition that they work to a defined set of clinical and operational standards. This accreditation scheme goes beyond the surgical hub definition used by the Department of Health and Social Care.

There are 5 domains containing a total 99 criteria of which 41 are deemed essential for all accredited hubs. The application process requires an application, site visit and review by panel. The process is designed to be simple with a minimal assessment burden to accreditation.

Table 43 - EOC design in alignment with GIRFT surgical hub accreditation

GIRFT Elective Hub Domains	NWL EOC DMBC design
1. The Patient Pathway	Both the EOC clinical model and the wider MSK pathway (Section 4.7) have been created with input from GIRFT standards
2. Clinical Governance	Chapter 7 documents our approach to EOC governance
3. Utilisation & Productivity	Section 7.10 sets out our benefits realisation plan with metrics to meet these
4. Facilities & Ring-Fencing	Section 4.8 sets out how and why the preferred option site was selected to protect EOC activity
5. Staff & Training	Section 7.9 documents our workforce model for the EOC and training plans

The NWL EOC model has been designed with the ambition to achieve accreditation by meeting the 41 essential criteria that demonstrate a commitment to quality clinical care and training (see table 41). We intend to submit an application to GIRFT as an integrated hub in advance of the EOC opening in November 2023. Assessments and site visits would be expected to take place in early 2024, with successful accreditation expected towards the end of 2024.

[17] Elective Surgical Hub Accreditation Scheme, GIRFT – November 23rd, 2023

7.8 Transport implementation

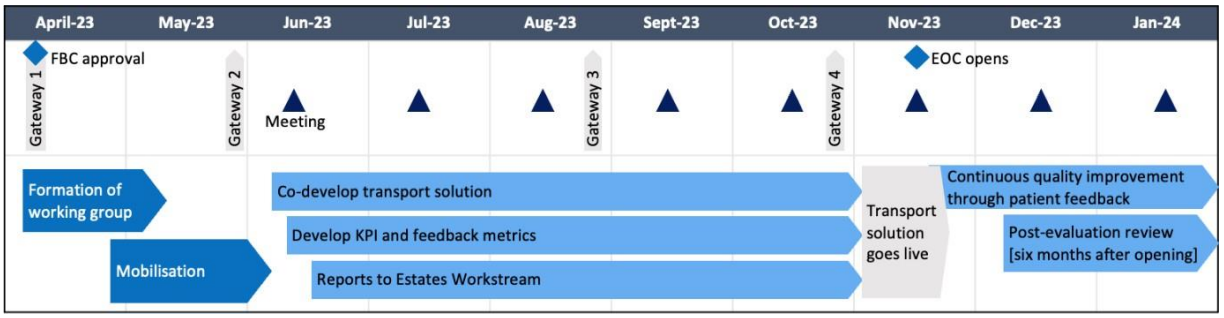
The transport solution, described in section 4.9, has been designed to provide information and facilitation to all patients attending the EOC for their operations, with transport being made available at no charge for any patients facing a long, complex, or costly journey to the EOC. This section outlines our agreed approach to implementation of that solution and will be fully developed through the implementation phase in readiness for go live.

We have already identified the patients and stakeholders that are likely to be affected by this transport solution and have consequently incorporated them into our co-design approach. Following the approval of the FBC, a transport working group will be established in April/May 2023. The purpose of this group is to develop the transport solution that has been endorsed in the DMBC to ensure that it works for the NWL community. During the mobilisation period its membership and terms of reference will be established. Within the working group we propose two components: an advisory group and a task and finish sub-group.

The advisory group would include members proposed at the NWL ICB Board Meeting in March 2023. The task and finish group would meet more frequently with membership drawn from patients and carers, staff and other key stakeholders to support the aims of the advisory group.

The transport working group will meet regularly to evaluate progress towards the collective goal of a transport solution that is ready and tested for the EOC opening in November 2023. This group will report into Estates Delivery workstream.

Figure 19 - NWL EOC transport working group



We will undertake pilot testing of the transport solution to ensure that it meets the requirements of patients, providers and other stakeholders while operating as intended. This will include collecting qualitative feedback from patients on their experience, reviewing patient attendance data, and uptake of the proposed solution. These metrics are new and will be developed by the transport working group (see appendix 11).

The EOC team including the care navigator roles will be aware of the travel support available to patients and the associated resources so that they feel confident about how to support patients to navigate their pathways.

The development of travel information, facilitation and travel solution will be monitored through implementation and feature in the gateway assurance framework. The transport solution will be improved continuously through quality improvement initiatives based on feedback from stakeholders, emerging technology solutions, and as the EOC is fully embedded in NWL's health and care system.

7.9 Workforce implementation

7.9.1 Workforce vision

NWL ICS has set out a People Plan with a commitment to a workforce vision, values and behaviours they will uphold and the actions they will take. The vision is set out below.

Our people are able to provide great care for our patients and communities because they have the skills, tools and capacity to do their jobs and the environment they work in is inclusive and supportive. Staff are motivated and engaged and have opportunities to grow, develop and innovate.

The vision has five collective goals: to Care, Lead, Include, Grow and Transform.

To support the achievement of the People Plan goals, the APC has set out its People Priorities for:

- Safe and sustainable staffing to reduce vacancies, turnover and premium rate temporary staff.
- Workforce redesign to support new models of care and new ways of working.
- Maximising the use of new roles.
- Developing the collaborative as a great place to work and London's acute employer of choice.
- Improving HR service effectiveness, efficiency and impact.
- Building more equitable and fair organisations (across the NWL ICS)
- Improving the health and wellbeing of our staff (across the NWL ICS).

The workforce model for the EOC forms part of the APC's initial priorities, under priority two, workforce redesign. This will align with the Transform pillar of the NWL People Plan and equip the workforce with the skills and structures to deliver new clinical models of care; operate in agile ways using technology; and transform operating models for support services.

The developing workforce plan for the NWL EOC aims to:

- make a significant difference to our ability to recruit and retain staff by making the NWL EOC and base hospitals desirable and innovative places to work for relevant staff, including training and non-training medical staff (including GPs), AHPs and nursing staff.
- enable productive working by enhancing digital capability and developing consistent pathways.
- utilise processes that are in existence (portability agreement) and being developed across NWL to build flexibility and mobility. This would allow staff to work in different organisations and locations, particularly orthopaedic surgeons, anaesthetists and other relevant clinical staff who would follow the patient between base hospitals and the proposed elective centre.
- develop consistent ways of working together with NWL-wide clinical protocols driven by the orthopaedic network.
- decrease the unsustainable strain on clinicians by increasing the level of cover to recognised standards.
- improve training opportunities for junior clinicians through greater access to specialists.
- reduce sickness and absence rates with a decreased workload reducing stress and tiredness.
- develop new roles where appropriate, which are likely to include advanced clinical practitioners and care navigators.
- reduce the use of bank and agency staff through more effective cover of the rotas through existing staff.
- deliver on the vision of 21st century care set out in the NHS Long Term Plan by reviewing skill mix, creating new types of roles and utilising different ways of working.
- develop training models in partnership with Health Education England (HEE) that ensure undergraduates have access to the highest quality education and training.
- ensure there are no unintended consequences for interdependent staff groups and services such as trauma, paediatrics and spinal.
- develop NWL support networks including system-wide multidisciplinary team.
- working structures and defined escalation pathways to access clinical expertise for complex patients.
- develop a NWL-wide recruitment strategy for orthopaedics.

7.9.2 Workforce capacity and capability

The workforce model has been developed collaboratively with the multidisciplinary service leads, built up on activity modelling and outcome requirements that deliver GIRFT standards for all patients, following GIRFT Best Practice Pathway and NICE guidance. The workforce model will be reviewed throughout the development and implementation of the workforce plan to ensure that it remains the optimal model to deliver the desired outcomes.

The roles and WTE numbers of staff for the proposed workforce model have been designed and quantified.

Table 44 - Staffing requirements for November 2023 opening

15 Administrative and Clerical	**21 Allied Health Professionals**	**20 Consultants**	**4 Management**
22 Medical (Non-Consultant)	**194 Nursing**	**2 Pharmacists**	**279 Total**

Table 45 - Predicted staffing position for November 2023, based on being able to recruit to pre-existing vacancy levels across the staff groups (accounting for existing fill rates)

11 Administrative and Clerical	**18 Allied Health Professionals**	**20 Consultants**	**3 Management**
22 Medical (Non-Consultant)	**152 Nursing**	**2 Pharmacists**	**228 Total**

We have estimated the EOC staffing position for November 2023 using the current vacancy rates across all staff groups. Based on this estimate there will be a temporary staffing requirement of 51 WTEs to meet the staffing requirements for November 2023 opening of 279 WTEs. There is an average fill rate across medical and nursing in T&O of 90% across NWL. Therefore, specific focus will need to be given to developing the temporary staffing pool to support the substantive workforce. Recruitment exercises will continue to be run to build a sufficient pipeline to move towards the 336 WTE requirement for 1st April 2024.

The proposed staffing model for the EOC will consist of a single team at the NWL EOC preferred site, doctors rotating to support the transferring patient activity and there will be consideration of rotational posts for specialist or hard to recruit roles.

Although it had been anticipated in the PCBC that there would be transfer of staff with the transferring activity, having analysed the workforce data returns, we have been unable to identify an organised grouping of staff whose principal purpose is delivering the transferring activity, so at this point we do not anticipate a requirement for staff to transfer employers. Instead, staff (not including doctors) currently delivering the activity within one of the 'home' trusts, will remain in their post and will be given the opportunity to apply for a role at the EOC (the process for this is being developed).

As there will be orthopaedic surgery remaining with home trusts undertaken by their staff and plans being developed to utilise existing capacity, it is not expected that any redundancies will be required. We will continue to engage with staff throughout the implementation phases and should an organised grouping of staff be identified whose principal purpose is delivering the transferring activity, then those staff identified will transfer with the activity to the EOC host under the protections of a 'TUPE transfer'. Should there be any proposed changes for staff, there will be formal consultation with those staff directly affected. This would most likely be from May 2023, following any approval of the FBC.

There is, therefore, an expectation that there will be a greater reliance on direct recruitment to staff the EOC.

The staffing risks grow for the EOC host with an increased requirement for direct recruitment and they decrease for 'home' trusts who will be able to strengthen their staffing position.

Impact on residual services

Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)

Local ASA 3 and 4 and day cases activity will continue to be delivered at CWFT. There is a small risk that should consultants not want to move with the transferring activity they could choose to take up posts elsewhere, which would have an impact on residual services. There will need to be a review of the impact on medical rotas to ensure that residual services are not negatively impacted.

Imperial College Healthcare NHS Trust (ICHT)

Local ASA 3 and 4 and day cases activity will continue to be delivered at ICHT, with the Charing Cross site being potentially designated as the major revision centre for the sector. There are not considered to be any risks around staffing to deliver this activity within T&O directorate, but strain could be placed on theatre nursing teams.

London North West University Healthcare NHS Trust (LNWHT)

Local day cases and ASA 3 will be delivered adjacent to the NWL EOC with ASA 4 activity delivered at Northwick Park Hospital. No risks have been identified around staffing to deliver this activity.

The Hillingdon Hospitals NHS Foundation Trust (THHT)

Local day cases will be delivered at MVH with ASA 4 activity undertaken at HH. Many of the staff currently delivering the transferring ASA 1 and 2 activity are doing so as a small proportion of their role. It is unlikely that they will transfer with the activity. Some of these staff will be specialists (therapy staff). There is the potential risk that if the repurposing of the released capacity is not within a specialism of interest to them, they may choose to take up new roles elsewhere that are more attractive to them. Should this risk materialise, resulting in an increase in turnover of AHPs (hard-to-fill), this would impact on the ability to run joint schools, manage ASA 3 and 4 activity and day cases remaining on-site and potentially impact wider developments to increase weekend occupational therapy and physiotherapy.

The retention of day case activity (the largest proportion of activity undertaken) could provide an opportunity to direct resources to address both growth and the PTL (that is, waiting list) backlog, offering services that are aligned to the special interest of any affected staff. Rotational posts will be explored as a potential solution, but there is a risk that the distance between THHT and CMH may mean that the posts are not as attractive.

Overall, it is expected that trusts (ICHT, CWFT and THHT) will strengthen their staffing position supporting residual services as:

- there are current vacancies across the staff groups which will be transferred to support ASA 1 and 2 activity (to be recruited into)
- where small proportions of roles are currently utilised to support delivery of ASA 1 and 2 activity, it is unlikely that these staff will transfer with the activity, thereby enabling trusts to strengthen their staffing position and supporting the repurposing of capacity.

As highlighted above for THHT, the likely strengthening of staffing positions for residual services could provide an opportunity to redirect resources to address growth and waiting list backlog at all of the provider trusts.

7.9.3 Recruitment and retention

It is expected that the majority of staff will be directly recruited to the EOC by LNWH. As it has not been possible to establish an organised grouping of staff, at home Trusts, whose principal responsibility is the transferring activity, staff will be able to apply for a role in the EOC.

Inclusive recruitment practices introduced/developed as part of the NHS People Plan in 2020 will be reviewed across the trusts, to evaluate their impact. All vacancies will be promoted in the local community or through community channels, to ensure the adverts reach a diverse pool of candidates. Selection panels will be diverse, and members will have had appropriate training. These are some of the interventions that evidenced contribution to organisational culture change in a report by NHS Employers

and commissioned by NHS England and NHS Improvement on Inclusive Recruitment – Leading Positive Change (April 2021).

We plan to work with an agency to support the design of a dedicated recruitment campaign for the EOC. This will include the identification of innovative ways of recruiting to key roles. Specific recruitment plans/specialist campaigns will be developed for the gaps identified in each staff group for the agreed workforce model. Delivery will be aligned with the People Priorities being developed for the acute provider.

We will hold a number of open days for nursing and AHP roles starting from April 2023, seeking to advertise the AHP open days in universities giving the opportunity to appoint to Band 4 student posts while they await their Health and Care Professions Council registration/exam results. We also have a strong reputation of attracting our third year student nurses after graduation to substantive posts.

We also run an apprenticeship programme for nurse associates with an established pipeline of graduates who start their career at LNWH. We are also incorporating a rehabilitation assistant role into the EOC wards to support early mobilisation and discharge. We also plan to explore the ongoing international nurse recruitment across the acute trusts to support the recruitment pipeline for the EOC.

There will be groups of staff retained by provider trusts, who will rotate to the EOC to undertake the transferring patient activity. This will apply to doctors and will be explored for hard-to-fill and specialist roles. Staff currently involved in delivering the transferring patient activity will be given the opportunity to express their interest in taking up roles in the EOC. This process will run concurrently with the external recruitment campaign.

Developing new ways of working across the system is crucial to developing a sustainable workforce model that builds local capacity, capability and competency to deliver care across end-to-end best practice MSK pathways.

The new model will provide opportunity to attract staff to NWL, together with challenges recruiting to a number of key disciplines.

The clinical model will enhance training opportunities, resulting in improved skills across the workforce and improved recruitment and retention. All trusts have been asked to review existing staffing gaps and ensure recruitment activity is paced up locally to support the transition to the new centre to strengthen and maintain sustainable staffing levels. The APC will also explore possibilities for joint recruitment campaigns for key staff groups. It is likely that recruitment will commence at pace to secure staffing for future gaps identified in the following staff groups:

a) post-anaesthesia care unit (PACU) nurse qualified
b) advanced nurse practitioner
c) qualified ward nurse
d) consultant anaesthetist
e) consultant orthopaedic surgeon
f) physiotherapist
g) radiographer
h) theatre nurse manager with orthopaedic experience

The biggest gaps in the existing workforce are for qualified nursing as well as administrative, while other roles are known to be ‘hard-to-fill’. Consequently, as well as exploring all conventional routes to recruitment we will, through the NWL Health Academy, utilise, develop and design training and skills programmes with the partnership skills providers to upskill existing staff and consider the use of alternate roles. There are a number of courses currently available ranging from diploma to Masters level across nursing; physician associates; MSK ultrasound; advanced clinical practice; physiotherapy; operating department practice; and a number of entry level apprenticeship courses.

Retention

Retention is one of the key priorities in the APC people priorities. Initiatives are being explored to retain staff within NWL, which will support the strengthening of staffing levels across the system.

Retention initiatives and reviews of workforce pressures will be considered across the pathway to ensure that specific actions (for example recruitment and retention plans, employee experience) are undertaken in a coordinated manner to avoid damaging recruitment and retention in different parts of the pathway.

The concerns raised through the public consultation around loss of staff as a result of travel/multi-site travel issues, will be largely mitigated by the fact that apart from doctors it is expected that the majority of staff will be directly recruited by the host, with others given the option to apply for roles.

Development of relevant apprenticeship posts, rotations, new roles for internal development (for example advanced care practitioners) will provide a greater opportunity for staff to develop and maintain skills across the pathway which will also support staff retention.

Options for flexible working will be made available for staff regardless of their role. The anticipated operating hours will provide an opportunity to offer staff more flexible working patterns and we will explore opportunities for colleagues from all professions who have recently retired to return to practice in the EOC.

Vacancies and retention are monitored by each of the People Committees within the Acute Collaborative and at the broader APC People Committee. The metrics within the Trusts and the APC Committee will be used to monitor the impact of the recruitment to the EOC and to identify at an early stage whether any interventions are required.

Temporary staffing
We plan to review and continuously monitor the temporary staffing pool across all staff groups to understand the capacity and likelihood of being able to supply the support required to the EOC. This will enable us to make any necessary interventions to build or develop the temporary staffing pools across all staff areas. We will be able to utilise the collaborative bank for nurses, which will enable a streamlined path to take up shifts in the EOC – further work will be undertaken to increase the number of nurses taking up shifts on the collaborative bank and we will be working on marketing material with communications teams across the four trusts.

Temporary staffing shifts for staff outside of medical and nursing are taken up through local banks, with use of agency. We will need to make sure the pipeline for these staff is sufficient within the host systems. There are good fill rates across administrative and AHPs, with the latter pipeline generated via agency.

7.9.4 Teaching, training, education and research at the core of the clinical quality

This innovative model of surgical hubs has been shown to offer significant opportunities and benefits for the teaching, training and education of key clinical staff, including doctors, nurses and therapists. Consolidating large volumes of routine elective surgery allows for excellent whole team routines, skills and relationships to be developed that enhance the training environment and make care consistently more efficient and safer. Attention to training, education and research will drive the culture, behaviours and expectations necessary for a high performing centre of excellence. This approach directly supports safe and high-quality care. We will emphasise staff development and career progression initiatives, including supporting staff who have not undertaken higher education. This will be achieved using our careers escalator and leveraging our competency framework that allows staff to receive a higher education qualification.

The EOC will be a protected facility dedicated entirely to elective care, with ring-fenced resources that allow them to stay active even when emergency pressures rise. These hubs are now seen as a key resource for more robust and sustainable elective services, backed by bodies such as NHS England and the Royal College of Surgeons of England.

Surgeons in training
Training is at the core of good care and the provision of an expert workforce for the future. Orthopaedic specialty surgical trainees will work and operate with and under the supervision of their normal clinical supervisors as part of the home trust surgical team, travelling to the EOC for theatre operating sessions.

The development of the NWL EOC was discussed and supported by the national Specialist Advisory Committee for Trauma and Orthopaedic Surgery, the body with delegated authority for training in trauma and orthopaedic surgery on behalf of the Joint Royal Colleges of Surgery and the Joint Committee for Surgical Training. The model and proposal is endorsed and felt to offer significant opportunities for improved training. Recent data shows that trainees and training in trauma and orthopaedic surgery have been disproportionately affected by the COVID-19 pandemic and reduced elective surgery volume. The specialty has the largest proportion of 'outcome 10' assessments at trainee annual competency assessments, where trainees have not been able to achieve the expected standards of operating because of the impact of the COVID-19 pandemic. The EOC will offer an important solution for this problem in NWL and will provide future trainees with high volume training in a supervised high volume performance environment.

This support is caveated with the requirement for the EOC to be designed and established in line with the GIRFT accreditation criteria which put training at the heart of the centre. The NWL ICB have made this commitment which will benefit clinical training for all specialties and will also support high-quality care.

Table 46 - GIRFT 'high volume low complexity' (HVLC) criteria for staff and training

Headline criteria	Core elements of headline criteria	What we will be looking for	Evidence	CQC KLOE
1. Dedicated & ring-fenced clinical and operational teams	1a. Robust clinical staffing model	• Clear rotational or permanent clinical staffing model in place • Staff vacancy rates are low • Hub has, or aims for, 80% substantive staff across all staff groups and on a rolling monthly basis • Hub review the number of additional hours that staff work to ensure staff well being	Self-certification Rotas Vacancy data Copy of plans	Effective
	1b. System in place to enable staff to work effectively at hub sites and to move efficiently between hubs	• Passporting process & rotational models fully embedded • Induction processes are in place for all staff, including these from other sites and visiting clinicians	Related policies Conversations with staff during site visit Self-certification	Effective
	1c. Robust ring-fencing applied to hub staff	• Chief Executive/Exec Tripartite decision required for breaking of ring-fence of hub staff • Winter/emergency pressures plans in place to avoid hub cancellations	Self-certification Conversation with staff during site visit Copy of plans	Effective
	1d. Effective strategy to address future staffing issues & robust staff management processes	• Plans to address recruitment and retention in place (e.g. networking with neighbouring hubs, rotational or innovative posts) • Plans for sole-development and ongoing training • Robust staffing processes such as appraisal, disciplinary etc.	Self-certification Copy of approach and results Copy of plans Copy of policies	Safe
2. Supported training of junior doctors & wider MDT	2a. There are regular, scheduled, training opportunities at the hub for junior doctors, including fellows	• Dedicated training operating lists to agreed GIRFT rations (e.g. 8 cataracts per training list v 10 non-training list)	Example theatre lists Model hospital data Conversations with staff during visits	Effective

	2b. Hub staff offered regular, relevant continued professional development (CPD) opportunities	• Systematic training opportunities in place for relevant hub staff	Training records	Effective
3. Strategy & approaches that promote staff well-being	3a. Staff have access to necessary basic facilities and services	• There is sufficient parking and transport arrangements for staff not permanently based at the hub • Staff access to a dedicated area for breaks/lunch • There is lockable storage and changing facilities are available for hub and non-hub staff • Smart card/relevant logon information for staff not permanently based at the hub is collected in a timely way	Observation during visit Conversations with staff during site visit Self-certification	Effective
	3b. Staff feel safe in their work environment	• Necessary estates safety checks carried out • Outdoor areas and parking is well lit	Self-certification Observation during visit	Effective
	3c. Staff feel valued and respected in their work environment	• Evidence of regular engagement with staff at all levels with evidence of actions taken to address suggestions and comments • Good levels of staff satisfaction	Self-certification Examples of impact Vacancy, sickness and turnover rates Trend data	Effective

Anaesthetists

The large volume of joint arthroplasty provides significant opportunities for the development of skills and training in regional anaesthesia as well as general anaesthesia in a fit and healthy (ASA 1 and 2) patient population. The clinical workstream team will explore with the School of Anaesthesia for Health Education England how these opportunities can be best developed and used.

Allied Healthcare Professionals (AHPs)

In addition, the EOC offers considerable opportunities for training and to develop real expertise and confidence for nurses, theatre operating department practitioners, physiotherapists and other AHPs. Clinicians have the opportunity to grow and develop in conventional roles working in a specialist environment or to develop advanced skills working more broadly in extended roles that support this innovative pathway such as advanced nurse practitioners supporting ward care, reporting radiographers, consultant or advanced practice therapists.

Sharing best practice

In addition, the volume of clinical work undertaken in the EOC provides opportunities for clinicians from home trusts and community partners to undertake placements at the EOC to develop their understanding of the whole patient pathway. It also provides opportunities to upskill and to develop competences and confidence that can be shared across providers to improve the clinical skills, knowledge and quality of care across NWL.

Research

Consolidating large volume elective work and expert clinical teams presents real opportunities for the EOC to lead and develop research programmes of work that will have meaningful impact for patients undergoing treatment for MSK procedures. The acute trusts are well placed to support this with excellent links with Imperial College and the new MSK laboratory in the Sir Michael Uren Building at the White City Campus.

Investing in our staff

Placing training and research as a core element and expectation of everything that we do will encourage the EOC to continue to: aim for the highest standards; to remain reflective and responsive to change; progress and challenge; and embrace true multidisciplinary working. Trauma and orthopaedics education and training is a key dependency whose implications need to be worked through in a collaborative way as part of the development and implementation of a new clinical delivery model. Our commitment to provide an excellent environment for training will help to make the EOC a great place for all to work, supporting our recruitment, retention and staff wellbeing. The positive impacts of all of these for patient safety are well recognised.

7.9.5 Working arrangements

Consultant job planning

Consultants will be required to have updated job plans in place to support the NWL EOC via existing portability agreements, while doctors in training, as in the SWLEOC model, would continue to be aligned to the home hospitals. Doctors in training should then follow their consultant to the proposed elective centres on their consultant's operating days to get their required exposure to elective cases.

Consultant job planning will be aligned with training junior doctors to ensure the delivery of high-quality education, training and supervision. It is intended that travel between sites in a single day will be avoided.

Consultant job plans will remain the responsibility of home trusts with a recharge mechanism for sessions allocated to the EOC. Oversight by the workforce workstream and shadow partnership board will be an important function to ensure all Trusts achieve the Gateway 2 requirement to complete job planning by 31 August 2023.

Each Trust will initially be asked to job plan both consultant surgeons and consultant anaesthetists into a two-session theatre list a day (08.30 to 16.30). This will be on the basis on a standard 42 weeks per consultant per year contract. Annualised job plans will be used between consultants and home trusts to ensure that utilisation is maintained in line with GIRFT best practice.

The centre aims to move to full six-day functionality by 1st April 2024 at the latest to meet GIRFT best practice. To enable this, we will undertake a 3 month post opening review (100 days) in February 2024. This review will include a plan and decision point (DP) to move to six-day working.

Where possible home Trusts should job plan to six days (Mon-Sat) but it is recognised this does not reflect current working arrangements in NWL. Remuneration/recharge will be based at 2.5 PAs per full day list (to reflect time spent seeing patients pre and post operatively) with an uplift of 0.5 to reflect proportionate SPA activity within a standard contract.

No further direct clinical care sessions need to be job planned by home Trusts as the clinical model provides for perioperative care from within EOC staffing. In addition, LNUWH will job plan to accommodate its day case and ASA 3+ work.

Each Trust will be expected to fill gaps in anaesthetic cover due to annual leave or sickness within their own workforce. Where this is not possible mutual support will be required and this will be coordinated by the EOC as far as possible but will remain at risk. Where cover at premium is required, the additional cost of this will be apportioned on a pro rata basis to Trusts on the basis of nominal 42-week provision.

There will be the facility to allocate theatres vacated by annual leave or sickness through a standard 6-4-2 process. EOC 6-4-2 will be part of LNWH standard 6-4-2, and then shared via common Cerner, CCS and EOC Teams channel across partner Trusts.

The home Trusts will be required to complete job planning for consultants involved in the EOC by end 31 August 2023. This allows a minimum of a 3-month period prior to EOC opening in November 2023. Job plans will be in place by 31 October 2023 to facilitate the opening in November 2023.

Doctors in training

Initial conversations have taken place with HEE and we will continue to liaise with HEE in the development of the training model to ensure training requirements are fully integrated into delivery plans. The presumption is the EOC would function without any reliance on overnight or ward-based support from trainees in home trusts.

Junior doctor support is likely to present challenges with regards to rota management and service provision and these will be addressed in detail within any education and training plan developed by providers.

7.9.6 Staff experience

The APC is currently reviewing the following opportunities where people improvement objectives may benefit from a collaborative approach. These are:

a) a joint programme to improve staff engagement and experience across the group
b) an employee value proposition
c) optimising the use of diversity data to drive and track improvement
d) de-biasing our HR processes and procedures
e) improving the progression of our colleagues with protected characteristics.

We aim to share and spread the best Equality, Diversity and Inclusion (EDI) practice within the APC, including EDI education and leadership programmes.

Should the proposal be approved, we plan to engage with staff to understand what we can introduce to make the EOC a desirable place to work.

The EOC will be designed in line with best practice staffing ratios, which should create a better environment for staff to work in. Staff will be encouraged and find it easier to take their breaks and rest.

We plan to review the provision of wellbeing support across the acute collaborative and identify areas/initiatives where pooling resource or sharing access could be achieved and would create benefits across the collaborative. Work is already in progress on a shared approach to financial wellbeing. The theatre build will include high quality dedicated staff rest areas (see appendix 13 for images).

We plan to embed a learning culture where all team members are actively encouraged to suggest ideas for improving efficiency and outcomes.

We plan to monitor the outputs from the staff survey to gain insight into staff experience at the EOC, comparing against wider T&O services and overall staff survey outputs. This will enable us to make the necessary improvements to ensure that the EOC is a desirable place to work.

7.9.7 Workforce implementations

Workforce engagement

The clinical model has been led and developed by senior clinicians from across all four acute trusts and the ICB. Much wider and deeper involvement will be essential as the implementation phase moves forward. So far, wider staff groups have been kept informed and have been able to raise concerns or questions with their managers, contributed via engagement sessions and informed via a dedicated email[18].

We are developing an ongoing programme of involvement for all staff who work in orthopaedic surgical and related care so that they can help shape the final SOPs and help develop the implementation plan and beyond.

[18] nhsnwl.eoc@nhs.net

Following the public consultation, we are holding monthly sessions to be led by trust programme leads and supported by workforce leads. Workforce leads meet with staff side representatives to discuss and keep them updated on the proposal and staff side are invited to the monthly sessions. To improve attendance and reach staff who cannot attend, we will be actively promoting these sessions to staff through existing communication outlets and sessions, with recordings being made available via the intranet and local systems. We will continue to provide regular updates via pre-existing directorate meetings.

7.10 Expected benefits of the model

Benefits realisation plan (BRP)
Successful implementation of the proposed service change would deliver improvements to both the people receiving elective adult orthopaedic services in NWL and for the staff delivering them.

A framework has been developed to monitor benefits realisation with the ICB and four acute trusts. This includes KPI themes, metrics, improvement targets, and expected milestones for achievement. The Benefits Realisation Plan (BRP) is shown in appendix 11.

All of the KPI themes within the BRP have been reviewed by programme board to ensure the baseline and target metrics remain valid and the trajectories continue to be achievable.

Table 47 - Key categories of benefits

Benefit description	Expected benefits
Clinical outcomes and experience	Improved patient satisfaction. Reduced burden on primary care.
Patient access	Improved patient satisfaction.
Productivity	Improved productivity.
Cost-effectiveness	Better use of resources.
Transport	Reduced numbers of patients who do not attend. Improved access to patient transport system. Improved patient satisfaction.
Patient satisfaction	Reduced number of complaints. Issues raised as part of complaints requiring action are addressed. Improved qualitative assessment.
Workforce	Low vacancy rates and low turnover.

The purpose of the benefits framework is to:

- describe the set of productivity and efficiency, quality and operational benefits we expect to achieve through the implementation of an EOC for NWL and how a subset of key indicators can be quantified
- demonstrate the impact of the changes to services in NWL to the public, commissioners and providers
- provide a focus for all stakeholders during and post-implementation, to monitor the value and to ensure the reconfiguration is delivering the changes required
- describe specific and measurable performance indicators, which directly link to benefits
- enable the realisation of the programme's benefits which will be monitored at a system and EOC level
- provide an early warning system for the programme to take remedial action if the achievements are not as expected and to address any issues arising.

Patient experience
As part of the implementation of the EOC and to assess the effectiveness of the new approach, the team is developing a comprehensive set of measures of service quality and accessibility from the patient's perspective. The measures outlined below will supplement existing business as usual processes including the Friends and Family Test (FFT) and review of patient complaints which will provide a broader assessment of the patient's view of service quality for the EOC for all of the NWL hospitals providing planned orthopaedic care.

There will be a consolidated set of metrics and analysis comprising baseline and targets including the following:

- FFT scores, which provide a service/site/ward-based assessment for the EOC and the other NWL hospitals providing planned orthopaedic care in respect of other elements of the pathway (pre-admission to and post-discharge from the EOC)
- volume and nature of patient complaints for the EOC and the home hospitals.
- bespoke and focused qualitative patient survey for the EOC
- targeted patient transport impact analysis, which was identified as a particular area of concern in the Public Consultation Report, as described below:
  a. Qualitative patient feedback focused on patients who live more than 45 minutes away from the proposed location of the EOC.
  b. Analysis of the profile of patients who do not attend (DNA) by postcode and age to test the assumption that patients who have mobility challenges or live further are more likely to be late/DNA.
  c. Post-implementation, a continuous review of the Patient Transport System data to analyse activity and the reason for eligibility and to see if there is a correlation between uptake and reduction in the DNA rate.

Management Reporting

The BRP data will be shared at the monthly Shadow Partnership Board meetings in the form of a consolidated summary report containing quantitative and qualitative analysis with feedback to the EOC Management Board and the originating hospitals.

A more detailed report will be considered by the EOC Management Board, which will also respond to recommendations from the 'Shadow' Partnership Board, with escalation as required through LNWH Trust governance arrangements.

In-scope and out-of-scope activity

As detailed in the BRP, KPI themes have been expanded to separate in-scope and out-of-scope for the EOC. The clinical outcomes and patient access for in scope activity will be directly monitored and reviewed by the EOC. This will be shared with the NWL APC. Out of scope activity defined as non-LNWH day case, ASA3+, spinal, paediatric and out of area activity will be monitored by their respective organisations and the NWL APC than the EOC Management Board.

Monitoring of the benefits in this way will ensure the risk of a two-tier system for in-scope and out-of-scope services is minimised as diverge or inequality can be spotted early on and remedial action to ensure consistent quality can be initiated by the APC. Both sets of data will be reviewed by the EOC Partnership Board to ensure there is line of sight on both in-scope and out-of-scope activity.

This is reflected in the NWL ICB Joint Forward Plan (publication pending) where the wider benefits of the EOC, including equity, quality and capacity creation across the MSK system, are anticipated to become part of the APC's governance and oversight.

This also aligns with the objectives set out in Our Way Forward: a New LNWH Strategy, to:

- Provide high-quality, timely and equitable care in a sustainable way
- Be a high-quality employer where all our people feel they belong and are
- empowered to provide excellent services and grow their careers
- Base our care on high-quality, responsive, and seamless non-clinical and
- administrative services
- Build high-quality, trusted ways of working with our local people and partners so that together we can improve the health of our communities

Community MSK services

Two patient pathway areas of focus have been identified as part of the consultation feedback and assurance review. These relate to access to MSK services pre- and post-operatively and the impact on social services of introducing the EOC . While these are two key issues; they do not form part of the BRP as they are indirectly associated with the establishment of the EOC. Access to MSK outside the EOC will be addressed through the patient satisfaction surveys and staff feedback within MSK and the EOC. The

impact on social services will be addressed through monitoring of the interaction with social services by the NWL ICB, the APC Board in Common and the EOC Management Board.

Post-evaluation review
The vision for this proposal, which constitutes one of the core objectives of the development, is to improve orthopaedic care and access across the whole patient pathway. A post-evaluation review (PER) will assess how well benefits have been realised and if there are any further actions required to enable greater delivery of benefits. Any lessons learned will be shared with future projects of a similar nature.

An initial PER will be carried out six months following the completion of the works. This will review the effectiveness of the model, patient experience and outcomes, building on the specific measures already outlined. It will have an explicit focus on patients from groups with protected characteristics to understand their experience of orthopaedic care in the model. This will inform providers and the clinical network of progress against overarching aims to report into the ICS leadership team and point to adjustments that providers may need to make to further improve care.

A comprehensive PER will be undertaken two years after completion. To gain maximum value from the PER, this will include representatives from each of the major project stakeholder groups.

7.11 Implementation challenges and risk management

Management of any significant barriers and risks to implementation will be undertaken via the Shadow Partnership Board and EOC Management Board, with monthly reports to the APC Board in Common. Should there be anything that cannot be managed by these entities, then they will be escalated by exception to the ICB Accountable Officer who will have delegated authority to decide if they are so material that implementation cannot proceed, or the mitigating steps which need to be put in place to allow progression.

Risk management
A comprehensive project risk register has been developed for all risks identified, using qualitative measures to calculate the overall level of risk according to their impact and probability. The full risk register records:

- Category of risk
- Description of the risk
- Likelihood of risk occurring
- Consequence of the risk
- Risk rating
- Mitigating actions
- Post-mitigation risk scoring
- Risk owner
- Review date
- Direction of travel
- Risk status

The risk register is reviewed and updated on a regular basis through the programme governance with key risks escalated to the NWL APC Board and NWL ICB if and when required. The highest scoring mitigated risks are summarised below. A full risk register is included in appendix 10.

Table 48 - Risk register

Risk description	Mitigating actions	Mitigated risk score
Clinical care		
There is a risk that the planned number of cases per list is not achieved	Implement best practice pathways supported by effective resources, training and development, and advanced operational intelligence. Clinical and operational agreement across partnerships	8

Risk description	Mitigating actions	Mitigated risk score
	and standing operational policies. Engagement of clinical staff in solutions.	
Financial		
There is a risk that energy and other supply chain pressures will affect project timelines and costs	Monitor and ensure early procurement of items where appropriate. Review of supply chains as per Secretary of State for Health instruction. Increase optimism bias from 15% to 23% in financial model.	12
There is a risk of insufficient capital funding to support the required theatre expansion and other infrastructure changes	Capital funding secured based on the outline business case (OBC) requirement. If the programme exceeds time thresholds, there is potential to allocate capital via LNWH agreed in principle. Control of implementation costs via proposed governance structure.	9
Significant increase in workforce to be based on the CMH site which, if not filled with substantial recruitment, then temporary staffing will be attracted at a higher cost	Agency premium has been factored in based on LNWH's current recruitment profile. Engagement and co-design of workforce plan with stakeholders. Sensitivity analysis in the OBC will reflect the risk to savings based on greater reliance on temporary staffing.	9
Operational		
Risk that delay to the project results in continuation of relatively low scores on clinical outcome metrics	Start to make changes prior to the new EOC opening, for example, Joint Weeks. Robust EOC programme governance and monitoring via Programme Board and APC governance. Clinical leadership, use of best practice guidance and data through the design, development, and implementation phases across the programme governance.	12
There is a risk that elective recovery across surgical specialities continues to impact on capacity available for orthopaedics at CMH	LNWH executive-led recovery delivery group meets fortnightly to monitor recovery across surgical specialties to plan and avoid any CMH orthopaedic impact.	12
There is a risk that delay to the project results in increased patient waiting times	Robust programme governance with ongoing surgical recovery plans and monitoring.	12
There is a risk that the implementation is delayed by shortage of key staff groups and that staff experience is poor	Executive-led workforce workstream to develop staffing strategies, including recruitment drives, rotational posts and ensure continuous professional development. Comprehensive engagement and involvement plan which includes all key stakeholder groups including staff communication, engagement, and consultation.	12
There is a risk that lack of clinical engagement with the EOC will result in under-utilisation of the EOC and unexpected pressure on the non-host trusts and NWL	Undertaking from each trust to contribute to expected activity levels. EOC programme governance, mobilisation and centre management including multidisciplinary team leadership Risks and benefits and supporting financial incentives to be incorporated in mobilisation plans. Professional/medical director leads and EOC Managing Director support.	12

Risk description	Mitigating actions	Mitigated risk score
	Clinical governance framework to measure and assure service quality and outcomes.	
Lack of a single digital patient pathway platform results in resource-heavy, inefficient management of patient pathways between organisations	Managed by digital workstream with regular updates to the Shadow Partnership Board. Implementation of sector-wide digital platforms.	9
Strategic		
There is a risk of public opposition to the proposed development of an EOC	Comprehensive engagement and involvement strategy to ensure user views inform the plan. Lay partner membership of the programme board and workstreams. Detailed and robust insights on the impact of all patient groups through a robust EHIA. Public consultation will inform mitigation with co-design with stakeholders and JHOSC.	9

Mitigated Risk Score	
15+	High
8 to 12	Medium
4 to 6	Low
< 4	Minimal

7.12 Contract management

Contracts will be managed in alignment with the approach to Change Management set out in section 7.2.

7.13 Organisational development

An organisational development programme will be commissioned to ensure that the EOC is able to function as a specialist centre within the host and to achieve the expected performance levels. We plan to take a holistic view of the host and the inter-relationships and impact between the different parts of the pathway.

We have identified the following initial focus areas:

1. Engagement inside and outside the EOC/host
2. Design of induction/orientation programmes to support onboarding
3. Operating model and procedures
4. Training programmes
5. Team working, values and culture
6. Management and leadership structure and associated appointments
7. How the EOC operates as a host of the partnership as well as being embedded within the host
8. Joint working between the host and NWL Acute trusts (sending/receiving organisations).

The detailed OD plan is being developed by the Workforce workstream of the NWLEOC Programme Board which involves representatives of all the respective Trust.

7.14 Environmental sustainability of services

The EOC has a responsibility and commitment to meet NHS England's net zero targets for emissions and mitigate the impact of the NHS on climate change. In response to feedback, we have outlined how the centre will give due consideration to environmental sustainability.

The implementation has been developed with consideration of the NWL ICB Green Plan (March 2022), a three-year plan which will start to reduce emissions from our sites, working practices and supply chain and support organisations within the ICB to deliver on their own green plans. The plan aims to bring positive change for our patients, communities and staff and address inequalities through improving environmental health and embedding social values.

The development will similarly reflect the overall aims of the LNWH Green Plan, published in August 2022. The ambition is to become a leader in the field of sustainable healthcare by proactively engaging with our staff on sustainability matters so that they are integral to, and feel part of, delivering our Green Plan.

The refurbishment of operating theatres at LNWH will be carried out under a partnership with ByCentral (PFI Project Co) which has developed trust-wide initiatives to meet the NHS objectives of Carbon Zero and Carbon Zero Plus. These initiatives include:

- planned lifecycle replacement programme that moves to modern (lower carbon) technology wherever possible (for example, over the operational phase of the PFI almost all light fittings are LED)
- targeted energy improvement works (for example, boiler burner upgrades, direct drive motors)
- energy investment initiatives (for example, installation of solar PV supported by battery technology) linked to external funding opportunities)
- wider carbon zero investments and opportunities hosted by external local initiatives (for example, Old Oak and Park Royal Development Corporation led local heat network that seeks to supply heat energy to the CMH site from a local data centre. The trust has endorsed this with a letter of "in principle" support for business case development.

Operationally, the EOC will help achieve carbon and resource savings through:

- the transition towards virtual preoperative assessment, reducing the need for patient travel.
- streamlining of high volume, low complexity surgical instrument kits.
- streamlined care pathways for patients to ensure the first contact is the right contact.
- reduced orthopaedic staff travel between sites with direct recruitment model.
- ASA 1 and 2 allows for high proportion of regional anaesthesia that can reduce anaesthetic gases use.

7.15 Digital transformation planning

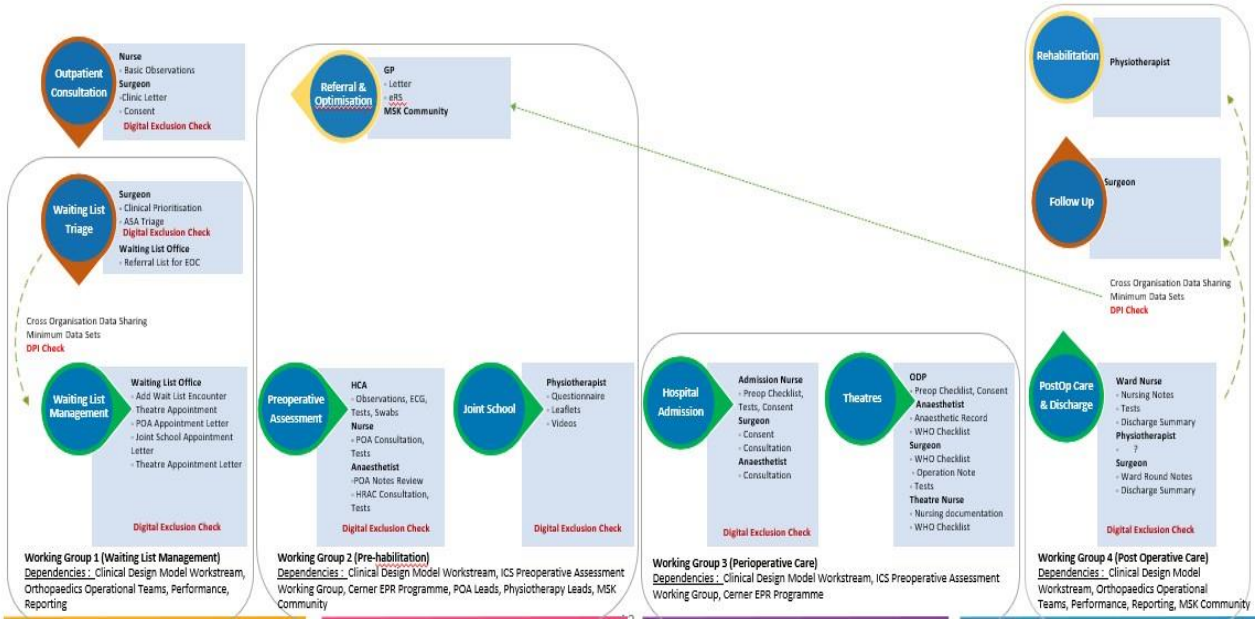
Sharing patient information across the whole care pathway will be of benefit to patients and staff across the whole ICB, delivering less duplication of work and freeing up capacity. The digital enablement and transformation workstream is working to address four main priorities:

- IT infrastructure requirements, funding and implementation.
- Inter-trust patient flows and operational processes ensuring safe transfer of patients to and from the EOC.
- Digital enablement of clinical processes for example pre-operative assessment.
- Digital inclusion building on ICB plans - ensuring all EOC process design includes digital and non-digital options.

The workstream is incorporating the challenges and opportunities arising from the forthcoming adoption of Cerner at LNWH and THHT.

The digital workstream's programme of work is categorised into four working groups (see Figure 20): waiting list management, pre-habilitation, perioperative care and post operative care.

Figure 20 - NWL EOC Digital workstream's programme of work



7.16 Translation and interpretation services

As lead provider, CMH will provide the EOC with language services in line with LNWH's inclusive communication and interpretation procedures and protocols. This service can be configured for: face-to-face interpreting, telephone call translation, video call translation, deaf and/or blind communication related services and print translations – and also provides a service for those using and designing communication services with digital and non-digital patients.

This service is currently operational at CMH and will be engaged during the design, transition and implementation stages before the go live of the centre. Feedback is monitored by CMH's patient and carer participation feedback group. They would provide a report to the EOC's weekly governance meeting once the centre is operational.

7.17 Contingency arrangements and planning

Contingency arrangements for non-delivery of the build is covered by the contract with PFI Project Co.

8 Recommendation

This Full Business Case sets out a vision for a new Elective Orthopaedic Centre based on a compelling case for change. If this is delivered, it will achieve a significant improvement in the quality and access to planned orthopaedic care for the people of NWL.

The North West London Acute Provider Collaborative Board in Common is asked to:

- **APPROVE** this Full Business Case and approve the capital funding requirement of £9.412m for an elective orthopaedic centre at Central Middlesex Hospital.

- **NOTE** that the Full Business Case has revenue implications, with a net income and expenditure benefit in the first full year of operation of £3.968m to the NWL system.

- **NOTE** that the Full Business Case has responded to all assurance feedback and requests for additional information received at various stages of governance (as detailed in appendix 14).

- **NOTE** that the Full Business Case includes:

Financial Case

a) The Trust is anticipating the capital funding requirement of £9.412m will be funded by the NHS Targeted Investment Fund (TIF). If there is a delay in receipt of TIF funding, the Trust will proceed at risk from its own capital programme whilst seeking capital funding from NWL ICS. It will need to monitor the position on an ongoing basis.
b) The financial modelling shows a net income and expenditure benefit in the first full year of operation of £3.968m to the NWL system.
c) The refreshed economic appraisal maintains option 5 as the preferred option, showing an NPV of £35.510m.
d) We have also considered the financially quantified social benefits of the service change, increasing the net present value over a 25-year term of the business case increases from £35.510m to £52.771m.
e) Outputs from the public consultation and assurance process have been assessed from a financial standpoint, and the only material change from a financial perspective is the patient transport solution. The proposed transport solution has been costed at £0.106m per year, increasing annual costs.
f) The principles underpinning the proposed financial and commercial arrangements between the NWL Acute Trusts have been jointly developed and were agreed at the Acute Collaborative Finance and Performance Committee on 10th March 2023. As part of the governance process, an addendum to the FBC has been produced setting out the activity and financial implications for each organisation to support decision making on an open and transparent basis.

Commercial Case

g) The proposal for a the NWL EOC will make use of high-quality estates at CMH, whilst also achieving compliance with national guidance for NHS hospital developments and aspiring to achieve strong BREEAM performance, contributing to Net Zero Carbon and utilising Modern Methods of Construction where appropriate.
h) These objectives will form an integral part of the procurement process and construction delivery. The team will build on a strong track record of partnership working with PFI Project Co on the CMH site.
i) The proposed development is aligned with the Trust's principles for developments across its sites. Considerable emphasis will be paid to aligning with the ICS Estates Strategy which will be developed when the ICS Acute Strategy has been finalised.
j) A comprehensive design process has been undertaken and a full set of RIBA Stage 4 drawings have been produced which have been signed off by the Design Team, including clinical representation.
k) It is essential that the enabling works are commissioned early at risk to avoid any adverse impact on the construction programme and to maintain progress against the critical path.
l) There is a clear recognition of the challenges within the construction market, with rapidly increasing costs of building materials and timing of the procurement will need to be carefully addressed to mitigate the risks of locking in these high prices.

m) The proposed location at CMH will benefit from the absence of any significant planning issues or need for planning approval, given this is refurbishment scheme with no change to the curtilage of the building.

9 Glossary of terms

Term/ Abbreviation	Definition
APC	Acute Provider Collaborative
ASA	American Society of Anaesthesiologists
AHP	Allied health professional
BOA	British Orthopaedic Association
BAU	Business as usual
CMH	Central Middlesex Hospital
CXH	Charing Cross Hospital
CW	Chelsea and Westminster Hospital
CWFT	Chelsea and Westminster Hospital NHS Foundation Trust
CRG	Clinical Reference Group
Core20	The most deprived 20% of the national population, as identified by the national Index of Multiple Deprivation,
CSFs	Critical Success Factors
DPIA	Data protection impact assessment
DC	Day case
DMBC	Decision-making business case
DTA	Decision to admit
DNA	Did not attend
DALY	Disability Adjusted Life Years
EPR	Electronic patient records
EOC	Elective orthopaedic centre
EH	Ealing Hospital
EHIA	Equality and Health Impact Assessment
FFT	Friends and family test
FBC	Full Business Case
GIRFT	Getting it Right First Time
GLA	Greater London Authority
HBN	Health building note
HEE	Health Education England
HVLC	High Volume Low Complexity
HH	Hillingdon Hospital
I&E	Income and Expenditure
IMD	Index of Multiple Deprivation
ICB	Integrated Care Board
ICS	Integrated Care System
ICHT	Imperial College Healthcare NHS Trust
IIA	Integrated Impact Assessment
IP	Inpatient

IOs	Investment objectives
JHOSC	Joint Health Overview and Scrutiny Committee
LOS	Length of stay
LCS	Locally Commissioned Services
LNWH	London North West University Healthcare NHS Trust
LSOA	Lower Layer Super Output Area
MFF	Market forces factor
MVH	Mount Vernon Hospital
MSK	Musculoskeletal
NCC	National Cost Collection
NEPTS	Non-emergency patient transport services
NPV	Net present value
NHSE	NHS England and NHS Improvement
NPH	Northwick Park Hospital
NWL	North West London
OBC	Outline Business Case
OSC	Oversight and scrutiny committee
OKS	Oxford Knee Score
PLICS	Patient Level Information and Costing System
PAS	Patient administration system
PID	Patient identifiable data
PTL	Patient Tracking List
PROMs	Patient Reported Outcome Measures
PLICs	Patient-level costings
PACU	Post-anaesthesia care unit
PER	Post-evaluation review
PIR	Post-implementation review
PCBC	Pre-Consultation Business Case
POA	Preoperative assessment
QIA	Quality impact assessment
QI	Quality improvement
RIBA	Royal Institute of British Architects
SMH	St Mary's Hospital
SMI	Severe mental illness
SOC	Strategic Outline Case
SSI	Surgical site infection
SWL	South West London
SWLEOC	South West London Elective Orthopaedic Centre
TIF	Transformation investment fund
TfL	Transport for London
THHT	The Hillingdon Hospitals NHS Foundation Trust
T&O	Trauma and orthopaedics

ULEZ	Ultra-Low Emission Zone
WM	West Middlesex Hospital
WAU	Weighted activity unit
WTE	Whole-time equivalent
WRES	Workforce Race Equality Standard

NWL Acute Provider Collaborative Board in Common (Public)
18/04/2023
Item number: 3.3
This report is: Public

Delegated Authorities to Provider Trust Committees

Author: Vikas Sharma
Job title: Trust Secretary, The Hillingdon Hospitals NHS Foundation Trust

Accountable director: Peter Jenkinson, Director of Corporate Governance (ICHT & CWFT)
David Searle, Director of Corporate Affairs (THH & LNWH)

Purpose of report

Purpose: Decision or approval

This paper seeks approval of the proposed delegated authorities from the respective Trust Boards to the local Board Committee as per the schedule within the report.

- Schedule 1 – The Board of Chelsea and Westminster Hospital NHS Foundation is asked to approve.
- Schedule 2 – The Board of Imperial College Healthcare NHS Trust is asked to approve.
- Schedule 3 – The Board of London North West University Healthcare NHS Trust is asked to approve.
- Schedule 4 – The Board of The Hillingdon Hospitals NHS Foundation Trust is asked to approve.

Report history

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

N/A Click or tap to enter a date. What was the outcome?	**N/A** Click or tap to enter a date. What was the outcome?	**N/A** Click or tap to enter a date. What was the outcome?

Executive summary and key messages

Ahead of the establishment of the NWL Acute Provider Collaborative in September 2022, it was agreed that the following items would be reserved for local Trust Board approval ahead of submissions/publication as required as part of the NHS year end process:

- Annual Report and Accounts
- Quality Account
- Self-certifications for Non Foundation Trusts
- Self-certifications for Foundation Trusts
- Modern Slavery Act Statement

We are now seeking to delegate sign off of these reports to the relevant Trust Quality or Audit and Risk committee as laid out in the schedules below.

This request for delegation is consistent with the process undertaken in recent years (prior to the establishment of the NWL Acute Provider Collaborative) by the respective Trust Boards, where delegated authority was supported by the Trust Boards. The expectation of delegation has been discussed at the recent meetings of the relevant Board committees.

<u>Schedule 1:</u> The Board of Chelsea and Westminster Hospital NHS Foundation is asked to approve the following delegations:

Item	Board Committee	Submission	By When
Audited Annual Report and Accounts 2022/23	Audit & Risk Committee	NHS England	30th June 2023
Quality Accounts 2022/23	Quality & Safety Committee	Publication to Trust website	30th June 2023
Self-Certification: General Condition 6 (GC6) & Continuity of services condition 7 (CoS7) of the NHS provider license	Audit & Risk Committee	Publication to Trust Website	31st May 2023
Self-Certification: Condition 4 Corporate Governance Statement	Audit & Risk Committee	Publication to Trust Website	30th June 2023
Modern Slavery Act Statement	Audit & Risk Committee	Publication to Trust Website	31st May 2023

<u>Schedule 2:</u> The Board of Imperial College Healthcare NHS Trust is asked to approve the following delegations:

Item	Board Committee	Submission	By When
Audited Annual Report and Accounts 2022/23	Audit, Risk & Governance Committee	NHS England	30th June 2023
Quality Accounts 2022/23	Quality Committee	Publication to Trust website	30th June 2023
Self-Certification: General Condition 6 (GC6) & Continuity of services condition 7 (CoS7) of the NHS provider license	Audit, Risk & Governance Committee	Publication to Trust Website	31st May 2023
Self-Certification: Condition 4 Corporate Governance Statement	Audit, Risk & Governance Committee	Publication to Trust Website	30th June 2023
Modern Slavery Act Statement	Audit, Risk & Governance Committee	Publication to Trust Website	31st May 2023

<u>Schedule 3:</u> The Board of London North West University Healthcare NHS Trust is asked to approve the following delegations:

Item	Board Committee	Submission	By When
Audited Annual Report and Accounts 2022/23	Audit & Risk Committee	NHS England	30th June 2023
Quality Accounts 2022/23	Quality & Safety Committee	Publication to Trust website	30th June 2023
Self-Certification: General Condition 6 (GC6) & Continuity of services condition 7 (CoS7) of the NHS provider license	Audit & Risk Committee	Publication to Trust Website	31st May 2023
Self-Certification: Condition 4 Corporate Governance Statement	Audit & Risk Committee	Publication to Trust Website	30th June 2023
Modern Slavery Act Statement	Audit & Risk Committee	Publication to Trust Website	31st May 2023

Schedule 4 - The Board of The Hillingdon Hospitals NHS Foundation Trust is asked to approve the following delegations:

Item	Board Committee	Submission	By When
Audited Annual Report and Accounts 2022/23	Audit & Risk Committee	NHS England	30th June 2023
Quality Accounts 2022/23	Quality & Safety Committee	Publication to Trust website	30th June 2023
Self-Certification: General Condition 6 (GC6) & Continuity of services condition 7 (CoS7) of the NHS provider license	Audit & Risk Committee	Publication to Trust Website	31st May 2023
Self-Certification: Condition 4 Corporate Governance Statement	Audit & Risk Committee	Publication to Trust Website	30th June 2023
Modern Slavery Act Statement	Audit & Risk Committee	Publication to Trust Website	31st May 2023

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

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)

18/04/23

Item number: 4.1

This report is: Public

Integrated Performance Report

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

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

Purpose of report

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

The Board in Common is asked to note the reports.

Executive summary and key messages

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

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

This report to the Board in Common represents a continuing development of the report that will be refined over the next few months to ensure it provides a balanced view of performance of sufficient granularity to ensure the Board is sighted, and can take action on, areas of concern.

The information in this report brings together the information covering a range of indicators that have been drawn from the Trust integrated performance reports and agreed by the lead Chief Executive for each area of performance and highlights areas of good practice and areas of concern. Financial performance is also now included in the pack as well as in separate reports at Item 4.2.

This report reflects performance data at Collaborative level for month 11 (February 2023). Trust level performance data is available on each of the four trust's website:

ICHT: Imperial College Healthcare NHS Trust | Publications and policies
LNWH: London North West University Healthcare NHS Trust | Quality and performance
CWFT: Chelsea and Westminster Hospital NHS Foundation Trust | Quality and performance
THH: https://thh.nhs.uk/performance

Strategic priorities

Tick all that apply

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

Impact assessment

Tick all that apply

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

Reason for private submission

Tick all that apply

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

N/A

NHS
North West London
Acute Provider Collaborative

Integrated Performance Report

February data (except Cancer & Maternity = January)
received by BIC April 2023

Integrated Performance Report - Summary

Introduction:

The Integrated Performance report has undergone **further development** since the last Board in Common (BIC) with the working groups for Quality, Operational Performance, Workforce and Finance agreeing key/sentinel indicators that support the BIC in monitoring and gaining assurance on the delivery of national and local plans at an Acute Collaborative level. I**t is anticipated that we will continue to refine the report for the BIC and its sub-committees as we move through 2023-24.** However, the importance of understanding how individual trust performance contributes to the overall position is recognised and the BIC report also demonstrates more granular data at an individual trust level for the month in question. This information is supporting work to reduce variation and drive up performance. In addition to this report, individual trusts have continued to produce a monthly Integrated Quality and Performance Report (IQPR) which is discussed at Executive meetings and Local Assurance Committees. The local IQPRs do contain information that is not included in the BIC report, because all trusts have a small number of key performance indictors (KPIs) that are specific to the range of services they provided or have agreed specific metrics that the Board wishes to monitor. Where issues of concern are raised at trust committees these are escalated to/discussed at the Acute Collaborative Committees in Common (ACCIC). The individual trust reports are available on trust websites and links to the individual reports can be found in the cover sheet to this report.

The format of the report should be self-explanatory, but in summary it consists of:

- Information on the layout of the slides
- A summary balanced score card (BSC) with icons signalling issues in relation to trends or assurance (grey – expected, blue – improving, red – concerning)
- Individual sections for each part of the BSC with an overarching summary supported by charts for each set of indicators

Performance:

Performance across the Acute Collaborative is broadly in line with expected given the current pressures on the NHS. There are examples where the Collaborative is leading the way on performance delivery and improvement, but equally the report identifies areas where performance is below agreed standards and action is underway to address this. The summary at the beginning of each sections pulls out the key issues for consideration by the BIC and highlights areas for escalation.

Overall, all Trusts in the Collaborative have made excellent progress against key operational metrics with patients waiting shorter times for elective procedures. However, there is more work to do to improve performance across the urgent and emergency care pathway.

Despite a difficult winter period, with high levels of sickness due to influenza and Covid, quality of care has been maintained and good progress has been made on recruiting to permanent positions.

Escalation:

All trusts responded well to periods of industrial action in quarter 4, but concerns have been highlighted throughout the report about the impact on patients and staff of continued action during 2023-24.

Layout of the KPI slides

TREND

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

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

NARRATIVE

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

CURRENT PERFORMANCE

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

STRATIFICATION

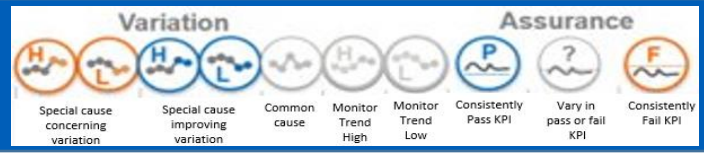
This section provides more granular detail under the specific metric/metrics. This section is under development.

GOVERNANCE

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

Balanced Scorecard

(note Maternity metrics are reported separately currently)



Quality	Expected	Actual	Trend	Assurance
Reporting rate of patient safety incidents per 1000 bed days	≥54.9	57.6		
Serious Incidents	n/a	0.22		
Patient safety incidents with severe/major harm	<0.26%	0.17%		
Patient safety incidents with extreme harm/death	<0.14%	0.13%		
Healthcare Associated c. Difficile Infections	n/a	15		
Healthcare Associated E. coli blood stream Infections	n/a	18		
Healthcare Associated MRSA blood stream Infections	0	2		
Formal complaints received per 1000 staff	n/a	7.19		
Good experience reported by inpatients	≥94%	95.9%		P
Good experience reported for maternity services	≥90%	92.5%		
Good experience reported for emergency depts.	≥74%	76.8%		
VTE Risk Assessments Completed	≥95%	94.7%		

Workforce	Expected	Actual	Trend	Assurance
Vacancy Rate	≤10%	9.5%	L	
Voluntary Turnover Rate	≤12%	12.6%		F
Sickness Absence Rate	≤4%	4.5%	L	F
Agency spend	≤2%	4.0%		F
Non-medical appraisals	≥95%	76.5%	H	F
Medical appraisals	≥95%			
Core skills compliance	≥90%	91.3%		P

Performance	Expected	Actual	Trend	Assurance
Ambulance handover waits	≥95%	82.9%		F
Waits in urgent and emergency care > 4 hours	≥76%	71.2%		F
Waits in urgent and emergency care > 12 hours	≤2%	4.1%		F
Referral to treatment waits > 52 weeks	≤2%	3.1%	H	F
Access to diagnostics > 6 Weeks	≤1.0%	8.5%		F
Access to cancer specialist < 14 days	≥93%	89.6%	H	
Access to Cancer Care (Faster Diagnosis) < 28 days	≥75%	69.9%		
Cancer First Treatment from Diagnosis < 31 days	≥96%	94.3%		
Referral to Cancer Treatment Pathways < 62 days	≤85%	61.0%		F
Theatre Utilisations (Hrs)	≤85%	83.6%		
Outpatient Transformation - PIFU	≤5%	1.2%	H	F
Critical Care – Unoccupied Beds	≤85%	89.6%		

Finance	Expected	Actual	Trend	Assurance
YTD VWA Performance (All Commissioners) - Month 10	108%	113.3%	L	P
YTD CWA Performance (NWL only) - Month 10	100%	113%	H	F
YTD Financial Delivery (I&E) - £m – Month 711	(16,203)	(46,351)	H	P
FOT Financial Delivery (I&E) - £m – Month 11	(5,600)	(5,600)	H	P
YTD Financial Delivery (CIP) - £m – Month 11	92,306	60,765	H	P
FOT Financial Delivery (CIP) - £m – Month 11	101,900	76,691	H	P
YTD Capital Spend - £m – Month 11	171,415	137,929	L	P
FOT Capital Spend - £m – Month 11	163,012	194,937	L	P

Quality/Clinical Performance

Safety Summary

Introduction: The quality metrics and reporting methodology were agreed following a detailed review of the trust board scorecards, national guidance and CQC insight reports. Since this data was last presented to the board in common, national and regional benchmarking data has been added, where available, to aid comparison. 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. The maternity metrics are presented, where available, in the new format for the first time to the board in common. The narrative in this report has been updated to reflect performance reported for February 2023 following discussion at the weekly quality meetings chaired by the ICHT CEO as acute collaborative lead for quality.

Performance: Key points to note include:

- Incidents causing harm: we have noted a recent increase in incidents causing severe and extreme harm. Individual trusts have reviewed these with no specific issues to highlight. This trend continues to be closely monitored.
- IPC: All trusts have exceeded their annual thresholds for E. Coli cases, and most trusts have either already exceeded, or are likely to exceed, their annual threshold for C. difficile; this is a noted trend regionally and nationally with local actions in place. The increase and associated actions are under review by the ICS IPC forum, including the community actions required.
- Mortality: The most recent data available (for the year Nov 2021-Oct 2022) shows that each trust continues to have a rolling 12-month HSMR below the national benchmark of 100; however THH and LNW's ratios have recently changed from "lower than expected" to "as expected" with a small change in their national ranking. All trusts have had an increase in rolling 12-month HSMRs with an average 9.4 point rise. Further analysis has confirmed a similar rise across the NHS, with an average increase of 11.3 per provider. Telstra health are supporting a review of the data and have suggested this is being driven by the data being rebased and changes made in the expected crude rate nationally. The SHMI did not increase in the same way and work will continue to provide assurance going forward.

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, including:

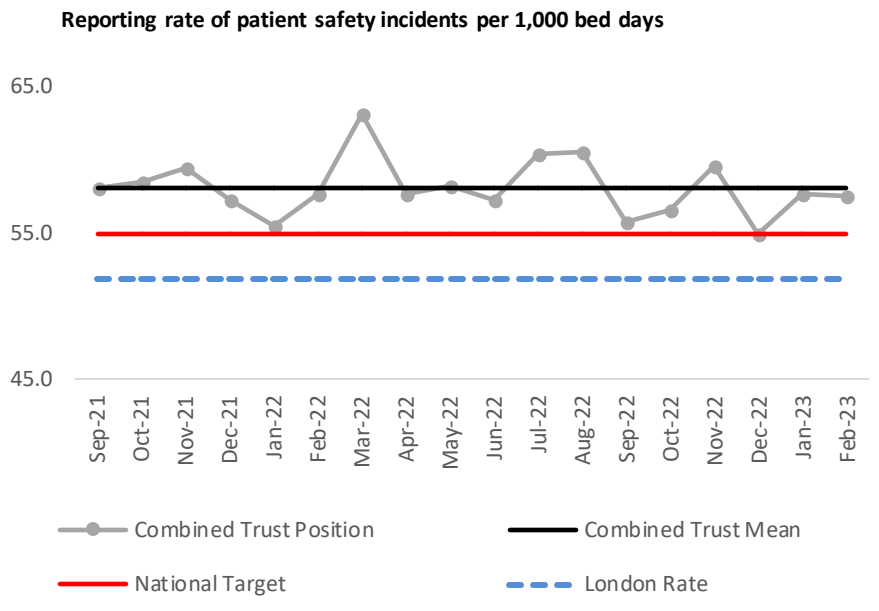
- Implementation of the patient safety incident response framework (PSIRF) and learning from patient safety events (LFPSE), including tendering a new incident reporting system. PSIRF implementation will be the focus of a deep-dive to June APCQC.
- User insight and focus work, including review of metrics reported and focus on meeting our patients' and communities' needs
- Review of mortality data, reporting and review processes across the APC.
- Maternity standards task and finish group focusing on sharing good practice and learning around maternity, focusing on transparent and open reporting, as well as creating a responsive culture to address safety and quality concerns.

Escalations by Theme: On-going workforce and operational pressures, and the impact of industrial action, may have a negative impact on some of our quality metrics over the coming months. All four trusts have robust plans to manage clinical risk and the continued safety of patients and staff during periods of industrial action.

Patient Focus

(Patient) Patient Safety Incidents

TREND



≥54.9

STANDARD

57.56

PERFORMANCE

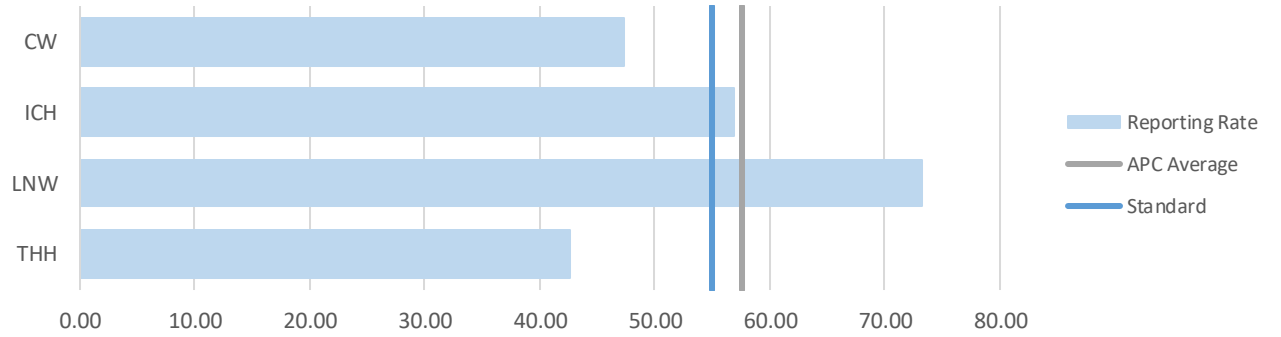
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total bed days	Reporting Rate	Difference from Standard	Patient Safety Incidents	12 Month Rolling Reporting Rate
CWFT	23,775	47.28	-7.62	1,124	49.09
ICHT	30,589	56.88		1,740	56.90
LNW	27,701	73.32		2,031	70.58
THH	11,436	42.58	-12.32	487	48.37
APC	**93,501**	**57.56**		**5,382**	**58.27**

STRATIFICATION



NARRATIVE

Performance: At APC level, we are consistently above both the national and London rates (54.9 and 51.89 respectively, based on NRLS published data for FY 2021/22). At trust level, ICHT and LNW are both above the target in month and on a rolling 12-month basis. Most trusts demonstrate common cause variation, with inconsistent achievement of the target; however LNW has consistently exceeded the target over the last 12 months.

Recovery Plan: LNW is undertaking further work to understand the reason for their increased rate so that learning can be shared. In the meantime, it has been noted that LNW report all mixed sex accommodation breeches as incidents and it has been agreed that the other trusts should now do the same to ensure we are capturing this important measure which impacts patient experience and can be an indicator of increased operational pressures. Reporting categories will be reviewed as part of the work to implement PSIRF, which will support the identification of additional learning to increase incident reporting across the APC.

Improvements: Work is underway to develop an agreed scope across the collaborative for the tender of a new incident reporting management system, with a focus on ensuring this is as user-friendly as possible (staff regularly feedback that current systems are barriers to reporting). This will inform a business case across the collaborative for implementation during Q 2/3 and should support improvement in reporting.

The implementation of 'Learning from patient safety events' (LFPSE), which replaces the National Reporting and Learning System (NRLS), will provide opportunity for further improvements, including training and communications.

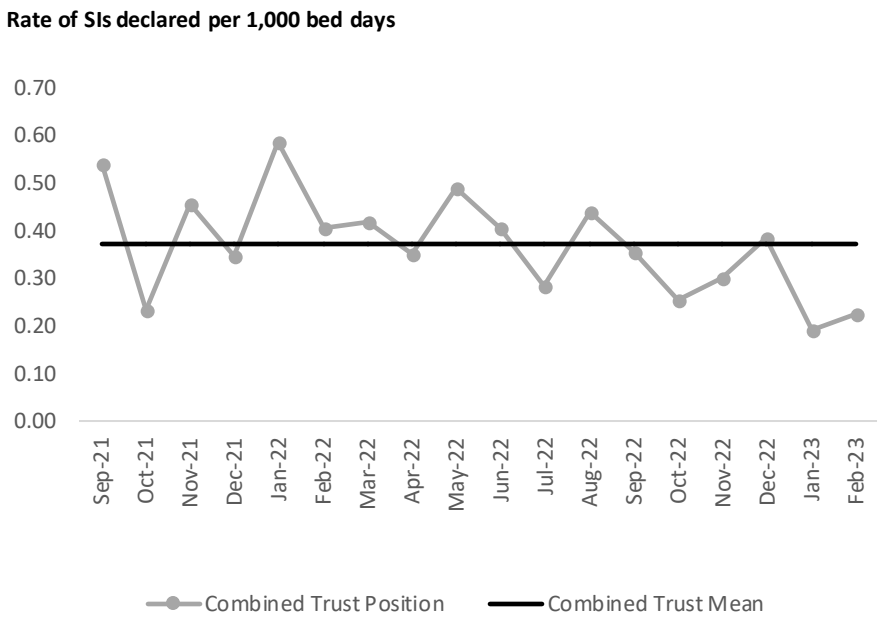
Forecast Risks: N/A.

GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Serious Incidents

TREND



n/a

STANDARD

0.22

PERFORMANCE

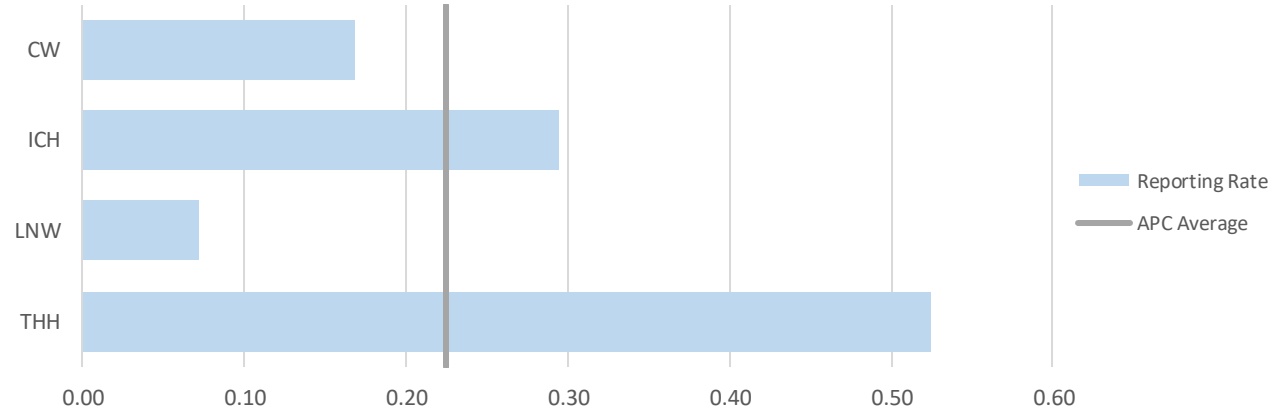
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total bed days	Reporting Rate	Serious Incidents	12 Month Rolling Reporting Rate
CWFT	23,775	0.17	4	0.24
ICHT	30,589	0.29	9	0.44
LNW	27,701	0.07	2	0.22
THH	11,436	0.52	6	0.64
APC	**93,501**	**0.22**	**21**	**0.34**

STRATIFICATION



NARRATIVE

Performance: There is no target for this metric, or data to enable benchmarking at national and regional level. An SI reporting rate per 1,000 bed days has been calculated, and a rolling 12-month rate included, to allow more meaningful comparison. At APC level, the trend shows common cause variation with the rate for February being below the mean. THH have a different approach to the declaration of pressure ulcer related incidents, which is contributing to their higher rate over the last 12 months. ICHT reports the most SIs overall.

There were no never events reported in February 2023.

Recovery Plan: The Chief Nurses are reviewing the approach to investigating pressure ulcers in advance of the PSIRF roll out.

Improvements: The APC is taking a collaborative approach to the implementation of the Patient Safety Incident response framework (PSIRF) which will replace the Serious Incident framework. A task and finish group is in place to deliver the required changes by Autumn 2023 which will support improved consistency in investigation processes and approaches, improve the quality of investigations, and support better involvement of patients and families. This will be the subject of a deep dive to APCQC in June.

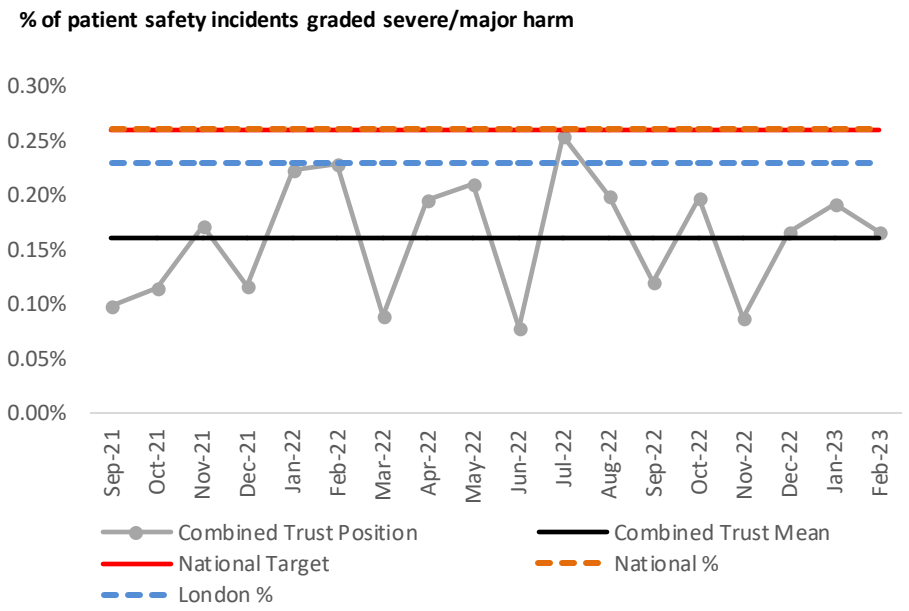
Forecast Risks: Risks have been raised regarding the resource and training required to successfully implement PSIRF. These are being managed by individual Trusts, and through the task and finish group where collective action is needed

GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Patient Safety Incidents with Severe/Major Harms

TREND



Below 0.26%

STANDARD

0.17%

PERFORMANCE

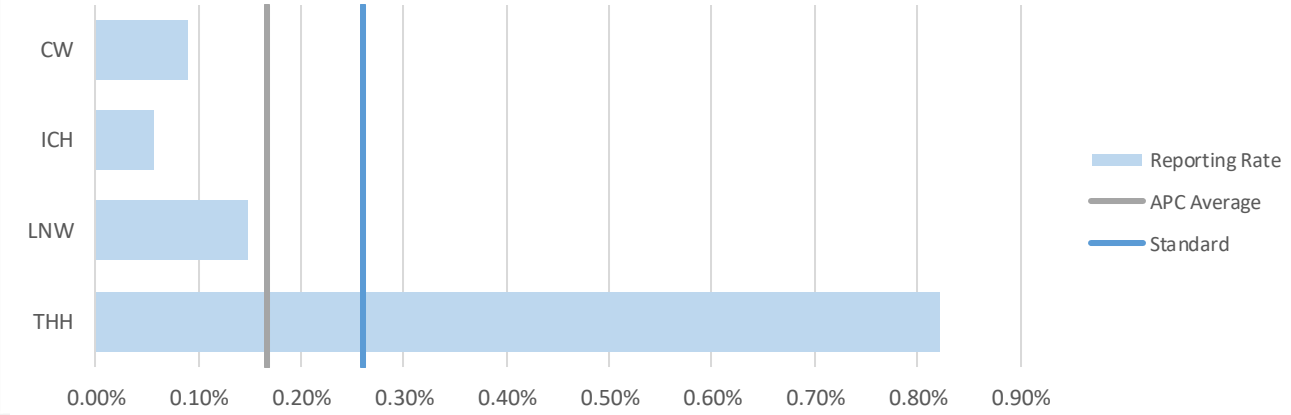
TREND

ASSURANCE

CURRENT PERFORMANCE

	Patient Safety Incidents	% Incidents	Difference from Standard	Severe/ Major Harm	12 Month Rolling % Incidents
CWFT	1124	0.09%		1	0.16%
ICHT	1740	0.06%		1	0.12%
LNW	2031	0.15%		3	0.18%
THH	487	0.82%	0.56%	4	0.27%
APC	**5,382**	**0.17%**		**9**	**0.16%**

STRATIFICATION



NARRATIVE

Performance: The percentage of patient safety incidents graded as severe/major harm remains below national average at APC level. There were 9 severe/major harm incidents reported in total in February, the largest number of which (n=4) were at THH which is just above the target for this month. Rolling 12-month data shows that all trusts are below national average except for THH.

Recovery Plan: There are no clinical issues to escalate from the incidents reported. A review of the harm levels following investigation is underway to ensure accuracy.

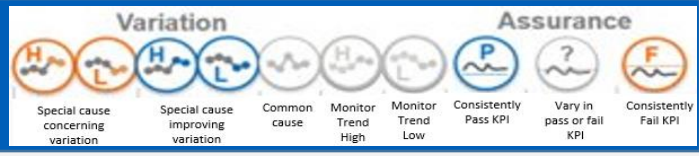
Improvements: Each trust has robust processes in place for the identification, and investigation, of patient safety incidents causing severe/major harm. Immediate actions are put in place in response to incidents, followed by learning and additional actions identified during the course of the investigation to prevent recurrence. Key priority workstreams for the APC around clinical harm review and prioritisation for patients who are waiting for treatment on admitted and non-admitted pathways, and care of the deteriorating patient, will support improvements in patient safety amongst these cohorts who are amongst the highest currently at risk of harm.

Forecast Risks: Continuing workforce and operational pressures, and the impact of industrial action, may result in an increase in incidents causing harm. Trusts have implemented enhanced processes to support the improved management of clinical risk.

GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Patient Safety Incidents with Extreme Harm/Death



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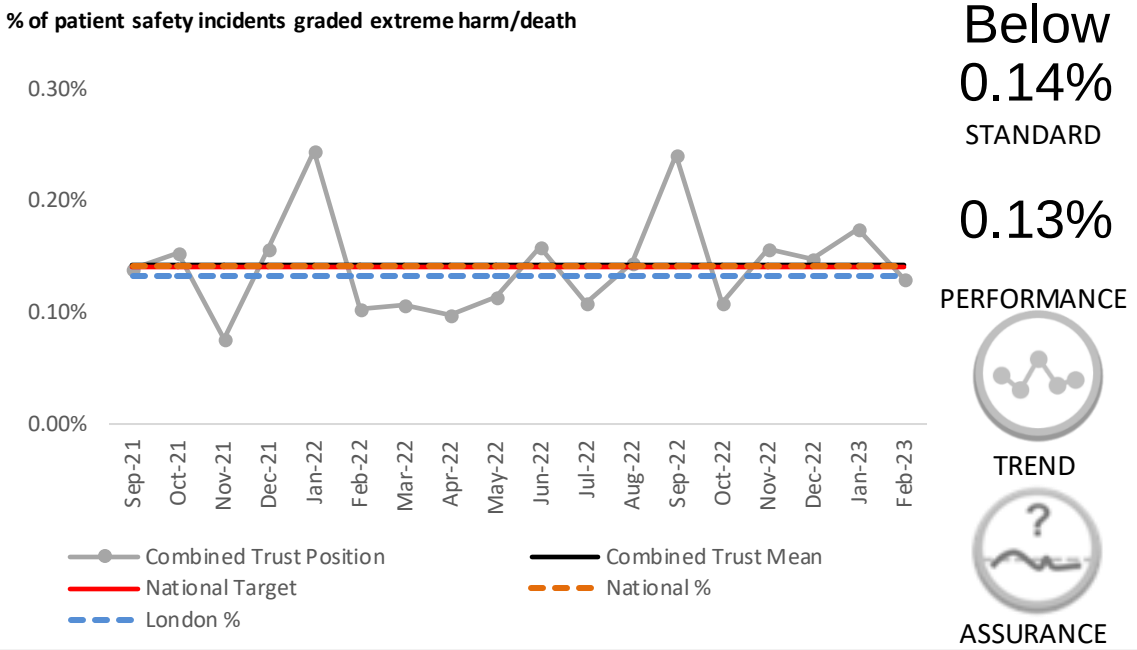


Below 0.14%

STANDARD

0.13%

PERFORMANCE

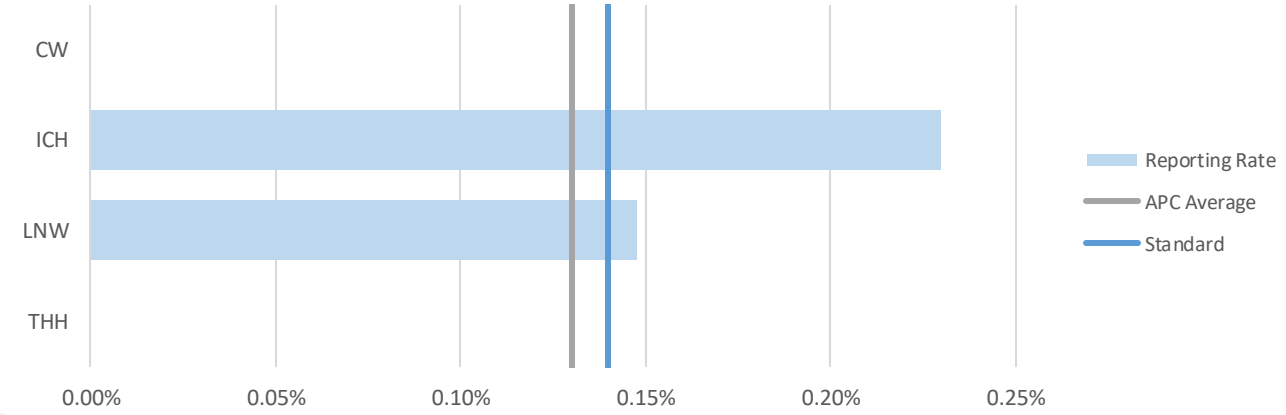
TREND

ASSURANCE

CURRENT PERFORMANCE

	Patient Safety Incidents	% Incidents	Difference from Standard	Extreme Harm/ Death	12 Month Rolling % Incidents
CWFT	1124	0.00%		0	0.07%
ICHT	1740	0.23%	0.09%	4	0.07%
LNW	2031	0.15%	0.01%	3	0.21%
THH	487	0.00%		0	0.25%
APC	**5,382**	**0.13%**		**7**	**0.14%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of patient safety incidents graded as extreme harm has been on or above target since August 2022. SPC shows common cause variation and we are just below target in February; however there are concerns about the recent increase across the APC. Two trusts were above the standard in month (LNW and ICHT). There were 7 extreme harm incidents reported in total, 4 of which occurred at ICHT. Rolling 12-month data shows that both LNW and THH are above national average, while CWFT and ICHT are below.

Recovery Plan: ICHT has confirmed that three of the cases have been downgraded following initial investigation. The remaining case is being investigated as a serious incident. LNW declared three deaths which were subject to initial review and presentation at SI declaring panel where two were declared serious incidents.

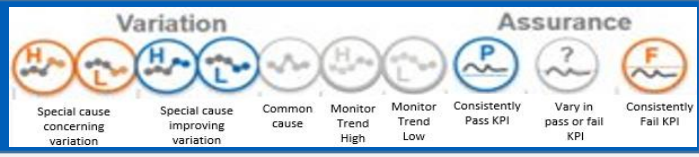
Improvements: Each trust has robust processes in place for the identification, and investigation, of patient safety incidents causing death/extreme harm. Immediate actions are put in place in response to incidents, followed by learning and additional actions identified during the course of the investigation to prevent recurrence. Key priority workstreams for the APC around clinical harm review and prioritisation for patients who are waiting for treatment on admitted and non-admitted pathways, and care of the deteriorating patient, will support improvements in patient safety amongst these cohorts who are amongst the highest currently at risk of harm. PSIRF will support standardisation of harm categorisation across the APC.

Forecast Risks: Continuing workforce and operational pressures, and the impact of industrial action, may result in an increase in incidents causing harm. Trusts have implemented enhanced processes to support the improved management of clinical risk.

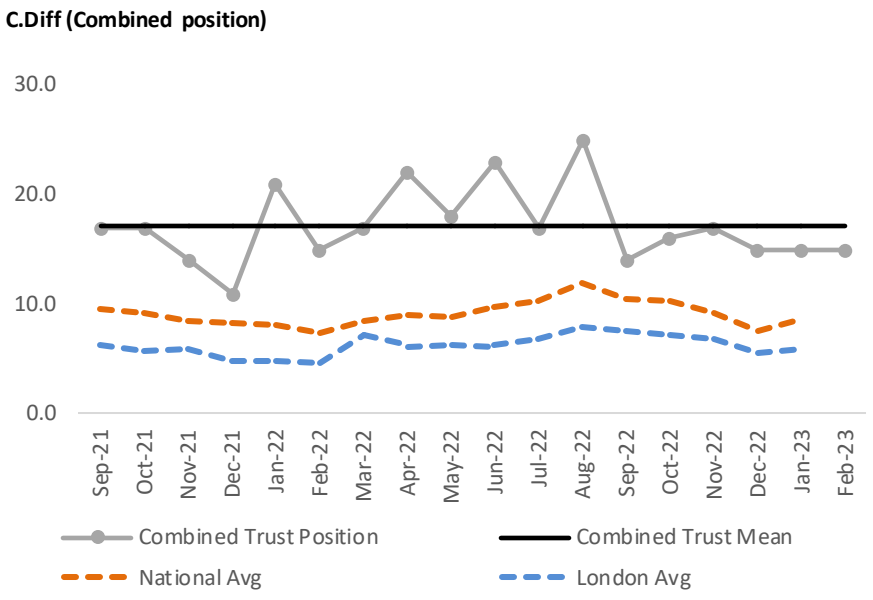
GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Healthcare Associated C.Difficile Infections



TREND



Trust Specific

STANDARD

15

PERFORMANCE

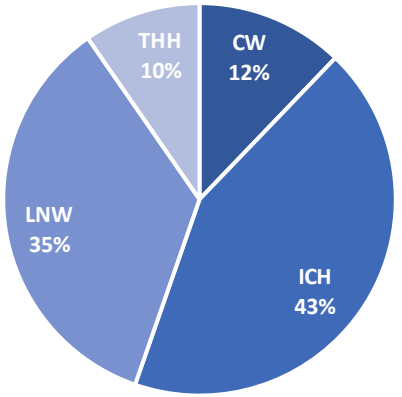
TREND

ASSURANCE

CURRENT PERFORMANCE

	Count of c.Diff cases in month	Count of c.Diff cases in year (FY 22/23)	Trust Threshold (FY 22/23)	Difference from Threshold
CWFT	2	24	25	
ICHT	8	85	67	-18.0
LNW	4	69	64	-5.0
THH	1	19	31	
APC	**15**	**197**	**187**	

STRATIFICATION



Trust share of APC count of infections in year

NARRATIVE

Performance: There were 15 healthcare associated cases of C. difficile reported across the APC in February 2023. The trend graph shows variation, with an overall decrease since September 2022. Over the last six months, the number of cases has been below the APC mean. Each trust has their own threshold agreed with UKHSA for FY 2022/23 based on factors including case-mix. ICHT and LNW have exceeded their threshold for the year and trajectories imply that CWFT may do the same. This increase is reflected regionally and nationally in relation to all gram-negative blood stream infections (BSI); however the APC numbers are higher than the national and London averages.

Recovery Plan: The increase and associated actions are under review by the ICS IPC forum, including the community actions required. Each Trust has robust processes for managing and investigating cases, with most organisations having on-going improvement work in place to reduce gram-negative BSIs, with a focus on improving routine IPC practice.

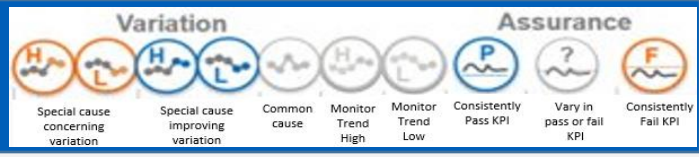
Improvements: Not applicable.

Forecast Risks: Mitigating actions are in place as described in the recovery plan section.

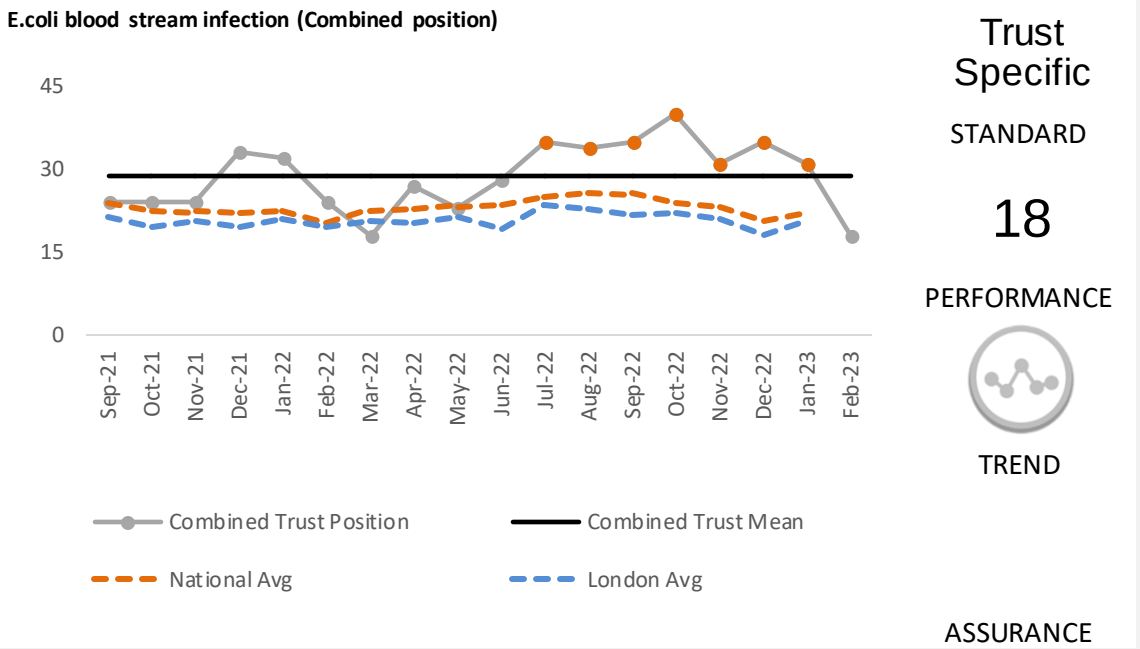
GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Healthcare Associated E. coli Infections



TREND



Trust Specific

STANDARD

18

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: The trend graph shows a reduction in February following a period of special cause concerning variation, with an increase in E. Coli blood stream infections (BSIs) across the ACP since May 2022. In February there were 18 cases reported across the APC, below the London and national averages. All trusts have exceeded their agreed thresholds for FY 2022/23.

Recovery Plan: The increase and associated actions are under review by the ICS IPC forum, including the community actions required. Each Trust has robust processes for managing and investigating E. Coli cases, with most organisations having on-going improvement work in place to reduce gram-negative BSIs, with a focus on improving routine IPC practice.

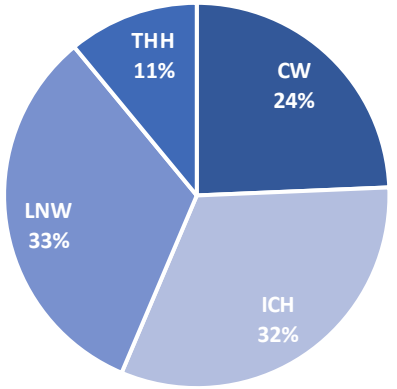
Improvements: Not applicable.

Forecast Risks: Mitigating actions are in place as described in the recovery plan section.

CURRENT PERFORMANCE

	Count of E.Coli BSIs in month	Count of E.Coli BSIs in year (FY 22/23)	Trust Threshold (FY 22/23)	Difference from Threshold
CWFT	0	82	73	-9.0
ICHT	4	108	95	-13.0
LNW	11	110	92	-18.0
THH	3	37	29	-8.0
APC	**18**	**337**	**289**	**-48.0**

STRATIFICATION

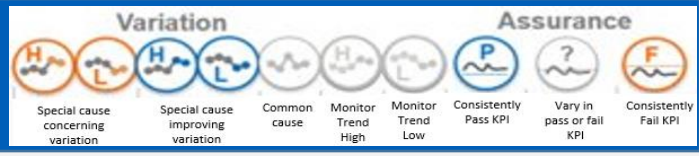


Trust share of APC count of infections in year

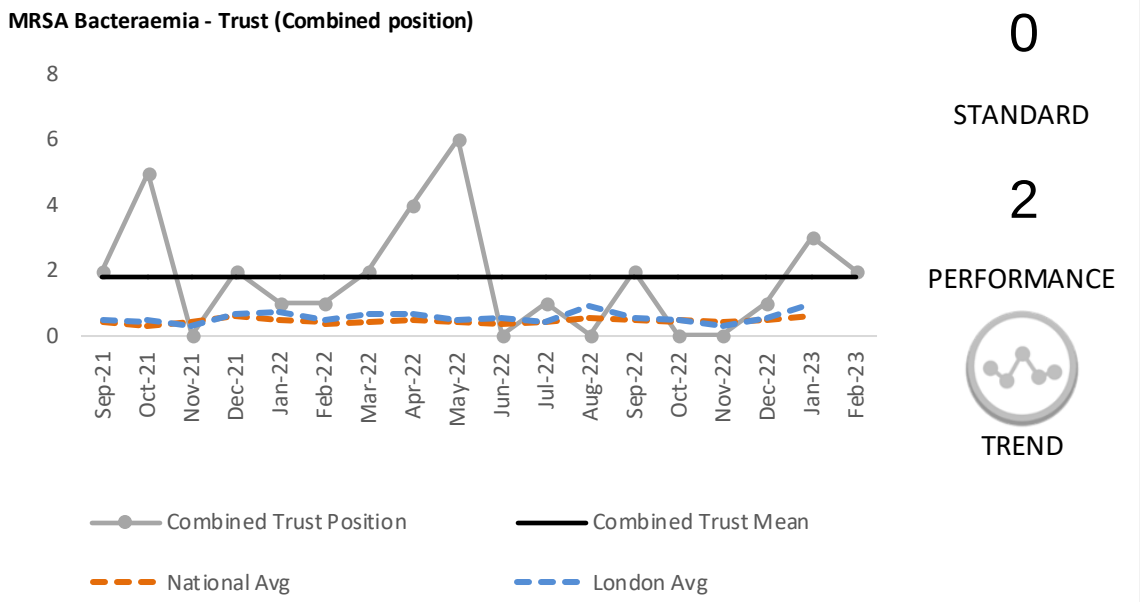
GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Healthcare Associated MRSA Infections



TREND



0

STANDARD

2

PERFORMANCE

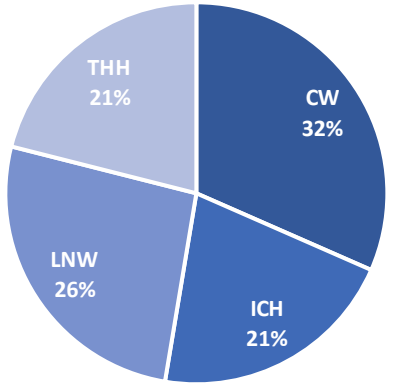
TREND

ASSURANCE

CURRENT PERFORMANCE

	Count of MRSA BSIs in month	Count of MRSA BSIs in year (FY 22/23)	Trust Threshold (FY 22/23)	Difference from Threshold
CWFT	0	6	0	-6.0
ICHT	1	4	0	-4.0
LNW	0	5	0	-5.0
THH	1	4	0	-4.0
APC	**2**	**19**	**0**	**-19.0**

STRATIFICATION



Trust share of APC count of infections in year

NARRATIVE

Performance: There were two MRSA BSIs reported across the APC in February 2023, one at ICHT and one at THH. All four trusts have exceeded the zero-case threshold for the FY 2022/23. Collectively we have reported 19 cases so far this FY.

Recovery Plan: Each Trust has robust processes for managing and investigating cases, with most organisations having on-going improvement work in place, with a focus on improving routine IPC practice.

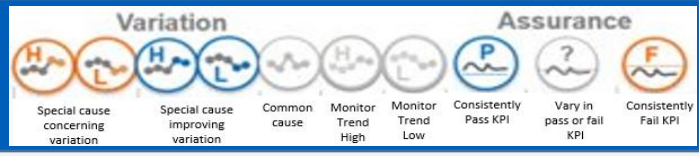
Improvements: Not applicable.

Forecast Risks: None.

GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Formal Complaints



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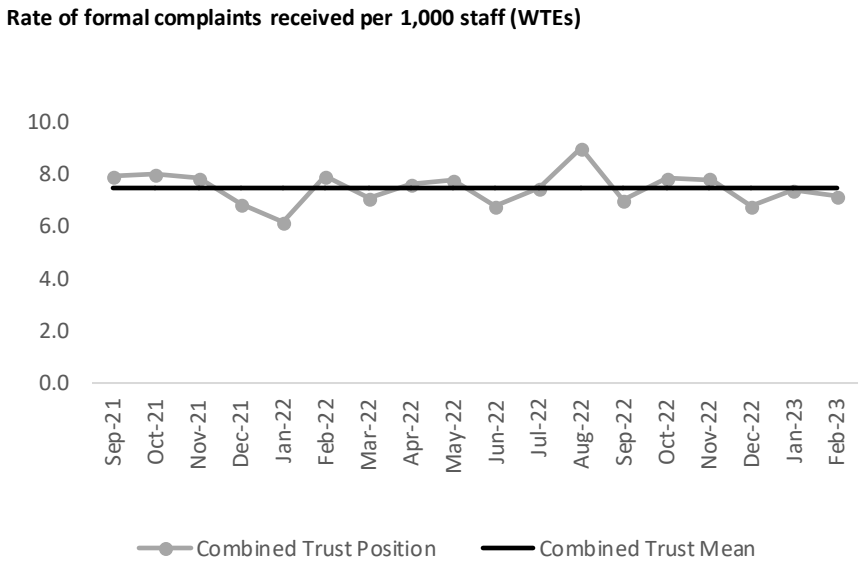


n/a

STANDARD

7.19

per 1,000 WTE

PERFORMANCE

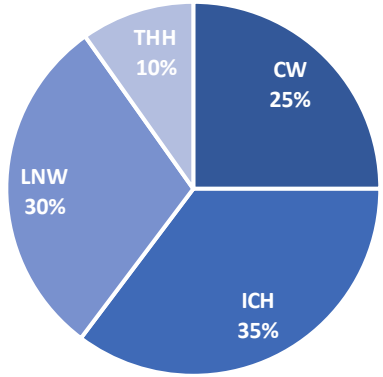
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total WTE Staff	Rate per 1,000 WTE	Count of Patient Complaints	12 Month Rolling Rate per 1,000 WTE
CWFT	6,564	8.53	56	5.95
ICHT	13,024	6.07	79	6.84
LNW	7,935	8.44	67	9.56
THH	3,621	6.08	22	8.21
APC	**31,144**	**7.19**	**224**	**7.49**

STRATIFICATION



NARRATIVE

Performance: There is currently no agreed standard for the rate of formal complaints per 1,000 WTE, and no benchmarking data available. The trend graph shows small amounts of variation across the last 18 months. The rate in February was 7.19, below the mean at APC level. Rates vary at trust level, with CWFT having the highest rate in month, but the lowest across the last 12-months. ICHT reports the highest number of complaints; however has the lowest rate in month and the second lowest rate over the last 12 months.

Recovery Plan: Not applicable.

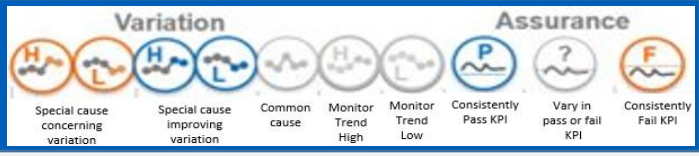
Improvements: The 'User insight and focus' improvement workstream is identifying and prioritising opportunities for shared learning and common approaches to understanding, measuring and improving responsiveness to the needs and views of our patients and local communities across the APC. The metrics, including those related to complaints, are under review to move on from our current process-heavy metrics to those that give more of a sense of whether or not we are meeting our patients' and communities' needs and reflecting their views.

Forecast Risks: None.

GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Inpatient Friends & Family Test



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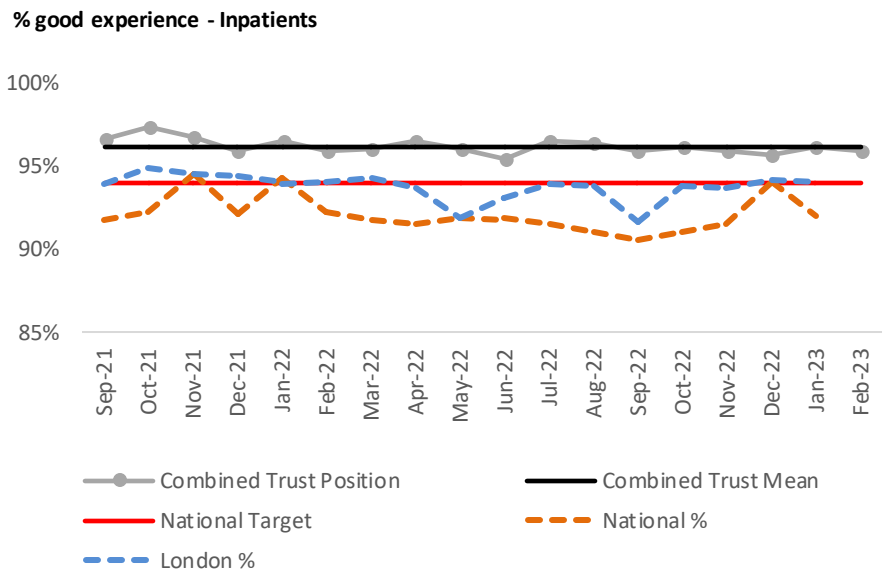


94%

STANDARD

95.9%

PERFORMANCE

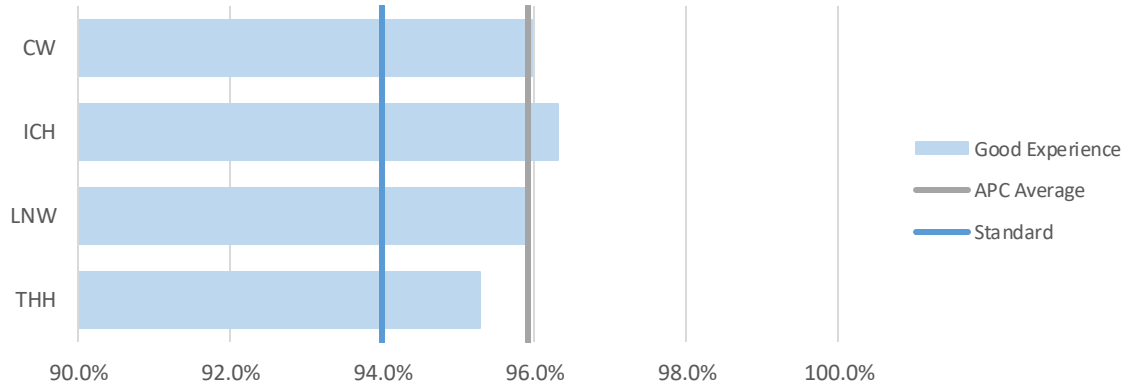
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	942	96.0%		904	95.6%
ICHT	2,034	96.3%		1,959	96.0%
LNW	1,350	95.9%		1,295	98.3%
THH	1,336	95.3%		1,273	89.2%
APC	**5,662**	**95.9%**		**5,431**	**96.1%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of inpatients reporting a good experience is consistently above target and above national and London average. All trusts met the target in month. THH's percentage increased considerably in February, and this was the first time in the last 18 months that they met the target – their denominator also increased from 200-300 to 1,226.

Recovery Plan: Improvement has been seen at THH in response numbers and a corresponding increase in experience data this month. This has been achieved by a multi-method approach to survey completion led by the experience and engagement team.

Improvements: The 'User insight and focus' improvement workstream is identifying and prioritising opportunities for shared learning and common approaches to understanding, measuring and improving responsiveness to the needs and views of our patients and local communities across the APC

Forecast Risks: Continuing workforce and operational pressures, and the impact of industrial action, are likely to have an on-going negative impact on patient experience.

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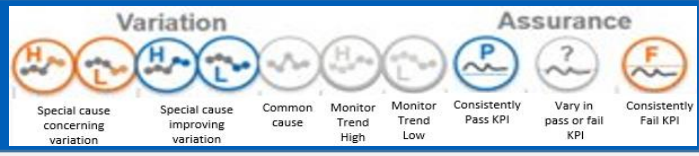
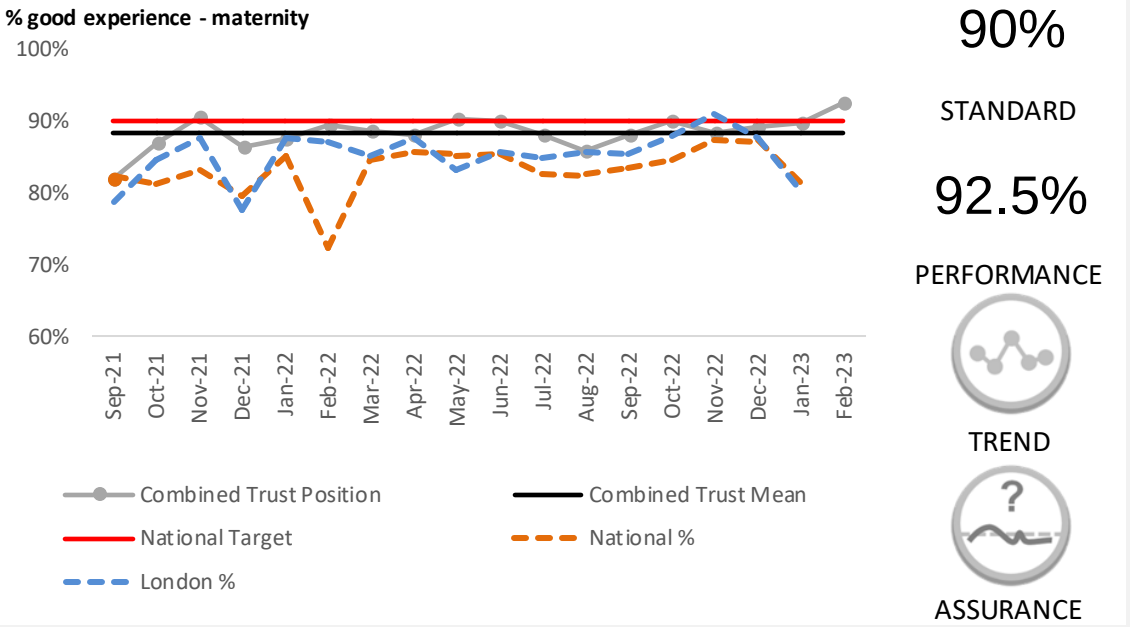
GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Maternity Friends & Family Test



TREND



90%

STANDARD

92.5%

PERFORMANCE

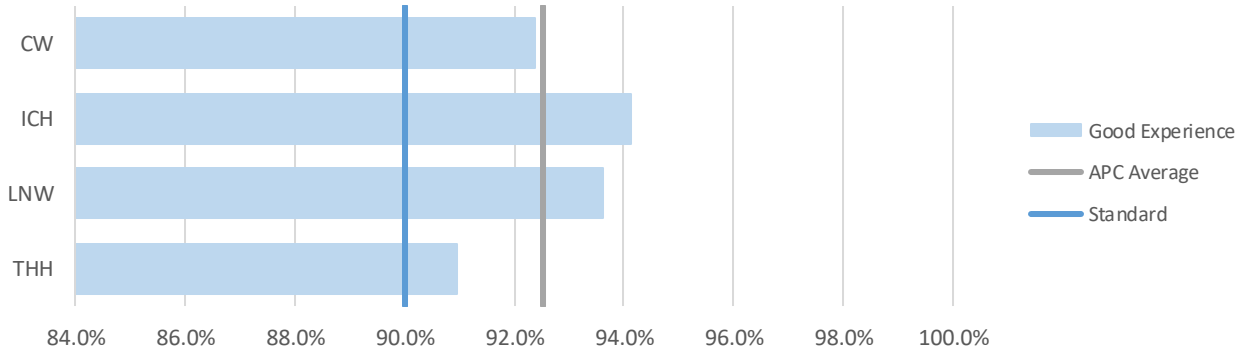
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	275	92.4%		254	88.4%
ICHT	222	94.1%		209	87.7%
LNW	47	93.6%		44	93.3%
THH	232	90.9%		211	90.0%
APC	**776**	**92.5%**		**718**	**89.0%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the monthly percentage of patients accessing our maternity services who report a good experience varies, although there has been a noted improvement overall since September 2021. In all trusts, the number of responses received is low which will result in greater fluctuations in the percentage of patients reporting a positive experience in month. Performance improved in February and is at its highest level across the last 18 months – all four trusts met the target this month.

Recovery Plan: There is a significant amount of work being undertaken within each trust to improve maternity care in response to recent national reviews (e.g. Ockenden and East Kent), and to mitigate against maternity staffing issues.

CWFT has trialled a rolling interview process for maternity services which has resulted in an increased FFT response rate and richer qualitative data on the experiences of our patients. This will be used by the service to help form the maternity improvement plan, in conjunction with the National Maternity patient survey results.

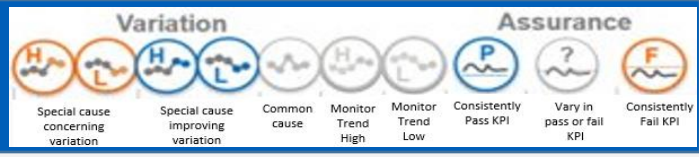
Improvements: Maternity standards is one of the ACP's quality priorities, with an agreed work-plan in place aiming to share good practice and learning around maternity, focus on transparent and open reporting, as well as creating a responsive culture to address safety and quality concerns.

Forecast Risks: Maternity staffing levels 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: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Emergency Department Friends & Family Test



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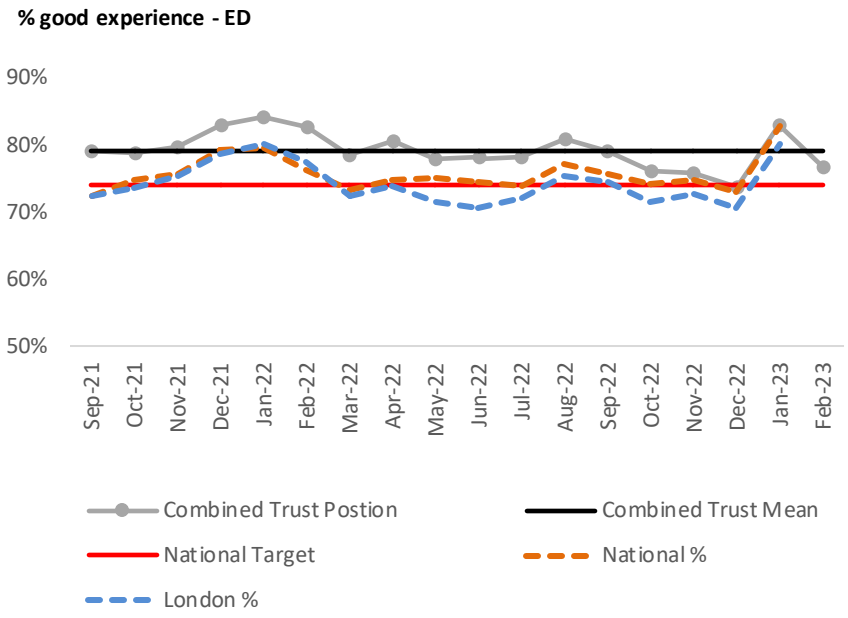


74%

STANDARD

76.8%

PERFORMANCE

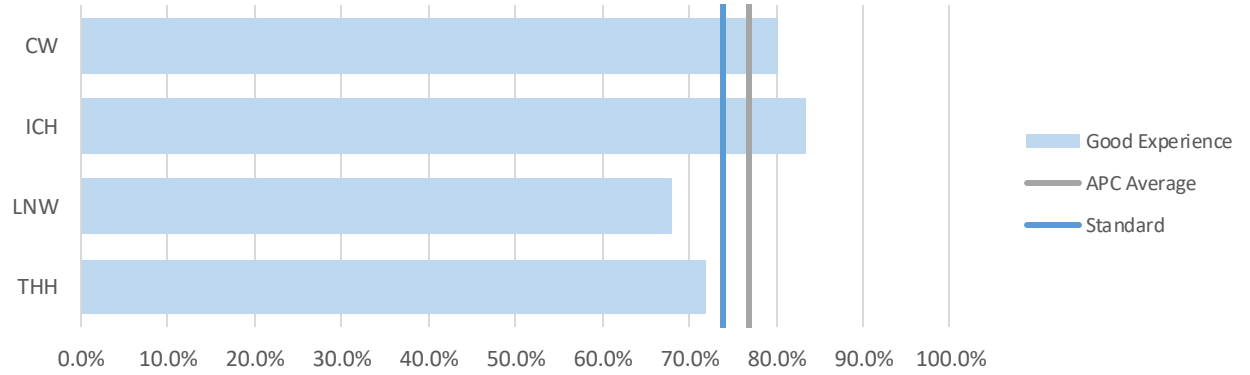
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	2,846	80.1%		2,280	79.3%
ICHT	1,038	83.3%		865	81.8%
LNW	1,424	68.0%	-6.0%	968	68.3%
THH	737	71.8%	-2.2%	529	72.3%
APC	**6,045**	**76.8%**		**4,642**	**78.1%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of patients accessing our emergency departments who report a good experience had been consistently above the standard, and above national average, since August 2021. However, performance started to reduce from August 2022 and the figure in December was below target, likely due to increasing operational pressures. January and February saw a return to above target. CWFT and ICHT met the target in month. The 12-month rolling figure shows that we are above the 74% threshold at ACP level, and in two trusts (CWFT and ICHT).

Recovery Plan: Not applicable.

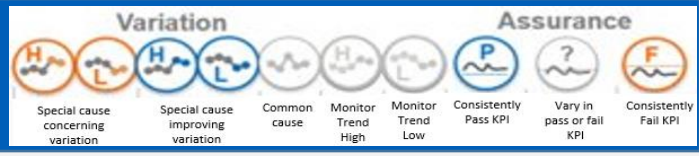
Improvements: Seven themes for improvement have been identified through the peer review process across the APC emergency departments. Clinical leads have been allocated to each theme and actions to be taken forward have been agreed. On 23rd March, a breakout session wash-up took place to pull together the change ideas, link them formally to performance metrics and to then agree how we then prioritise these. The final improvement workstreams will be implemented from April 2023.

Forecast Risks: Continuing workforce and operational pressures, and the impact of industrial action, are likely to have an on-going negative impact on patient experience.

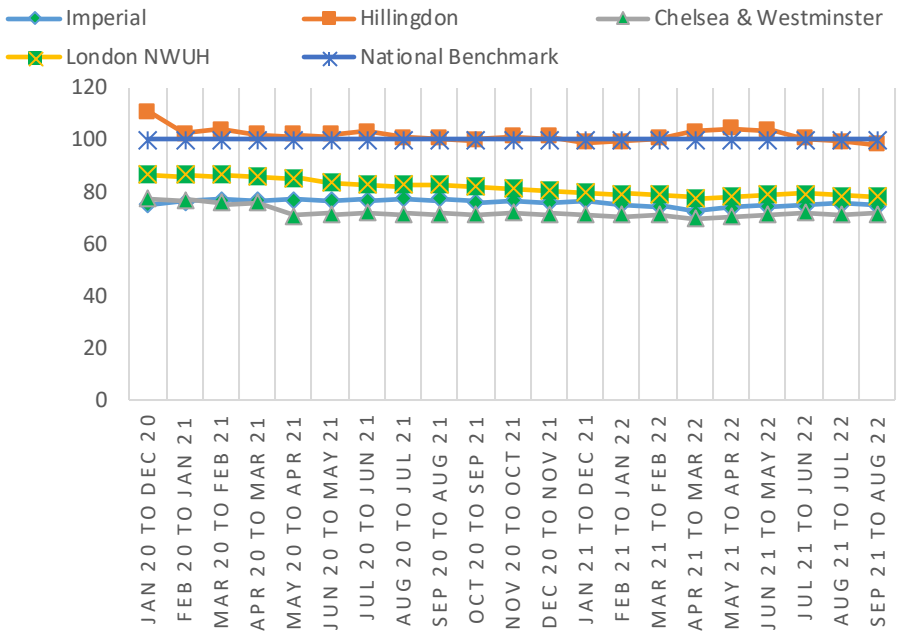
GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Summary Hospital-level Mortality Index



TREND



100
England Average

STANDARD

n/a

PERFORMANCE

n/a

TREND

n/a

ASSURANCE

NARRATIVE

Performance: For three of the four trusts (CWFT, LNW and ICHT), the rolling-12 month SHMI remains lower than expected with the most recent data available (July 2021- June 2022) demonstrating similar figures to previous reporting periods. THH's rate is consistently 'as expected'.

Recovery Plan: None

Improvements: There are opportunities for process and surveillance alignment and optimisation across the sector, work on which is being led by the NWL Acute Collaborative Mortality Review task and finish group. The initial priorities are to align HSMR and SHMI reporting and palliative care coding to identify any further improvements required.

Forecast Risks: On-going operational and workforce pressures could impact on our mortality rates going forward. Trust approaches to managing system clinical risk will help mitigate some of this risk.

CURRENT PERFORMANCE

Summary Hospital-level Mortality Index (SHMI) Year to Aug 2022

	Provider Spells	SHMI	SHMI banding
CWFT	87515	71.84	3 = lower than expected
ICHT	98495	74.75	3 = lower than expected
LNW	99015	78.10	3 = lower than expected
THH	35145	98.36	2 = as expected

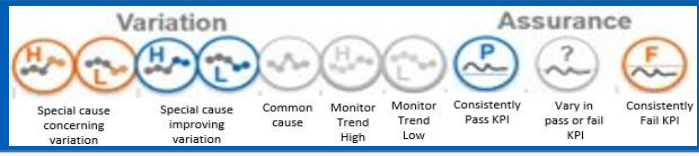
STRATIFICATION

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

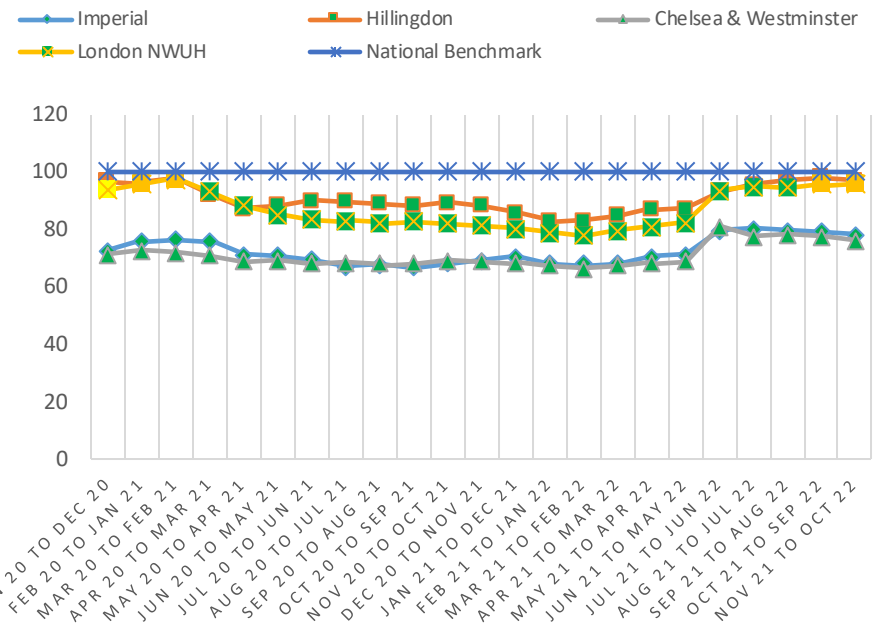
GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied and quality assured by Telstra Health

(Patient) Hospital Standardised Mortality Ratio



TREND



100

England Average

STANDARD

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

NARRATIVE

Performance:. The most recent data available (for the year Nov 2021-Oct 2022) shows that each trust continues to have a rolling-12 month HSMR below the national benchmark of 100, however THH and LNW's ratios have recently changed from "lower than expected" to "as expected" with a small change in their national ranking. All trusts have had an increase in rolling twelve-month HSMRs with an average 9.4 point rise. Further analysis has confirmed a similar rise across the NHS, with an average increase of 11.3 per provider. Telstra health are supporting a review of the data and have suggested this is being driven by the data being rebased and changes made in the expected crude rate nationally. Work will continue to provide assurance going forward.

Recovery Plan: None

Improvements: There are opportunities for process and surveillance alignment and optimisation across the sector, work on which is being led by the NWL Acute Collaborative Mortality Review task and finish group. The initial priorities are to align HSMR and SHMI reporting and palliative care coding to identify any further improvements required.

Forecast Risks: On-going operational and workforce pressures could impact on our mortality rates going forward. Trust approaches to managing system clinical risk will help mitigate some of this risk.

CURRENT PERFORMANCE

Hospital Standardised Mortality Ratio (HSMR): Year to October 2022

	Provider Superspells	HSMR	HSMR – relative risk ranking
CWFT	39,303	76.1	Lower than expected
ICHT	66,980	78.3	Lower than expected
LNW	55,788	95.9	As expected
THH	15,555	96.8	As expected

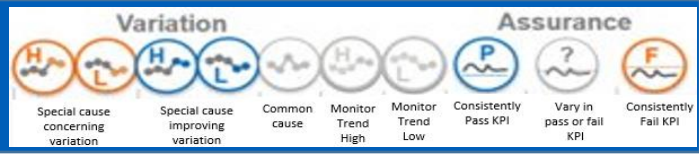
STRATIFICATION

- 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

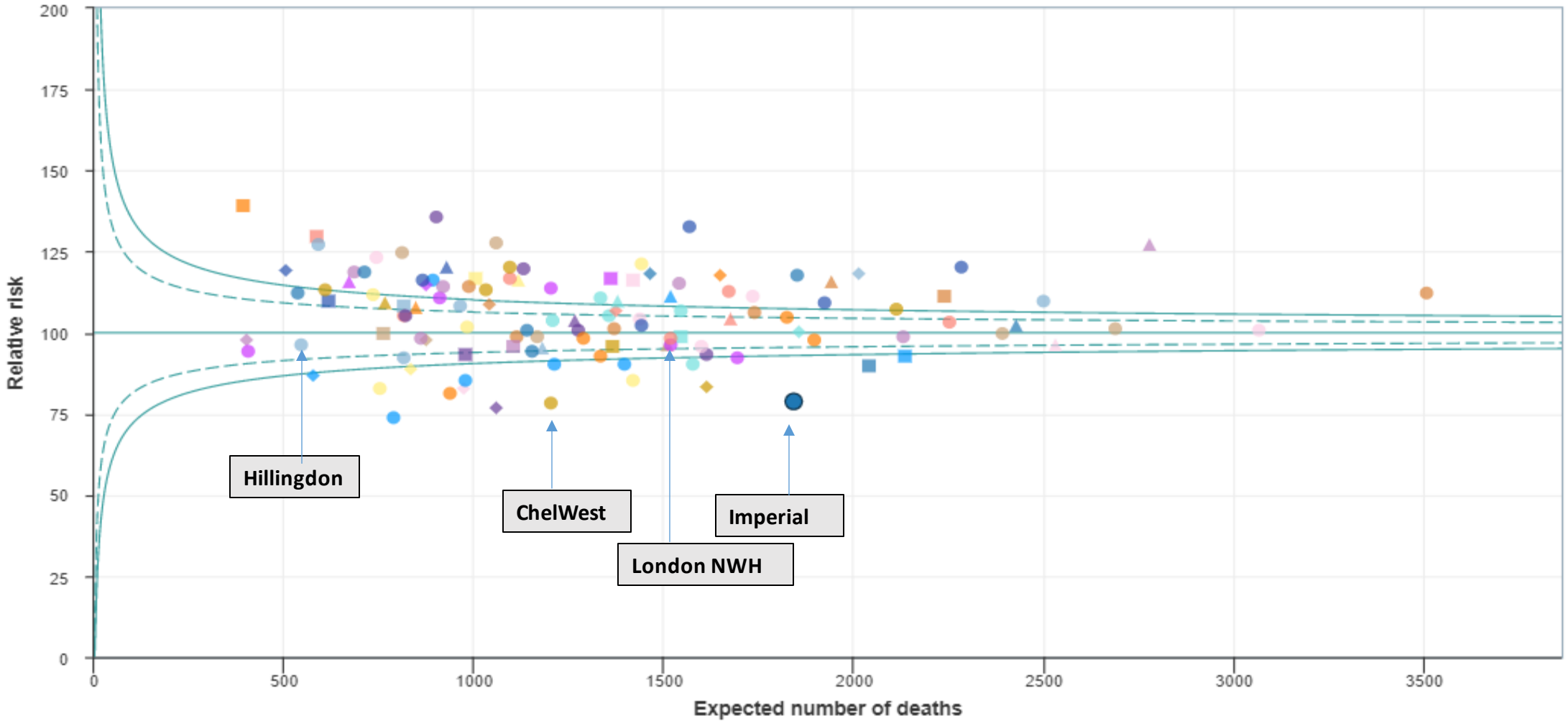
Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied and quality assured by Telstra Health

(Patient) Hospital Standardised Mortality Ratio

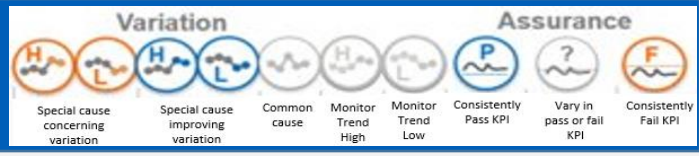


Diagnoses - HSMR | Mortality (in-hospital) | Nov-21 to Oct-22 | ALL (acute, non-specialist)

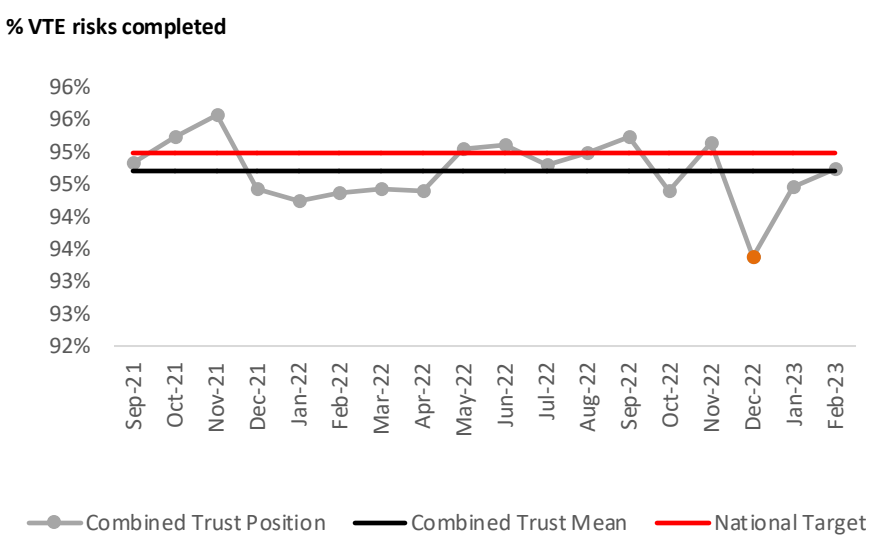
Peers ALL (acute, non-specialis ⌄ *Measure* Relative risk ⌄ *Benchmarks* Model ⌄ *Group by* Region (of provider) ⌄ *Show* All ⌄



(Patient) VTE Risk Assessments Completed



TREND



95%

STANDARD

94.7%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Benchmarking data is not available for this metric as national reporting was paused in response to the pandemic in 2020. The trend chart shows variation in performance with the requirement to risk assess 95% of inpatients for VTE within 24 hours, with data for December demonstrating special cause concerning variation. There was a slight improvement in January and February 2023; however we remain below target at APC level, with two of the three trusts who report data for this metric being below 95% both in-month and rolling 12-month. Plans are in development at LNW to undertake an audit of compliance, this will be reported when available.

Recovery Plan: LNW has established a VTE Task and finish group which will review systems and oversight for data, coding and practice. THH has improvement work underway, including a mandatory e-learning module with positive uptake; further improvements are expected as a result of Cerner implementation trustwide (planned for November 2023). CWFT has identified that some issues with the denominator for this metric; once amended this will improve compliance to above target.

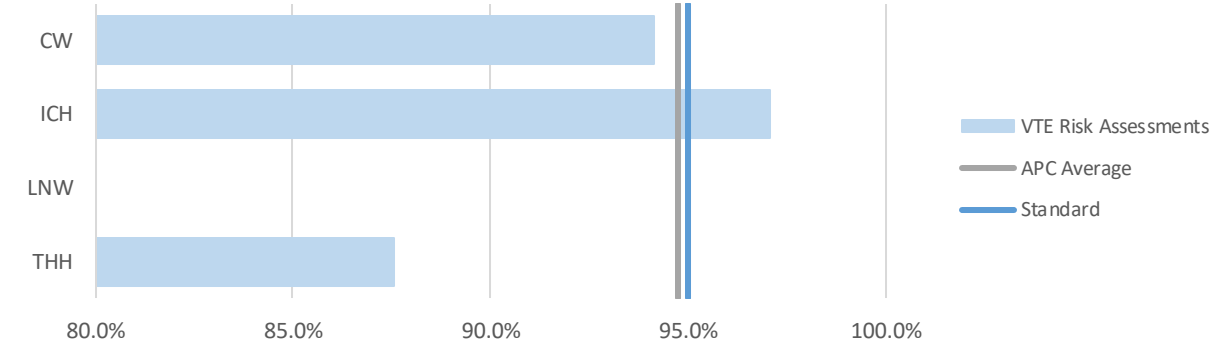
Improvements: ICHT uses functionality in Cerner to ensure that VTE risk assessments are undertaken where required. This is under review to see if it can be replicated at CWFT, and at THH and LNW once Cerner implementation is complete.

Forecast Risks: None.

CURRENT PERFORMANCE

	Total Inpatient Admissions	VTE Risk Assessments	Difference from Target	Count of Inpatients With Completed Risk Assessments	12 Month Rolling VTE Risk Assessments
CWFT	6,713	94.2%	-0.8%	6,321	93.5%
ICHT	13,052	97.1%		12,672	96.5%
LNW					
THH	3,713	87.6%	-7.4%	3,252	90.3%
APC	**23,478**	**94.7%**	**-0.3%**	**22,245**	**94.7%**

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes. N.B. LNW do not currently report data for this metric.

Neonatal and Maternity Report

Scorecard January 2023

Maternity	Expected	Actual	Trend	Assurance
Crude still birth rate (per 1000 birth rate)	3.3	5.0		
Number of neonatal intrapartum brain injuries as escalated to HSIB?	Downward Trend	3		
% of babies delivered in appropriate care setting for gestation (in a care setting within an NICU for singletons <27+0 weeks or <800gms, or all multiples <28+0 weeks)	>85%	100%		
Avoidable Term Admissions in Neonates; proportion of babies >=37 weeks GA admitted to neonatal care for 24 hours or more	<6%	4%		

Trend

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

Assurance

Fail	
Pass	
Flip Flop	

Introduction & metric definition

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 women and birthing people with the options of obstetric or midwifery led birth. There are two level three neonatal units, providing neonatal intensive care for all gestations of newborns. Three level two neonatal units providing critical and intensive care to babies >28 weeks gestation and one special care baby unit providing care to babies born >32 weeks gestation.

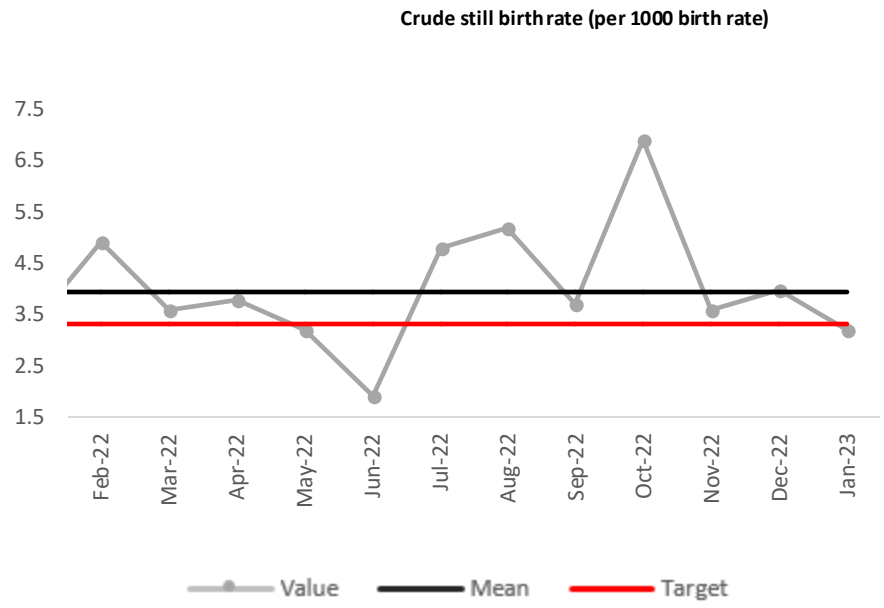
Acute provider trust	Maternity unit	Annual number of live births (2021/22)	Neonatal care provision
Chelsea & Westminster Hospital Foundation Trust (CWFT)	Chelsea and Westminster Hospital	5,643	Level 3
	West Middlesex Hospital	5,019	Special care baby unit
Imperial College Healthcare NHS Trust (ICHT)	Queen Charlotte's and Chelsea Hospital	5,402	Level 3
	St Mary's Hospital	3,172	Level 2
London North West Hospitals NHS Trust (LNW)	Northwick Park Hospital	3,968	Level 2
The Hillingdon Hospitals NHS Foundation Trust (THH)	Hillingdon Hospital	4,137	Level 2
Total live births		**27,341**	

Metric definitions:

1. Crude still birth rate (per 1000 birth rate) - babies born showing no signs of life at 24 weeks or more gestation
2. Number of suspected neonatal intrapartum brain injuries as escalated to HSIB - Number of births reported to NHS resolution as meeting Each Baby Counts criteria.
   Potential severe brain injury diagnosed in the first seven days of life, when the baby:
   - Was diagnosed with moderate or severe (grade III) hypoxic ischaemic encephalopathy (HIE). This is brain injury caused by the baby's brain not getting enough oxygen.
   - Was therapeutically cooled (active cooling only). This is where the baby's body temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.
   - Had decreased central tone (was floppy) and was comatose and had seizures of any kind.
3. % of babies delivered in an appropriate care setting for gestation –An appropriate care setting for singletons <27+0 weeks or <800gms, or all multiples <28+0 weeks is one that has NICU provision. Chelsea and Westminster Hospital and Queen Charlotte's and Chelsea Hospital both have level 3 neonatal units and would therefore be an appropriate care setting.
4. Avoidable Term Admissions in Neonates - proportion of babies >=37 weeks Gestational Age admitted to neonatal care for 24 hours or more.
   The ATTAIN programme focuses on four key areas relating to term admissions – hypoglycaemia, jaundice, respiratory conditions and asphyxia (hypoxic–ischaemic encephalopathy) – and the factors leading to these admissions. These represent some of the most frequently recorded reasons for admission according to neonatal hospital admissions data. Avoidability is determined by reviewing all babies with an unplanned admission to NNU >37 weeks within the first 28days of life. This review is completed by a multi-professional team from the maternity, obstetric and neonatal service. Any areas where care could have been improved in relation to the 4 categories are recorded to inform improvements in practice and shared with other units across the collaborative.

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

TREND



3.3

STANDARD

3.2

PERFORMANCE

TREND

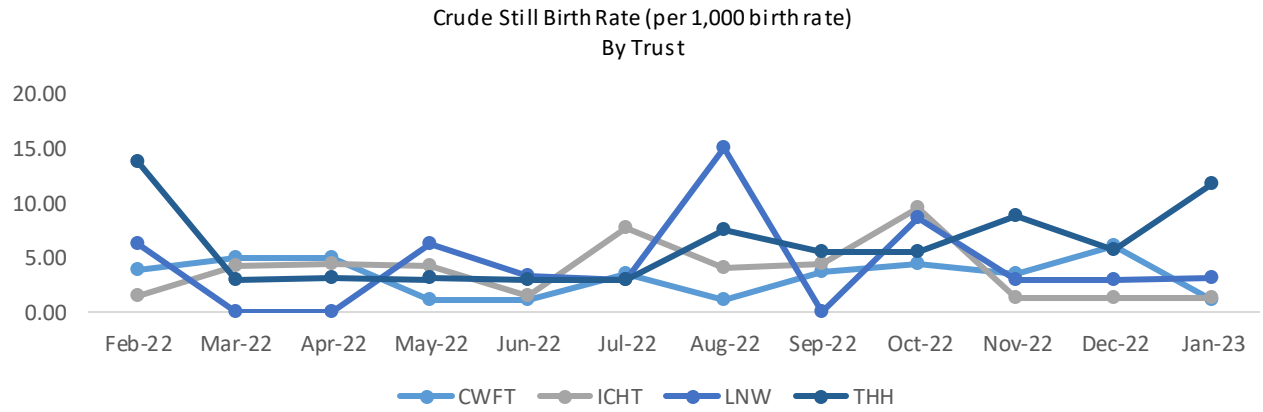
ASSURANCE

CURRENT PERFORMANCE

Crude still birth rate (per 1000 birth rate) - **JANUARY**

	Total Births	Total Still Births	Crude Still Birth Rate (in month)	Crude Still Birth Rate YTD	Difference from Standard (in month)
CWFT	826	1	1.2	3.13	
ICHT	719	1	1.4	4.04	
LNW	318	1	3.1	4.65	
THH	341	4	11.7	5.82	8.40
APC	**2204**	**7**	**3.2**	**4.06**	

STRATIFICATION



NARRATIVE

Performance: Year to date crude stillbirth rate for APC in Jan 23 sits at 4.06. CWFT 3.13, ICHT 4.04, LNW 4.65 and THH 5.82. CWFT is the only provider in NWL to regularly meet this target (not adjusted for risk).

Recovery Plan: All trusts undertake detailed review and analysis of stillbirths, investigate any issues found and share findings with the LMNS to address common themes. All trusts are compliant with care and safety bundles targeted towards reducing perinatal mortality rates. THH is reporting a significant increase over the last two quarters in the number of still births in birthing people who were either un-booked or booked late. This is particularly in people who are housed in local hotels whilst seeking asylum and have complex needs.

Improvements: The complex needs midwifery team at THH are working with different organisations (local authorities and hotels) to identify pregnant women in this high risk group and to encourage earlier access to the maternity services and antenatal care. In addition to Trusts focusing on continuity of carer teams to those at greatest risk, there is increased focus to provide personalised care and support plans, and the provision of smoke free pregnancy services are directed at reducing perinatal mortality rates.

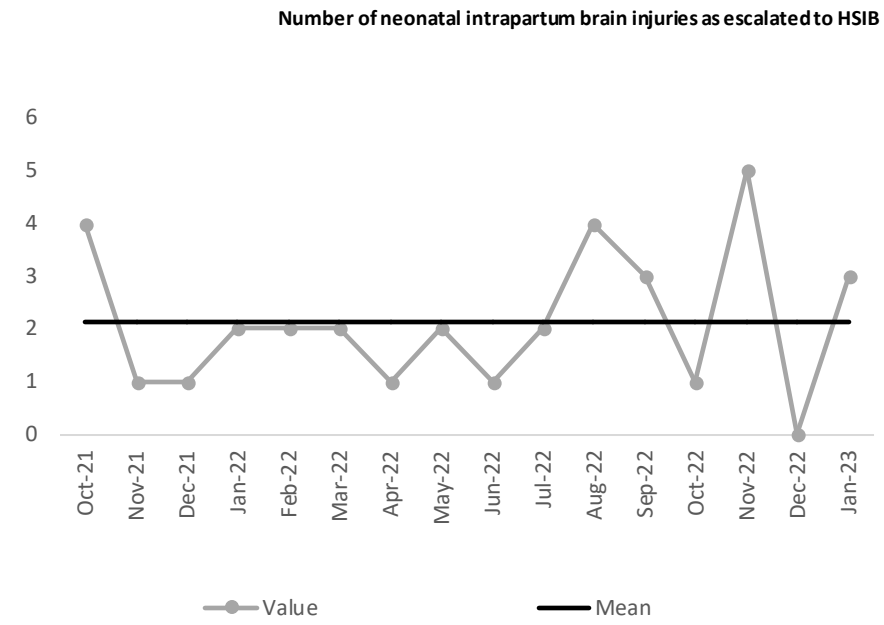
Forecast Risks: The forecast for year end still birth rate is likely to be above the trajectory set in 2019 as part of the national 'halve it ambition'

GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee

(Maternity) Neonatal intrapartum brain injuries (suspected)

TREND



Downward Trend

STANDARD

3

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: The number of suspected neonatal intrapartum brain injuries is forecast to be 15% less than in 21/22. Each case is referred to the healthcare safety investigation branch (HSIB) for investigation with learning and themes shared in each Trust and with the LMNS.

Recovery Plan: To understand the data fully, further analysis is required to capture those cases where following investigation no injury has been identified, and any correlation between the cases of suspected brain injury and neonatal death rates. This work is being taken forward and will report in future.

Improvements: MDT staff training in fetal well-being, human factors training, establishment of safety champions are interventions that may be contributing to improved performance in this domain.

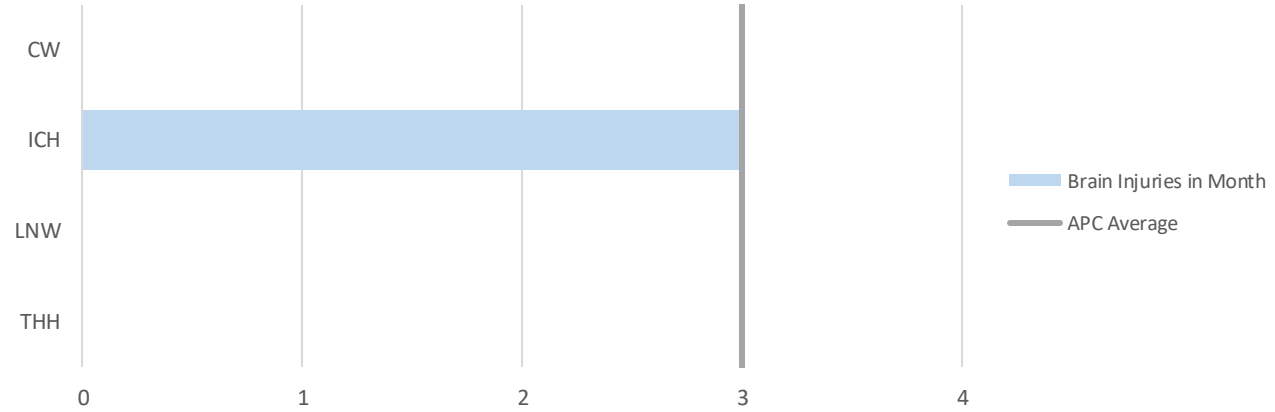
Forecast Risks: None identified

CURRENT PERFORMANCE

Number of suspected neonatal intrapartum brain injuries as escalated to HSIB - **JANUARY**

	Total Births	Suspected brain Injuries in Month	Year to Date suspected brain injuries	Year to Date Early Notifications of Concern
CWFT	826	0	2	under development
ICHT	719	3	11	under development
LNW	318	0	3	under development
THH	341	0	6	under development
APC	**2204**	3	22	under development

STRATIFICATION

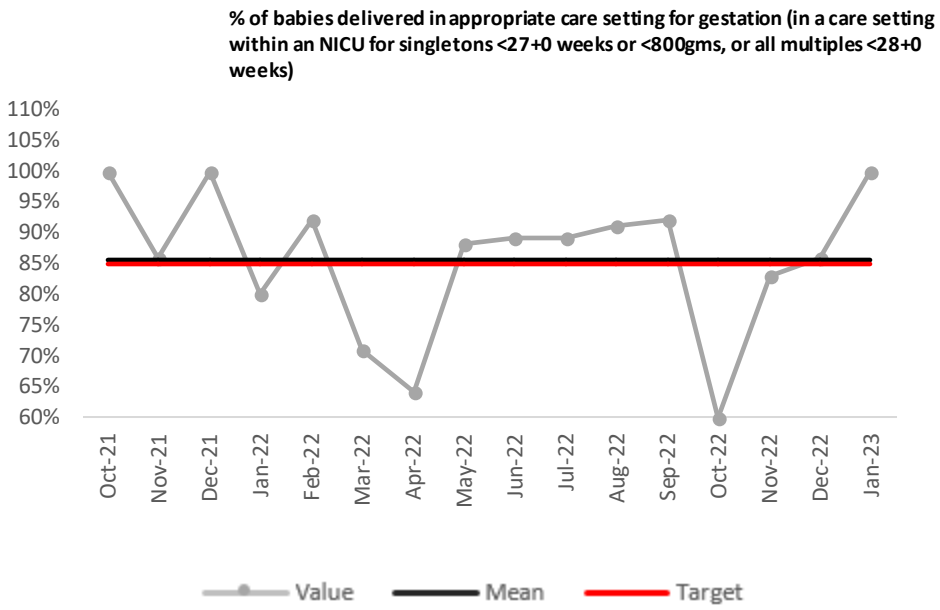


GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee

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

TREND



>85%

STANDARD

100%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Year to date figures indicate that APC is not on track to meet the required standard (79.5%). This is reflected at London level. There is variation in performance with improvements seen in the last quarter. Staffing ratios have improved over this time period in both maternity and neonatal units which may be supporting improvement. LNW & THH do not have a level 3 neonatal unit at their Trusts. Low performance often correlates with timeliness of presentation of the women.

Recovery Plan: Review data collection to establish time to present and establish number of births that presented to sites without a level 3 unit and were successfully transferred prior to birth.

Improvements: Preterm birth clinics being established in THH and LNW, increased focus on personalised care, investment in urgent care translation services (cardmedic pilot to commence in May 23).

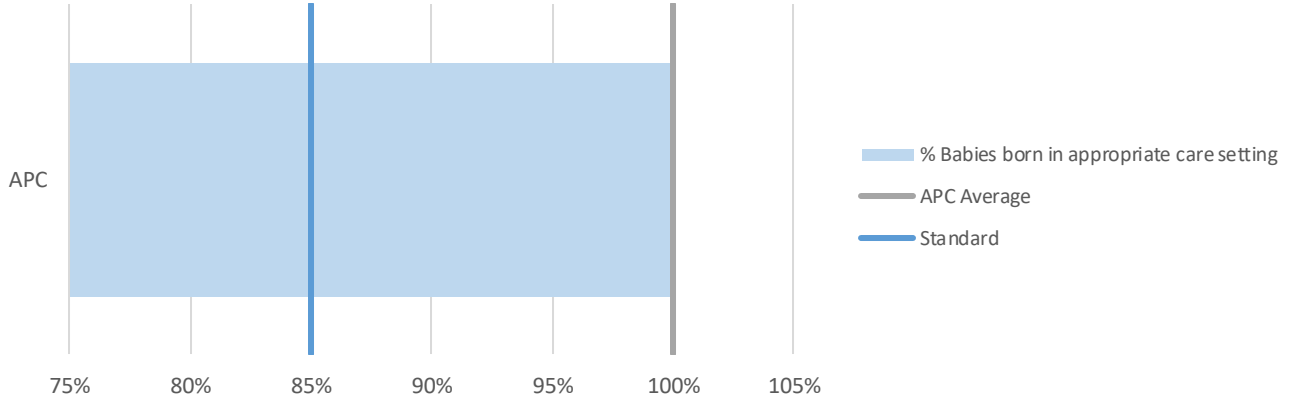
Forecast Risks: None identified

CURRENT PERFORMANCE

% of babies delivered in an inappropriate care setting for gestation (in a care setting) - **JANUARY**

	% Babies Born in an Inappropriate Care Setting	Number of Babies born in an inappropriate care setting / number of babies of that gestation In Month	Number of Babies Born in an Inappropriate Care Setting / number of babies of that gestation YTD
CWFT	0	0 / 4	2 / 25
ICHT	0	0 / 2	3 / 47
LNW	0	0 / 0	5 / 5
THH	0	0 / 0	5 / 5
APC	100%	0 / 6	15 / 82

STRATIFICATION



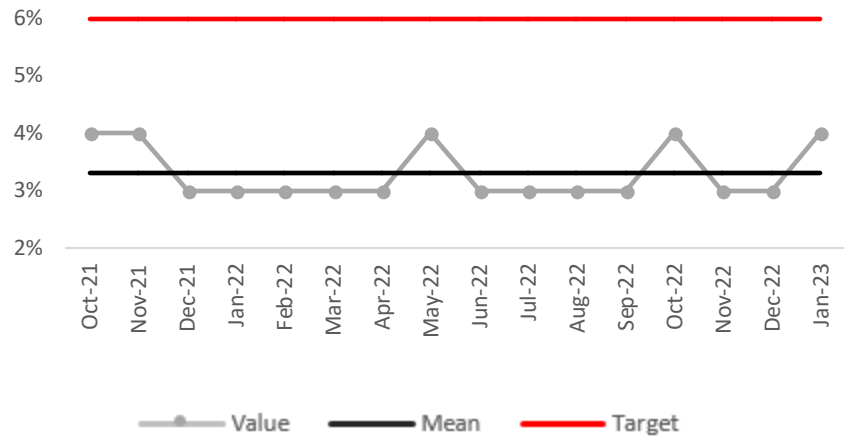
GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee

(Maternity) Avoidable Term Admissions in Neonates

TREND

Avoidable Term Admissions in Neonates; proportion of babies >=37 weeks GA admitted to neonatal care for 24 hours or more



<=6%

STANDARD

4%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: NWL consistently performs well in this domain with lower that average avoidable term admissions to neonatal units (ATAIN). All APC maternity units have transitional care units and ongoing quality improvement projects to maintain best practice. ATAIN audits are reported quarterly as part of Maternity Incentive Scheme and there is a newly formed LMNS Neonatal workstream to share practice and improvements.

Recovery Plan: N/A

Improvements: Review of data sources prior to data submission to ensure complete accuracy.

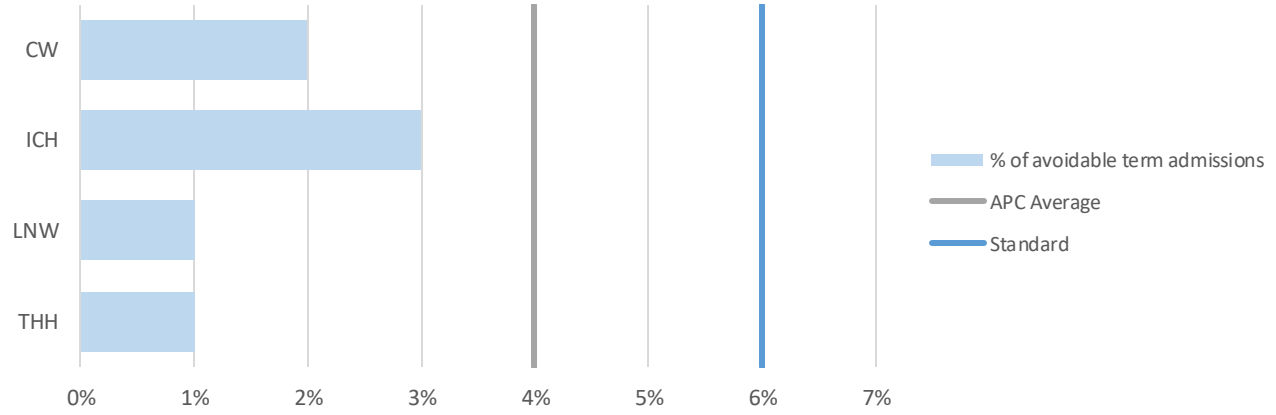
Forecast Risks:. None identified

CURRENT PERFORMANCE

Avoidable Term Admissions in Neonates; proportion of babies >=37 weeks GA admitted to neonatal care for 24 hours or more - **JANUARY**

	Number of Avoidable Term Admissions	Number of Avoidable Term Admissions YTD	% of Avoidable Term Admissions	Difference from Threshold
CWFT	14	138	2%	-4%
ICHT	23	124	3%	-3%
LNW	2	47	1%	-5%
THH	5	45	1%	-5%
APC	44	354	4%	-2%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Tim Orchard, CEO, ICHT
Committee: Acute provider collaborative quality committee

Operational Performance

Operations Summary

Introduction:

The last quarter of the 22/23 financial year has seen unprecedented operational challenges including severe winter pressures, increased numbers of Covid-19 positive patients and industrial action. Despite these challenges the Acute care collaborative has shown sustained improvement in elective recovery performance and maintained UEC performance.

Performance:

The Trusts have all increased activity which is having overall positive impact on long waits. There is a continued reduction in 78 ww and there is reduction in 52ww across the ACC.

January and February have shown strong performance recovery from December.

Theatre utilisation and PIFU have shown positive improvement

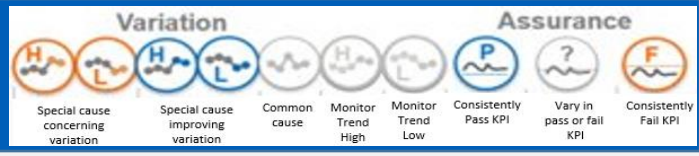
Key Actions:

ED performance requires improvement to be above 76%
Continued focussed work on Discharge with Peer reviews staring in March 2023.

Escalations:

On-going Industrial action is high risk for all domains of performance.

Operations Ambulance Handover Waits



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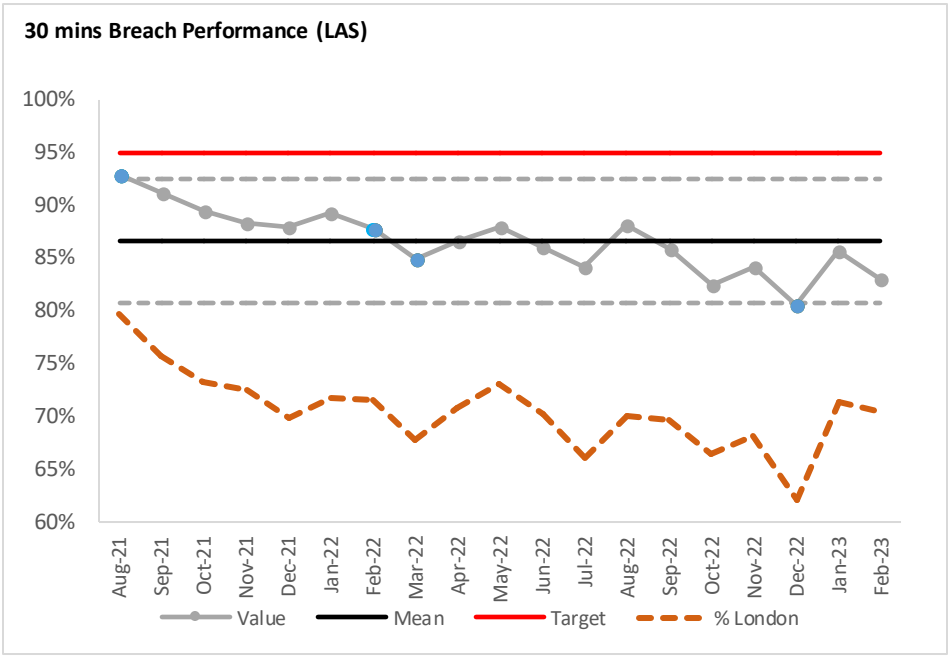


95%

STANDARD

82.9%

PERFORMANCE

TREND

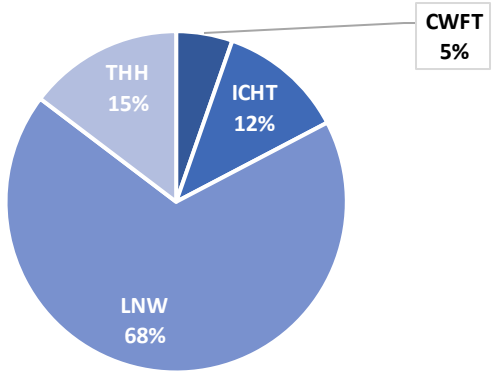
ASSURANCE

CURRENT PERFORMANCE

LAS Handover Waits within the thirty minute standard – **February**

	Total Conveyances	30 mins Performance	Difference from target	30 min + delays	Of which	Impacts on	
					60 min + delays	15 min + delays	LAS time lost (hours)
CWFT	3446	96.9%		107	18	1208	155
ICHT	2549	90.2%	-4.8%	249	8	1061	174
LNW	3984	65.8%	-29.2%	1363	692	2123	3272
THH	1799	83.7%	-11.3%	294	68	699	230
APC	**11778**	**82.9%**	**-12.1%**	**2013**	**786**	**5091**	**3831**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: NWL typically receives c25% of LAS conveyances and accounts for c20% of offload delays. All sites have a focus on minimising delays. Cohorting and rapid release protocols are established at all sites. CWFT and ICHT continue to maintain some of the best handover times in London. The most pressured site is NWPH. Fortnightly meetings are in place with the surge team and LAS to review performance. Redirection of conveyances continues when handover times peak.

Recovery plan: Hospital Ambulance Liaison Officer (HALO) in place at NWPH, a pilot trial of the Remote Emergency Access Coordination Hub (REACH) model, continued focus on discharge to improve overall flow.

Improvements: There is an ongoing effort to promote the use of alternative care pathways including Urgent Community Response (UCR), Same Day Emergency Care (SDEC), virtual ward.

Forecast risks: Industrial action.

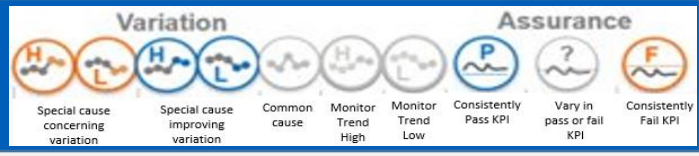
GOVERNANCE

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

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL UEC Board (Chair: Claire Hook)

Data Assurance: These figures are provided by LAS

Operations Urgent & Emergency Department Waits



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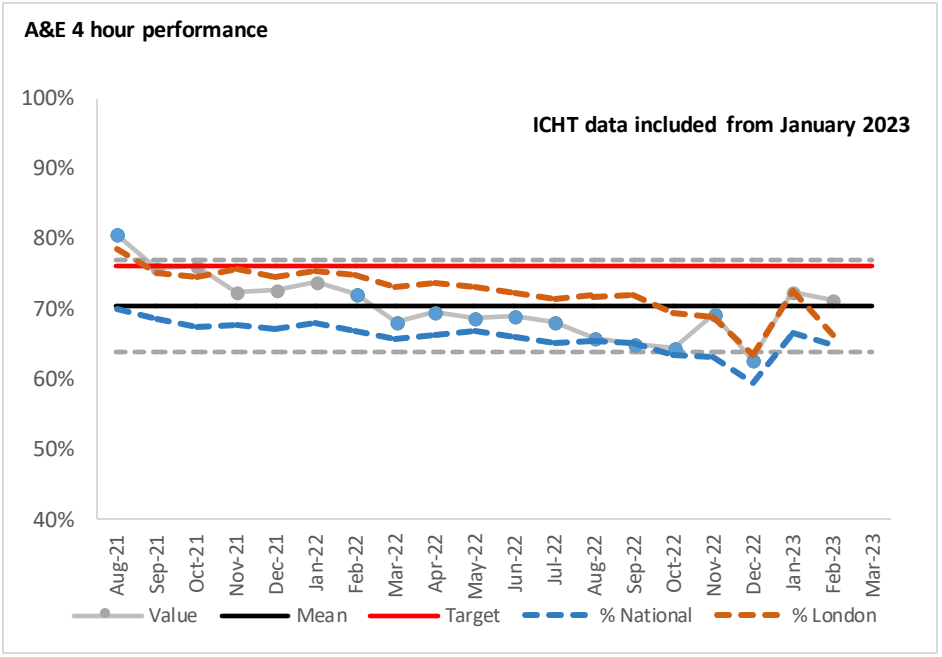


76%

STANDARD

71.2%

PERFORMANCE

TREND

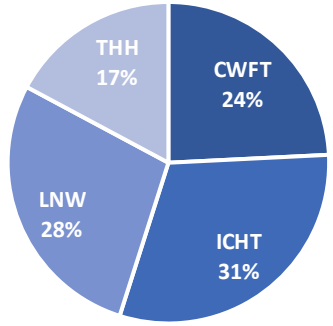
ASSURANCE

CURRENT PERFORMANCE

Time spend in Emergency Department: 4-Hour Standard – **February**

	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	26535	78.3%		5746	5624	69.0%	122	98.5%	1094
ICHT	20382	64.3%	-11.7%	7284	6941	51.4%	343	94.4%	3571
LNW	24097	72.5%	-3.5%	6624	5810	51.0%	814	93.3%	910
THH	11293	63.9%	-12.1%	4077	3642	36.7%	435	92.1%	1070
APC	**82307**	**71.2%**	**-4.8%**	**23731**	**22017**	**56.0%**	**1714**	**94.7%**	**6645**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: CWFT and ICHT recommenced external reporting against this standard at the beginning of March. All emergency departments (EDs) have a plan to improve performance to a minimum of 76% during 2023/24. Changes in the arrangements for the urgent treatment centres placed additional pressure on THH and LNW initially and performance is now improving.

Recovery plan: A range of measures have been implemented to respond to rising UEC demand, improve performance and maintain safe levels of care, including a programme to embed best practice ward routines; expanding same day emergency care (SDEC) services; and opening additional beds in line with the winter plan.

Improvements: All schemes agreed as part of the winter plan have been implemented. All EDs have a local plan to implement recommendations from the NWL peer review. An overarching programme to deliver benefits across the collaborative is being finalised.

Forecast risks: Continued increases in demand, continued delays with discharge for medically optimised patients, further peaks in respiratory infection, industrial action.

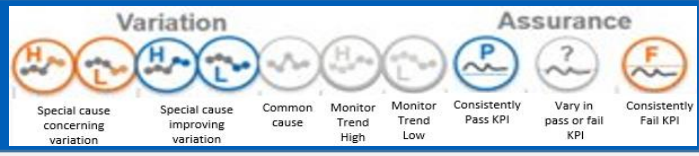
GOVERNANCE

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

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL UEC Board (Chair: Claire Hook);

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

Operations Urgent & Emergency Department Long Waits



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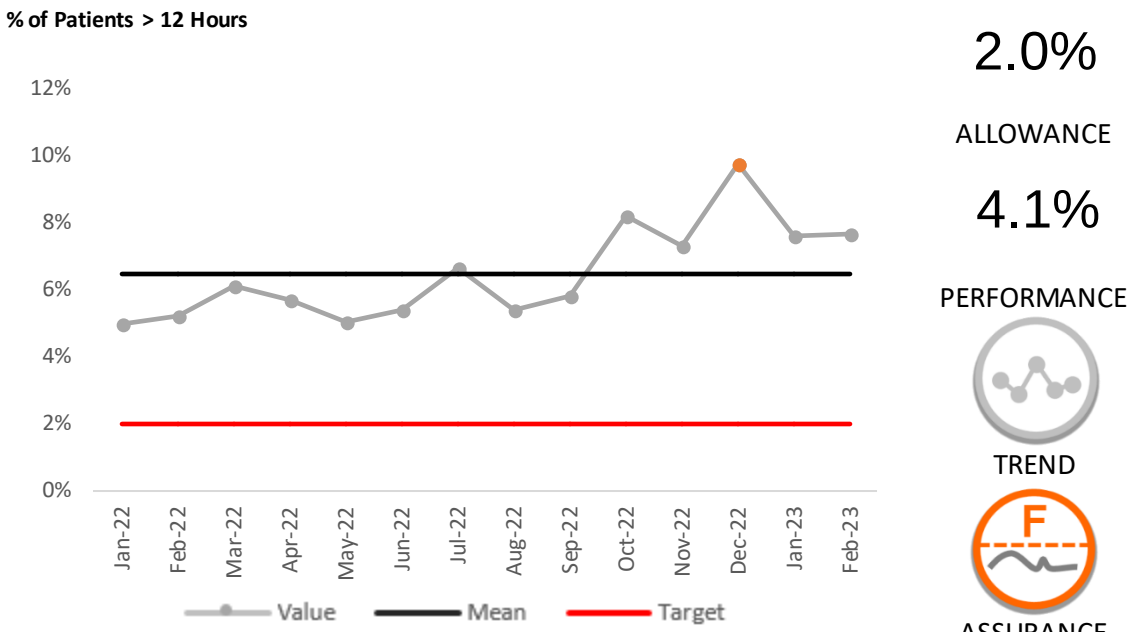


2.0%

ALLOWANCE

4.1%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: Long waits in the ED have increased and are linked to the flow through the hospital as well as those waiting for beds outside the hospital. Late December and early January were particularly pressured due to increased rates of COVID-19, Influenza and other respiratory diseases, coupled with a prolonged period of cold weather on top of already rising UEC demand.

Recovery plan: A range of measures have been implemented to help mitigate these pressures and maintain safe levels of care, including a programme to embed best practice ward routines; expanding same day emergency care (SDEC) services; and opening additional beds.

Improvements: Discharge remains challenging. Additional funded community and Local Authority capacity came on line in January and should reduce delays for patients who are medically optimised waiting in acute beds.

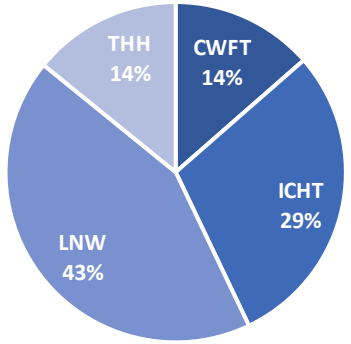
Forecast risks: Continued increases in demand, continued delays with discharge for medically optimised patients, further peaks in respiratory infection, industrial action.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 12-Hour waits - **February**

	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	26535	1.7%		462	462	0	31
ICHT	20382	4.9%	-2.9%	1000	1000	0	76
LNW	24097	6.1%	-4.1%	1463	1463	0	575
THH	11293	4.3%	-2.3%	482	482	0	15
APC	**82307**	**4.1%**	**-2.1%**	**3407**	**3407**	**0**	**697**

STRATIFICATION



Trust share of APC waits longer than standard

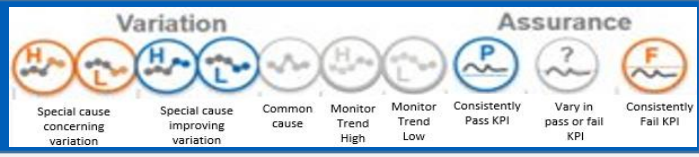
GOVERNANCE

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

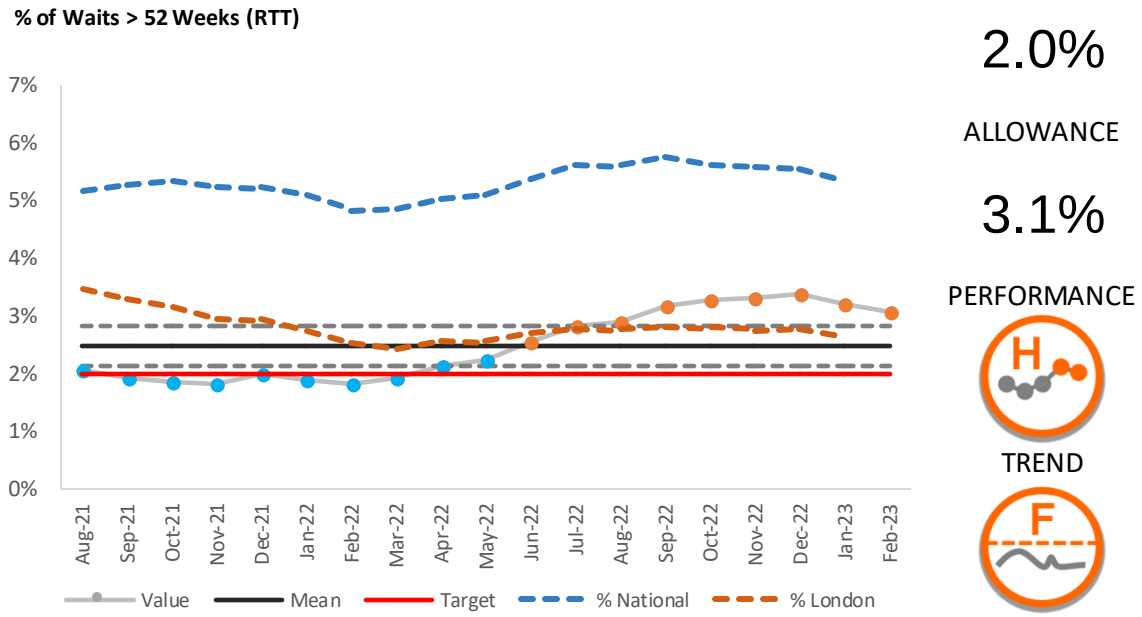
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL UEC Board (Chair: Claire Hook);

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)

Operations Referral to Treatment Waits



TREND



2.0%

ALLOWANCE

3.1%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

The total PTL across the collaborative saw a slight increase of 1.5% in February but remains relatively stable. Overall, there was a slight reduction in 52ww from 8,234 to 8,002.

In February there were no 104ww patients outside of one breach at Imperial which is classified as patient choice and booked in April. Although the collaborative saw a large reduction in 78ww in month, challenges remain in specific specialties: Vascular at CWFT, Allergy at ICHT, ENT at THH and Gynaecology at LNW.

All trusts are finalising demand and capacity modelling and implementation of operational plans to ensure PTL stabilisation, 52ww reductions and 78ww erradication into the new year. Activity levels showed an improvement trajectory through February which supported backlog reductions.

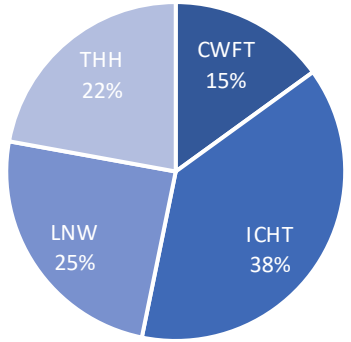
Risks to electives include non-elective winter pressure and further industrial action.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 18-Week Standard - **February**

	Total Waiting List	Waits > 52 weeks	Difference from target	52 + weeks	Of which		Impacted by	Impacts on
					78 + weeks	104 + weeks	OTDCs not booked < 28 days	Average wait (weeks)
CWFT	55196	2.2%	-0.2%	1202	68	0	3	17.49
ICHT	99257	3.1%	-1.1%	3056	47	1	17	18.09
LNW	75585	2.6%	-0.6%	1972	59	0	0	17.73
THH	30617	5.8%	-3.8%	1772	68	0	0	20.88
APC	**260655**	**3.1%**	**-1.1%**	**8002**	**242**	**1**	**20**	**18.19**

STRATIFICATION



Trust share of APC waits longer than standard

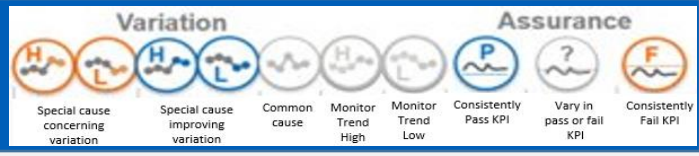
GOVERNANCE

Senior Responsible Owner: Rob Hodgkiss, Deputy CEO and Chief Operating Officer, CWFT

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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

Operations Access to Diagnostics



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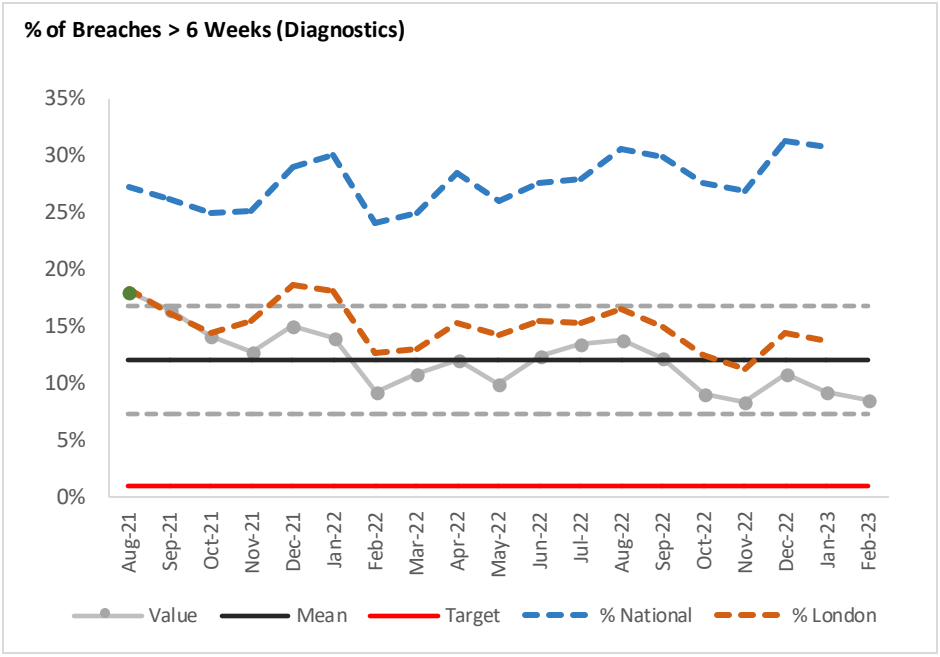


1.0%

ALLOWANCE

8.5%

PERFORMANCE

TREND

F

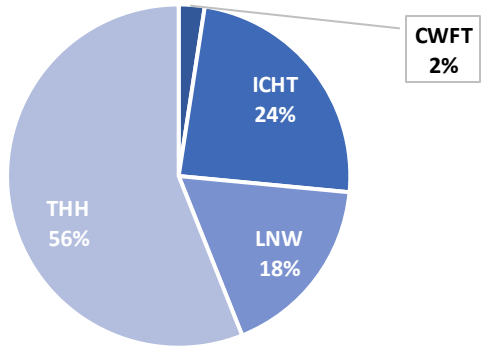
ASSURANCE

CURRENT PERFORMANCE

Waits for Diagnostic Tests: 6-Week Standard - **February**

	Total Waiting List	Waits > 6 weeks	Difference from target	6 + weeks	Of which 13 + weeks
CWFT	9229	0.9%		80	26
ICHT	12736	6.2%	-5.2%	790	221
LNW	10199	5.6%	-4.6%	573	89
THH	6662	27.6%	-26.6%	1839	754
APC	**38826**	**8.5%**	**-7.5%**	**3282**	**1090**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: 6 week breaches has reduced back to pre-Christmas levels. The numbers are largely being driven by Endoscopy at ICHT and MRI at THH.

Recovery Plan: Performance in Endoscopy is currently being impacted by the industrial action in a way that other diagnostics are not. The second MRI scanner at Mount Vernon is driving significant changes in the backlog at THH and this is expected to continue to improve.

Improvements: There has been an overall reduction in the patients waiting over 6 weeks for diagnostics.

Forecast Risks: Industrial action.

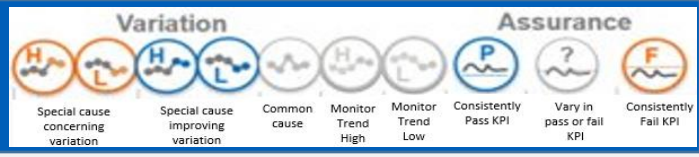
GOVERNANCE

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

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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

Operations Access to Cancer Specialist



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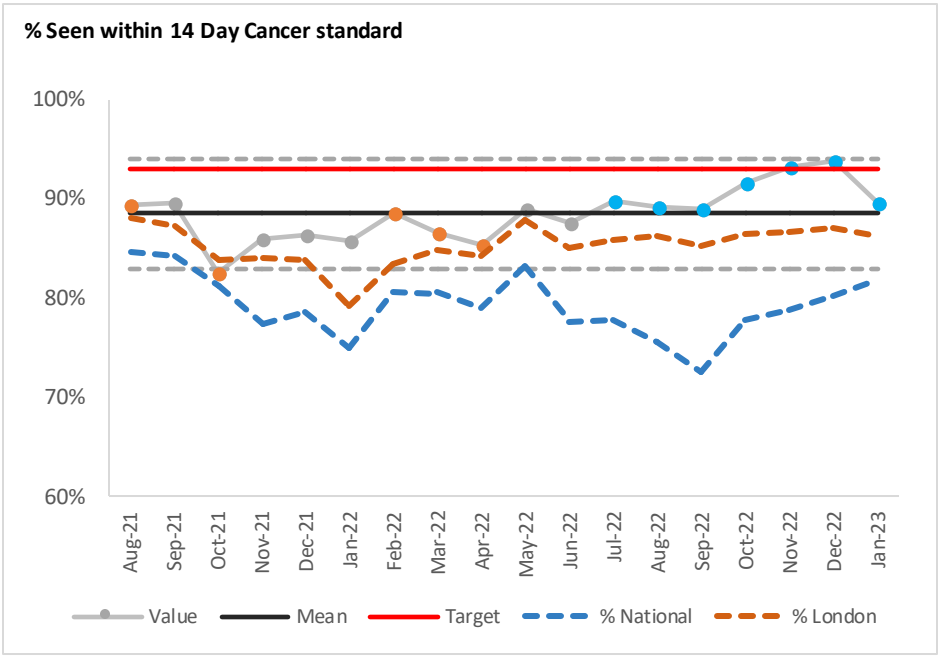


93%

STANDARD

89.6%

PERFORMANCE

TREND

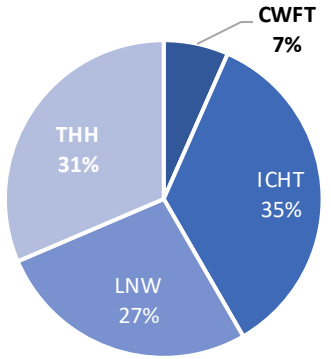
ASSURANCE

CURRENT PERFORMANCE

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

	Total Seen	Two-week wait performance	Difference from target	14 + days	Of which	
					28 + days	Breast symptomatic referrals
CWFT	2030	97.4%		53	11	100
ICHT	2014	86.0%	-6.0%	281	0	169
LNW	2583	91.6%	-0.4%	216	39	244
THH	1105	77.2%	-14.8%	252	40	57
APC	**7732**	**89.6%**	**-2.4%**	**802**	**90**	**570**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance:
Two week wait (2ww) demand remains high. Performance shortfall impacted by diagnostic imaging capacity and specialty pressures in Urology and Gynae.

Recovery Plan:
Continued high focus on cancer patient tracking. Action plans in place for specialty 2ww recovery.

Improvements:
Timed pathway reviews for complex tumour groups and further development of imaging capacity where needed.

Forecast Risks:
Workforce pressures were high in January and February's position will be challenged by Industrial Action.

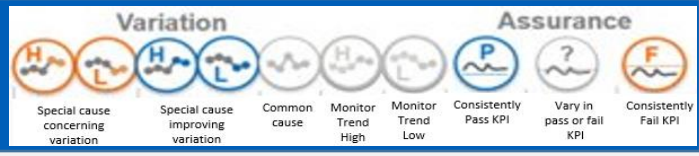
GOVERNANCE

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

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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

Operations Access to Cancer Care (Faster Diagnosis)



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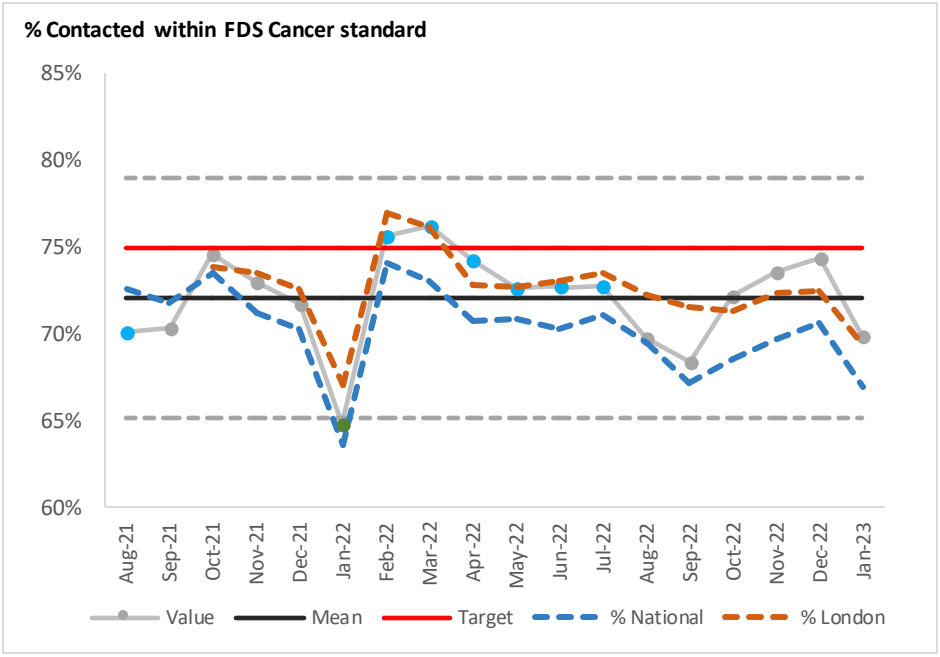


75%

STANDARD

69.9%

PERFORMANCE

TREND

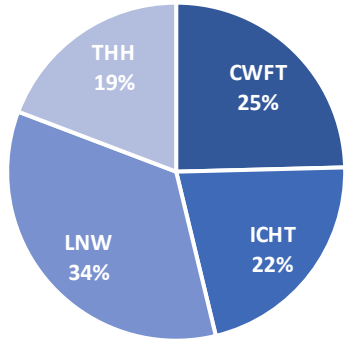
ASSURANCE

CURRENT PERFORMANCE

Access to Cancer Care (Faster Diagnosis) - January

	Total Contacts	Faster Diagnosis performance	Difference from target	28 + days	Of which 62 + days
CWFT	2104	70.9%	-4.1%	613	156
ICHT	1917	71.9%	-3.1%	539	0
LNW	3071	72.0%	-3.0%	861	172
THH	1176	59.3%	-15.7%	479	131
APC	**8268**	**69.9%**	**-5.1%**	**2492**	**459**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance:
FDS performance shows a deterioration in the January data. This has been driven by staffing pressures and diagnostic capacity, particularly MRI.

Recovery Plan:
February performance is expected to show some improvement. THH has additional MRI capacity, which has recently come online.

Improvements:
FDS Champions in place and concentrating on improving referral to diagnosis times.

Forecast Risks:
Workforce capacity and demand pressures were challenging in January. February's position will show some impact of the Industrial Action at certain sites.

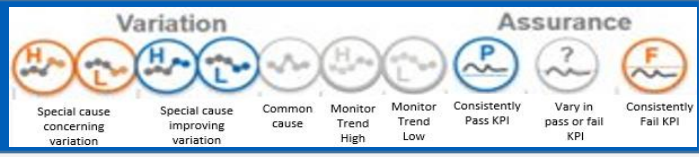
GOVERNANCE

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

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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

Operations Cancer First Treatment from Diagnosis



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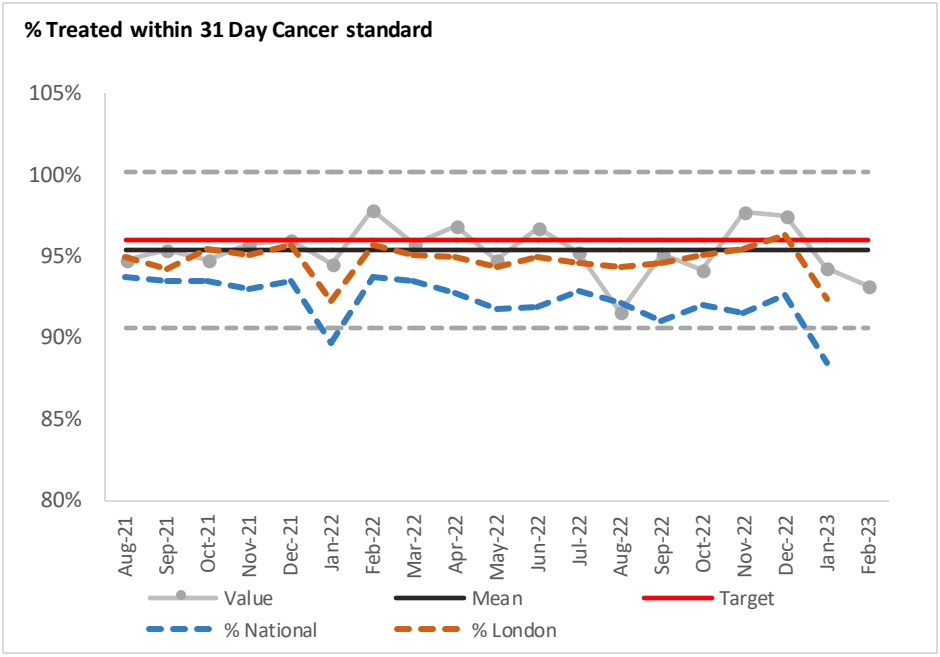


96%

STANDARD

94.3%

PERFORMANCE

TREND

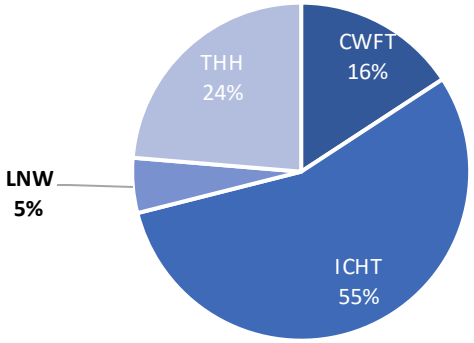
ASSURANCE

CURRENT PERFORMANCE

Cancer Pathways Treated following Confirmed Diagnosis Performance : 31-Day Standard - January

	Total Treated	31 day performance	Difference from target	31 + days	Of which 62 + days
CWFT	118	94.9%	-1.1%	6	2
ICHT	280	92.5%	-3.5%	21	0
LNW	153	98.7%		2	0
THH	120	92.5%	-3.5%	9	0
APC	**671**	**94.3%**	**-1.7%**	**38**	**2**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance:
First Treatment performance fell slightly for January. This was caused mainly by demand pressures.

Recovery Plan:
Continued focus and support to ensure treatment capacity is secure and sustainable.

Improvements:
Maintaining grip and forward planning on treatment pathways.

Forecast Risks:
Workforce and demand pressures were challenging in January. February's position will show some impact of the Industrial Action at certain sites.

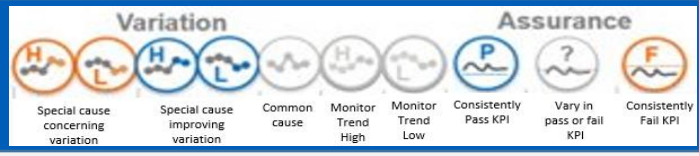
GOVERNANCE

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

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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

Operations Referral to Cancer Treatment Pathways



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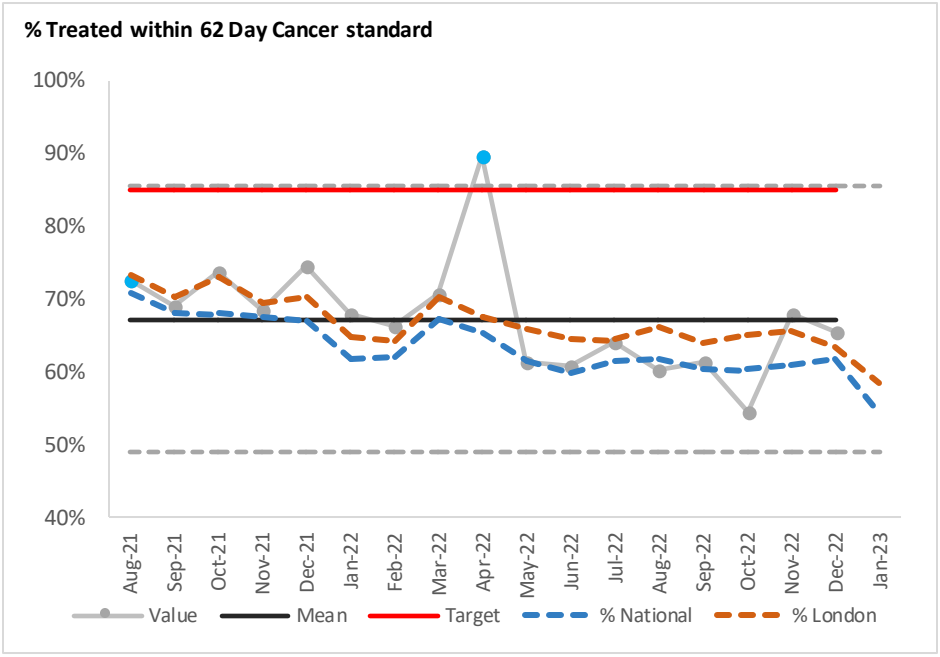


85%

STANDARD

61.0%

PERFORMANCE

TREND

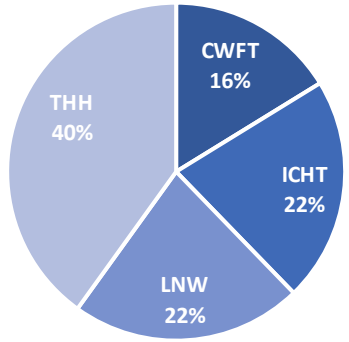
ASSURANCE

CURRENT PERFORMANCE

Unacceptable Waits for the Treatment of Cancer: 62-day Standard - January

	Total Treated	62 day performance	Difference from target	62 + days	Of w hich	Impacts on
					104 + days	Backlog 104 + days
CWFT	86	71.5%	-13.5%	24.5	0	33
ICHT	103	68.4%	-16.6%	32.5	0	57
LNW	104.5	67.9%	-17.1%	33.5	7.5	0
THH	93.5	35.3%	-49.7%	60.5	11.5	10
APC	**387**	**61.0%**	**-24.0%**	**151**	**19**	**100**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance:
62 day backlog recovery continued well, to it's lowest level in the sector this year. However, despite being above the national and England performance level, NWL percentage performance remains challenging. NWL continues on an improvement pathway, with demand pressures impacting performance.

Recovery Plan:
Continued focus on operational resilience and accessing treatment and diagnostic capacity.

Improvements:
Forward planning on 63+ day tip-overs remains stable with good oversight.

Forecast Risks:
Workforce pressures and February's position will show some impact of the Industrial Action at certain sites.

GOVERNANCE

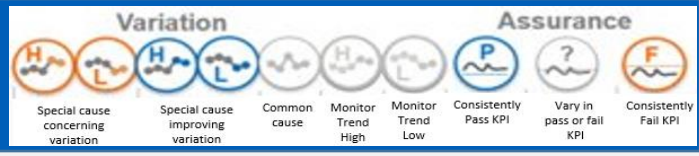
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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

Demand and Capacity Measures

Operations Theatre Utilisation



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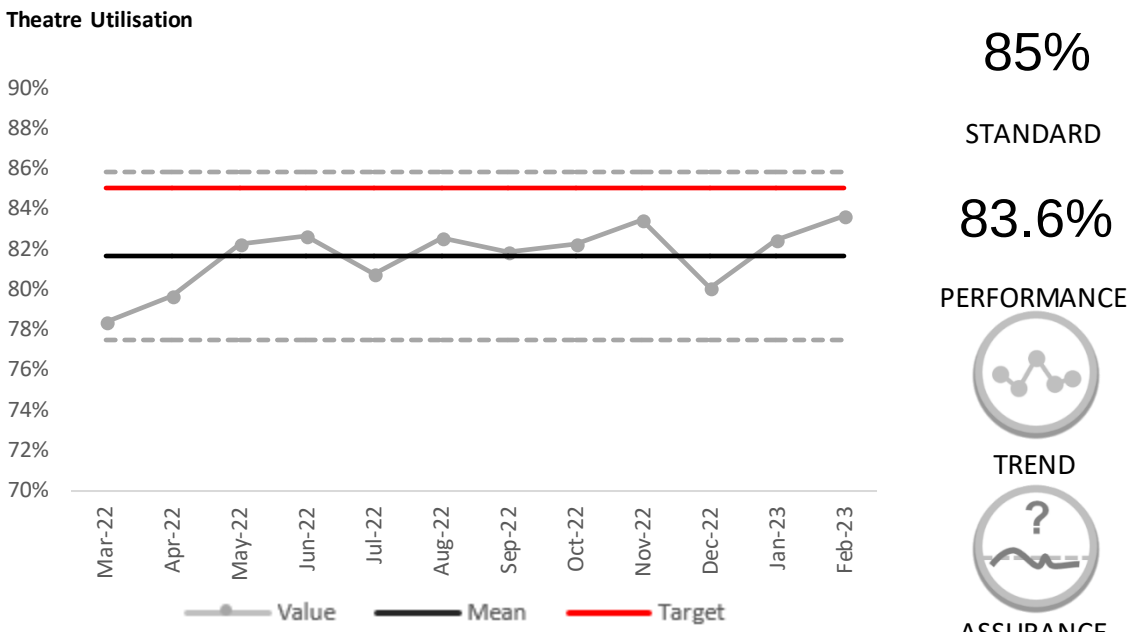


85%

STANDARD

83.6%

PERFORMANCE

TREND

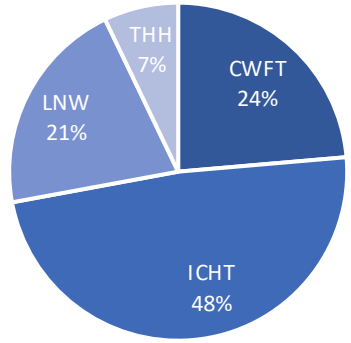
ASSURANCE

CURRENT PERFORMANCE

Theatre Session Utilisation Performance - February

	Planned operating time (hours)	Theatre utilisation	Difference fromtarget	Unused time (hours)
CWFT	2413	82.6%	-2.4%	419
ICHT	4543	81.1%	-3.9%	860
LNW	2752	86.6%		369
THH	1145	89.0%		126
APC	**10853**	**83.6%**	**-1.4%**	**1775**

STRATIFICATION



NARRATIVE

Theatre utilisation has remained on an improvement trajectory since December reaching 83.6% in February. LNW and THH have maintained strong performance. CWFT and Imperial remain behind the 85% national target.

All Trusts remained focused on identifying and delivering improvements in theatre productivity, including work with Productive Partners, digital scheduling and pre-operative assessment pathways.

Key risks include shortages in critical staffing groups and further industrial action.

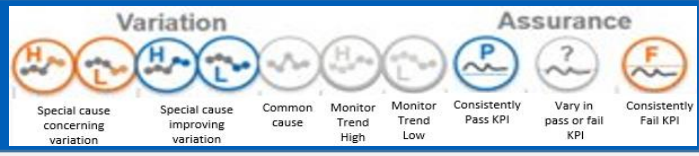
GOVERNANCE

Senior Responsible Owner: Rob Hodgkiss, Deputy CEO and Chief Operating Officer, CWFT

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

Data Assurance: tbc

Operations Outpatient Transformation



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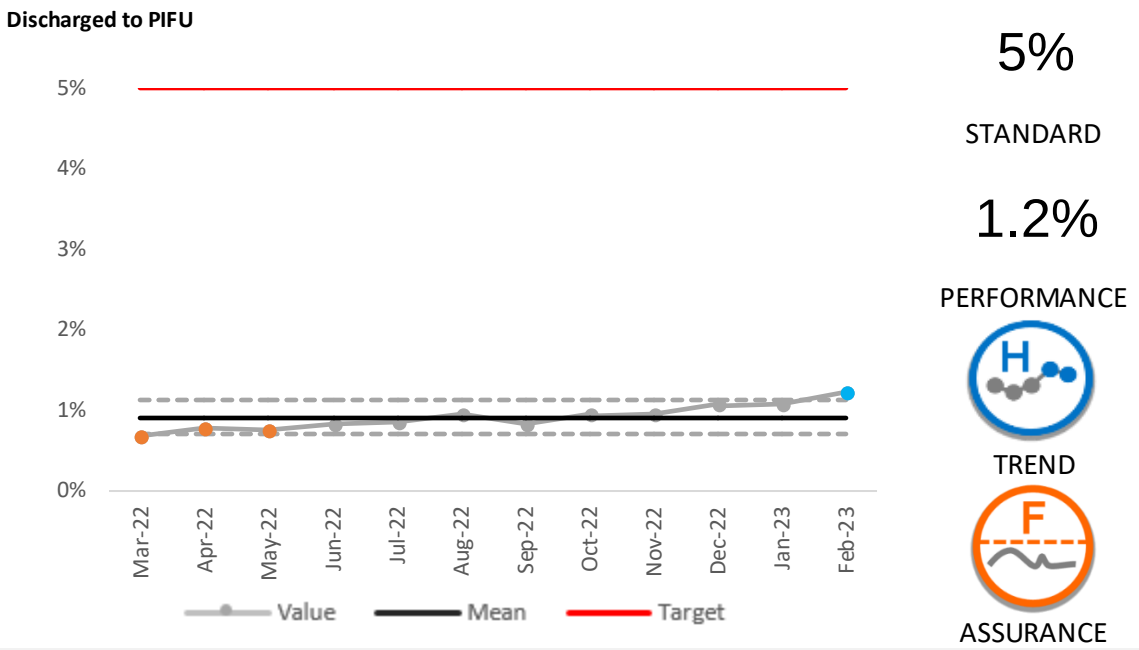


5%

STANDARD

1.2%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

The PIFU pathway has continued on an improvement trajectory since January but still remains behind the National target of 5%. CWFT and THH maintain strong positions in sector but are still below 5%.

All trusts are focused on continued PIFU rollout to more specialities and increasing uptake. Operational planning and implementation plans also support PIFU capacity increases into the new year.

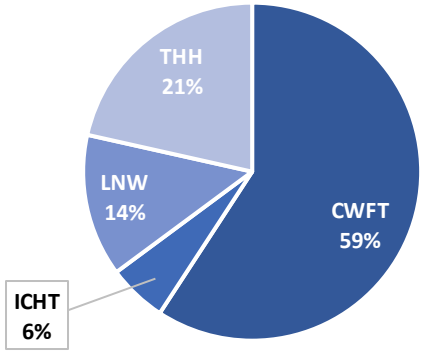
Risks remains around digital infrastructure and implementation during industrial action during Q4 2022/23 and Q1 2023/24.

CURRENT PERFORMANCE

Outpatient Transformation - February

	Total OP contacts	Discharged to PIFU	Difference from target	Moved / Discharged to PIFU	Impacts on OPFA DNAs	Impacts on OPFU DNAs	Impacts on Virtual contacts
CWFT	60991	2.9%	-2.1%	1749	10.5%	9.2%	7785
ICHT	94033	0.2%	-4.8%	167	13.4%	9.6%	19149
LNW	58595	0.7%	-4.3%	403	9.2%	9.8%	13668
THH	28184	2.3%	-2.7%	635	10.3%	8.8%	3620
APC	**241803**	**1.2%**	**-3.8%**	**2954**	**11.0%**	**9.5%**	**44222**

STRATIFICATION



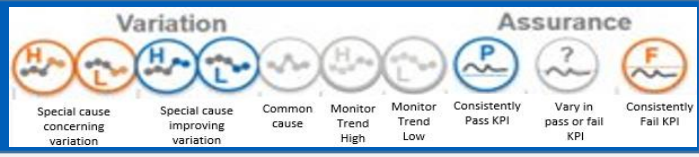
GOVERNANCE

Senior Responsible Owner: Rob Hodgkiss, Deputy CEO and Chief Operating Officer, CWFT

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

Data Assurance: tbc

Operations Critical Care



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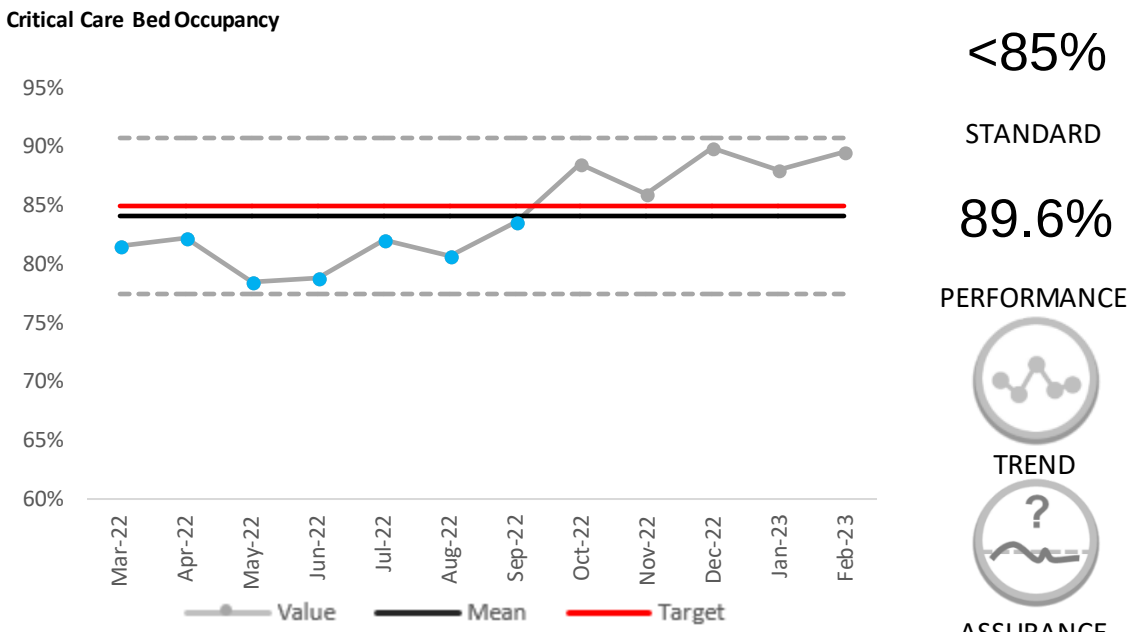


NARRATIVE

Performance: Remains higher than target but operationally within tolerance.

Recovery Plan: Not required at this time

Improvements: Not required at this time.

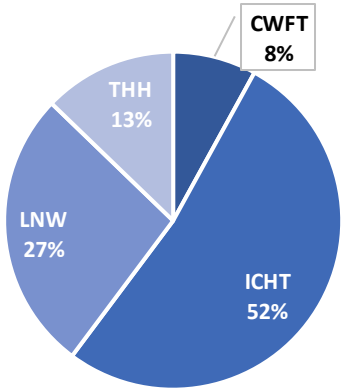
Forecast Risks: None.

CURRENT PERFORMANCE

Critical Care (Adults only) - February

	Available critical care beds	Bed occupancy	Difference from target	Unoccupied critical care beds
CWFT	25	93.6%		1.6
ICHT	100	89.5%		10.5
LNW	56	90.3%		5.4
THH	12	77.8%	-7.2%	2.6
APC	**193**	**89.6%**		**20.1**

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Rob Hodgkiss, Deputy CEO and Chief Operating Officer, CWFT

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

Data Assurance: tbc

Workforce Performance

Workforce Executive Summary

An overview of performance against all indicators, by Trust, is shown in figure 1 using statistical process control variation assurance. In summary three indicators are improving, 2 have worsened and one has seen no change.

Collectively we are reporting an over-establishment of 991 whole time equivalent (WTE) against the reported post establishment WTE position; driven by higher levels of temporary staffing to cover sickness absence, industrial action and elective recovery plans.

Vacancy rates at collaborative level are now a special cause improving and below the collaborative target of 10%. Over the past five months the collaborative vacancy level has steadily reduced to its current position of 9.2% and this reduction in vacancies is the result of targeted recruitment campaigns, both at home and abroad, with a continuing focus to drive further improvement. Collaborative action is focussed on the hard to fill vacancies.

Voluntary turnover is a special cause concern variation but over the last four months, there has been a steady reduction from 13.2% to the current position of 12.8%. All Trusts have active retention projects and / or programmes and a retention programme, supported by national resource, being initiated across the NWL ICS. Acute Collaborative HRDs have shared details of existing retention initiatives, informing planning for future local and collaborative action.

After 12-months of increase, we are starting to see a reduction in the rolling **sickness absence** rate; down from 4.8% in November to the current position of 4.6%. Sickness absence continues to be impacted by Covid-19 resurgences as well as seasonal illness which had a particular impact in January 2023. All Trusts have plans in place to manage absence, particularly long-term absence linked to Covid. Current absence levels are now back to expected seasonal rates.

Agency spend, as a proportion of overall pay bill, is our productivity measure with a collective target set at 2%. Current performance for January 2023 was 4.0%,driven by additional staffing requirement due to impacts of increased sickness as well as industrial action by healthcare workers, and is a special cause concern. 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.

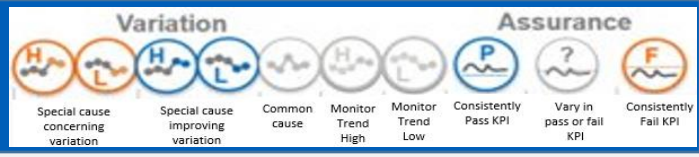
Completion rates, for both non-medical and medical **Performance Development Reviews** (PDR), is also an area of concern. With the exception of non-medical appraisals at Imperial (which have a set window for completion) all Trusts operate a rolling programme for PDRs and are working towards the common target of 95% to drive improvement. Performance in this area has been affected by increased levels of seasonal sickness absence.

Options for KPIs and collaborative action on **Equality, Diversity and Inclusion** have been reviewed. We have proposed that the national employer goals for Race Equality are used as the primary indicator, with the 9 WRES indicators and selected staff survey measures used as secondary metrics and the basis for a collaborative programme of work to be presented to the People Committee in Common.

Escalations by Theme:

- Trust and Collaborative preparedness and planning for impact of industrial action on key performance metrics and continued winter activity.
- High levels of vacancies with specific hard to recruit roles and gaps.
- Increased levels of voluntary turnover and seasonal / Covid sickness absence.

Workforce Vacancies



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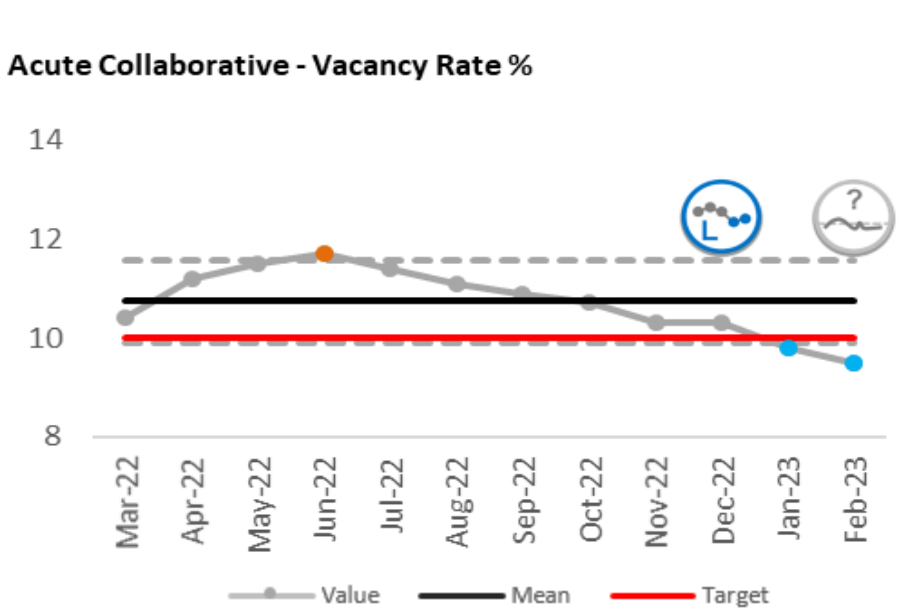


=/<10%

STANDARD

9.5%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Vacancy rates at collaborative level are now a special cause improvement and below the lower process limit and below target. Over the past five months the collaborative vacancy level has reduced to its current position on 9.5%; a result of an overall establishment growth of 267 WTE and an additional 551 WTE staff inpost since October 2022. This reduction in vacancies is the result of successful targeted recruitment campaigns both at home and abroad with a continuing focus to drive further improvement.

Our top five areas of concern continues to be those hard to recruit roles, due to a national shortage of qualified staff; Operating Department Practitioners (30 WTE vacancies), Sonographers (22 WTE vacancies), Occupational Therapists (24 WTE vacancies) and Middle Grades for Emergency Medicine (27 WTE vacancies). 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: Midwives (176 WTE vacant), Physiotherapists, Speech & Language Therapists (5 WTE vacancies), Healthcare Scientists and band 5 nursing roles (677 WTE vacancies) continue to receive focus with continued planned international recruitment campaigns, rolling recruitment and targeted recruitment campaigns to reduce vacancies.

We continue to see increasing numbers of internationally appointed nurses receiving their OSCE and able to practice as registered nurses. This has had a positive impact on general nursing vacancies and we have a strong pipeline to convert more over the coming months. Also of continued focus is the recruitment of midwives and maternity staff, with continued appointments to preceptorship roles, new obstetric nurse roles and scrub/theatre nurses.

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

Forecast Risks: High levels of vacancies puts additional pressure on bank staffing demand at a time of increased activity (winter & elective recovery) and sickness (seasonal & COVID).

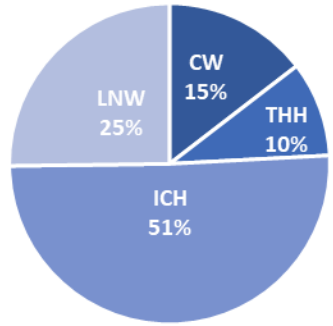
CURRENT PERFORMANCE

Vacancies

	Target %	Month 11 Vacancy Rate %	Variance to Target %	Vacancy WTE
CWFT	10%	6.9%	3.1%	475
ICHT	10%	11.3%	-1.3%	1,653
LNW	10%	9.3%	0.7%	822
THH	10%	8.6%	1.4%	313
APC	**10%**	**9.5%**	0.5%	**3,264**

STRATIFICATION

Trust proportion of vacant WTE across the ACC Month 11



GOVERNANCE

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

Workforce Vacancies by Staff Group

Acute Trusts Staffing Group Vacancies - February 2023	Post WTE	Staff Inpost WTE	Vacant WTE	Vacancy Rate %
Admin & Clerical (bands 1/2/3/4/5/6)	4,958	4,417	542	10.9%
Allied Health Professional (Qualified bands 5+)	1,920	1,762	158	8.3%
Allied Health Professional (Unqualified bands 2/3/4)	317	261	57	17.8%
Ancillary	1,585	1,345	241	15.2%
Doctor (Career Grade)	246	224	22	8.8%
Doctor (Consultant)	2,133	2,055	78	3.7%
Doctor (Training & Trust Grade)	3,313	3,229	84	2.5%
Nursing & Midwifery (Qualified bands 5+)	11,547	10,340	1,207	10.5%
Nursing & Midwifery (Unqualified bands 2/3/4)	3,617	3,322	295	8.2%
Pharmacist	458	452	6	1.4%
Physician Associate	30	38	-9	-28.7%
Scientific & Technical (Qualified bands 5+)	1,330	1,172	157	11.8%
Scientific & Technical (Unqualified bands 2/3/4)	878	739	138	15.8%
Senior Manager (non-clinical bands 7/8/9/VSM)	2,142	1,841	301	14.1%
Other Staff	23	38	-15	-65.2%
Totals	34,497	31,234	3,264	9.5%

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

The overall vacancy rate is 9.5% which has reduced by 9% over the past year; in February 2022 the collective vacancy rate was 10.5%.

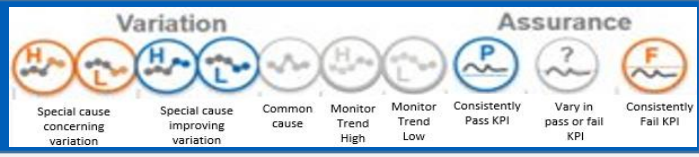
Over the same period, a significant reduction in vacancies has been realised for the ancillary workforce down from 23.5% to 15.2%.

Also for qualified Pharmacist roles, the number of WTE vacancies has reduced from 23 in February 2022 to 6 in February 2023.

In general, there has been a reduction in vacancy rates for all staff groups with the exception of non-clinical senior managers which has increased from 11.6% to the current position of 14.1%

As highlighted previously, within staff groups, there are hard to recruit roles and there is ongoing local and collective focus and action to reduce these.

Workforce Voluntary Turnover



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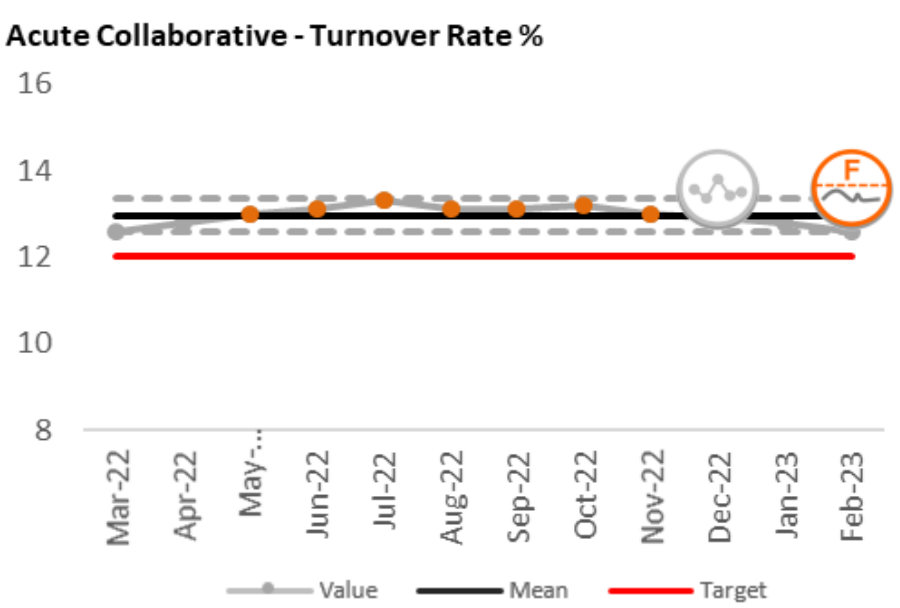


=/<12%

STANDARD

12.6%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Voluntary **turnover** is a special cause concern variation but over the last four months, there has been a steady reduction from 13.2% to the current position of **12.6**%. With the exception of LNW, all Trusts are over target currently. All Trusts have active retention projects and / or programmes and a retention programme, supported by national resource, initiated across the NWL ICS. Acute Collaborative CPOs have shared details of existing retention initiatives to inform planning for future local or collaborative action.

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

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

A prominent reason for leaving is cited as 'relocation' which is not something we can directly influence. In terms of reducing the number of leavers, but hindering analysis and interventions to reduce turnover, is the use of 'other/not known' as a leaving reason and we are working to improve the capture and recording of this data to inform retention plans. A careers hub is proposed as one of the top priorities for 2023/24.

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

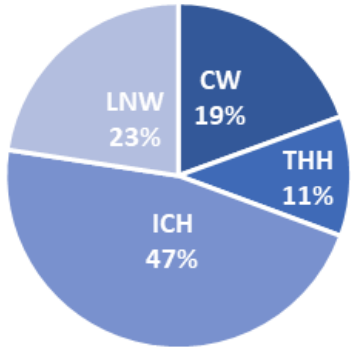
CURRENT PERFORMANCE

Voluntary Turnover

	Target %	Month 11 Turnover Rate %	Variance to Target %	Voluntary Leavers WTE (rolling 12 months)
CWFT	12%	14.2%	-2.2%	779
ICHT	12%	12.5%	-0.5%	1,908
LNW	12%	11.8%	0.2%	915
THH	12%	12.2%	-0.2%	451
APC	**12%**	**12.6%**	-0.6%	4,052

STRATIFICATION

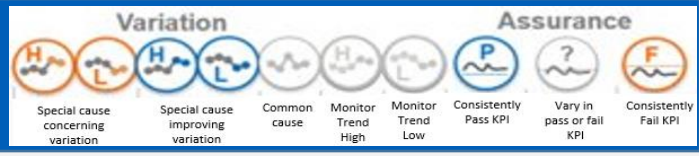
Trust proportion of voluntary leavers wte (rolling 12 months) across the ACC Month 11



GOVERNANCE

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

Workforce Sickness Absence



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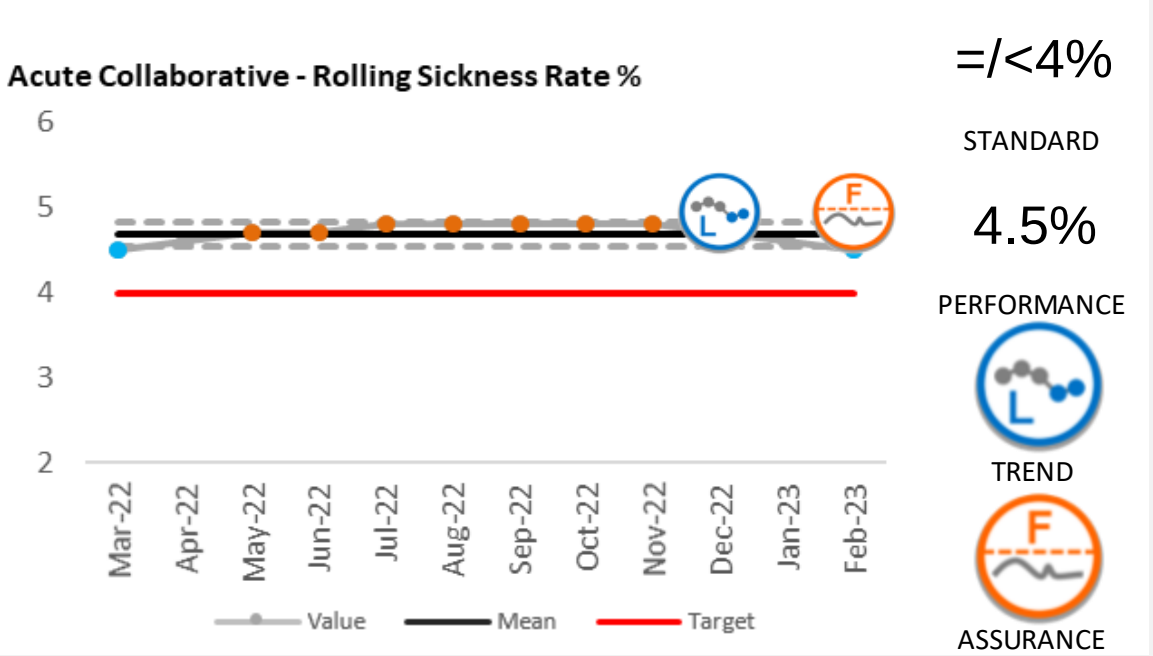

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STANDARD

4.5%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: After 12-months of increase, we are starting to see a reduction in the rolling sickness absence rate; down from 4.8% in November to the current position of 4.5%. Sickness absence continues to be impacted by Covid-19 resurgences as well as seasonal illness which had a particular impact in January 2023. All Trusts have plans in place to manage absence, particularly long-term absence linked to Covid.

Current absence levels are now back to expected seasonal rates. Trusts continue to work locally to re-deploy staff and mitigate safe staffing risks 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 with weekly reporting to North West London Gold (NWL Gold), 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: Increasing seasonal sickness absence levels which could be impacted by a further Covid illness wave

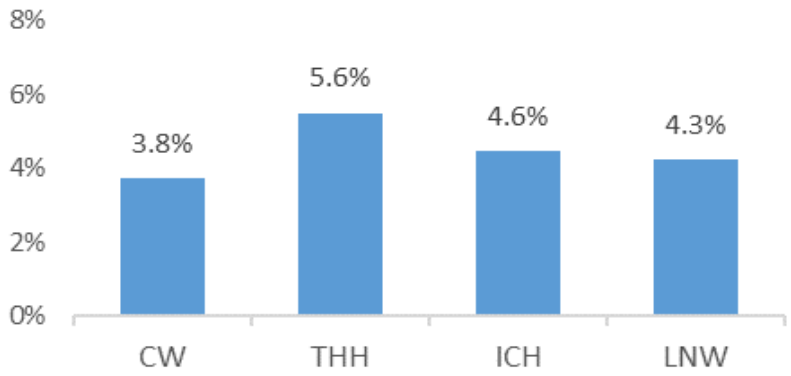
CURRENT PERFORMANCE

Rolling Sickness Absence

	Target %	Month 11 12 Month Rolling Sickness Absence Rate %	Variance to Target %	Month 11 In-Month Sickness Absence Rate %
CWFT	4%	3.8%	0.2%	3.5%
ICHT	4%	4.6%	-0.6%	4.2%
LNW	4%	4.3%	-0.3%	4.4%
THH	4%	5.6%	-1.6%	5.1%
APC	**4%**	**4.5%**	-0.5%	**4.2%**

STRATIFICATION

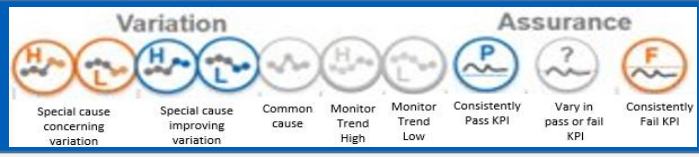
12 Month Rolling Sickness Absence Rate % across the ACC Month 11



GOVERNANCE

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

Workforce Productivity - Agency Spend



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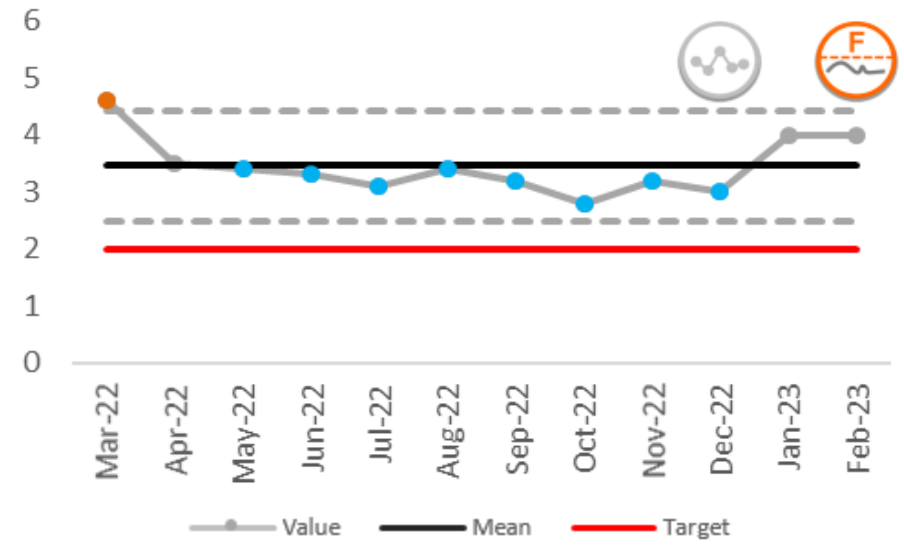


=/<2%

STANDARD

4.0%

PERFORMANCE

TREND

ASSURANCE

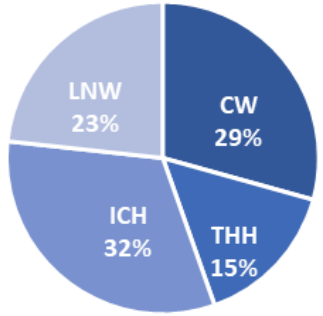
CURRENT PERFORMANCE

Productivity - Agency Spend

	Target %	Month 11 Agency Spend Rate %	Variance to Target %	Agency Spend £ (in Month)
CWFT	2%	4.8%	-2.8%	1,912,356
ICHT	2%	2.7%	-0.7%	2,095,364
LNW	2%	3.2%	-1.2%	1,519,534
THH	2%	5.2%	-3.2%	998,245
APC	**2%**	**4.0%**	-2.0%	**6,525,498**

STRATIFICATION

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



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 January 2023 was 4.0%; driven by additional staffing requirement due to impacts of increased sickness as well as industrial action by healthcare workers, and is a special cause concern.

.

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.

Harmonised and uplifted bank rate for AfC staff are in place across 3 out of 4 Trusts to attract more staff to work on the bank. Transition plans are being agreed for Hillingdon and some specialist areas where existing rates are above the harmonised rates to reduce the risk of bank fill dropping.

Recovery Plan / Improvements: As we continue to move through the winter period, 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.

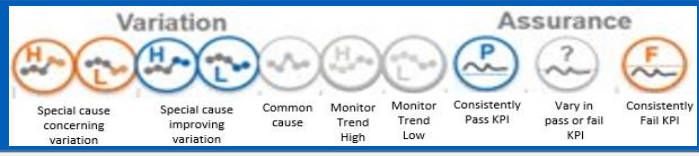
Agency workers, whilst costing more than bank or substantive staffing, are essential for the delivery of some services where staff vacancies are nationally hard to recruit such as sonography, cardiac physiologists and pathology.

Forecast Risks: High levels of vacancies, as we continue to move through the winter period, puts additional pressure on bank staffing demand at a time of increased activity and sickness (seasonal & COVID) and industrial action

GOVERNANCE

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

Workforce PDR / Appraisal



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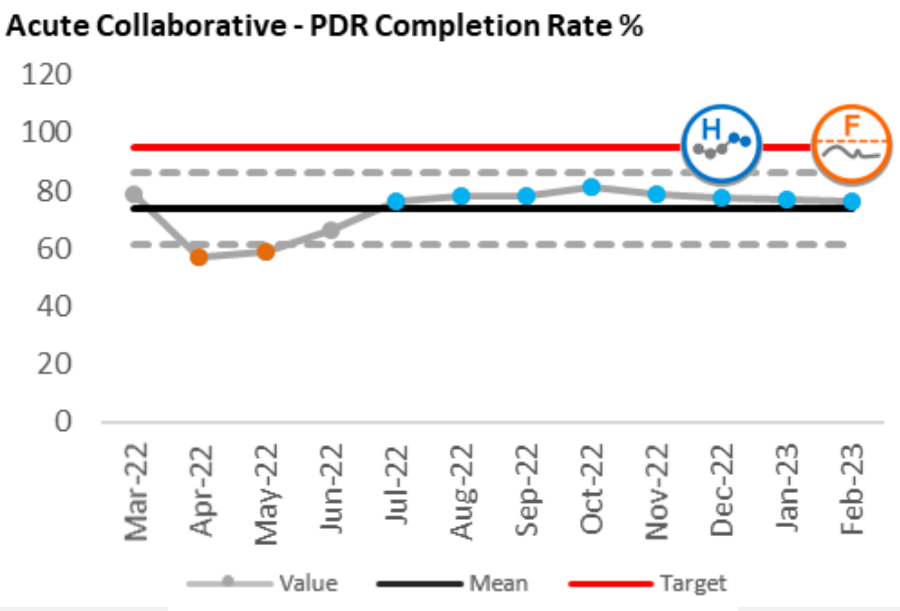


=/<95%

STANDARD

76.5%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Completion rates, for both non-medical and medical **Performance Development Reviews** (PDR), is an area of concern . 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.

Weekly reporting and on-line appraisal training are in place to support improvement against these core workforce metrics.

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, as well as high levels of sickness absence, continue to contribute to the challenge of conducting and completing the appraisal and PDR conversations and, as we go through a period of heightened activity and seasonal sickness.

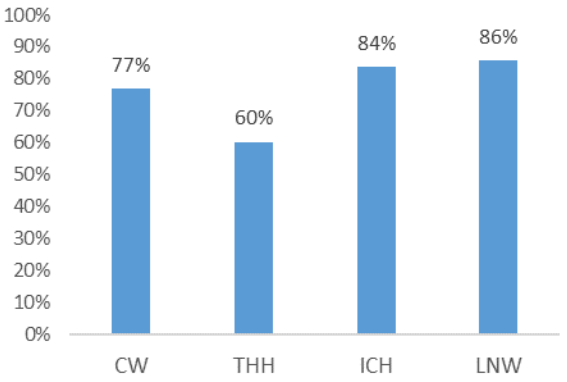
CURRENT PERFORMANCE

PDR / Appraisal

	Target %	Month 11 PDR / Appraisal Rate %	Variance to Target %
CWFT	95%	76.8%	18.2%
ICHT	95%	83.6%	11.4%
LNW	95%	85.6%	9.4%
THH	95%	60.1%	34.9%
APC	**95%**	**76.5%**	18.5%

STRATIFICATION

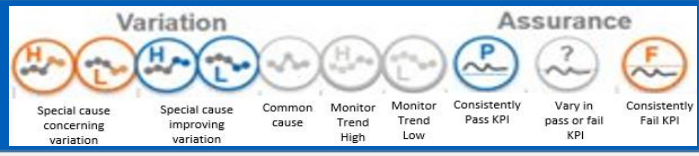
Month 11 PDR / Appraisal Rate % by Trust across the ACC



GOVERNANCE

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

Workforce Core Skills Compliance



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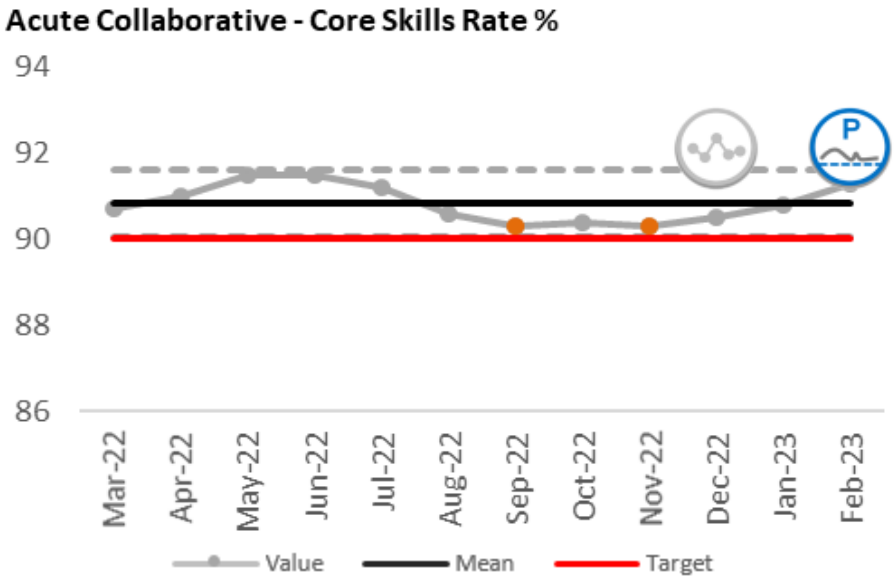


=/<90%

STANDARD

91.3%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Core Skills (statutory & mandatory training) compliance is essential in the delivery of safe patient care as well as supporting the safety of staff at work and their ability to carry out their roles and responsibilities in an informed, competent and safe way (figure 9). Apart from very temporary marginal reductions, all Trusts across the collaborative continue to perform well against their individual targets 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 August and February.

Where possible, auto-reminders are in place for both employees and their line managers to prompt renewal of core skills training as are individual online compliance reports and in addition, further communications have been sent out about how to get previous mandatory training accredited for new starters and doctors on rotation to support compliance.

Forecast Risks: None

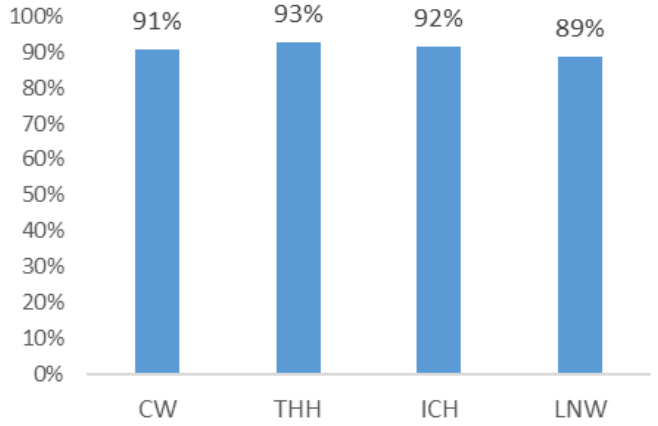
CURRENT PERFORMANCE

Core Skills Compliance

	Target %	Month 11 Core Skills Compliance Rate %	Variance to Target %
CWFT	90%	91.5%	1.5%
ICHT	90%	91.7%	1.7%
LNW	90%	89.6%	-0.4%
THH	90%	93.1%	3.1%
APC	**90%**	**91.3%**	1.3%

STRATIFICATION

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



GOVERNANCE

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

Workforce Equality, Diversity & Inclusion

Proposed Acute collaborative EDI metrics 23/24

Equality Indicator	KPI	Rationale
Gender Pay Gap	% & £ average pay gap	Acute Trusts employ over 70% female staff. Key equity measure to achieve gender pay parity
Women in senior roles	% women in top pay quartile	As above
BME staff in senior roles	% BME in top pay quartile	Acute Trusts employ over 50% BME staff. Key equity measure to increase leadership diversity
BME staff subject to grievance / discipline	% BME in formal procedures	WRES indicator. Goal to monitor and improve BME staff experience.
Staff recording disability	% of disabled staff	Address known underreporting by disabled staff. Campaign to promote disability equality and anti- stigma and improve support and reasonable adjustments
Staff recording LGTBQ status	% of LGBTQ	Address known under-reporting by LGBTQ staff. Campaign to promote equality and anti-stigma and inclusive culture.

Finance

Finance Summary

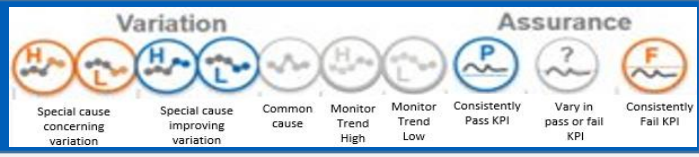
Introduction:
The detailed Finance Report for the Collaborative is included within the Board papers for the meeting. This has been reviewed by the Acute CFO Group and covers the reporting period to Month 11. This pack contains supplementary information on Cost Weighted Activity and Value Weighted Activity metrics, with work in hand to strengthen reporting and validation of these key productivity indicators.

Performance:
At Month 11, the Acute Provider Collaborative (APC) is reporting a year-to-date deficit of £46.3m against a plan of £16.2m deficit - a £30.2m adverse variance. The rate of overspend against budget continues to decrease, as was planned for, with the in-month position being a £2.9m surplus, resulting in a favourable variance of £3.5m. Three trusts report YTD adverse variances to plan, one trust is on plan.
ERF is breakeven against year-to-date planned values. The annual ERF plan is income of £81.5m, the year-to-date plan and actual is £74.7m. The rate of under delivery has significantly declined in the second half of the year due to the agreement to fund ERF in full for NWL ICS. Trusts have also assumed full recovery on Non NWL contracts including NHSE specialised services contracts.
The APC continues to report an adverse variance on the CIP plan, at £31.5m adverse to date with a forecast under delivery of £25.2m. The under delivery is mitigated by non-recurrent measures.
In agreement with the ICB CFO the forecast reported to NHSE at month 11 is to meet the annual plan (a £5.6m deficit).
To note, LNW & THH have received financial support from the NWL ICB (£5.7m and £10.3m respectively) to support these trusts to achieve their year-end plans.

Key Actions:
CFOs continue to review the financial position in detail, both within Trusts and across the Collaborative, and to look at options to strengthen the financial reporting and management arrangements across the Collaborative.

Escalations:
No items have been escalated

Finance Value Weighted Activity – Elective Work



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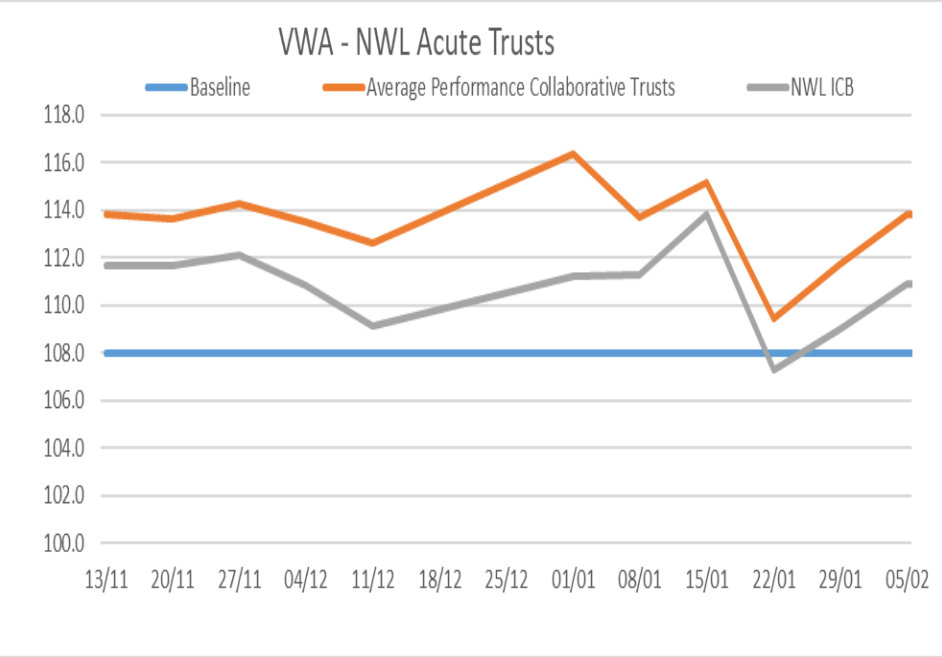


113%

STANDARD

108%

PERFORMANCE

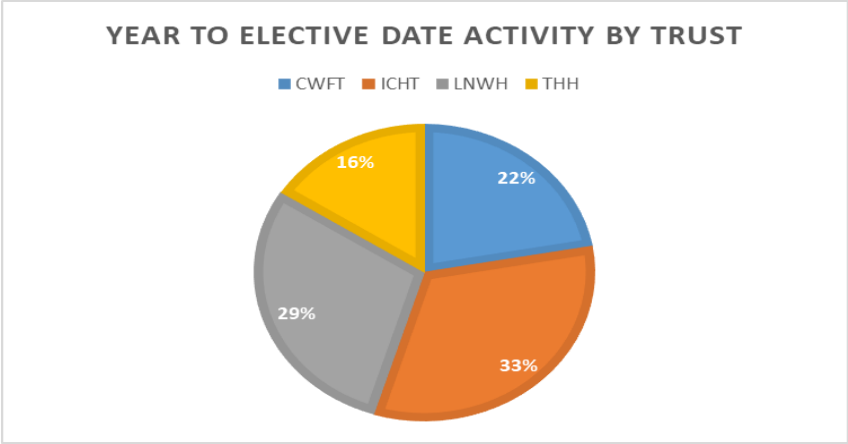
TREND

ASSURANCE

CURRENT PERFORMANCE

	01/01	08/01	15/01	22/01	29/01	05/02	Jan Average
CWFT	135.1	131.5	135.1	130.2	129.8	132.2	132.4
ICHT	113.7	107.8	109.4	101.0	104.3	106.1	107.2
LNWHT	109.7	110.2	110.5	105.0	104.1	105.5	107.9
THH	106.9	105.2	105.5	101.6	108.6	111.4	105.5
Baseline	108.0	108.0	108.0	108.0	108.0	108.0	108.0
Average	**116.4**	**113.7**	**115.1**	**109.4**	**111.7**	**113.8**	**113.3**
NWL ICB	*111.2*	*111.3*	*113.8*	*107.3*	*109.0*	*110.9*	*110.5*

STRATIFICATION



This is a count of the year to date elective activity by Trust which includes day cases, inpatients, outpatient first, follow up and procedures.

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NARRATIVE

Value-Weighted Activity is calculated using the formula (elective activity during 2019/20 in the month/elective activity during 2022/23 in the same month). It gives an indication of the level of elective activity undertaken. The figure used in this calculation is taken from the latest data pack (22nd March). LNW coding delays mean activity increases in later reports, typically in order of 3-4%. **NWL is consistently best performer in London.** Early data from December suggests consistent performance above 107%.

Elective Pathways VWA is published on a weekly basis, using 'faster SUS' data. This typically understates actual delivery due to coding delays for more recent months. **Note that this is not the ERF VWA calculation which is adjusted for a notional cap on outpatient follow-ups in line with the ERF calculations**. The NWL Acute CFO Group is working to consistently review the reporting arrangements for both ERF and VWA.

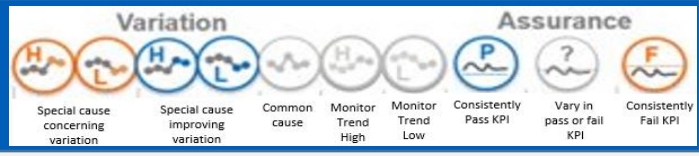
GOVERNANCE

Senior Responsible Owner: Jonathan Reid, Chief Financial Officer, LNW

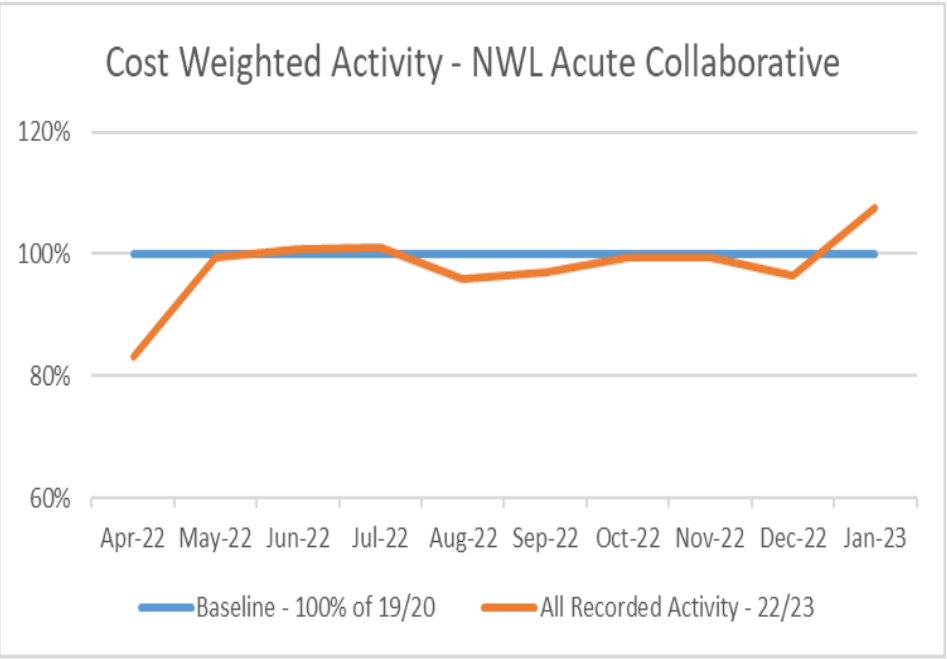
Committee: NWL Collaborative Finance and Performance Committee

Data Assurance: These VWA %'s are published by NHS London. Note timing delay discussed in narrative.

Finance Cost Weighted Activity – All Work (NWL ICB)



TREND



100%

STANDARD

108% (in Jan)

PERFORMANCE

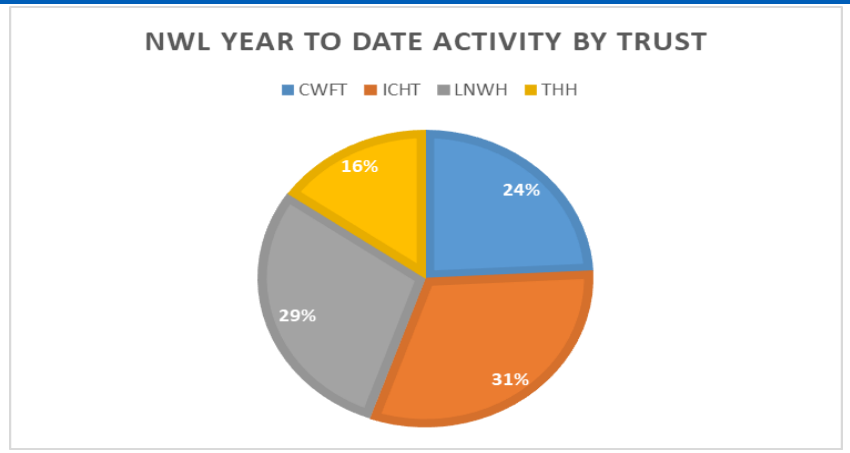
TREND

ASSURANCE

CURRENT PERFORMANCE

NWL Acute Collaborative	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Elective Day Care Spells	(11%)	1%	2%	2%	14%	6%	17%	17%	10%	27%
Elective Ordinary Spells	(16%)	(1%)	(13%)	(3%)	(7%)	(9%)	13%	13%	3%	40%
Outpatients first	25%	36%	4%	10%	19%	11%	28%	28%	7%	17%
Outpatients FU	6%	27%	(2%)	(0%)	14%	4%	19%	19%	(0%)	21%
Outpatients procedure	(32%)	(17%)	(26%)	(33%)	(28%)	(24%)	(31%)	(31%)	(26%)	(21%)
Critical Care	(5%)	19%	13%	25%	17%	45%	36%	36%	(41%)	(14%)
Accident and Emergency	(1%)	6%	5%	3%	2%	(1%)	(0%)	(0%)	(1%)	(1%)
Non-Elective Activity	(27%)	(10%)	3%	2%	(12%)	(7%)	(11%)	(11%)	(16%)	(15%)
All Recorded Activity	**(17%)**	**(1%)**	**1%**	**1%**	**(4%)**	**(3%)**	**(1%)**	**(1%)**	**(4%)**	**8%**

STRATIFICATION



Note that Specialist/Other Commissioners are not included in this initial data set

NARRATIVE

Cost-Weighted Activity is a new metric designed by the ICB. This tests the value of all monthly activity (elective and non-elective) against the 2019/20 activity and contract baseline. Work is in train through the ICB and the CFO group to review the robustness of the underlying data, and to broaden out the reporting approach to include all Commissioner activity – including NHSE and Specialised Commissioners – to give a fuller picture of performance. However, in the interim, CWA gives an initial indication of the extent to which activity levels have recovered to 2019/20 levels. In addition, CFOS are working with the ICB to develop a measure of cost change to support the calculation of an overarching cost/productivity metric for the Collaborative.

After a challenging start to the year, the Trusts are now converging at around 100% of pre-COVID activity, with variation between and across Trusts. **Data to Month 10 (Jan).**

GOVERNANCE

Senior Responsible Owner: Jonathan Reid, Chief Financial Officer, LNW

Committee: NWL Collaborative Finance and Performance Committee

Data Assurance: These figures are published by NWL ICB in partnership with the NWL Acute CFO Group

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 Finance and Performance Committee
23/03/2023
Item number: 4.2
This report is: Public

Finance Report Month 11 Collaborative

Author: Acute CFO Group, supported by Helen Berry
Job title: Assistant Director of Finance

Accountable director: Lesley Watts
Job title: Chief Executive Lead, Finance and Performance

Purpose of report

Purpose: Assurance

This report sets out the financial position of the Collaborative at Month 11, noting that all four Trusts are forecasting delivery of their financial plans after agreement with the ICB on the year-end financial position. The report sets out the combined position across the four Trusts and brings to the attention of the Committee any material variances and risks, including actions to address these.

Report history

The Collaborative Finance Report is drawn by Helen Berry on behalf of the CFOs, and reviewed through the Acute CFO Group. It is, as appropriate and where timing permits, shared with the Acute Programme Board and the Joint Executive Group. The report is aligned with the internal reporting at each of the four Trusts.

Acute CFO Group Virtually in advance of submission Agreed		Committee name Click or tap to enter a date. What was the outcome?

Executive summary and key messages

Each of the Trusts has a Finance and Performance Committee which monitors financial performance and ensures that appropriate action is being taken to mitigate risks. The Acute CFO group supports and enables collaborative working across the four Trusts on financial matters and ensures alignment in working with the ICB.

At month 11 the Collaborative reports a forecast which meets the annual deficit plan of £5.6m, in agreement with the ICB CFO.

At month 11, the Acute Provider Collaborative (APC) is reporting a year to date deficit of £46.3m, against a plan of £16.2m deficit - a £30.2m adverse variance. The rate of overspend against budget continues to decrease, as was planned for, with the in-month position being a £2.9m surplus, resulting in a favourable variance of £3.5m. Three trusts report YTD adverse variances to plan, one trust is on plan. The drivers are:

Cost Improvement Programmes (CIP): The APC continues to report an adverse variance on the CIP plan, at £31.5m adverse to date with a forecast under delivery of £25.2m. The under delivery is mitigated by non-recurrent measures. Trusts have been reviewing the non-recurrent delivery as part of the preparation of 2023/24 financial plans including CIP plans. Non recurrent CIP impacts the overall underlying position of the APC and the financial planning process for 2023/24 has included a refresh of the underlying position. Acute CFOs continue to review the efficiency and productivity programmes within their Trusts on a formal and regular basis. The Acute Efficiency Leads Group meets regularly, working in joint partnership on planning for 2023/24 schemes and other projects such as standardising the CIP measurement and processes throughout the ACP.

Operational Pressures: Expenditure on operational pressures including the opening of additional winter capacity supported by the use of agency staff has continued to cause pressure on operational budgets during the month.

Inflation: Continued rises to CPI has significantly impacted Trust's expenditure, particularly increased utility prices and the impact of the National Living wage increases on contracted out services. The CFOs are reviewing key elements of this expenditure to support actions to mitigate where possible. However, the risk remains that these costs cannot be fully mitigated within the current financial envelopes.

Elective Recovery Funding (ERF): At month 11 ERF is breakeven against year to date planned values. The annual ERF plan is income of £81.5m, the year to date plan and actual is £74.7m. The rate of under delivery has significantly declined in the second half of the year due to the agreement to fund ERF in full for NWL ICS. Trusts have also assumed full recovery on Non NWL contracts including NHSE specialised services contracts, in line with advice received.. Income teams continue to work on assessing the VWA calculations upon which ERF is earned, this is complex, so there remains a very small risk that around ERF recovery in the last month of the year (for non NWL contracts). The Elective Care Board, plus Trust Recovery Groups, continues to support a steadily improving performance. Trust CFOs are working closely with COOs, and with the ICB CFO to confirm Q4 elective performance and establish trajectories for the 2023/24 financial year to meet the published targets for trusts and the ICB

The paper notes that the four Trusts are forecasting delivery of the capital and cash plans.

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

N/A

North West London Acute Provider Collaborative

Month 11 (February 2023) Financial Performance

Jonathan Reid, LNWH CFO.

Helen Berry, Asst Director of Finance

Executive Summary

Financial Performance

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Operational Pressures: Expenditure on operational pressures including the opening of additional winter capacity supported by the use of agency staff has continued to cause pressure on operational budgets during the month.

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Forecast: At month 11 the APC reports a forecast which meets the annual deficit plan of £5.6m, in agreement with the ICB CFO.

Collaborative Financial Performance to Month 11

NWL Acute Collaborative (Month 11 Financial Performance)

2022/23	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	280,795	301,938	21,143	3,093,176	3,189,076	95,900	3.1%	3,374,945	3,497,679	122,734
Pay	(168,224)	(185,232)	(17,008)	(1,861,769)	(1,962,960)	(101,191)	-5.4%	(2,029,588)	(2,143,316)	(113,728)
Non-Pay	(108,373)	(110,382)	(2,009)	(1,193,245)	(1,224,494)	(31,249)	-2.6%	(1,301,661)	(1,318,074)	(16,413)
Non Operating Items	(4,891)	(3,542)	1,349	(54,365)	(47,973)	6,392	11.8%	(49,296)	(41,889)	7,407
Total	**(693)**	**2,782**	**3,475**	**(16,203)**	**(46,351)**	**(30,148)**	**-186.1%**	**(5,600)**	**(5,600)**	**0**

At Month 11, the APC is £30.1m adverse to plan, with a favourable variance against plan in the month of £3.5m. The favourable in month position reflects an expected reduction in the run rate in Q4 as a result of full recovery of ERF income and other income streams agreed to support the year end position.

The in month pay adverse swing is higher than the previous month by £3m (£17m compared to £14m), in part due to a full month's operating of the UTCs at LNWH & THH (compensated by an equal amount of income). Non pay is adverse by £2m reflective of some significant non recurrent benefits (NWL Pathology) being brought in the previous month. The income variance is slightly higher than previous months as additional income from the ICB continues to be accounted for throughout Q4 (at LNWH and THH) to support the year end position and income (and costs) are included for the operation of the UTCs at LNWH & THH.

The year to date and in month overspend on Pay is in part as a result of the payment of the 2022/23 agenda for change and consultant's pay award from month 6, which is partially compensated for by a favourable position on income where the corresponding funding for the pay award is reported. In addition, pressures on the pay budget are reported on CIP delivery, ICU, theatres and temporary staffing to cover vacancies, sickness and the specialling of mental health patients. The harmonisation of AfC bank rates across the sector from Nov 22 has added to the impact. Winter pressures causes a further burden on the pay budget during February.

Pressures on the non pay budget are primarily caused by excluded drugs and devices spend and Inflationary pressures which impact materially on non-pay, linked to increased utility prices.

At Month 11, Trusts are reporting a forecast which meets the submitted plans.

Collaborative Financial Performance to Month 11 by Trust

NWL Acute Collaborative (Month 11 Financial Performance by Trust)

2022/23	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
THH	(1,069)	1,816	2,885	(15,863)	(20,388)	(4,525)	(5,600)	(5,600)	0
LNWH	280	2,250	1,970	(273)	(7,892)	(7,619)	0	0	0
CWFT	96	234	138	(67)	(39)	28	0	0	0
ICHT	0	(1,518)	(1,518)	0	(18,032)	(18,032)	0	0	0
Total	**(693)**	**2,782**	**3,475**	**(16,203)**	**(46,351)**	**(30,148)**	**(5,600)**	**(5,600)**	**0**

The position by Trust notes that all Trusts report adverse YTD variances to plan with one slightly above plan.

In agreement with the ICB CFO the forecast reported to NHSE at month 11 is to meet the annual plan (a £5.6m deficit).

To note, LNWH & THH have received financial support from the NWL ICB (£5.7m and £10.3m respectively) to support these trusts to achieve their year end plans. For THH this support allows the Trust to mitigate £5.3m of impairments.

During Q4, additional income streams and non recurrent benefits, as well as cost control measures already in place are supporting the APC in achieving a significant reduction in the run rate for the last quarter to realise the achievement of the £5.6m deficit plan by financial year end. Most of these benefits will be accounted for in the final month of the year.

Month 11 ERF Income Summary

In agreement with the NWL ICB, full achievement of YTD planned ERF income is reported. ERF earned from all commissioners – NWL, non NWL and NHSE is almost breakeven.

The ERF position has changed significantly since H1 (£14.9m adverse) due to the agreement to fund ERF in it's entirety to planned values at NWL ICB.

ERF elective activity targets for 2023/24 have been published and Trusts have set operational and financial plans to meet the overall ICB target (108% compared to 19/20 valued weighed activity, the target in 22/23 is 104%).

ERF impact on I&E to Month 11

	Ann Plan ERF £000	Plan to date £000	Actual to date £000	Variance £000
CWFT	19,947	18,285	18,285	0
ICHT	33,464	30,675	30,675	0
LNWH	19,751	18,105	18,105	0
THH	8,296	7,605	7,605	0
Total	**81,458**	**74,670**	**74,670**	**0**

Month 11 CIP Summary

Efficiency Month 11	YTD Plan			YTD Actuals			YTD variance	Annual Plan			Annual Forecast			Fcast Variance
	R £000	NR £000	Total £000	R £000	NR £000	Total £000	£000	R £000	NR £000	Total £000	R £000	NR £000	Total £000	Total £000
CWFT	20,905	0	20,905	10,404	5,751	16,155	(4,750)	22,900	0	22,900	11,654	11,246	22,900	0
ICHT	33,916	0	33,916	4,463	8,094	12,557	(21,359)	37,000		37,000	5,074	10,417	15,491	(21,509)
LNWH	26,925	0	26,925	7,877	19,233	27,110	185	30,000	0	30,000	8,811	21,189	30,000	(0)
THH	10,560	0	10,560	2,789	2,154	4,943	(5,617)	12,000	0	12,000	5,856	2,444	8,300	(3,700)
Total	**92,306**	**0**	**92,306**	**25,533**	**35,232**	**60,765**	**(31,541)**	**101,900**	**0**	**101,900**	**31,395**	**45,296**	**76,691**	**(25,209)**

At Month 11, CIP delivery is under target by £31.5m for the Acute Collaborative. All trusts have supported their year to date delivery with non recurrent measures totalling £35m to date.

The overall forecast at month 11 is an under delivery against plan of £25.2m with £45.3m of non recurrent measures supporting this this position. However, to note the Collaborative is forecasting to meet it's 2022/23 financial target, thus the year end adverse variance reported in CIP delivery is mitigated in year by financial control actions including further non recurrent measures. CIP forecasts are reviewed monthly in line with the overall forecast refinement.

<u>Actions to address CIP delivery include:</u>

- Common methodology for measuring CIP across the collaborative (from 23/24) to ensure consistency of reporting agreed.
- Acute Collaborative Efficiency group meets regularly with agreed TOR to facilitate CIP delivery across the sector..
- Trusts' HFMA financial sustainability audit results comparison exercise completed to benchmark results with the aim of driving best practice.
- Planning 23/24 Productivity and Efficiency schemes at the Collaborative level underway.

Month 11 Capital Summary

At Month 11, the APC reports a £33.5m underspend against the year to date capital plan, with a current forecast overspend of £30.7m; greater than the notified CRL. However this position is not expected to result in a full year overspend as the capital control totals have increased to reflect the funding due. The underspend at THH reflects changes to the timing of the new hospital build.

This additional schemes are a result of the approval by NHSE of major strategic projects under national capital programme and the Targeted Investment fund (TIF):

National Capital Programme:

- Community Diagnostic Hubs
- Digital Diagnostic Capacity (Imaging and Pathology)
- Digital (Cerner implementation at THH and LNWH and the Patient Engagement Portal)
- Investment to support Endoscopy capacity.
- MRI acceleration software, gamma camera, MRI enabling works

Capital	Year to date Month 11			Annual 22/23		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	26,627	21,468	5,159	34,148	32,955	1,193
ICHT	66,400	61,232	5,168	72,998	103,489	(30,491)
LNWHT	27,214	40,698	(13,484)	31,638	66,462	(34,824)
THH	51,175	14,531	36,644	58,376	24,986	33,390
Total	**171,416**	**137,929**	**33,487**	**163,012**	**194,937**	**(30,732)**

Targeted Investment Fund:

- Elective Orthopaedic Centre LNWH
- Ambulatory Diagnostic Centre CWFT
- Treatment Centre Redevelopment CWFT
- CT & Cath lab ICHT
- Western Eye Hospital Theatres ICHT

Month 11 Cash Summary

At Month 11, the APC reports a cash balance of £440.8m, a reduction of £76.4m since the beginning of the financial year.

Three trusts report a decrease in their cash balances and one trust reports an increase.

The decrease reflects payment of creditors including capital creditors towards the end of the financial year. In addition the decrease is also as a result of year to date adverse I&E positions.

The increase at CWFT relates to an increase in NHS income receipts.

Cash balance	31 March 2022	28 February 2023	Movement
NWL APC	£'000	£'000	£'000
CWFT	152.82	179.59	26.77
ICHT	237.50	171.70	(65.80)
LNWH	70.44	66.96	(3.47)
THH	56.42	22.50	(33.92)
Total	**517.17**	**440.75**	**(76.42)**

Acute Collaborative Trust Summary Narrative

THH:

The Trust is reporting a £20.4m deficit against a £15.9m deficit plan at the end of month 11, a £4.5m adverse variance to date. The position in month 11 is a £2.9m favourable variance. The ICB support is not yet reflected in the YTD position.

The in-month position includes accrued benefits totalling £3.6m and a £1.7m credit note related to the Trust's share of surplus from NWL Pathology.

The high number of junior doctor gaps has continued into month 11, in addition to higher costs for premium agency usage to cover consultant vacancies and sickness levels. RMN usage has reduced by c30% in the month, to £0.08m below the trend.

The Trust remains on target to deliver the planned deficit of £5.6m with agreed support from the ICB and after accounting for £5.3m of impairments that would impact on the Trust's adjusted financial performance.

CWFT:

At month 11 the Trust is reporting an in-month deficit of £0.23m and a YTD deficit of £0.04m. This is £0.14m favourable against the plan in month and £0.03m favourable YTD. The Trust is forecasting to deliver its breakeven plan in 2022/23. The expenditure includes the reversal of impairments of £7.3m arising from the annual valuation exercise of the Trust's estate, although this doesn't impact the Trust's adjusted position.

ERF income is recognizing full achievement for all commissioners. The Sexual Health contract is also a driver of income above planned values.

Overspend on the pay budget (£3.34m YTD) is caused in part by the opening of significant additional capacity to support winter pressures, which is offset by income. Other pressures are CIP slippage, medical pay and pass-through drug costs.

The grip and control framework continues to address increases in run rate and the governance arrangements for divisions adverse to plan to review and mitigate the gap on the CIP

LNWH:

The year to date position is a deficit of £7.9m, a £7.6m adverse variance to plan and compared to last month is a headline improvement., at £2.2m favourable variance in the month.

The ICB support of £5.7m is accounted for in full in Month 11. ERF continues to be shown as being to plan in line with guidance.

The year end forecast remains on plan (breakeven) & assumes the impact of the recent industrial action will not materially affect the outlook

The Month 11 position includes £1.7m of costs related to the running of the UTC with an assumption of income to match. The Trust is working through with the ICB on the ongoing funding arrangements.

The Trust's Financial Delivery Group continues to ensure financial control is maintained by monitoring transformational and CIP delivery and the Grip and Control Framework, including setting actions to improve financial sustainability.

ICHT:

At Month 11, the Trust is reporting a £18m deficit YTD against a breakeven plan. The key net driver for this adverse position continues to be the under delivery of efficiency target. There remain additional cost pressures in theatres, trauma and critical care where pay spend is above plan due to ongoing reliance on additional temporary staffing including the use of off-framework agency. ERF income is breakeven against plan and assumes no 'claw back' of funding where activity is below target as per national guidance and agreed with the NWL ICS CFO.

The Trust is forecasting to deliver its breakeven plan in 2022/23 and relies on the use of non-recurrent mitigations to achieve this position.

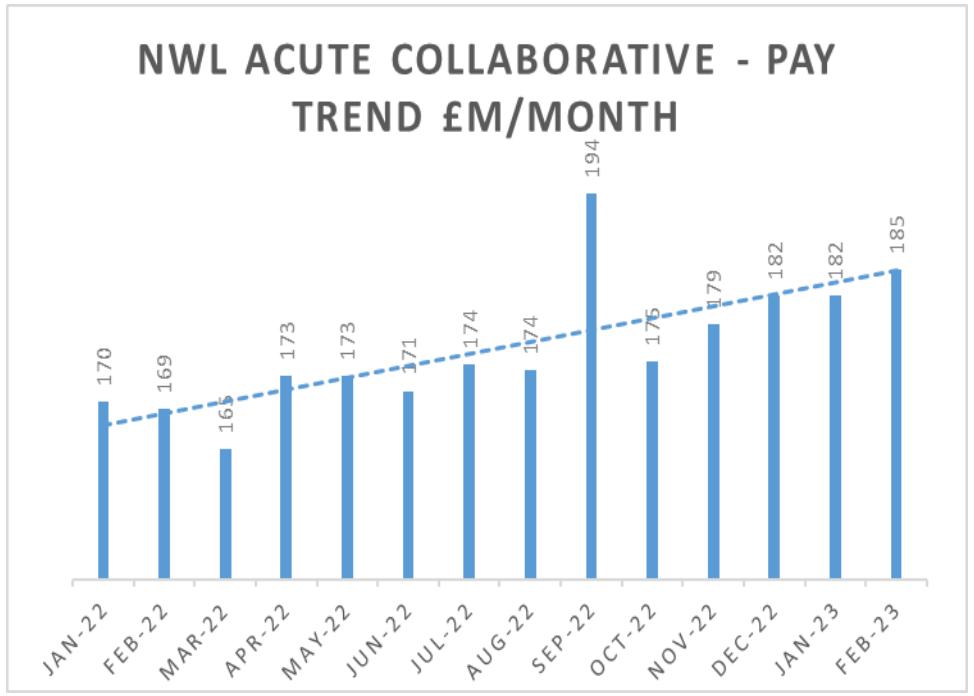
The Productivity & Efficiency Programme Board continues to work with operational teams to identify, mobilise and deliver recurrent efficiencies and the Trust will be resetting its performance framework to enhance the approach to financial sustainability.

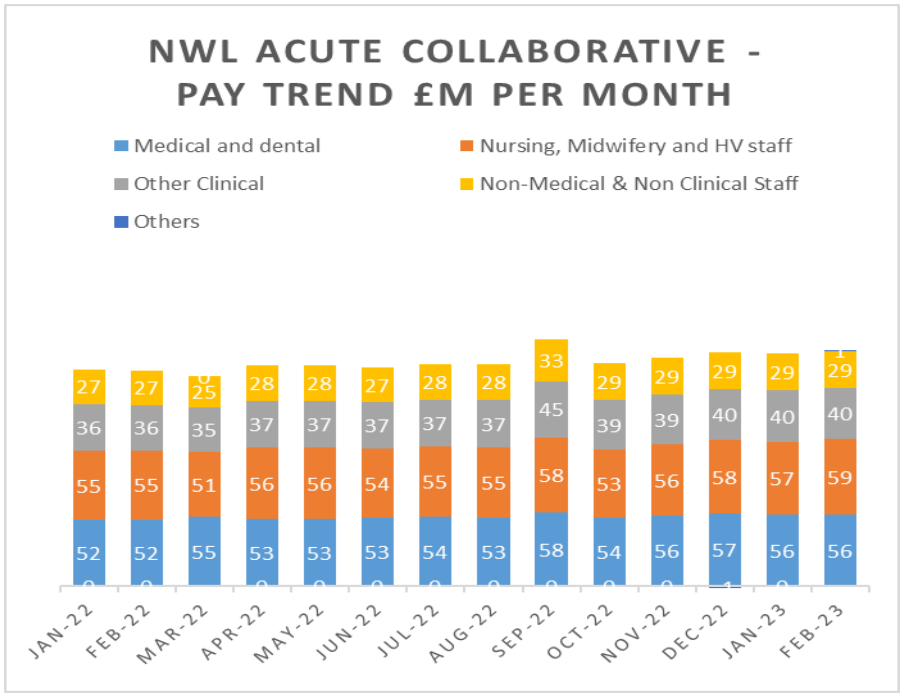
Month 11 (February 2023) Financial Performance

Appendices

Month 11 Income and Expenditure run rates

Collaborative Pay Run Rate to Month 11

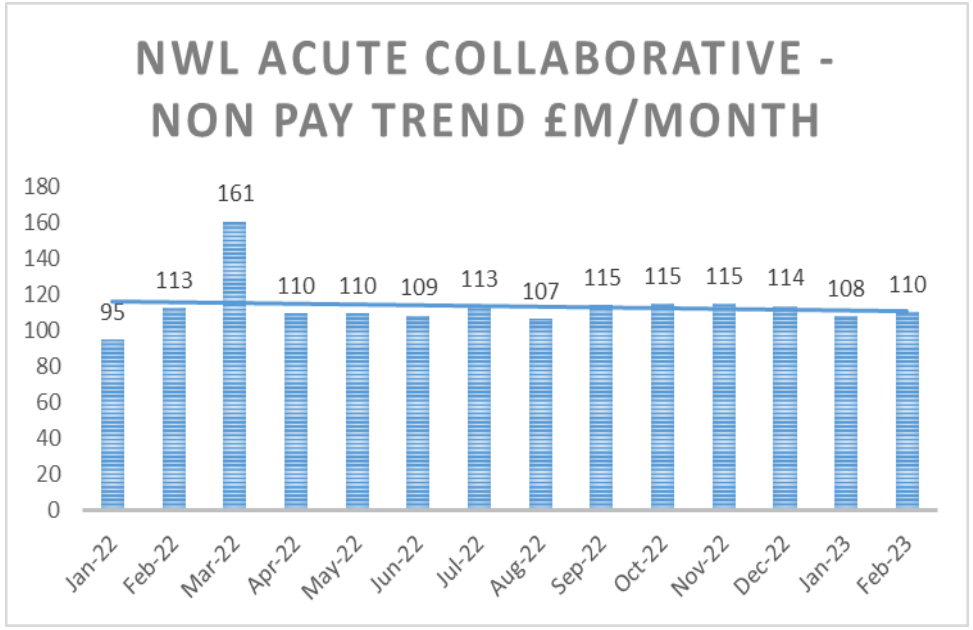


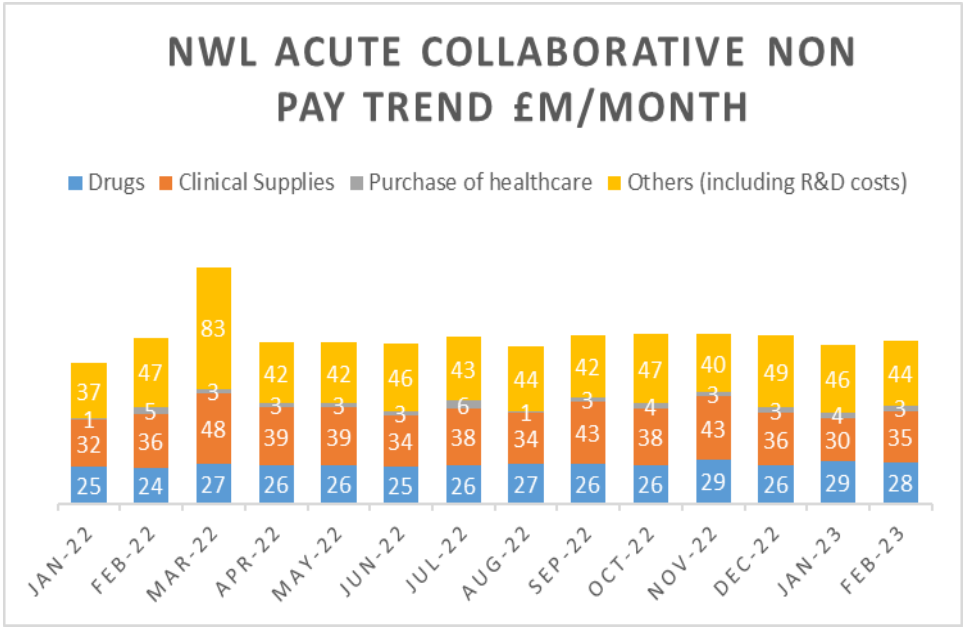


The pay run rate shown is absolute figures, not adjusted for covid or other underlying adjustments.

The average run rate H2 21/22 to H1 22/23 has increased from £168m per month in 21/22 to £178m in 22/23 or 6.2%, to note the pay award (c3% for AfC and 4.5% for consultants). The pay award including back pay was paid in Sept 22, hence the spike here. The NI increase of 1.5% was paid April – Sept and reversed from Oct 22.

Collaborative Non Pay Run Rate to Month 11

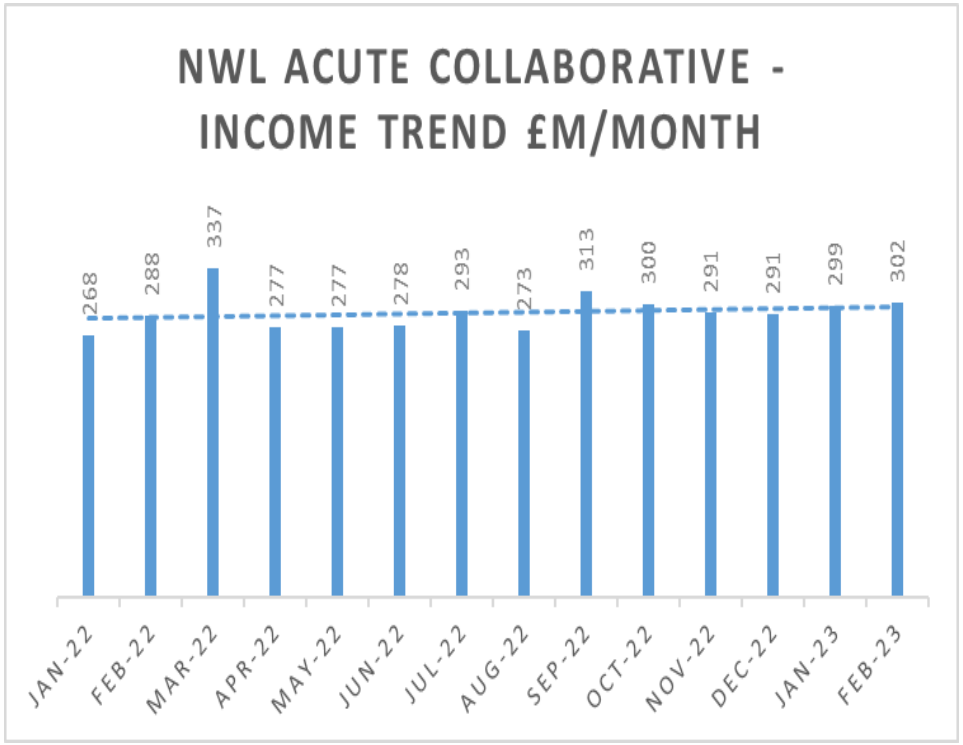


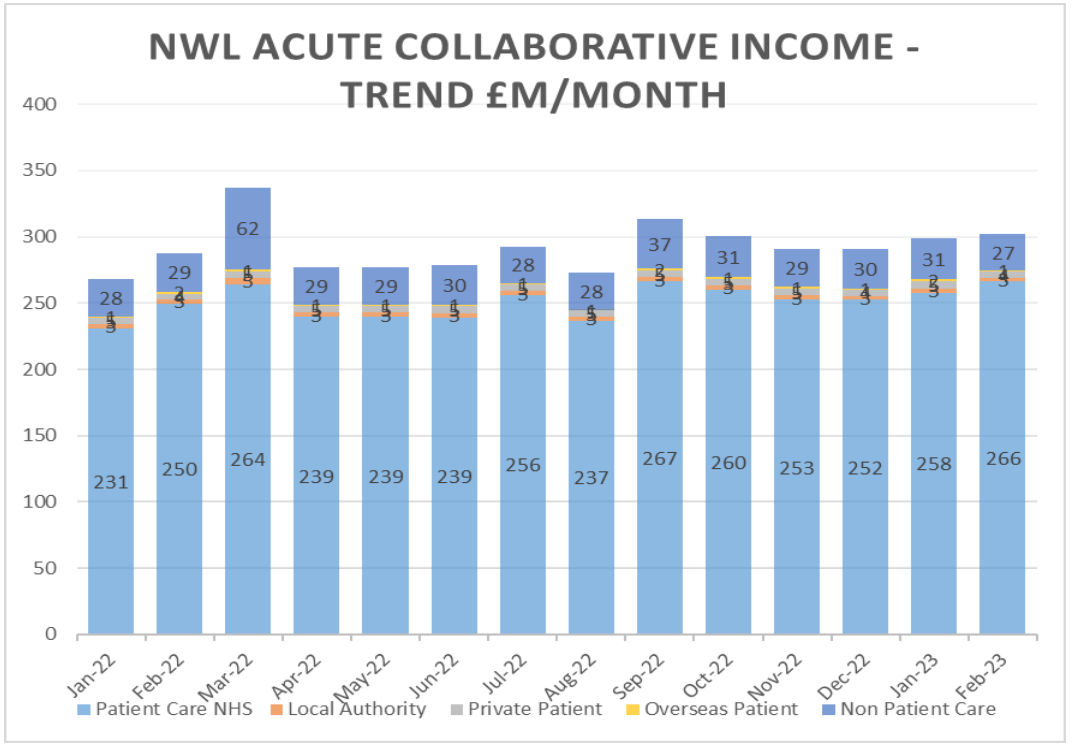


The non pay run rate shown are absolute figures, not adjusted for covid or other underlying adjustments.

The average run rate has increased from £103m per month in 21/22 (second half of year) to £111m in 22/23 YTD (8% increase). The run rate on clinical supplies has increased by 9%, and purchase of healthcare is stable, drugs spend has increased by 10% and other spend by 5%.

Collaborative Income Run Rate to Month 11





The income run rate shown is absolute figures, not adjusted for non recurrent income / underlying adjustments.

The average run rate 21/22 to M1-M10 22/23 has decreased by 2.4%, £298m to £290m.

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)
18/04/2023
Item number: 4.3
This report is: Public

North West London Acute Provider Collaborative – Highlight Report from Collaborative Committees

Accountable director: Catherine Jervis, Chair of the Collaborative Finance and Performance Committee
Steve Gill, Chair of the Collaborative Quality Committee Janet Rubin, Chair of the Collaborative People Committee
Bob Alexander, Chair of the Collaborative Infrastructure and Capital Committee

Purpose of report

Purpose: Assurance

The Board in Common is requested to receive assurance that all Collaborative Committees met during March 2023. Chairs of the respective Collaborative Committees are invited to highlight any pertinent points.

Report history

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

N/A

Executive summary and key messages

Attached are the Committee Chair's highlight reports for the following Collaborative Committees:

- Collaborative Finance and Performance Committee – 23 March 2023
- Collaborative Quality Committee – 21 March 2023
- Collaborative People Committee - 27 March 2023
- Collaborative Infrastructure and Capital Committee – 22 March 2023

The Board in Common is asked to note the key highlights in each of the reports and items escalated to the Board in Common.

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

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

Highlight Report of the meetings held on 10th and 23rd March 2022

1. Purpose and Introduction

1.1 The purpose of this report is to provide the Board in Common with assurance of the work undertaken by the Collaborative Finance & Performance Committee at its last meetings held on 10 and 23 March 2023 and to provide any feedback to it and to request if it requires further work to be done within the Committee's remit.

1.2 The role of the Collaborative Committee is: -

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

2. Key Highlights

Financial statements and collaborative mechanism for the NWL Elective Orthopaedic Centre development

2.1 The Committee received an update on the development of the business case for the north west London Elective Orthopaedic Centre, noting that the DMBC would be presented to the Board in Common Cabinet (by e-governance) on 14 March, followed by presentation to the Board in Common in April. The Committee noted that the OBC had been approved by trust boards in 2022, including the proposed financial model.

2.2 The Committee focused attention on the proposed financial model underpinning the NWL EOC, to support the approval of the DMBC at the forthcoming Board in Common Cabinet meeting and in advance of the finalisation and presentation of the FBC.

2.3 The Committee noted the changes from OBC to DMBC and FBC, highlighting the key sensitivities, including the additional cost of transport arising from the public consultation, and discussed the process for securing the anticipated efficiency savings.

2.4 The Committee discussed the assumptions regarding capacity release, noting that no assumptions had been made for the first 12 months. The Committee noted further opportunities for efficiency savings through use of spare capacity released, as well as consultant job planning.

2.5 The Committee noted the update, and welcomed the opportunity to raise any queries or concerns before the presentation of the DMBC. No concerns for the DMBC were noted, but the Committee agreed the key areas for the LNWH CFO to develop in the finalisation of the FBC – including the level of ambition against GIRFT metrics and key productivity indicators.

2.6 The Committee also noted the need to finalise the implementation plan and agreed that the management case in the FBC should be clear around management arrangements for the EOC. It was agreed that London North West Hospitals NHS Trust would be the trust responsible for the EOC and would therefore report on progress to the Board in Common via the Collaborative F&P Committee, with monitoring at executive level via the Elective Care Board. All trust finance committees will also need to oversee the management of impact at the local Trust level, where this necessitates specific savings delivery, cost base or income projection changes.

2.7 The Committee noted the financial assumptions and sensitivity analysis, to be included in the FBC, noting the current assumptions regarding financial benefit but noting the ambition to achieve greater productivity and efficiency gains in the future. The Committee noted the areas for further assurance, including the plan for mobilisation, and the need to confirm the governance arrangements post go-live.

Integrated performance report

2.8 At its meeting on 23 March, the Committee reviewed month 10 performance and received an oral update on current operational performance:

- All sites continue to focus on reducing any patients waiting for over 30 minutes for handover from London Ambulance, and NW London continues to have some of the best performing acute sites in that regard. The most challenged site for handovers is Northwick Park, due to volume of ambulance attendances as well as the redevelopment of Hillingdon Hospital; further work was being done on the criteria for transfer to Ealing Hospital and on patient flow and discharge, as well as working with London Ambulance to review their conveyancing protocols.
- All sites are now reporting against the 4 hours waiting time target in EDs.
- As a sector, it is now not likely that the target of zero patients waiting for more than 78 weeks for an elective procedure would be achieved, due to disruptions to elective activity as a result of industrial action. The aim is now to achieve zero by end of April, in accordance with the revised national target.
- All Trusts are performing against the cancer waiting time targets, with improvement seen at Imperial College Healthcare NHS Trust.
- Work continues with the support of BCG on improving theatre utilisation.
- Access to diagnostics remains challenged across the sector, to be addressed through mutual aid and additional capacity being developed as part of the business plan for 2023/24.

2.9 The Committee noted planned further industrial action in April and noted the potential impact on planned and emergency activity.

2.10 The Committee considered the benefits of measuring and reporting value weighted activity and cost weighted activity, in assessing the productivity of services.

Financial performance 2022/23

2.11 The Committee considered the month 10 financial position and noted that all Trusts were predicting achieving break even at year end, although some of that achieved via non-recurrent support.

Business and operational plans 2023/24

2.12 The Committee considered the revised draft versions of the operating and financial plans at a collaborative level, noting that approval of Trust level plans had been delegated to Trust finance committees. The Committee welcomed the fact that NW London Integrated Care Systems (ICS) was only one of four ICSs, and the only ICS in London, with a balanced plan at that time.

2.13 The Committee considered the draft operating plan, including activity plans and workforce. The operating plan reflected the activity planned for 2023/24, noting that all areas were compliant in their plans with the national operating framework, apart from bed occupancy in GA beds (96% occupancy planned, versus 92% target). The operating plan also reflects a temporary reduction of activity from 108% to 105%, due to the Cerner implementation.

2.14 The Committee considered the workforce planning, agreeing an expectation that the establishment should be flat or reducing. Noted that all trusts were planning to remain staffed under establishment, but that this needed to be clarified in the final plan.

2.15 The Committee welcomed that the Collaborative was now collectively reporting a break-even financial plan, due to improvements achieved in the Imperial College Healthcare NHS Trust and The Hillingdon Hospital NHS Foundation Trust plans. However, the Committee has noted the level of risk inherent in achieving these plans, in particular around the delivery of Cost Improvement Plans (CIPs) and Elective Recovery Fund (ERF) income. The Committee agreed that 50% of the CIP target should be identified by end of March and stressed the need for collaborative schemes to contribute towards trust level targets. The Committee also noted the importance of run rate control to ensure delivery of the plan.

2.16 The Committee also considered the draft business plan for the Collaborative, including the strategic narrative to support the operating and financial plans and the priorities for the Collaborative in 2023/24; these were a product of the discussions at the Joint Executive Group and the Board in Common development session. The Committee welcomed the progress made in identifying the priorities but recognised that more work was required to develop them into objectives and identifying the co-dependencies across the various initiatives and the risks to achievement. The Committee noted that the biggest impact on delivery of the operating and financial plans would arise from reducing unwarranted clinical variation and the consolidation of services.

Positive Assurances Received

2.17 The Committee received an update on the development of the business case for the north west London Elective Orthopaedic Centre, as above.

2.18 The Committee considered the month 10 financial position and noted that all Trusts were predicting achieving break even at year end, although some of that achieved via non-recurrent support.

Key Risks to Escalate

2.19 As a sector, it is now not likely that the target of zero patients waiting for more than 78 weeks for an elective procedure would be achieved, due to disruptions to elective activity as a result of industrial action.

2.20 The Committee noted planned further industrial action in April and noted the potential impact on planned and emergency activity.

2.21 The Committee has noted the level of risk inherent in achieving the financial plans, in particular around the delivery of Cost Improvement Plans (CIPs) and Elective Recovery Fund (ERF) income.

Concerns Outstanding

None, in addition to the risks above.

Key Actions Commissioned

2.22 To further develop the business plan, operating and financial plan for presentation to the Board in Common for approval.

2.23 To develop the FBC for the EOC for presentation to the LNWH Trust Board for approval, at the Board in Common.

Decisions Made

None

3. Summary Agenda

No.	Agenda Item	Purpose
1.	Financial statements and collaborative mechanism for the NWL Elective Orthopaedic Centre development	
2.	Integrated Performance Report (month 10 2022/23)	Noting
3.	Finance Report & CIP delivery (month 10 2022/23)	Noting
4.	Business planning 2023/24 – business plan, operating plan and financial plan	Noting
5.	Update on Collaborative Financial & Performance Risks and Assurance	Noting
6.	Trust Level Committee Assurance Reports	Noting
7.	Draft Forward Agenda Planner	Noting
8.	Key issues for the Board in Common	Noting

4. 2022 / 23 Attendance Matrix

Meeting held on 10 March

	Attended	Apologies & Deputy Sent	Apologies
Members			
Catherine Jervis, (Chair)	✓		
Nilkunj Dodhia	✓		
Bob Alexander	✓		
David Moss	✓		
Lesley Watts	✓		
Matthew Swindells	✓		
Jon Bell	✓		
Tina Benson	✓		
Rob Hodgkiss	✓		
Virginia Massaro	✓		
Claire Hook			✓
Jazz Thind	✓		
James Walters	✓		
Jonathan Reid	✓		
Jennifer Howells	✓		
Peter Jenkinson	✓		

Meeting held on 23 March

	Attended	Apologies & Deputy Sent	Apologies
Members			
Catherine Jervis			✓

Nilkunj Dodhia			✓
Bob Alexander (Chair)	✓		
David Moss	✓		
Lesley Watts	✓		
Matthew Swindells	✓		
Jon Bell	✓		
Tina Benson		✓	
Rob Hodgkiss	✓		
Virginia Massaro	✓		
Claire Hook	✓		
Jazz Thind		✓	
James Walters		✓	
Jonathan Reid	✓		
Jennifer Howells	✓		
Peter Jenkinson	✓		

North West London Acute Provider Collaborative
Collaborative Quality Committee Chair's Highlight Report to the Board in Common – for discussion
April 2023

Highlight Report

1. Purpose and Introduction

The role of the Collaborative Committee 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 Board in Common's attention matters they need to agree, or note

2. Key Highlights

2.1. Emergency Pathway Peer Review

2.1.1. The Committee received the Emergency Pathway Peer Review report which provided an update on the peer review which was established to enhance collaborative working and allow comparison and shared learning across the acute provider collaborative. Emergency medicine was agreed to be the pilot for this process, with the aim of identifying areas of good practice both those already delivered in sector and also taking learning nationally to inform opportunities for improvement.

2.1.2. The Committee noted that each Trust undertook a self-assessment during August – September, following which peer reviews were carried out throughout October-December. The peer reviews were carried out by multi-professional teams, including the Executives from each Trust to ensure they were equally challenging as well as maintaining a focus on learning rather than inspection.

2.1.3. The Committee noted that the findings from the peer reviews had been presented at a Quality summit held in December and an update presented to the Committee where it was noted that the summit had identified seven themes for improvement. These were linked to areas of variation in performance in terms of metrics as well as on clinical judgement of what the Trusts should prioritise for improvement.

2.1.4. The Committee noted that clinical leads had been allocated to each theme and "break out" sessions had been occurring throughout February and March to discuss and agree the actions to be taken.

2.1.5. The Committee were assured that the Trust was managing and mitigating the risks associated with the themes identified from the peer reviews.

2.2. Review of Acute Provider Collaborative Quality Priority workstreams

2.2.1. The Committee received the report which set out the progress of the agreed quality metrics and the priority workstreams for the North West London acute provider collaborative:

- Improving the care of deteriorating patients and those at the end of their life
- Reporting from and learning from Getting it Right First Time (GIRFT) and the Clinical Reference Groups
- User focus and insights
- Implementing the National Patient Safety Strategy
- Standardising reporting and improvement of maternity standards
- Learning and improvement from Mortality and Clinical Harm Reviews

2.2.2. The Committee received progress updates from each workstream lead and noted the progress which was being monitored through the weekly acute collaborative quality meeting. The workstreams had completed the project initiation phase for the five original priorities, with key metrics, risks, milestones, and objectives identified. The user focus and insights workstream, which was agreed at the last Committee, had progressed into the early stages of establishing the workstream with a joint workshop to share best practice and challenges in early May 2023.

2.2.3. GIRFT: The Committee agreed that the programme of Peer Pathway reviews would form part of the GIRFT workstream; 'Discharge' (April/May); and Peadiatric ED (June/July) were proposed as the next Peer Pathway reviews. The Committee requested that future GIRFT workstream updates focused on a small number of priority areas supported by data to evidence quality issues and action plans.

2.2.4. Mortality and Clinical Harm: The Committee discussed the spike of approx. 10 points in the rolling 12-month scores for HSMR in all 4 NWL Trusts and agreed that whilst this appeared to be a national issue additional investigation was required to understand this, given there was no change in the national rankings.

2.3. Summary of priorities from the Board development session and agreed next steps

2.3.1. The Committee received an oral update following the Board in Common Development Session which had focused on the Quality priorities and had confirmed the priorities already agreed by the Collaborative Quality Committee.

2.4. Quality/clinical outcomes dashboard

2.4.1. The Committee received the Quality/Clinical outcomes dashboard. The Committee noted that the quality metrics and reporting methodology were agreed following a detailed review of the Trust Board scorecards, national guidance and CQC insight reports. The Committee noted the trends highlighted in the dashboard at acute provider collaborative level for each metric with in-month data for each Trust. The Committee noted that all areas of variance highlighted within the dashboard were being managed with action plans in place to support improvement.

2.4.2. The Committee noted that on-going workforce and operational pressures, and the impact of upcoming industrial action, may have a negative impact on some of the quality metrics over the coming months however were assured that all four Trusts had robust plans to manage clinical risk

2.5. Trust Quality – Function Reports

2.5.1. The Committee received quality performance reports from each Trust, noting exceptions against quality key performance indicators and measures being taken to address areas of variance against target. The Committee were assured of the work of each of the Trust's quality committees as well as reviewing the areas of variance.

2.6. Quality account/report 2022/23 process

2.6.1. The Committee received the Quality account 2022/23 process report which set out the process for review and approval of the North West London Acute provider collaborative Trust's Quality accounts for 2022/23, for approval ahead of presentation to the Board in Common.

2.6.2. The Committee noted the summary of the consultations and draft priorities outlined in the report which ensure that the North West London Acute Provider Collaborative Quality accounts for 2022/23 will be completed in line with requirements set out by NHS England.

2.6.3. The Committee approved delegated authority for final approval and sign off of the Quality account to be given to the individual Trust Committees.

2.7. Learning from deaths quarterly reports – Quarter three 2022/23

2.7.1. The Committee received the learning from deaths quarterly report from each Trust prior to onward submission to the Board in Common. The Committee noted that all four Trust's reports provided 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.

2.7.2. The Committee noted that across the Acute Provider Collaborative mortality rates were lower than, or as expected when compared nationally, with regular review of these now occurring internally and through the Acute Provider Collaborative Committee in Common.

2.8. Clinical Negligence Scheme for Trusts - Maternity Incentive Scheme - Year 4 final submission report

2.8.1. The Committee noted that all four Trusts had submitted their declarations of compliance ahead of the submission deadline. Full compliance against the 10 safety actions was declared by Chelsea & Westminster Hospital, Imperial College Healthcare and Hillingdon Hospitals NHS Trust. London North West Healthcare were compliant with 9 of the safety actions and had noted non-compliance against safety action one due to the submission of three cases to mothers and babies reducing risk through audits and confidential enquires across the UK outside of the 7 day timescale.

2.8.2. The Committee noted that each Trust had undertaken a quarterly self-assessment of compliance against each of the 10 safety actions.

3. Assurances, risks and escalation to the Board in Common

3.1 Assurance was gained that these were being managed within each Trust with detailed improvement plans for each. It was agreed that there were no risks or issues for escalation to the Board in Common, although noted common risks across Trusts in relation to workforce and the potential impact on quality from operational pressures and recommended that these risks are considered in collaboration with the other committees.

4. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	Emergency pathway peer review			To note	9.	Summary of priorities from the Board development session and agreed next steps			To note
2.	Review of Acute Provider Collaborative Quality Priority workstreams			To note	10.	Quality/clinical outcomes dashboard			To note
3.	Deteriorating patients/treatment escalation and End of life care			To note	11.	Trust Quality Committee – Function reports			To note
4.	User focus and insights			To note	12.	Quality account/report 2022/23 process			To agree
5.	Mortality & clinical harm review			To note	13.	Learning from deaths quarterly reports – Quarter three 2022/23			To note
6.	National patient safety strategy including PSIRF implementation Plan			To note	14.	Clinical Negligence Scheme for Trusts - Maternity Incentive Scheme - Year 4			To note
7.	Maternity standards			To note	15.	Committee forward planner			To note
8.	How we gain insight from the CRGs & GIRFT			To note					

5. 2022 / 23 Attendance Matrix

	Attended	Apologies & Deputy Sent	Apologies
Members			
Steve Gill, Vice chair (CWFT) (Chair)	✓		
Peter Goldsbrough, Non-executive director (ICHT)	✓		
Syed Mohinuddin, Non-executive director (LNWT)	✓		
Linda Burke, Non-executive director (THHT)	✓		
Tim Orchard, Chief executive (ICHT)	✓		
Julian Redhead, Medical director (ICHT)	✓		
Raymond Anakwe, Medical director (ICHT)	✓		
Roger Chinn, Medical director (CWFT)	✓		
Gubby Ayida, Medical director (THHT)	✓		
Jon Baker, Medical director (LNWT)	✓		
Melanie Van Limborgh, Chief nurse (THHT)	✓		
Robert Bleasdale, Chief nurse (CWFT)	✓		
Janice Sigsworth, Chief nurse (ICHT)	✓		
Lisa Knight, Chief nurse (LNWT)	✓		
In attendance			
Matthew Swindells, Chair	✓		
Shona Maxwell, Chief of staff			✓
Peter Jenkinson, Director of corporate governance	✓		

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

28 March 2023

Highlight Report

1. Purpose and Introduction

The role of the 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

2.1 The final position from NHSE on the flu and covid vaccinations are detailed in the table below. The Acute Collaborative scored slightly above the ICS average for both flu and COVID. Next year, focus will be given to increase uptake.

Trust	Flu Rate	Covid Rate
LNWH	44.2%	46.4%
Imperial	44.8%	52.6%
Chelwest	49.3%	49.3%
Hillingdon	47.7%	41.0%
Acute Collaborative	45.9%	49.1%
ICS	45.7%	48.1%
London Region	43.1%	42.7%
England Region	51.9%	50.1%

2.2 The Committee discussed the NWL People priorities for 2022-23:

- *Joint recruitment to reduce the hardest to fill vacancies*
  The reduction in vacancies will result in improved continuity of care; reduced turnover; sickness levels; and a reduction in spend. Actions include identifying a list of common hard to recruit or high-volume vacancies, and a suite of recruitment initiatives across the Collaborative will help to address the issues. A further update was requested on the

international medical graduates' programme to help with the doctor shortage and reduce agency spend. Consideration will also be given to tracking educational institutions pipelines in order to address future vacancies. The Committee noted that LNWH is the first trust in London to achieve an international recruitment charter.

- *Reduce variation in bank and agency pay rates and the volume of shifts paid over agreed rates*

  Bank and agency spend is high, and with the exception of London North West, all Trusts are currently reporting agency spend above the 2% of the total pay bill target. The aim is to reduce agency spend to a maximum of 2% of the pay bill. THH are unable to implement this from April but the intention is to harmonise and implement as soon as possible. The reduction in agency usage is expected to take place over the next six months and an escalation process is in place to control off framework usage. Continued monitoring of this area was requested.

- *Develop and deliver the NWL Elective Orthopaedic Centre workforce plan*

  The teams are working to a tight timescale but the project is on track. The priority is to recruit to the vacant posts (200) and a staff engagement plan has been developed and agreed. A bespoke recruitment campaign is in place with an external company to support the project and job planning for doctors will be key to the resourcing plan. ODPs were noted as a recruitment risk and concerns were noted over the complexity of the schedule for the workforce workstream for job plans, especially for surgeons and anaesthetists. The Committee requested sight of the workforce workstreams.

- *Implement joint initiatives to support staff financial well-being*

  Supporting staff financial well-being will help support staff stay at work and resist leaving the NHS for financial reasons as well as reduce the risk of physical or mental health conditions that also may affect attendance and retention. Good practice is being shared across the Collaborative. The Committee agreed that delivery should be evidence through the staff survey. For example, comparing the health and wellbeing results in LNWH with those in THH for the staff survey.

2.3 The Committee received the 2023/24 priority people programmes. The Committee agreed that as well as completing any outstanding actions on the 2022/23 priorities, the following were approved for immediate action to meet urgent and immediate needs as well as take the first steps towards our longer-term ambitions:

1. Recruitment hub for hardest to fill vacancies
2. Careers hub and transfer scheme to help retain staff
3. Improve the take up of Apprenticeships
4. Joint working on violence, aggression, bullying and discrimination
5. HR aspects of corporate consolidation

2.4 The Committee received the Acute Collaborative workforce dashboard. Collectively we are reporting a staffing level that is 991 WTE over establishment (2%) in January 2023; driven by higher levels of temporary staffing to cover seasonal sickness absence, industrial action and elective recovery plans.

2.5 The Committee discussed the EDI metrics and requested that the CPOs also consider the five metrics done by model hospitals (and if chosen, devise quarterly updates).

2.6 The Committee received an update around progress of the work of the ICB as an Anchor Institute and the delivery of apprenticeships across the Acute Collaborative. It was highlighted that the identification of internal roles for apprenticeships is key as well as linking with local organisations and educational institutions for potentials.

2.7 The Committee received the local provider committee reports. The importance of staff stories at local committees was highlighted and they should be encouraged to support learning across the Collaborative.

2.8 The Committee received an update from the ICS people workstream and noted that the people plan is expected to be published in June. It was explained that Community and MH trusts were concerned that the Acute Provider Collaboratives (APC) was going ahead alone. Pippa Nightingale has liaised with the ICS workforce executive lead, information will be shared and it was noted that the APC did not need to move at pace.

2.9 The Committee received the workforce EDI report detailing the results of the 2022 gender pay gap reports for the provider trusts. Since reporting began in 2017 the average gender pay gap has reduced in 3 out of 4 of the Provider Trusts with Imperial achieving a 50% reduction in the mean gender pay gap since 2017 and reducing the median pay gap to under 2%. Learning will be shared across the trusts as ICHT has made positive improvements over the last 5 years. LNWH will focus on increasing women in upper pay quartiles. Data is due to be submitted in the next 12 months, so action is needed now to make a difference.

2.10 The Committee's terms of reference were reviewed and no changes were noted. The document will be considered again during the formal governance review.

3. Positive Assurances Received

3.1 The 2022 gender pay gap report shows that since reporting began in 2017, the average gender pay gap has reduced in 3 of the Provider Trusts.

4. Key Risks to Escalate

4.1 People priorities 23/24

4.2 Appraisals and role modelling

4.3 Apprenticeship and anchor institution

4.4 Bank & agency conversion to permanent

4.5 Gender pay gap

5. Concerns Outstanding

5.1 None.

6. Key Actions Commissioned

6.1 The Chief People Officers will consider the KPIs around conversion from temporary staff to permanent / full time employment.

6.2 The Committee will review the 200 vacant posts breakdown for the NWL Elective Orthopaedic Centre.

6.3 The desired outcome from the investment into the joint initiatives to support staff financial wellbeing will be a focus and evidenced through the staff survey.

6.4 Chief People Officers to review local committee workplans to include a staff story.

6.5 Chief People Officers to agree the best way to add a standard general statement, in relation to collaborative expectations, to executive job descriptions for both new and existing roles.

6.6 Future agendas to include forward thinking time.

6.7 EDI metrics to be reviewed and the ability to provide quarterly information considered.

7. Decisions Made

7.1 The Committee agreed that as well as completing any outstanding actions on the 2022/23 priorities, the following were approved for immediate action to meet urgent and immediate needs as well as take the first steps towards our longer-term ambitions:

1. Recruitment hub for hardest to fill vacancies
2. Careers hub and transfer scheme to help retain staff
3. Improve the take up of Apprenticeships
4. Joint working on violence, aggression, bullying and discrimination
5. HR aspects of corporate consolidation

8. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	Welcome and Apologies for Absence			-	9.	Local Trust People Committee reports			Noting
2.	Declarations of Interest			-	10.	Update from the ICS people workstream			Discussion
3.	Minutes of the meeting held on 20 December 2022			Approval	11.	Workforce EDI Report Gender Pay Gap			Discussion
4.	Matters arising and review of action points			Discussion	12.	Terms of Reference review			Discussion
5.	NWL People Priorities 22-23			Discussion	13.	Actions and Escalations			Verbal
6.	Finalised 23/24 people priorities			Approval	14.	Committee Forward Planner			Approval
7.	Acute Collaborative Dashboard			Discussion	15.	Any other business			Verbal
8.	Anchor Institution Update			Discussion					

9. Attendance Matrix

	Attended	Apologies & Deputy Sent	Apologies
Members:			
Janet Rubin, Non-Executive Director (Chair)	✓		
Sim Scavazza, Non-Executive Director	✓		
Simon Morris, Non-Executive Director	✓		
Ajay Meta, Non-Executive Director	✓		
Pippa Nightingale, Chief Executive (LNWH)	✓		
In attendance			
Matthew Swindells, Chair in Common	✓		
David Searle, Director of Corporate Affairs	✓		
Lindsey Stafford-Scott, Interim Chief People Officer (CWFT)	✓		
Jo Fanning, Interim Chief People Officer (THHFT)	✓		
Tracey Connage, Chief People Officer, (LNWH)	✓		
Kevin Croft, Chief People Officer (ICHT)	✓		
Alexia Pipe, Chief of Staff to Chair in Common			

North West London Acute Provider Collaborative
Collaborative Infrastructure & Capital Committee Chair's Highlight Report to the Board in Common

Date of the meeting: 22 March 2023

Highlight Report

1. Key Highlights

The Committee received:-

Update from the Board Development Session and next steps for the Committee
The committee discussed the areas of focus in 2023-24 agreed at the BIC development session on 21 February. It is proposed that digital and data transformation will be a priority for the Acute collaborative in 23/24 and 24/25 as these are critical years in terms of implementation and embedding of infrastructure, and systems that impact on quality of care, reducing unwarranted variation, productivity and efficiency and tackling workforce issues. However, the committee also stressed the need to commence work on an Estates programme.

Deep-Dive Strategic Reporting Solutions
The committee received an update on the approach being taken to the development of the Strategic Reporting Solution for the Acute Provider Collaborative as follows:-

- A Board in Common Performance Report covering finance, operational performance, clinical outcomes and workforce that gives an accurate view of what is happening across all four trusts
- Delivering, as a first step, the development of a Strategic Reporting Solution that could be used across the Acute Provider Collaborative and beyond
- The ultimate vision is for a Strategic Reporting Solution that is used across the Integrated Care System (ICS) and provides an accurate overview of performance from Ward to Board and also provides predictive analytics to help drive future action

Cerner EPR project
The report provided an update on the Cerner EPR programme delivering a converged Acute EPR solution across the Integrated Care Board with the deployment of LNWH and THH onto the existing solution in use at ICHT and CWFT to create a single shared Acute Cerner domain for North West London.

The target go live dates are:-

- LNWH – Cutover from 17th August 2023 with go live the following week.
- THH – Cutover from 2nd November 2023 with go live the following week.

Progress to date includes:-
- Deployment Progress and Gateways
- Training Approach
- Operational Engagement
- Go Live Activity Reduction

- Finance and Benefits
- High Level Risks
- Summary Assessment

Update on Acute Collaborative Digital and Data Strategy

The committee were provided with an overview of the approach being taken to the development of the Digital and Data Strategy. The plan is that a North West London Digital and Data Strategy will be produced that supports the wider ICS strategic priorities and provides an umbrella for the provider collaborative(s) digital and data strategies and, where necessary, the individual organisation strategies.

Green plan sustainability development approach

The committee received an update on the work required to deliver the interim target of 80% reduction in the Acute Provider Collaborative (APC) carbon emissions by 2028 to 2032.

There is already a strong track record of collaborative work across, and between, the four Acute Trust, with a number of achievements already delivered, such as the anaesthetic gas switches, reduction of desflurane usage, and 4 work streams are in place to drive forward the green work programme.

A key enabler will be the recording of current carbon footprint data to monitor and report against progress. ICHP have been commissioned to develop a consistent tool to support this in conjunction with the ICS.

An estates decarbonisation strategy is being developed, which will provide a costed net zero roadmap that supports the wider ICS strategy, and provides clarity on the steps and actions needed to allow the four Acute Provider Collaborative (APC)Trusts to become net zero by 2040. ICHT has developed an investment plan to deliver the interim net zero target and this will be extended across the APC to develop an APC net zero plan.

Further work will be undertaken to include action plans and realistic timescales for discussion at the next meeting.

Estates Scoping

The committee discussed the development an Acute Provider Collaborative Estates programme in 2023/24 and it was agreed that an embryonic Estates group would be established to scope out a programme of work to map out the estate, develop an estates strategy and identify the resource needed to deliver a 21st century estates programmes. Further update would be provided at the next meeting.

Acute Collaborative Capital Plans

The committee received the Acute Provider Collaborative Capital Plan for 2023/24.

Strategic Imaging Asset Management Business Case

The committee received a summary of the strategic outline case (SOC) for the Strategic Imaging Asset Management Programme (SIAM), following approval by the NWL Acute Provider Collaborative Board in Common on 17th January 2023.

2. Positive Assurances Received

Cerner EPR project
The committee received assurance on the progress made across; the key workstreams, the mitigation of key risks, the very strong clinical leadership in the EPR Programme team, the increasing engagement and support from clinical and operational teams as well as the recent securing of essential additional capital investment. The programme is currently on track to deliver the Cerner EPR programme in line with planned 'go-live' dates.

To ensure this position is maintained there will be increased reporting into executive groups in both Trusts and more frequent meetings between the CIO, Cerner Programme Delivery Manager and Joint SRO's from each Trust.

3. Key Risks to Escalate

None

4. Concerns Outstanding

None

5. Key Actions Commissioned

Further actions for the next meeting:

- Progress and prioritisation of the Acute Provider Collaborative Digital Strategy for 2023/24 and 2024/25.
- Estates programme development and scope of future plan.
- Further development and action plans on the Green plan and sustainability.

6. Decisions Made

None

7. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	Welcome & Apologies				9.	Green plan sustainability development approach and next steps with a specific focus on the 2028 interim Carbon target			For Information
2.	Declarations of Interest				10.	Estates Programme			For Information
3.	Minutes of the meeting held on the				11.	Acute Collaborative Capital plans			For Assurance

4.	Action Log and Matters Arising not covered by the rest of the agenda				12.	Strategic Imaging Asset Management (SIAM) business case			For Information
5.	Feedback from Board Development session – next steps for the Infrastructure and Capital Group			For Discussion	13.	ICHT Summary Report: Redevelopment Committee			For Information
6.	Digital Deep Dive – Strategic Reporting Solutions – in the APC and NWL ICS			For Information & Discussion	14.	THH – Redevelopment update			Information
7.	Cerner programme update including financial information			For Assurance	15.	Forward Plan 2022/23			Information
8.	Update on Acute Collab Digital and Data strategy inc timelines for delivery			For Information	16.	Key issues for the Board in Common			

8. 2022 / 23 Attendance Matrix

		Attended	Apologies & Deputy Sent	Apologies

Members:		A	M	J	J	A	S	O	N	D	J	F	M
Bob Alexander	Chair												
Neville Manuel	Non-Executive Director												
Aman Dalvi	Non-Executive Director												
David Moss	Non-Executive Director												
Patricia Wright	CEO Lead for the Collaborative I&C Committee												
Jason Seez	Director of Strategy THHT												
Dr Bob Klaber	Director of Strategy ICHT												
Simon Crawford	Director of Strategy LNW												
Virginia Massaro	Chief Financed Officer C&W & Collaborative CFO representative												
Kevin Jarrold	Chief Information Officer												
Hugh Gostling	Collaborative Director of Estates representative												

NWL Acute Provider Collaborative Board in Common (Public)
18/04/2023
Item number: 4.4
This report is: Public

Learning from deaths

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

Accountable director: Jon Baker, Gubby Ayida, Julian Redhead, Raymond Anakwe and Roger Chinn
Job title: Trust 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 processes which is achieved through a detailed quarterly report to the individual Trust quality committees, which are then presented to the acute provider collaborative quality committee and the board-in-common. This report introduces the four individual Trust reports providing a summary of the processes, opportunities for further alignment, and the themes and learning in common.

Report history

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

Trust Quality Committees	**Acute Provider Collaborative Quality Meeting**	**Acute Provider Collaborative Quality Committee**
Various Individual trust reports were reviewed at each quality committee and approved for onward submission.	06/03/2023 Trust level summaries were reviewed before onward submission to Acute Provider Quality Committee.	21/03/2023 The committee reviewed this summary report and the reports from the individual trusts. Following discussions, further analysis of HSMR performance is included in section 3.

Executive summary and key messages

1.1. Each Trust provides a quarterly report to their quality committee on their mortality surveillance and learning from deaths processes, which are in line with the National Quality Board learning from deaths framework published in March 2017.

1.2. The most recent report that went to each individual Trust Quality Committee is included with this summary. These provide assurance that deaths are being scrutinised appropriately in line with the requirements, and learning being shared and acted upon through Trust governance processes.

1.3. There are no specific issues highlighted for escalation.

1.4. There is variation in process including the reporting of outcomes. There are opportunities for process and surveillance alignment and optimisation hence this has been identified as a quality priority for the Acute Collaborative. A mortality review task and finish group is in place, led by Dr Chinn which reports to the acute provider collaborative quality committee as part of the priority work streams.

1.5. Once processes are aligned there will be opportunities to identify variation in outcomes which will drive improvement priorities going forward.

1.6. It is important to note that these reports include data for deaths that occurred in quarter 3, data in the clinical outcomes dashboard is from subsequent months and so the HSMR and SHMI data is more up to date and the narrative therefore is different for two trusts.

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 across the Acute Provider Collaborative 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 expectations, 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. **Introduction**

2.1. The most recent learning from death reports from each Trust are appended to this summary report. The individual Medical Directors will highlight key points from their report. This report identifies areas of commonality as well as areas where there are differences in reporting and opportunities for alignment which are being taken forward as part of the priority work stream.

3. **Mortality data**

3.1. Mortality rates are included in each report, with all Trusts using the standardised hospital mortality indictor (SHMI) to compare their performance nationally, and THH and ICH also using hospital standardised mortality ratio (HSMR). Both of these are now included in the clinical outcomes/quality dashboard reviewed at the Acute Provider Collaborative Quality Committee and Board in Common.

3.2. All Trusts are reporting fewer deaths being observed than expected given our data models when considering HSMR. When looking at SHMI which includes death within 30 days of discharge from hospital, there is wider variation with THH within expected range and others lower than expected range.

3.3. The most recent data available (for the year Nov 2021-Oct 2022) shows that each trust continues to have a rolling-12 month HSMR below the national benchmark of 100, however THH and LNW's ratios have recently changed from "lower than expected" to "as expected" with a small change in their national ranking. All trusts have had an increase in rolling twelve-month HSMRs with an average 9.4 point rise. Further analysis has confirmed a similar rise across the NHS, with an average increase of 11.3 per provider. Telstra health are supporting a review of the data and have suggested this is being driven by the data being rebased and changes made in the expected crude rate nationally. The SHMI did not increase in the same way, work will continue to provide assurance going forward.

3.4. There is variation in how mortality data is reported and used locally, including the accuracy of palliative care coding which is important to ensure the data is not adversely affected, and which is currently under review by the mortality review task and finish group.

3.5. The mortality review task and finish group has commenced a project to align HSMR and SHMI reporting across organisations which includes aligning systems and reporting outputs to standardise the production, analysis and use of both mortality indicators. A

joined up approach to reporting will make assessing quality, forming insights and identifying improvements more effective, leading to improved patient outcomes.

4. Governance

4.1. All Trusts have a mortality review group in place which meets regularly to provide Trust wide scrutiny of outcomes from the learning from deaths process.

4.2. There is regular reporting in place to the Trust quality committees, and to the Acute Provider Collaborative quality committee via the quality function reports, although the reporting cycles are different across the four trusts. Work is underway to align the quality reporting structures across the Acute Provider Collaborative.

4.3. The mortality review task and finish group is also assessing metrics used by each Trust for local mortality review group reports to identify and implement a shared core data set to be used across organisations. This commonality will contribute to local and Acute Provider Collaborative assurance and shared learning and insights.

5. Process

5.1. All Trusts have a medical examiner service in place which scrutinises deaths which occur in the acute setting. Deaths where there are concerns, or which meet certain agreed criteria, are then referred on for a case note 'level 2' or 'structured judgement' review, with variation in the 'triggers' for review as well as in the form this review takes between Trusts.

5.2. Who carries out these reviews also varies across Trusts. ICH has a small team of five trained consultant reviewers who undertake all reviews with dedicated time in their job plans for the roles, whereas at CWH the review is undertaken by the team involved in the care of the patient with divisional oversight. Reviews at THH are undertaken by clinical teams within existing job plans.

5.3. Each Trust reports data on the number of deaths referred for further review, performance with undertaking these and plans for improvement where required, however there are different deadlines for completion (varying from 45 days to 7 days).

5.4. A review of these process and people variations is underway by the mortality review task and finish group. The objective is to align on a 'to be' process and agree shared triggers and compliance monitoring so these reviews are carried out uniformly.

5.5. Trusts are working collaboratively to expand Medical Examiner scrutiny to all non-coronial deaths occurring in NWL boroughs. A task and finish group with representation from our four Trusts as well as the NWL Integrated Care Board (ICB) and primary care borough directors is working to implement this new pathway before it becomes a statutory requirement. Systems and processes have been established and piloted with success ahead of full roll-out in April 2023.

6. Identification of care concerns

6.1. Each Trust uses a scoring system to identify whether there were care or service delivery issues, and in some cases whether a death was avoidable, and provides data on the outcomes in their quarterly report, however these differ between Trusts which makes comparison difficult.

6.2. Through their mortality review processes, each Trust has identified local areas requiring further investigation. These are summarised in individual Trust reports and do not require escalation.

6.3. The mortality review task and finish group are working to develop a standardised scoring system for the outputs of Level 2 reviews across the Acute Provider Collaborative.

7. Learning

7.1. There is a common theme regarding the use of treatment escalation plans and end of life care. This is a quality priority for the Acute Provider Collaborative, with a task and finish group in place.

7.2. THH has recognised the need to improve how learning is shared across the Trust and has actions in place to support this. Both THH, LNW and ICH have work underway to improve their morbidity and mortality (M&M) meeting processes to strengthen local learning and ensure consistency.

8. Next steps

8.1. There is scope to improve our learning from deaths processes across the Acute Provider Collaborative. Work is underway through the mortality review task and finish group with the aim of driving:

- Improved collaboration and shared learning;
- Better understanding of the mortality review processes in place across organisations;
- Identification of best practice and areas for shared learning and improvement;
- Identification of themes from aggregated Learning from Deaths data and external sources (e.g. Prevention of Future Death Notices);
- Defined shared mortality review priorities and key areas for improvements;
- Opportunities to share resource and reduce duplication of work.

9. Conclusion

9.1. 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.

9.2. Across the Acute Provider Collaborative our mortality rates are lower than, or as expected, when compared nationally, with regular review of these now occurring both internally and through the quality committee in common. A full review of HSMR is being undertaken in response to the increase noted in June 2022.

9.3. Review of learning set out in the most recent Trust reports includes a common theme around improving end of life care and how we agree and document treatment escalation plans. This has been recognised as an issue for all four Trusts previously and is one of the quality priorities for the Acute Provider Collaborative with a work-plan in place.

9.4. There is variation in the review processes being undertaken in each Trust. A task and finish group is in place to review the opportunities to share learning, initiate improvements and inform quality priorities and interventions moving forward.

Learning from deaths

1. Background

The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed.

The Summary Hospital Level Mortality Indicator (SHMI) is used to compare the Trust's relative risk of mortality with other acute (non-specialist) providers in England. The SHMI is not a measure of quality care but it does flag variation, and therefore, potential problems that may require further investigation.

The Trust utilises the following core systems to support its learning from death objectives:

The Medical Examiner (ME) system was introduced across England and Wales in April 2020 to provide greater scrutiny to deaths and to offer a point of contact for bereaved families wishing to raise concerns. Learning from the medical examiner process is embedded within the Trust's approach to learning from deaths.

Mortality case review is undertaken by the clinical teams involved in a patients care; it provides clinicians with the opportunity to review expectations, outcomes and potential improvements. All adult and child in-hospital deaths are initially screened to identify triggers for full retrospective case record review. Outcomes from review are shared at local, divisional and trust wide level to ensure learning outcomes are appropriately cascaded.

The national Perinatal Mortality Review Tool (PMRT) provides a standardised and structured review process support learning from late fetal losses, stillbirths, and neonatal deaths. Very detailed information about the care the mother and baby received throughout pregnancy, birth and afterwards is captured with the PMRT online tool.

The Mortality Surveillance Group (MSG) provides leadership to this programme of work; it is supported by monthly updates on relative risk of mortality, potential learning from medical examiners, and divisional learning from case record screening / review. The MSG is a sub-group of the Patient Safety Group and is aligned to the remit of the Quality Committee.

This report provides a Trust-level quarterly review of mortality learning for Q3 2022/23.

2. Relative risk of mortality

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) to monitor the relative risk of mortality. This tool was developed by NHS Digital to calculate the relative risk of mortality for each patient and then compare the number of observed deaths (in-hospital and within 30 days of discharge) to the number of expected deaths; this provides a relative risk of mortality ratio (where a number below 100 represents a lower than expected risk of mortality).

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI is

designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality the Trust is able to make comparisons between peer organisations and seek to identify improvement areas where there is variance.

2.1. Summary Hospital-level Mortality Indicator: Trust wide

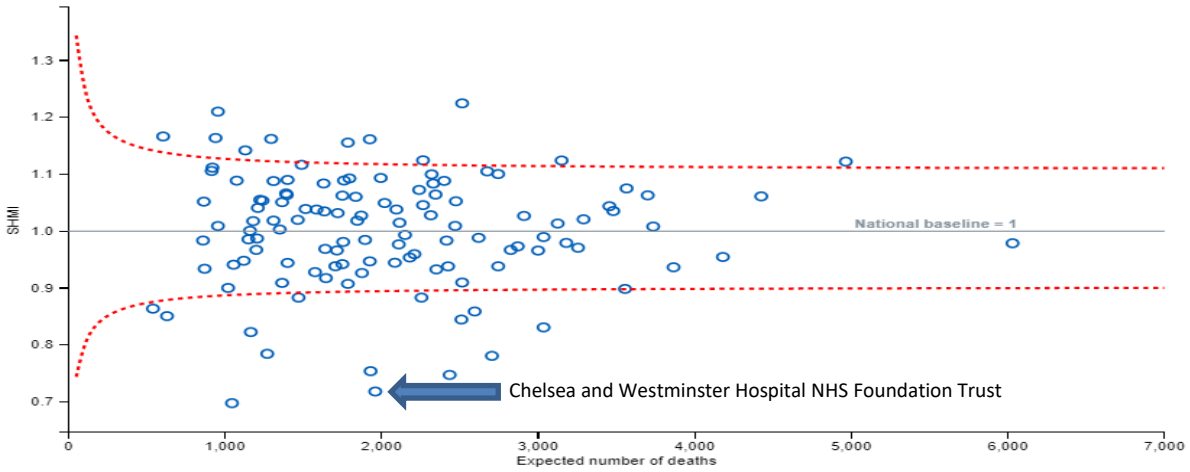


Fig 1 – SHMI comparison of England acute hospital Trusts September 2021-August 2022, published 12/01/2023

The Trust is the second best performing acute provider in England in relation to the SHMI relative risk of mortality indicator. The Trust wide SHMI for the period September 2021 – August 2022 is 0.7184 (where a number below 1 represents better than expected risk of mortality).

North West London Acute Collaborative SHMI indicators

	SHMI	Observed Deaths	Expected Deaths	Provider Spells
Chelsea and Westminster Hospital NHS FT Current position Previous position	0.7184 (0.7192)	1,410 (1,375)	1,960 (1910)	87,515 (87785)
Imperial College Healthcare NHS Trust	0.7475	1,820	2,435	94,590
London North West University Healthcare NHS Trust	0.7810	2,115	2,705	99,015
The Hillingdon Hospital NHS Foundation Trust	0.9836	845	860	35,145

This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality:

- West Middlesex University Hospital:
  SHMI value 0.7390 (845 observed deaths, 1,140 expected deaths, 44,790 provider spells)

- Chelsea and Westminster Hospital:
  SHMI value 0.6897 (565 observed deaths, 820 expected deaths, 42,730 provider spells)

2.2. Summary Hospital-level Mortality Indicator: Diagnostic Groups

The SHMI is made up of 142 different diagnostic groups which are then aggregated to calculate the Trust's overall relative risk of mortality. The Mortality Surveillance Group monitors expected and observed deaths across diagnostic groups; where statistically significant variation is identified the group undertakes coding and care review to identify any themes or potential improvement areas.

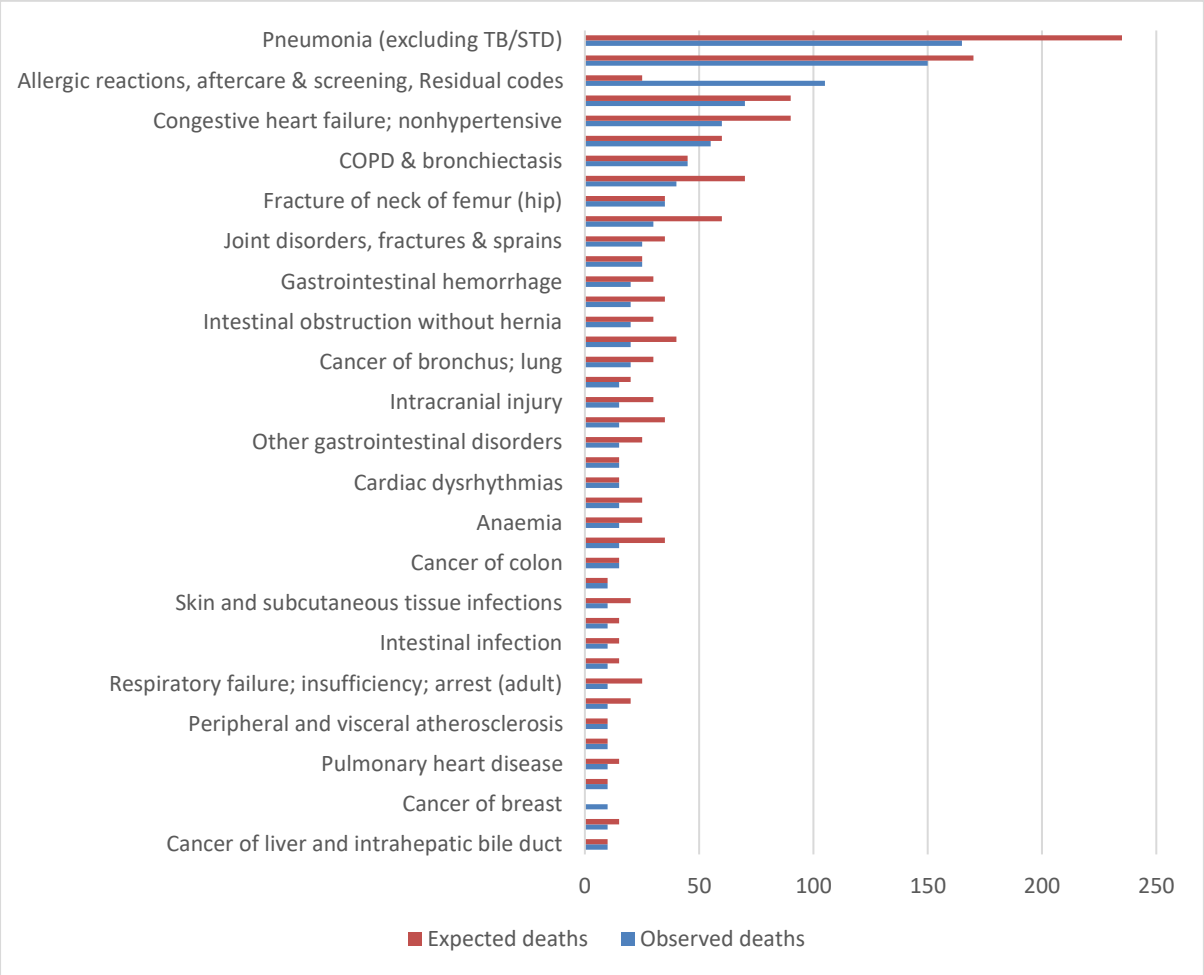


Fig 2 – Expected and observed deaths by diagnostic group (null values omitted), September 2021-August 2022, published 12/01/2023

During Q2 2022/23 a coding review was undertaken relating to diagnostic group 'allergic reactions, aftercare & screening, R codes'. The review identified that 95 cases within the NHS Digital dataset (used to calculate the SHMI) were categorised as residual codes: unclassified (R Codes) and that these were being included within this overarching group. Audit of local clinical systems identified that data was being correctly recorded at Trust level but that the national upload arrangements were affecting coding availability for the SHMI calculation. No increased risk of mortality associated with allergic reaction was identified and amendment of Trust data upload arrangements is proposed to correct this external reporting error.

3. Crude mortality

Emergency spells (activity) and the deaths associated with those spells (crude number) can be used to calculate the rate of in-hospital deaths per 1000 patient spells (this calculation excludes elective and obstetric activity).

Crude mortality rates must not be used to make comparisons between sites due to the effect that population demographics, services offered by different hospitals, and services offered by intermediate / community care has on health outcomes (e.g. crude mortality does not take into account the external factors that significantly influence the relative risk of mortality at each site). Crude mortality is useful to inform resource allocation and strategic planning.

The following crude rates only include adult emergency admitted spells by age band. This approach is used as it reduces some of the variation when comparing the two sites and support understanding and trend recognition undertaken by the Mortality Surveillance Group.

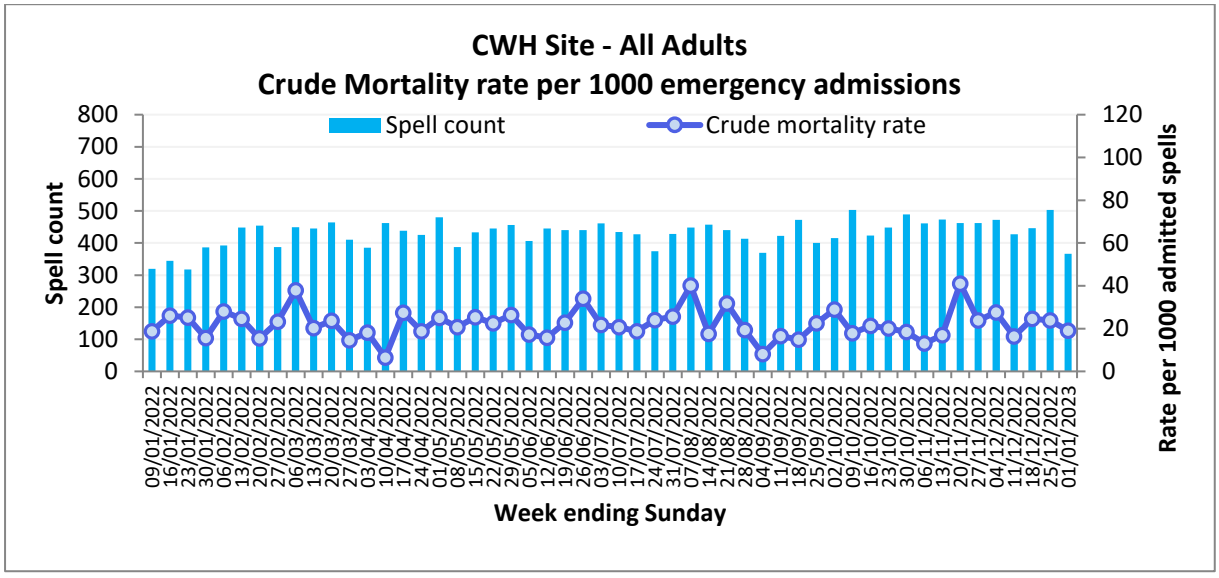


Fig 3 – Crude mortality rate per 1000 emergency admissions, West Middlesex University Hospital

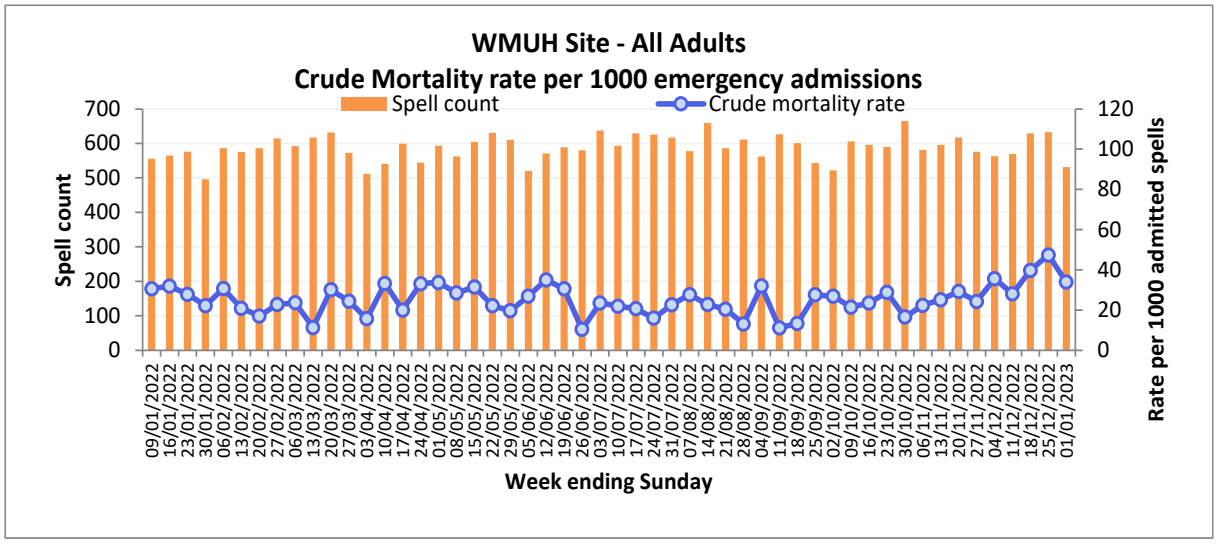


Fig 4 – Crude mortality rate per 1000 emergency admissions, Chelsea and Westminster Hospital

By comparing the actual number of emergency spell mortalities with the same week in the previous 5 year mean (pre COVID 2015-2019); WestMid site has experienced an uplift in the number of mortalities in the last 8 weeks of Q3 (this is not an indicator of quality or safety).

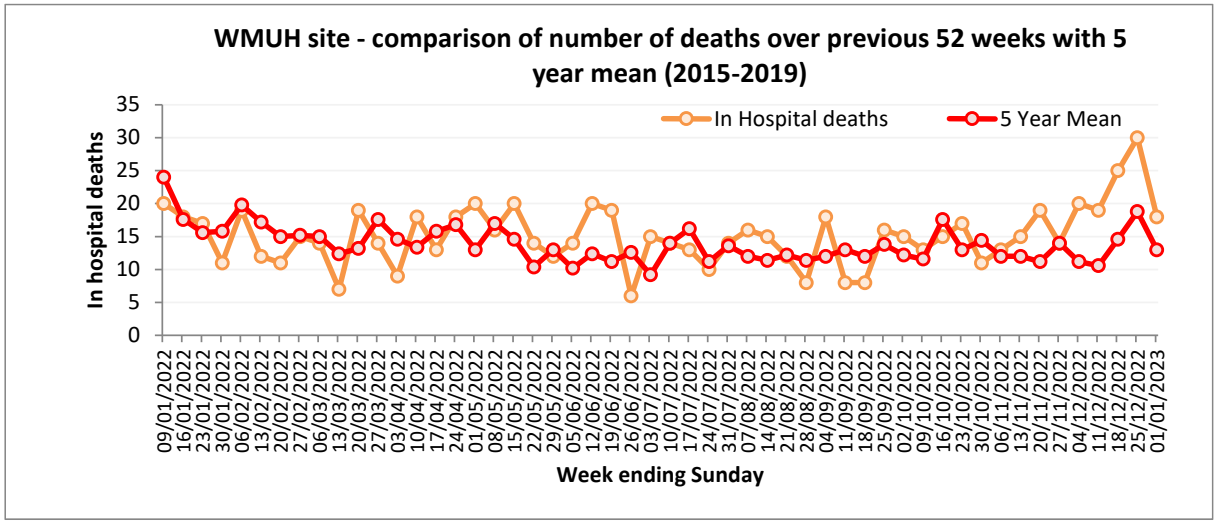


Fig 5 – Crude mortality in last 52 weeks compared with 5 year mean, West Middlesex University Hospital

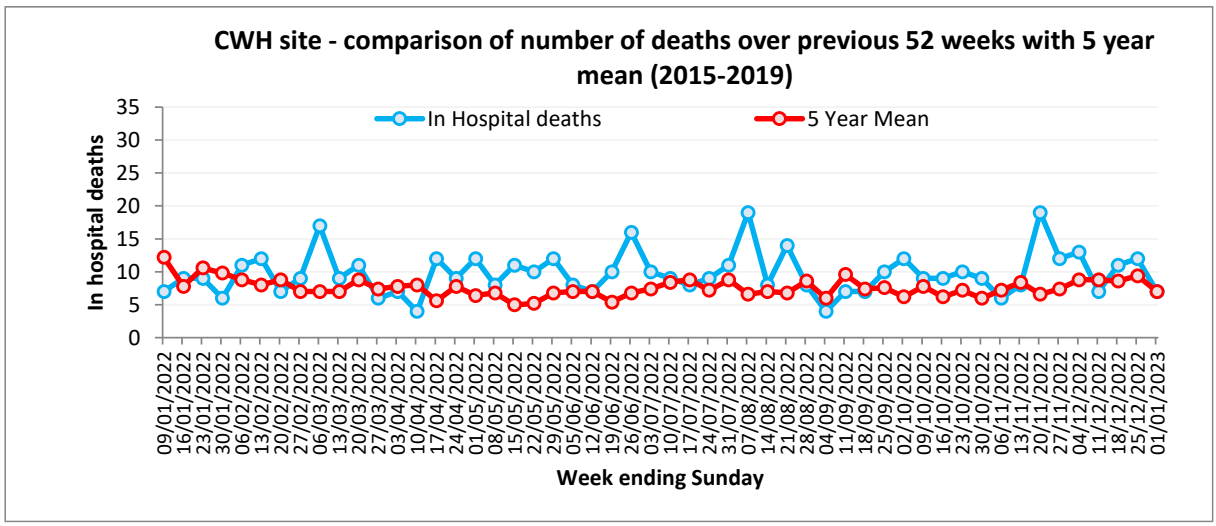
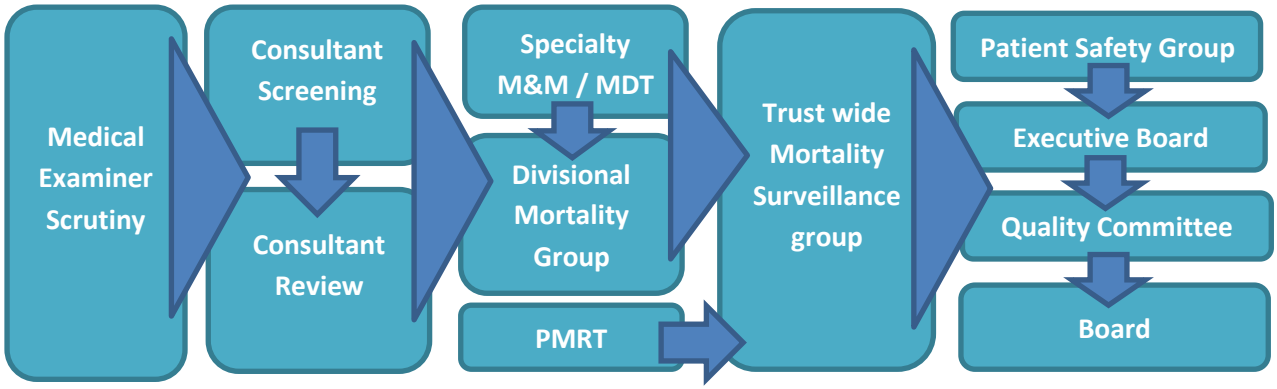


Fig 4 – Crude mortality in last 52 weeks compared with 5 year mean, Chelsea and Westminster Hospital

4. Learning from deaths process

The Mortality Surveillance Group (MSG) challenges assurance regarding the opportunity and outcomes from the Trust's learning from deaths approach.



The MSG provides leadership to this programme of work; it is supported by monthly updates on relative risk of mortality, potential learning from medical examiners, learning from inquests, and divisional learning from mortality screening / review. The MSG is a sub-group of the Patient Safety Group and is aligned to the remit of the Quality Committee.

4.1. Medical Examiner's office

An independent Medical Examiner's service was introduced to the Trust in April 2020 to provide enhanced scrutiny to deaths and to offer a point of contact for bereaved families wishing to raise concerns.

The purpose of this service is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data

During Q3 2021/22 the medical examiners service scrutinised 100% of in-hospital deaths adult and child deaths and identified 71 cases of potential learning for the Trust and 12 cases of potential learning for other organisations. Potential learning identified during medical examiner scrutiny is shared with the patient's named consultant, divisional mortality review group and the Trust-wide Mortality Surveillance Group. Full consultant led mortality review is required whenever the MEs identify the potential for learning.

4.2. Adult and child mortality review

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

In-hospital adult and child deaths are screened by consultant teams using the screening tool within Datix, this supports the identification of cases that would benefit from full mortality review.

Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through Divisional Mortality Review Groups and the trust-wide Mortality Surveillance Group (MSG).

Trust mortality review targets:

- 100% of in-hospital adult and child deaths to be screen
- At least 30% of all adult and child death aligned to the Emergency and Integrated Care (EIC) Division to undergo full mortality review
- At least 80% of all adult and child deaths aligned to Planned Care Division (PCD), Women's Neonates, HIV/GUM, Dermatology (WCHGD), and West London Children's Health (WLCH) to undergo mortality review
- 100% of cases aligned to a Coroner inquest to undergo full mortality review
- 100% of cases where potential learning identified by Medical Examiner to undergo full mortality review

During the 12-month period to end of December 2022; 1447 in-hospital adult and child deaths were recorded within the Trust's mortality review system (Datix), of these 87% have been screened and 35% have had full mortality case review closed following speciality discussion.

	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with Full Review	% Pending
Q4 21/22	329	168	142	19	**94%**	**43%**	**6%**
Q1 22/23	360	181	145	34	**91%**	**40%**	**9%**
Q2 22/23	342	177	113	52	**85%**	**33%**	**15%**
Q3 22/23	416	228	101	87	**79%**	**24%**	**21%**
Totals	**1447**	**754**	**501**	**192**	**87%**	**35%**	**13%**

Gaps in process compliance at Specialty and Divisional level are monitored by the Mortality Surveillance Group. Divisional plans to achieve the required compliance are reported to the Mortality Surveillance Group and Executive Management Board.

	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with Full Review	% Pending
EIC	1188	751	339	98	**92%**	**29%**	**8%**
PCD	246	0	160	86	**65%**	**65%**	**35%**
WNHGD	6	4	0	2	**67%**	**0%**	**33%**
WLCH	7	0	2	5	**29%**	**29%**	**71%**
Totals	**1447**	**754**	**501**	**192**	**87%**	**35%**	**13%**

Process compliance is monitored by the Divisional Mortality Groups, Mortality Surveillance Group, and overseen by the Patient Safety Group, Executive Management Board, and Quality Committee.

4.2.1. Mortality review outcomes

The Trust's mortality review programme provides a standardised approach to case review designed to improve understanding and learning about problems and processes in healthcare associated with mortality, and also to share best practice.

Where problems in care are identified these are graded using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories:

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

CESDI grades January 2022 – December 2022

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q4 21/22	118	23	1	0
Q1 22/23	123	20	2	0
Q2 22/23	98	15	0	0
Q3 22/23	84	17	0	0
Total	**423**	**75**	**3**	**0**

During this 12 month period 501 full mortality reviews have been completed and discussed at specialty, divisional or Trust wide mortality review groups.

3 cases of sub-optimal care that might have made a difference to the patient's outcome were identified in the last 12 months; each of these cases were escalated to the Executive and declared as serious incidents. The organisation publishes a Learning from Serious Incidents report on a quarterly basis and outcomes / learning is received by the Patient Safety Group and Executive Management Board on a monthly basis.

The Divisional Mortality Review Groups provide scrutiny to mortality cases so as to; identify themes and escalate any issues of concerns, during Q3 22/23 there were 17 cases where improvement opportunities were identified, but where outcome would not have been changed (CESDI 1). Key themes related to:

- Documentation: Data accessibility & quality – *Each Division has an aligned Digital Clinical Information Officer supporting quality improvement in this area; work is overseen by the EProg Group.*
- Communication – *Clinical handover is a Trust Quality Priority; the programme is overseen by the Improvement Board and Executive Management Board.*
- Staffing: Staffing levels on wards may impact quality – *Staffing levels, recruitment and retention are monitored by the People and Organisational Development Committee. The trust is engaged in significant recruitment activities and resource allocation programmes to ensure clinical staffing levels are maintained.*
- Planning: Escalation Plans (to be recorded on Cerner and communicated with families) – *Support, guidance, and advice regarding the completion of treatment escalation plans is provided via the Trust's end of life group.*

- End of life care: *Care at the end of life is a Trust Quality Priority; the programme is overseen by the Improvement Board and Executive Management Board.*

All cases of suboptimal care are presented to the Mortality Surveillance Group to ensure shared learning.

4.3. Perinatal mortality review

The Perinatal Mortality Review Tool (PMRT) is a national mandatory monitoring and assurance dataset developed by MBRRACE-UK. It is used to collect very detailed information about the care mothers and babies have received throughout pregnancy, birth and afterwards. The purpose of the PMRT is to support hospital learn from deaths by providing a standardised and structured review process.

The PMRT is designed to support review of:

- All late fetal losses (22 weeks + 0 days to 23 weeks + 6 days);
- All antepartum and intrapartum stillbirths;
- All neonatal deaths from birth at 22 weeks + 0 days to 28 days after birth;

Learning from these cases is captured only within the PMRT and not duplicated within the Trust's mortality review system (datix). The national target is to complete PMRT review within 6 months. During the 12 month period ending December 2022; 59 cases have been identified as requiring PMRT review.

	No. reported	Not supported for review	Review in progress	Review completed	Grading of care: no. with issues in care likely to have made a difference to outcome
Stillbirths and late fetal losses	55	21	18	15	**0**
Neonatal and post-natal deaths	33	5	8	18	**3**

Learning from PMRT review is reported to the Mortality Surveillance Group; where sub-optimal care that could have impacted outcome is identified cases are escalated as potential serious incidents. The organisation publishes a Learning from Serious Incidents report on a quarterly basis and outcomes / learning is received by the Patient Safety Group and Executive Management Board on a monthly basis.

Learning Disabilities Mortality Review (LeDeR)

The national Learning Disabilities Mortality Review (LeDeR) programme was established in May 2015 in response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities.

The LeDeR programme seeks to coordinate, collate and share information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward at both local and national levels. To support this aim the Trust is committed to ensure deaths of patients with known / pre-diagnosed learning disabilities are reported to the LeDeR programme and reviewed in line with the programme requirements.

During this 12 month reporting period ending in December 2022; 15 in-hospital adult or child death where the patient had a pre-diagnosed learning disability were identified. The Trust's Lead Nurse for Learning Disability and Transition supports the LeDeR process for all identified cases.

5. Conclusion

The outcome of the Trust's mortality surveillance programme continues to provide a rich source of learning that is supporting the organisations improvement objectives. A step change in the relative risk of mortality was experienced in March 2017 and has continued into Q3 2022/23; the Trust continues to be recognised as having one of the lowest relative risk of mortality (SHMI) across NHS England.

Learning from deaths report Quarter 3 2022/23 – Imperial College Healthcare NHS Trust

1. Executive summary and key messages

1.1. Our mortality rates remain statistically significantly low.

1.2. We are currently reviewing two areas with high/increasing HSMR; cardiac and maternity/neonatology. The cardiac review was presented to executive management board quality group (EMBQ) in February with no concerning trends specific to Imperial identified.

1.3. The maternity/neonatology review is being undertaken by Imperial College; while this is underway, the service have completed a review of each death and benchmarked our performance with national and international datasets, which show we are not an outlier. The outcomes from the Imperial College review will be summarised in the quarter one report, along with any actions planned as a result of the findings.

1.4. Our mortality review processes are in line with national guidance. All deaths are scrutinised by the medical examiner, with those where there are concerns about the quality of care then referred for structured judgment review (SJR). Deaths are no longer rated on whether the might have been 'avoidable', but instead on the quality of care (graded from excellent to very poor), with a final decision then being made on whether the death was more likely than not to have occurred due to problems in care.

1.5. Following a rise in referrals for SJR in quarter two (Q2) in response to work to clear a backlog of cases, the number has reduced in quarter three (Q3). This has also been affected by approved changes to the triggers for SJR e.g. removal of the automatic trigger for deaths following healthcare onset Covid-19 infection.

1.6. In this reporting period, two SJRs concluded that the care provided to the patient in the lead up to their death was poor. Both of these are now being investigated as serious incidents following review at the Medical Director's incident panel.

1.7. In addition to this, a regular death review panel is in place to consider any complex cases and triangulate all associated investigations. Of the cases reviewed at this panel since October 2022, poor care was confirmed in four and for two of these, the panel concluded that the deaths were more likely than not to have occurred due to problems in care.

1.8. The themes from SJRs completed within this time period are consistent with previous quarters with no new risks to escalate; however there was specific learning identified following an inquest in December 2022 around timely response to stroke symptoms, and actions implemented in response. The inquest was given a narrative verdict, with no prevention of future deaths notice.

1.9. Work has commenced to review the maternity and neonatal death process, including the perinatal mortality review tool (PMRT) process, and align it with our overall mortality review governance and reporting to improve visibility of outcomes and actions. The amended process should be implemented before the end of Q1 2023/24.

1.10. We will continue to work with the other Trusts in the NWL Acute Provider Collaborative to improve our learning from deaths processes collectively. Any changes to our internal processes as a result of this work will be described in this report and taken forward through our governance processes.

We are on track to implement the community medical examiner service by April 2023; the systems, processes and resource are in place and the pilot has been successful. A task and finish group is leading on a plan to implement a joint weekend medical examiner service between Imperial and Chelsea and Westminster once a funding agreement has been confirmed by the Regional Medical Examiner.

2. Mortality rates

2.1. Our mortality rates remain statistically significantly low. Our rolling 12-month HSMR is 79.4 against an expected relative risk of 100, sixth lowest when compared to other acute non-specialist trusts. Our SHMI is fourth lowest in the country.

2.2. Reviews are being undertaken into two specialities which show a high/increasing HSMR:

2.2.1 **Neonatology and maternity**: An on-going review into the high HSMR in neonatology and maternity is being undertaken with Imperial College. Our initial internal review did not identify a clear reason for the high rate; data points to the number of babies transferred to the trust who were not born here at early gestational age being the potential driver. For assurance, the service have benchmarked our mortality with other similar organisations using MBRAACE data, data from the LMNS and ICS, the PMRT process and the Vermont Oxford Network, which show we are not an outlier.

2.2.2 **Cardiac**: analysis of the recent increase in HSMR in cardiac undertaken by the service with support from Telstra Health was presented to February EMBQ. The increase appears to be reflected nationally across Heat Attack Centres (HACs) where patients are presenting with more severe disease and sometimes later, potentially as a result of the pandemic. The review did not identify any concerning trends specific to Imperial. This will continue to be monitored and an updated report will be presented to June EMBQ to provide further assurance that there are no unexpected trends.

2.3. We receive mortality alerts via the Telstra health analytics services. These alerts do not infer clinical issues but indicate that the data for the diagnosis group is significantly different at Imperial to similar diagnosis groups in the NHS. The alert triggers may change over time with modification of the overall data resulting from coding audits and corrections by Imperial and/or changes in the overall NHS data set. Where a coding issue is identified this is corrected. However if the coding is correct, the individual cases are reviewed to identify if there are any clinical themes or trends that should undergo further investigation or action

2.4. Between June 2022 and September there were four alerts:

- Complications of surgical procedures or medical care (3 patients)
- Crushing injury or internal injury (7 patients)
- Other injuries and conditions due to external causes (9 patients)
- Short gestation, low birth weight, and fetal growth retardation (6 patients)

2.5. The six maternity cases are under review by the maternity directorate, the cases from the three other alerting groups have been reviewed and one has been reported as a potential patient safety incident on Datix. No clinical concerns have been identified for the remaining cases.

2.6. A review of the processes and function of the specialist mortality and morbidity meetings across the trust, including the data being used has been undertaken. This involved a scoping exercise with an online questionnaire that was completed by all the divisions. This data is currently being analysed and will be presented at the learning from deaths group with recommendations then to executive management board quality group (EMBQ) in March 2023.

3. Summary of learning from deaths data – Q3 2022/2023

3.1. There were a total of 485 deaths in Q3, compared to 448 in Q2 2022/2023.

3.2. Of these 485 deaths, 40 died with a positive Covid-19 swab within 28 days of death or on the medical certificate as cause of death, compared to 51 in Q2 2022/2023. This has reduced from the last quarter but still reflects the ongoing prevalence of Covid-19 in the community.

3.3. In October, EMB Quality Group approved a proposal to stop automatically undertaking SJRs for patients who die with a HOCI. This was not a national requirement but was an important part of our scrutiny whilst we learnt about the evolving pandemic. Through this process we incorporated learning into our policies and guidelines but we did not find any significant lapses in care. We have now reverted to the standard mortality review process where the medical examiner would trigger a SJR review if concerns are raised.

3.4. Twenty-seven cases were referred for SJR by the medical examiner in Q3. The triggers for these can be seen in Table 2 below.

Table 2 – Triggers for SJR by quarter

Triggers by Quarter	Q4 20-21	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23
Medical Examiner Concern	3	3	16	11	16	15	9	12
Clinical Concern	3	1	5	2	2	1	2	3
Family Concern	3	6	13	6	3	8	22	2
Score 1-3	0	0	0	0	0	0	0	0
Coroner/Inquest	0	0	0	0	0	1	1	0

SI / Incident	0	0	0	0	0	0	1	0
Vulnerable group	9	4	9	3	8	9	18	5
Age Range	3	1	6	1	0	0	7	1
Specialty /Condition	36	38	34	11	25	21	35	3
Other	4	5	16	17	4	17	38	13

(Note: there may be multiple triggers for a SJR)

3.5. The number of cases being referred for SJR has reduced following an increase last quarter in response to a backlog of cases building up in the mortality module (27 in Q3 compared to 110 in Q2). This has been rectified with a weekly report now in place and no further issues in evidence. The removal of some automatic triggers, including for HOCI deaths as described in section 7.3, has also reduced the number of cases which are automatically referred for SJR.

3.6. This reduction is also reflected in the number of SJRs that were completed in the quarter (32 SJRs in Q3, compared to 103 in Q4). (Note: these SJRs do not all relate to deaths within Q3 2022/2023).

3.7. Of the 32 SJRs completed, overall care scores were as follows:-

Number of cases	**Rating of overall care**
2	2 - Poor care
5	3 - Adequate care
22	4 - Good care
3	5 - Excellent care

3.8. Where care has been assessed as poor these cases are referred for a more in-depth incident investigation. The learning from these is then fed into the incident reports that come to Quality Committee regularly through the assurance reports. Safety improvement priorities are set annually based on these and are tracked through the appropriate reporting mechanisms.

3.9. Two of the 32 SJRs gave an overall score of 'poor' care, compared to five in the previous quarter.

3.10. In addition to review at incident panel, we have a regular death review panel meeting, chaired by the medical director consider any complex cases and triangulate all associated investigations. The final level of harm will also be attributed to the case at the panel.

3.11. The panel has met eight times since November 2022 and reviewed 16 outstanding HOCI cases as well as four other cases where the SJRs concluded that the care provided to the patient in the lead up to their death was poor. No new issues were identified with the HOCI cases.

3.12. Poor care was confirmed in the other four cases and the final harm levels of three of the investigations were agreed; 1 severe, 1 moderate and 1 low (downgraded from moderate). For the fourth case, more information was required before a decision could be made; an update on this case will be provided in the Q4 report. In two of the cases there was learning related to communication with the patient's family, in particular around how we approached the concerns they raised as part of the

investigation process, which will be fed into our plans for developing our Trust approach and process for engaging patients/families/carers in learning responses and improvement as part of PSIRF.

3.13. For the case downgraded to low harm, the panel concluded that the quality of end of life care was poor but that this did not contribute to the death.

3.14. For the two cases graded severe and moderate the panel concluded that poor care had contributed to the death of the patients. The learning from these cases was:

- **Moderate harm**: the patient clinically deteriorated and later died following a PEG retention device becoming loosened, though the cause of this has not been identified. The patient did not receive proper nutrition. There were also issues around end of life care and documentation. As a result of this case, our guidance is being reviewed to ensure that it is clear regarding how often assessments should be carried out following PEG insertion, and an audit is underway of complex device and insertions to identify any further learning.
- **Severe harm**: The team were focused on the patient's COVID-19 diagnosis and significant cardiac history as the cause of the patient's symptoms leading them to not consider pulmonary embolism as the primary diagnosis in the initial period following admission, leading to a delay which it was felt contributed to the death. The pathways and processes in place have been reviewed and amended as a result.

3.15. A look back exercise has commenced to ensure that all the HOCI SJRs as well as all the SJRs with an overall rating of care scored as poor or very poor since the beginning of 2020 have been presented at the death review panel. The outcomes will be confirmed in the Q4 report.

4. Themes and Learning

4.1. Learning from Deaths is a standard monthly agenda item on all the Divisional Quality and Safety meetings where developments in the LFD agenda and learning is shared which is then disseminated to all the directorates and throughout the division. In addition, a bi-monthly newsletter is now being produced.

4.2. The learning and recurring themes from reviews continue to centre on timely referral for palliative and end of life care.

4.3. Improving end of life care is a safety improvement programme priority for the Trust. Recent actions include the approval of a business case to enhance education and training. This is also a quality priority for the acute provider collaborative, with a task and finish group in place.

4.4. In Q3 there was specific learning identified following an inquest into the death of a patient who suffered a stroke after undergoing cataract surgery at Riverside. The learning related to the response to the patient's deterioration, including delays in recognising their condition, issues with escalation and staff not knowing to call 2222 or take the patient to ED. Actions had already been put in place prior to the inquest,

including a bespoke multidisciplinary training package. The inquest was given a narrative verdict, with no prevention of future deaths notice.

5. Summary of Perinatal Mortality Reviews using the national tool (PMRT)

5.1. A separate process is in place for perinatal mortality consisting of designated review meetings where each aspect of care is scored and action plans to address any issues are approved. These are recorded on the national PMRT database and the generated reports are collated and analysed nationally and within the Trust for trends and themes to facilitate learning.

5.2. We have a backlog of 76 PMRT cases from previous years caused by pausing of the review process in pandemic surges. A recovery plan is in progress which will be overseen by the division with escalation processes in place. This will be completed by December 2023. Additional resource has been allocated to support this important work.

6. Next steps

6.1. Work has commenced to review the maternity and neonatal death process, including the perinatal mortality review tool (PMRT) process, and align it with our overall mortality review governance and reporting to improve visibility of outcomes and actions. The amended process should be implemented before the end of Q1 2023/24.

6.2. The outcomes from the Imperial College review of our maternity/neonatology mortality rates will be summarised in the Q1 report, along with any actions planned as a result of the findings.

6.3. We will continue to work with the other Trusts in the NWL Acute Provider Collaborative to improve our learning from deaths processes collectively. Any changes to our internal processes as a result of this work will be described in this report and taken forward through our governance processes.

6.4. We are on track to implement the community medical examiner service by April 2023; the systems, processes and resource are in place and the pilot has been successful. A task and finish group is leading on a plan to implement a joint weekend medical examiner service between Imperial and Chelsea and Westminster once a funding agreement has been confirmed by the Regional Medical Examiner.

7. Conclusion

7.1. Mortality rates across the Trust remain statistically significantly low. When considered with our harm profile and the outcomes of our structured judgement reviews we can provide assurance to the committee that we are providing safe care for the majority of our patients. Where care issues are found we have a robust process for referral for more in-depth review.

7.2. The learning themes are consistent with previous quarters with no new risks to escalate.

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Date: 23rd February 2023

List of appendices
Appendix 1 - Learning from Deaths Dashboard

Imperial College Healthcare NHS Trust

Learning from Deaths Dashboard Quarter 3 2022-23

Up to: Quarter 4

Latest Quarter

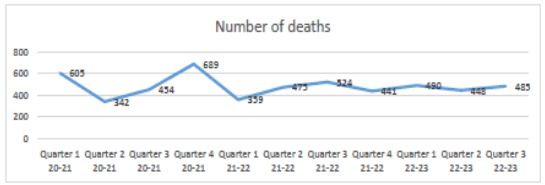
Deaths	Last Quarter	Very Poor/Poor Overall Quality of Care	Last Quarter
485	448	2	5

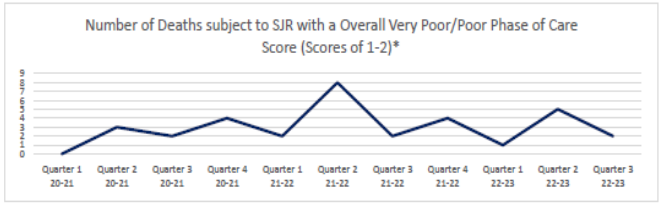
Latest Quarter

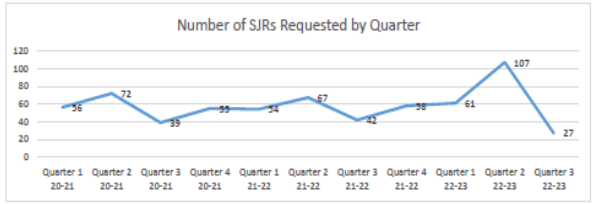
SJRs Requested	Last Quarter	SJRs completed	Last Quarter
27	107	32	103

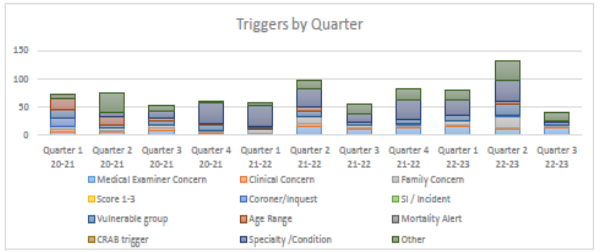
Latest Quarter

PMRTs requested	Last Quarter
18	18









*please note that there can be more than 1 trigger for each SJR.

Learning from Deaths

1.0 Executive Summary: -

1.1 The Trust is committed to accurately monitoring and understanding its mortality outcomes to ensure the highest possible standard of care for patients. This report summarises the Trust position for the last quarter (Q3 = Oct/Nov/Dec 2022).

1.2 There is a smooth interface between the Quality & Patient Safety Team, Medical Examiner Service, and the Bereavement Team, utilising Datix to capture the reviews taking place. Medical Examiners work in partnership with the Bereavement Team to log and review all in-patient deaths.

1.3 The Medical Examiners review the individual care that deceased in-patients received and the Quality & Patient Safety Team assess each case to see if it meets a national or local trigger for a Level 2 In-Depth Review (the equivalent of a Structured Judgement Review [SJR]), using the categories below:-

- Concern raised by bereaved family or friends.
- Concern raised by staff or care graded as 2 or 3 using the Confidential Enquiries into Stillbirths and Deaths in Infancy (CESDI) Classifications.
- Medical Examiners Flag.
- Patients with a Learning Disability.
- Patients detained under the Mental Health Act.
- Coroners' Cases that are subject to an Inquest or Enquiry
- Patients under the age of 25.
- Any data that shows that the Trust is an outlier in monitoring data, or any alert raised via national benchmarking systems (such as NHS Digital)
- Any Elective patients who had surgery on this or a recent admission (within one year, dependent on surgery type).

2.0 Summary of Data

2.1 The Trust subscribes to Dr. Foster's Healthcare Intelligence Portal benchmarking tool for national benchmarking and regularly reviews data gathered via NHS Digital.

2.2 The trust has a consistently low mortality risk rate across the last twelve consecutive months: it is currently one of ten Trusts with 'lower than expected' deaths, as ranked according to the Summary Hospital Mortality Indicator (SHMI) in England over the period. Encouragingly, the trust's SHMI trend over the last five financial years remains in the 'lower than expected category' (Table 1, Appendix 1).

2.3 Key Headlines

- The Trust is one of ten Trusts across the UK with lower-than-expected deaths (based on September 2021 to August 2022 NHS Digital data).

- All in-patient deaths have been subject to an immediate Level 1 Review undertaken by the Medical Examiners, who consider the quality of care delivered and discuss any concerns with a patient's family/friends at the same time.

- From April to December 2022 there were 1,764 in-patient deaths (including deaths due to Covid).

- From April 2022 to December 2022, 7% (117) deaths triggered a Level 2 In-depth Mortality Review, of which 61% (71) have been completed to date (a drop of 1% since end of Quarter 2 2022-23).

- Of the 71 completed Level 2 In-Depth Reviews, sub-optimal care was found in 30% (21) cases which is consistent with the last report. 1 of which was classed as Grade 3 (sub-optimal care, with different management would reasonably have been expected to have made a difference to the outcome).

- The Trust is required to submit data on learning from deaths to NHS England in the form of a quarterly dashboard (see Appendix 2); this gives a breakdown of all in-patient deaths and all patients identified as having a Learning Disability.

- The Trust reviews the number of patient deaths and the number of Level 2 In-Depth Mortality Reviews completed and the reasons for them being triggered each month. As in previous reports, the data shows that the main triggers for an In-depth review were Medical Examiner Requests followed by Coroners Cases and Family Concerns. While both these are national triggers for an In-depth Review, the referrals to the Coroner are not are not necessarily an indication of poor care but rather to meet legal requirements when there has been an unexpected death from a road traffic accident etc.).

3.0 Key Learning from Quarters 3 2022-23

3.1 Across the Trust Mortality & Morbidity Meetings are held monthly by specialities, where they discuss each in-patient death within their service. These discussions are the summarised and recorded by teams within Datix and presentations of learning are made to the Learning from Patient Death Group yearly. Below is a summary of learning and action take from presentations made to the group during Q3 2022-23:

3.2 Assurance from Reviews and some Lessons Learnt:

- The continued importance of communication with families
- The importance of full multi-disciplinary discussion of complex patients to endorse management plans and share learning.
- Vast majority of patients were found to have complex needs including those with cancer, sepsis, pneumonia, and liver disease.
- Need for better communication between the vascular team and anaesthetic team to compensate for a temporary reduction in the number of anaesthetic consultants at the time. Which has resulted in greater teamworking between the two specialties.

- Increasing awareness that it is not acceptable to continue life-prolonging treatment that is not in a patient's best interest or in line with their wishes, despite family pressure to do so.
- Importance of clearly defined and timely Treatment Escalation Plans with appropriate communication with relatives.

3.3 Action Taken:

- Updated Standard Operating Procedure within Cardiology for the centralised monitoring of information on patients who have fallen.
- The management of high-risk vascular in-patient require the care and ongoing support of elderly physicians for complex medical conditions. Department to consider developing a business case to support this work going forward.

4.0 Conclusion

4.1 Optimal care was found in 1,743 of the completed Level 1 and the Level 2 In-Depth Reviews from Quarters 1, 2 and 3, which is consistent with the Trust's consistently low mortality rate, when benchmarked by NHS Digital.

4.2 To the end of Quarter 3 the trust saw a 1% reduction in the number of completed Level 2 In-depth Mortality Reviews in comparison to the previous quarter, however when considered in context of the winter surge, the 61% completed rate is relatively strong. Mortality & Morbidity meetings have continued throughout, and teams continue to expand the numbers attending and regularity of these meetings building upon the learning being shared and discussed within teams and across the trust.

Appendix 1 Trust Comparison against National Mortality Data

5.0 September 2021 to August 2022: -

5.1 The data below is gathered by NHS Digital and used to develop the Summary Hospital Mortality Indicator (SHMI) for Trusts. This publication of the SHMI relates to discharges in the reporting period September 2021 to August 2022, which is the latest publication available.

5.2 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 hospitals in England who died either while in hospital or within 30 days of being discharged. Deaths related to COVID-19 are excluded from the SHMI.

5.3 To help users of the data understand the SHMI, trusts have been categorised into bandings indicating whether a trust's SHMI is 'higher than expected', 'as expected', or 'lower than expected'. If the observed number of deaths falls outside of the 'as expected' range, a trust is considered to have a higher or lower SHMI than expected.

5.4 The SHMI is not a measure of quality of care. A higher-than-expected number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance.

5.5 The overall SHMI value for this Trust is 78.10. This rate is in the "lower than expected" range. The Trust's SHMI remains significantly low with a very slight decrease from the last quarterly report:

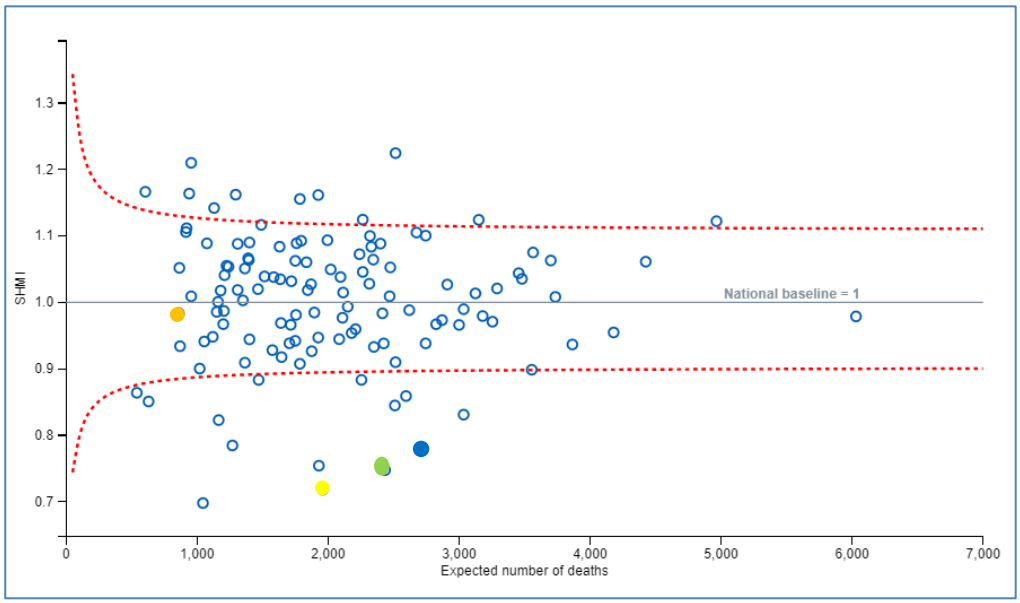
Table 1: Trust and Site level SHMI Data.

Provider name	SHMI value	Range	Number of spells	Observed deaths	Expected deaths
London North West University Trust	78.10	Lower than expected	99,015	2,115	2,705
Northwick Park	84.18	Lower than expected	66,825	1,445	1,715
Ealing Hospital	67.14	Lower than expected	26,965	605	905
St Marks Hospital	100.05	As expected	1,340	50	50
Central Middlesex Hospital	25.85	Lower than expected	2,720	10	35

Table 2: Gives a comparison with North West London Acute Collaborative partners: -

Provider name	SHMI value	Range	Number of spells	Observed deaths	Expected deaths
London North West University Trust	78.10	Lower than expected	99,015	2,115	2,705
Imperial College Healthcare Trust	74.75	Lower than expected	94,590	1,820	2,435
Chelsea & Westminster Hospital Trust	71.84	Lower than expected	87,515	1,410	1,960
The Hillingdon Hospitals Trust	98.36	As expected	35,145	845	860

Chart 1: Summary Hospital-level Mortality Indicator: Trust wide and Acute Collaborative Partners: -

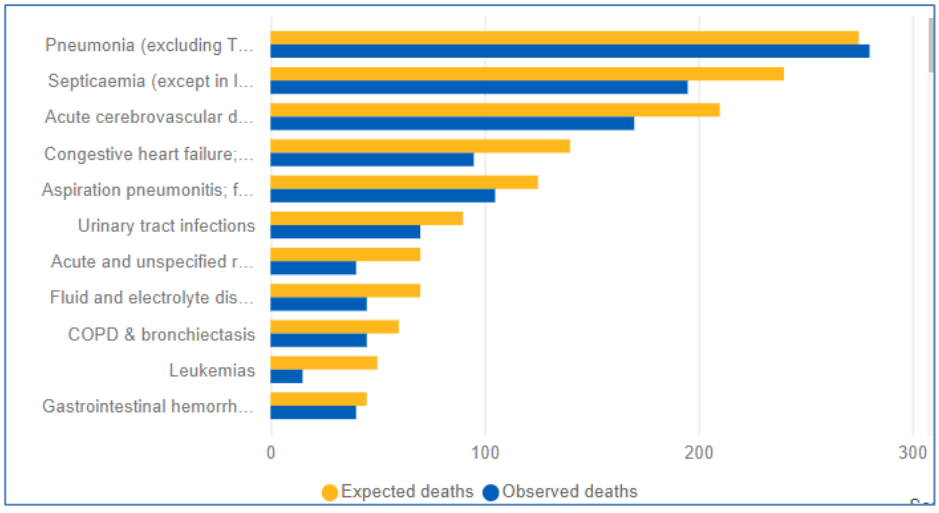


Key:

Blue = London North West University Trust
Yellow = Chelsea & Westminser
Green = Imperial College Healthcare Trust
Amber = The Hillingdonw Hospitals Trust

Table 3 below shows that the Trust has lower than expected mortality across several categories.

Table 3: Comparison of Observed & Expected Deaths by Diagnosis Group for Sep-21 to Aug-22:



*NB There has been a general fall in the number of spells due to Covid-19 impacting on activity from March 2020 onwards, which this had affected some diagnosis groups more than others. This will continue to be monitored by NHS Digital as the pandemic continues.

5.6 All in-patient deaths are graded using the Confidential Enquiries into Stillbirths and Deaths in Infancy (CESDI) Classifications: -

Grade 0 No sub-optimal care
Grade 1 Sub-optimal care but different management would have made no difference to the outcome
Grade 2 Sub-optimal care, different management might have made a difference to the outcome
Grade 3 Sub-optimal care, different management would reasonably have been expected to have made a difference to the outcome.

These classifications are amalgamated in the table below to reflect on the care as being 'Optimal Care' (Grade 0) or 'Sub-Optimal' (Grades 1, 2 or 3); exact numbers can be seen in Appendix 2.

Table 4: Summary of Patient Care Grading from Completed Reviews

CESDI Classifications	2018-19	2019-20	2020-21	2021-22
Completed reviews - Optimal care	1869	2155	2669	2234
Completed reviews -Sub-optimal care	138 (7%)	75 (3%)	68 (3%)	44 (2%)

Appendix 2: Summary of In-Patient Deaths and Reviews by Grading of Care

Summary of the total number of In-patient deaths, Cases Reviewed and Grading of Care

Total Number of Deaths, Deaths Reviewed and In-Depth Reveiws

		All In-Patients					Reviewed by CESDI Grading of Care			
		No. of In-Patient Deaths	No. of Level 1 Reviews Triggered	No. of Level 1 Reviews Completed	No. of Level 2 In-Depth Reviews Triggered	No. of Level 2 In-Depth Reviews Completed	**Grade 1:** Sub-optimal care but different management would have made no difference to the outcome.	**Grade 2:** Sub-optimal care, different management might have made a difference to the outcome.	**Grade 3:** Sub-optimal care, different management would reasonably have been expected to have made a difference to the outcome.	Optimal Care
2022-23 Quarter 1	Apr-22	197	183	183	14	11	4	0	0	193
	May-22	180	167	167	13	9	1	0	0	179
	Jun-22	181	175	175	6	6	2	1	0	178
2022-23 Quarter 2	Jul-22	193	179	179	14	12	2	0	0	191
	Aug-22	177	162	162	15	9	2	0	0	175
	Sep-22	191	179	179	12	8	3	0	1	187
2022-23 Quarter 3	Oct-22	197	183	183	14	7	1	1	0	195
	Nov-22	197	182	182	15	8	2	1	0	194
	Dec-22	251	237	237	14	1	0	0	0	251
	2021-22	2278	2121	2121	157	148	34	8	2	2234
	2020-21	2737	2456	2456	281	271	56	9	3	2669
	2019-20	2230	1992	1992	238	234	65	8	2	2155
	2018-19	2007	1692	1692	315	315	129	8	1	1869

Patients with Learning Disabilities

		No. of In-Patient Deaths	No. of Level 2 In-Depth Reviews Triggered	No. of Level 2 In-Depth Reviews Completed	**Grade 1:** Sub-optimal care but different management would have made no difference to the outcome.	**Grade 2:** Sub-optimal care, different management might have made a difference to the outcome.	**Grade 3:** Sub-optimal care, different management would reasonably have been expected to have made a difference to the outcome.	Optimal Care
2022-23 Quarter 1	Apr-22	2	2	2	0	0	0	2
	May-22	1	1	1	0	0	0	1
	Jun-22	3	3	3	0	0	0	3
2022-23 Quarter 2	Jul-22	0	0	0	0	0	0	0
	Aug-22	1	1	1	0	0	0	1
	Sep-22	1	1	0	0	0	0	0
2022-23 Quarter 3	Oct-22	5	5	2	0	0	0	2
	Nov-22	3	3	2	0	0	0	2
	Dec-22	4	1	0	0	0	0	1
	2021-22	21	21	19	1	0	0	18
	2020-21	27	27	27	2	1	0	24
	2019-20	15	15	15	1	0	0	14
	2018-19	24	24	24	1	0	0	23

Learning from Deaths

1. Executive Summary

To provide the Board with an update on the Trust's Learning from Deaths programme. This report presents the mortality data for the Trust from October 2021 to September 2022. Data for Learning from Deaths is presented for Q3 2022/23 together with the data dashboard. Update is given on the Medical Examiner Service and a summary of the Q2 National Cardiac Arrest Audit (NCAA) report is also presented.

2. Background

2.1 Dr Foster continues to provide a bi-monthly detailed report for the Mortality Surveillance Group (MSG). This provides assurance that there are no high mortality risks for Hillingdon Hospitals NHS Foundation Trust and enables focus on areas where there may be a potential for learning.

2.2 The Trust uses the HSMR data which is supported by Dr Foster. SHMI data is provided from NHS Digital.

2.3 Cases are identified for a Structured Judgement Review (SJR) following completion of the Trust Mortality Level 1 review form by the Certifying Doctor and Medical Examiner. Following review the Mortality Level 1 form has been updated to ensure that the most appropriate cases are selected for a detailed Structured Judgement Review.

2.4 Work is ongoing to embed the Learning from Deaths process. The data from the SJR process is yet to be discussed in the Unplanned Care Mortality & Morbidity (M&) Meeting. These meetings need to be established to allow for discussion and subsequent learning across the Division and wider Trust. A M&M meeting is scheduled for February 2023.

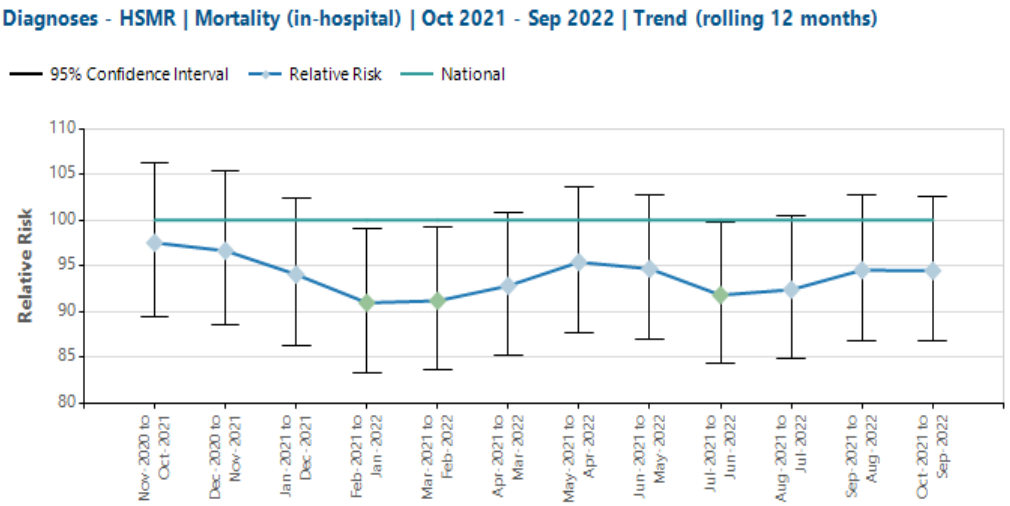
2.5 The National Cardiac Arrest Audit Q2 report evidenced that that rate of Cardiac Arrest Calls on the Ward has improved and provides some assurance that DNACPR forms are being completed when it is appropriate and consequently we are resuscitating the right patients.

3. Mortality data

3.1 Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis which represent approximately 80% of in hospital deaths (palliative care deaths are excluded). Summary Hospital-Level Mortality Indicator (SHMI) captures all hospital deaths and those within 30 days of discharge, palliative care deaths are included.

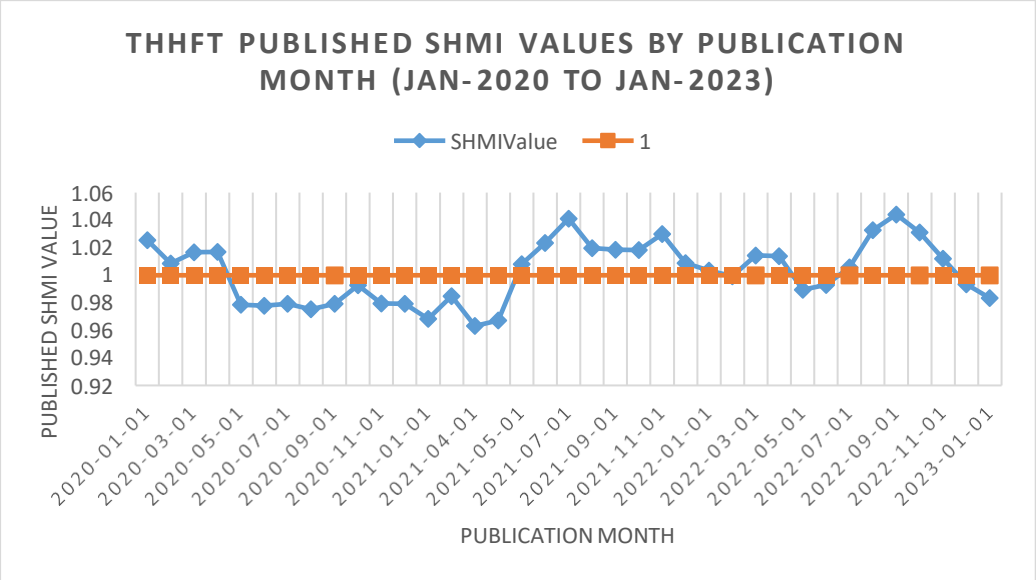
3.2 The Trust is supported by Dr Foster and so is able to interrogate the HMSR data. The SHMI mortality model is supported by NHS Digital and limited interrogation can be undertaken on their website. The Mortality Data presented is the most up to date from Dr Foster and NHS Digital.

3.3 Hillingdon rolling 12 month HSMR remains below the benchmark of 100 which is reassuring as 100 is the measure of expected deaths for the Trust.



3.4 SHMI data is presented for the last three years. It can be seen that the values lie around the expected benchmark of 1. At no time has the SHMI value been of concern even when above the benchmark of 1. These values all lie within the expected range.

The Hillingdon Hospital SHMI values by publication month (January 2020 to January 2023) (Figure 2)



3.4 The Trust's SHMI is higher than our HSMR. Having interrogated the data of the four Acute Trusts across North West London; Hillingdon has the lowest proportion of deaths in hospital:-

THH: 67%, LNWH: 70%, C&W: 72.7%, Imperial: 73%.

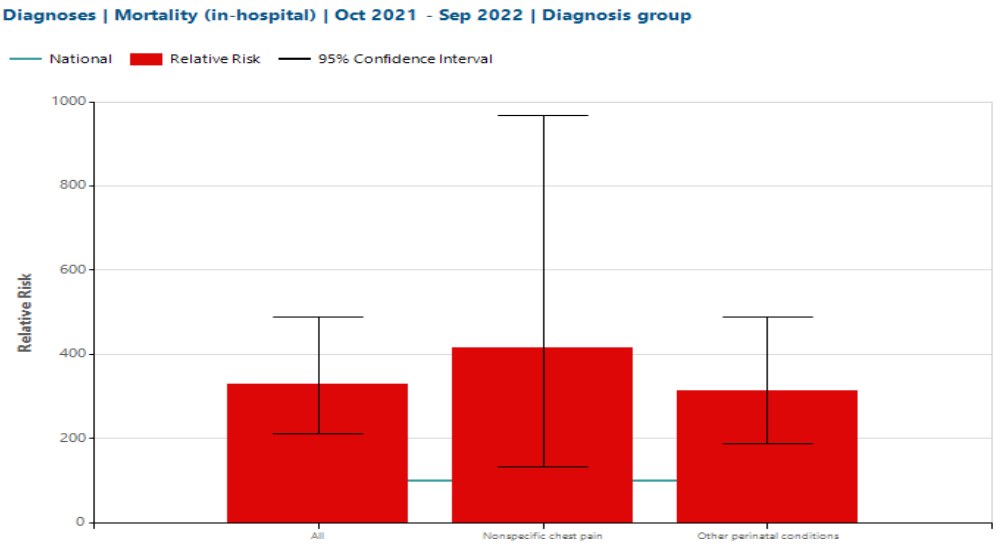
It is recognised that with more patients being allowed to die out of hospital, including palliative care deaths, the SHMI will be higher than the HSMR.

3.5 SMR Statistically Significant Diagnosis Groups (Figure 3)

These are used to identify areas of higher than expected deaths, Hillingdon has seen positive reporting in our SMR alerts in the last year and there are now only two alerts remaining, as seen below.

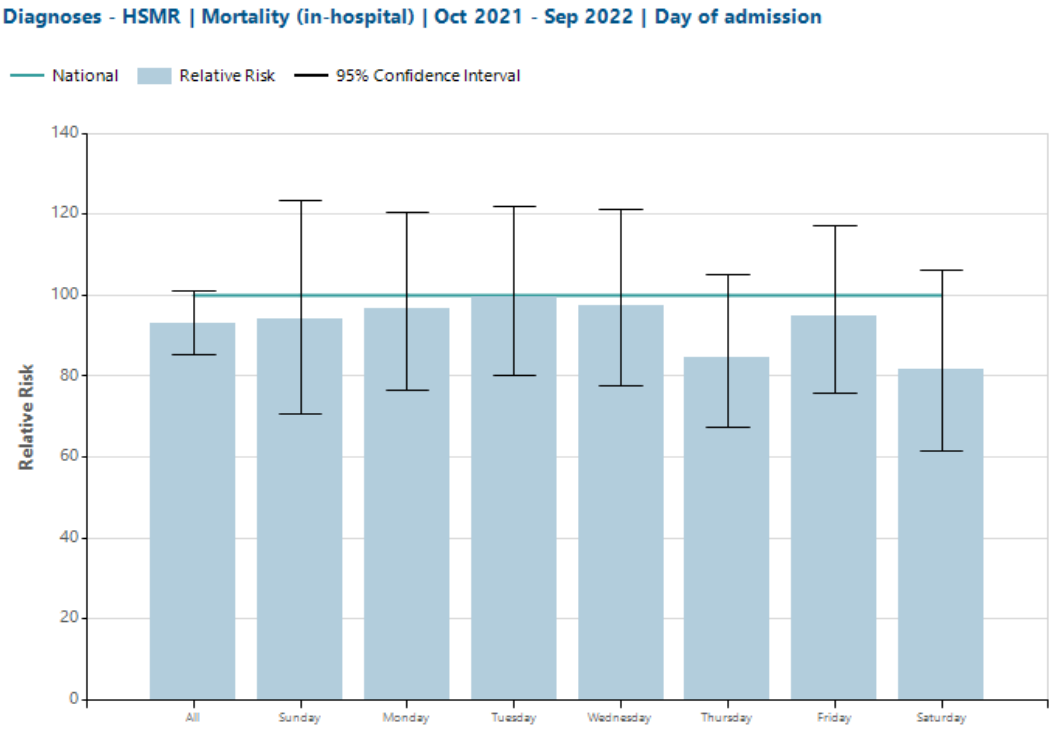
A review of patients for the 'non-specific chest pain' was carried out and it was identified that coding was incorrect for 4.5 of the 8 cases reviewed. Urgent refresher training of coders was carried out and a further checking process put in place to flag any deceased patient coding that appears to indicate a symptom code – these will be deferred back to the relevant consultant for clarification.

'Other perinatal conditions' is a common trigger for many Trusts. A previous audit identified a need for improved coding in live births. Despite this the alert has triggered again. A recent meeting with the Lead from West Middlesex, who previously had similar alerts, has identified that coding for stillbirths and neonatal losses is key. Action is now underway to identify improvements in coding. The lead of the coding team has been invited to be a core members of the Mortality Surveillance Group.



3.6 HSMR Day of admission – Emergency only (Figure 4)

Weekend admissions relative risk is now 87.4, which represents a consistent improvement in performance in the recent updates. Weekday admissions remain within expected range at 94.4, and lower than the NHS benchmark of 100. Data is consistent that there is not any one day that is outlying for any particular day of admission.



3.7 Palliative Care Coding

There is work being undertaken by the sector Mortality Working Group to look at palliative care coding across the four Acute Trusts. At Hillingdon we have a good process to capture data for patients that are reviewed by the Specialist Palliative Care Team to ensure that they are appropriately coded as receiving palliative care, this is currently under review.

The palliative care coding within SHMI shows Hillingdon to be close to the national average of 4.6%, compared to others in the Acute Collaborative.

- Imperial 6.2%
- THH 4.7%
- Chelsea 4.5%
- LNWH 3.0%

4. Medical Examiners Service

4.1 The Medical Examiner Service has scrutinised 630 adult and 4 paediatric deaths in Q1 to Q3 2022/23. This was 100% of in-patient deaths (excluding stillbirths); 45 deaths in Q3 were from outside the hospital. These 45 deaths are evidence of our preparedness for the statutory rollout of the Medical Examiner Service to scrutinise all non-coronial deaths in the non-acute sector from April 2023.

4.2 There were 157 (24.9%) referrals to the Coroner during this time, of which 47 (13.3%) were returned with instructions to complete a Medical Certificate of Cause of Death, and 73 (11.5%) were selected for further investigation. National comparator average figures for Coroner referrals are approximately 40% of deaths, with 17% further investigated. This is

evidence that the Medical Examiner Service is working successfully with the Coroner to reduce unnecessary referrals.

Our collaborative working with the Coroner is evidenced in a small number of cases where we have been asked by the Coroner to find a hospital certifier for patients discharged within the previous month where the GP feels unable to complete any certification.

4.3 The Medical Examiner Service recommended 49 (12.7%) Structured Judgement Reviews in Q1 to Q3 2022/23. This is an increase over the last period. We have recently redesigned the Level 1 Mortality Review from and streamlined the collection process into an online system.

4.4 The Health and Care Act 2022 contains the primary legislative framework for the rollout of the Medical Examiner Service to scrutinise all non-coronial deaths in the non-acute sector in addition to the acute sector, to be implemented in April 2023. Recruitment has been successful at Hillingdon to allow for this extra work.

4.5 5 A framework of pathways has been developed for each of the 5 types of community providers, in partnership with North West London ICB and the other stakeholders. The referral from Hillingdon GPs will be via their EMIS record system, and each GP practice has been contacted and offered training in advance of the rollout. Pilots are underway to assess and refine the models developed. There is full scrutiny of all deaths on the Mount Vernon Hospital site, from Michael Sobell Hospice and the Mount Vernon Cancer Centre. Negotiations are underway with Bishops Wood Hospital.

We are able to advise and assist GP's with Coroner referral where judged appropriate.

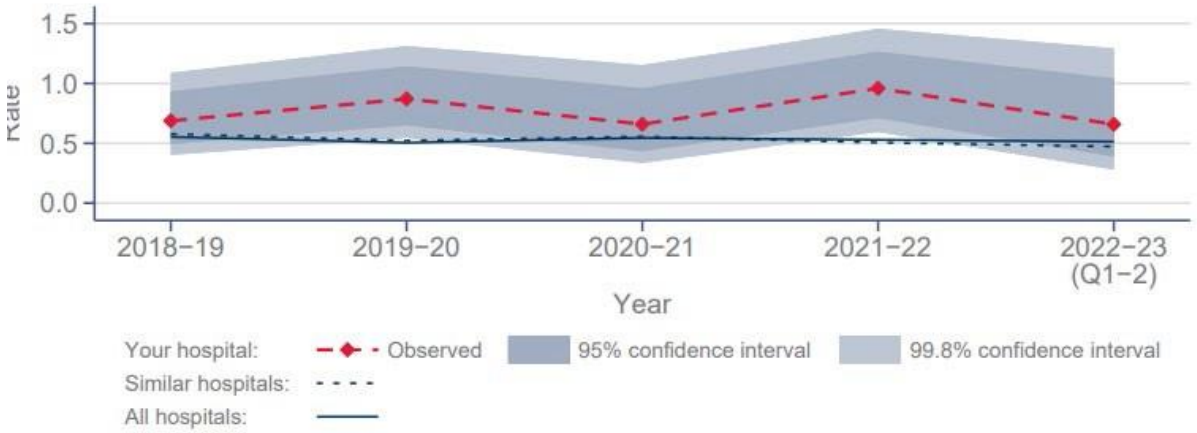
4.6 Work is underway to refine the models for urgent scrutiny outside normal office hours as required by some Faith traditions, and negotiations at a national level concerning funding are ongoing. Due to our current reliance on paper clinical records, we anticipate providing a local, rather than regionally networked solution for this.

5. National Cardiac Arrest Audit (NCAA) - Q2 1st April 2022 to 30th September 2022

5.1 NCAA data are collected for any resuscitation event, commencing in-hospital, where an individual (excluding neonates) receives chest compression(s) and/or defibrillation and is attended by the Trust's Resuscitation Team.

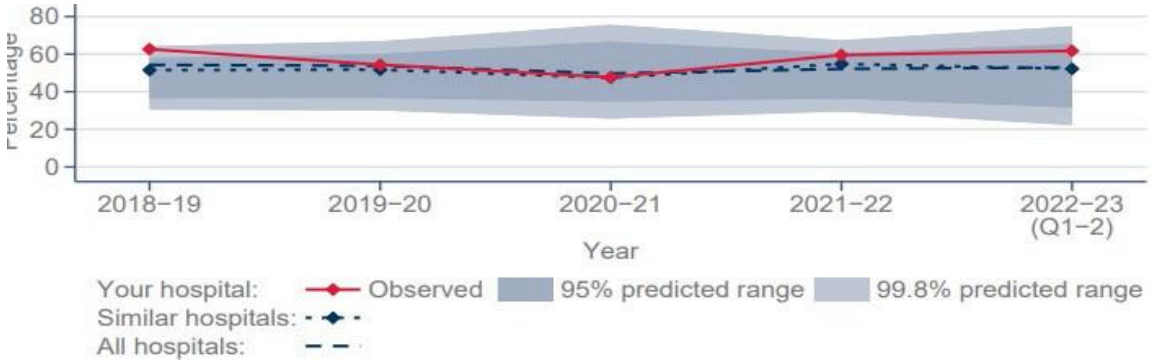
5.2 There were 27,342 patient admissions from 1st April 2022 to 30th September 2022 of which 36 patients had 46 Cardiac Arrest calls.

5.3 The rate of Cardiac Arrests per 1000 on the Ward has improved and reduced from Q1. This provides assurance that DNACPR forms are being completed when it is appropriate and consequently we are resuscitating the right patients.

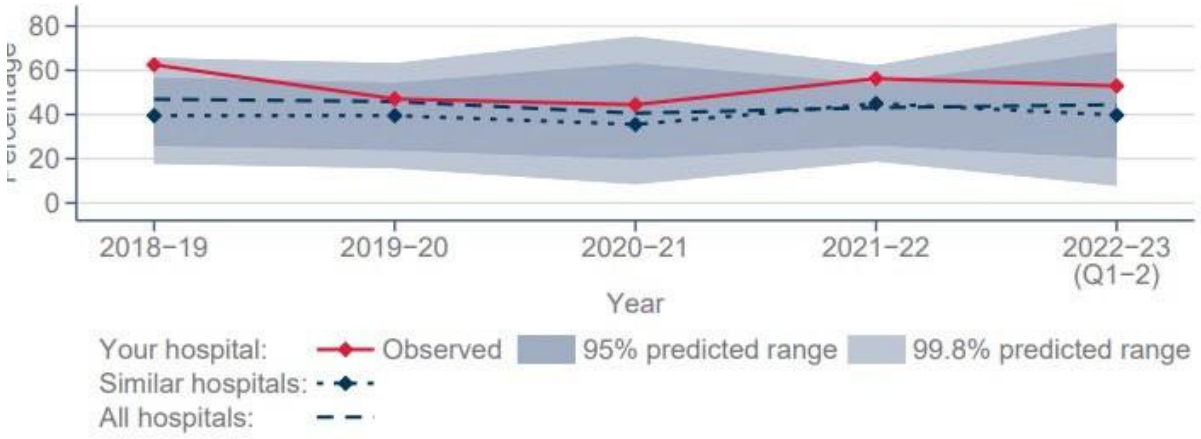


5.4 For the risk adjusted outcomes (compared to other similar hospitals) we are within or above the expected range for return of spontaneous circulation (ROSC) and survival to hospital discharge

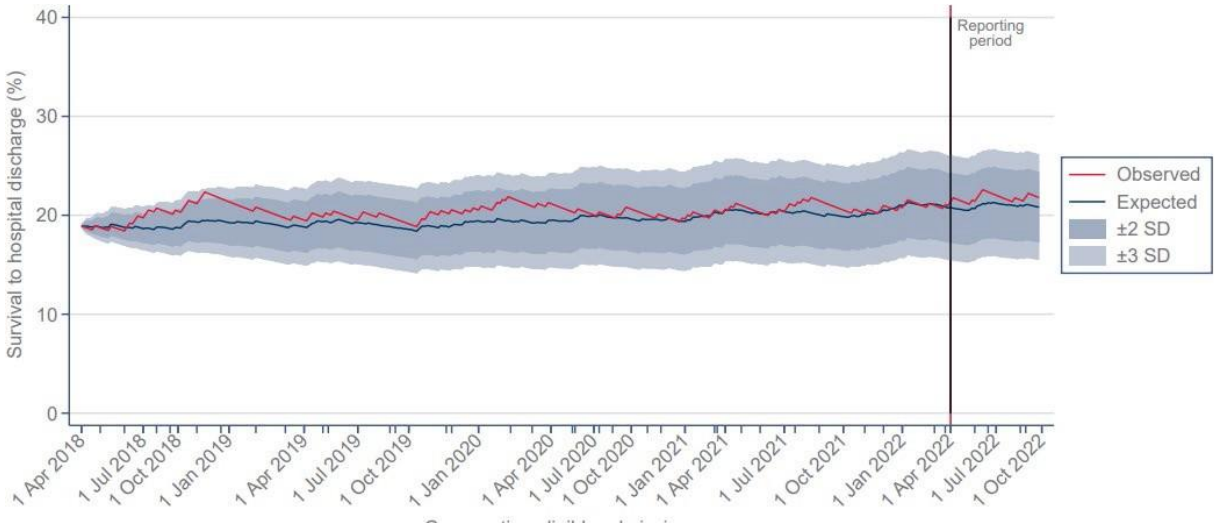
ROSC >20 minutes – above national average. Above expected.



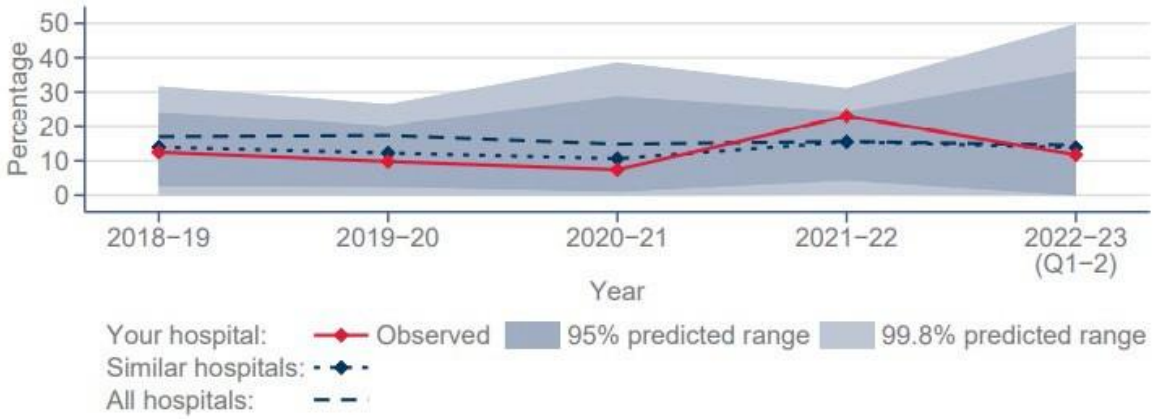
ROSC >20 minutes – Ward – 4th out of 20 hospitals similar to Hillingdon. Above expected.



Survival to Hospital discharge – Above expected.



Survival to hospital discharge on the ward has increased – 25%. Expected.



6. Summary of learning from deaths data Q3 2022/2023

6.1 There were a total of 168 inpatient deaths in Q3 2022/23, compared to 159 in Q2.

6.2 Of the total 168 deaths in the last quarter, 19 had Covid-19 on the Medical Certificate of Cause of Death compared to 32 out of the 159 deaths in Q2 2022/23.

6.3 There were 2 deaths in Q3 2022/23 of patients with Hospital Acquired Covid-19.

6.4 Although it is not a national requirement the Trust will continue to scrutinize any deaths for patients who had Hospital Acquired Covid-19 to ensure that there were no lapses in care or learning to be had. The 2 patients who subsequently tested positive for Covid-19 have had a Structured Judgement Review carried out.

6.5 29 cases for a Structured Judgement Review to be carried out were identified following completion of the Mortality Review Level 1 form for Q3 2022/23. On review not all of these cases met the criteria for a Structured Judgement review to be completed and feedback on these cases has been sent to the Lead Medical Examiner and Medical Examiner Officers to ensure we are requesting reviews for patients that are appropriate. The triggers for these can be seen in Table 1 below.

Table 1 – Level 1 Review Triggers for SJR by quarter

Triggers by Quarter	Q1 2022-23	Q2 2022-23	Q3 2022-23
Hip Fracture in this admission	2	5	6
Patient known Learning Disability	2	2	2
Patient known to have severe Mental Illness	2	0	4
Patient not expected to die by the Clinical Team	11	12	14
Family/Carers raised concerns about the care	12	10	6
Medical Examiner/certifying Doctors' concern	7	9	5
Potential for further learning in this case	10	27	12

(Note: There may be multiple triggers for a SJR)

6.6 15 Structured Judgement Reviews have been allocated for Q3 2022/23. Of the 15 cases allocated, 14 SJRs have been completed. The Clinical Governance Facilitator for Mortality is working with the Clinician to ensure that the 1 remaining SJR outstanding is completed.

6.6 Of the 14 Structured Judgement Reviews completed avoidability of death scores for Q3 2022/23 can be seen in Table 2 below.

Table 2 – Avoidability of Death Scores for Q3 2022/23

Number of cases	Avoidability of Death scores
0	Score 1 – Definitely avoidable
0	Score 2 – Strong evidence of avoidability
0	Score 3 – Probably avoidable (more than 50:50)
1	Score 4 – Possibly avoidable but not very likely (less than 50:50)
2	Score 5 – Slight evidence of avoidability
11	Score 6 – Definitely not avoidable

6.7 One of the 14 Structured Judgement Reviews completed gave an avoidability of deaths score of '4'. This case was been referred to the Division of Planned Care to review the areas highlighted for concern and to consider whether additional investigation is required.

6.8 The Mortality Level 1 Review form has been updated to take effect from 16th January 2023 with simpler triggers to identify if a Structured Judgement Review is required. The triggers can be seen in Table 2 below.

Table 3 – Level 1 Review Triggers for SJR from 16th January 2023

Unexpected death of a child under 18 (excluding stillbirth)
Patient had hospital acquired Covid
Patient had a recent procedure or operation
Patient had a known Learning Disability
Safeguarding concerns
Patient known to have severe Mental Health illness
Medical Examiner or certifying Doctor has concerns about the care
Concerns raised by family carer requiring further investigation
Potential for further learning
Patient was referred to the Coroner, for concerns about care

6.10 The Mortality Surveillance Group has decided to move to use the SJRplus review form as this is supported the 'Better Tomorrow' Team from NHSI. This is an electronic format which allows for easier interrogation of the outcome data. Training will be supported by the Better Tomorrow Team.

7. Themes and Learning

7.1 The outcomes of the 14 Structured Judgement Reviews completed was largely positive.

7.2 Good Practice identified that we had good recognition of the patients' condition with clear communication with patients/family and timely completion of 'DNAR' forms.

7.3 Work is underway to improve capture of themes and learning from the SJR process

7.4 Through Mortality & Morbidity (M&M) meetings cases will be discussed to identify key recommendations and actions. Learning will then be fed back through the Mortality Surveillance Group and disseminated via the Divisional Governance Groups for trust wide Learning.

7.5 M&M meetings take place monthly for surgery and trauma & orthopaedics. Learning is captured but needs to be better disseminated. Unfortunately there is not currently a mortality lead for surgery. The mortality governance facilitator will attend future M&M meetings to aid dissemination of learning

7.6 M&M meetings have not taken place yet in the Division of Unplanned Care as the first date set to take place during Grand Round in January 2023 was cancelled. This is rescheduled for 28th Feb 2023

7.7 Unplanned care do have an excellent Learning Newsletter that is distributed to the whole division after each quality and governance forum, this included learning from cases that have been investigated as complaints or SI. Documentation and communication are common themes, clear actions have been identified to improve which include an ongoing documentation audit and Next of Kin documentation proforma.

7.7 Learning from paediatric cases include resuscitation issues which have been included in MDT teaching and simulation training.

8. 'Better tomorrow Gap Analysis'

8.1 The Trust continues to participate in the 'Better tomorrow' process, run by NHSE&I. The Gap Analysis is reviewed and monitored via the Mortality Surveillance Group. The Gap Analysis table can be seen below. (Appendix 2)

9. Conclusions

8.1 The monthly HSMR and SHMI for Hillingdon remain within the normal range. The MSG continues to interrogate the data and drive improvement, particularly in coding.

8.2 Cases that identify areas of concern are referred to the appropriate division for review and to consider whether additional investigation is required.

8.3 Work continues to improve capture of themes and learning from the Learning from Deaths process

8.4 There are no risks to escalate for Q3 2022/23.

10. Recommendations

The Quality and Safety Committee are asked to note the mortality data and update to the learning from deaths process. These will be monitored through the Mortality Surveillance Group.

Appendix 1. **Dashboard for Structured Judgement Review avoidability scores**

Data from the Learning from Deaths table above is continuously collated into the Dashboard and reflects the Structured Judgement Reviews that have been completed but not the SJR's that have been issued and are outstanding as these will be updated when they have been returned. The avoidability scores from the outstanding Structured Judgement Reviews will be added to the data once completed and reflected in the next quarterly report. **Data accurate as of 20th January 2023*

	Month	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	1	2	3	4	5	6	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%
2022-23	Q1	167	23	0	0	0	0	0	3	22	2	2	0
2022-23	Q2	157	13	0	0	0	0	0	2	13	2	2	0
2022-23	Q3	168	14	0	0	0	0	0	2	14	2	2	0

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

Appendix 2. **Gap Analysis following initial review**

Criteria for excellence	Gap	Progress	Rag Rating
The Trust has an up-to-date Learning from Deaths Policy or Framework in place that conforms to national guidance.	Is there a plan for handling national changes and guidance that might take place before the next review in 2024? (particularly ME statutory provisions)	Any changes will be discussed in the Mortality Surveillance Group (MSG) and the Policy updated as appropriate.	
The Trust has established mortality oversight group with senior clinical leadership (including nurses and AHPs), clear terms of reference and a forward plan. The group meets regularly and has attendance and engagement from the appropriate corporate and clinical teams.	How does the Trust plan to evidence sustained multi-professional engagement, including Allied Health Professionals (AHPs)?	The current membership of the MSG includes a Specialist Midwife and a Deputy Director of Nursing Senior Nurses and AHP have been identified and are undertaking SJR Training. Once trained they will undertake SJR jointly with an established medical reviewer to gain experience	
The Trust uses a recognised tool such as Structured Judgement Review (SJR) to review deaths.	How will the Trust ensure that the information is collated without duplication of review? Particularly of any investigation process that may already have been already undertaken.	The Mortality Governance Lead co-ordinates such, that any cases that are investigated as a Serious Incident do not require a Structured Judgement Review but that the learning is captured and discussed as appropriate in Morbidity & Mortality (M&M) meetings.	

There is a named Learning from Deaths Lead and Medical Examiner with dedicated PAs, admin support and access to	Is the Trust part of a regional mortality group and is Trust mortality qualitative and	A Mortality Review Group task and finish group has been created as part of the Acute Collaborate. This group is meeting weekly to establish current practice across the	

Criteria for excellence	Gap	Progress	Rag Rating
professional development and a	thematic data shared with	Acute Collaborative, to ensure that	
local/regional/national network.	these groups?	appropriate data is presented to the Board and that learning from deaths is established equally across all 4 Trusts.	
There is enough skilled support to interrogate critical data sources – clinical systems, Datix, PLICS, claims database and highlight trends and themes.	How could the Trust make better use of internal data analytics and be confident in this business intelligence?	Currently the Mortality Data is provided by Dr Foster with excellent support in the Mortality Surveillance Group meetings. The Acute Collaborative Mortality Review Task and Finish Group are working to align HSMR and SHMI across the 4 Trusts	
Divisions report their data and learning into the Trust-wide group in a useful and meaningful way.	Is the Trust assured that all Divisions report their data in a meaningful way and that is there a way to ensure that reporting is not just process reporting with no learning?	The Data will be discussed in the M&M meetings. Work continues within the Division of Unplanned Care to establish regular M&M meetings, which are expected to commence in Q4 2022/3. The outcomes of these meetings will be monitored through the Divisional Governance meetings	

Mortality data is shared with external stakeholders.	How will the Trust ensure that other data is shared across the system to develop more comparative, rounded view of how well the Trust and system is performing; building on the work done and relationships made around covid deaths?	The MSG reports into the Trust Integrated Quality and Performance Report (IQPR) bi-monthly. This is reported through TMB to the Trust Board Subcommittees and ultimately to Trust Board. With the establishment of the Acute Collaborative the mortality data will be presented to the Joint Board.	

Criteria for excellence	Gap	Progress	Rag Rating
	Is any joint other work across	The Acute Collaborative Mortality Review	
	systems taking place, other than the Covid work?	Task and Finish group is currently establishing how data, processes and learning will be shared across the 4 Trusts.	
There is a defined risk management policy in place which sets out criteria for escalating mortality and avoidable harm risks to the appropriate level of management and expectations of teams for managing their risks.	Is there an established process that promotes consideration of mortality data in the wider clinical context of risk? Is this robust?	Currently the SI process captures those cases with the most significant learning; this is considered as part of key risks across the Trust. As the M&M meetings are established there will be actions identified which will allow the governance structure to triangulate work across incidents, complaints, audits as well as the SJR process. The Mortality Surveillance Group does have a clear escalation process through QSC to highlight risks from mortality.	
The Trust can evidence that it learns from deaths.	What measures does the Trust have in place to ensure there is active learning from deaths? How is the Trust assured it is working to create improvement?	Learning from Serious Incidents. M&M meetings in Planned Care Division. Learning can be disseminated via the Hils Bulletins and through the Divisions.	

Criteria for excellence	Gap	Progress	Rag Rating
		This does need to be more robust and will	
		be monitored though the Divisional Governance Groups and the MSG.	

NWL Acute Provider Collaborative Board in Common (Public)
18/04/2023
Item number: 5.1
This report is: Public

Audit and Risk Committee Chairs' Report

Accountable director: Aman Dalvi, Non-Executive Director and Audit Committee Chair – Chelsea and Westminster NHS Foundation Trust
Nick Gash, Non-Executive Director and Audit Committee Chair - Imperial College Healthcare NHS Trust
Vineta Bhalla, Non-Executive Director and Audit Committee Chair – London North West University Healthcare NHS Trust
Neville Manuel, Non-Executive Director and Audit Committee Chair – The Hillingdon Hospitals NHS Foundation Trust

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.

Chelsea and Westminster NHS Foundation Trust Audit and Risk Committee 31 January 2023

The Hillingdon Hospitals NHS Foundation Trust Audit and Risk Committee 20 February 2023

Imperial College Healthcare NHS Trust Audit, Risk and Governance Committee 18 January 2023

London North West University Healthcare NHS Trust Audit and Risk Committee 17 February 2023

Executive summary and key messages

Attached are the highlight reports from the audit and risk committee meetings:

- Chelsea and Westminster NHS Foundation Trust (31 January 2023)

- Imperial College Healthcare NHS Trust (18 January 2023)
- London North West University Healthcare NHS Trust (17 February 2023)
- The Hillingdon Hospitals NHS Foundation Trust (20 February 2023)

The Board in Common is asked to note the key findings in each of the reports and items escalated to the Board in Common from the individual Audit and Risk Committees.

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

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

North West London Acute Provider Collaborative
Chelsea & Westminster Hospital NHS Foundation Trust - Audit and Risk Committee
Chair's Highlight Report to the Board in Common – for discussion

Date of Audit and Risk Committee: 31 January, 2023 and 30 March 2023

Highlight Report of the meeting held on 31 January, 2023 and Escalation Matters from the meeting held on 30 March 2023

1. Purpose

1.1 The purpose of this report is to provide the Board in Common with assurance of the work undertaken by the Audit & Risk Committee at its last meeting on 31 January, 2023, and to highlight any matters of escalation from the meeting held on 30 March 2023.

2. Key Highlights

2.1 Positive Assurances Received

Counter Fraud Progress Report

2.1.1 The Local Counter Fraud Specialist (LCFS) Progress Report set out the activities pursued by the Counter Fraud team, and confirmed ongoing investigations and progress was being made since the previous Audit and Risk Committee meeting.

Counter Fraud Work Plan 2023/24

A full assessment had taken place and the Counter Fraud Work Plan for 2023/24 was approved. A prospective deep dive programme was agreed that included "pre-employment screening".

Annual Counter Fraud Functional Standards Return (CFFSR) Draft Submission

The Committee considered and approved the CFFSR Draft Submission. Strong performance was noted with all indicators achieving green status (an improvement on the previous year) with the exception of indicator 12 – policies and registers for gifts, hospitality and COI. It was noted that this indicator had been awarded amber status due to the current difficulty in providing assurance that all relevant staff had made either a positive or nil declaration in a timely manner. It was confirmed that from end April 2023, an electronic solution would be in place to achieve automated reporting, tracking and reminders to relevant staff on all required declarations.

Internal Audit

2.1.2 The Committee received a progress report from BDO against the internal audit plan and received and discussed the following :

2021/22 Internal Audit Plan
HR & IT RA Smartcard

2.1.3 A rating of limited assurance was given over the design and effectiveness of current controls and recommendations for improvement were accepted. A follow up report on implementation and effectiveness of the improvements was requested in advance of the June, 2023 meeting.

MCA & Consent

2.1.4 Internal Auditors concluded substantial assurance over design and moderate assurance over effectiveness of the controls in place.

Environmental Maturity

2.1.5 This was an advisory report, and the Trust has agreed to all of the recommendations and to build these into the Sustainability plan.

Staff Health and Wellbeing

2.1.6 Internal Auditors concluded substantial assurance over design and effectiveness of the controls in place. The auditors concluded this was a good report that illustrated how Health and Wellbeing was in place to support staff across the Trust.

Business Continuity

2.1.7 A rating of substantial had been awarded for design opinion and a rating of moderate for design effectiveness

Key Financial Systems

2.1.8 A rating of substantial had been awarded for design opinion and a rating of moderate for design effectiveness.

HfMA Financial Sustainability and Benchmarking

2.1.9 The Trust conducted its own self-assessment and the results demonstrated a high level of compliance. At the March meeting we received the comparative findings across the NWL Acute Provider Collaborative to enable shared learning to take place in relation to aspects of strength.

Serious Incidents

2.1.10 Internal Auditors concluded substantial assurance over design and effectiveness of the controls in place. This report was commended and issues were being addressed.

Board Assurance Framework (BAF)

2.1.10 During December, 2022, and January 2023, Executive Directors were requested to update their relevant BAF risks prior to consideration at their respective overseeing Committees; Finance & Performance Committee, People & Workforce and Quality Committee in January, 2023. The risk scores were populated based on the strength and effectiveness of existing controls and assurances. Whilst some gross inherent risk scores were noted as 'red' in the BAF templates, these were mitigated by a range of controls and assurances. The Audit & Risk Committee considered that the BAF process was good and that there was visibility of the risks.

Risk Assurance Framework

2.1.11 The Committee received a report which provided an overview of the risk register process and the risks recorded within the Trust's Datix risk register system. The dataset was used to support risk assurance reporting to all the committees of the Board (and sub-groups) so that a snap shot of the Trust's risk profile could be assessed. There were a total of 293 risks. It was agreed that a discussion would take place between Audit Chairs across the Collaborative relating to risk appetite levels and approaches.

Cyber Security Report

2.1.12 The Trust has scaled up focus on Cyber Security and through the capital investment programmes, support work has been undertaken to improve compliance and security of both the PC and Server estates. The Trust continues to rank in the lower risk category for workstations and medium risk for Server estate. In respect to Ransomware attacks, it was confirmed that regular back-ups were done and measures in place in order to prevent such an attack from happening.

Impact of New Accounting Standards

2.1.13 New Accounting Standards IFRS17 come into effect on 1 April, 2023, but they are not expected to have a significant impact.

Annual Report and Accounts Process and Timetable

2.1.14 Committee noted the timeframe and production of the Annual Report and Accounts 2023/24.

2.2 Key Risks to Escalate

2.2.1 Nothing to report

2.3 Concerns Outstanding

2.3.1 Nothing to report

2.4 Key Actions Commissioned

2.4.1 Nothing to report

2.5 Decisions Made

2.5.1 The following policies were approved:

- Counter Fraud and Corruption Policy
- Salary Under and Overpayments Policy
- Expenses Policy
- Standing Financial Instructions
- Scheme of Delegation
- Fixed Asset Policy and Procedure
- Capital Governance Framework
- Credit Management Policy
- Treasury Management Policy

3. Summary Agenda

January 2023

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Counter Fraud Progress Report	Noting	9.	Impact of New Accounting Standards	Noting
2.	Internal Audit 2022/23 Progress Report	Noting	10.	Policies for Approval	Approval
3.	Internal Audit Recommendations and Implementations	Noting	11.	Losses and Special Payments including Write Offs	Noting
4.	Internal Audit Reports	Noting	12.	Waivers of SFIs	Noting
5.	External Audit	Noting	13.	Audit Committee Forward Plan	Noting
6.	Board Assurance Framework	Noting			
7.	Risk Assurance Framework	Noting			
8.	Cyber Security Report	Noting			

March 2023

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Counter Fraud Progress Report	Noting	10.	Information Governance Update	Noting
2.	Annual Counter Fraud Functional Standards Return (CFFSR) Draft Submission	Approval	11.	Review of Committee Effectiveness	Noting
3.	Internal Audit 2022/23 Progress Report	Noting	12.	Better Payments Practice Code	Noting
4.	Internal Audit Recommendations and Implementations	Noting	13.	Annual Review of Banking Arrangements	Noting
5.	Internal Audit Reports	Noting	14.	Policies for Approval	Noting
6.	External Audit	Noting	15.	Property Plant and Equipment Valuation	Noting
7.	Annual Report and Accounts Process	Noting	16.	Losses and Special Payments	Noting
8.	Risk Assurance Framework	Noting	17.	Waivers of SFIs	Noting
9.	Cyber Security Report	Noting	18.	Audit Committee Forward Plan	Noting

4. 2022 / 23 Attendance Matrix

	Attended				Apologies & Deputy Sent				Apologies			
Members:	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Nick Gash (ceased membership)	X	X	X	✓	X	X	-	-	-	-	-	-
Steve Gill (ceased membership)	X	X	X	✓	X	X	-	-	-	-	-	-
Aman Dalvi	X	X	X	✓	X	X	✓	X	X	✓		✓
Dr Syed Mohinuddin	-	-	-	-	X	X	✓	X	X	✓		✓
Catherine Jervis	-	-	-	-	X	X	✓	X	X	✓		✓

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

North West London Acute Provider Collaborative
Imperial College Healthcare NHS Trust
Audit and Risk Committee Chair's Highlight Report to the Board in Common

Date of Audit and Risk Committee: 18th January 2023

Highlight Report

1. Key Highlights

External Audit

1.1 The Committee received a report on the audit plan for 2022/23 which set out the scope of work, and any changes to this.

1.2 The Committee noted the significant risks around property valuation, capital expenditure, management override of controls, and existence of plant and machinery, information technology and fixtures and fittings and the planned focus on responding to these.

1.3 The Committee also noted that there had been a change in accounting standards with the implementation of the IFRS 16 from 1st April 2022 which had a significant impact on the Trust with an expected right of use asset of £34.4m and a lease liability of £33.9m being recognised.

Update on valuations process and deployment of fixed assets policy

1.4 The Committee noted a report updating on actions being undertaken with regards to the Trust's accounting processes for the valuation of land and buildings assets in preparation for the 2022/23 statutory accounts.

1.5 The committee noted that it had been jointly agreed that the timing of the valuation process for 2022/23 would be brought forward, with the core work being undertaken earlier than in previous years to improve the management of the audit work and capacity.

Accounting treatments/judgements paper

1.7 The Committee received the report outlining the approach to several significant accounting judgements which may be taken for accounting purposes, and indicates, where possible, the applicable accounting standards that underpin these treatments.

1.8 The Committee noted that additional assurance had been built in this year's report following recommendations from the 2021/22 audit.

1.9 The committee were assured that all actions would be monitored regularly by the finance team and any challenges that arose would be addressed sooner rather than later.

1.10 The Committee also noted that the new IFRS 16 leasing standard came into effect from 1st April 2022, and this had been included in the report.

Internal audit update

Internal audit progress report

1.11 The committee received the report providing an update on the work undertaken against the 2022/23 internal audit plan noting that all actions were on track, and a number of assignments had been finalised and circulated to the Committee.

1.12 The Committee noted that one of the final report on Discharges: Data Quality had received a rating of 'Partial assurance with improvements required'. The Committee were assured that the Trust now had an organisational programme focused on embedding daily board rounds and the audit had allowed the Trust to identify and plug any gaps. The Trust had also recently allocated responsibility for discharges to clinical directors, and therefore anticipated this would have an impact. A detailed report on data quality will be presented at the next meeting in April 2023 which should provide significant assurance.

Counter fraud progress report

1.14 The Committee received the counter fraud progress report detailing progress made against the 2022/23 plan.

1.15 The Committee noted that the final targeted workshop for Divisions, ICT and Estates were planned for January 2023, and scoping work on mandate fraud workshops for senior management and accounts payable teams had begun.

1.16 The Committee had previously noted that the number of reactive referrals appeared low, however were informed that the number of reactive referrals received had now started to increase.

Risk and Assurance Report including update on Collaborative Risk Management Approach

1.17 The committee received a verbal update, noting that there was no written report largely due to operational teams prioritising activity to responding to operational pressures rather than maintenance of risk registers.

1.19 The Committee also noted that the proposed Collaborative risk management approach had been discussed by the audit chairs in December 2022, and it had been agreed that in general risks should be owned and managed at Trust level, with the purpose of the Collaborative being to identify actions that could be taken collectively to help Trusts manage their risks.

Reports from Board sub-committees re risk and assurance deep dives and key risks

1.20 The committee received the sub-committee Board summary report from the People Committee, and Finance, Investment and Operations Committee, noting that the Quality Committee was to take place following this meeting, on 19th January 2023.

Losses and Special Payments

1.21 The Committee noted the report outlining all losses and special payments approved in the third quarter of the 2022/23 financial year.

Tender Waiver Report

1.22 The Committee noted the report setting out the number and value of tender waivers authorised during Quarter 3 of the financial year 2022/2023.

Committee Forward Planner

1.23 The committee received and reviewed the forward planner.

2. Positive Assurances Received

Annual committee report – People Committee

2.1 The Committee received the report outlining key highlights from the People Committee over the last 12 months, updates on how the People Committee receives assurance around key risks, and strategic priorities for 2022/23.

2.2 The Committee noted that staff stories are provided at each meeting, which had proved to be very helpful in providing assurance that the Trust are committed in Equality, Inclusion and Diversity.

2.3 A number of key highlights were discussed, including the development of the Health & Safety Framework being developed to ensure that the Trust were following rules and guidelines. The annual National staff survey results and action plan, and driving response rates had been a big focus of the committee.

2.4 The People Committee regularly reviewed the risk register for people and OD, including violence and aggression toward staff, looking at ways to protect staff; The risk of BAME staff not progressing to band 7+ roles to reflect the workforce composition, with the committee assisting in creating a sense of accountability on a number of recruitment decisions; The Committee were also looking into one of the biggest risks, Recruitment and Retention and were looking into mid-long term actions to put in place.

Extreme Risks Deep Dive

2.5 The Committee noted that, since the discussion held at the November meeting around risk profile and the 110 extreme risks, a thorough review had taken place at an Executive Transformation Session, looking at risk assessments for each risk along with controls and mitigations in place. The executive team were then able to appropriately downgrade a number of risks. Subsequent follow up validation work was then carried out with divisions and directorates which in turn led to bringing that number down to 38 currently. Work to validate those that remain was ongoing.

2.6 All risks would be reviewed and validated by the Executive Management Board, and an updated report will be brought the next meeting in March 2023. We would then look at the process of allocating those to appropriate committees to seek oversight and management of those risks.

3. Key Risks to Escalate

None

4. Concerns Outstanding

None

5. Key Actions Commissioned

None

6. Decisions Made

None

7. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	External Audit Report			To note	9.	Reports from Board sub-committees re risk and assurance deep dives and key risks			To note
2.	Update on valuations process			To note	10.	Losses and Special Payments			To note
3.	Implementation of FAR & deployment of Fixed assets policy			To note	11.	Tender Waiver report			To note
4.	Accounting treatments/judgements paper			To note	12.	Committee Forward planner			To note
5.	Internal Audit Update			To note	13.				
6.	Risk and Assurance Report including update on Collaborative Risk Management Approach			To note	14.				
7.	Risk and Assurance Deep Dive – Extreme Risks			Assurance	15.				
8.	People Committee Annual Deep Dive			Assurance	16.				

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

North West London Acute Provider Collaborative
London North West University Healthcare NHS Trust
Audit and Risk Committee Chair's Highlight Report to the Board in Common
Date of Audit and Risk Committee: 17 February 2023

Highlight Report

1. Key Highlights

Audit
Internal Audit Report

1.1 The draft internal audit plan for 2023-24 was presented to the Committee for approval. Four final audit reports were presented.

External Audit Report

1.2 The Charitable Fund financial statements were filed with the Charities Commission ahead of the January deadline. Work is being undertaken to finalise the interim audit and complete the value for money risk assessment.

HMRC PAYE Compliance Audit

1.3 HMRC undertook a PAYE compliance audit on the Trust's salary sacrifice schemes; the audit is now complete and no issues were identified.

Risk
Board Assurance Framework

1.4 The Board Assurance Framework has been refreshed by the Executive Team and has been transformed from 12 to 7 risks. They will be monitored and used to set organisational goals. Some risks sit outside of the Trust's risk appetite and they will be reviewed at the end of the financial year.

Risk Report

1.5 The latest approved risk register was presented to the Committee.

Governance

1.6 Summary year end accounts timetable 2022/23

The Committee received a summary timetable for the 2022/23 financial statements and a detailed step-by-step operational timetable for the year end accounts process. The Committee reviewed the accounting policies and assumptions for 2022/23.

Losses and Compensation Report

1.7 The Committee received the losses and compensation claims processed in the current financial year up until 31 January 2023.

Debt Write-Offs

1.8 The Committee received a report containing the debt write-offs authorised by the Chief Financial Officer and Chief Executive Officer as at 31 January 2023. The Committee noted

that overseas visitor debt continues to be an area of difficulty and agreed that it may be beneficial to address this as part of the Collaborative.

Counter Fraud Report

1.9 The Committee received a summary of work that has taken place since the last meeting.

2 Positive Assurances Received

Internal Audit Programme 2022/23

2.1 The Internal Audit Programme for 2022/23 is progressing to plan, and the Committee reviewed the following completed internal audit reports:

- Complaints
- Divisional governance – surgery
- Cultural maturity
- Key financial systems – inventory

3 Key Risks to Escalate

3.1 None

4 Concerns Outstanding

4.1 None

5 Key Actions Commissioned

Key Financial Systems – Inventory

5.1 This internal audit received limited assurance on opinion and design; it is unlikely that there is a material problem with the inventory valuation, but a lack of control was noted. A detailed update will be produced for the TEG to enable review of the action plan, a progress report will be submitted to the Committee and an in-depth follow-up internal audit report has been requested by the end of 23-24.

HFMA Benchmarking Report

5.2 The Trust scored below average in a number of areas of this report and an improvement plan in place. The Collaborative benchmarking report is available and will be circulated to the Committee and the Collaborative Finance and Performance Committee for consideration.

6 Decisions Made

Draft Internal Audit Plan 2023-24

6.1 The Committee received and approved the 2023/24 internal audit plan.

Summary year end accounts timetable 2022/23

6.2 The Committee approved the timetable for the production of the 2022/23 annuals accounts and report. The Committee noted the agreement to request delegation of authority from the NWL Acute Collaborative Board in Common for the local Committee to approve the annual accounts and report.

7 Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	Welcome and Apologies for Absence			-	10.	Summary year end accounts timetable 2022/23			Discussion

2.	Conflicts of interest			-	**11.**	Review of accounting policies and assumptions 2022-23			Discussion
3.	Minutes of the meeting held on 2 December 2022			-	**12.**	2022/23 Financial Statements - Going concern assessment			Discussion
4.	Review of Action Register			-	**13.**	Land and Buildings valuation 2022/23			Discussion
5.	Internal Audit Report			Approval	**14.**	Losses and Compensation Report			Discussion
6.	External Audit Report			Approval	**15.**	Review of Debtors and Creditors			Discussion
7.	HMRC PAYE Compliance Audit			Assurance	**16.**	Debt Write Offs			Discussion
8.	Board Assurance Framework			Assurance	**17.**	Counter Fraud Report			Discussion
9.	Risk Report			Assurance	**18.**	Any other business			Discussion

North West London Acute Provider Collaborative
The Hillingdon Hospitals NHS Foundation Trust

Audit and Risk Committee (ARC) Chair's Highlight Report to the Board in Common

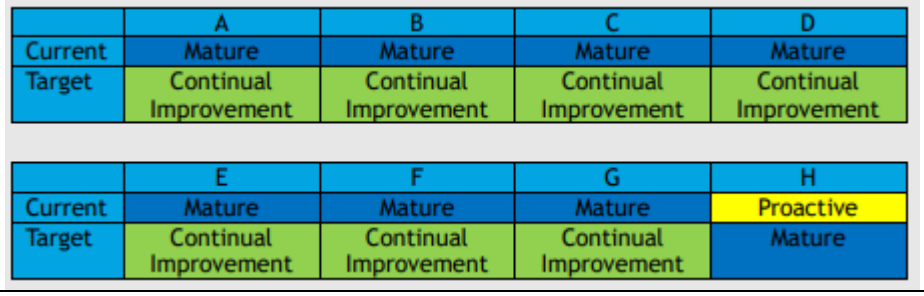
Date of Audit and Risk Committee: 20th February 2023

Highlight Report

1. Key Highlights

Internal Audit

1.1.1 The Committee received the Internal Audit Progress report – with four audits finalised and one at the draft report stage. Of the 4 audits completed the committee noted the rating, findings and recommendations as follows:

Name	Design rating	Effectiveness Rating
Sickness Absence	Moderate	Limited
Clinical Coding	Substantial	Moderate
Accounts Receivable	Moderate	Moderate
HFMA Financial Sustainability		

1.1.2 The committee has triangulated these reports to relevant committees of the Board.

1.1.3 The committee noted good progress made against closing recommendations from previous Internal Audits.

1.1.4 The committee received and the draft Internal Audit Plan for 2023/24, and agreed to triangulate this with Board committee chairs for input, ahead of final approval.

1.1.5 The committee also received and noted:

- Hillingdon HFMA Benchmarking Report
- North West London Health Economy HFMA Benchmarking Report
- EDI – Considerations for Audit Committee report

External Audit

1.2.1 The Committee received and noted the planning report for the year-end audit and regulatory changes to the audit process and requirements for the year ending 2022/23.

Finance

The committee noted:

1.3.1 Review of losses and special payments: No write offs in quarter 3 of 2022-23. The committee noted two minor ex-gratia payments following patient claims.

1.3.2 Review of non-compliance with SFIs: The volume and value of waivers has decreased in the current financial year, and waivers relating to capital expenditure continue to be a significant reason for waivers to be raised. The committee requested further granular breakdown of the data by area to identify any hotspots.

1.3.3 Debtors – That aged debtor balances are £2.3m higher than the level at the last year end. Overseas visitors make up approximately 50% of the balance, NHS organisations approximately 28%, and non NHS organisations approximately 20%. The committee noted mitigating actions and escalations, and that the Overseas process will be explored by Internal Audit in 2023/24.

1.3.4 Better Payment Practice Code (BPPC) – That BPPC performance has remained high, with 92% of all invoices (by value) being paid within 30 days.

1.3.5 Implementation of IFRS16 - The actions taken by the Trust so far in relation to the implementation of the new standard, assesses the impact of the standard and sets out next steps in relation to the financial statements.

Update on SFIs

1.4.1 The committee received a verbal update and noted work underway to standardise SFIs across the NWL Acute Provider Collaborative.

Grip and Control

1.5.1 The committee received an update against the delivery of the Grip and Control Programme and noted that following good progress on the Grip and Control (G&C) workstream, the Trust will move to a second phase of G&C using a revised checklist being piloted by NHSE

Counter Fraud

1.6.1 The committee noted one new referral and received an update on 4 open cases. The committee noted the proactive work the LCFS has continued to deliver i.e. Monthly 'Fraud Chats', Newsletters and onsite engagement with staff, work underway to assess matches

against the National Fraud initiative for 2022/23, and declaration of secondary employments.

Health & Safety Executive - Sharps Improvement Notice

1.7.1 The Committee received assurance and noted the progress made to date and further work underway to address the Health & Safety Executive improvement notice for radiology and the Notice of Contravention related to the management and prevention of sharps injuries.

Board Assurance Framework Refresh

1.8.1 The committee approved the Trust Risk Appetite Statements, approved the refreshed Board Assurance Framework Risk (BAF) aligned to the committee and noted the refreshed BAF risks aligned to committees of the Board.

Report from the Risk Management Group

1.9.1 The Committee received assurance and noted:

- The Trusts Risk Management KPIs
- Outputs from the Trust Risk Management Seminar December 2022
- The Trusts Risk Management Training arrangements.
- Progress against the recommendations from the KPMG Strategic Risk Governance Review
- A Summary of work undertaken by the Risk Management Group between July 2022 and February 2023.

2. Positive Assurances Received

Emergency Preparedness, Resilience and Response (EPRR)

2.1.1 The Committee noted following the Trusts annual EPRR visit led by NHS England EPRR team, the Trust was assessed as being Substantially Compliant against the EPRR Core standards.

Timetable for the Annual Reports and Accounts 2022/23

2.2.1 The Committee noted the timetable for the production of the 2022/23 Annual Report and Accounts. The Committee noted the agreement to request delegation of authority from the NWL Acute Collaborative Board in Common for the Committee to approve the Annual Report and Accounts.

3. Key Risks to Escalate

None

4. Concerns Outstanding

None

5. Key Actions Commissioned

None

6. Decisions Made

Health and Safety Policy

6.1.1 The Committee will seek delegated authority from the Hillingdon Board of Directors via the next Board in Common to ratify the Health and Safety Policy.

Derestriction of Charity Funds

6.2.1 The committee supported the proposal to derestrict two funds held by the Trust charity, as recommended by the Charitable Funds Committee, for onward approval by the THH Trust Board.

7. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	Welcome and Apologies for Absence			-	10.	Grip and Control update			Assurance
2.	Conflicts of interest			-	11.	Sharps Improvement Notice			Assurance
3.	Minutes of the meeting held on 28th November 2022			-	12.	Health and Safety Policy			Approval
4.	Review of Action Log			-	13.	Report from the Risk Management Group			Assurance
5.	Internal Audit Report			Assurance	14.	Board Assurance Framework Refresh			Approval
6.	External Audit Report			Note	15.	Timetable for the Annual Report and Accounts 2022/23			Assurance
7.	Counter Fraud Report			Note	16.	EPRR Assurance			Discussion
8.	Finance Report			Assurance	17.	Any other business			Discussion
9.	Update on SFIs			Note	17.1	Derestriction of Charity Funds			Approval

NWL Acute Provider Collaborative Board in Common (Public)
18/04/2023
Item number: 5.2
This report is: Public

Board in Common Cabinet – Committee Summary

Author and Job Title: Philippa Healy, Business Manager

Accountable director: Matthew Swindells
Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

This paper provides an update on items discussed at the Board in Common Cabinet held on 14 February and items conducted via e-governance on 14 March 2023.

Report history

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

Board in Common Cabinet 14/02/2023 Noted	**Board in Common Cabinet (via e-governance)** 14/03/2023 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.

Due to industrial action on 14 March 2023, the Board in Common Cabinet meeting was stood down and any business was conducted via e-governance. The following four business cases were endorsed/approved:

1. Elective Orthopaedic Centre – Decision Making Business Case (EOC DMBC)

- The North West London Elective Orthopaedic Centre (EOC) Decision Making Business Case (DMBC) was presented to the Board in Common Cabinet, via e-governance, for

consideration and endorsement to proceed to the NWL Integrated Care Board on 21 March 2023.

- Members highlighted the following:
  - The Full Business Case will need to be clear on a number of outstanding issues as noted at the Acute Provider Collaborative Finance and Performance Collaborative Committee on 10 March 2023, including the financial business case and the governance for continued monitoring of the implementation.
  - Recruitment to the EOC, and whether it can be staffed in the timescale anticipated, were key risks to the successful implementation.
- The Board in Common Cabinet **endorsed** the Elective Orthopaedic Centre Decision Making Business Case to proceed to the North West London Integrated Care Board on 21 March.

2. London North West University Hospital Trust (LNWH): Endoscopy Capital Development – Final Business Case

- The Final Business Case for the LNWH Endoscopy Capital Development was presented to the Board in Common Cabinet, via e-governance, for approval. The programme aims to support Joint Advisory Group (JAG) accreditation and improve productivity and efficiency at both the Central Middlesex and Northwick Park sites for the delivery of endoscopy.
- The LNWH Finance and Performance Committee approved the final business case, subject to further work on efficiency, at its meeting on 22 February 2023.
- The Board in Common Cabinet **approved** the Endoscopy Capital Development – Final Business Case.

3. Chelsea and Westminster NHS FT (CWFT): Ambulatory Diagnostics Centre - Outline Business Case

- The Outline Business Case (OBC) for the planned development of an Ambulatory Diagnostic Centre (ADC) was presented to the Board in Common Cabinet, via e-governance, for approval. The planned development, on a vacant site to the rear of the West Middlesex site, will enable the expansion of existing clinical services, such as increased capacity for imaging, haematology and oncology treatments and renal dialysis services.
- The CWFT Finance and Performance Committee, at its meeting on 28 February 2023, recommended the case for approval to the Board in Common Cabinet.
- The Board in Common Cabinet **approved** the CWFT Ambulatory Diagnostics Centre Outline Business case.

4. Chelsea and Westminster NHS FT (CWFT): Treatment Centre Refurbishment - Strategic Outline Case

- The Treatment Centre Refurbishment - Strategic Outline Case was presented to the Board in Common Cabinet, via e-governance, for approval. The case for change focussed on refurbishing the 7 treatment centre theatres at the Chelsea site, developing a 23 hour recovery model and set out how the Trust will maintain activity and the next steps for enabling the refurbishment.
- The CWFT Finance and Performance Committee, at its meeting on 28 February 2023, recommended the case for approval to the Board in Common Cabinet.
- The Board in Common Cabinet **approved** the CWFT Treatment Centre Refurbishment Strategic Outline Case.

Executive summary and key messages

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

The key items to note from the Board in Common Cabinet meeting held on 14 February were:

CEO Update on significant issues

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

- Preparations for the 'Go live' implementation date for Cerner at London North West University Hospital Trust (LNWH) and The Hillingdon Hospitals NHS Foundation Trust (THHFT)
- Implications of wider digital programmes, business intelligence, IT infrastructure and resource.
- A brief discussion around capital spend allocations.
- Gubby Ayida, Medical Director at THHFT, was due to leave the Trust at the end of May 2023. Interim arrangements were being put in place pending appointment to the substantive post.
- Industrial action preparation and implications across the Trusts.

Integrated Performance, Quality and Workforce Report

No performance report was provided to the Board in Common Cabinet on this occasion.

Urgent Treatment Centres

The Board in Common Cabinet received an update on the Urgent Treatment Centres (UTC) at LNWH and THHFT. Both Trusts have currently taken on the temporary UTC provision and staff worked hard to ensure a smooth transition in challenging circumstances. The North West London Integrated Care Board are leading the process on the procurement of UTC services.

Elective Orthopaedic Centre

The Board in Common Cabinet received an update on the Elective Orthopaedic Centre (EOC) which had entered the decision making and consultation phase. The public consultation report was formally presented to the NWL Joint Health Overview and Scrutiny Committee on 8 March 2023. Feedback from the public consultation evaluation report was positive, overall participants felt the EOC would improve patient outcomes. Work is ongoing in response to feedback in some key areas including patient transport and post-operative discharge.

The decision making business case (DMBC) was presented to the Board in Common Cabinet, via e-governance, in March (see above), and subsequently the NWL ICB Board endorsed the DMBC, delegating authority for the Acute Provider Collaborative to oversee the full business case and implementation of the programme.

Update on business planning and joint forward plan

The Board in Common Cabinet noted operational, finance and workforce plans were being developed for 2023/24 and were progressing well. Further work was needed around financial plans, following review by the Acute Chief Finance Officers group. The draft plan was submitted

to the Finance and Performance Collaborative Committee in March and would then go on to the Board in Common in April 2023. The Board in Common Cabinet noted the good progress made however noted further granularity was needed around cost improvement plans.

Board development session agenda
The Board in Common Cabinet noted the agenda and planning for the Board in Common development session on 21 February 2023, where the Board discussed the Collaborative priorities for 2023/24 to support the Business Planning process.

Corporate Governance model
The Board in Common Cabinet received an update on the preferred model for the provision of corporate governance services at Trust and Collaborative level, and agreed approach.

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

NWL Acute Provider Collaborative Board in Common (Public)
18/04/2023
Item number: 6.1
This report is: Public

Trust Seal Annual Report

Author: Jessica Hargreaves
Job title: Deputy Director of Corporate Governance, ICHT

Accountable director: Peter Jenkinson & David Searle
Job title: Director of Corporate Governance (ICHT & CWFT) & Director of Corporate Affairs (LNWH & THHFT)

Purpose of report

Purpose: Information or for noting only

The Trust's standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis. The report includes the use of the Trust seal during FY 2022/23 for all four Trusts within the Acute Provider Collaborative.

The Board in Common is asked to note the report and the use of the Trust Seal.

Report history

Outline committees or meetings where this item has been considered before being presented to this meeting: N/A

Executive summary and key messages

The Trust's standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis. The report includes the use of the Trust seal during FY 2022/23 for all four Trusts within the Acute Provider Collaborative.

The Board in Common is asked to note the report and appendices and the use of the Trust Seal.

The appendices detail each Trusts use of their Trust seal:

Appendix 1: Chelsea & Westminster NHS Foundation Trust
Appendix 2: The Hillingdon Hospitals NHS Foundation Trust

Appendix 3: Imperial College Healthcare NHS Trust
Appendix 4: London North West University Healthcare NHS Trust

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Reporting use of the Trust seal enables review of the contracts, property agreements and other documentation that has been entered into during the year, acting as a control to reduce risk of misuse

Reason for private submission

Tick all that apply

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

If other, explain why

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Use of the Trust Seal

This report covers the period April 2022 to March 2023.

Seal No.	Date	Description
212	01/04/2022	Chelsea & Westminster Hospital Foundation Trust & CW Medicines Limited - Lease relating to Pharmacy unit on the ground floor at Chelsea & Westminster Hospital, 369 Fulham Road, London SW10 9NH
213	18/05/2022	Assura Aspire Limited, Chelsea & Westminster Hospital Foundation Trust & CW Medicines Limited - License to underlet relating to the part lower ground, part ground, first, second, third and fourth floor premises at 56 Dean St, London W1 + Chelsea & Westminster Hospital Foundation Trust & CW Medicines Limited Reversionary Underlease relating to third floor premises at 56 Dean St. London W1 + Chelsea & Westminster Hospital Foundation Trust & CW Medicines Limited underlease relating to Part third floor premises at 56 Dean St. London
214	24/05/2022	Underlease of Retail Space at West Middlesex Hospital Site, Isleworth between by West Limited + Chelsea & Westminster Hospital Foundation Trust
215	24/10/2022	Renewal Lease of Premises on second floor of Chelsea & Westminster Hospital Foundation Trust Ref. MTA/134848 with friends staff (C&W) Ltd.
216	09/12/2022	Chelsea Harbour Yard Reversionary Lease
217	20/02/2023	Lease of second floor INTL AIDS Vaccine
218	09/03/2023	Lease of Heart of Hounslow Health Centre, 92 Bath Rd. London TW3 3EL

Magdalena Farias, Corporate Governance Administrator, CWFT

Appendix 2

The Hillingdon Hospitals
NHS Foundation Trust

Use of Trust Seal

The Report covers the period April 2022- March 2023

	Document Details		Signators	Role of Signators	Date Signed & Sealed
0018	Settlement Deed and Release in respect of First and Second Floor, Batchworth House (Building 64), Mount Vernon Hospital, Rickmansworth Road, Northwood, Middlesex, HA6 2RN	Between THHFT - Accellacare UK Limited	Patricia Wright	CEO	07/04/2022
			Tina Benson	COO	07/04/2022
0019	Third deed of variation pursuant to section 106A of the town and country planning act 1990	Between THHT - The London Borough of Hillingdon	Patricia Wright	CEO	16/06/2022
			Jon Bell	CFO	16/06/2022
0020	Rooftop Lease - the communications site situated at Hillingdon Hospital	Between THHT - EE Limited	Patricia Wright	CEO	01/08/2022
			Jon Bell	CFO	01/08/2022

Leigh Franklin, Assistant Trust Secretary, THHFT

Appendix 3

Imperial College Healthcare NHS Trust

Use of the Trust Seal

This table is a record of the use of the Trust seal as required by the Trust Standing Orders from 1 April 2022 – 31 March 2023

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Signed by	Date of affixment of seal
260	Imperial College Healthcare NHS Trust and R Nash and DD Ross	3 year lease for reams in GP Practice in Hanwell to provide breast screening services	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	10 May 2022
261	Imperial College Healthcare NHS Trust and Limited Kingdom Research Institute (UKRI - MRC)	Licence for alterations	Janice Sigsworth, Chief Nurse, Acting CEO Peter Jenkinson, Trust Company Secretary	27 June 2022
262	Imperial College Healthcare NHS Trust and Hayes Cottage Renal Unit Ltd	Renewal of 5 year lease for provision of community dialysis service	Janice Sigsworth, Chief Nurse, Acting CEO Peter Jenkinson, Trust Company Secretary	27 June 2022
263	Imperial College Healthcare NHS Trust and Network Rail Infrastructure Ltd	To enable design work for emergency and permanent repair works to Mint Wing support beams	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	1 August 2022

Appendix 3

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Signed by	Date of affixment of seal
264	Imperial College Healthcare NHS Trust and British Land	Lease for 7A Sheldon Square	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	1 August 2022
265	Imperial College Healthcare NHS Trust and Breathe Energy Ltd	Phase A and B of Trust decarbonisation project	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	6 October 2022
266	Imperial College Healthcare NHS Trust and CBRE	For Charing Cross Hospital Endoscopy Ventilation and enabling works	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	1 November 2022
267	Imperial College Healthcare NHS Trust and West Hertfordshire Hospitals NHS Trust	Lease of Premises at Horace Brown Renal Unit, Watford General Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	1 December 2022
268	Imperial College Healthcare NHS Trust and Third Party Contractors pursuant to LMA Development Agreement at Hammersmith Hospital	Collateral warranties relating to LMS Development at Hammersmith Hospital.	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	1 December 2022
269	Imperial College Healthcare NHS Trust and Cuffes PLC	Samaritan building stabilisation and fire safety works	Professor Tim Orchard, Chief Executive	23 January 2023

Appendix 3

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Signed by	Date of affixment of seal
			Peter Jenkinson, Trust Company Secretary	
270	Imperial College Healthcare NHS Trust and Cuffes PLC	WEH theatre and treatment rooms refurbishment	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	23 January 2023
271	Imperial College Healthcare NHS Trust and Cuffes PLC	Charing Cross Hospital 8 South full refurbishment	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	23 January 2023
272	Imperial College Healthcare NHS Trust and Cuffes PLC	Hammersmith Hospital 6th Cath lab enabling works	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	23 January 2023
273	Imperial College Healthcare NHS Trust and Cuffes PLC	Phase 2+3 endoscopy refurbishment at Charing Cross Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	23 January 2023

Yewande Oyesanya, Trust Secretariat Manager, ICHT

Use of the Trust Seal

This report covers the period April 2022 to March 2023.

Seal No.	Date	Description
2022/11	24/05/22	Deed of Variation relating to the land on northside of Acton Lane, London – LNWH NHS Trust & Network Homes LTD
2022/12	24/05/22	Underlease for part of Alexandra Avenue Health and Social Care Centre – Community Health Partnership Ltd and LNWH NHS Trust
2022/13	11/08/22	License to underlet for part of Alexandra Avenue Health and Social Care Centre – Community Health Partnership Ltd and LNWH NHS Trust
2022/14	21/12/22	Collaboration Agreement and Agreement for Highway Works in relation to Land at Northwick Park, Brent - The Keepers and Governors of the Possessions Revenues and Goods of the Free Grammar School of John Lyon within the town of Harrow-on-the-Hill and LNWH NHS Trust and University of Westminster and Network Homes Ltd
2023/01	30/01/23	Renewal Lease by Reference in relation to Block V Level 7 (part) at Northwick Park Hospital – Parexel and LNWH NHS Trust
2023/02	03/03/23	Deed of Agreement under Section 106 of Town & Country Planning Act 1990 and Section 38 of the Highway Act 1980 relating to land adjacent to Northwick Park Hospital – Mayor and Burgesses of London Borough of Brent and LNWH NHS Trust and Network Homes Deed of Indemnity related to above – Network Homes and LNWH NHS Trust

Nikki Walcott, Corporate Governance Manager