

**North West London Acute Provider Collaborative
Board in Common - Public
Tuesday 17 October 2023, 9.00am – 12:00noon
Chelsea Old Town Hall, Small Hall, Kings Road, London SW3 5EE**

AGENDA

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	Verbal
	1.2	Minutes of the previous NWL Acute Provider Collaborative Board Meeting held on 18 July 2023	Matthew Swindells	1.2
	1.3	Matters Arising and Action Log	Matthew Swindells	Verbal
09:05	1.4	Patient Story	Lesley Watts	Verbal
Delivery and Assurance				
09:20	2.1	Report from the Chair in Common <i>To note the report</i>	Matthew Swindells	2.1
09:25	2.2	Reports from the Chief Executive Officers <i>To note the reports</i>		2.2
		• London North West University Healthcare NHS Trust	Pippa Nightingale	2.2a
		• The Hillingdon Hospitals NHS Foundation Trust	Patricia Wright	2.2b
		• Chelsea and Westminster Hospital NHS Foundation Trust	Lesley Watts	2.2c
• Imperial College Healthcare NHS Trust	Tim Orchard	2.2d		
09:45	2.3	Review of governance processes and systems - patient safety <i>To note the letter to Trust CEOs and Chairs from NHS England and consider Collaborative response</i>	Pippa Nightingale	2.3
Decision Making and Approvals				
10:05	3.1	Equity, Diversity and Inclusion Action Plan <i>To receive an update on the EDI action plan</i>	Pippa Nightingale	3.1
10:15	3.2	Acute Provider Collaborative - Scheme of Delegation <i>To note the update, approve the continued delegation and proposals re Quality Committee</i>	Peter Jenkinson	3.2
Integrated Quality, Workforce, Performance and Finance				
10.20	4.1	Business Plan Progress Report Months 1-6 <i>To note the report</i>	Jonathan Reid	4.1

	4.2	Integrated Quality, Workforce, Performance and Finance Report <i>To receive the integrated performance report</i>	CEO Workstream Leads	4.2
	4.3	Finance Performance Report <i>To receive the financial report</i>	Jonathan Reid	4.3
	4.4	Winter planning, including elective capacity plans <i>To receive latest position on planning for winter and meeting elective capacity requirements</i>	Lesley Watts/Robert Hodgkiss	4.4
10.50	4.5	Reports from Collaborative Committees: <i>To receive functional reports from the collaborative committees, to note progress in key workstreams and to note risks and assurances</i>		4.5
		<ul style="list-style-type: none"> • Collaborative Finance and Performance Committee 	Catherine Jervis	4.5a
		<ul style="list-style-type: none"> • Collaborative Quality Committee 	Steve Gill	4.5b
		<ul style="list-style-type: none"> • Collaborative People Committee 	Janet Rubin	4.5c
		<ul style="list-style-type: none"> • Collaborative Digital and Data Committee 	Steve Gill	4.5d
		<ul style="list-style-type: none"> • Collaborative Estates and Sustainability Committee 	Bob Alexander	4.5e
11.05	4.6	Collaborative Complaints Annual Report <i>To approve the report</i>	Robert Bleasdale	4.6
11.15	4.7	Learning from Deaths Report <i>To note the report</i>	Jon Baker	4.7
Governance and Risk				
11.25	5.1	Reports from Trust Audit Committees <i>To note the reports</i>	Audit Chairs	5.1
		<ul style="list-style-type: none"> • The Hillingdon Hospitals NHS Foundation Trust 		5.1a
		<ul style="list-style-type: none"> • Imperial College Healthcare NHS Trust 		5.1b
		<ul style="list-style-type: none"> • London North West University Healthcare NHS Trust 		5.1c
		<ul style="list-style-type: none"> • Chelsea and Westminster Hospital NHS Foundation Trust 		5.1d
11.35	5.2	Report on items discussed at the Board in Common Cabinet meeting held in September <i>To note any items discussed at the Board in Common Cabinet meetings</i>	Matthew Swindells	5.2
Reports for Information Only				
Any Other Business				
11.40	6.0	Nil Advised		

Questions from Members of the Public			
11:45	7.0	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			
16 January 2023, 09:00 – 12:00 Venue: The Storey Club, 4 Kingdom Street, London W2 6BD			
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)			

North West London Acute Provider Collaborative Board in Common Public Meeting

Tuesday 18 July 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 (ICTH) & 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 (ICTH)
Ms Linda Burke	Non-Executive Director (THHFT & ICTH)
Mr Aman Dalvi	Non-Executive Director (CWFT & ICTH)
Ms Patricia Gallan	Non-Executive Director (CWFT & THHFT)
Mr Nick Gash	Non-Executive Director (ICTH & THHFT)
Mr Peter Goldsbrough	Non-Executive Director (ICTH & CWFT)
Professor Desmond Johnston	Non-Executive Director (LNWH & THHFT)
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 & ICTH)
Ms Baljit Ubhey	Non-Executive Director (LNWH & 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 Simon Crawford	Deputy Chief Executive Officer (LNWH)
Ms Claire Hook	Chief Operating Officer (ICTH)
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 (ICTH)
Professor Julian Redhead	Chief Medical Officer (ICTH)
Mr Jonathan Reid	Chief Financial Officer (LNWH)
Mr Jason Seez	Deputy Chief Executive Officer/Director of Strategy (THHFT)
Professor Janice Sigsworth	Chief Nursing Officer (ICTH)
Ms Jazz Thind	Chief Financial Officer (ICTH)
Mr James Walters	Chief Operating Officer (LNWH)
Ms Lesley Watts	Chief Executive Officer (CWFT)
Ms Patricia Wright	Chief Executive Officer (THHFT)

In Attendance

Ms Kofo Abayomi	Head of Corporate Governance (LNWH)
Ms Tracey Beck	Head of Communication (LNWH)
Ms Tracey Connage	Chief People Officer (LNWH)
Ms Dawn Clift	Director of Corporate Affairs (LNWH)

Mr Kevin Croft
 Ms Emer Delaney
 Mr Peter Jenkinson
 Ms Alexia Pipe

Chief People Officer (ICHT)
 Director of Communications (CWFT)
 Director of Corporate Governance (ICHT & CWFT)
 Chief of Staff to Chair in Common

Apologies for Absence

Mr Neville Manuel
 Ms Sim Scavazza
 Ms Jo Fanning
 Ms Michelle Dixon
 Mr Robert Hodgkiss
 Dr Roger Chinn

Non-Executive Director (THHFT & CWFT)
 Non-Executive Director (ICHT & LNWH)
 Interim Chief People Office (THHFT)
 Directors of Communications (ICHT)
 Deputy CEO and Chief Operating Officer (CWFT)
 Chief Medical Officer (CWT)

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. The Chair noted that some clinical board members were attending virtually from Trust sites to ensure on-site executive clinical presence during ongoing industrial action.	
1.0.2	The Chair highlighted that the term of office for three Non-Executive Directors within the North West Acute Provider Collaborative is coming to an end and on behalf of the Board, the Chair thanked Dr Andy Bush (ICHT & CWFT), Prof Desmond Johnston (LNWH & THHFT) and Peter Goldsborough (ICHT & CWFT) for their contributions to the Trusts and the Collaborative.	
1.0.3	Apologies were noted from Neville Manuel (NED THHFT & CWFT), Sim Scavazza (NED ICHT & LNWH), Rob Hodgkiss (Deputy CEO/COO CWFT).	
1.1	Declarations of Interest	
1.1.1	There were no new declarations of interest to those already published.	
1.2	Minutes of the Meeting held on 18 April 2023	
1.2.1	The Board in Common approved the minutes of the Board in Common meeting held on the 18 April 2023.	
1.3	Matters Arising and Action Log	
1.3.1	Nil	
1.4	Patient Story	
1.4.1	Dr Jon Baker, Chief Medical Officer (LNWH) introduced the patient story relating to LNWH anti-infective virtual ward. The patient was admitted to hospital with a methicillin sensitive staphylococcus aureus (MSSA) bacteraemia and discitis and required a 6-week course of intravenous flucloxacillin to treat this infection. Prior to the availability of elastomeric devices, patients would need to stay in hospital for 6 weeks to complete treatment because the antibiotic requires multiple times a day	

<p>1.4.2</p> <p>1.4.3</p> <p>1.4.4</p>	<p>administration. In this case, the patient was able to be discharged home on the flucloxacillin elastomeric to complete 21 days of the treatment. Elastomeric devices are single-use balloon infusion pumps designed to deliver a continuous flow of safe and accurate infusions for a variety of treatments including antibiotics. These devices are used for OPAT (Outpatient parenteral antimicrobial therapy) when antibiotics would otherwise be administered multiple times per day enabling patients to be discharged home as they can deliver a 24-hour dose with only once daily manipulation.</p> <p>The Board noted that this was a significant milestone in the NHS i.e., patients receiving care of this nature in their homes. The Board also noted some of the remarkable pathways in the Acute Provider Collaborative that enables delivery of significant outpatient care and mitigating more patients coming into hospital and the significant benefits to primary care.</p> <p>In response to Dr Mohinudddin’s query around safety and the governance approach to virtual care particularly in regard to communities/patients that are less digitally literate. Dr Baker explained that this was the same as inpatient care i.e., incidences are recorded and fed through the governance channels. Dr Baker assured the Board that minimal incidences have occurred from virtual care, this was an improved service with no harm to patients. Support is offered to patients who are less digitally literate for them to be able to access virtual care. Prof Redhead added safety of virtual care is supported by international research which showed that no harm is suffered from receiving care at home.</p> <p>The Board in Common noted the patient story.</p>	
<p>2.0</p>	<p>Report from the Chair in Common</p>	
<p>2.0.1</p>	<p>The Chair presented his report and highlighted the following:-</p> <ul style="list-style-type: none"> • Welcome was extended to Patricia Gallan, Non-Executive Director (CWFT & THHFT) and Baljit Ubhey, Non-Executive Director (LNWH & THHFT) who recently joined the Board of Trusts in the Acute Provider Collaborative and Sarah Burton, Chief Nurse, THHFT. The Chair summarised their professional background and experiences. The Board noted that Carolyn Downs will be joining the Boards of ICHT and CWFT in September2023. • The Chair summarised his visits to the Acute Provider Collaborative sites to celebrate NHS 75 with patients and staff and highlighted some of the recent visits he had been on. • The Chair noted the ongoing Uxbridge bi-elections and that the Hillingdon Hospital rebuild plan has been a significant part of the bi-elections. He thanked Ms Wright and her team for accommodating and supporting candidates visits to the Hillingdon hospital site. 	

2.0.2	The Board in Common noted the report.	
2.1	Reports from the Chief Executive Officers	
2.1.1	<p><u>The Hillingdon Hospitals NHS Foundation Trust (THHFT)</u> Ms Wright reported that there was sustained improvement in performance. Previous areas of concern were now improving i.e., waiting times and progress was being made in emergency care. The Board in Common noted ongoing discussions with NHS England to move the Trust from National Oversight Framework (NOF) 4 to NOF 3, in recognition of progress achieved around financial recovery.</p>	
2.1.2	<p>Ms Wright reported that Sarah Burton took up position as THHFT Chief Nurse on 1 May 2023; Dr Alan McGlennan has been appointed as the Trust's new Chief Medical Officer and he will be in post in August 2023 and Cynthia Oji the new Equality, Diversity and Inclusion lead who joined the Trust in July 2023.</p>	
2.1.3	<p>Celebrating NHS 75, THHFT had a staff celebration and had the opportunity to highlight their services at various events across the Trust. The Trust launched its new food ordering system on 17 April 2023. This makes ordering food using an app on a tablet operated at the patient bedside.</p>	
2.1.4	<p>The Board noted that THHFT achieved some of the highest scores in London under the 2022 Patient- Led Assessment of Care Environment (PLACE). The results for 2022 showed that in every domain the Trust achieved a higher percentage score than the national and London-wide averages.</p>	
2.1.5	<p><u>Imperial College Healthcare NHS Trust (ICHT)</u> Prof Orchard presented the report with contributions from Prof Readhead and Ms Hook. ICHT continued to maintain performance against key quality measures. Mortality rates are consistently amongst the lowest in the NHS, Incident reporting rates are increasing overall, and harm levels are well below national average. In 2022/23 ICHT exceeded the threshold for E.Coli and C.diff cases and are above trajectory so for this financial year. There have been five cases of MRSA reported in the course of the year. There has been focus on infection prevention control and work being done around hand hygiene. The Board noted that the patient safety incident response framework (PSIRF) will replace the serious incident framework from September 2023 across the NHS.</p>	
2.1.6	<p>Ms Hook summarised ICHT operational and financial performance. It was noted that operational performance although not at pre-Covid levels continues to improve. Recovery of the financial position was expected with a break-even position to be achieved by the end of the financial year.</p>	
2.1.7	<p>Prof Orchard highlighted senior management changes including the appointment of Dr Raj Bhattacharya as Divisional Director of Surgery, Cancer and Cardiovascular. Dr Amrish Mehta was appointed</p>	

	<p>substantively as Divisional Director of Women, Cardiac, Clinical service and sexual health in June 2023. Following the retirement of Hugh Gostling, Andrew Murray, Head of Facilities is acting as Interim Director of Estates and Facilities while recruitment for a permanent postholder is completed. Prof Orchard thanked Mr Gostling for his many years of service.</p>	
2.1.8	<p>The Board noted that the Care Quality Commission (CQC) inspected ICHT maternity in March 2023 and the report is expected to be published later in July. Prof Orchard reported that the Human Tissue Authority had recently inspected ICHT's compliance with the requirements of the post-mortem licence in May 2023 and the Trust is awaiting the report.</p>	
2.1.9	<p>ICHT have been awarded £4,6m of capital funding from National Institute for Health and Care Research (NIHR) to support clinical and translational research.</p>	
2.1.10	<p>Prof Orchard reported that on 13 June 2023 ICHT launched Paddington Life Sciences, a collaboration between the NHS, local life sciences businesses, academia and local communities.</p>	
2.1.11	<p>Prof Orchard highlighted a number of colleagues awards and successes.</p>	
2.1.12	<p><u>London Northwest University Healthcare NHS Trust (LNWH)</u> Ms Nightingale reported that there was a targeted attack on three members of staff at the Central Middlesex Hospital. The members of staff involved are being supported and receiving care. Ms Nightingale noted that the response to the incident reflected the Trusts emergency preparedness which was timely and professionally managed. Response from emergency services was also robustly managed. Staff who witnessed the attack were offered psychological support.</p>	
2.1.13	<p>LNWH published its Quality Account on 28 June, the account reviewed progress against last year's priorities. Ms Nightingale was proud to report that all three of the Trust's aims were achieved and three new priorities have been set and these were highlighted in the report.</p>	
2.1.14	<p>Ms Nightingale reported that during June, a series of events took place across LNWH as part of the national estates and facilities celebration to recognise their hard work and valued contribution of estates colleagues. The Board also noted that the latest patient-led assessment of the hospital environment (PLACE) scores was published, with each of the hospital sites scoring well above the national average.</p>	
2.1.15	<p>In June, LNWH was accredited as Veteran Aware, an indication that the Trust shows greater awareness and support for the Armed Forces community in line with standards laid down by the Veterans Covenant Healthcare Alliance (VCHA).</p>	
2.1.16	<p>Ms Nightingale provided an update on progress of the Trust's approach to equity, diversity and inclusion (EDI). The Trust now has a formal statement on anti-racism. The governance process around EDI has also</p>	

	<p>been revamped and led by Ms Connage, Chief People Officer. The Trust HEART values were also relaunched as part of the Trust Strategy, there are now 42 HEART ambassadors across the Trust.</p> <p>LNWH had two stakeholder engagement group events, with the sickle cell population in Brent and on the Elective Orthopaedic Centre.</p>	
2.1.17	<p>Mr Crawford provided an update on progress made on deployment of Cerner which is scheduled to go live in 5 weeks. The Board noted the system had been tested with key issues identified and mitigated ahead of go-live. Weekly meetings are now in place with the Cerner team for progress, updates and escalation. Staff training on the system also continues.</p>	
2.1.18	<p><u>Chelsea and Westminster NHS Foundation Trust (CWFT)</u></p> <p>Ms Watts highlighted that although the industrial action and sustained demand across the sector had an impact, the Trust was able to manage patient flow effectively, deliver safe, urgent and emergency care and was able to sustain some elective activity. Ms Watts thanked CWFT staff for their hard work during the period. Ms Watts also reported that the pressure on urgent and emergency care was felt during the June heatwave. The Trust recorded attendance of 1450 patients across the emergency departments and urgent treatment centres. The Board in Common noted that there have been overall improvements in operational performance.</p>	
2.1.19	<p>CWFT hosted the London Accelerating FemTech event. The Board in Common noted that the Research Innovation and Quality Improvement (RIQI) week took place earlier in the month, the Trust show cased best practice across the Trust via in-person and live-streamed events.</p>	
2.1.20	<p>Mr Morris thanked the Chief Executives for their reports and noted that all the reports mentioned the industrial actions. He enquired about impact on staff and whether there were offerings and well-being support available to staff due to the pressure. Ms Watts responded that CWFT approach was “we are in it together and we all have a part to play” which enables all views to be expressed and understood. The key part of this is ensuring that there is least impact on patients, and that patients are prioritised while offering support to our staff.</p>	
2.1.21	<p>Mr Mehta asked about how Cerner roll out makes delivery of patient care beneficial and seamless. It was noted that there are significant advantages such as ease of use, accuracy of data, ability to share patient information, seamless process of transferring patients across the Collaborative. It allows reduction in variation, assisting with coordination solution for patients with an end-to-end pathway. In addition to patient benefits, there are also benefits to staff across the collaborative.</p>	
2.1.22	<p>The Board in Common noted the updates.</p>	

3.1	North West London Acute Provider Collaborative Code of Conduct	
3.1.1	Mr Jenkinson presented the North West London Acute Collaborative Code of Conduct. The board code of conduct set out the values and principles on which the collaborative is governed and how it operates as a board, collectively and as members of the individual boards. The code of conduct is based on the Code of Governance for NHS providers, which has just recently been revised and the agreed collaborative values as set out in the statement of intent.	
3.1.2	Mr Jenkinson sought approval of the code of conduct from individual Trust Boards and collectively as a Board in Common.	
3.1.3	There was unanimous support and approval to the Board Code of Conduct.	
3.2	Executive Governance arrangements and terms of office for the Acute Provider Collaborative Management Board	
3.2.1	Mr Jenkinson presented the report. He explained that the purpose of the report was to set out changes agreed to the governance arrangements for the collaborative and the associated amendments to the scheme of delegated authority, which enables changes to the governance arrangements. The report also included a set of draft terms of reference for the newly established committees.	
3.2.2	Mr Jenkinson highlighted that the governance arrangements were also reviewed to further enable delivery of the collaborative business plan approved at the last Board in Common meeting. Mr Jenkinson summarised changes made to the Collaborative Infrastructure Committee which had now been separated into two committees, an Estates and Sustainability Committee and a Digital and Data Committee. The executive governance arrangement was also reviewed, and an Acute Provider Collaborative Executive Management Board was established to strengthen oversight of the delivery of the business plan. The Board in Common noted that these changes had been discussed with board members in various forums and were approved by the Board in Common Cabinet to expedite implementation of these changes. The report was presented for information. It was noted that the draft terms of reference will continue to be developed ahead of the first meetings of the collaborative committees taking place in September. The first meeting of the Executive Management Board took place earlier in July. The Chair highlighted to the board that he invited expression of interests from the Chief Executive Officers in regard to chairing of the Executive Management Board, and it was unanimously agreed that Prof Tim Orchard would take up the role. The chair also summarised the functions within the Executive Management Board. The Board noted that the	

3.2.3	<p>Estates and Sustainability Committee will be chaired by Mr Alexander and the Digital and Data Committee will be chaired by Mr Gill.</p> <p>The Board in Common noted the North West London Acute Provider revisions to the governance arrangements.</p>	
3.3	<p>Developing and Strengthening the Strategic Partnership Between THHFT and CWFT</p>	
3.3.1	<p>Ms Wright introduced the report and summarised the relationship between THHFT and CWFT, the benefits and how the alliance strengthens the Trusts. The partnership was originally established in 2020 to improve THHFT position from special measures. Since this time there have been improvements to THHFT and both organisations have benefitted from the partnership. The recommendation was to continue to build and strengthen the partnership which is supported by NHS England.</p>	
3.3.2	<p>Ms Burke noted the importance of the partnership and keeping Non-Executive Directors (NEDs) updated and engaged so that they are able to fulfil their duties. Ms Burke asked how quickly the partnership will be communicated to the public to avoid confusion about the purpose of the partnership with two organisations within the collaborative. Ms Watts explained that engagement with the NEDs will be done through the regular NED meetings. Regarding communication to the public, the partnership is an internal arrangement and the individual Trusts remain sovereign organisations.</p>	
3.3.3	<p>Mr Moss noted the governance arrangements in place i.e., the collaborative and now the partnership between THHFT and CWFT. He asked why not have a merger. Ms Wright explained that a merger is a complex arrangement which required a significant amount of work, however with the collaborative and the strategic partnership, we have been able to demonstrate that collaborative working has advantages. We have been able to maximise working together, share learning and establish some shared back-office functions which do not require a merger. There are also benefits to our patients working collaboratively.</p>	
3.3.4	<p>Ms Rubin asked how the staff reacted to the partnership and how CWFT have learnt from the partnership. Ms Watts highlighted that when the partnership was established, it was perceived as a takeover from CWFT even though the communication was clear that it was not, and when talks commenced about continuing the partnership the same question was raised. CWFT has learned building strong stakeholder relationships from THHFT, managing large scale projects such as the new hospital programme. Ms Wright added that the partnership was yet to be formally launched and communicated to staff, getting BiC approval was the first step. They will now plan the most effective way to communicate the strategic partnership to both sets of staff.</p> <p>The Board of Hillingdon Hospitals NHS Foundation Trust agreed the Strategic Partnership.</p>	

3.3.5	<p>The Board of Chelsea and Westminster Hospital NHS Foundation Trust agreed the Strategic Partnership.</p> <p>The Board in Common noted the Strategic Partnership.</p>	
4.1	<p>Staff Survey Results</p>	
4.1.1	<p>The Board received the summarised staff survey results report and agreed actions across the collaborative. Ms Connage explained that annually, we hear from our staff about their experiences of working in our Trusts and their aspirations and intentions for their career. Individually the Trusts use the results to inform and underpin workforce priorities, people strategies and actions. The staff survey results also report common areas of strengths and areas for improvement. The Board noted that the people strategy agreed for the collaborative to align with the action plan arising from the staff survey.</p>	
4.1.2	<p>Ms Burke noted that a lot of work had gone into the actions however she felt that this was still lacking in ambition and urgency particularly around the new roles and development of roles so that people are operating at the top of their licenses. Ms Burke was not assured that that the report fully reflected views of staff expressed to her during her walkabouts and ward visits. She asked how work can be done at pace. Mr Croft explained that the new roles and new ways of working has been a challenging area and required further ongoing development and attention. He referenced some recent successes in this area such as virtual wards, the Elective Orthopaedic Centre and the Community Diagnostic Centres, Mr Croft highlighted that response to new roles have been slow, not just in the collaborative but across London. Learnings will be taken from parts of the country that are well established in these areas; we will also engage further with colleagues.</p>	
4.1.3	<p>Mr Moss was concerned that despite all the work done on inclusion, less than half of the staff population responded to the survey. He asked what more can be done on inclusion and improving the response rate. Ms Connage explained that the Chief People Officers are actively engaging with staff to highlight the importance of hearing their views, to develop plans and activities that represent our staff population. The Board in Common noted actions put in place including staff protected time to complete the survey. Assurance was given that over time there would be incremental improvements and there will be a continued push to achieve improvement.</p>	
4.1.4	<p>Mr Mehta asked about the collective ambition of the Chief People Officers to drive improvement against next year and the top measurable actions in response to the challenging areas. The Board noted that targeted collaborative interventions would be challenging although more work can be done around the collaborative culture. Targeted interventions need to be locally owned for meaningful improvements.</p>	
4.1.5	<p>The Board in Common noted the staff survey results report.</p>	

4.2	Integrated Quality, Workforce, Performance and Finance report	
4.2.1	<p>Mr Baker presented the quality metrics within the report. He explained that there have been no concerning variations in the metrics since the last reporting period. The Board was asked to note the following key highlights:</p> <ul style="list-style-type: none"> • Spike in incidents of extreme harm and death driven by LNWH, this is due to the way LNWH record their metrics, this will be adjusted to align with other Trust reporting in the collaborative • All trusts in the collaborative have exceeded their E coli, MRSA and C.diff targets. Work continues to drive a change in culture and improvements • Mortality: HMSR – the most recent data shows that each Trust continues to have a rolling 12-month HSMR below the national benchmark of one hundred. LNWH’s ratio has returned to lower than expected following a recent change to ‘as expected’. THHFT remained as expected. Work continues through the new APC mortality surveillance group to standardise the system and process for producing mortality reports to drive improvements • Never Events: there were three never events declared in April, THHFT (1) and CWFT (2). Actions have been taken locally and assurances of their completion provided on a collaborative level • Patient Experience: there is ongoing work by the User Insight group to improve patient experience • PSIRF: work is progressing to establish the new incident reporting system. 	
4.2.2	<p>Mr Bleasdale reported that the collaborative continues to consistently perform well with avoidable admissions to the neonatal unit. The Board was asked to note that there is an increase in the number of stillbirths at CWFT, this is a recent trend as CWFT had previously performed below the threshold in previous years. There was also a slight increase at THHFT. Cases at CWFT and THHFT are being reviewed and discussed through the mortality and maternity workstreams across the ICS. Mr Bleasdale reported that the four metrics in the report will be reviewed in light of the single delivery plan, the metrics will be expanded in coming weeks through the maternity workstream.</p>	
4.2.3	<p>Ms Watts thanked the collaborative Chief Operating Officers for all their hard work in the last few months organising work around the industrial actions. The Board in Common noted the following operational performance highlights:</p> <ul style="list-style-type: none"> • Urgent and Emergency Care: the collaborative is the first in London to pilot and implement the new London Ambulance Service standard operating procedure for immediate handover in 45 minutes. The pilot has made a difference. The Trusts will continue to review actions from the peer review. 	

	<ul style="list-style-type: none"> • Elective: 78 weeks wait continue to reduce with a rise in 52 weeks wait. Activity overall is still increasing, with all sites driving to do as many elective patients as they can to reduce the overall waiting times for patients. • Diagnostics: activities through our diagnostic services, including our Community diagnostics is over and above the operational plan, this impacts all pathways including cancer pathways. • Cancer Services: industrial actions have had an impact on performance particularly within the two-week wait referral standards which is currently at 85% of the 95% standard although the latest data for May shows improvements. The collaborative is performing above standard and above national and London average offering performance of 94.8%. We continue to improve overall performance, working closely with RM partners across the collaborative and sharing learnings across the different treatment pathways. 62-day pathway remains challenged for long waiters however the May data shows that we have moved to one of lowest points of 62-day waiters across the cancer pathways. 	
4.2.4	<p>Ms Watts provided a verbal update on delayed discharge and highlighted that with regard to ambulance handovers, work is ongoing reviewing the conveyances and conversion rates to ensure robust use of ambulances. Updates will be provided in future reports. The Board noted the additional funding to manage discharges, the Better Care Fund and ongoing work with the Local Authorities within the collaborative and the ICB. Mr Gill noted that individual Trusts review patient tracking and advised that this is included in the report going forward. Action: Delayed Discharge and Patient Tracking List to be included in the Integrated Performance Report.</p>	
4.2.5	<p>Mr Croft summarised workforce performance. The Board noted that an area of focus is appraisals and PDRs, and this has been extensively discussed by the People Collaborative Committee where it was agreed that local trust executive management intervention is required to improve performance. In addition, work is required to ensure that workforce spend does not exceed activity.</p>	
4.2.6	<p>Mr Mehta noted that agency spend was a significant issue within the collaborative, currently only ICHT had managed to reduce agency spend. He also noted that there had been no improvements in the PDR targets despite extensive discussions at the Collaborative People Committee and asked for assurance that this is being managed. Mr Croft explained that significant work has been done around reducing agency spend although industrial action has impacted progress work continues in increasing</p>	

4.2.7	<p>substantive recruitment. On the issue of appraisals and PDRs, Mr Croft explained that there are a number of actions in place, but this now required local leadership and management interventions to improve performance.</p> <p>The Board in Common noted the Integrated Quality, Workforce Performance and Finance Report.</p>	
4.3	Financial performance report	
4.3.1	<p>Mr Reid presented the report and set out the financial position of the Collaborative at Month 2, noting that at the end of the reporting period, the collaborative reports a deficit of £31.8m against YTD deficit plan of £9.4m, thus reporting a £22.4m adverse variance to plan. The Board noted that the main drivers for the variance were cost improvement programmes, junior doctors' industrial actions, inflation, operational pressures/ run rate overspend and contract income performance.</p>	
4.3.2	<p>Mr Gill noted that there is a £50m gap and asked how areas that are not within the collaborative control will be managed. Mr Reid summarised allocation of inflationary funding available to the ICB and partnership working with the ICB Chief Financial Officer regarding the funding. There is also a tracking and minimisation piece of work that will be reported to NHS England regional and national level.</p>	
4.3.3	<p>Mr Dalvi enquired about assurance that we will spend on the priorities identified at the beginning of the financial year. Mr Reid explained that this is dependent on individual Trusts to demonstrate this, and assurance will be provided via the local finance and performance committees.</p>	
4.3.4	The Board in Common noted the financial performance report.	
4.4	Reports from Collaborative Committees	
4.4.1	<p><u>Report from Collaborative Finance and Performance Committee Chair</u> Ms Jervis presented a summary of the discussions held at the previous collaborative committee meeting. The Board noted areas of escalation including patients waiting more than 78 weeks, influenced by industrial action. The Committee was assured that there is granularity in terms of the patient list and mitigations in place. The Committee also noted that the industrial actions have impacted both performance to patients and our financial performance and associated risks, in addition there are also issues of sustainable staffing levels for some services. Actions were around continuing risks and escalation processes to manage the financial position. Progress of the Elective Orthopaedic Centre, implementation, go-live period was discussed and understanding of the Equality Impact Assessment of the transport strategy which enables access for our patient groups in North West London.</p>	

4.4.2	<p><u>Report from Collaborative Quality Committee Chair</u> Mr Gill presented a summary of the discussions at the previous collaborative committee meeting. The Committee considered operational reports of each Trust and actions around infection prevention control. Areas of escalation included quality impact resulting from the industrial actions, continued pressure on the workforce. The Committee commissioned a review of impact of the management of patients with mental health needs as this was a continuing and growing issue across the collaborative. There was also an action about understanding the mortality statistics by site and diagnostic speciality.</p>	
4.4.3	<p><u>Report from Collaborative People Committee Chair</u> Ms Rubin presented a summary of the discussions at the previous collaborative committee meeting. The Committee was pleased with the project plans relating to the six people priorities. It was noted that work is in progress to establish HR shared services with the possibility of support from NHS England. Lastly the local people committees have been asked to help move the dial on race issues particularly in relation to Black and ethnic minority groups who are more likely than their white colleagues to end up in formal disciplinary procedures and not being able to progress into senior grades.</p>	
4.4.4	<p><u>Report from Collaborative Infrastructure and Capital Committee Chair</u> Mr Alexander presented a summary of the discussions at the previous collaborative committee meeting. The Committee received updates on Cerner go-live and assurance that this was on track at both LNWH and THHFT. Digital deliverables for remainder of the financial year were considered and the acute digital strategy arising from the ICS approach to digital, which is now within the remit of the new digital committee. The Committee also identified the Estates work programme which moves to the new Estates and Sustainability committee. Finally, the Committee considered the extent to which the positive contributions can be made to EDI in terms of digital inclusion and how we can improve support services for our patients.</p>	
4.4.5	<p>The Board in Common noted the reports provided.</p>	
4.5	<p>Learning from deaths</p>	
4.5.1	<p>Mr Baker presented the report which had been discussed at the local quality committees with assurances provided on deaths scrutinised. The Board noted that a standard reporting template is being developed to ensure standardised reporting from the Trusts. Mr Baker reported that end of life continues to be a theme which will be managed through the priority workstream.</p>	
4.5.2	<p>The Board in Common received and noted the report.</p>	

5.0	Reports from Trust Audit Committees	
5.0.1	The reports from the Trust Audit Committee Chairs were received. Committee Chairs by the Board in Common.	
5.0.2	The Board in Common noted that Audit Committee Chairs met to consider and agree the terms of reference for the internal audit governance review. The Chairs also considered the possibility of a shared audit provider across the collaborative.	
5.1	Report on items discussed at the Board in Common Cabinet meetings held in May and June 2023	
5.1.1	The Chair highlighted the business discussed at the Board in Common Cabinet in <ul style="list-style-type: none"> • Tender Award: Linen and Laundry Contract (ICHT) • Amendments to the collaborative governance model • CEO updates • Integrated Performance Quality and Workforce report • Business plans and implementation Cost Improvement Programme (CIP) • Non-Executive Director Appointments • Review of Equality, Diversity and Inclusion (EDI) activities • National Hospital Programme announcements 	
5.1.2	The Board in Common noted the items discussed at the Board in Common Cabinet.	
6.0	Any Other Business	
6.0.1	There was no other business discussed at this meeting.	
7.0	Questions from the Public	
7.0.1	The Board in Common noted that questions were received in advance of the meeting. The Chair summarised the questions and asked members of the Board to provide answers, noting that written responses would be provided on the website.	
8.0	Date of the Next Meeting	
8.0.1	The next meeting would take place on 17 October 2023 at 9.00am until 12 noon	

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

Item number: 2.1

This report is: Public

Report title

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

Executive summary and key messages

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

Strategic priorities

Tick all that apply

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

- Achieve a more rapid spread of innovation, research, and transformation

Impact assessment

Tick all that apply

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

1. The Acute Provider Collaborative

2. It has been just over a year since we formed the North West London Acute Provider Collaborative (APC). It has been a year filled with many challenges across the NHS. I want to start by thanking staff for their continued commitment to ensuring we run the safest and best services we can for our patients.
3. We decided to form the APC to harness the best of the four acute trusts in North West London by using our committed and diverse workforce, our world-leading research capabilities and our ever-deepening community relations to work with our partners, stakeholders and communities to deliver the best care in the NHS and address the significant health inequities across our system. The evidence of our finances, clinical outcomes and access performance in the context of what is happening in the rest of the NHS suggests that we are making positive strides towards that ambition, though there is still a long way to go.
4. We pride ourselves on being learning organisations and an important part of that is being willing to evolve and change as we mature. The APC is a unique structure within the NHS and you will notice that we have implemented some changes to our governance in the past three months which will be reflected at the Board meeting. The “Collaborative Infrastructure Committee” that reports to the Board has been split into “Digital and Data”, chaired by Steve Gill, the Vice Chair from Chelsea and Westminster Foundation Trust (CWFT); and “Estates and Sustainability”, chaired by Bob Alexander, the Vice Chair from Imperial College Healthcare Trust (ICHT). Their first reports are in these Board papers. The Chief Executives have also put in place a “Collaborative Executive Management Board” with representatives from all four Trusts, to streamline joint decision making. We have also asked our internal auditors to do a review of our governance structures and advise us on where we can improve the way we work.

5. Recovery Support Programme (RSP)

6. I am delighted that The Hillingdon Hospitals NHS Foundation Trust (THHFT) has moved out of the Recovery Support Programme from the National Oversight Framework (NOF) 4 to NOF 3, with confirmation from NHS England last month, recognising the improvements seen in finance, UEC, quality and governance at the Trust. THHFT is making progress on its long waiters and is sitting comfortably in the pack on A&E performance and we’ve had the next stage of the development of a new hospital before 2030 approved. There is still a way to go but I am pleased that THHFT successes in the past year are being recognised and we are moving in the right direction.

7. Haematology at Northwick Park

8. In September following a recommendation by NHS England, the General Medical Council (GMC) confirmed that the Haematology department at Northwick Park Hospital has had its enhanced monitoring status revoked. This is a welcome development as we

continue to improve our services and I would like to thank the team for all the efforts to achieve this.

9. Cerner implementation

10. We are currently in the middle of a major transformation to get all acute sites in North West London to share a common electronic patient record (EPR). The hospitals within ICHT and CWFT have been sharing a common electronic record for a number of years. London North West University Healthcare NHS Trust (LNWH) moved onto the same EPR and went nearly paperless in August and THHFT will follow in November. Once this is complete, we will be able to provide care for any patient in North West London in any of our acute hospitals without worrying whether we have access to all of their medical records which will assist in managing care safely and efficiently across all sites.
11. LNWH went live with Cerner in August at all three sites Northwick Park, Ealing and Central Middlesex over the space of a week. We switched all wards, outpatient, planned care areas and theatres to the new electronic patient record. It is a big adjustment and staff are working to get to grips with the new system but overall it has been one of the best managed go-lives that the NHS has seen, thanks to the efforts of staff and the sharing of experience from ICHT and CWFT, who had been through all this before.
12. We now turn our attention to THHFT as they go live in a few weeks, we have taken lessons learnt from the LNWH implementation and are feeding their experiences into the planning at THHFT, so we can support staff to make the switch from paper as smoothly as possible.

13. Urgent Treatment Centres

14. From 18 October, all the Urgent Treatment Centres (UTCs) across North West London will be managed by the Trusts. UTCs provide care to patients with a range of urgent medical problems and minor injuries that are too urgent to wait for a GP appointment but do not need to be seen in an Emergency Department.
15. Urgent care services play a pivotal role in effective patient flow, ensuring our patients are seen in the right place at the right time. Earlier this year we took over the running of the UTCs at Northwick Park and Hillingdon, which we had to do with little time to plan and at a quick pace. I was impressed with how our teams managed to deliver this service change, which was a huge amount of work and the transition was handled smoothly by our teams. Since then we have managed to design the UTCs into our pathways which will bring better benefits for our patients and communities.
16. A big welcome to all colleagues from the UTCs and a huge thank you to staff who made these transitions happen.

17. Redevelopment

18. The New Hillingdon Hospital project continues to make good progress, stage 2 approval of the planning application was confirmed by the Greater London Authority in September 2023. This now allows the London Borough of Hillingdon to formalise determination of the application, which is anticipated in October 2023 and will mean full planning approval

for the new hospital and multi-storey car park and outline approval for the residual estate (housing, public realm).

19. Enabling and decant works are continuing to clear the site for the new hospital. Earlier this year, the New Hospital Programme approved plans to start work to establish the electrical infrastructure for the new hospital and work is well underway. In addition, GRAHAM were appointed as Principal Supply Chain Partner in the summer to oversee the delivery of the remaining projects in the enabling and decant programme, which are expected to give a cleared site for the new Hillingdon Hospital by mid-2025.
20. THHFT is continuing to work closely with the New Hospital Programme to agree next steps for the business case. In September 2023, we welcomed the Minister responsible for the New Hospital Programme, Lord Markham, to Hillingdon Hospital for a briefing on the new hospital plans, which demonstrated our maturity.
21. As a general election nears, it should be noted that over the summer, both the main parties have pledged to build the new Hillingdon Hospital. [The Secretary of State for Health and Social Care re-confirmed that Hillingdon remained part of their new hospitals manifesto commitment](#) while [Labour's shadow health minister pledged to deliver a new hospital within a similar timeframe](#) during the first term of a labour government, should they win the next election.
22. As highlighted before, unfortunately the Government decided to delay its main capital funding for Imperial College Healthcare's 'cohort 4' schemes in the New Hospital Programme (St Mary's, Charing Cross and Hammersmith) until after 2030. As Tim has explained eloquently on many occasions, the fabric of St Mary's Hospital, in particular, is completely unsuitable for 21st century medicine and it is a tribute to our staff that they continue to deliver innovative and world class care in facilities that bring shame on the NHS.
23. We are continuing to explore, with the support of the NHP, a range of practical funding and design options that would enable us to accelerate the full re-build of St Mary's Hospital and make an earlier start on the major refurbishment and expansion schemes at Charing Cross and Hammersmith hospitals. Since August, we have had two visits to the St Mary's site by Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care, and one visit by Lord Markham, to discuss the redevelopment. We are also continuing discussions on redevelopment options with a range of other political and community stakeholders.

24. Appointments and Recruitment

25. I am delighted to welcome a number of Non-Executive Directors (NEDs) on to the Board in Common (BiC), who started their roles on 1 September 2023. Carolyn Downs is a Board member for ICHT, where she chairs the Quality Committee, and is a board member for CWFT, where she is a member of the Finance and Performance Committee and the People Committee. Carolyn has recently stepped down as the Chief Executive at Brent Local Authority and I know is keen to keep supporting the diverse communities we serve across North West London.

26. We also welcome Professors Neena Modi and Martin Lupton who joined the BiC last month as our Academic NEDs. These appointments play a vital role in ensuring our organisations continued links into research, education and training. Professor Neena Modi sits on the Board at CWFT and ICHT, she is Vice Dean (International) and Professor of Neonatal Medicine in the Faculty of Medicine at Imperial College London, and a consultant in neonatal medicine at CWFT. Neena is going to take a special interest in developing research and access to innovative medicines across all our Trusts. Martin Lupton sits on the Board at LNWH and THHFT, he is the Vice-Dean (Education) for the Faculty of Medicine at Imperial College London. He is also a consultant in Obstetrics and Gynaecology at CWFT. Martin is going to take a special interest in developing medical education across all our Trusts.

27. In February 2024 Janet Rubin, Vice Chair at LNWH will be stepping down at the end of her term with the Board in Common, we recently ran an expression of interest process across the APC for a new Vice Chair at LNWH. I am pleased to announce David Moss (current NED at LNWH and ICHT) will take up the post when Janet leaves.

28. We have recently started a new NED recruitment campaign as we will have two vacancies on the BiC in early 2024. We are working to get a diverse and talented pool of candidates, as the best boards are those that reflect the workforce and communities they serve.

29. Industrial Action

30. The Chief Executives are going to report on the recent Industrial Action (IA) but I would just like to add my thanks to everyone involved for ensuring we have been able to continue to provide safe care for our patients during the action while also, where relevant, ensuring our staff were able to exercise their right to take action.

31. Annual Members meetings

32. We made a commitment when we became a Board in Common that all four Trusts would still hold their Annual Members/General meetings where members of the public and staff can hear about the achievements and challenges of the individual organisations, get a current update on progress and have the chance to ask questions to the Board and senior Executives. We held the ICHT and CWFT in July, THHFT and LNWH had their meetings last month. It was great to speak to staff and members of the public about each of the Trusts.

33. Staff Excellence awards

34. LNWH and THHFT both held staff awards recently, it was great to see so many staff nominated for awards and the amazing innovations that are being developed to improve their trusts and bring the best care to patients. Well done to all nominees and award winners.

35. I was proud to give two awards, which highlighted the great work the trusts were doing but also showcased the tremendous collaborative working which is happening organically across our whole patch.

36. At LNWH the Radiology Ultrasound Academy won team of the year. The academy allows training-focused lists in a hospital setting with direct supervision of the trainees and longer appointments to facilitate learning. Since its inception it has grown taking on more trainee sonographers and midwives from surrounding trusts as well as Radiology trainees from LNWH and ICHT. Working with other partners across North West London to deliver much needed sonographer training.
37. At THHFT the 'I am change' award went to the Medical Haematology Daycare Unit (MHDU). The unit were nominated by the Multiple Sclerosis (MS) team for supporting and enabling a new service to deliver MS medications locally, at Hillingdon Hospital. People from Hillingdon and surrounding boroughs with a diagnosis of Multiple Sclerosis had a complicated process to access medication to manage their condition, needing to go to Charing Cross hospital. The MHDU team introduced a solution and approach to help make the change to achieve care closer to the patient's home. Working together with Charing Cross to improve the lives of our patients.

38. Acute Provider Collaborative Visits

39. On Wednesday 26 July, I went to Central Middlesex Hospital for a series of visits which included a walk around the new Endoscopy department and a tour of St Marks. I went with Pippa, Edgar Swart, Divisional Director of Nursing and Carolynne Vaizey, Divisional Medical Director to have a walk around new the Endoscopy department, which at that time was a construction site. It was good to see the nearly finished department and the much improved facilities for staff and patients. Edgar also took me to see several of the wards at St Marks, I was lucky to see a number of the Wow boards across the site, including the Central Middlesex winner Roundwood ward. Well done to all staff for the effort in creating such inspiring pieces.
40. I and a large group of the NEDs had a tour around the Elective Orthopaedic Centre (EOC), Mark Titcomb, Managing Director of the EOC, CMH & Ealing and by Matt Bartlett, Medical Director, EOC took us around the site. We walked the pathway our patients will follow, heard about the work happening to ensure we have the right job planning in place. We are due to open the EOC next month, with the full activity in place by early 2024.
41. On Wednesday 27 September I visited the Urology service at Northwick Park and met with a large group of the team, I was taken around by Vivian Baje, General Manager Trauma & Orthopaedics and Urology, and Giles Hellawell, Urology Clinical lead and Lead Consultant Urological Surgeon. The team have recently moved from Central Middlesex to the Northwick Park site which brings almost all of urology at LNWH on to one site for the first time. I was impressed with the strong working links across the teams.
42. Also two visits I mentioned earlier in my report, I joined Lord Markham when he visited ICHT on Monday 3 July with Nickie Aiken, MP for Cities of London, Westminster, and Felicity Buchan, MP for Kensington. We had a tour of the St Mary's hospital site and discussed the redevelopment and next steps.
43. Then in September Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care visited ICHT, he had a tour of the A&E at St Mary's to see how we are preparing for winter, followed by a discussion on redevelopment and life sciences and the huge potential around the Paddington Basin to continue our strong links to research.

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 Our new electronic patient record system (EPR) is now live, after go-live started on 18 August. Transferring our patient information to the new system went well, with all wards, outpatient, planned care areas and theatres live by the 23 August.

Our command centres and EPR team responded rapidly to issues as they arose, making sure we had the right resource in the right place to keep us on track.

The new EPR will have major advantages for our teams and for our communities, bringing LNWH care records into one place for the first time in our organisation's history, and giving clinical teams access to the right information at their fingertips. Patients and service users will also benefit from our teams being able to share information appropriately and far more easily with our partners, offering them smoother pathways.

The change represents a great step forward for LNWH, and marks more than three years of preparation and planning. I would like to thank staff across LNWH for dealing so professionally with all the pressure that inevitably comes with any change of this scale.

- 1.2 The BMA consultants' strike (Tuesday 19 September to Thursday 21 September) and the junior doctors' strike (Wednesday 20 September to Saturday 23 September) affected all inpatient and outpatients' services at Central Middlesex Hospital, Ealing Hospital, Northwick Park Hospital, and St. Mark's Hospital.

Unfortunately we had to cancel many appointments and planned procedures. We have contacted all patients affected and are arranging new appointment dates for as soon as possible. Extensive work on social media, with local media outlets, and with Integrated Care Board (ICB) partners to support community outreach has highlighted the anticipated impact of each strike to local people.

Careful planning and huge support from our clinical teams has allowed us to continue running emergency care safely during these periods, while also demonstrating our respect for our colleagues' right to strike.

Our maternity services remained open as usual. Gold Command was run between 9am and 5pm throughout both periods of industrial action. At the time of writing this report, further joint industrial action by junior doctors and consultants is due to take place from Monday 2 October through to Wednesday 4 October.

- 1.3 We intend to deliver a phased opening of the North West London Elective Orthopaedic Centre (NWL EOC) from November 2023 through to February 2024, with an initial operating capacity of three theatres, increasing to five theatres by the end of February

2024. This approach will allow the new patient pathways to be safely and closely monitored, while ensuring that any operational issues can be resolved early, which should assist the progression to full theatre utilisation.

The three theatres currently in use at Central Middlesex Hospital, and their associated recovery and ward space, are remaining in operation throughout the work to build two new additional theatres required for the NWL EOC.

Our transport working group is now finalising details of a three-step approach to patient transport, with a view to having a transport solution that is ready and tested for when the NWL EOC opens.

The partnership agreement and proposed NWL EOC governance arrangements have built on the intent in the Full Business Case and have been reviewed and supported by APC EMB, the LNWH F&P and collaborative F&P. The APC EMB has now approved the terms of reference for the partnership board.

2. Quality and safety

2.1 I have recently written to all staff at LNWH about raising concerns and to explain what we're doing to make that process work better for everyone.

We are conducting a review of our raising concerns process, which will include looking at how we provide feedback, both to people who have raised concerns and to our wider teams. We will also look at how we can best eliminate any form of cultural or professional barriers to speaking up. The review will conclude at the end of October when I write to staff and stakeholders about what action we are taking to improve the ways in which we support staff to speak up at LNWH.

2.2 As part of the new national Patient Safety Incident Response Framework (PSIRF) to be implemented in the autumn, we are strengthening our processes for quickly and effectively reviewing patient safety incidents.

We will use the Initial Incident Review (IIR) instead of 72-hour reports. Amongst the aims for this change are more timely escalation, review, learning and improvement from patient safety events. Drop-in sessions are being held to inform staff about the change.

We are also introducing the new national 'Learn From Patient Safety Events' (LFPSE) service. This is a central NHS service for recording and analysing patient safety events. We are upgrading our local Datix system to allow locally submitted records of patient safety events to be automatically uploaded to this new national service.

2.3 Our falls team marked falls prevention awareness week (18-24 September) with best practice demonstrations, including post fall management and recovering patients from the floor using specialist equipment.

Stalls across all our sites hosted a range of professional advice, including dietitians, pharmacists, therapists, specialist nurses, and manual handling advisers. They shared information on factors that contribute to falls and on how to prevent falls, focusing on nutrition, bone health, manual handling, medication review and strength and balance exercises.

- 2.4 The annual inpatient survey commissioned by the Care Quality Commission has highlighted a marked improvement in how patients say they are treated by our hospitals.

The annual independent survey approached 1,181 patients, asking them their experience in hospital.

LNWH was the only trust in the country to have made significant improvements since the previous year's scores, with patients rating their overall care 8.3 out of 10.

3. Operational performance

- 3.1 **Emergency department performance:** reported 70.9% for August 2023. This is the tenth highest performance in London for the 18 acute trusts reporting against this standard. Some 94% of patients were treated within 12 hours against the 98% standard. LNWH continues to be ranked as one of the busiest emergency departments in London receiving the most conveyances, with Northwick Park Hospital the single busiest site in London.

Across the summer the Trust has implemented a staffing rota to improve ambulance handover times in line with the London Ambulance Service pilot for the 45-minute offload standard operating procedure. The additional staff has significantly improved ambulance handover times but has created an increase in demand to the hospital sites.

We continue with a range of initiatives to support the emergency pathway:

- The previous year's winter plan remains partly in place to manage the continued demand for admissions across both Northwick Park and Ealing Hospitals
- Continuation of the LNWH Flow Model to support ambulance handover and site flow.
- Direct pathways from the emergency department to ambulatory care settings
- Daily discharge planning with community partners, length of stay focus and joint working with Mental Health Trusts and Social Care partners to expedite assessment and transfer of adults and children into the right location for their on-going needs.
- Daily focus on repatriations to and from local hospitals for stroke, speciality and trauma patients.
- Planning for the continued impact of scheduled industrial action as further dates continue to be announced.

We are progressing the build for the new modular ward on the Northwick Park site, which remains on schedule for a go live at the start of March 2024. Prior to this, we are implementing our winter plan from the start of October 2023 comprising of additional inpatient beds across sites and additional staffing to manage the sessional demand.

- 3.2 **Cancer waiting times:** We continue to focus on cancer to drive down the backlog and meet our planned trajectories. Following the combined impact of the Cerner EPR

implementation and the continued BMA industrial actions which has impacted 35 days to-date, our position performance has been impacted. We are actively working on the recovery of the timed pathways to return to the national expectations.

Throughout this impact, we have maintained a positive performance / over-delivered the national expectations for faster diagnosis within 28 days.

The final position for July 2023 (reporting a month in arrears) was:

- 2-week wait for suspected cancer: reported 85.8%% against the 93% standard
- 28-day faster diagnosis: reported 84.7% against the 75% standard
- 62-day wait for treatment following GP referral: reported 70.7% against the 85% national standard

3.3 18 weeks referral to treatment: We continue to focus on elective recovery despite the on-going impact of national industrial action campaigns, which is impacting the 52 week waiter position. Despite this, the Trust is delivering higher levels of activity in accordance with the operating plan and is continuing to work on increasing activity levels, whilst prioritising our most clinically urgent and longest-waiting patients to avoid further delays from industrial action.

The final position for August 2023 reported 55.8%, with 2,868 patients waiting 52 weeks, of which 32 were waiting over 78 weeks. There are no patients waiting over 104 weeks.

4. Finance and estates

4.1 Finance:

At the end of Month 5, there are some small signs of improvement in the finances for the Trust, after a challenging few months. We have now identified 101% of our cost improvement target for the year of £31.8m, and we have delivered on this target for two months in a row. Similarly, the underlying position excluding the costs of industrial action and 'excess' inflationary pressures is steadily improving. The numbers are still challenging – at the end of Month 5, we are £12.1m adverse to plan – of which £7.4m is the cost/income effect of industrial action and £2.8m is a driven by excess inflation above funding levels. The 'core' Trust position is a variance to plan of £2.3m – whilst we are adverse to plan for our CIP programme by £3.8m, this is offset by really strong delivery from the operational teams against our ERF targets.

In summary, our position is very much in line with and similar to local and national provider colleagues, with the majority of the challenge in the plan driven by industrial action. For those financial issues within the Trust's direct control, we are seeing a trajectory of improvement. We continue to work very closely indeed with our Provider Collaborative partners and we share the combined aspiration to deliver the core financial plan, noting that at Month 5 we expect the only variation in the full year plan delivery to

be the costs and impact of industrial action. Our capital programme is progressing very well, and we continue to work to strengthen our cash flow management and forecasting.

4.2 **Estates:**

This has been another busy period for estates and facilities on the three sites within the Trust – both in terms of building and refurbishment work, and in terms of delivering core services. Looking first at building and refurbishment, at Central Middlesex we have made solid progress – working alongside with our PFI partners – on progressing our new endoscopy and elective orthopaedic facilities.

Similarly, at Ealing, we continue to work hard on the implementation of the Community Diagnostics Centre as well as continuing site maintenance. And, at Northwick Park, work has started in earnest on the new acute medical unit, 5GG, based on top of our existing Emergency Department – and work continues on the new road around the site being built in partnership with Brent and other One Public Estates partners. Our staff and patients have all been really patient over the summer months, as these works have led to noise, disruption and redirection – but as the work completes, we will see a continued improvement in our estate and an expansion in the services that we offer for our patients. Our core facilities and estates services continue to work hard to maintain high quality support for staff and patients, and in recent months we have seen positive results from the PLACE reviews. We have completed our PAMS and ERIC reviews on the quality of the estate and the built environment, and we are working with Collaborative partners on new ways to compare and contrast the detailed data to support the new Estates Committee.

5. **People**

- 5.1 Baljit Ubhey and Martin Lupton have been appointed to our Trust board as non-executive directors. Baljit will chair the Trust's audit committee and Martin will hold the non-executive board role reserved for an academic and will also be a member of the Trust's quality committee.

Baljit is currently Director of Strategy and Policy at the Crown Prosecution Service. Martin is currently Associate Dean and Head of Undergraduate Medicine at Imperial College.

Baljit and Martin have replaced Vinetta Bhalla and Professor Desmond Johnston who have stepped down from their roles as non-executive directors after completing their terms of office.

I am delighted to welcome Baljit and Martin to team LNWH. I would also like to thank Vinetta and Des for the huge contributions they have made during their tenures with us.

- 5.2 I am delighted to welcome Ludmila Ibesaine, our new head of safeguarding, to LNWH. Ludmila joins us from Surrey and Borders Partnership NHS Trust, having spent nearly two decades in the NHS working as a nurse and health visitor.
- 5.3 In July I was delighted to welcome Lara Waywell to her new role as Director of Cancer Services. Lara is working closely with clinical lead Dr Arnab Datta to develop a cancer care centre providing superb quality of care and an empathetic, supportive experience for our local people.

- 5.4 In September we welcomed Imam Rizwan Rawat as the new head of our chaplaincy service. Rizwan is the first Imam to take the role at LNWH, and previously worked as a chaplain in HMP Belmarsh.
- 5.5 I am pleased to announce that Dr Viv Sathianathan has now started as our new divisional medical director for Surgery.

6. Equity, diversity and inclusion

- 6.1 In July we marked South Asian Heritage Month. This year's theme is Roots/Routes, exploring of cultural identity and belonging. All staff were invited to an event on 28 September, to listen and share stories of family journeys as we celebrated the rich tapestry of experiences that contribute to the diverse and vibrant heritages of the East and Southeast Asian community at LNWH.
- 6.2 We marked Black Leaders Awareness Day on Tuesday 18 July. Head of Midwifery Caroline Macrae told us how she became a midwife and what her aspirations are for herself and her team.
- 6.3 At the end of September, we launched our new equity, diversity and inclusion festival, which began with virtual reality sessions to mark national inclusion month.

The festival includes our Black History Month celebrations, led by our BME network, as well as three themed weeks focussing on a range of inclusion issues, before concluding with our celebration of Disability History Month, led by our disability inclusion network.

Throughout the festival period, staff will benefit from talks from high profile speakers, education events, and the launch of new tools and guidance.

7. LNWH updates

- 7.1 Work has started on a new 32-bed unit being built on top of the existing A&E department at Northwick Park Hospital. The benefits of the £20m unit include reducing the amount of time patients wait in A&E for a bed, improving patient safety, reducing ambulance waits and better managing seasonal demand, especially in winter.

We have one of the biggest and busiest A&Es in the country so this will be a welcome and much needed addition to our capacity. The unit will receive its first patients in spring 2024.

- 7.2 LNWH Charity has generously committed £1 million towards big strategic initiatives. We are asking staff for suggestions on how they believe the money would be best spent to help us improve the quality and equity of our care, our quality as an employer, and our support to the health of our communities.

Once we have gathered all staff ideas, everyone will get to vote on the projects that will become our highest priority for this £1 million funding.

- 7.3 Lord Swraj Paul has generously donated £500,000 to Northwick Park Hospital's maternity unit. The money will be used to improve the façade of the building and make improvements to the main entrance. All of us at LNWH are very grateful to Lord Paul for his generous donation.

8. Research and innovation

- 8.1 Central Middlesex Hospital has won the backing of the National Institute for Health and Care Research (NIHR) to fund the large-scale study to understand the impact of Sickle Cell Disease on eyesight. This is the first time the NIHR has funded a project on sight loss caused by Sickle Cell Retinopathy.

Central Middlesex Hospital has teamed up with Moorfields Eye Hospital and 14 other areas around the UK with large Black and Asian communities including Bristol, Manchester and Leeds, to form the Sickle Eye Collaborative. The two-year project is supported with an unrestricted grant from Roche UK.

- 8.2 More than 50 people are taking part in Sanius Health's digital platform for remote monitoring of sickle cell disease at our Clinical Research Facility at Northwick Park Hospital. The platform monitors sickle cell in real time so we can get a far greater understanding of its nature. This will support clinical research and predictive medicine to determine someone's likelihood of developing pain and complications.

9. Stakeholder engagement

- 9.1 We have written to all key stakeholders across north west London to advise on the phased opening of the North West London Elective Orthopaedic Centre (NWL EOC) in November. An all-staff update has also been published across the collaborative.

Councillors and members of the public visited to Central Middlesex Hospital on the 4 October. The visit included a walkaround the NWL EOC site to explore the patient pathway from entering the site to visiting the wards. This was followed by hybrid meeting to explore feedback and insights from the site visit.

- 9.4 Channel 4 has commissioned a seven-minute news report called the *Sickle Cell Diaries* looking at the challenges facing people living with the condition and what the NHS is doing to address them. Filming recently took place at Northwick Park Hospital, where I was interviewed along with a patient and consultant psychologist. It is due for broadcast in October.

10. Recognition and celebrating success.

- 10.1 Rose Amankwaah, theatres matron at Central Middlesex Hospital has received the Silver Medal Award in recognition of a nursing career that has spanned four decades. She was presented with the award in a surprise presentation by Ruth May, Chief Nursing Officer for England.
- 10.2 Sala Abdalla, an Ealing surgeon and founder of the charity Operation International UK (OIUK) is to head a team of surgeons, nurses and anaesthetists helping people in Ghana

who can't afford to pay for surgical procedures, such as hernias, gallbladder and stomach operations.

This will be Sala's fourth trip to West Africa with OIUK. The long-term goal is to create a pool of clinical volunteers that can come together under one umbrella organisation. Sala is meeting with the Royal College of Surgeons with a view to coordinating efforts.

- 10.3 The trust has welcomed its latest group of students as part of pre-Project SEARCH work experience. This is a national initiative offering work experience and employment opportunities to students with learning disabilities and autism.

The national employment rate for people with learning disabilities and autism is 6% but the trust has offered more than 70% of its interns paid employment since 2017.

- 10.4 We held our annual staff excellence awards at Wembley Stadium on Friday 8 September. More than 600 staff attended the ceremony, which attracted more than 900 nominations from across the Trust. This included nominations from patients and members of the public.

It was a welcome opportunity for staff to celebrate and look back over the achievements of the past year and recognise the individuals and teams that went above and beyond.

Chief Executive Officer's Report – The Hillingdon Hospitals NHS Foundation Trust

Accountable director: Patricia Wright
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

- 1.1 The Trust has been informed it can leave the Recovery Support Programme and move from Segment Four to Segment Three of the NHS Oversight Framework. This is down to the hard work of colleagues and financial discipline exercised across the organisation.
- 1.2 The Trust was also formally notified by NHS England that it was satisfied that the Trust had complied with all of the Trust's Enforcement Undertakings accepted by NHS Improvement in July 2018 and that these have now been removed.
- 1.3 In August 2023 our Maternity service received a Care Quality Commission (CQC) focused inspection. We have received some high-level feedback and are awaiting the full draft inspection report. High-level feedback outlined some positives and areas for improvement which are being addressed through a wider programme of work within the Maternity service.
- 1.4 Industrial action by junior doctors and consultants took place throughout July, August and September. The Trust has continued to work hard to keep disruption to a minimum and continued to support patients, visitors, the public and staff during the strikes.
- 1.5 Our pilot Frailty Unit at Hillingdon, which was launched in November 2022, has been so successful it has been agreed to make the service permanent. This emergency service for older adults has; helped reduce average length of stay from 12 to seven days, achieved 89% same-day discharge and set up direct pathways with London Ambulance Service and community partners.
- 1.6 Our CernerEPR is on track to launch on Friday 3 November 2023.
- 1.7 On Tuesday 26 September 2023 we held our Annual Members Meeting, showcasing our performance in 2022/23, where we have got to so far in 2023/24 and looking ahead. I would like to thank all those involved and those that attended the meeting.

2. Quality and Safety

- 2.1 An internal campaign, 'Call don't fall', was introduced in September 2023 to encourage patients to ask for help instead of risking a fall, allied to the existing 'See yellow, think falls' awareness measures in some wards.
- 2.2 There has been continued progress in rolling out the Patient Safety Incident Response Framework (PSIRF) programme. PSIRF is a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The emphasis is on learning and improvement.

- 2.3 The Trust re-launched a monthly Learning Summit, which intends to put the focus on 'learning from ...' – with feedback from incidents, complaints, audits and quality rounds.
- 2.4 A training package for our preceptorship nursing group is under development, in collaboration with the manual handling lead for the trust and the trauma lead. This will focus on enhancement of our post-falls management within the trust, improving staff knowledge and patient experience.
- 2.5 The Trust opened the 'Hillingdon Lighthouse' in partnership with Central and North West London NHS Foundation Trust to offer a calm environment for our patients awaiting admission to care in mental health services.

3. Operational performance

- 3.1 Referral To Treatment (RTT) 52 week waiting patients are reducing as a result of concerted actions which are gaining traction over and above cancelled activity as a result of industrial action.
- 3.2 Elective total activity, (Inpatient and Daycases) remains below target levels with resilience planning continuing. Inpatient activity has seen a significant improvement in August but remains a current area of focus for the Trust.
- 3.3 The Trust continues to perform well in theatre utilisation with figures consistently above 80% and is predominantly placed in the top quartile of Model Hospital data.
- 3.4 Diagnostics 6 week performance is a special cause improvement for the Trust with concerted effort to increase capacity and reduce backlog. July and August saw a slight reduction in 6 week performance with reduced activity in Non-Obstetric Ultrasound.
- 3.5 Cancer 62 day waiting patients remains static. Diagnostics (radiology) capacity poses greatest risk to reduction trajectories.
- 3.6 The urgent treatment centre (UTC) is performing well, however type 1 A&E performance remains challenged.

4. Finance performance

- 4.1 At Month 5 (M5), the Trust is reporting a year to date (YTD) deficit of £13.9m, an adverse variance to plan of £4.8m. The main drivers of the variance are the impact of the junior doctor's strikes (£2.0m) and unfunded inflation on utilities (£0.9m). Registered Mental Nurse (RMN) costs remain exceptionally high with £1.1m spent on RMNs in the first five months.
- 4.2 The Trust has posted a deficit of £1.4m in month 5 against the planned £1.4m deficit. The £12k favourable variance in month is driven by ERF income adjustment of £2.1m, partly offset by the impact of junior doctor's strikes (£0.6m); energy cost pressures (£0.2m); RMN costs (£0.2m); pathology costs (£0.1m) and the impact of the agreed pay award arrears (£0.1m).

4.3 The efficiency target for 2023/24 is £10.8m, which is phased to increase as the year progresses. The target for M5 was £0.8m, which has been achieved.

5. People

5.1 We would like to welcome Non-Executive Directors Patricia Gallan, Baljit Ubhey and Martin Lupton to the Board of Hillingdon, and thank you to the outgoing Non-Executive Director Des Johnston.

5.2 We would also like to welcome Dr Alan McGlennan who has taken up his post as the Trust's Chief Medical Officer.

5.3 Our medical trainees were recognised for leadership, improvement and excellence at the Trust's Medical Education Awards on Wednesday 12 July.

5.4 The Trusts has re-introduced monthly CARES awards for staff as a way of recognising excellence in their colleagues and as a way to honour those who 'live' our CARES Values, with a Trust 'CARES Week' planned for October 2023.

5.5 The Trust held a Maternity open day on Monday 4 September at Hillingdon Hospital for anyone interested in a career in midwifery. The event was well attended, and attendees could speak to our recruitment team directly and see our current vacancies.

6. Equality, Diversity and Inclusion (EDI) update

6.1 The Trust was delighted to welcome our new EDI lead, Cynthia Oji, who will be responsible for the various staff networks across the Trust, such as LGBTQ+ and Allies, Multicultural, Disability and the Women's Empowerment Network.

7. Hillingdon Hospital Redevelopment

7.1 Progress on the new Hillingdon Hospital continued as the Trust selected a contractor to get the site fully ready for building work to start. A number of projects will soon be underway, including a temporary staff car park and services diversion and building demolitions.

7.2 As part of the engagement work the Trust continues to hold key briefings with stakeholders and the local community. Key visits include:

- Lord Markham, Parliamentary Under Secretary of State at the Department of Health and Social Care who is responsible for the New Hospitals Programme visited Hillingdon Hospital on Thursday 7 September. The visit included a hospital tour, an update on our redevelopment progress and an overview of our preparations for electronic patient records.

8. Updates from the Council of Governors (CoG)

8.1 The CoG met on 27 July 2023 and received a briefing on 11 September 2023, on how the Trust was performing against its People objectives.

8.2 The Trust officially opened its Governor elections on Friday 21 July and closed on Friday 18 August. With lots of nominations received, voting opened on Thursday 7 September and closed on Thursday 28 September. I would like to welcome our incoming Governors

and thank our outgoing Governors for their valuable insights and input, dedication and support to the Trust.

9. Research and innovation

- 9.1 A new staff app went live in September and has already proved very popular with 500 members of staff downloading and installing it on to their personal devices in two weeks.
- 9.2 Our Trust secured funding for a Da Vinci Xi surgical robot system. The system is highly valuable for training and is linked to a new operating table. It is currently housed on Jersey Ward at Hillingdon while colleagues are trained, and we anticipate performing our first cases with mentors in October 2023. The Da Vinci will be used by general and colorectal surgery and gynaecology to begin with.

10. Stakeholder engagement

- 10.1 The Trust held a successful open day at Mount Vernon Hospital on Saturday 8 July, as part of the wider NHS 75 celebrations.

11. Recognition and celebrating success

- 11.1 The Trust held its Annual Staff Awards Ceremony on 5 October 2023. This was an uplifting event, allowing us to celebrate the dedication and commitment of our workforce.

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. It has been a busy and varied quarter for the Trust and we are now in full preparation for the winter period. We have set out our Winter Plan with key initiatives in place to support the Trust meet an increase in non-elective demand, as well as service specific plans for each of the affected service areas.

Our plan aims to reduce demand on front door services, and support hospital flow through either admission avoidance or earlier discharge. This includes: urgent treatment centre (UTC)/emergency department (ED) demand management and flow, front door frailty service, admission avoidance and earlier discharge (same day urgent care (SDEC), virtual wards), use of digital tools to support flow and discharge, seven day working and phasing of elective demand.

We have already kick started our winter vaccinations with COVID-19 jabs across our hospital sites. This year we have co-designed a campaign that focuses on the armour of protection that both vaccinations provide which has been endorsed nationally by NHS England.

- 1.2. We were delighted to be shortlisted in the national HSJ Trust of the Year category, recognising our outstanding contribution to healthcare. We have also been shortlisted for the 'Driving Efficiency Through Technology' award category as part of the North West London Acute Provider Collaborative on the Care Coordination Solution to better manage elective patient care. Thank you to all our staff for their dedication in providing outstanding patient care and continuous drive to be leaders in digital innovation.
- 1.3. Our focus on innovation continues with DERM artificial intelligence (AI) work which is helping speed up the diagnosis of skin cancer and improve the patient experience. The DHSC recently met with our clinicians leading on DERM AI technology to see how it is helping to reduce dermatology waiting lists, enabling more time to be dedicated to more complex cases.
- 1.4. In September we marked the eight year anniversary of West Middlesex University Hospital and Chelsea and Westminster Hospitals joining forces to become the organisation we have grown today- much has been achieved in this period and we are looking forward to the impact the Ambulatory Diagnostic Centre will deliver for diagnostics across the communities of West London.
- 1.5. The escalation of the national industrial action pay dispute continues to have a sustained demand across the sector, an impact we were largely able to manage patient flow effectively, deliver safe urgent and emergency care and sustain some elective activity. I

am extremely grateful to our staff for their outstanding contribution and teamwork in ensuring patient safety and timely care during the ongoing industrial action.

2. Quality and Safety

- 2.1. The Trust's Quality Account was approved by our Quality Committee members in the last quarter. The report, which is available on our website, sets out how we have delivered against our quality priorities for 2022/23 and outlines our quality priorities for 2023/24.
- 2.2. Core to ensuring we have safe and high quality services is ensuring that we listen to and learn from patients. Work on embedding and implementing our patient experience strategy, with a focus on 'you said, we did' has been central to this. This has included upskilling staff on patient feedback mechanisms and using the information more effectively. In turn this is resulting in improvements to survey response rates with more staff wanting to be involved in patient experience activities. Further actions are being identified as part of the Trust's ward accreditation programme.

3. Infection Control

- 3.1. From April – 19 September 2023 the Trust reported two MRSA blood stream infections bringing the Trust to a total of two cases to date this financial year. There were nine cases of C.difficile infections between July-September and year to date there have been 17 Trust apportioned cases.
- 3.2. As E.coli bacteraemia cases increase across the sector, we continue to work closely with ICS and APC sector colleagues to identify and establish improvement workstreams with primary care - an example being the implementation of a standard catheter passport given the number of cases that are linked to catheters. The team has also commenced a systematic (monthly) review of all Trust attributed blood stream infections.
- 3.3. The infection prevention and control team continues with a programme of education and reviews of clinical practice focusing on the management of invasive devices. A 'gloves off' campaign has also been designed and will be launched in September. The campaign aims to reduce the use of non-sterile gloves to improve hand hygiene compliance, reduce the Trust's use of single use plastics and improve staff hand health.
- 3.5. We are working closely with the APC Quality Infection Prevention and Control (IPC) workstream towards standardising winter planning, infection surveillance systems, shared learning practices to improve healthcare acquired infection rates and implementing a penicillin de-labelling programme.

4. Operational performance

- 4.1. In August, A&E four hour performance was 82.66%. The Trust ranked fifth nationally and second in London. We achieved the national targets for cancer two- week wait referrals, 31-days diagnosis to treatment, 62-day cancer screening and the cancer faster diagnostic standard (FDS). The Trust remains a top performer nationally for cancer treatment waiting times.

4.2 Elective referral to treatment (RTT) 18-week wait performance remained challenged, but broadly stable, with efforts continuing to see long waiting and clinically urgent patients. The Trust remained resilient in delivering planned activity levels despite industrial action.

4.3 Enhanced oversight and targeted interventions remain in place for at-risk specialities: trauma and orthopaedics, colorectal surgery, plastic surgery, vascular and general surgery

5. Finance performance

5.1. We are reporting a £4.42m adjusted deficit position for the year to date (at month four), which is £4.62m behind plan. The Trust's plan and forecast for the year is break-even.

5.2. We are working across the Trust and more widely across the collaborative to recover the position, which is largely driven by industrial action and associated increased staff cover costs and loss of elective recovery fund. Inflation also continues to have an impact.

5.3 The capital spend at month four is £5.92m against our plan of £6.12m due to timing differences in the capital programme. At the end of month 4 the cash balance was £165.78m.

6. People

6.1. Richard House has been appointed as Deputy Director for Learning and Development for the Trust. He has an extensive career working both in the UK and internationally on major development programmes working for John Lewis, and his career ranges from the Royal Marsden, Surrey ICS, Sussex, NHS England leading on their digital integration. Richard joins us at a key point with expanding and accessibility of our learning and development (L&D) provision to staff.

6.2. Natasha Singh will be taking the reins of EDI Board advisor from October. Natasha is a consultant obstetrician and gynaecologist who has lead one of the largest maternity services in London with West Mid recently retaining ratings of Outstanding for maternity and Good for the Chelsea hospital site. Natasha has also been part of the cultural safety programme which is pioneering best practice for EDI in supporting patients and their families, this appointment marks an important step in progressing our focus on EDI at the Trust.

6.3. Patricia Gallan, Carolyn Downs and Professor Neena Modi joined the Board as Non-Executive Directors and we look forward to working closely with them. Nilkunj Dodhia, Peter Goldsbrough and Professor Andrew Bush all reached the end of their respective terms and the Trust extends thanks and gratitude for their time and contribution.

7. Equality, Diversity and Inclusion (EDI) update

7.1. We celebrated South Asian Heritage Month event with a special event at West Mid which was nothing short of spectacular - with so many of our staff sharing aspects of their culture through dance performances, food, music and henna painting. This led to a whole

month of events across both hospital sites to recognise the enormous contribution of our South Asian workforce and community. The events were featured widely in local media.

- 7.2 On Saturday 1 July the Trust we marched at the London Pride parade. This is the second year that the Trust (as a whole) has had a presence at Pride, and for the first time staff travelled on a branded float. This was an important opportunity to demonstrate our solidarity with the LGBTQ+ community and highlight our role as a national leader in sexual health and gender services. Our LGBTQ+ Staff Network submitted our first Stonewall Workplace Equality Index application.
- 7.3 The Trust has led on the creation of the 'Access-Able' Working Group, chaired by our Deputy Chief Nurse, and which our Disabled Staff Network are key stakeholders;
- 7.4 NHS England have commended our work with the use of virtual reality (VR) technology to provide immersive learning experiences for staff in equality, diversity and inclusion training.

8 Trust highlights

- 8.1 On 5 July, we celebrated 75 years of the NHS across all our hospital sites. On the morning we hosted BBC Radio 4 Today programme with live interviews and some pre-recordings from earlier that week showcasing our robotic surgery and patient stories of their incredible while at the Trust. Amanda Pritchard, chief executive of NHS England joined the trust on the day to mark the celebrations as a former employee of the hospital. Sky News broadcast live for the entire day at West Mid hospital site with interviews with leading clinicians, volunteers, primary care leaders to demonstrate the varied and roles in multi-disciplinary roles that support the NHS.
- 8.2 NHS England has awarded our Trust the contract to deliver TransPlus – the first integrated gender, sexual health and HIV service to be commissioned in England. Since 2020, it has delivered invaluable care and support to over 700 patients – including diagnosing gender dysphoria, hormone initiation and monitoring, speech and language therapy, and surgical referral alongside an extensive wellbeing programme.
- 8.3 The new discharge lounge facility at West Middlesex has received national recognition from the Department for Health and Social Care (DHSC), with Ministers sharing it as an exemplar. The new discharge facilities were developed following a successful £1m bid to the NHS England support fund earlier this year—enabling our Trust to improve the quality of care and experience for patients.
- 8.4 Our Trust has recently launched our smoking cessation campaign Smokeless, ahead of Stoptober to support our patients and staff. To support the service we have welcomed two smoking cessation advisors, as they work across both sites in providing tailored support and information. The new revised service will have a major impact on respiratory care ahead of the winter months.

9 Member and governor update

- 9.1 We held a positive Annual Members Meeting on 20 July showcasing our achievements during 2022/23. Attendees heard about our innovative robotic surgery and how this is transforming care for patients, alongside the experience shared by our butterfly volunteers who support patients in the last days and hours of their lives.
- 9.2 We have strengthened engagement with our wider community, including Trust members and governors. To support increased participation, in September our Council of Governors (CoG) and Trust Board members approved amendments to the Trust's Constitution, bringing greater clarity to the staff constituencies in time for the recently launched process seeking nominees for election to the CoG.

10 Research and innovation

- 10.1 In October, we celebrated the fourth anniversary of CW Innovation and hosted events across both sites where staff got involved as we develop our vision for the future. With thought-provoking talks and hands-on demonstrations, we were delighted to recognise the breath of work that is leading pioneering changes for the NHS nationally and more locally.
- 10.2 Research, Innovation and Quality Improvement (RIQI) week took place from 3–6 July, where we showcased best practice across the Trust via in-person and live-streamed events. This was the largest events that has taken place across the organisation to embrace and celebration the role of research and innovation.

11 Stakeholder engagement

- 11.1 Below is a summary of significant meetings and communications with key stakeholders:
- Chief Executive NHSE, Amanda Pritchard celebrated with us to mark the NHS birthday at the Chelsea hospital site –5 July
 - Ruth Cadbury MP leads on Osterley Park NHS Parkrun –8 July
 - Munira Wilson MP visits West Mid to hear more about our services, including the Trust's takeover of the Urgent Treatment Centre – 24 July
 - Allied Health Professionals (AHPs) invited to Minister's Roundtable with Minister of State Department of Health and Social Care, Will Quince – 6 September
 - Series of public Meet the Governor sessions across sites from July- August

12 Recognition and celebrating success

- 12.1 Our green plans have stepped up with The Trust is always looking for more sustainable ways of working, supporting our pledge to achieve net zero emissions by 2040. We have moved to Ecosia as our default search engine. Ecosia benefits the environment with each search made, with 100 percent of profits going towards planting new trees across the world.

- 12.2 We have been highly commended in the Virtual or Remote Care Initiative of the Year category at this year's HSJ Patient Safety Awards which recognises safety, culture and positive experience in patient care. The Trust was commended for their Mpox virtual monitoring initiative, which has proved invaluable in the remote care of people with Mpox infection, by reducing the challenging impact on the workforce as observed at the start of the Mpox outbreak.
- 12.3 Working with Hounslow Council, Sadia Khan, Service Director for Cardiology at the Trust has spearheaded a new project, Digital Inclusion for Social Health Impact, aiming to reduce digital exclusion and breakdown health barriers impacted by digital inequalities. The results of this partnership includes the Trust now recycling old tech via the council's laptop recycling project Our Barn so that more residents can have digital access at home.
- 12.4 Our Maternity Cultural Safety team has been recognised for creating a culturally safe maternity unit at the Trust, in the prestigious Nursing Times Awards. The team has also has been shortlisted for the Dame Elizabeth Anionwu Award for Inclusivity in Nursing and Midwifery and finally our maternity and neonatal team has been nominated for the UK Maternity Unit Marvel Awards, held by the UK's leading maternity safety charity, Baby Lifeline.
- 12.5 Our Trust has received a Gold Award from the Armed Forces Covenant Employer Recognition Scheme. This prestigious award recognises our work in supporting and advocating for patients and staff who are current or serving members of the armed forces.
- 12.6 The Burns team recently presented at the 20th European Burns Association congress held in Nantes (France), highlighting our latest advancements and introduction of an online academic-based Advanced Burns care course in the UK that is hosted on the unit at Chelsea.

Chief Executive Officer's Report – Imperial College Healthcare NHS Trust

Accountable director: Professor Tim Orchard
Job title: Chief Executive Officer

1 Key messages

- 1.1 I would like to give a warm welcome to Carolyn Downs and Professor Neena Modi who joined the Board of Imperial College Healthcare NHS Trust as Non-Executive Directors on 1 September 2023. Sincere thanks to Peter Goldsbrough and Professor Andrew Bush, who have stepped down as Non-Executive Directors, for their time and significant contributions to the Trust.
- 1.2 I am delighted that the Trust's maternity services continue to be rated as outstanding, following a Care Quality Commission (CQC) inspection which took place in March 2023 and was published on 20 July 2023. Following this focused inspection, the overall rating for the maternity services at both Queen Charlotte's and Chelsea and St Mary's hospitals remains as outstanding, and good for how well-led and safe the services are.
- 1.3 I welcomed Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care, to St Mary's for two visits in August and September. The first was focused on Op RESTORE, the veterans' physical health and wellbeing service, and at the second, the Secretary of state heard about our services and winter planning. We also discussed our redevelopment needs and plans as we have been working closely with the New Hospital Programme (NHP) to progress and accelerate the redevelopment of our hospitals.
- 1.4 On 25 July 2023, together with Imperial College London, we announced HRH Prince William as Patron for the fundraising appeal being established to support the development of the Fleming Centre at St Mary's Hospital. Due to open in 2028, to mark a century since the discovery of penicillin, the Centre will aim to drive a global movement to tackle antimicrobial resistance. Chaired by Professor the Lord Darzi of Denham, the Fleming Centre will combine cutting edge research, public engagement, and work with policymakers to drive a global change. It will deliver both research programmes and public exhibitions and engagement activities to educate, inspire and take action.
- 1.5 Operationally, our emergency departments continue to consistently deliver some of the shortest handover times within London and we have made improvements against the four hour standard, which states that all Trusts see and admit or treat and discharge 76 per cent of patients arriving at an urgent treatment centre or emergency department within four hours, achieving the target in July and August. Unfortunately, industrial action continues to disrupt our services and place additional strain on our elective pathways, resulting in a number of cancellations meaning we are currently off trajectory for reducing 78- and 65-week waits. We continue to manage the impacts of industrial action, though this has become more difficult over time. It has been announced that the Trust will take over running the urgent treatment centre (UTC) at St Mary's Hospital from mid-October 2023, following a competitive tender by North West London Integrated Care Board.

1.6 Financially, we are currently reporting an £16.9m deficit but working to recover our position and forecasting to break even at the end of the year excluding the impact of industrial action and unfunded excess inflation.

2 Quality and safety

2.1 We continue to maintain good performance against key quality measures. Mortality rates are consistently amongst the lowest in the NHS, incident reporting rates are increasing overall which is positive, and harm levels are well below national averages. We have recently seen a small increase in incidents causing harm which we are monitoring closely through our weekly panel with the Medical Director. We have started to better capture incidents from complaints and inquests and are therefore seeing some late reported incidents that could have been identified through the morbidity and mortality review process, this is contributing to the increase seen. We are also seeing some real time increases though in clinical areas and themes. Investigations are underway where appropriate and a number of quality review meetings have been triggered to better understand the increases, improvement plans will be agreed through this process. We do have safety improvement programmes linked to themes that are progressing well including patient falls, safe blood transfusion and care of patients with sepsis where we are seeing improvements in key metrics. A weekly incident report is now reviewed at the executive meeting to better triangulate data with the operational updates so we can track any links between on-going pressures and care for our patients.

2.2 Performance in meeting the infection prevention and control (IPC) nationally mandated targets remains challenged. There is no obvious root cause and so we have begun a trust-wide enhanced monitoring and improvement approach including hand hygiene compliance, isolation practices, invasive line care, patient facing equipment cleaning, water management and antibiotic stewardship. We will monitor the improvement plan monthly, giving intensive support as required. The new acute provider collaborative IPC quality workstream is welcomed to support any additional learning. We were pleased to recently be recognised as the first UK Centre for Excellence by the Global Antimicrobial Stewardship Accreditation Scheme.

2.3 Delivery of the patient safety incident response framework (PSIRF) and learn from patient safety events (LFPSE) remain on track within national timeframes, with detailed implementation plans in place. Testing of the new processes is progressing well and we are live in one division with positive feedback and lots of learning for when we transition trust-wide. Resource to manage transition remains the most significant risk.

2.4 The Trust provides oversight of quality assurance within the maternity and neonatal services via a maternity quality oversight assurance report to each Quality Committee meeting. We are delighted that our maternity services have retained our outstanding rating from the CQC. Work continues to improve the quality of care and patient experience, including through implementation of the clinical negligence scheme for trusts maternity incentive scheme (CNST MIS) year 5. Risks to delivery, including the additional audit burden and timely completion of perinatal mortality reviews, have been identified and have mitigating actions are in place.

2.5 Following the events at the Countess of Chester hospital, with the other trusts in the NWL Acute Provider Collaborative, we have undertaken a review of our processes across quality and safety, people and culture to ensure we are doing everything possible to prevent this happening in one of our organisations. This review is being presented separately to the Board and provides good assurance overall.

3 Operational performance

- 3.1 We have maintained our good ambulance handover performance, and our emergency departments continue to consistently deliver some of the shortest handover times within London. We have made progress against the national standard for handing over 95 per cent of ambulance attendances within 30 minutes, and our performance was 95.4 per cent and 95.6 per cent for July and August respectively. We have also made improvements against the four hour standard, which states that all Trusts see and admit or treat and discharge 76 per cent of patients arriving at an urgent treatment centre or emergency department within four hours, meeting our performance trajectory since April and achieving 78.1 per cent in July and 76.7 per cent in August.
- 3.2 We continue to work through our 78-week waiter position and to ensure that our patients are prioritised appropriately. Unfortunately, industrial action continues to disrupt our services and place additional strain on our elective pathways, resulting in a number of cancellations. Consequently, we were unable to meet our trajectory of zero 78-week waits by the end of July 2023. We are currently off trajectory for 65-week waits for August but still intend to achieve our target of achieving zero by the end of March 2024. Our teams are ensuring that patients are rebooked and treated as quickly as possible when affected by industrial action.
- 3.3 The number of patients on a cancer pathway for more than 62 days increased at the end of August and did rise slightly above our trajectory. We worked hard to recover the position during September, and the backlog was quickly brought back down under trajectory. We remain absolutely committed to reducing the size of the backlog and we have robust and detailed plans in place to ensure that all of our cancer services can achieve this. We have continued to improve against the faster diagnostic standard, which requires that 75 per cent of patients be diagnosed or have cancer ruled out within 28 days of referral. We have achieved this for the last four consecutive months, with our latest validated performance in July at 84.7 per cent.

4 Financial performance

- 4.1 The Trust has set a breakeven plan for the year which is dependent on the delivery of 104 per cent value weighted elective activity levels (4 per cent above 2019/20) and achieving £53.4m of efficiencies. This level of efficiency equates to 3.6 per cent of turnover and is line with other organisations.
- 4.2 At month four, the Trust is reporting an £16.9m deficit against a breakeven plan. The key drivers remain under-delivery against an equally-phased cost improvement plan, additional inflationary costs above funded levels, impacts of industrial action and run rate pressures in pay and non-pay. We continue to review the cost base, improve activity levels, implement other non-recurrent mitigating actions and focus on run rates to meet the plan. Therefore we expect to recover the financial position and are forecasting to break even at the end of the year excluding the impact of industrial action and unfunded excess inflation.
- 4.3 The Trust's estimated Capital Resource Limit (the amount we can spend on our capital programme excluding grants and donations) is £77.7m. This is made up of £63.9m of internally generated cash and £13.8m of national funding. At the end of July, the Trust had invested £18.8m of expenditure – 92 per cent of the year to date capital plan.
- 4.4 The Trust has a cash balance of £163m as of 31 July 2023, a reduction of £16.2m since the beginning of the year.

5 Workforce update

- 5.1 The NHS national staff survey launched on 12 September 2023 and will close on Friday 24 November. Although we know there are negative perceptions of NHS in the media and industrial action is causing ongoing difficulties for staff, we are encouraging staff to respond, to share their views honestly and anonymously so we can continue to make improvements.

Industrial action

- 5.2 We have been managing the monthly periods of industrial action since December 2022. The BMA and HCSA (junior doctors) have successfully re-balloted their members and a further six months mandate for strike action was achieved. The BMA (consultants) have a mandate for strike action that continues until December 2023. Dates for strike action in September and October have been confirmed with 24 hours in September and 48 hours in October where both Consultants and Junior Doctors will be on strike at the same time. The BMA have agreed to support Christmas Day staffing arrangements during that time. We are continuing to robustly manage industrial action to continue to run our hospitals safely. This has become more difficult over time and will pose additional challenges into winter.

Senior management changes

- 5.3 Steve Hart was substantively appointed as Divisional Director of operations for Surgery and Cancer in August, having undertaken the interim role for the previous six months.
- 5.4 I and all the executive are sad to say goodbye to Ann Mounsey, who retired on 29 September after 35 years in the Trust, and in the role of chief pharmacist since 2014.

Equality, diversity and inclusion (EDI)

- 5.9 We have now begun our anti-racism and anti-discrimination engagement programme, which will help our Trust to establish a shared understanding of what it means for us to be a truly fair and inclusive organisation. This will include a series of engagement sessions with employees, patients, and lay partners from October 2023.

6 Regulatory compliance Care Quality Commission (CQC) Update

- 6.1 As noted earlier, the Trust's maternity services at St Mary's and Queen Charlotte's and Chelsea Hospital were inspected by the CQC in March and the final report published on 20 July 2023. I am delighted that the overall rating for the maternity services at both Queen Charlotte's and Chelsea and St Mary's hospitals remains as outstanding, and good for how well-led and safe the services are. As this was a focused inspection, the CQC didn't look at the other domains, so the existing rating for effective remains as good. The ratings for caring and responsive remain outstanding.
- 6.2 Radiotherapy at Charing Cross Hospital was inspected on 6 July 2023 in relation to its compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER). This was a routine inspection. The report set out three actions for improvement (not enforcement actions) the Trust. Ratings are not awarded as a result of IRMER inspections, nor do IRMER inspections impact on trusts' overall CQC rating.
- 6.3 The CQC is developing new methodology for regulating NHS trusts. Rollout in London will take place over an eight week period commencing late November / early December 2023 through to the end of January 2024. As soon as the rollout commences, the CQC will begin to resume routine activity with the Trust; by the end of the eight week period, the Trust will be regulated fully in the new regime.

7 Research and innovation

- 7.1 The NIHR Imperial Biomedical Research Centre (BRC) at the Trust has been awarded £4.7m of capital funding from the National Institute of Health & Care Research (NIHR) for 2023/24 and 2024/25 to purchase new items of equipment to support early-phase experimental medicine research in the Trust, and to refurbish additional space for delivery of clinical research trials for patients. This is subject to approval of an internal business case and associated revenue costs.
- 7.2 As part of the NIHR Imperial BRC and NIHR Imperial Clinical Research Facility (CRF) programmes of work, we have submitted a strategy to NIHR to improve the equality diversity and inclusion of participants in our clinical research studies and to improve and diversify our recruitment and retention practices to develop a more balanced workplace.
- 7.3 Recent research stories include:
- A [proof-of-concept blood test](#) which may be able to rapidly diagnose the cause of febrile illness in children brought into hospital.
 - [Findings of the MELODY study](#) which identified those people with compromised immune systems who are less likely to have COVID-19 antibodies, and who therefore could be more vulnerable to a severe COVID-19 infection.
 - A case report of the [first womb transplant in the UK](#) carried out following more than 20 years of research. The surgical team was co-led by surgeons at ICHT and Oxford University Hospitals NHS Foundation Trust.
- 7.4 Paddington Life Sciences continues to flourish as an emerging life sciences cluster, and last month hosted the NHS Assembly, including facilitating members of the Assembly, and senior NHS England colleagues to visit our digital collaboration space and hear about a number of innovative projects being established across Trust, academic and industry partners.

8 Estates and redevelopment update

- 8.1 We have carried out a table-top exercise to verify that there is no reinforced autoclaved aerated concrete (RAAC) in any of our buildings and are working on detailed site survey to confirm this.
- 8.2 A new children's playroom opened at St Mary's Hospital at the end of August. The space on the Great Western Ward was outdated and no longer suitable for the growing number of patients. Funded by Imperial Health Charity, it has been transformed into a bright, modern, and exciting play and therapies space that can meet the needs of everyone who uses it.

Redevelopment

- 8.3 The Trust has continued to develop plans for its three sites in the New Hospital Programme – a rebuild of St Mary's hospital and extensive refurbishment to Charing Cross and Hammersmith hospitals. The Government announced in May that our schemes would not be completed in the original timescale, before 2030, which is disappointing. However, we will be funded to progress all our schemes to full business case. We are progressing our work on the business cases and doing all we can to accelerate the redevelopment - looking at alternative funding arrangements to rebuild St Mary's Hospital and ensuring we can take advantage of any additional funding that becomes available sooner than the current plan for the refurbishments in Charing Cross and Hammersmith.
- 8.4 In July 2023, the New Hospital Programme (NHP) launched a 9-month scheme typology prioritisation and preparation process, which is intended to inform the batching and phasing

of schemes based on deliverability (maturity and affordability) and will feed into the next iteration of the programme business case due autumn 2023. The process involves three phases: Phase 1 has now completed. Phase 2 commenced on 12 September 2023 with the Trust asked to complete a questionnaire to help NHP better understand the current status of individual schemes.

9 Stakeholder engagement and visits

9.1 Below is a summary of significant meetings I have had with stakeholders:

- Cllr Neil Nerva, London Borough of Brent, 19 July 2023
- Cllr Ketan Sheth, London Borough of Brent, 2 August, 6 September 2023
- Hammersmith and Fulham Save our NHS, 8 September 2023
- Nickie Aiken MP, 12 September 2023
- Andy Buck MP and Karen Slaughter MP, 20 September 2023
- Cllr Butler-Thalassis and Cllr Piddock, City of Westminster, 20 September 2023

9.2 Our AGM was held on Wednesday 19 July in the Mary Cochrane Lecture Theatre, at Charing Cross Hospital, with the option to attend virtually. Patients, carers, families, local residents and staff attended to hear about our work and performance in 2022/23 and our plans for the future.

9.3 We have also hosted several visits to the Trust, including

- On 3 July, Lord Markham, Parliamentary Under Secretary of State at the Department of Health and Social Care, Felicity Buchan MP and Nickie Aiken MP visited St Mary's Hospital. We showed them the damaging impact of our failing estate on patients and staff and discussed the many benefits of our redevelopment plans. I met with them again in September to follow up on next steps.
- On 10 July 2023, Amanda Pritchard, CEO of NHS England, attended St Mary's Hospital. We took her for a community walk around Edgware Road and Church Street, showing the work we're doing with our local community and GP practices. We also discussed some of the innovative projects we're running as part of Paddington Life Sciences. She was impressed by the important role we're playing as an anchor institution in our community.
- On 29 August 2023, we hosted a visit from Rt Hon Johnny Mercer MP, Minister of State for Veterans' Affairs and Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care who visited St Mary's hospital to learn about Op RESTORE, the veterans' physical health and wellbeing service. Op RESTORE is hosted by Imperial College Healthcare NHS Trust and ministers took part in a roundtable with clinicians and veterans to learn about the great work that the service provides for veterans. The Secretary of State was then joined by Neil O'Brien MP, Parliamentary Under-Secretary of State for Primary Care and Public Health, for a subsequent meeting with admin and clerical and hotel services staff about careers progression.
- On 14 September 2023, Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care, returned to St Mary's Hospital. He met staff and patients in our SDEC (same day emergency care) unit and A&E and hear about our challenges and plans for winter. I and other senior leaders then led a discussion about our redevelopment needs and plans.

Media updates

9.4 Channel 4's documentary Emergency returned on 15 August 2023, with four episodes in total during August. Filming took place in July 2022 and staff from our major trauma

pathway and emergency department featured extensively, with the programme following the minute-by-minute decisions trauma teams make to treat patients.

- 9.5 The Trust has also featured in recent articles in the Financial Times and the New Statesman focused on our estate and the need for redevelopment and capital spending across the NHS.

10 Recognition and celebrating success

- 10.1 The Trust has been shortlisted the Nursing Times Workforce Awards in the Best Use of Workplace Technology category. Congratulations to our Digital Education Team and all our Imperial People who have worked on efforts to introduce data driven education to promote efficient nursing workflows in Cerner.
- 10.2 The Trust has also been shortlisted in the Towards Net Zero category at the upcoming HSJ Awards (taking place on 16 November), to recognise the work in delivering on our Green Plan which has seen our NHS carbon footprint fall by 13 per cent from 2019/20 levels.
- 10.3 Congratulations to our nursing directorate education team who has been shortlisted for the upcoming London Healthcare Support Worker (HCSW) Awards 2023 in three categories: Trust of the Year, Collaboration & Partnership, and Innovation in Recruitment.
- 10.4 Congratulations to our four nurses who have been awarded prestigious NIHR fellowships, Magda Lampridou, Maria Reguenga, Peter Wilding and Claire Petersen. These fellowships support individuals on their trajectory to becoming future leaders in health and social care NIHR research.
- 10.5 Congratulations to our hotel services and equality, diversity and inclusion teams whose exceptional efforts were recognised in the Healthcare People Management Association (HPMA) Awards on Tuesday 19 September. Although we didn't win, we were shortlisted as finalists for categories in equality, diversity and inclusion employee engagement.
- 10.6 Congratulations to all Imperial staff who received academic promotion from Imperial College, London this year. This includes:
- Bob Klaber - Professor of practice (population health),
 - Justin Roe - Professor of practice (speech and swallowing rehabilitation)
 - Robina Coker - Professor of practice (respiratory medicine)
 - Alexander Comninos - Professor of practice (endocrinology)
 - Mark Gilchrist - Professor of practice (infectious disease)
 - Paul Edison - Professor of neuroscience
 - David Owen – Reader in molecular pharmacology and experimental medicine
 - Nichola Cooper – Professor of immune haematology
 - Niamh Martin – Professor of endocrinology
 - Nicholas Powell – Professor of gastroenterology
 - Ahmed Ahmed – Clinical reader in metabolic surgery
 - James Kinross - Reader in general surgery
 - David Pinato – Clinical reader medical oncology
 - Rohini Sharma – Professor of clinical pharmacy and medical oncology
 - Rasha Al-Lamee – Clinical reader in cardiovascular science
 - Fu Siong Ng - Reader in cardiac electrophysiology
 - Dr James Seddon - Professor of global child health

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

Item number: 2.3

This report is: Public

Review of governance processes and systems - patient safety

Author: Shona Maxwell and Tracey Connage
Job title: Chief of staff, Imperial College Healthcare NHS Trust and Chief People Officer, London North West University Healthcare NHS Trust

Accountable director: Pippa Nightingale
Job title: CEO, London North West University Healthcare NHS Trust and lead acute provider collaborative CEO for quality and workforce

Purpose of report

Purpose: Assurance

This report sets out a review of the monitoring processes and associated governance in place across the North West London Acute Provider Collaborative (APC). The focus is on what we have in place to identify potential issues, to support staff and patients/families to report them and how we respond when they do. The aim is to provide assurance where possible and identify any additional actions that could strengthen governance to further mitigate the risk of similar events happening in our APC Trusts.

Report history

APC quality meeting and Workforce CPO meeting

11/09/2023

The relevant sections were discussed and confirmed that the content reflects current practice across all organisations.

APC quality committee

27/09/2023

The committee discussed the quality sections and agreed we have positive assurance in many areas. Proposed actions were endorsed, resulting implementation plan will be presented to the December meeting.

APC people committee

26/09/2023

The committee discussed the workforce sections in conjunction with other agenda items and agreed with the positive assurance and endorsed the proposed actions. Resulting implementation plan will be presented to the December meeting.

Executive summary

- 1.1 NHS England wrote to Trusts and Integrated Care Boards on 18 August, setting out their response to the crimes committed at the Countess of Chester Hospital NHS Foundation Trust, including plans for an independent inquiry.
- 1.2 As part of this, all boards were asked to review the processes and systems in place with specific reference to implementation and oversight of the national Freedom to Speak Up policy. The letter also referenced steps which have already been/are currently being taken to strengthen patient safety monitoring, including the introduction of the Medical Examiner service and the new Patient Safety Incident Response Framework.
- 1.3 This paper sets out the processes and systems in place in the Trusts of the North West London Acute Provider Collaborative (APC). The content was considered at APC and Board level committees, including the APC Quality Committee and APC People Committee before presentation to the Board in Common.
- 1.4 We have confirmed assurance in many areas and that when issues are raised they are investigated following a governance or HR process with actions then taken in response, with a recognition that this is reliant often on reporting.
- 1.5 The area that requires most focussed improvement is how we triangulate data within and across the quality and people domains. This and the other potential actions set out in this report to further strengthen our processes and systems will be discussed at the APC Executive Management Board and a plan for those agreed then developed.
- 1.6 Once the outcome of the independent inquiry is known and the circumstances of what happened are better understood we will review and consider any further recommendations.

Strategic priorities

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

Impact assessment

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

The processes described in this report and actions underway/planned support all trusts across the APC to respond effectively to concerns when they are raised, compassionately engage with those affected and foster an open and honest culture across all levels of our organisations and with the wider healthcare system.

Main Report

1. Introduction

- 1.1 It is important to note that governance in the NHS has changed since the years the crimes which took place at the Countess of Chester Hospital NHS Foundation Trust occurred (2015-2016). This paper summarises what is in place, how we report and how the board receives assurance from the executives on any emerging risks.
- 1.2 There are numerous processes in place to support the identification of issues and to support continual improvement in the services we provide. These include:
- The incident reporting and investigation process
 - The medical examiner service and the learning from deaths process
 - The coronial processes
 - Claims related to clinical care (although these are often not in real time)
 - Morbidity and Mortality meetings
 - Benchmarking data, including national clinical audits, NCEPOD, 'getting it right first time' (GIRFT), and the specialised services quality dashboards
 - Processes to support patients to raise concerns, including complaints and patient advice and liaison service (PALS)
 - Processes to support staff to raise concerns where they feel anxious to, including Freedom to Speak Up, anonymous reporting and escalation through the responsible officer process to the relevant executive director
 - HR processes to investigate and resolve issues raised, which follow the Trust raising concerns resolution policies
- 1.3 These are set out below, along with how we report data and outcomes through trust governance processes including the Board in common, and any improvements underway/planned, or that could be considered.

2. Patient safety incident reporting and investigation

2.1 The current process

- 2.1.1 Incident reporting is an important source of patient safety information, helping us to identify risks to patients and staff. Reporting enables us to identify actual or potential harm; analysing this data alongside other sources of intelligence helps us to learn and continuously improve. The weakness in this system is that it relies on staff to report on the electronic reporting system so is unlikely to capture all events.
- 2.1.2 Each trust has processes and policies in place to support and encourage staff to report and to then review and investigate incidents in clinical care, patient and staff safety. There is an option to report anonymously although in practice this is rarely used.
- 2.1.3 All incidents are locally investigated, with those that meet criteria then subject to further review and investigation through the current national Serious Incident (SI) framework. Immediate actions are taken, followed by learning and additional actions identified during the investigation. Regular review of cases allows themes to be identified; these are used to define quality and safety improvement priorities as individual trusts and across the APC.
- 2.1.4 Incidents meeting set criteria in maternity and neonatal care are referred to and investigated by the Healthcare Safety Investigation Branch (HSIB). Cases are reviewed internally before referral to identify immediate concerns.

2.1.5 Current data across the APC shows incident reporting rates below national average, lower than we would like. Harm levels are good though with most Trusts having lower than average percentage of major and extreme harm incidents.

2.2 Improvements underway/planned

2.2.1 Each trust is committed to increasing incident reporting through supporting staff to feel confident and comfortable to do so with training, communication and engagement in place. We are working together to transition to the new 'Learn from patient safety events' (LFPSE) system. There is an opportunity to develop an engagement programme to further encourage reporting, this would be a natural extension of the work we are already doing.

2.2.2 We are procuring a new incident and risk management system, which will make the process of reporting easier (a barrier often raised). The new system will allow incidents to be pulled directly from the electronic patient record which will ensure we are capturing commonly occurring incidents and complications robustly.

2.2.3 The system will allow data management and reporting in a systematic way across the APC, and support improved identification and sharing of learning from incidents.

2.2.4 We will consider how to enable patient and family members to report incidents.

2.2.5 The SI framework is changing as part of the NHS patient safety strategy with the Patient Safety Incident Response Framework (PSIRF) launching this autumn. This is a significant shift in the way we respond, with a focus on data and understanding how things happen, engaging with families, and taking steps to improve and deliver safer care.

2.2.6 PSIRF gives more focus to immediate review of incidents and engagement with those involved to help direct the learning response. It takes away mandatory reporting with a focus on learning rather than bureaucratic investigation processes allowing resource to be redirected. This should bring investigation timeframes forward meaning learning and identification of risks are improved.

2.2.7 Compassionate engagement with clinicians, patients and families involved gives an opportunity to better identify issues. We are developing the systems and processes to support this including:

- a survey coproduced with Patient Safety Partners (PSPs) to gain insight on being involved in an investigation, to help us further define our approach;
- our support offer with our staff counselling services, based on the Emergency Services Trauma Intervention programme (ESTIP) model.

2.2.8 In addition we are:

- introducing patient safety partners who will become active partners in all elements of safety governance, monitoring and improvement.
- implementing the national training programme for staff at all levels.

3. Medical examiner service and the learning from deaths processes

3.1 The current process – Medical examiner service

3.1.1 Following the Shipman inquiry in 2017 it was agreed that all deaths in the UK would be reviewed by a medical examiner. This has taken time to become statute however it became so from April 2020 for all in-hospital deaths. Deaths in the community are not statute yet but we anticipate this from April 2024.

3.1.2 All APC Trusts have a medical examiner (ME) service in place, responsible for reviewing every death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner where required. The ME also discusses the proposed cause of death and any concerns about the care delivered with bereaved relatives.

3.1.3 The ME service has helped ensure that the proposed cause of death is accurate, there is appropriate and consistent referral to the coroner, that the bereaved understand the cause of death and have an opportunity to raise any concerns, and that cases are appropriately referred for further case note review through the learning from deaths process when there are concerns (either from the ME, the bereaved, or the clinical teams involved) or specific criteria are met.

3.2 The current process – learning from deaths

3.2.1 The National Quality Board learning from deaths framework was introduced in 2017 following a CQC review published in 2016¹ which found some providers were not giving this sufficient priority and so were missing valuable opportunities to identify and make improvements in the quality of care.

3.2.2 Each Trust has a policy and processes in place which are in line with this framework.

3.2.3 These processes involve further review and investigation of cases referred by the ME as described above and referral where required to the SI framework. Any cases found to have been likely caused by an incident are reported to board in common. Across the APC the number of deaths considered to meet that criteria is low.

3.2.4 There are a number of other national processes in place for review of deaths for specific cohorts of patients. These include:

- Child Death Overview Panel (CDOP)
- Perinatal Mortality Review Tool (PMRT)
- Learning Disabilities Mortality Review (LeDeR)

3.2.5 The outcomes of these reviews are fed back and linked to the other mortality review processes. Where external reviews are involved given inevitable delays an initial trust review happens so we can identify immediate concerns.

3.2.6 These processes provide improved opportunities to identify any areas where there are specific issues or concerns, improve clinical outcomes and experience for patients and their families, and ultimately reduce in-hospital mortality.

3.3 Improvements underway/planned

3.3.1 All APC trusts have lower than or as expected mortality rates as measured by SHMI and HSMR. We are working to align reporting, standardising triggers for in depth review and a new mortality surveillance group is now in place.

3.4 The surveillance group is now progressing work to align the process for review of diagnostic group data, focusing on areas where mortality is above the expected rate. This process will ensure early identification of issues and opportunities for learning.

3.5 We are now considering an APC wide review of how we engage with and involve families in the learning from deaths processes, ensuring any concerns are addressed and findings are fed back in a clear and timely way.

4. Coronial processes

4.1 The current process

4.1.1 As a result of the Notification of Death Regulations, the coroner receives notification of deaths in-hospital from the medical examiner under set circumstances including where the family have concerns.

4.1.2 The coroner reviews and decides whether a post-mortem or an inquest is required.

4.1.3 An inquest is held if after the coroner's review the cause of death is still unknown.

4.1.4 Cases are reviewed internally and where there is a possible patient safety incident which has not already been investigated, an investigation process is commenced.

¹ ['Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England'](#)

- 4.1.5 Following the inquest, Coroners may make recommendations for learning and improvements including Regulation 28 reports (report to prevent future deaths), which must be responded to with actions.
- 4.1.6 In the majority of cases, areas for improvement are identified through our internal review processes before the Coroner has completed their review.

4.2 Improvements underway/planned

- 4.2.1 Data and themes from inquests could be more explicitly drawn out in the Trust LFD reports and the summary to APC Quality Committee (QC) and Board in common. We will review this and make changes to the report template if necessary.
- 4.2.2 PSIRF will require a review of the inquest clinical review processes, we should consider reporting as part of this.

5. Claims related to clinical care

5.1 The current process

- 5.1.1 Although not often reported in real-time, claims are another way to identify issues.
- 5.1.2 Concerns can be identified and where there is a possible patient safety incident which has not already been reported, an investigation process will be commenced.
- 5.1.3 Learning and outcomes are shared through our governance structures, and a bi-annual report on themes is reported to executive and board quality committees.
- 5.1.4 NHS Resolution publish an annual dashboard for each Trust, most recently in August.

5.2 Improvements underway/planned

- 5.2.1 We could consider reporting a summary of trust data and themes to the APCQC to improve visibility and share learning.

6. Morbidity and Mortality (M&M) meetings

6.1 The current process

- 6.1.1 M&M meetings support a systematic approach to the review of patient deaths or care complications. The meetings give ownership to clinical teams and offer a direct opportunity to improve care in a timely manner with peer review at the centre of this.
- 6.1.2 All cases where ME review has identified issues of concern must be reviewed at M&M meetings, as well as cases that demonstrate an opportunity for reflection or learning.
- 6.1.3 Reviews should be objective and multidisciplinary involving at least one consultant not directly involved often including senior clinicians from other relevant specialities.
- 6.1.4 These meetings are a key forum where clinical concerns can be identified, discussed and escalated as appropriate.

6.2 Improvements underway/planned

- 6.2.1 We could review current processes and consider a consistent policy including how we report compliance and outcomes via the new reporting system.

7. Benchmarking data

7.1 The current process

- 7.1.1 Best practice is reviewed through multiple sources (national clinical audits, NCEPOD, GIRFT, and the specialised services quality dashboards). Some national programmes also provide data for specific clinicians, primarily consultants, helping to identify potential concerns related to individual practice. Action plans are developed which are monitored through internal governance processes.
- 7.1.2 Used in conjunction with our risk management systems, we have good assurance that these support the identification of emerging risks or patient safety concerns so that we can act appropriately however there is a considerable time lag in this data.

7.2 Improvements underway/planned

7.2.1 The new incident and risk management system will allow improved triangulation of outcomes from audit, incidents, complaints, litigation and inquests both internally and across the APC. This will further support the identification of areas of potential concern.

8. Patient/family concerns

8.1 The current processes

- 8.1.1 Trusts have robust processes and policies through PALS (Patient advice and liaison service) and complaints to enable patients to raise concerns, and these are clearly signposted online, on the hospital premises and in correspondence.
- 8.1.2 If the complaint is not suitable for informal resolution, the formal complaints process is triggered with dedicated investigators who link with other investigations underway, including incident and mortality reviews.
- 8.1.3 If a complainant is unhappy with how trusts have handled their complaint, they have recourse to the Parliamentary and Health Service Ombudsman which is an independent organisation. They can also report concerns to the CQC.
- 8.1.4 Local actions are taken and thematic analysis is undertaken to identify trust-wide themes for improvement.
- 8.1.5 Feedback is obtained from other sources, including: local surveys, friends and family test, patient feedback in the consultant appraisal process, the national patient surveys, with regular reporting on data and outcomes which feed into our improvement plans.

8.2 Improvements underway/planned

- 8.2.1 An APC priority workstream is in place to look at how we measure and improve responsiveness to the needs and views of our patients and local communities.
- 8.2.2 We recognise that our current metrics related to patient experience are primarily process driven. The workstream is developing and testing indicators that will give more sense of impact and outcomes – such as satisfaction with complaint responses and, eventually, new metrics such as ‘what matters to you’.
- 8.2.3 One of the other aims is also to identify effective approaches that help us:
- connect insights from different sources
 - gather and use feedback from stakeholders and local communities
 - ensure lay and patient views help inform key developments and improvements

9. Staff concerns

9.1 The current process

- 9.1.1 Across trusts there are numerous processes in place to support staff to raise concerns including through the line management structure, staff surveys, consultant and junior doctor forums, regular Q&A sessions with the chief executives. Staff are encouraged to raise concerns and issues of any nature, with action being taken in response.
- 9.1.2 Safety concerns can be escalated through the Responsible Officer process for doctors and the Nursing and midwifery revalidation process, and we have policies in place to support the appropriate handling of concerns about staff members’ conduct, performance and health.
- 9.1.3 All trusts have raising concerns policies in which Freedom to Speak Up (FTSU) is a mechanism staff can use to raise a concern in confidence. The FTSU process aims to resolve the individual’s concerns and reports themes and trends to each trust people committee quarterly. As part of this there is appointed FTSU guardian and a designated non-executive director.

- 9.1.4 All trusts have policies to support resolution of concerns raised about performance. Outcomes of these are confidential and so transparency of data is complex and there is a potential for issues not to be linked to other information.
- 9.1.5 The weakness in these systems are that they rely on staff to report so are unlikely to capture all events.

9.2 Improvements underway/planned

- 9.2.1 All Trusts are benchmarking their FTSU processes against the new recommendations and a gap analysis will be produced across the APC; this will be completed in October.
- 9.2.2 Currently individual cases are not formally escalated to the relevant executive lead. Going forward each FTSU concern will be reviewed as part of the investigation process by the relevant executive director ensuring the confidentiality of the person raising the concern is maintained.
- 9.2.3 As described above, although each trust has numerous mechanisms for staff to raise concerns informally or formally, there is currently no triangulation of the themes of concerns raised via these mechanisms. Triangulation reports could be produced by each trust going forward. Themes will then be collated as part of an APC level report.
- 9.2.4 Each trust has different communication approaches to encourage staff to raise concerns, promoting that everyone's voice matters. We will look to develop a collaborative engagement programme as part of supporting a positive culture where staff feel safe to speak up in all four Trusts.
- 9.2.5 A review is underway of the FTSU reports to ensure they are standardised and provide adequate assurance. A combined report setting out key themes will also be provided to the APC workforce group and board-in-common annually.

10. Governance and reporting

- 10.1 The governance and reporting processes for each of the areas described above were reviewed in detail at the relevant board committee with agreement that the actions described should be considered to strengthen governance going forward. Reporting on data and learning from each process was described at all levels of our Trusts from ward and clinical areas, directorate and divisional committees, executive committees, trust board and APC committees and ultimately to board in common.
- 10.2 The use of national comparison and benchmarking data was set out and the use of scorecards to compare described and the escalation processes in place to ensure concerns are picked up and reported.
- 10.3 Where theme specific trust wide meetings are in place they were set out including incident review panels and learning from deaths with the escalation and reporting shown in context of the divisional and executive committees.

11. Conclusion

- 11.1 The APC executives are assured that we have good processes in place to support the identification of concerns when they occur, and the subsequent reporting and sharing of learning and implementation of actions in response.
- 11.2 This review has identified some improvements in addition to those already underway that we could make to further strengthen our processes. The area that requires most focussed improvement is how we triangulate data within and across the quality and people domains.
- 11.3 The actions described will be discussed further at the APC quality and workforce meetings and at APC Executive Management Board and a plan for implementation agreed for those we agree to take forward.

- 11.4 The actions will be reported to the relevant board committee at trust and APC level and considered as part of the priority workstreams and reported accordingly.
- 11.5 When the outcome of the national inquiry is known we will implement recommendations.

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

Item number: 3.1

This report is: Confidential

APC Equity, Diversity and Inclusion Improvement Plan

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

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

Purpose of report

Purpose: Assurance

Update the Collaborative Board in Common on progress made against agreed committee obligations to progress equity, diversity and inclusion (EDI) actions during 2023-24 and an APC EDI Improvement Plan for 2024 onwards

Report history

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

<p>NWL Acute Provider Collaborative Board in Common (Private) 19/07/2023 Approved</p>		
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Executive summary and key messages

Our NWL APC hospitals have the most diverse staff in the NHS serving amongst its most diverse communities. We need to now lead the NHS in achieving equity and justice.

In June, the Board discussed and agreed short term actions to better mainstream equity, diversity and inclusion within its discussions and ways of working. This paper provides an update on sub-committee tasks due by September.

These insights will inform the creation of an APC EDI improvement plan from 2024 onwards. This will be developed be overseen and coordinated by the APC Management Board and recommended for adoption by January 2024.

Strategic priorities

Tick all that apply

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

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

Impact assessment

Tick all that apply

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

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

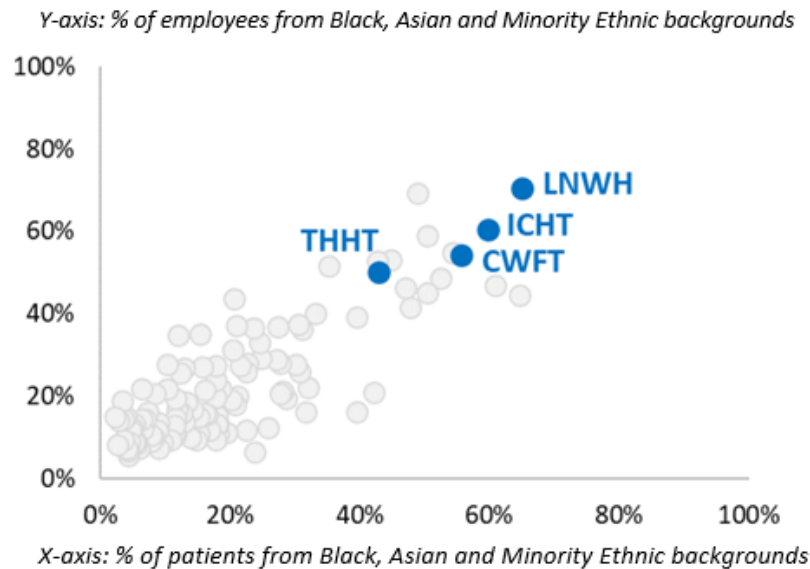
Reason for private submission

N/A

Introduction

Our NWL APC hospitals have the most diverse staff in the NHS serving amongst its most diverse communities. We need to now lead the NHS in achieving equity and justice.

The NWL acutes have some of the highest % of staff and patients from Black, Asian and Minority Ethnic backgrounds in the NHS



*In this paper we use the term **Black, Asian and Minority Ethnic** as the collective noun to describe people that are from international and ethnic backgrounds that are not white British. This choice in terminology has been informed by prior discussions within board in common private workshops and our intention to be inclusive. It may need to evolve over time with broader societal conversations and understanding.*

The case for change to address racism and discrimination is not new. It is first and foremost an ethical issue. The NHS was founded on the principle of equity: that anyone would receive the healthcare and treatment **they need** irrespective of their means or background. Anti-racist and anti-discriminatory actions align with this founding value.

The “NHS equality, diversity, and inclusion improvement plan” published on 8 June 2023¹ focuses on equity for NHS staff restates the case for change in terms of its quality and efficiency benefits:

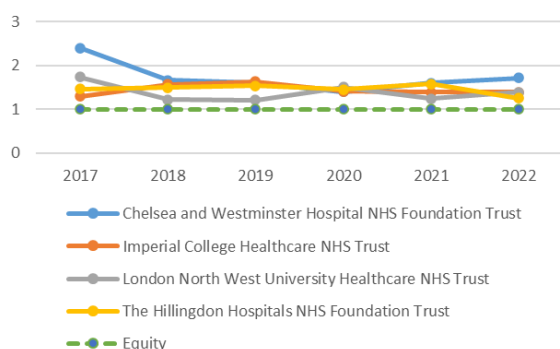
“Where diversity – across the whole workforce – is underpinned by inclusion, staff engagement, retention, innovation and productivity improve. Inclusive environments create psychological

¹ Its six High Impact Actions are listed in Appendix 1. The full plan can be found here: <https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/>.

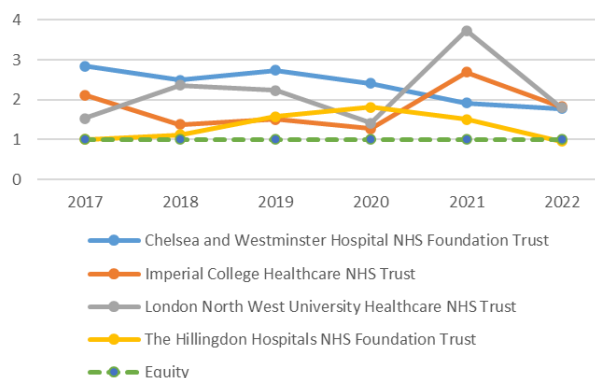
safety and release the benefits of diversity – for individuals and teams, and in turn efficient, productive and safe patient care.”

Thanks to this work, the task and metrics to measure progress are well developed and understood. We have examples within our own data to evidence the discriminatory outcomes of current policies and practices. For example, we know that our Black, Asian and Minority Ethnic colleagues are less likely to be appointed from shortlisting and more likely to enter a formal disciplinary process. This impacts career progression where colleagues from Black, Asian and Minority Ethnic backgrounds disproportionately “drop off” as Agenda for Change band seniority increases.

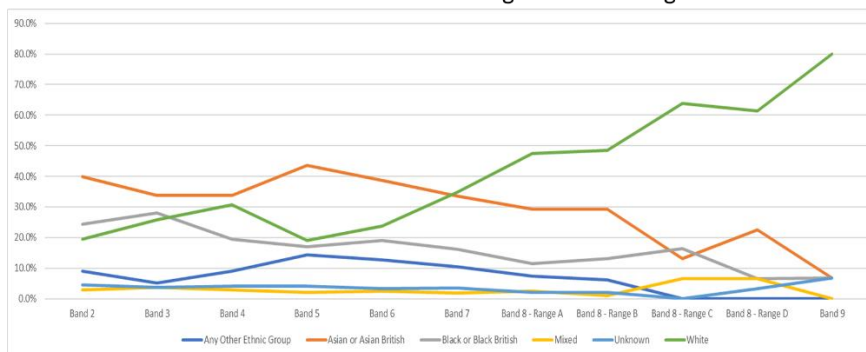
WRES2: Relative likelihood of appointment from shortlisting (BME/White)



WRES3: Relative likelihood of entering a formal disciplinary process (BME/White)



Ethnicities of NWL APC staff at each Agenda for Change Band



However, equity and diversity not just about staff experience. Equity is about the ease of access and the quality of care our patients receive and how our communities see us. In the APC strategy we are determined to address equity for our staff, our patients and our community in all its dimensions and this will require some new thinking.

The metrics for equity outside of workforce are less well defined and measured. In some areas of clinical outcomes such as neonatal mortality being higher for black and asian families, the correlation with ethnicity is well known; but in other more administrative areas, such as whether race or disability impacts how long patients wait for care, this has not been measured previously and we will need to create new ways to identify problems and measure improvement.

The case for change and efforts to implement improvements are not new, but we have seen limited progress within our APC, across London and nationally. We view equity, diversity and inclusion as covering all aspects of our work because it impacts our staff, our patients, their families and our wider community.

In this paper we set out how we will mainstream equity, diversity and inclusion across our organisations and make it a central pillar to our improvements.

Recent actions and findings

Our board-in-common has used recent development sessions and private board discussions to understand how we can become an exemplar and make meaningful progress more quickly.

We are committed to understanding and considering inequity across all our responsibilities. In pursuit of this, we agreed immediate actions for each board subcommittee to investigate where we are today and develop tools to support improvement.

As a starting effort, each committee agreed to develop metrics that would ensure we understood where we have inequity, put plans in place to address this, and then track whether we were having an impact in the short- and medium-term. Their focuses are:

- **Workforce Committee** - looking at inequity as it affects our staff, including daily experiences such as bullying and fair career progression opportunities.
- **Quality Committee** - looking at inequity affecting the outcomes and experience for our patients, carers and families.
- **Finance and Performance Committee** - looking at inequity of access to our services such as waiting times for planned procedures.
- **Digital and Data Committee** - looking at inequity of access to our digital solutions and the way in which we use data to identify inequality.
- **Estates and Net Zero Committee** - looking at how our facilities are designed to support different needs and inequity in experience.

Race and racism was our main lens to explore inequity because of its systemic and disproportionate impact on outcomes between patients, families and colleagues. Evidence suggests that progressing anti-racist actions will support more inclusive cultures and environments that in turn will benefit all protected characteristics and areas of exclusion. However, when reviewing the data, some of the committees have found that disability, age and other protected characteristics need a particular focus, and so we are addressing those issues as well.

The committees found that workforce metrics for measuring inequity are already well defined and measured nationally. This means we can leverage existing work to support our own programme.

In other areas, the metrics are either partial or do not exist. For example, some clinical outcomes such as neonatal mortality are well developed, but only capture a narrow part of our pathways and services. We will also need to create our own calculations, such as whether our waiting list or outpatient booking is being managed solely based on need.

The appendix below shows the progress made by the Board committees on their short-term objectives. Each has appointed a board champion and discussed how it will mainstream equity, diversity, and inclusion within its future discussions. Workforce Committee has been able to be specific in the metrics it wishes to prioritise. Digital and Data Committee will focus initially on getting good quality data on accessibility together to support the other work streams. Quality and Finance and Performance Committees are clear on the work that need to be done, but do not yet have proposed specific metrics, though we should have those by the next Board. Estate and Net Zero Committee is proposing to develop an EDI assessment for business cases.

Developing our 2024- onwards APC EDI Improvement Plan

As well as these immediate efforts across our committees, we will also create an APC EDI Improvement Plan for 2024 and 2025. This will be recommended to the board in January and its development overseen by the APC Executive Management Board. Our approach will:

- Agree how we will meet the NHSE EDI Improvement Plan six high impact actions that must be implemented over 2024 and 2025, each with supporting metrics.
- Expand our engagement with our patients, communities, and our staff on designing and embedding actions that promote equity, including through creating the Improvement Plan.
- Use the 2023-24 committee actions and their initial learning through the summer and autumn.

Our APC EDI Improvement Plan for 2024 onwards will communicate our priority interventions, how we know changes are an improvement, the resources we are committing to this change, and a timeline to guide expectations on progress. Although we are designing a plan, we recognise this plan will evolve as we improve how we include voices and viewpoints we are not reaching today. The engagement and partnership with patients, communities and our staff needed to progress our EDI commitments will itself take time including building trust, empowering leaders, and expanding networks.

A working group is being created to develop this plan and coordinate contributions from each organisation. It will be chaired by the CEO workforce lead and a nominated NED.

Proposed action plan

Timing	Actions	Who
October/ November	<ul style="list-style-type: none"> Establish coordinating group involving patients, staff and leadership to coordinate creation of APC Improvement Plan Communicate this overall approach and change in pace, alongside the board committee obligations, to our staff, through our staff networks and publicly through local communities. Use this communication to invite engagement into developing our improvement plan Synthesise data, analysis and context across APC for consolidated understanding of our challenges and issues Supplement this analysis by drawing on qualitative insights generated through committee discussions Facilitate engagement and discussion with CEOs and vice chairs to determine priority objectives and areas for focus, co-creating ideas and approaches Support engagement on NHSE High Impact Actions including their alignment with existing areas or whether additional interventions are required 	<p>CEO workforce lead and nominated NED EDI champion</p> <p>Communication leads</p> <p>Strategy leads</p> <p>Strategy leads</p> <p>Committee chairs and respective CEO leads</p>
November – initial recommendations	<ul style="list-style-type: none"> Develop “specific and measurable” EDI objectives [for board members] to which they will be individually and collectively accountable – <i>NHSE High Impact Action 1</i> Recommend priority focus and supporting objectives for the action plan, including future ways of working that continues to build on engagement and inclusion Recommend measurement approach including targeted ambitions Recommend resourcing plan to progress EDI Improvement plan, its governance and accountability. Some actions will require us to think differently, rather than work for longer. Better understanding what works and what does not from existing efforts will also enable reprioritisation of any existing capacity. Other new or different inputs may still though be required which could be explored as an APC-wide approach 	<p>APC EMB</p> <p>APC EMB</p> <p>APC EMB</p> <p>APC EMB</p>
January – Agree APC EDI Improvement Plan	<ul style="list-style-type: none"> Approve EDI improvement plan which includes more specific actions with timelines than November draft 	APC Board-in-Common
February onwards	<ul style="list-style-type: none"> Begin implementation 	

Alongside developing this plan, progress during 2023-24 within and across our APC committees on agreeing metrics, taking improvement actions, and tracking their impacts will be shared in the APC Executive Management Board reporting to the APC Board-in-Common. The APC Management Board will consider the emerging findings and recommendations of each committee to synthesise into progress updates in future private boards and inform the development of the APC EDI Improvement Plan.

For next financial year, all priority projects will have an EDI impact assessment identifying risks to EDI and how they will be mitigated and opportunities to improve EDI in programmes.

Appendix 1

NHS equality, diversity, and inclusion improvement plan

Date published: 8 June 2023

<https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/>

High impact action 1:

Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

High impact action 2

Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

High impact action 3:

Develop and implement an improvement plan to eliminate pay gaps.

High impact action 4:

Develop and implement an improvement plan to address health inequalities within the workforce.

High impact action 5:

Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.

High impact action 6:

Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Appendix 2

Action plan to develop APC EDI Improvement Plan

Sub-committee	Metric(s) prioritised	EDI Champion/ committee chair	Agreements on how to incorporate into future committee governance, including:
Quality	Reducing inequalities in patient care, experience, and outcomes	Roger Chinn/ Steve Gill	<ul style="list-style-type: none"> • The mortality data will include an analysis of mortality data broken down by ethnicity so that themes and trends can be understood, and improvements targeted to the required areas. • Understanding the demographics of or patients who make formal and informal complaints so we can understand and direct quality improvements in these and target populations of our communities. • EDI metrics to be identified in the 9 quality workstreams and to be reported on progress at each APC quality committee.
People	<p>Continue to Reduce the ethnicity gap between staff in a band 8a and above post.</p> <p>Continue to reduce the number of BAME staff in formal disciplinary processes.</p>	Tracey Connage/Janet Rubin	<ul style="list-style-type: none"> • APC workforce priority workstream with progress and performance metrics built into the IQPR for each committee. • Standardised improved leadership and development pathways across the 4 acute trusts expanding and aligning the inclusive recruitment process. • Review and standardisation of the disciplinary processes and practices across the 4 acute trusts.
Finance and Performance	Reviewing the Patient treatment list broken down by ethnicity, deprivation, and disability to ensure there is no disadvantage to these	James Walters/Catherine Jarvis	<ul style="list-style-type: none"> • Analysis of the PTL broken down by the four protected characteristics in the first instance to evaluate if there are and disproportionate disadvantages and delays in these group of patients. This analysis will be undertaken using CCS and Cerner.

	group of patients		
Digital and data	<p>Increase the % of patients where there is a complete record of their EDI characteristics recorded in their care record (Target – 90%)</p> <p>Increase the % of staff where there is a record of their EDI characteristics recorded in the EPR (Target – 90%)</p> <p>Ensure that the process for procurement of hardware and software considers patient and staff accessibility</p>	<p>Matt Towers/Steve Gill</p>	<ul style="list-style-type: none"> • Use data extract from WSIC to supplement data held within other clinical systems • Work with Cerner to ensure EDI fields are mandatory in all health records where this is not the case • All trusts to clean EPR records and undertake an active campaign with staff updating their personal record by 31 March 2024 • Record of action taken to develop a procurement checklist
Estates and sustainability	<p>Exploring how our facilities are designed to support different needs and inequity in experience</p>	<p>Tim Orchard/Robert Alexander</p>	<ul style="list-style-type: none"> • As part of a stocktake of estates across the APC, all Trusts to share an assessment of (and plan to increase) the accessibility of estates, including for patients and staff with access needs and increasing the accessibility of signage/wayfinding • Estates business case template to be updated to strengthen the equality impact assessment

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

Item number: 3.2

This report is: Public

North West London Acute Provider Collaborative – Scheme of Delegation

Author: Peter Jenkinson
Job title: Director of Corporate Governance, NWL Acute Provider Collaborative

Accountable director: Chief Executive Officers

Purpose of report

Purpose: Decision or approval

The four Trust Boards that make up the North West London Acute Provider Collaborative Board in Common are requested to renew their approval of the Scheme of Delegation which sets out the delegated roles and responsibilities (including delegated financial authorities) within the governance arrangements of the North West London Acute Provider Collaborative, noting changes to the scheme of delegated authority since October 2022.

Report history

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

Committee/Meeting	Date	Notes
NWL APC Executive Management Board	04/10/2023	The updates were noted and changes since October 2022 endorsed.

Executive summary and key messages

The Scheme of Delegation (SoD) for the North West London Acute Provider Collaborative (the 'Collaborative') sets out the delegated roles, responsibilities and financial authorities of each tier of the North West London Acute Provider Collaborative governance model.

The scheme was developed to ensure that statutory responsibilities aligned to individual Trust Boards are retained and that compliance with the legislation surrounding NHS Foundation Trusts and Acute Provider Trusts continues to be adhered to.

The four Trust Boards approved the scheme of delegation at the inaugural meeting of the Collaborative Board in Common in October 2022. It was agreed that this approval of delegated authority would be reviewed and approved on an annual basis.

Amendments previously approved

Since the approval of the initial scheme in October 2022, there have been several amendments approved by the Trust Boards:

- The dis-establishment of the Collaborative Digital and Infrastructure Committee, to be replaced by two collaborative level committees – the Collaborative Strategic Estates and Sustainability Committee and the Collaborative Digital and Data Committee.
- Delegation of authority to Trust level quality committees and audit committees to approve various year-end processes, including the Trust annual accounts and annual report, quality accounts, self-certification against provider licence conditions, and modern slavery statements..

Amendments for approval

Proposed amendments for approval at this meeting includes:

- Each Trust's Quality Committee has the delegated authority of the Trust Board to govern compliance with all requirements of the Maternity Incentive Scheme including approval of the Board Declaration Form.

Further amendments

In the ICHT external audit recommendations following completion of the audit of the annual report and accounts, the auditors have made a recommendation that the Collaborative scheme of delegated authority is amended to clarify the delegation of decision-making authority to the Collaborative Finance and Performance Committee and the Board in Common Cabinet. This is also within the scope of the ongoing internal audit review of the Collaborative governance model. It is therefore recommended that the findings of the internal audit review are considered along with the external audit recommendations, and any further amendments to the scheme of delegated authority reflected. Any further amendments will be presented to the Trust Boards at the next meeting.

Recommendation

The four Trust Boards are therefore asked to note the amendments to the scheme as approved during the year, and to approve the continued delegation of authority to enable the Collaborative

governance arrangements to continue, including the continuation of the Collaborative Board in Common. Trust Boards are asked to approve the delegation of authority to Trust level quality committees to govern compliance with all requirements of the Maternity Incentive Scheme including approval of the Board Declaration Form.

The scheme of delegated authority will continue to be reviewed and amended as appropriate, including following the completion of the internal audit review of governance arrangements, and any further amendments presented to the four Trust Boards for approval.

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

Positive impact on all of the above domains. The Scheme of Delegation does not impact on the statutory responsibilities of Governors or individual Trust Boards.

Reason for private submission

N/A

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

Item number: 4.1

This report is: Public

2023/24 NWL APC Business Plan Progress Report Months 1-6

Author: Jonathan Reid, CFO, LNWUHT
Job title: Chief Financial Officer, LNWUHT

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

Purpose of report

Purpose: Assurance

This report provides a half-year progress report on the delivery of the NWL APC Business Plan. The paper describes the strengthened governance in place through the formation of the Executive Management Board, and the steady progress on delivery – and actions in train to adverse areas of non-delivery. The paper also sets out some indicative planning work for 2024/25 and future years.

Report history

The Business Plan delivery report is a collaborative piece, building on reports considered at the Executive Management Board (EMB). It has been reviewed by the EMB, and approved for onward progress to the Board-in-Common.

NWL APC EMB 04/10/2023 Agreed		
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Executive summary and key messages

The NWL APC Business Plan agreed by the Board-in-Common in April 2023 set out 22 key deliverables for the Collaborative - but recognised that these would be subject to change as the Collaborative evolves. This paper provides a mid-year update on delivery and progress.

This paper describes the steps which have been put in place to strengthen governance and

delivery of the plan, including the formation and operation of the Executive Management Board (EMB) and the role that the two new sub-Committees for Digital & Data and Estates & Sustainability will play.

The Business Plan now comprises 26 key deliverables, reporting to the relevant Committees, with a further two EMB-led Programmes (Corporate Programme and Pathways Programme). A further Programme is under development, led by the Chair of the EMB, and which will report to the Estates & Sustainability Committee in due course. The EMB also oversees two key projects for the Collaborative – the Elective Orthopaedic Centre and the Ophthalmology projects.

The paper summarises progress against the plan for the Q1 and Q2, noting strong progress despite the very significant impact of industrial action on capacity across all the team. Most (16) of the deliverables are rated 'amber' recognising that work is in train both to deliver the programme and to finalise key metrics and delivery arrangements. Five schemes are 'green' and already progressing well (activity delivery and corporate consolidation, plus all digital schemes). Two schemes are 'red' and the subject of focused action by the CFOs (financial sustainability and outpatients transformation). Three schemes are in the discovery stage, and are new and additional to the overall programme.

Finally, the paper provides an initial indication of the process for planning for 2024/25, which will be led by the Executive Management Board. This work will be led by the EMB over the next six months, and reported through the Board sub-Committees and 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

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

N/A



**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

Business Plan 2023/24 Delivery: Summary of Performance Q1 & Q2

Report for Collaborative Board-in-Common

Jonathan Reid, CFO LNWHT

October 2023

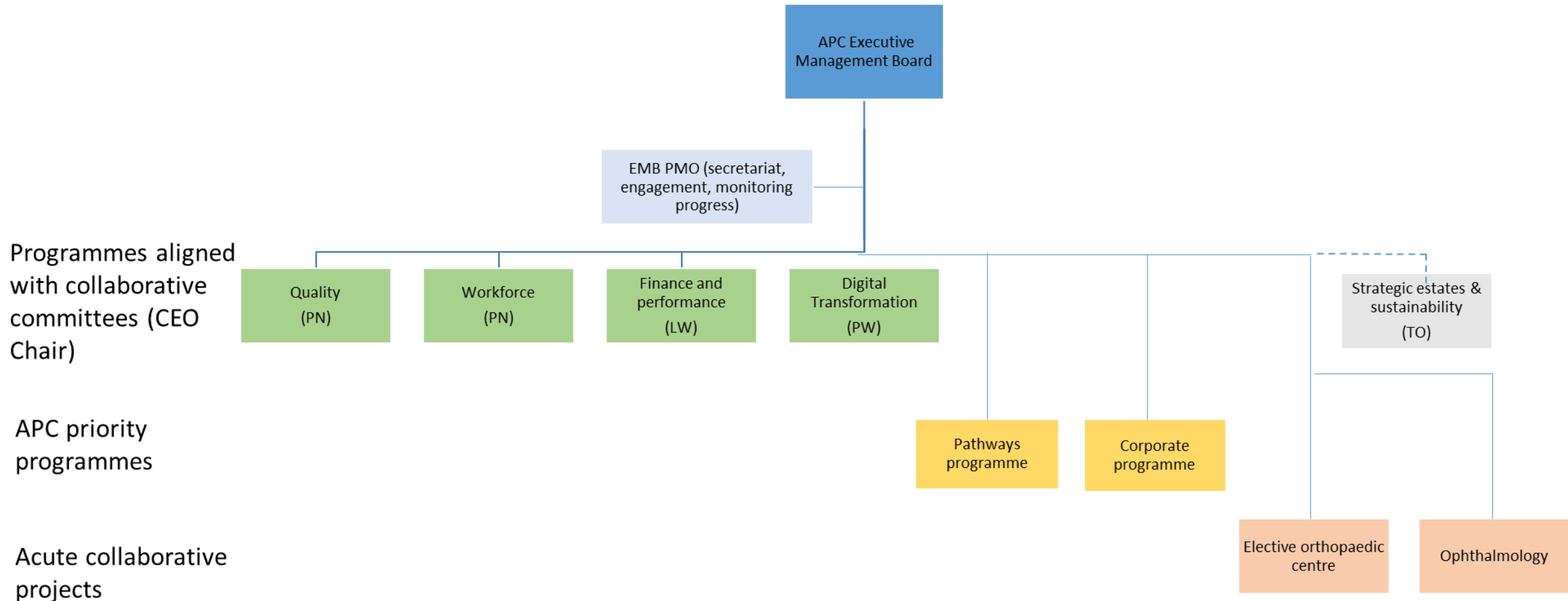
Executive Summary

- This paper presents progress on the Business Plan deliverables the NWL Acute Provider Collaborative Board. On a monthly basis, the APC Executive Management Board (EMB) monitors performance across the workstreams.
- The Business Plan agreed in April 2023 set out 22 key deliverables for the Collaborative - but recognised that these would be subject to change as the Collaborative evolves. This paper describes some of the steps which have been put in place to strengthen governance and delivery of the plan, including the formation and operation of the EMB and the role that the two new sub-Committees for Digital & Data and Estates & Sustainability will play.
- Through the operation of the EMB, the Business Plan now comprises 26 key deliverables, reporting to the relevant Committees, with a further two EMB Programmes (Corporate Programme and Pathways Programme). A further Programme is under development, led by the Chair of the EMB, and which will report to the Estates & Sustainability Committee in due course. The EMB also oversees two key projects for the Collaborative – the Elective Orthopaedic Centre and the Ophthalmology projects.
- The paper then summarises progress against the plan for the Q1&Q2, noting strong progress despite the very significant impact of industrial action on capacity across all the team. Most (16) of the deliverables are rating ‘amber’ recognising that work is in train both to deliver the programme and to finalise key metrics and delivery arrangements. Five schemes are ‘green’ and already progressing well (activity delivery and corporate consolidation, plus all digital schemes). Two schemes are ‘red’ and the subject of focused action by the CFOs (financial sustainability and outpatients transformation). Three schemes are in the discovery stage, and are new additional to the overall programme.
- Finally, the paper sets out some proposed priorities for Q2&Q3, and provides an initial indication of the process for planning for 2024/25, which will be led by the Executive Management Board. This work will be led by the EMB over the next six months.

Strengthening Governance – the role of the APC EMB

- The Business Plan was developed with the support of the Joint Executive Group and through Board Workshops and discussions with leadership groups. Since the production of the Business Plan, the APC Executive Management Board has been formed, chaired by CEO Tim Orchard, and meets on a monthly basis. The Executive Management Board now has a proactive role in monitoring and steering the delivery of the Collaborative Business Plan. At each meeting, the agenda is structured around the 'Priorities' and 'Programmes' within the plan, with a particular focus on core programmes such as the Corporate Programme. This provides a valuable Executive scrutiny and support function for the implementation of the Business Plan. It is now a firmly established principle that any changes to the Business Plan must be signed off by the EMB which has overall oversight and responsibility. Each CEO has a delivery support mechanism supporting the delivery of their Business Plan objectives.
- The business plan contained four CEO-led workstreams. Over the past six months of delivery, these workstreams have been amended to be as follows:
 - Quality – led by Pippa Nightingale, CEO LNWH
 - Workforce – led by Pippa Nightingale, CEO LNWH
 - Finance and Performance – led by Lesley Watts, CEO CWFT
 - Digital Transformation – led by Patricia Wright, CEO THHT
 - Strategic estates and sustainability – led by Professor Tim Orchard, CEO ICHT
- Additional programmes have been developed to deliver on some of the specific ambitions
 - Clinical pathways, considering how to redesign key pathways across the collaborative – led by Dominic Conlin, Director of Strategy, CWFT
 - Corporate programme, considering how best to manage corporate services across the collaborative – led by Virginia Massaro, Chief Financial Officer, CWFT
- EMB is also receiving regular assurance on key projects for the collaborative, such as the new Elective Orthopaedic Centre. This paper highlights progress on the business plan and how the collaborative executive is supporting delivery.

Summary of EMB Oversight Role for the Collaborative Plan



Strengthening Governance – Other Changes during Q1&Q2

Changes to Board Committees

- At the same time, during Q1& Q2, the Board has set up two new sub-Committees – Digital & Data and Estates & Sustainability – replacing the previous combined sub-Committee for Infrastructure and Capital, and there is a significant strengthening and enhancement of the Business Plan deliverables in this area. This sets the scene for a more ambitious level of delivery in H2 and a plan for 2024/25 which is more granular and aligned with strategic developments – an issue for each of the programmes of work.

A Renewed Focus on Strategy

- Following its formation as a fully established statutory body, and after a period of development, the ICB has now started work to articulate the 'NWL Acute Strategy' as part of a broader programme of strategy development. This is supported by strategic development work at the Collaborative and a joint programme of improvement and delivery is underway.
- In this context, the Collaborative has recognised the need to start the development of an overarching Strategy to support the forward development of the Trusts and the collective work underway to strengthen financial and clinical sustainability, Through the Executive Management Board, the CEOs will be starting some work on developing an initial strategy for the Collaborative in the coming months. This work will provide a strengthened foundation for developing the Business Plan for 2024/25.
- A later section in this paper discusses some starting principles and proposals for Business Planning for 2024/25, making an explicit link to work on the development of the Collaborative Strategy, over the next six months. The existence and function of the EMB will support a significantly improved Business Planning process. Similarly, both the work on the Strategy for the Collaborative and the enhanced support and scrutiny by the Estates and Sustainability Committee, and the Digital and Data Committee will also provide enhanced Non-Executive input into the process, alongside the existing Quality, Workforce and Finance & Performance Committees.

Summary of Progress – Business Plan

Quality Priority	Lead	Status (RAG)
Clinical harm review, access and inequality	Alan McGlennan	
Mortality Review	Jon Baker	
Peer review	Julian Redhead/ Lesley Watts	
User insights and focus	Michelle Dixon	
Care of the deteriorating patient	Raymond Anakwe	
End of life care	Sarah Burton	
Maternity and Neonatal – delivery plan	Robert Bleasdale	
Mental health in an acute setting	Lisa Knight	N/A – in discovery phase
Implement new national patient safety strategy	Shona Maxwell	
Incident and risk management system	Shona Maxwell	
Infection prevention and control	Julian Redhead	N/A – in discovery phase
Digital transformation (Quality) - may move to Digital	Janice Sigsworth	N/A – in discovery phase

Workforce Priority	Lead	Status (RAG)
Reduce premium rate staffing expenditure	Kevin Croft / Louise Clark	
Elective orthopaedic centre workforce transition	Tracey Connage / Phil Spivey	
Recruitment hub for hard to fill vacancies	Lindsey Stafford-Scott	
Careers hub and staff transfer scheme	Kevin Croft / Sue Grange	
Increase apprenticeship levy uptake	Lindsey Stafford-Scott / Christine Catlin	
Reduce violence, aggression, bullying and discrimination	Jo Fanning / Tracey Connage	

Finance & Performance Priority	Lead	Status (RAG)
Delivery of the activity targets in the 23/24 operational plan	Rob Hodgkiss	
Support Services Consolidation	Virginia Massaro	
Jointly develop and support a programme of discharge planning and reducing medically optimised patient LOS with ICB and collaborative partners	Jonathan Reid	
Agree a programme of efficiency and productivity for £66m, reducing reliance on ICB support for 23/24 and improving our financial sustainability	Jonathan Reid	
Outpatient Transformation	Jonathan Reid & Tina Benson	

Digital & Data Priority	Lead	Status (RAG)
Finalise the APC Digital and Data Strategy	Kevin Jarrold	
Implementation and Optimisation of Cerner system	Robbie Cline & Kevin Jarrold	
Improving patient flow and capacity using care co-ordination solution	Bruno Botelho	

Status of Programmes/Projects	Number in Category	Status (RAG)
Schemes delivering against identified targets	5	
Schemes progressing, but too early to confirm status	16	
Schemes behind trajectory, with remedial action	2	
Schemes in discovery stage	3	N/A – in discovery phase

- A refreshed set of deliverables is being developed for the Strategic Estates Programme, led by the EMB.

Summary of Progress – Quality & Workforce

Quality:

There were 11 priority quality workstreams in the business plan for 2023/24 with changes made in year due to emerging risks including care of patients with mental health needs and infection prevention and control practice. The focus remains on streamlining and ensuring consistent reporting across the APC, improving how we share learning and implement actions collectively to improve quality, patient care, experience and outcomes for our diverse patient populations.

Key achievements include: collaborative implementation plan for PSIRF in progress with delivery on track within national timescales; business case for a joint incident and risk management system approved to commence procurement; standardisation of key elements of mortality data and reporting with detailed review in place for diagnostic groups where variance exists; the completion of peer reviews in paediatric ED and for discharge with actions now being taken forward; work commenced to collaboratively implement Universal Care Plans at the end of life, and CQUIN 7: Recording of and appropriate response to NEWS2 score for unplanned critical care admissions.

Over the next six months we will move our focus where possible from standardisation of reporting to improving outcomes for patients and staff. We will transition to PSIRF and will implement a standardised governance framework for sharing learning and improvement that will support us in doing so. The new workstreams will have project goals defined and will start to report outcomes in the same way as the others. We will also review the metrics in the clinical outcomes dashboard to ensure these are aligned with our priorities.

Workforce:

Achievements over last 6 months

We have developed a hub and spoke model to support the education, recruitment, and retention of International Medical Graduates. A partnership arrangement has been agreed for the provision of the Career Focus platform providing resources and a digital platform to support staff in their career progression. We have also agreed to procure a common Learning Management System and have created a set of learning and leadership work programmes with shared leadership from across the collaborative. There has been an increase in the collaborative apprenticeship levy usage from 39% to 49%. We have analysed the impact of bank rate harmonisation and it appears to have a positive impact, with a reduction in agency spend as a proportion of total pay bill from 3.5% in March to 2.8% in August 2023 (review planned to establish drivers). We are progressing a virtual reality anti-discrimination behavioural change pilot across the Trusts and are developing shared policies where possible. Delivery of the implementation plan for the NWL EOC continues, with an improvement in the staffing position and ongoing recruitment to key posts (no candidates currently under offer from partner trusts).

Plans over next 6 months:

Recruitment plans will be developed and implemented for hard to fill roles, and we will be making an expression of interest to NHS England for International Medical Graduates in ED, General Medicine, Paediatrics, and Respiratory Medicine as part of a new international scheme. Implementation plans for the Career Focus platform will be developed with go live dates agreed for the 3 new trusts. We plan to develop the apprenticeship strategy to align with workforce plans across the APC. We will continue to work towards harmonised pay rates, agreeing plans for any AFC outliers and developing a NWL review and approval process for requests for escalated rates. We will evaluate the virtual reality EDI training pilot and review annual workforce EDI results to identify potential collaborative action points. Workforce plans will continue to be taken forward to facilitate the launch of the NWL EOC.

Summary of Progress – Finance & Performance, Digital

Finance & Performance

Activity on the elective side has been considerably above the planned trajectory for the first six months of the year, delivering a significant ERF financial contribution, and despite the impact of industrial action. Waiting lists are pressured, and focused work is in hand on key specialities to address the issues. Emergency activity continues to be high at all sites, and plans are in place for Winter.

The Corporate Programme is progressing well. The plans to identify £66m of underlying financial improvement have not progressed at the pace required – with £48m of targets identified and distributed – and the CFOs are working closely with the COOs and the ICB to manage and mitigate the risks involved. This is being aligned with, and rolled into, the planning process for 2024/25 financial year, which has started across all the Trusts.

The Outpatients transformation programme has moved across to the CFO/COO group from the Digital Group. Executive leads have been identified and a review the Trust cost base has been undertaken – work is now in hand to develop an ambitious and broad-ranging programme of change for the balance of 2023/24 and moving into 2024/25.

The workstreams have been impacted by the financial challenges of Month 1-6, including the effects of industrial action – but solid progress can be observed across the workstreams, with escalation as appropriate. The Finance & Performance Workstream Board meets every two weeks, chaired by the CEO Lead, to monitor progress and identify remedial actions.

Digital & Data

Achievements over last 6 months

Work has progressed on the completion of the Digital and Data Strategy for the APC. This has been developed in the context of the wider ICS Digital and Data Strategy. The focus is now on the development of the 2024/5 Digital and Data Implementation Plan.

By far our biggest digital project is the implementation of the Cerner electronic patient record into London North West and Hillingdon. London North West had a successful go-live in August and Hillingdon is now gearing up for go live in early November. Once they are live we will have a single electronic patient record solution in place supporting the delivery of care across the whole of the APC. Work has continued on the Cerner optimisation programme – this is aimed at improving the end user experience and planning for the way in which the use of the system can be optimised as we bring it into use across the whole APC.

The Coordinating Care Solution programme of work is on track with Waitlist and DQ; Theatre Management & Scheduling; Assisted Scheduling; 6:4:2; OPTICA. Work continues on plans to deploy Outpatients waitlist + Validation, Patient Cohorting, and Clinic Management. The Accelerate Incubator work: i.e., Timely Care Hub, Cancer PTL, Diagnostic Scheduling, EOC/Mutual Aid, Virtual Wards, PLICS is also on track. A decision on the preferred supplier for the NHS Federated Data Platform is expected in the next few weeks.

Planning for 2024/25 – Enhancing Strategic Focus

- EMB has embarked on a programme of work to develop an initial strategy for the Collaborative, and is supporting business planning for 2024/25. The national planning programme will also commence in Q3 – and a small group reporting to EMB will support the co-ordination of these planning activity. Shown below is an indicative model of the planning activities over the next few months. CFOs have commenced work on the financial planning process.

October 2023

- EMB & CEOs to provide steer to plan developments leads on initial priorities, and consultant with Committee Chairs. CEO leads to be supported to work with Executive Leads on 'longlist' of priority schemes, linked to emerging strategy priorities.
- Clinical leads to work with CRGs and clinical stakeholders
- Monthly Planning Delivery Group set up, reporting to the F&P CEO and the ACMB – closely aligned with Strategy Development process. (Small core working group with wide consultation reach).
- 'Lessons learned' from 23/24 supported review for CEOs



November/December 2023

- Business Planning group up and running, with regular 'check-ins' upwards with CEO leads and EMB, and across with CRGs and Executive Leads to progress schemes into a priorities list.
- JELG seminar/workshop in November/December to refine the schemes, and discussions at the Collaborative Committees and NED groups to reach an emerging conclusion on the priority programmes for next year.
- Draft Collaborative Business Plan in circulation for consultation with key stakeholders, including the ICB and Place Partners, etc.
- Test the links between the Collaboratives Plan and the Operating Plan priorities, including financial assumptions.

CEOs supported to 'sift' and identify priorities. Joint Executive Group to test and validate

Iterative drafting process testing the development of the Strategic Priorities as well as the in-year priorities

Development of Plan aligned with and integrated with the Operational Plan development process

January 2024

- Board in Common meeting to review draft Collaborative Business Plan alongside key strategic priorities and plans, as well as scrutiny by Committees. Sense check of priority schemes against emergent strategy and draft Operating and Financial Plans for 2024/25.
- Executive leads for delivery identified, and programme/project specifications developed and agreed by CEO leads. Resource requirement identified and costs/benefits of delivery fully articulated for approved by CEO/CFO groups – resource plans in train, including adverts/requests for secondments.



March 2024

- Plan approved by Boards and BIC, with clearly articulated delivery arrangements in place. Significant proportion of Collaborative schemes alongside robust Trust-level efficiency schemes, on TRAKIT [Note alignment with financial plan]
- Transition from 23/24 schemes to 24/25 schemes arranged with clear handovers and transfer to BAU as appropriate.
- Cross-Collaborative projects and programmes agreed with partners, with SROs and clear delivery plan.
- Signed off at same meeting as Financial & Operational plan, following confirmation by Finance & Performance Committee

Conclusion and Next Steps

- At the halfway point of the financial year, the Business Plan shows evidence of delivery. As this is the first time the Collaborative has developed and delivered a plan, significant focus during this first six months has been placed on getting the governance and oversight via the Executive Management Board right, alongside the relationship with Board sub-Committees. The programme has also been refined and enhanced, with some changes in leadership and lead responsibilities.
- Overall, it is too early to forecast the outcomes of many of the deliverables, with 16 of the 26 rated as amber. However, as the detailed highlight reports show, extensive work is in train to ensure that these are fully articulated and then delivered over the remainder of the financial year.
- Several (5) schemes are delivering well – digital, elective activity and corporate schemes – but it is important to note the risks and challenge caused by the implementation of Cerner moving into H2. Only two schemes need firm remedial action, around the financial sustainability programme and around outpatients transformation, and work is in hand through the COOs and CFOs to address this challenge.
- In addition to focusing on delivering the programmes and projects for the balance of the 2023/24 financial year, work has started on planning for 2024/25. The planning process will be more comprehensive, with a greater articulation of the Collaborative Strategy supporting more targeted schemes and deliverables – and an early start will allow for clearer identification of actions and resources required.



North West London Acute Provider Collaborative

Four acute NHS trusts working together



Chelsea and Westminster
Hospital NHS Foundation Trust



The Hillingdon Hospitals NHS
Foundation Trust



Imperial College Healthcare
NHS Trust



London North West University
Healthcare NHS Trust

Appendix 1 – Programme Reports

Quality Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to delivery	Upcoming milestones/ decisions
Clinical harm review, access and inequality	Alan McGlennan, Chief medical officer, THH	<ul style="list-style-type: none"> Increased visibility of harm levels; Increased incidents reported while we increase focus; Evidence of reduced harm to affected cohorts; Improved access for those who have known inequality risks 	Any incidents where harm has been caused are reported through the trust incident reports – no significant harm escalated.		Achievements have included the standardisation of prioritisation of prioritisation and harm review processes in particular those of prioritisation to prevent harm. The data for this reports through the operational meetings and the chief operating officers. The project will now focus on agreeing a standard reporting process to improve visibility of areas of risk to quality and outcomes.	<ul style="list-style-type: none"> Industrial action affecting services and causing further delays on our waiting lists EDI data to track inequalities to target interventions Capacity in trust governance and operational teams to deliver this work 	<ul style="list-style-type: none"> Trust reports received and collated APC summary document written by end of Q3 APC standard reporting template agreed and in use by Q4 Operational data & available EDI data collated through trust reports by Q4 A confirmed single recording system and governance process for clinical harm reviews (this will require all trusts to be on Cerner) – date TBC
Mortality Review	Jon Baker, Chief medical officer, LNW	<p>HSMR and SHMI reporting standardised and occurring through BiC dashboard.</p> <p>Each project element has key outcome metrics to assess internal process quality.</p>	Each trust continues to have a rolling-12 month HSMR below the national benchmark of 100. Investigation of the higher HSMR at THH will now be commenced although the actual rate is “as expected”.		<p>The Mortality T&F group stood down following completion of discovery work to identify areas for improvement. Progress includes standardisation of HSMR and SHMI reporting, mortality review triggers and grading system, and of templates for LFD reporting.</p> <p>New mortality surveillance group established to oversee implementation of further recommendations.</p>	Resource requirements to lead, plan and implement priority projects. Project resourcing could influence quality outcomes, benefit realisation and implementation timelines.	<ul style="list-style-type: none"> ICHT contract with Telstra to be novated to include data analysis services for all four trusts – September 2023 Trusts to start reporting on new triggers and grades in local learning from death reports- Q2 Review how each trust currently carries out palliative care coding for deaths and conduct a cost benefit analysis of each Trust approach – Q2

Quality Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to delivery	Upcoming milestones/ decisions
Peer review	Julian Redhead, Medical director, ICHT Lesley Watts, CEO, CWFT	Improvements with agreed KPIs for each pathway	ED metrics monitored through NWL urgent and emergency care (UEC) board		ED peer reviews completed in December. Eight key improvement workstreams agreed with associated actions and clinical leads. To support delivery of the priority actions group has been set up to develop a programme of work. by November 2023, an ED peer review working Hospital discharge peer reviews completed in July 2023. Quality summit will be organised to review the key themes, and identify actions, with the aim of being ready for winter 2023. Paediatric ED peer review completed in July with priorities agreed. NWL UEC CYP Steering Group is now developing a programme of work to address the findings.	Key risks are related to resource and capacity to deliver the outputs of the peer reviews, particularly with the potential impact of industrial action and upcoming winter pressures	Next pathway to undergo the peer review process will be acute medical which is proposed to start in October. A process for agreeing areas for future peer reviews, linked to the pathways work is being developed. This will be a deep dive to September's APCQC.
User insights and focus	Michelle Dixon, Director of engagement and experience, ICHT	<ul style="list-style-type: none"> FFT results Complaints numbers and response rates <p>Better alignment of metric reporting and development of indicators which give more of a sense of impact and outcomes are workstream objectives for 23/24</p>	Performance with existing KPIs reported in the BiC dashboard is largely positive. Improvements required at APC level include increasing FFT response rates.		A collaborative workshop was held on 19 th May and areas of improvement were identified as a result including: <ul style="list-style-type: none"> Friends and family test (increasing uptake; re-tendering of survey platforms); Development of an improved collaborative approach to gathering, sharing and responding to data on complaints and concerns. Patient and public involvement and measuring user-focus in collaborative projects: development of consistent approaches to PPI and measurement of user focus across our key collaborative projects. Natural language processing: explore use of Imperial College's tool to analyse free text data in FFT. 	<ul style="list-style-type: none"> The 'home' for this work is in a range of different teams across the four trusts, which will make it harder to co-ordinate and oversee actions. There is a clear link between this work and organisational strategy and culture, which can make progress on the ground more difficult when it is not all aligned. This work tends to be de-prioritised when operational pressures are high. Our patients and local communities have increasing expectations of progress in this area and we do not always have the focus and resources to match those expectations. 	<ul style="list-style-type: none"> The next workshop is planned for November. Explore options for re-tendering FFT – decision on whether to proceed to be confirmed in Q3 Test new approach to complaints and concerns in Q4 Decision on whether to proceed with use of natural language tool by early 2024

Quality Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to delivery	Upcoming milestones/ decisions
Care of the deteriorating patient	Raymond Anakwe, Medical Director, ICHT	<ul style="list-style-type: none"> • ICNARC national audit participation and performance • No and outcomes of Medical Emergency Calls/Critical Care Outreach Calls • NEWS/MEWS/PEWS audit outcomes • Outcome from in-hospital cardiac arrest calls: mortality within 24-hours • Sepsis: Administration of antibiotics within 1 hour of diagnosis • Workforce and staffing GPICS standards • Complaints and incident theme numbers 	No key issues to escalate from metrics currently available. The group aim to automate data collection where possible.		Metrics defined and discovery phase completed. Priorities agreed as: <ul style="list-style-type: none"> • Improved recognition and response deteriorating patients • Education and training for staff • Standardise reporting and reduce variation in these areas • Working to achieve 23/24 CQUIN : Recording of and response to NEWS2 score for unplanned critical care admissions 	<ul style="list-style-type: none"> • Resource requirements to lead, plan and implement priority projects. Project resourcing could influence quality outcomes, benefit realisation and implementation timelines. • Risks will further reviewed as part of the project planning process to define level of risk and mitigating actions. 	Review of Q1 CQUIN data
End of life care	Sarah Burton, Chief nurse,	<ul style="list-style-type: none"> • Increase no of logins to UCP by 25% • Increase no of logins within the ED by 25% above baseline • Increase the number of UCPs created/updated on discharge from hospital to the community by 25% above baseline 	Once we are confident in our ability to report and monitor on these we will work to agree clinical outcomes measures that are applicable to acute hospitals		Identified priorities around challenges faced & analysis of National Audit (NACEL) results: <ul style="list-style-type: none"> • Universal Care Plan (UCP) • Cerner & Data • Education Current work is focused on the Universal Care Plan.	<ul style="list-style-type: none"> • Resource within the palliative and end of life teams to deliver the interventions • Limitations of data – we currently can't split the UCP data received by the 4 individual hospitals • Ownership from ICS leads/system leads for improvement – at present the palliative and end of life NWL ICS commissioning lead does not have a remit that supports the acute hospitals 	TBC - draft driver diagram will be confirmed at next collaborative meeting and prioritised activities with milestones will be agreed as the next steps.

Quality Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to delivery	Upcoming milestones/ decisions
Maternity and Neonatal – delivery plan	Robert Bleasdale, Chief Nursing Officer, CWFT	<ul style="list-style-type: none"> Crude still birth rate No of neonatal deaths Suspected intrapartum brain injuries Babies born in appropriate care setting for gestation Avoidable term admissions in neonates Proportion of BAME women receiving continuity of care at 29 weeks Maternity vacancy against establishment 	<p>Data on 4/7 metrics reported in BiC dashboard – no key issues to escalate.</p> <p>Work underway to improve the timeliness of the data.</p>		<p>In year one the workstream has:</p> <ul style="list-style-type: none"> Agreed and piloted quarterly Trust workforce and quality reports aligned to learning from the national maternity support scheme and against core documents Formalised reporting of MIS year 4 and all 4 Trusts have achieved the 10 standards Initiated informal peer reviews to support preparation for inspections Agreed the metrics aligned to the LMNS and BiC, to report for APC and Trust level, working to publish all metrics monthly <p>Following the publication of the single delivery plan, MIS year 5, Saving Babies Lives V3 and national competency frameworks, the work stream’s priority will be to deliver the requirements of these through the established pillar structure of the LMNS.</p>	<p>Resourcing requirements due to the national reporting requirement specific to maternity and neonatal services. There is an opportunity to mitigate some of the burden through standard reporting template and resources within LMNS</p>	<ul style="list-style-type: none"> Implement all clinical/workforce metrics within BiC report Agree governance reporting process for pillar workstreams to the APCQC Complete MIS reporting timelines for APC against technical guidance Providers t complete gap analysis against SDP requirements Immediate actions agreed against areas of risk for MIS and SDP Work plan for pillars and SDP agreed, aligning with APC/LMNS
Mental health in an acute setting	Lisa Knight, Chief Nursing Officer, LWN	TBC	N/A	N/A – in discovery phase	<p>Newly established workstream in response to increasing risk identified through trust quality reports. The aim will be to review best practice with a focus on:</p> <ul style="list-style-type: none"> Review of assessment process for patients / risk profile and allocation of nursing/ security staff as a result Size and cost of EO teams Sedation and restraint policies Staff knowledge of mental health conditions and education required Skills in de-escalation and breakaway Physical safe environments for patients/ ligature assessments Extra security measures for staff – bodycams/flak jackets Staff understanding and administration of mental health act 	<p>Other operational and strategic priorities Potential financial costs</p>	TBC

Quality Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to delivery	Upcoming milestones/ decisions
Implement new national patient safety strategy	Shona Maxwell, chief of staff, ICHT	<ul style="list-style-type: none"> Evidence of involving patients, families and staff in learning responses and improvement Training compliance with patient safety syllabus modules (level 1a, 1b and 2) and PSIRF training requirements Clinical leads with time for investigations in job plans Safety Culture Surveys 	<p>Compliance with level 1a varies from 84% to 46%. Plans are in place to ensure compliance by end Sept 2023.</p> <p>Measurement of the other KPIs will commence as the key elements go live</p>		<p>Full implementation plan in place and progressing well. Delivery of PSIRF and LFPSE across the APC is on track against national timeframes. PSIRPs approved for each trust and pending approval alongside policy by ICB (date TBC).</p>	<ul style="list-style-type: none"> Financial costs of meeting the standards including protected time for clinical investigators and commissioning and delivery of the training required. The need to change role functions in teams, whilst continuing with business as usual under the current serious incident framework. 	<p>Key milestone next steps:</p> <ul style="list-style-type: none"> Identified staff to undertake PSIRF training for learning response leads, engagement leads and oversight roles (commenced in July) APC policy to be ratified through trust governance Share documents with ICB leads Confirm ICB stakeholder group dates Confirm dates for testing as part of soft launch across the APC Learning response templates finalised and being tested Maternity, IPC and coroners processes and learning responses TBC Safety improvement plans to be shared. LFPSW live in test environment and final go live dates TBC
Incident and risk management system	Shona Maxwell, Chief of staff, ICHT	Proposed KPIs for the new shared system will be developed further as a preferred solution is identified.	N/A		Scope for new system agreed and business case finalised. Procurement process commenced.	<ul style="list-style-type: none"> A risk register is reviewed weekly and includes risks related to the possible cost, and potential legal and IG issues. 	<ul style="list-style-type: none"> Approval to go to formal procurement Confirmation of business case approval process once procurement costs confirmed

Quality Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to delivery	Upcoming milestones/ decisions
Infection prevention and control	Julian Redhead, Medical director, ICHT	<ul style="list-style-type: none"> Hospital acquired infections (C diff; MRSA bacteraemia, E.coli) COVID/Flu outbreaks Number of patients de-labelled for penicillin allergy AMS metrics to be agreed 	Above thresholds for key infections at APC level and within most trusts	N/A – in discovery phase	<p>Agreed as a priority workstream on 31/07/2023. PID presented to APC quality meeting on 21/08/2023. Key priorities agreed as:</p> <ul style="list-style-type: none"> ➤ Standardising Winter planning ➤ HAI reduction-through education/benchmarking/shared practice ➤ Shared antimicrobial/IPC surveillance system ➤ Penicillin de-labelling programme 	<ul style="list-style-type: none"> Capacity within IPC teams to support another work stream Variation in data collection, measurement and access to data Differing capacity across teams to support improvement priorities Possible cost implications with changes in practice and reporting 	<ul style="list-style-type: none"> First meeting of IPC group to take place in September 2023 where plans will be developed to take forward improvements in the key priority areas.
Digital transformation (Quality)	Janice Sigsworth, Chief nurse, ICHT	<ul style="list-style-type: none"> Delivery of HFC reports PPID adoption within acute sites Delivery of a mental health record within the EPR Delivery of an optimised Maternity record within the EPR Use of Care plans across the entire APC 	N/A	N/A – in discovery phase	This workstream is being reviewed to agree whether this best sits within quality or as part of the digital workstream.	<ul style="list-style-type: none"> Funding. PPID completion is dependent on equipment provision on all sites (especially CWFT and THH sites) Ability to move the quality reporting into the federated data platform (when established) to ensure that a single report is visible across the sector. 	<ul style="list-style-type: none"> Confirm if this will remain a quality priority or will move to the digital workstream – under review by ICHT chief nurse and THH CEO.

Workforce Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to delivery	Upcoming milestones/ decisions
Reduce premium rate staffing expenditure	Kevin Croft / Louise Clark	<ul style="list-style-type: none"> Agency spend as a proportion of overall pay bill to be reduced to a maximum of 2% Reduction in premium rate pay Increase in bank fill rates 	<ul style="list-style-type: none"> Agency spend as a proportion of overall pay bill was 2.5% in month 4. 		<p>Four priority areas for 23/24 are being delivered through the temporary staffing leads group / collaborative bank group:</p> <ol style="list-style-type: none"> Contracts, systems and suppliers documents collated and opportunities identified to achieve highest potential saving and/or efficiency Scoped out operating models for agency management arrangements Agency rate cards and PSL –existing agency rates collated. Lowest rates will be the basis for agencies invited to join tier one PSL Local rates/specialist rates and outliers identified and work in progress to move rates to the agreed rate cards. 	<p>Risk</p> <ul style="list-style-type: none"> Impact of industrial action on pay rates and overall spend <p>Mitigation</p> <ul style="list-style-type: none"> Central reporting to support benchmarking across London Increased visibility of rates paid, with weekly reporting into execs for each trust. Review of escalation processes periodically to ensure they are effective 	<ul style="list-style-type: none"> New bank rates at Hillingdon to be implemented week commencing 4 September 2023 Complete the analysis of Trust data on impact of bank rate harmonisation Moving forward with joint tender of our e-roster systems to make financial savings and DE identified as potential area for harmonisation and financial saving Developing an options appraisal for agency operating model Working towards a harmonised NW London Acute agency rate card Working through AfC outliers and developing NWL review and approval process for requests for escalated rates Bank / agency fill data to be collected monthly across the four Trusts to provide a collated set of metrics for the collaborative and comparison with London rates
Elective orthopaedic centre workforce transition	Tracey Connage / Phil Spivey	<ul style="list-style-type: none"> 279 staff in post on implementation (Nov 23) 336 staff in post by 1st April 24 	<ul style="list-style-type: none"> 152 wte in post plus 61 candidates under offer 		<ul style="list-style-type: none"> Monthly Pulse update to Staff Side Networks & Partner Trusts Development of training packages for EOC staff Understanding of workforce requirement as a result of repurposed capacity in partner organisations supported by the Finance work stream Rotas being developed for consultant job planning Commenced discussions on a combined Specialist Nurse Practitioner & SHO rota Continued recruitment processes EOI form shared with stakeholders as part of the EOI process Agreed transfer and salary recharge process for staff from partner organisations 	<p>Risk</p> <ul style="list-style-type: none"> Implementation delayed by shortages in key staffing <p>Mitigation</p> <ul style="list-style-type: none"> CPO/executive led workforce workstream to develop staffing strategies, including recruitment drives, rotational posts, CPD 	<ul style="list-style-type: none"> To ensure Equality Impact Assessment for staff sign off To ensure sign off of a monthly Pulse update to Staff Side Networks to be replicated by Partner Trusts Webinar and a team brief slot to update on EOC Progress discussions on development of training packages to support extra needs of EOC staff Launching and collating Expressions of Interests from Partner Trusts To progress consultant job planning following agreement of theatre scheduling Agree a roster solution for SHOs and SNP for ward cover based on the 3 options presented Further development of workforce sustainability and recruitment plans
Recruitment hub for hard to fill vacancies	Lindsey Stafford-Scott	<ul style="list-style-type: none"> Reduction in vacancies across hard to fill Reduction in associated temp staffing spend Reduction in turnover 	<ul style="list-style-type: none"> Baselines agreed – progress to be available from end September 		<ul style="list-style-type: none"> List of common AfC hard to recruit or high-volume vacancies identified for programme to focus on – targets agreed with CPO's New models of recruitment plan in consultation with stakeholders Medical staffing leads utilised vacancy data to consolidate top 5 priority Medical 'hard to fill' areas to focus campaign and activity on IMG Project in delivery – Fratrem contract in final stages Established a consistent approach towards Medics relocation packages for the sector 	<p>Risk</p> <ul style="list-style-type: none"> Lack of funding for joint recruitment projects/campaigns <p>Mitigation</p> <ul style="list-style-type: none"> Escalation via NWL HRD group and APC CPO Group 	<ul style="list-style-type: none"> Recruitment plans to be finalised/initiated for Hard to fill roles Medic vacancy rate and targets to be finalised New models of recruitment plan to be finalised Working towards consistent approach for recruitment & retention payments to Medics Working with the BMJ for discounted advertising credits Exploring joint campaign for Medical Hard to fill roles

Workforce Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to delivery	Upcoming milestones/ decisions
Careers hub and staff transfer scheme	Kevin Croft / Sue Grange	<ul style="list-style-type: none"> Number of contacts with careers hub/careers tool or careers coaching support Staff survey (or specific project survey) measures on career progression (nursing and midwifery) Number of internal transfers in Nursing and midwifery 	<ul style="list-style-type: none"> Baseline to be established 		<ul style="list-style-type: none"> Proposal to adopt Career Focus as digital platform for career progression was taken to APC EMB on 15th August A revised price and proposal has been negotiated with a supplier who provides the Career Focus platform with a view to this being adopted across the 4 Trusts. This has been shared with all Trusts and we are near to final agreement to adopt this common platform to support Career Development 	No risks identified at this stage	<ul style="list-style-type: none"> Review comparative internal transfer schemes and ensure scheme in place in all Trusts Agree common career coaching model across Trusts Establish baseline for key metrics Develop model for transfer/shadowing across Trusts Roadmap for roll out of Career Coaching digital platform across all Trusts Proposal for transfer/shadowing process between Trusts
Increase apprenticeship levy uptake	Lindsey Stafford-Scott / Christine Catlin	<ul style="list-style-type: none"> Number of staff in apprenticeships % Utilisation of Levy Variety of apprenticeships being accessed 	<ul style="list-style-type: none"> No of Apprentices due October 2023 Collaborative Levy Usage as of August 2023: 49% 		<ul style="list-style-type: none"> Data gathering for reporting end of Q2 by second week in October Agreed to expand new entry apprenticeship programmes Increase in current uptake 1289 apprentices on programme across the APC average 3.2% of total staff per organisation Development of report on uptake of apprenticeships and frequency: Planning for setting yearly target of Apprenticeship starts and analysing vs actual starts. 	<p>Risk</p> <ul style="list-style-type: none"> Services unable to utilise apprenticeship levy because of backfill issues <p>Mitigation</p> <ul style="list-style-type: none"> Lobbying within each trust to facilitate backfill to enable more effective use of the levy Exploring how the apprenticeship levy has been utilised in other organisations 	<ul style="list-style-type: none"> Discussions between CPO and CN to see if there can be standardisation of the HCSW entry and qualification route to then enable levy to be bought back into the organisations. Important that this is taken forward in September 2023 as Trusts demonstrating high levy uptake are those investing in high spend apprenticeships e.g. NA and RNDA (Example:- University Hospitals Birmingham 76% uptake have over 400 NA in training) . Discussion on collaborative commissioning with focus on hard to recruit areas as specific need in the APC.
Reduce violence, aggression, bullying and discrimination	Jo Fanning / Tracey Connage	<ul style="list-style-type: none"> Reduction in negative experiences for our staff Existing measurements of negative experiences will exist in all Trusts – incident reporting, sickness absence, staff survey results, ER cases 	<ul style="list-style-type: none"> Annual staff survey outcomes 		<p>Violence and aggression</p> <ul style="list-style-type: none"> Comparison of existing 4 policies and training policies commenced with agreement to develop shared policy Comparison of existing training offers commenced Work commenced to identify differences in reporting categories in Datix Agreement to continue to progress individual Trust Kindness campaigns but continue to share best practice <p>Bullying and Discrimination</p> <ul style="list-style-type: none"> APC EDI leads group established Reviewing anti-racism, bullying and discrimination policies and initiatives across the Trust Reviewing EDI training offer with initial focus on shared content for mandatory and level 1 training Reviewing APC sign up to Race at Work Charter Progressing virtual reality anti discrimination behavioural change pilot across the Trusts 	No risks identified at this stage	<p>Violence and aggression</p> <ul style="list-style-type: none"> Development of shared policy Complete comparison of existing training offers and identify areas for sharing resource/gaps Seek opportunities to align reporting categories in Datix <p>Bullying and Discrimination</p> <ul style="list-style-type: none"> Review of annual workforce EDI results and identification of potential collaborative action points e.g mentoring programmes Decision re Sign up to Race at Work Charter Evaluation of outcomes of VR EDI training pilot

Digital Transformation Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to delivery	Upcoming milestones/decisions
Finalise the APC Digital and Data Strategy	Kevin Jarrold	<ul style="list-style-type: none"> Engage end users and get their involvement and input into the strategy. Secure approval for the APC Digital and Data Strategy 	The APC Digital and Data Strategy has been through trust governance and taken to the APC Digital and Data Steering Group. It has been noted at the NWL APC Collaborative Digital and Data Committee	G	The strategy has been developed alongside the wider ICS Digital and Data Strategy and was approved at the last meeting of the APC Digital and Data Steering Group. Work is now getting underway on developing the 24/25 implementation plan	<ul style="list-style-type: none"> Resource availability due to other pressures 	<ul style="list-style-type: none"> Develop and sign off the 2024/5 Digital and Data Implementation Plan
Implementation and Optimisation of Cerner system	Robbie Cline & Kevin Jarrold	<ul style="list-style-type: none"> Deploy and implement Cerner EPR across LNWH & THHT to deliver a single Cerner domain across NWL Acute Collaborative NWL Cerner Optimisation - Continuous improvement and enhancement of the Cerner Solution 	<ul style="list-style-type: none"> Deployment and implementation of Cerner EPR across LNWH & THHT – On track NWL Cerner Optimisation – On track 	G	<ul style="list-style-type: none"> Deployment and implementation of Cerner EPR at LNWH completed. Planning for deployment and implementation of Cerner EPR at THHT is currently underway NWL Cerner Optimisation programme is ongoing: <ul style="list-style-type: none"> Elsevier - Care Nursing Care Plan: <ul style="list-style-type: none"> Solution Implemented across the domain, live at ICHT on 1st April, live at CWFT on 1st August, and live at LNWH on 18th August; Anticipated go-live at THHT in November Clinical decision support in place for non-elective pathways Dynamic documentation in place, which went live on 1st August, that brings the care plan outcomes into the Nurses Notes Acute medicine workflow - changes have been completed– implementation planning and support materials are in progress. End-to-end complex discharge – EDN, NBA, reporting, alignment with TCH and board round form all optimised and live 	<ul style="list-style-type: none"> Resource availability to ensure successful delivery of the Cerner deployment at THHT Resource and priority over multiple workstreams 	<ul style="list-style-type: none"> Cerner go-live and Early live support at THHT – November Elective Orthopaedic Centre (EOC) anticipated go live: Oct-Dec 23 Optimisation of Endorsement of results on Cerner anticipated go live: Oct 23 NICU Bed Monitoring Device Integration to Cerner anticipated go-live: Oct – Nov 23
Improving patient flow and capacity using care co-ordination solution	Bruno Botelho	<ul style="list-style-type: none"> Adopt agreed modules: Waitlist and DQ; Theatre Management & Scheduling; Assisted Scheduling; 6:4:2; OPTICA. Continue to work on the plans to deploy Outpatients waitlist + Validation, Patient Cohorting, and Clinic Management. Accelerate Incubator work: i.e., Timely Care Hub, Cancer PTL, Diagnostic Scheduling, EOC/Mutual Aid, Virtual Wards, PLICS. 	<ul style="list-style-type: none"> Adopt agreed modules: Waitlist and DQ; Theatre Management & Scheduling; Assisted Scheduling; 6:4:2; OPTICA. – On track Continue to work on the plans to deploy Outpatients waitlist + Validation, Patient Cohorting, and Clinic Management. - On track Accelerate Incubator work: i.e., Timely Care Hub, Cancer PTL, Diagnostic Scheduling, EOC/Mutual Aid, Virtual Wards, PLICS – On track 	G	<ul style="list-style-type: none"> Timely Care Hub (MVP) & Optica (Discharge) - Re-started operational use on 25/08 Data & training issues impacted operational efficiency – additional training support being provided and most critical issues now resolved. RTT (waitlist validation) - Testing started 23/08 with target to restart BAU operations from 04/09 (assuming successful deployment of final fixes) Inpatients (Theatres and Waitlist) - Target to restart BAU operations from 04/09 (assuming successful deployment of final fixes) Outpatients - Delayed due to late provision of key data tables. Target date for restarting BAU operations TBC w/c 04/09 	<ul style="list-style-type: none"> Resource availability and conflicting priorities to implement solution at local level (within the respective Acute Trusts) 	<ul style="list-style-type: none"> Demonstration of Incubator Cancer PTL and Cancer capability developed by ICHT complete. Direct Connection to Somerset + Solihull Realtime HFC Mx, alongside data clinic for WMs / Mats. Integration with Alertive, testing complete in being live trials in progress Incorporation of workflows with Discharge Lounge CW + WM (include DCL eligibility from EPR). Potential to utilise BEV.

Finance and Performance Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to Delivery	Upcoming milestones/decisions
Delivery of the activity targets in the 23/24 operational plan	Rob Hodgkiss	ERF activity delivery against plan. ERF funding recovered.	Progress on KPIs not confirmed from national team. Local reporting > 108.5%		At the end of Month 4, the Collaborative is delivering above ERF targets, even prior to the impact of industrial action. National responses to the industrial action are in circulation, but have not yet been finalised. National data issued shows significant overperformance but is under review.	Implementation of Cerner at LNWHT and THH represents a material risk to delivery, notified to the national team. Industrial action has had a significant impact on delivery.	Finalisation of the industrial action mechanics to adjust ERF rates. Agreement on VWA metrics with national team. Baseline adjustments for Cerner.
Support Services Consolidation	Virginia Massaro	KPIs to be confirmed through working group.	Working group set up, aligned with the ICB working group.		At the end of Q1, the business case for consolidation of financial services has been approved, and a review of procurement consolidation has been proposed. All Trusts have completed the most recent back-office benchmarking support.	Capacity for change across the Collaborative creates a risk to delivery.	Articulation of Collaborative forward programme under development through working group.
Jointly develop and support a programme of discharge planning and reducing medically optimised patient LOS with ICB and collaborative partners	Jonathan Reid	Reduction in LOS	LOS >21 days remains above plan and a focus for the Collaborative and the ICB.		At the end of Q1, a number of interventions have been put in place across all site and with other key providers working with the ICB, with an initial impact on reported results. However, a significant opportunity remains for improvement.	Capacity constraints in primary, community and mental health services create a risk to delivery. Trust and ICB working closely on plans for strengthening delivery in Winter and for 2024/25.	Refresh of existing plans. Agreement of next steps with ICB and partners, with an ambitious target for improvement.

Finance and Performance Priorities

Priority	Lead	Key metrics	Progress against metrics	Status (RAG)	Summary of progress	Risks to Delivery	Upcoming milestones/decisions
Agree a programme of efficiency and productivity for £66m, reducing reliance on ICB support for 23/24 and improving our financial sustainability	Jonathan Reid	Identification of £66m financial plans for 2024/25	Targets issued for £48m, based on evidence from costing group. Work in hand to identify balance during Q2.		At the end of Q1, the first tranche of savings targets have been issued. The arrangements for delivering CIP (both in-year and in 24/25) are under review, with a new structure proposed. Additional resourcing is being brought together by the CFOs to support delivery.	Operational and in-year financial pressures create a significant risk to delivery. The CFOs are seeking to align this with the planning process for 2024/25, and to create additional capacity to deliver.	Second tranche of targets from the costing work to be identified. Delivery arrangements for the overall programme to be confirmed.
Outpatient Transformation	Jonathan Reid & Tina Benson	Articulation of a clear programme for the Transformation in delivery of Outpatients by end Q3.	Programme has been reset and transferred from Digital to Finance & Performance. Metrics to be agreed in Q3.		The initial business plan programme was narrow in scope - and the implementation of the pilot has been delayed. The project is now being refreshed to look more broadly at the potential for transformation of Outpatients.	Ambiguity on the project scope and drivers is likely the single most significant risk.	Articulation of the full refreshed scope of the programme, identification of SRO and resourcing support.

NWL Acute Provider Collaborative Board in Common (Public)

17 October 2023

Item number: 4.2

This report is: Public

Integrated Performance Report

Author: Pippa Nightingale, Tim Orchard, Lesley Watts, Patricia Wright

Job title: Chief Executive Officers

Accountable director: Pippa Nightingale, Tim Orchard, Lesley Watts, Patricia Wright

Job title: Chief Executive Officers

Purpose of report

Purpose: To provide assurance that performance across the quality, workforce 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 report.

Executive summary and key messages

This report provides the Board in Common with an overview of the performance of all four Trusts against key quality, workforce 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.

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

This report reflects performance data at Collaborative level for month 5 (month 4 for some metrics). 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

Integrated Performance Report

August data

(Cancer, Maternity & Op Plan Performance = July)

received by BIC October 2023

Integrated Performance Report - Summary

Introduction:

The integrated performance report continues to be developed to ensure the Board In Common gains assurance that performance is being monitored and that risks to delivery across the domains of quality, people, operational performance and finance are being managed and mitigated. The performance report to M5 has been updated to include some new metrics and will be further updated in the next 3 months to refine the metrics in advance of 2024-25.

Performance:

The summary report to month 5 (month 4 for some metrics) demonstrates continued strong performance and focused action where performance is off track.

Where action at an individual Trust level is required, this is managed at a local level. However, increasingly, learning across all four Trusts is being used to drive out variation and improve standards of practice for the benefit of patients.

Escalation:

There are two areas of escalation for the Board in Common

- Impact of Industrial action (IA) and rise in Covid infections, with some specific actions highlighted in individual sections
- Potential negative impact of Cerner 'go live' at LNW and planned 'go live' at THHFT in November 2023 on activity (and hence financial performance) due to baseline positions not being adjusted within the operating plan. Work is underway to mitigate this, but is confounded by IA

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

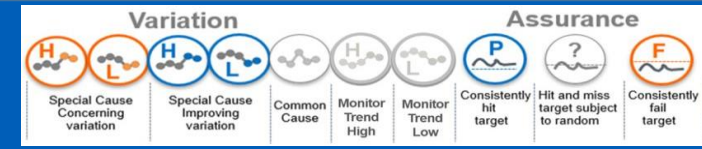
STRATIFICATION

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	47.98		
Serious Incidents	n/a	0.41		
Patient safety incidents with severe/major harm	<0.26%	0.20%		
Patient safety incidents with extreme harm/death	<0.14%	0.02%		
Healthcare Associated c. Difficile Infections	n/a	15		
Healthcare Associated E. coli blood stream Infections	n/a	39		
Healthcare Associated MRSA blood stream Infections	0	1		
Formal complaints received per 1000 staff	n/a	8.96		
Good experience reported by inpatients	≥94%	96.1%		
Good experience reported for maternity services	≥90%	89.9%		
Good experience reported for emergency depts.	≥74%	83.3%		
VTE Risk Assessments Completed	≥95%	95.0%		

Workforce	Expected	Actual	Trend	Assurance
Vacancy Rate	≤10%	9.7%		
Voluntary Turnover Rate	≤12%	11.3%		
Sickness Absence Rate	≤4%	4.1%		
Agency spend	≤2%	2.8%		
Non-medical appraisals	≥95%	89.4%		
Medical appraisals	≥95%	89.4%		
Core skills compliance	≥90%	91.3%		

Performance	Expected	Actual	Trend	Assurance
Ambulance handover waits	≥95%	92.8%		
Waits in urgent and emergency care > 4 hours	≥76%	75.9%		
Waits in urgent and emergency care > 12 hours	≤2%	3.7%		
Referral to treatment waits > 52 weeks	≤2%	3.7%		
Access to diagnostics > 6 Weeks	≤1.0%	11.5%		
Access to cancer specialist < 14 days	≥93%	91.1%		
Access to Cancer Care (Faster Diagnosis) < 28 days	≥75%	81.4%		
Cancer First Treatment from Diagnosis < 31 days	≥96%	95.9%		
Referral to Cancer Treatment Pathways < 62 days	≤85%	68.5%		
Theatre Utilisations (Hrs)	≤85%	85.5%		
Outpatient Transformation - PIFU	≤5%	2.7%		
Critical Care – Unoccupied Beds	≤85%	91.3%		

Finance	Expected YTD £m	Actual YTD £m	Variance YTD £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m		
Financial Delivery (I&E)	(13.3)	(52.4)	(39.1)	0	0	0		
Financial Delivery (CIP)	47.4	25.5	(21.9)	119.5	119.5	0		
YTD Capital Spend - £m	82.7	60.9	21.8	262.5	270.2	(7.7)		
Elective Over/Under Performance £m YTD	0	3.7	3.7	0	n/a	n/a		
CWA (Cost weighted Activity) YTD	100%	102%	2%	100%	n/a	n/a		

Quality/Clinical Performance

Safety Summary

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

Performance: Key points to note include:

- Incident reporting: Following a review of how this data is reported to ensure only Trust occurring National Reporting and Learning System (NRLS) reportable patient safety incidents are included, performance at APC level has been recalculated and is now consistently below the target. ICHT is the only trust which regularly meets the standard. The current focus is on the implementation of 'Learn from patient safety events' (LFPSE), which replaces the NRLS and will provide opportunity for improvements, including training and communications.
- SIs per 1,000 bed days: There was an increase in August 2023, with 39 SIs declared, the majority at ICHT (n=26). The high number at ICHT in month is as a result of a recent increase in incidents reported as moderate or above harm requiring investigation. This is due to a number of factors, including an increase in incidents identified from complaints, claims and inquests, primarily due to process change, and an increase in some key themes including diagnosis delays. Retrospective review of previous serious incidents related to delayed cancer diagnosis and a thematic review are underway. A quality review meeting (QRM) is being arranged for the beginning of October to agree and take forward any additional actions. There was one never event reported in August, at LNW, which is being investigated.
- IPC: annual thresholds are in place, with infection rates above trajectory. Each Trust has robust processes for managing and investigating cases, and on-going improvement work focussed on improving routine practice. Although an ICS improvement group is in place and is important to support work that spans across the system, an APC priority work stream has been set up to consider challenges and opportunities for learning within the acute setting.

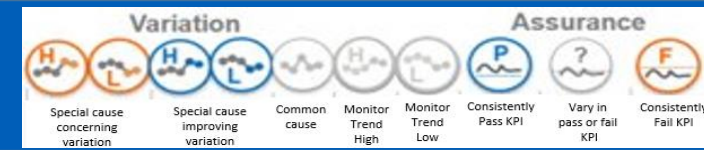
Key Actions: All areas of variance in the data are being managed with action plans in place to support improvement. There are examples where areas of variance align to the agreed quality priority work streams and where the actions planned will drive further improvement across the APC, including:

- Implementation of the patient safety incident response framework (PSIRF) and learning from patient safety events (LFPSE), including tendering a new incident reporting system. Work to transition to PSIRF in line with national timeframes progressing well with work to align systems, processes, governance led by a task and finish group to maximise opportunities for learning and benefits for patients and staff.
- User insight and focus work, including review of metrics and focus on meeting our patients' and communities' needs. The first collaborative workshop was held on 19th May; key areas of focus have been agreed and are progressing, and a second workshop is planned for November to review progress and develop our shared approaches further.
- Work underway to further align mortality review processes and reporting of outcomes through the mortality surveillance group. This will further improve how we identify and share learning from deaths.
- Maternity standards task and finish group focusing on transparent and open reporting, as well as creating a responsive culture to address safety and quality concerns. The current focus is on undertaking a self-assessment against NHSE's three year delivery plan in addition to the delivery and monitoring of year 5 of the Maternity Incentive Scheme (MIS).
- The initial discovery phase of the new IPC workstream will be completed by the end of quarter 3 with improvement work starting in January 2024. Given timing will coincide with winter we will prioritise reviewing our approach to testing, precautions in place and treatment of winter infections.

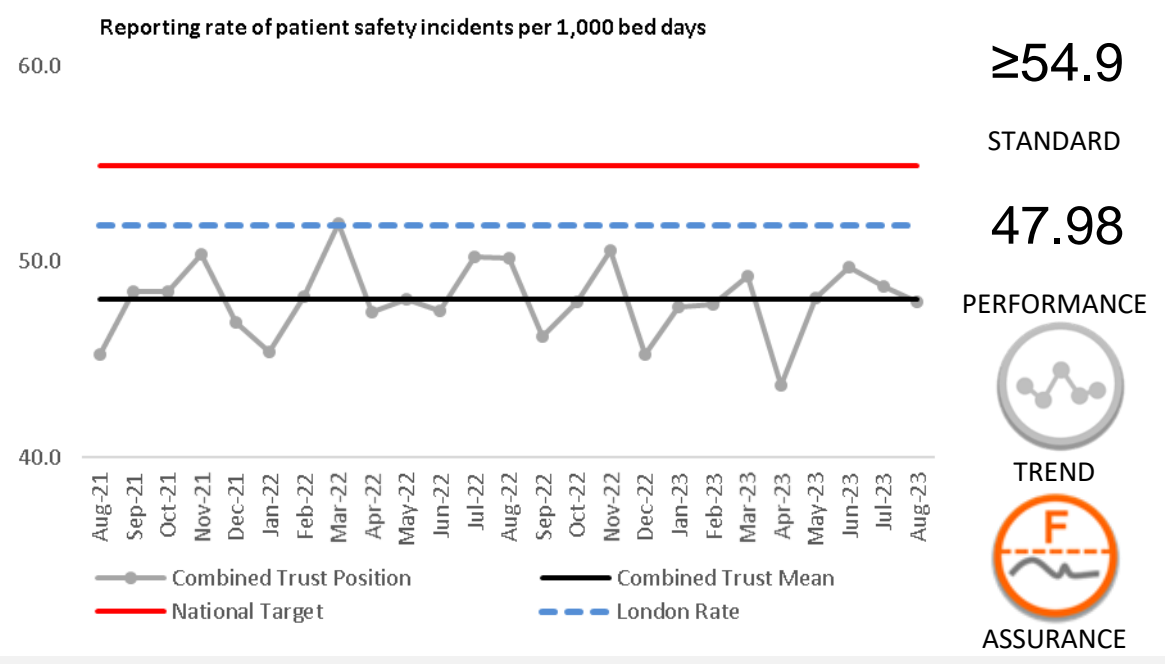
Escalations by Theme: On-going workforce and operational pressures, and the impact of industrial action, may have a negative impact on some of our quality metrics over the coming months. All four trusts have robust plans to manage clinical risk and the continued safety of patients and staff during periods of industrial action.

Patient Focus

(Patient) Patient Safety Incidents



TREND



NARRATIVE

Performance: Following a review of how this data is reported to ensure only Trust occurring NRLS reportable patient safety incidents are included, performance at APC level has been recalculated and is now consistently below the target. ICHT is the only trust which regularly meets the standard.

Recovery Plan: Trusts are currently focused on the implementation of 'Learn from patient safety events' (LFPSE), which replaces the National Reporting and Learning System (NRLS), and will provide opportunity for further improvements, including training and communications. 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.

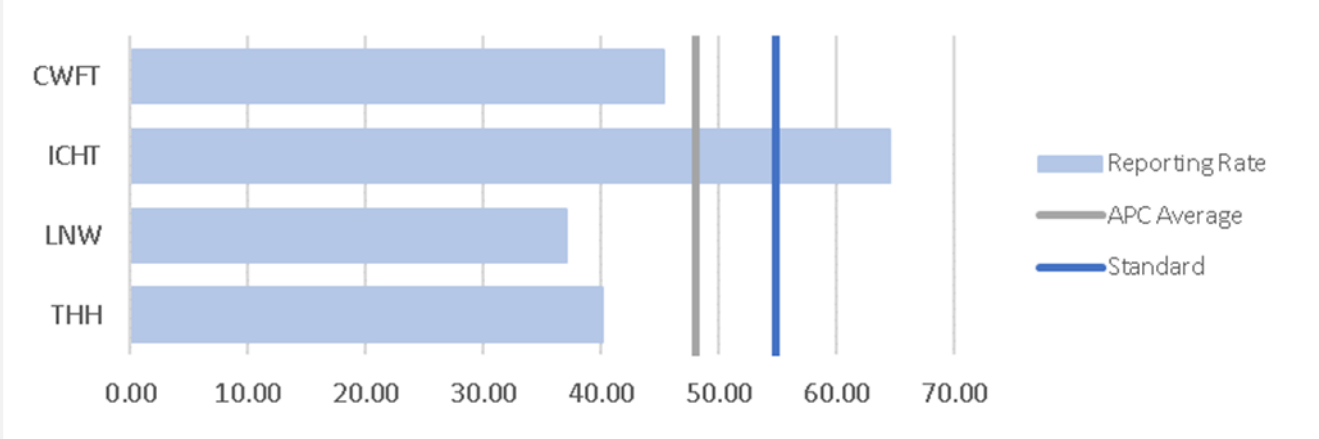
Improvements: The scope and requirements for the new incident reporting management scheme have been agreed across the collaborative and procurement has now commenced. As well as supporting standardisation of processes and allowing us to meet the requirements of LFPSE together, this should also ensure the system is as user-friendly as possible (staff regularly feedback that current systems are barriers to reporting). Once this is procured and in use incidents will be able to pull directly from Cerner however this is a longer term action.

Forecast Risks: N/A.

CURRENT PERFORMANCE

	Total bed days	Reporting Rate	Difference from Standard	Patient Safety Incidents	12 Month Rolling Reporting Rate
CWFT	23,536	45.25	-9.65	1,065	41.05
ICHT	29,867	64.49		1,926	58.44
LNW	30,677	37.00	-17.90	1,135	44.31
THH	11,739	40.12	-14.78	471	43.36
APC	95,819	47.98	-6.92	4,597	47.76

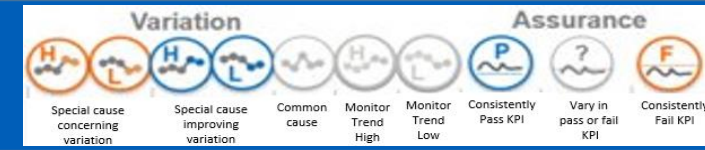
STRATIFICATION



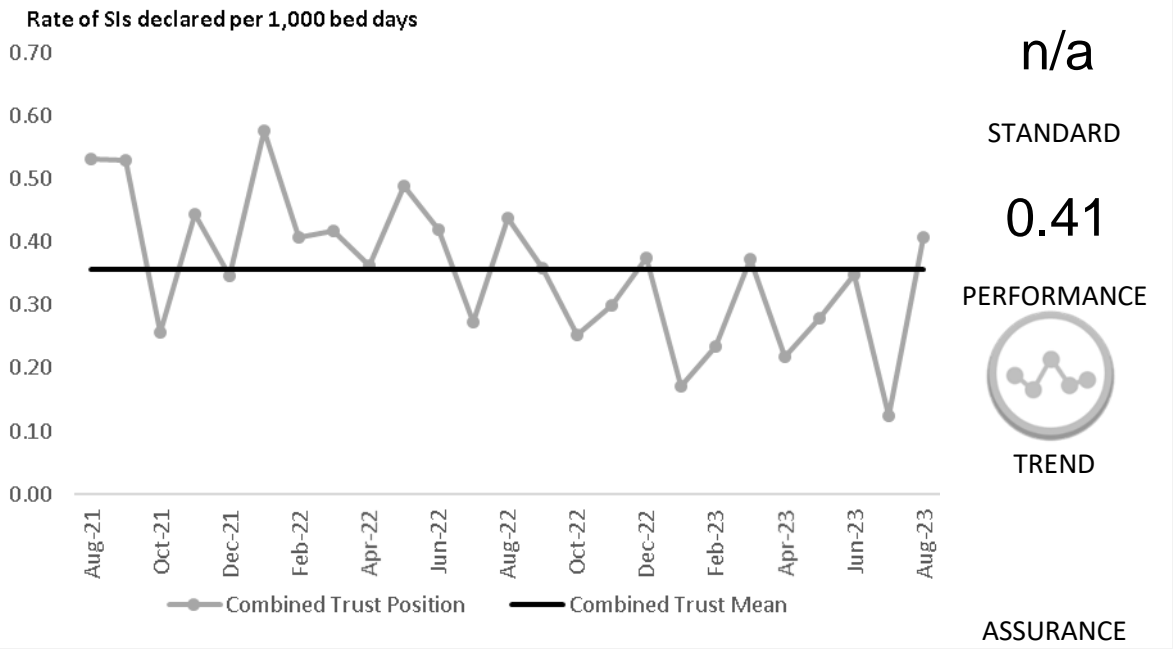
GOVERNANCE

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

(Patient) Serious Incidents



TREND



NARRATIVE

Performance: There is no target for this metric, or data to enable benchmarking at national and regional level. A 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 an overall reduction since August 2022, however there was an increase in August 2023, with 39 SIs declared, the majority at ICHT (n=26).

There was one never event reported in August, at LNW which is being investigated. This was a wrong site nerve block, where the patient came to no long-term harm and initial review identified the contribution of human error. The never event reported at CWFT in July remains under investigation.

Recovery Plan: The high number at ICHT in month is as a result of a recent increase in incidents reported as moderate or above harm requiring investigation. This is due to a number of factors, including an increase in incidents identified from complaints, claims and inquests, primarily due to process change, and an increase in some key themes including diagnosis delays. Retrospective review of previous serious incidents related to delayed cancer diagnosis and a thematic review are underway. A quality review meeting (QRM) is being arranged for the beginning of October to agree and take forward any additional actions.

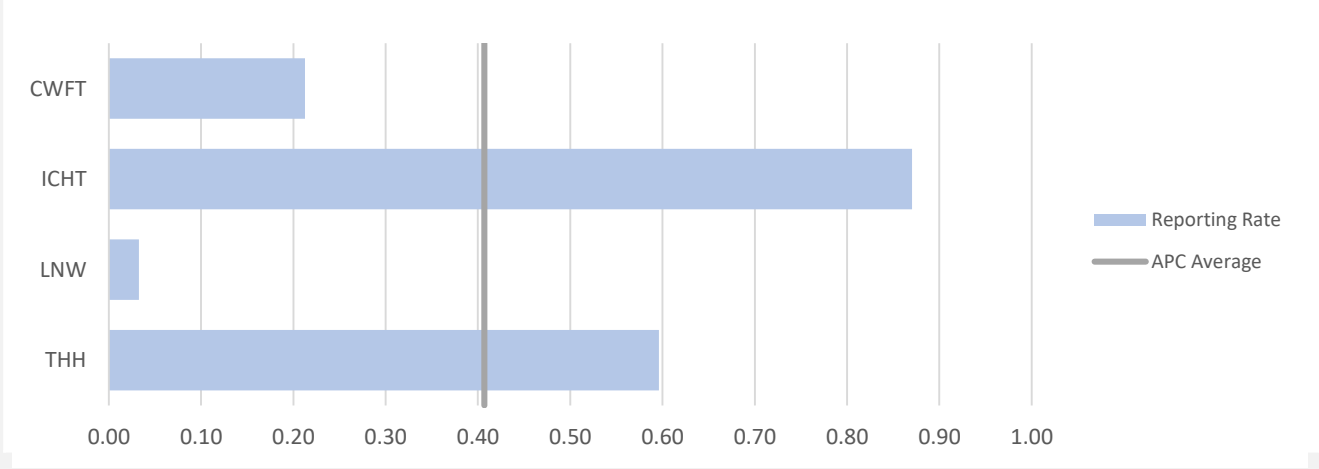
Improvements: The APC is taking a collaborative approach to the implementation of the Patient Safety Incident response framework (PSIRF) which will replace the Serious Incident framework. A task and finish group is in place to deliver the required changes by Autumn 2023 which will support improved consistency in investigation processes and approaches, improve the quality of investigations, and support better involvement of patients and families.

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.

CURRENT PERFORMANCE

	Total bed days	Reporting Rate	Serious Incidents	12 Month Rolling Reporting Rate
CWFT	23,536	0.21	5	0.19
ICHT	29,867	0.87	26	0.38
LNW	30,677	0.03	1	0.18
THH	11,739	0.60	7	0.53
APC	95,819	0.41	39	0.29

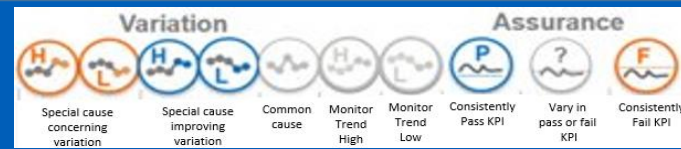
STRATIFICATION



GOVERNANCE

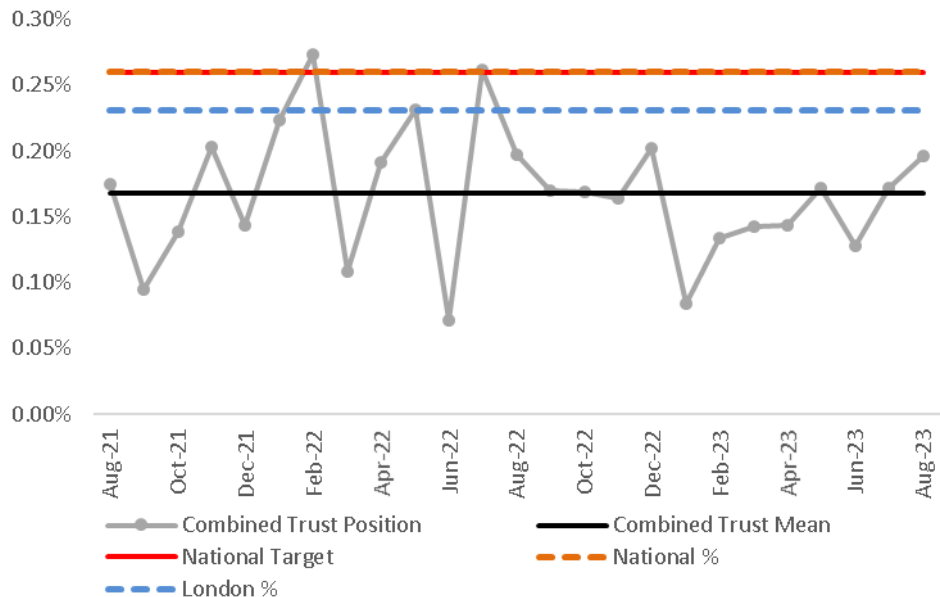
Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Patient Safety Incidents with Severe/Major Harms



TREND

% of patient safety incidents graded severe/major harm



Below
0.26%

STANDARD

0.20%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: The percentage of patient safety incidents graded as severe/major harm remains below national average at APC level. Rolling 12-month data shows that all trusts are below national average. There was a slight increase in month, with CWFT and THH above the standard and LNW just meeting the target. The 3 cases at CWFT are being investigated as SIs. They include an unplanned return to theatre and identification of necrotic small bowel, a delayed return to theatre and transfer between sites and delayed diagnosis of testicular torsion. One of the incidents at THH has been downgraded; the second is being investigated as a SI. LNW is reviewing the 3 cases to determine learning and improvements. None so far have been declared SIs and will await more in-depth understanding. The case at ICHT was an inpatient fall resulting in a hip fracture which is being investigated as a SI.

Recovery Plan: N/A

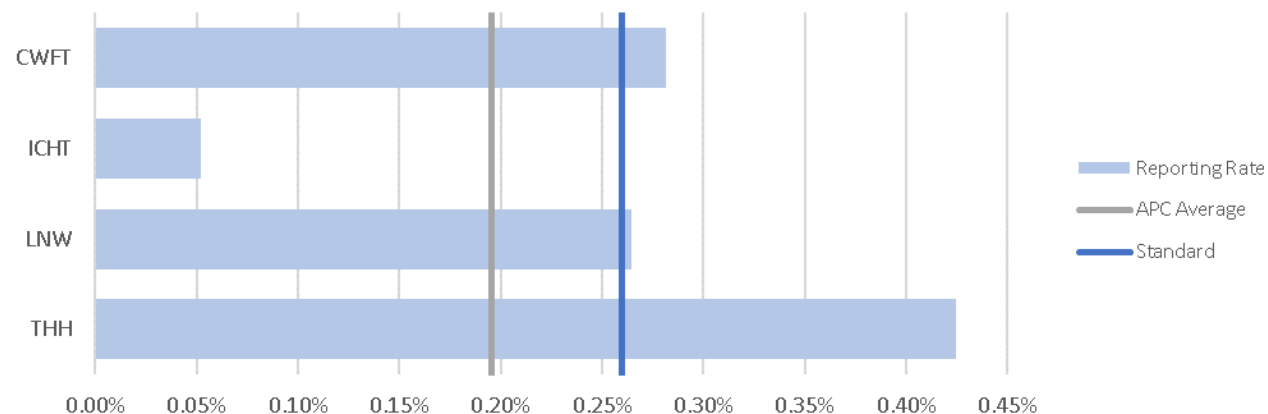
Improvements: Each trust has robust processes in place for the identification, and investigation, of patient safety incidents causing severe/major harm. Immediate actions are put in place in response to incidents, followed by learning and additional actions identified during the course of the investigation 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.

CURRENT PERFORMANCE

	Patient Safety Incidents	% Incidents	Difference from Standard	Severe/ Major Harm	12 Month Rolling % Incidents
CWFT	1065	0.28%	0.02%	3	0.18%
ICHT	1926	0.05%		1	0.11%
LNW	1135	0.26%	0.00%	3	0.17%
THH	471	0.42%	0.16%	2	0.22%
APC	4,597	0.20%		9	0.16%

STRATIFICATION



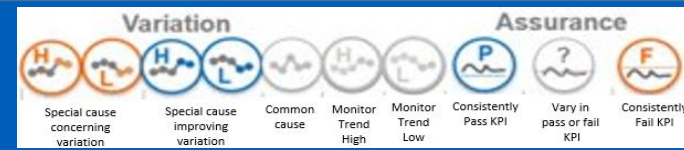
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

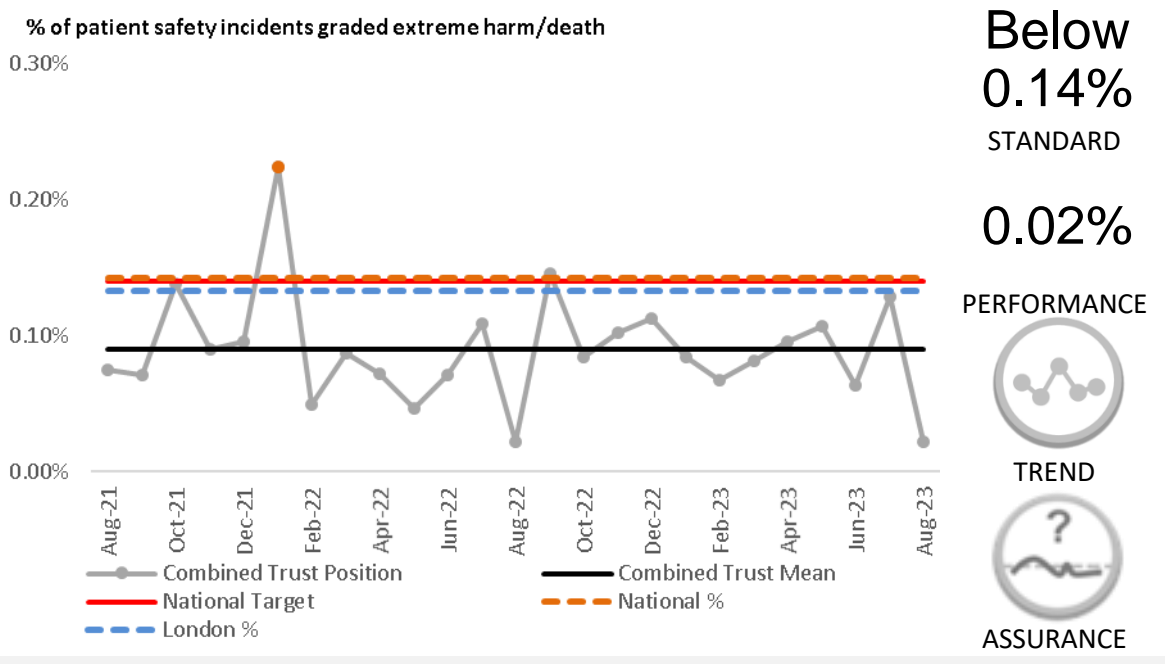
Committee: Acute provider collaborative executive management board

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

(Patient) Patient Safety Incidents with Extreme Harms/Death



TREND



NARRATIVE

Performance: Following a review undertaken by LNW to ensure the correct harm levels are assigned to these incidents in alignment with the other trusts, a number of historic incidents have had their harm downgraded. This has led to an overall reduction in the percentage of these incidents within LNW and also at APC level. In August, the percentage was below the standard with one case reported at LNW and is a death of a deteriorating patient being investigated under the PSIRF model.

Recovery Plan: N/A

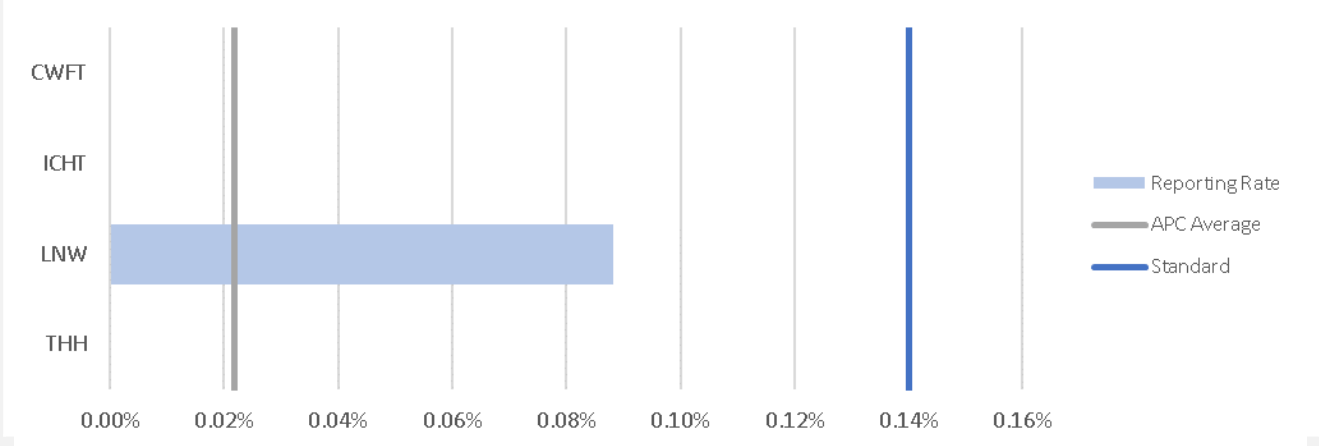
Improvements: Robust processes are in place for the identification, and investigation, of incidents causing death/extreme harm. Immediate actions are taken followed by learning and additional actions identified during the course of the investigation to prevent recurrence. Key priority workstreams for the APC around clinical harm review and prioritisation for patients who are waiting treatment and care of the deteriorating patient, will support improvements. 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.

CURRENT PERFORMANCE

	Patient Safety Incidents	% Incidents	Difference from Standard	Extreme Harm/Death	12 Month Rolling % Incidents
CWFT	1065	0.00%		0	0.06%
ICHT	1926	0.00%		0	0.08%
LNW	1135	0.09%		1	0.13%
THH	471	0.00%		0	0.10%
APC	4,597	0.02%		1	0.09%

STRATIFICATION



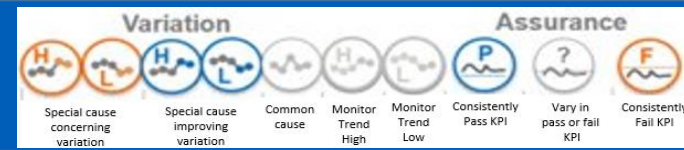
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

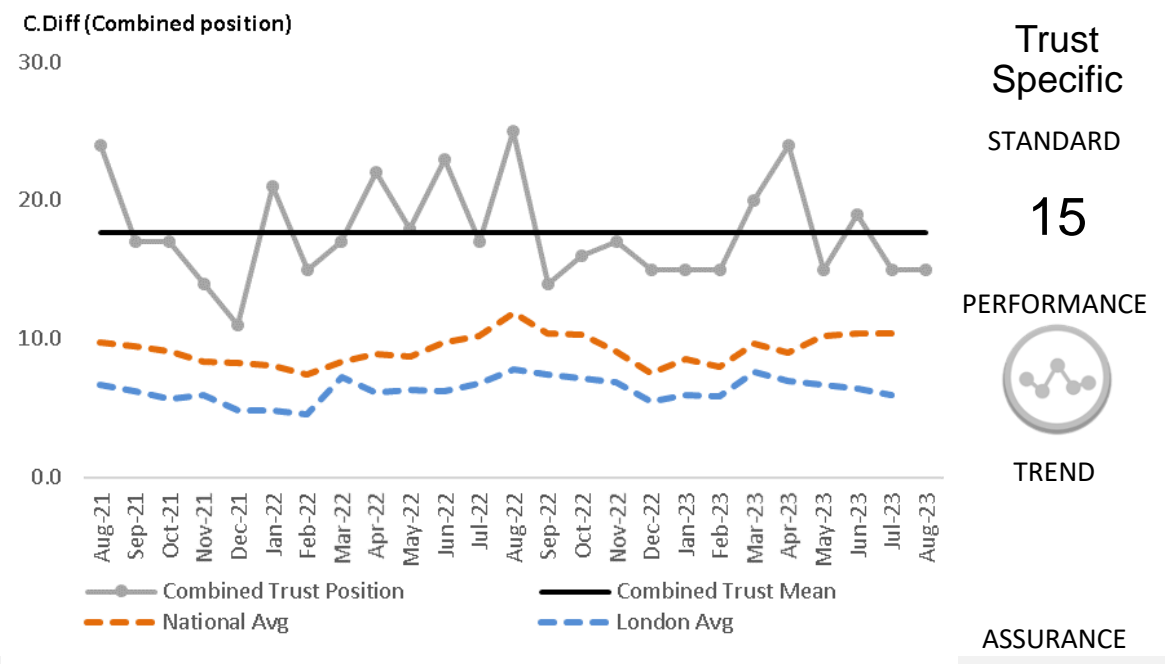
Committee: Acute provider collaborative executive management board

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

(Patient) Healthcare Associated C. Difficile Infections



TREND



NARRATIVE

Performance: There were 15 healthcare associated cases of C. difficile reported across the APC in August 2023. The trend graph shows variation. All trusts except THH exceeded their agreed thresholds for FY 2022/23. This increase was reflected regionally and nationally, however the APC numbers are higher than the national and London averages. Thresholds have been set by NHSE for FY 2023/24. ICHT, LNW and CWFT are exceeding their trajectories for this point in the financial year.

Recovery Plan: The increase and associated actions are under review by the ICS IPC forum, including the community actions required. A NWL task and finish group has been set up to examine the rise in cases with a particular focus on sample collection, the environment and a further understanding of potential risk factors. Each Trust has robust processes for managing and investigating cases, with on-going improvement work in place to reduce infection rates, with a focus on improving routine IPC practice.

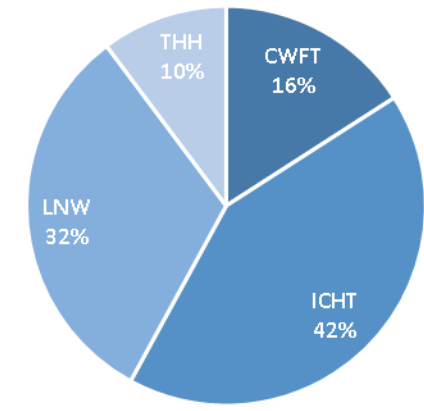
Improvements: An APC priority work stream is now in place to consider challenges and opportunities for learning. The initial discovery phase will be completed by the end of quarter 3 with improvement work starting in January 2024. Given timing will coincide with winter we will prioritise reviewing our approach to testing, precautions in place and treatment of winter infections.

Forecast Risks: Mitigating actions are in place as described in the recovery plan section.

CURRENT PERFORMANCE

	Count of c.Diff cases in month	Count of c.Diff cases in year (FY 23/24)	Trust Threshold (FY 23/24)	Difference from Threshold
CWFT	3	14	25	
ICHT	5	37	65	
LNW	5	28	63	
THH	2	9	23	
APC	15	88	176	

STRATIFICATION

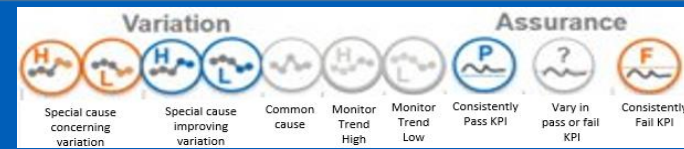


Trust share of APC count of infections in year

GOVERNANCE

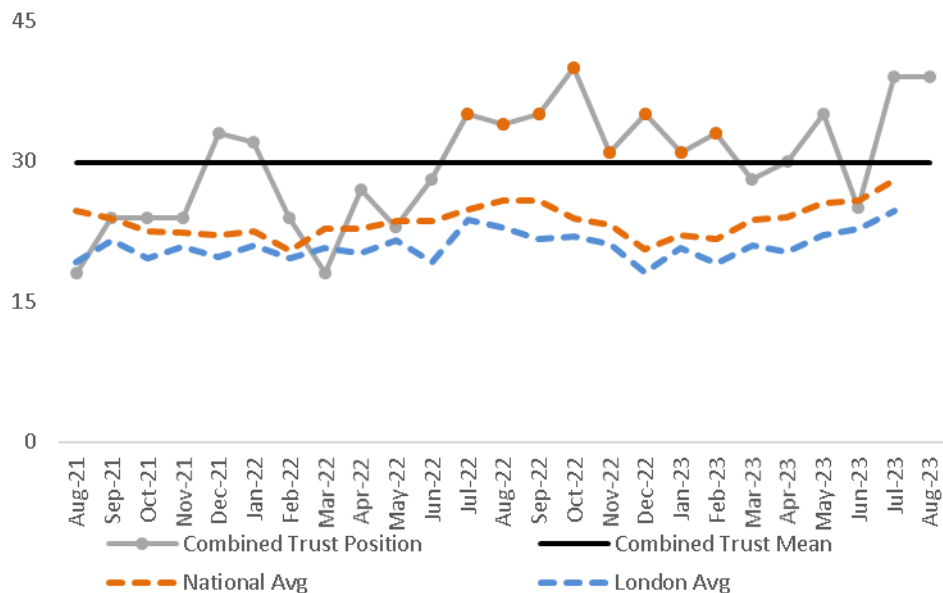
Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Healthcare Associated E. coli Infections



TREND

E.coli blood stream infection (Combined position)



Trust Specific

STANDARD

39

PERFORMANCE



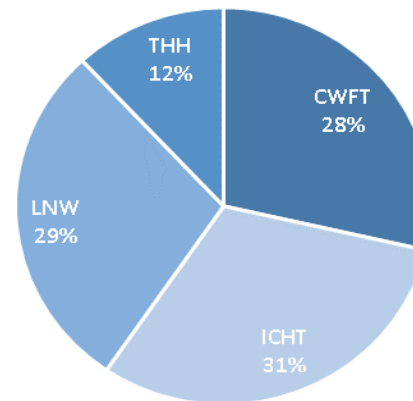
TREND

ASSURANCE

CURRENT PERFORMANCE

	Count of E.Coli BSIs in month	Count of E.Coli BSIs in year (FY 23/24)	Trust Threshold (FY 23/24)	Difference from Threshold
CWFT	16	48	70	
ICHT	12	52	90	
LNW	8	48	87	
THH	3	20	27	
APC	39	168	274	

STRATIFICATION



Trust share of APC count of infections in year

NARRATIVE

Performance: The trend graph shows an increase in E. Coli blood stream infections (BSIs) across the APC since May 2022. In August there were 39 cases reported across the APC. All trusts exceeded their agreed thresholds for FY 2022/23. Thresholds have been set by NHSE for FY 2023/24. All trusts are exceeding their trajectories for this point in the year.

Recovery Plan: The ICS are focused on reduction of E.coli blood stream infections in line with the NHS Long Term Plan that supports a 50% reduction in Gram-negative bloodstream infections by 2024/25. Robust processes for managing and investigating cases, and on-going improvement work is in place, with a focus on improving routine IPC practice.

Improvements: An APC priority work stream is now in place to consider challenges and opportunities for learning. The initial discovery phase will be completed by the end of quarter 3 with improvement work starting in January 2024. Given timing will coincide with winter we will prioritise reviewing our approach to testing, precautions in place and treatment of winter infections.

Forecast Risks: Mitigating actions are in place as described in the recovery plan section.

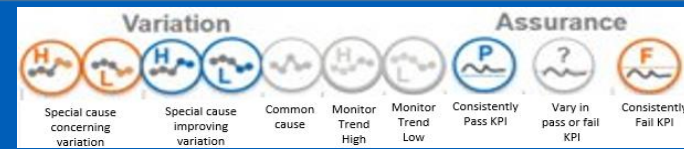
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

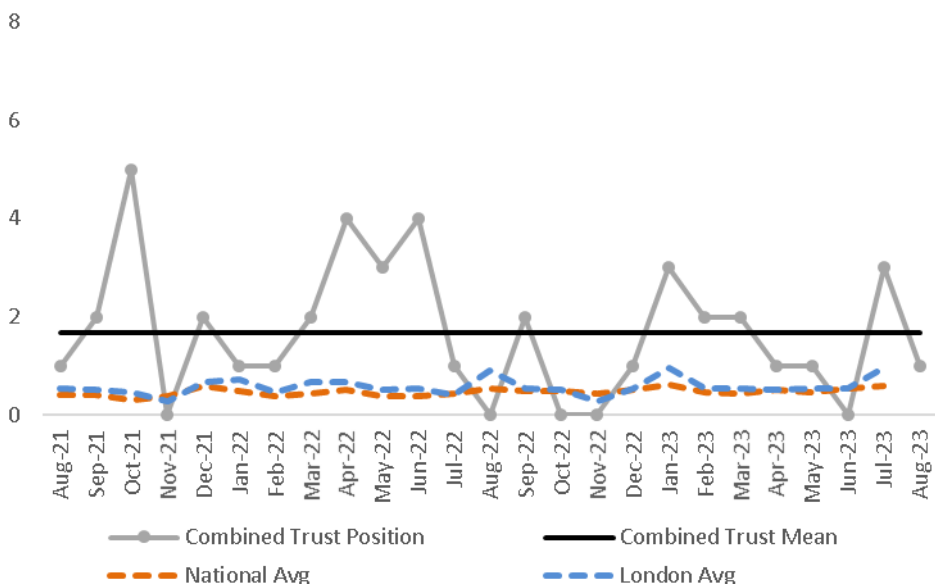
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Healthcare Associated MRSA Infections



TREND

MRSA Bacteraemia - Trust (Combined position)



0

STANDARD

1

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: There was one MRSA BSIs reported in August 2023, at CWFT, and 6 in total so far this financial year, the majority of which were at ICHT (n=3).

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

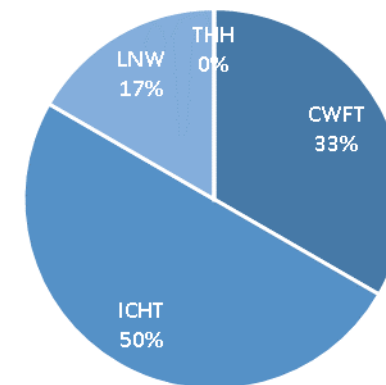
Improvements: An APC priority work stream is now in place to consider challenges and opportunities for learning. The initial discovery phase will be completed by the end of quarter 3 with improvement work starting in January 2024. Given timing will coincide with winter we will prioritise reviewing our approach to testing, precautions in place and treatment of winter infections.

Forecast Risks: None.

CURRENT PERFORMANCE

	Count of MRSA BSIs in month	Count of MRSA BSIs in year (FY 23/24)	Trust Threshold (FY 23/24)	Difference from Threshold
CWFT	1	2	0	-2.0
ICHT	0	3	0	-3.0
LNW	0	1	0	-1.0
THH	0	0	0	0
APC	1	6	0	-6.0

STRATIFICATION



Trust share of APC count of infections in year

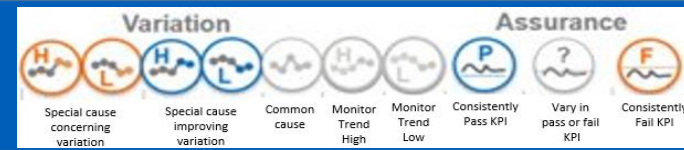
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

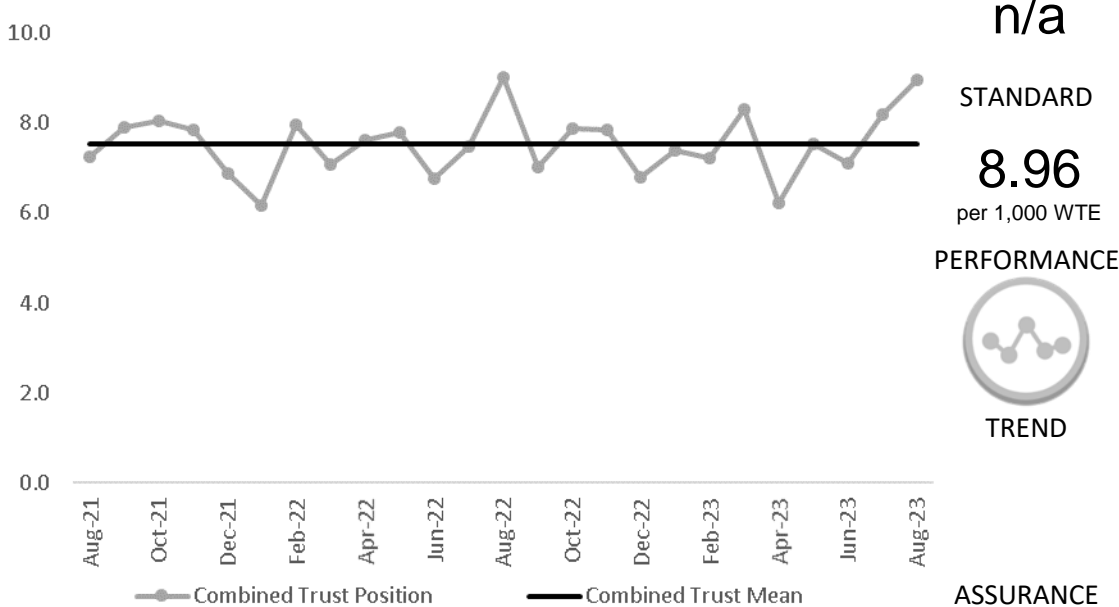
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Formal Complaints



TREND

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



NARRATIVE

Performance: There is currently no agreed standard for the rate of formal complaints per 1,000 WTE, and no benchmarking data available. The trend graph shows small amounts of variation across the last 18 months, with an increase over the last two months. The rate in August was 8.96. Rates vary at trust level, with LNW having the highest rate in month and across the last 12 months. LNW experienced a 33% increase in complaints after assuming management for the UTCs on each site. Despite the increase, the trust continues to achieve a 93% response rate within the deadline. There was also an increase at THH in August which has been reviewed and attributed to standard variation.

Recovery Plan: N/A

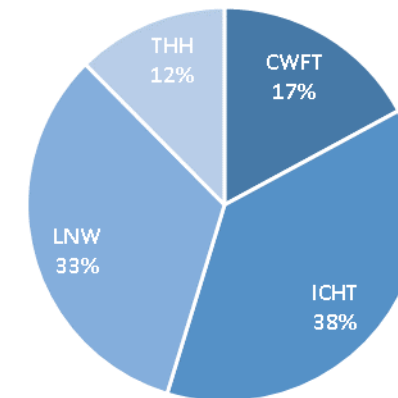
Improvements: The 'User insight and focus' improvement workstream is identifying and prioritising opportunities for shared learning and common approaches to understanding, measuring and improving responsiveness to the needs and views of our patients and local communities across the APC. The metrics, 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.

CURRENT PERFORMANCE

	Total WTE Staff	Rate per 1,000 WTE	Count of Patient Complaints	12 Month Rolling Rate per 1,000 WTE
CWFT	6,951	7.34	51	6.28
ICHT	13,167	8.51	112	6.83
LNW	9,518	10.30	98	9.75
THH	3,627	10.20	37	7.43
APC	33,263	8.96	298	7.55

STRATIFICATION



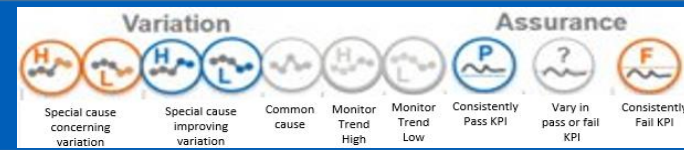
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

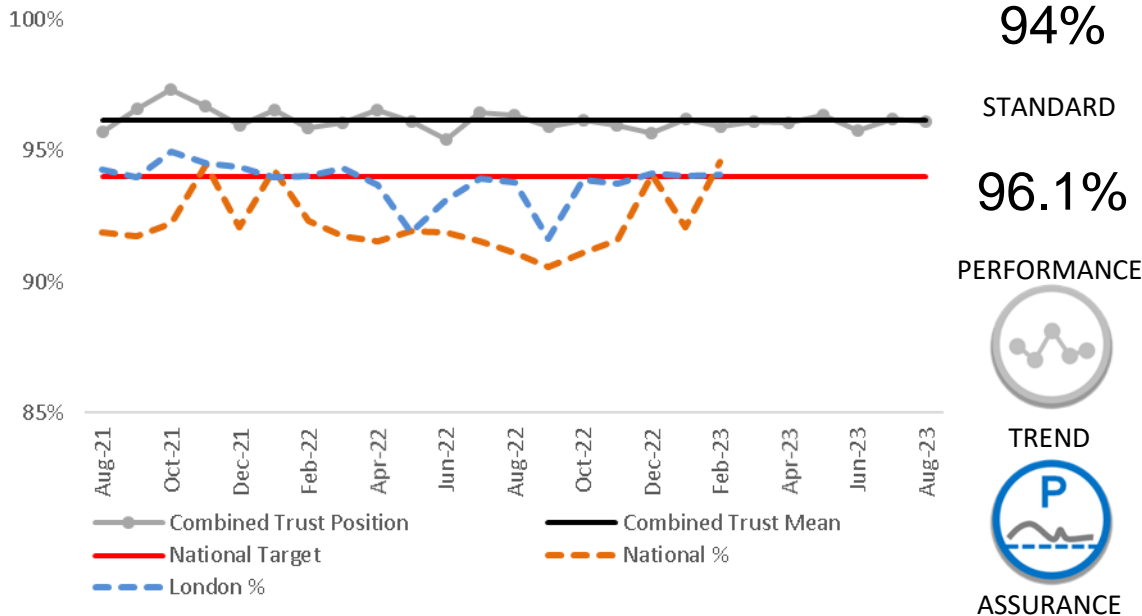
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Inpatient Friends & Family Test



TREND

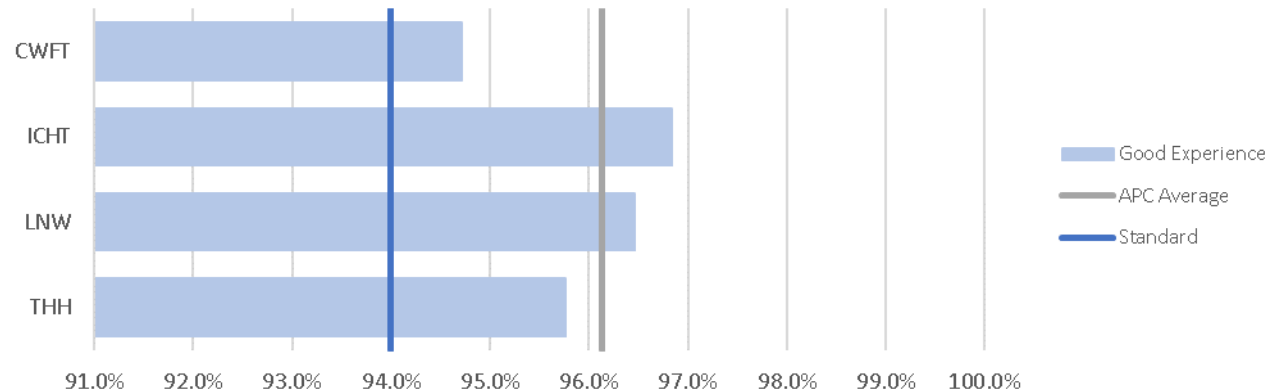
% good experience - Inpatients



CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	1,304	94.7%		1,235	95.8%
ICHT	2,592	96.8%		2,510	96.1%
LNW	1,639	96.5%		1,581	97.0%
THH	1,392	95.8%		1,333	94.6%
APC	6,927	96.1%		6,659	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 (N.B. national data from February 2023 onwards is not currently available). All trusts met the target in month.

Recovery Plan: N/A

Improvements: Work is underway within the user insights and focus workstream to improve how we manage and use the friends and family test, including looking at ways to increase uptake, re-tender survey platforms and potentially deploying the natural language processing tool developed by Imperial College to analyse free text data.

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.

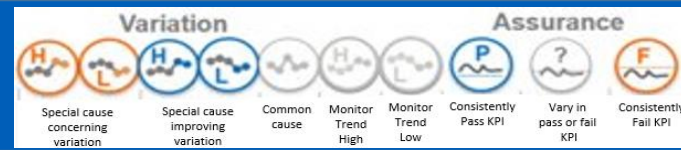
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

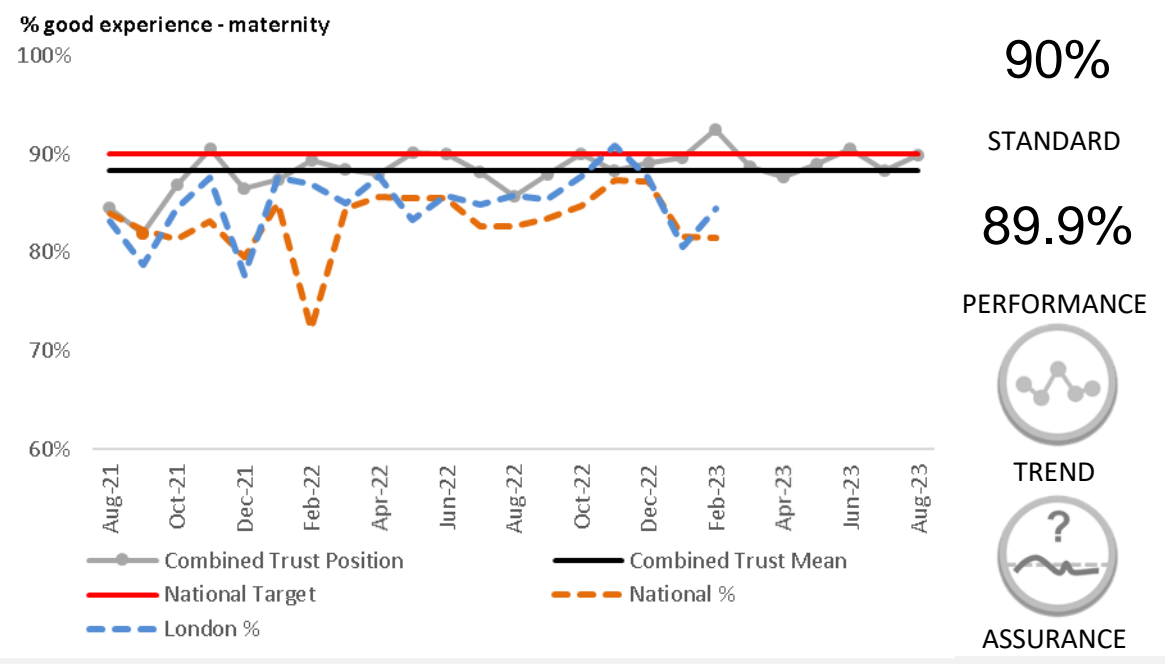
Committee: Acute provider collaborative executive management board

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

(Patient) Maternity Friends & Family Test



TREND



NARRATIVE

Performance: At APC level, the monthly percentage of patients who report a good experience varies, although there has been a noted improvement since September 2021. Performance at APC level is just below the standard in August, with LNW and THH both below target. The number of responses received is low, particularly for LNW, which will result in greater fluctuation.

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.

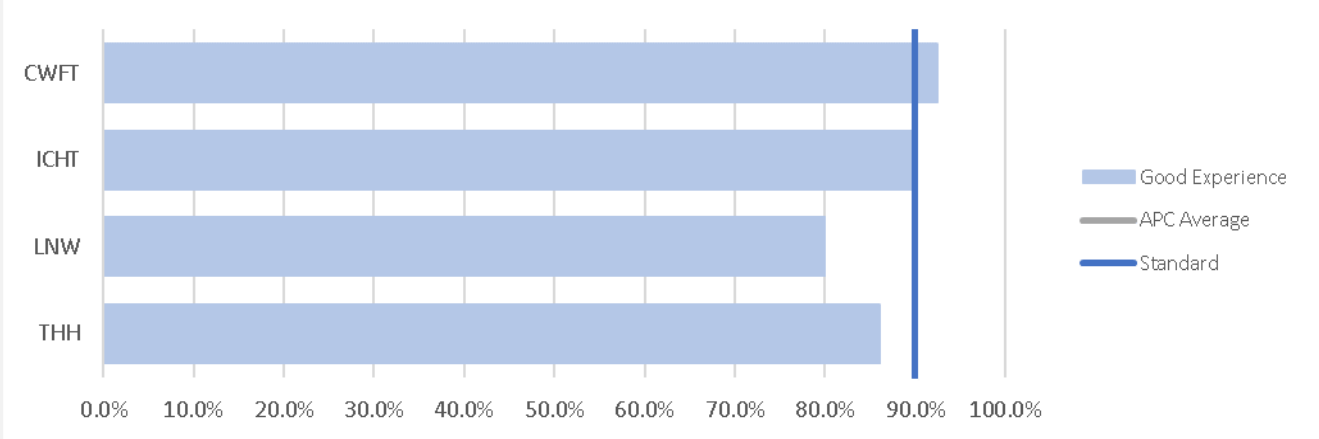
Improvements: Maternity standards is one of the APC's quality priorities, with an agreed work-plan in place aiming to share good practice and learning.

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

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	372	92.5%		344	89.3%
ICHT	315	90.2%		284	89.0%
LNW	5	80.0%	-10.0%	4	87.7%
THH	258	86.0%	-4.0%	222	89.8%
APC	950	89.9%	-0.1%	854	89.3%

STRATIFICATION



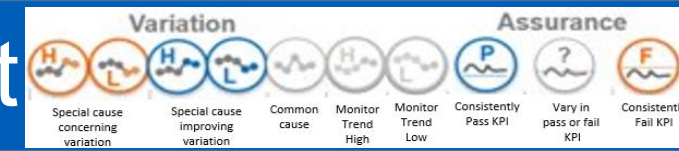
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

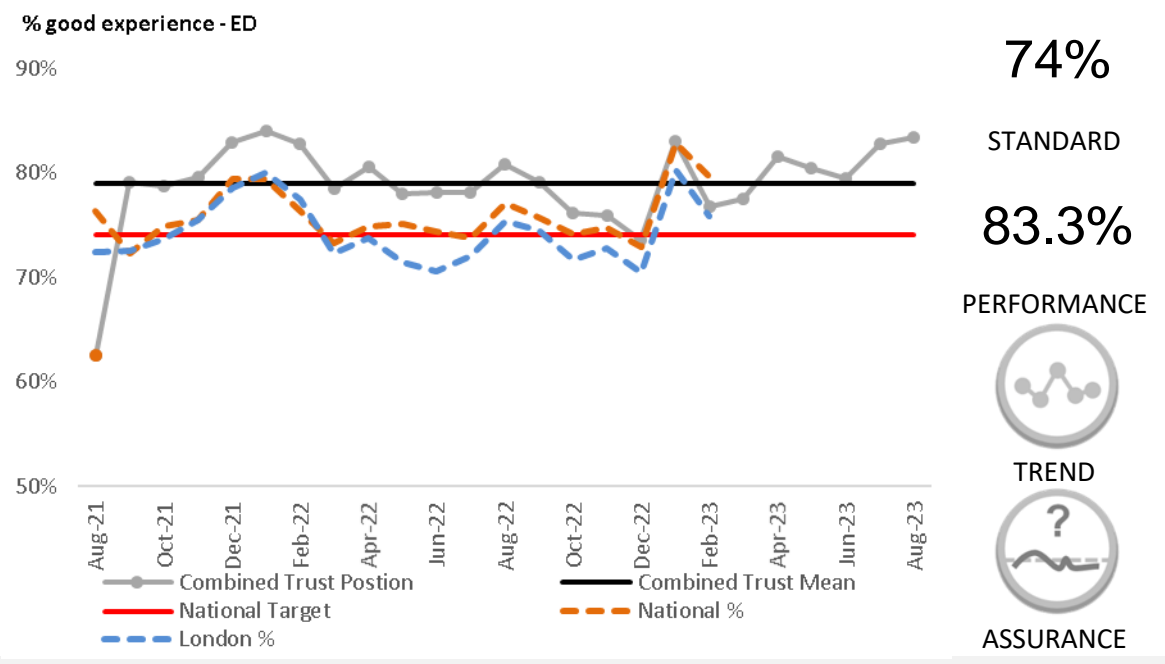
Committee: Acute provider collaborative executive management board

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

(Patient) Emergency Dept Friends & Family Test



TREND



NARRATIVE

Performance: At APC level, the percentage of patients accessing our emergency departments who report a good experience has been consistently above target since January 2023. All trusts met the target in August. The 12-month rolling figure shows that we are above the 74% threshold at ACP level, and in all trusts except LNW.

Recovery Plan: Not applicable.

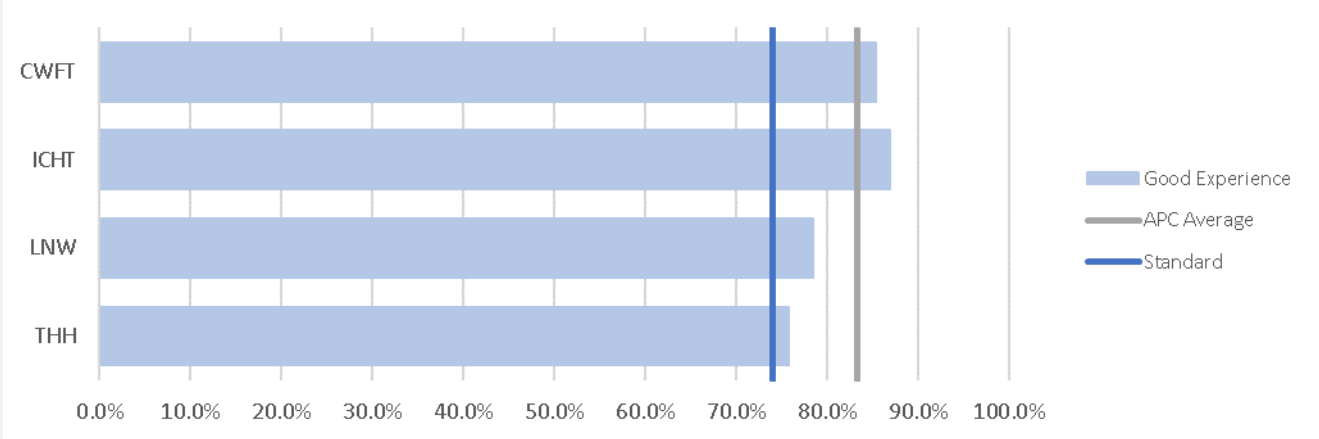
Improvements: Following the peer review process undertaken in 2022, eight key improvement workstreams have been agreed with associated actions and clinical leads identified. An ED peer review working group is leading on a programme of work to address the findings from the peer reviews and support implementation via existing workstreams / steering groups or new workstreams where gaps have been identified.

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.

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	3,506	85.3%		2,991	80.8%
ICHT	1,194	86.9%		1,037	84.7%
LNW	1,082	78.4%		848	72.2%
THH	753	75.7%		570	75.7%
APC	6,535	83.3%		5,446	79.3%

STRATIFICATION

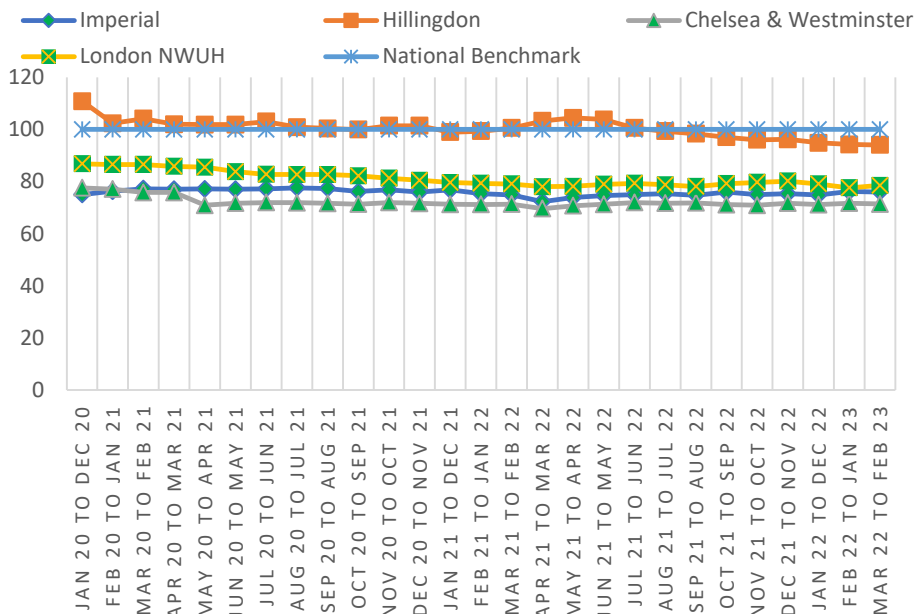


GOVERNANCE

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

(Patient) Summary Hospital-level Mortality Index

TREND



100
England Average
STANDARD
n/a
PERFORMANCE
n/a
TREND
n/a
ASSURANCE

CURRENT PERFORMANCE

Summary Hospital-level Mortality Index (SHMI) Year to Feb 2022

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	91485	71.37	Lower than expected
ICHT	95465	76.0	Lower than expected
LNW	102140	78.5	Lower than expected
THH	35875	94.05	as expected

STRATIFICATION

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

NARRATIVE

Performance: For three of the four trusts (CWFT, LNW and ICHT), the rolling-12 month SHMI remains lower than expected with the most recent data available (March 2022– Feb 2023) demonstrating similar figures to previous reporting periods. THH's rate is consistently 'as expected', but is reducing and remains below the national benchmark of 100.

Recovery Plan: None

Improvements: Work continues through the new APC mortality surveillance group to standardise the system and process for producing SHMI and HSMR mortality reports using aggregated data and a standard set of processes for using this data to drive quality improvements.

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.

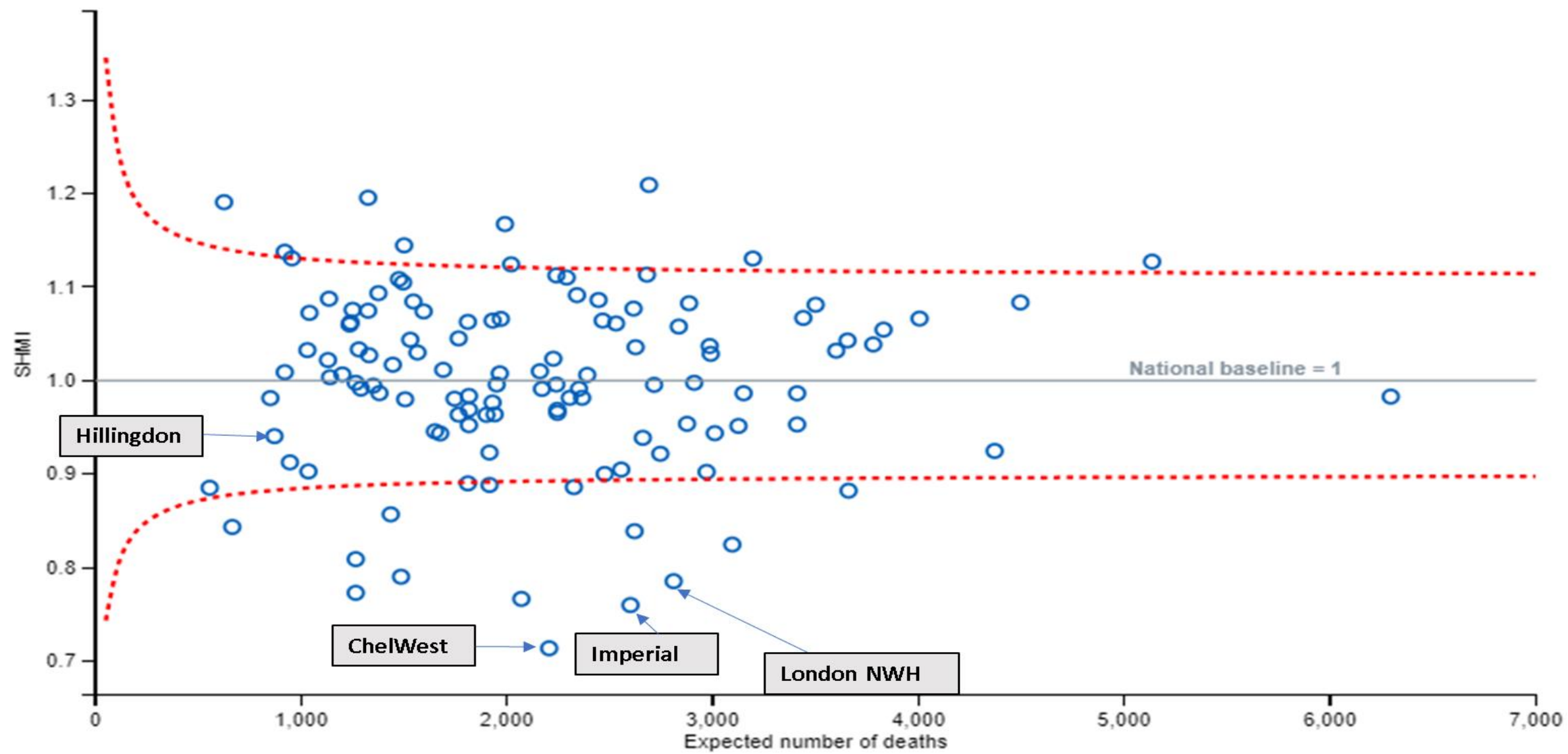
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

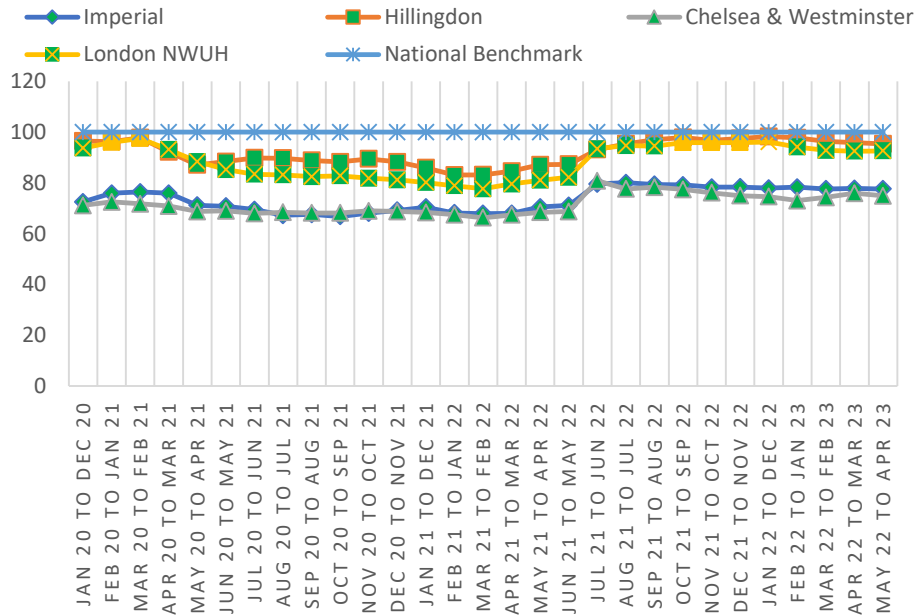
Data Assurance: Data is supplied and quality assured by Telstra Health

(Patient) Summary Hospital-level Mortality Index



(Patient) Hospital Standardised Mortality Ratio

TREND



NARRATIVE

Performance: The most recent data (for the year May 2022–April 2023) shows that each trust has a rolling 12-month ratio below the national benchmark. THH's rate remains as expected.

Recovery Plan: N/A

Improvements: Work continues through the new APC mortality surveillance group to standardise the system and process for producing SHMI and HSMR mortality reports using aggregated data and a standard set of processes for using this data to drive quality improvements.

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 April 2023

	Provider Spells	HSMR	SHMI- relative risk ranking
CWFT	43766	74.9	Lower than expected
ICHT	68403	77.6	Lower than expected
LNW	59961	92.6	Lower than expected
THH	15854	95.42	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: Pippa Nightingale, CEO, LNW

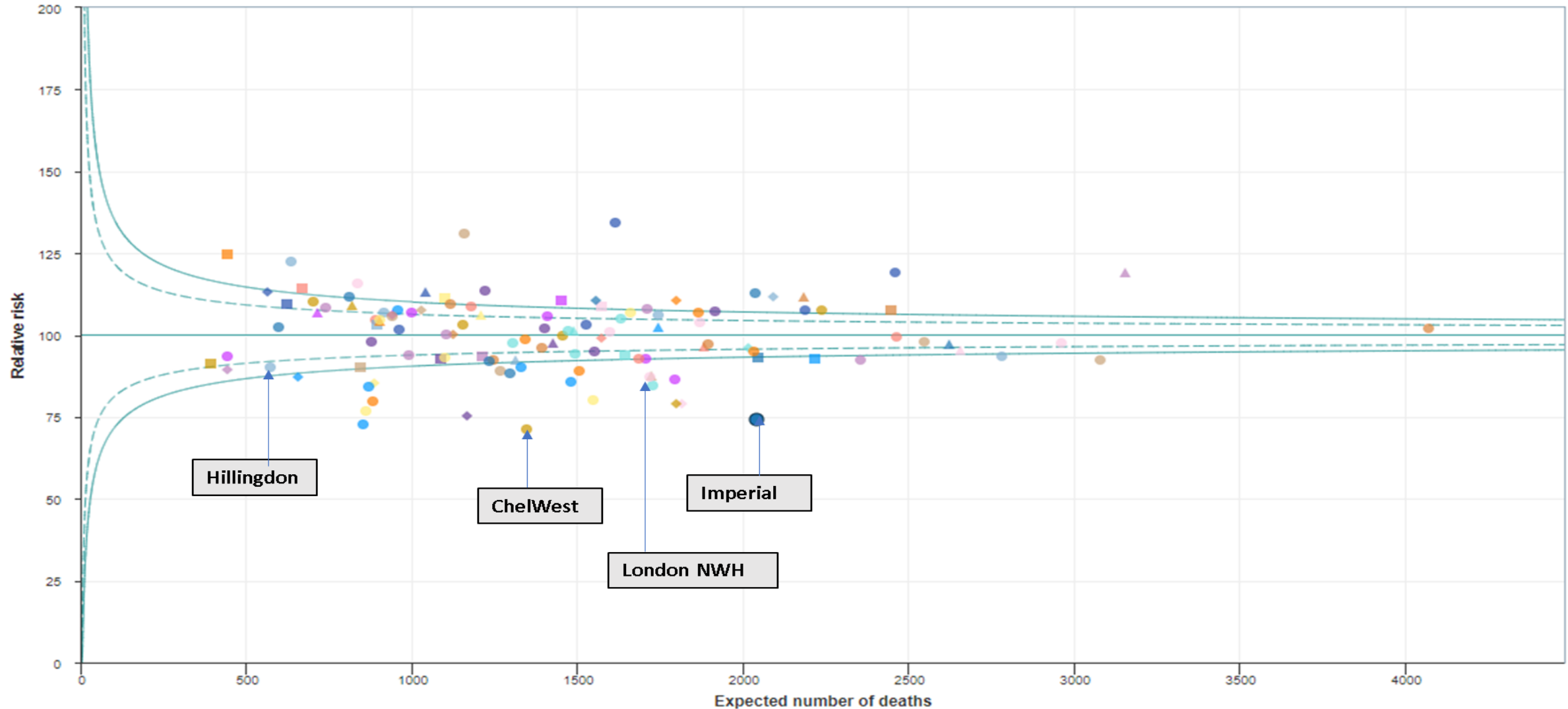
Committee: Acute provider collaborative executive management board

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

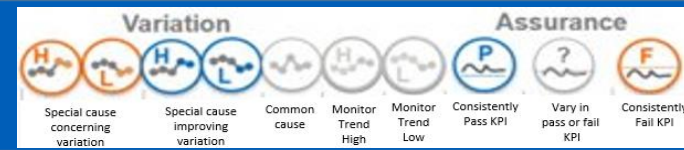
(Patient) Hospital Standardised Mortality Ratio

Diagnoses - HSMR | Mortality (in-hospital) | May-22 to Apr-23 | ALL (acute, non-specialist)

Peers Measure Benchmarks Group by Show

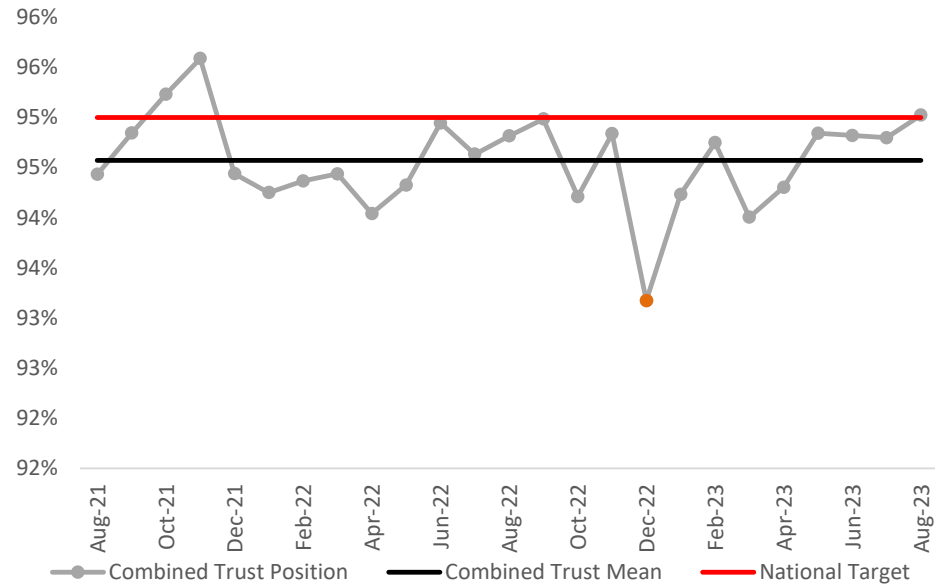


(Patient) VTE Risk Assessments Completed



TREND

% VTE risks completed



95%

STANDARD

95.0%

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 common cause variation. In August, we met the target at APC level, although two of the three trusts who report data for this metric are below target. LNW are undertaking quarterly local VTE audits, with improvements being seen.

Recovery Plan: LNW has established a VTE Task and finish group which will review systems and oversight for data, coding and practice; one of their confirmed quality priorities for 2023/24 is focused on improving the VTE process, with the aim of ensuring that they are meeting the target for this metric by March 2024. Local VTE audits are continuing. THH has improvement work underway, including a mandatory e-learning module with positive uptake; further improvements are expected as a result of Cerner implementation trust wide (planned for November 2023). CWFT has identified some issues with the denominator for this metric; once amended this will improve compliance to above target.

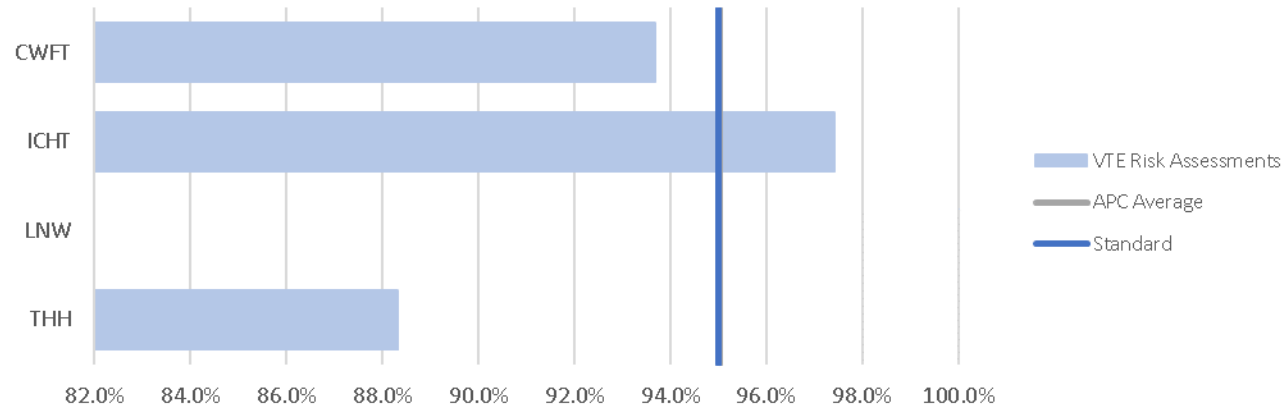
Improvements: ICHT uses functionality in Cerner to ensure that VTE risk assessments are undertaken where required. This is under review to see if it can be replicated at THH and LNW once Cerner implementation is complete.

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	7,181	93.7%	-1.3%	6,728	93.2%
ICHT	14,390	97.4%		14,019	96.9%
LNW					
THH	3,723	88.3%	-6.7%	3,288	88.2%
APC	25,294	95.0%		24,035	94.5%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Neonatal and Maternity Report

Scorecard July 2023

Maternity	Expected	Actual	Trend	Assurance
Crude still birth rate (per 1000 birth rate)	3.3	3.7		
Number of neonatal intrapartum brain injuries as escalated to HSIB	Downward Trend	4		
% 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%	89%		
Avoidable Term Admissions in Neonates; proportion of babies >=37 weeks GA admitted to neonatal care for 24 hours or more	<6%	3.3%		
Pre-Term Births	<8%	6.8%		
BAME Maternity Continuity of Care (MCoC)	Upward Trend	27.9%		
Neonatal Crude Deaths (per 1000 birth rate)	0.94	0.92		
Maternal Deaths	0	0		

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

Assurance	
Fail	
Pass	
Flip Flop	

Introduction

Introduction:

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

Acute provider trust	Maternity unit	Annual number of live births (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	

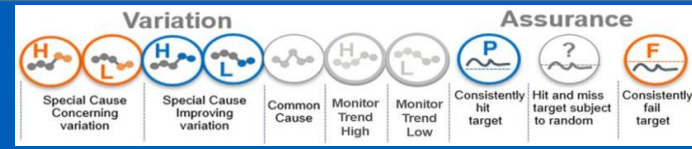
Metric definition

Metric definitions:

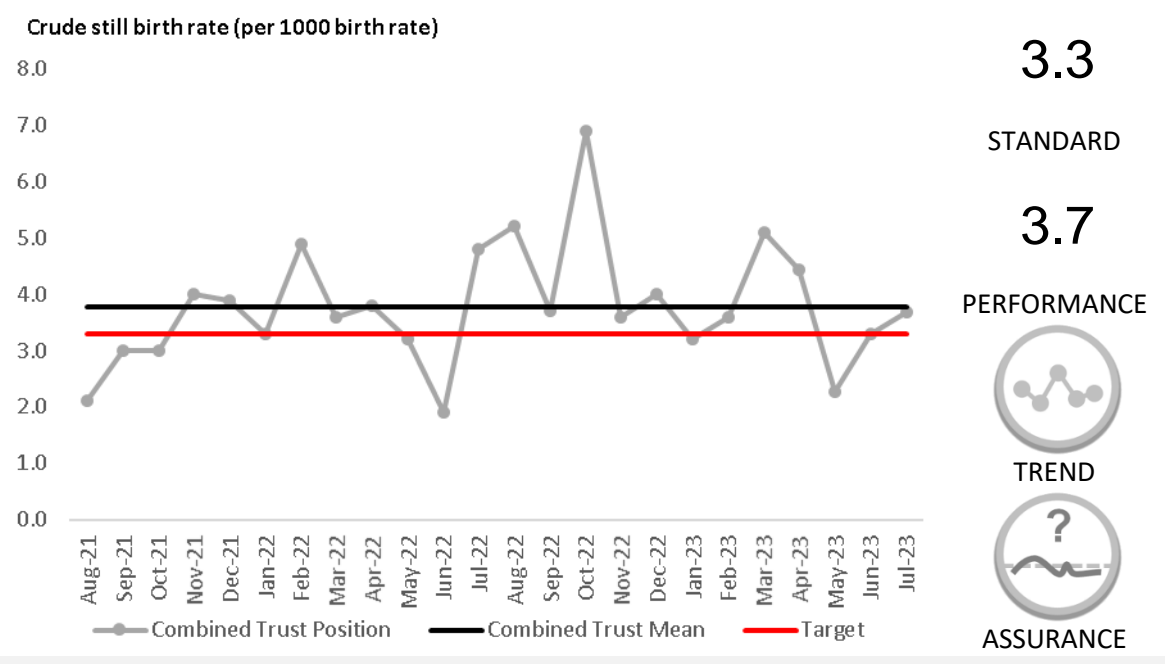
1. Crude still birth rate (per 1000 birth rate) - babies born showing no signs of life at 24 weeks or more gestation
2. Number of suspected neonatal intrapartum brain injuries as escalated to HSIB - Number of births reported to NHS resolution as meeting Each Baby Counts criteria. Potential severe brain injury diagnosed in the first seven days of life, when the baby:
 - Was diagnosed with moderate or severe (grade III) hypoxic ischaemic encephalopathy (HIE). This is brain injury caused by the baby's brain not getting enough oxygen.
 - Was therapeutically cooled (active cooling only). This is where the baby's body temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.
 - Had decreased central tone (was floppy) and was comatose and had seizures of any kind.
3. % of babies born in an appropriate care setting for gestation –An appropriate care setting for singletons <27+0 weeks or <800gms, or all multiples <28+0 weeks is one that has NICU provision. Chelsea and Westminster Hospital and Queen Charlotte's and Chelsea Hospital both have level 3 neonatal units and would therefore be an appropriate care setting.
4. 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 28 days 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.
5. Pre-term births – Total Number of live Births before 37 weeks
6. Maternity continuity of care – Proportion of Black and Asian birthing women and people receiving CoC at 29 weeks of pregnancy. Continuity of Care is defined as the care delivered is offered by the same known care provider or care provider team across two or more parts in the care continuum—antenatal, intrapartum, postnatal and neonatal periods.
7. Crude neonatal death rate - Neonatal mortality rate p/1000 live births - adjusted to remove <24 wks and those not born in NWL
8. Maternal deaths – Number of maternal deaths

The data in this dashboard is for month 4 (July 2023). Work is underway to improve the timeliness of the data for these metrics.

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



TREND



NARRATIVE

Performance: The NWL APC stillbirth rate was above target in July. CWFT and ICHT have above threshold rates in month. The YTD rate is also above target at APC level and for CWFT and THH.

Recovery Plan: Following an increase in the crude stillbirth rate for THH in 2022/23, the rate is beginning to reduce. There were three ICHT antepartum stillbirths and three at CWFT. There are no immediate clinical concerns to escalate. All trusts undertake ongoing detailed review and analysis of stillbirths via PMRT, investigate any issues found and share findings with the LMNS serious incident oversight group to address common themes. All trusts are compliant with care and safety bundles targeted towards reducing perinatal mortality rates.

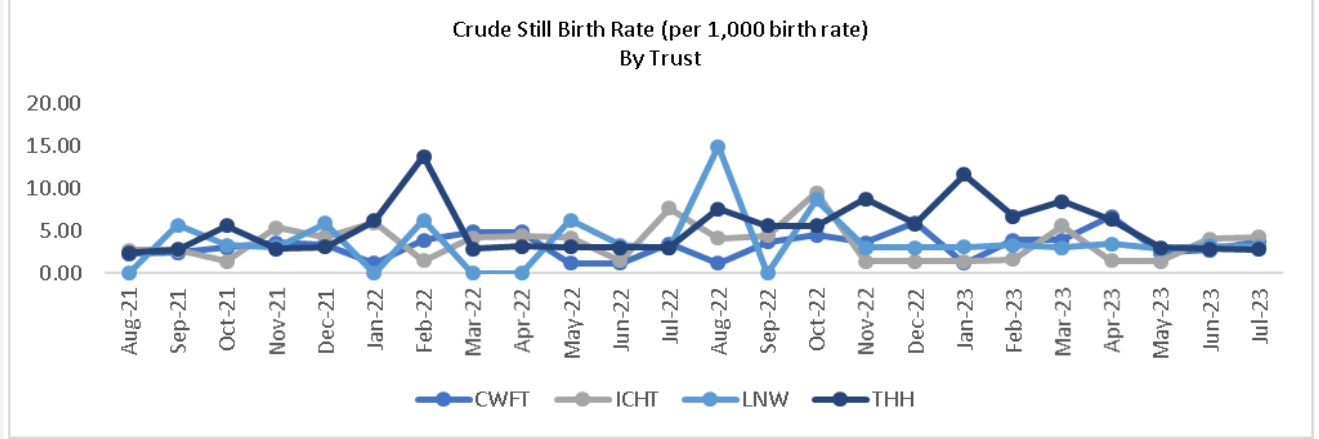
Improvements: The complex needs midwifery team at THH are expanding their capacity and working with different organisations (local authorities and hotels) to identify pregnant birthing women and people in this high-risk group and to encourage earlier access to the maternity services and antenatal care. 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. ICHT continue to work in collaboration with the Neonatal Teams to improve counselling to all birthing women and people booked and transferred in-utero for level 3 neonatal services with an increased focus on clearly documented personalised care and support plans and risk assessments. CWFT working towards optimising AN continuity and are in the process of extending the length of AN appointment.

Forecast Risks: As per 2019 'halve it ambition' trajectories for 23/24 reduce from 3.3 to 3.1. 22/23 year-end performance was at 4.11. Therefore, there is a risk that the ambition will not be realised. LMNS board to review monthly as priority via Pillar1.

CURRENT PERFORMANCE

	Total Births	Total Still Births	Crude Still Birth Rate	Crude Still Birth Rate YTD	Difference from Standard
CWFT	792	3	3.8	4.22	0.49
ICHT	703	3	4.3	2.82	0.97
LNW	313	1	3.2	3.16	
THH	358	1	2.8	3.70	
APC	2166	8	3.7	3.51	0.39

STRATIFICATION

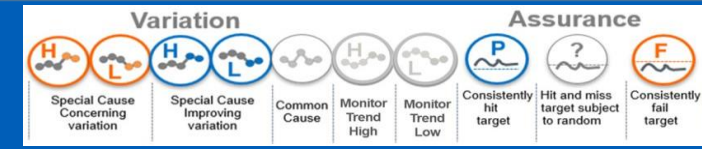


GOVERNANCE

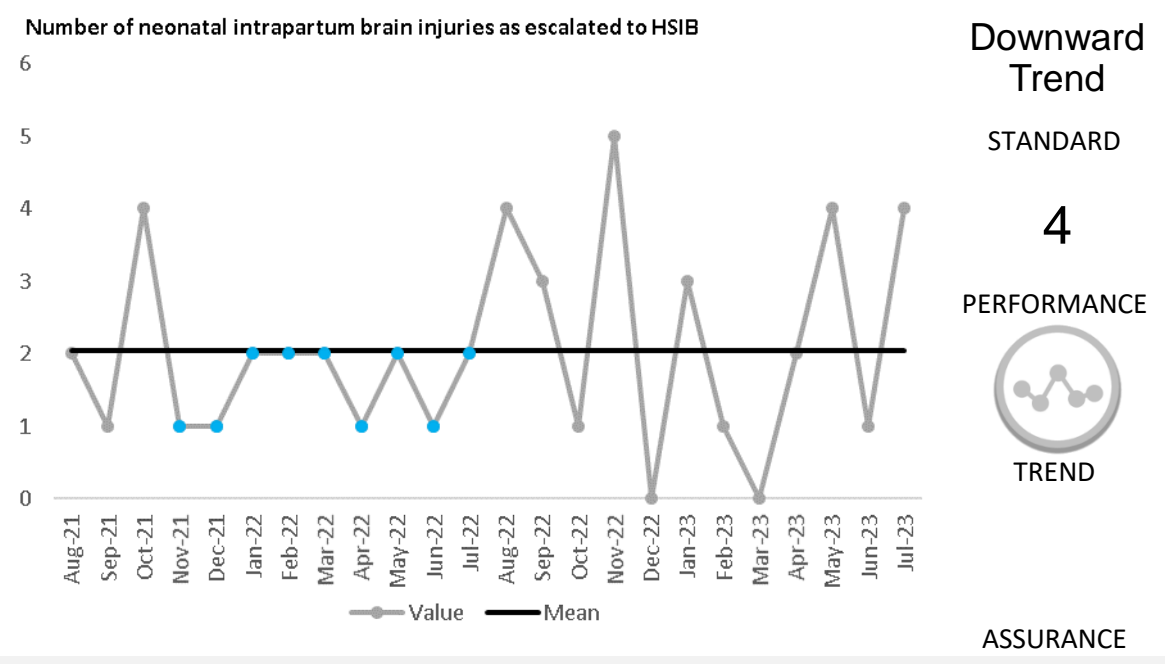
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

(Maternity) Neonatal intrapartum brain injuries (suspected)



TREND



NARRATIVE

Performance: There were four cases of suspected intrapartum brain injury in NWL in July, three of which occurred at ICHT. 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: The 11 cases to date will be reviewed by HSIB and the APC will undertake a themed analysis of the recommendations to identify and share any learning.

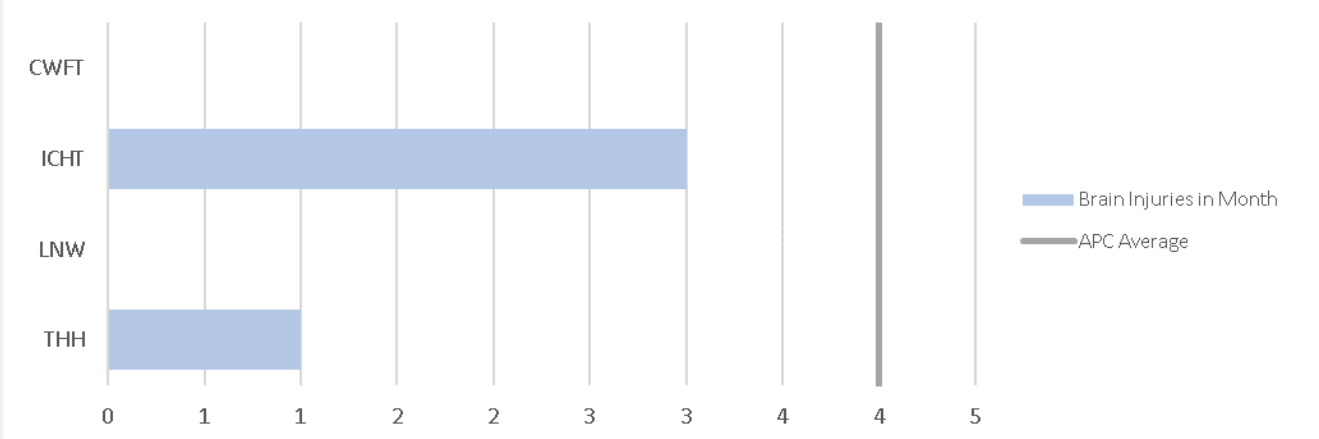
Improvements: MDT staff training in fetal well-being, human factors training, establishment of safety champions are interventions that will contribute to ongoing improvements in this domain.

Forecast Risks: None identified. 23/24 data will be presented highlighting any early notifications of concerns received in any NWL acute provider.

CURRENT PERFORMANCE

	Total Births	Brain Injuries in Month	Brain Injuries YTD	Early Notifications of Concern YTD
CWFT	792	0	2	
ICHT	703	3	7	
LNW	313	0	0	
THH	358	1	2	
APC	2166	4	11	

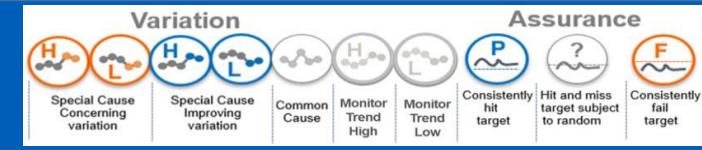
STRATIFICATION



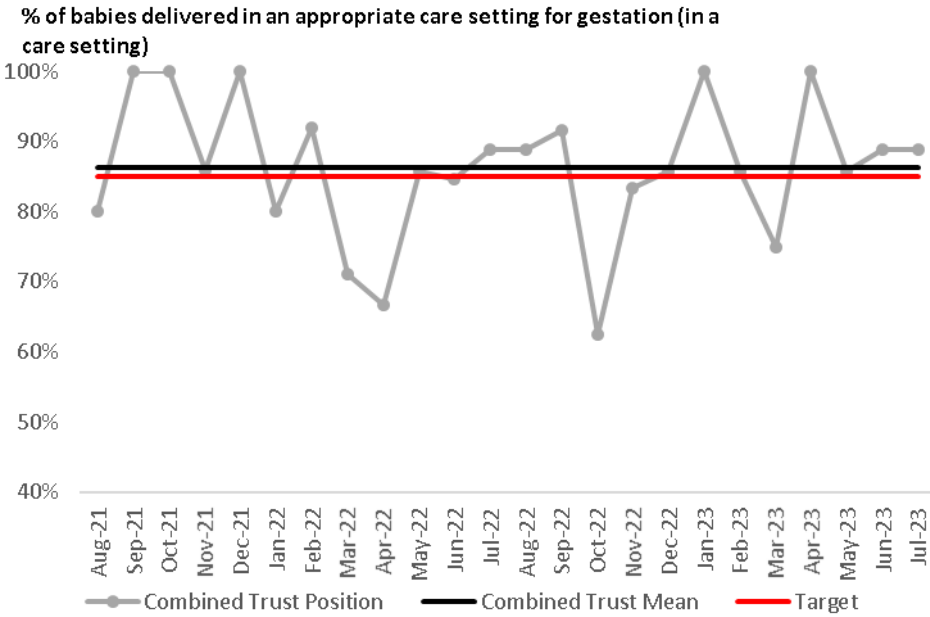
GOVERNANCE

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

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



TREND



>85%

STANDARD

89%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: The APC has met the target for this metric in July 2023.

Recovery Plan: N/A

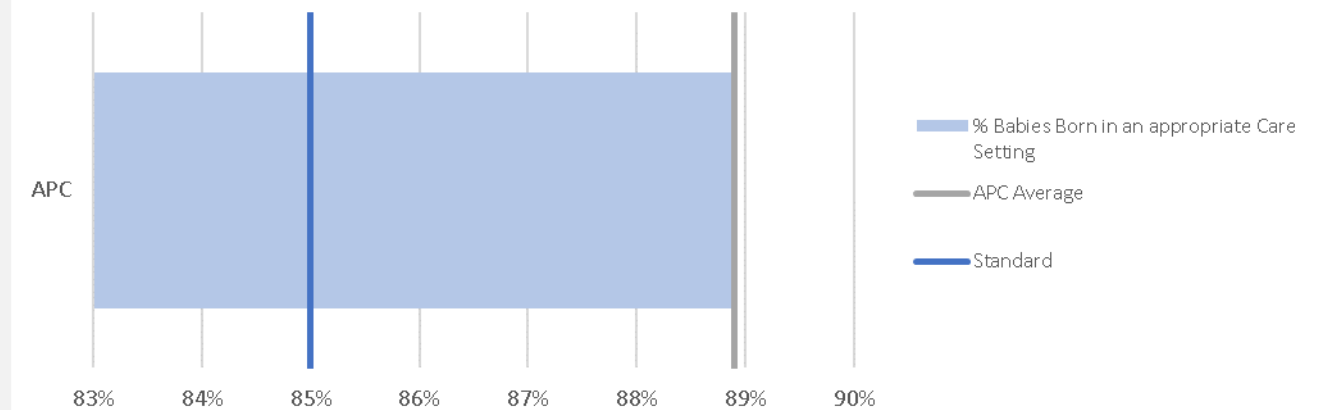
Improvements: Pan London IUT guidelines to launch in October 2023. LMNS is working with the ICB and London region to identify barriers to implementation of new protocol including training needs. Mapping of NWL maternity bed and neonatal cot capacity and escalation management is underway.

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

CURRENT PERFORMANCE

	% Babies Born in an appropriate Care Setting	Number of Babies Born in an Inappropriate Care Setting / Number of Babies of that Gestation In Month	Babies Born in an Inappropriate Care Setting / Number of Babies of that Gestation YTD
CWFT	100%	0 / 1	0 / 14
ICHT	100%	0 / 7	0 / 24
LNW	-	0 / 0	1 / 1
THH	0%	1 / 1	3 / 3
APC	89%	1 / 9	4 / 42

STRATIFICATION

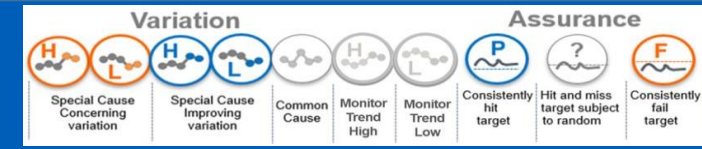


GOVERNANCE

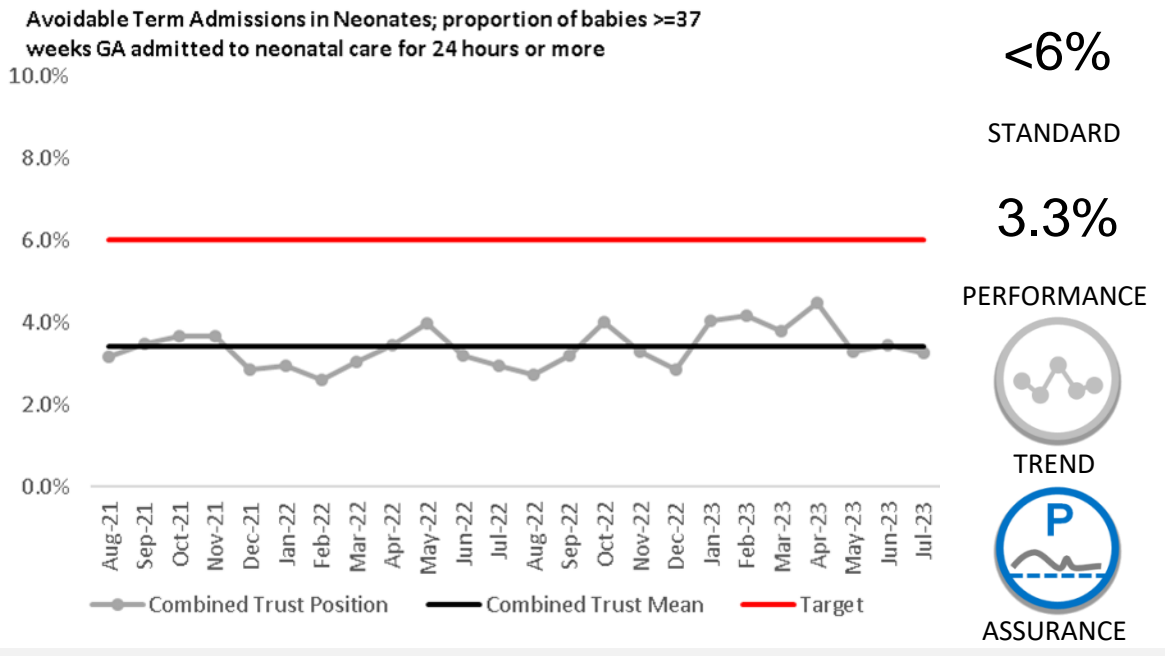
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

(Maternity) Avoidable Term Admissions in Neonates



TREND



NARRATIVE

Performance: In June, NWL had 3% avoidable term admissions to neonatal units (ATAIN) which is well below the 6% national target. All APC maternity units have transitional care units and ongoing quality improvement projects to maintain best practice.

Recovery Plan: N/A

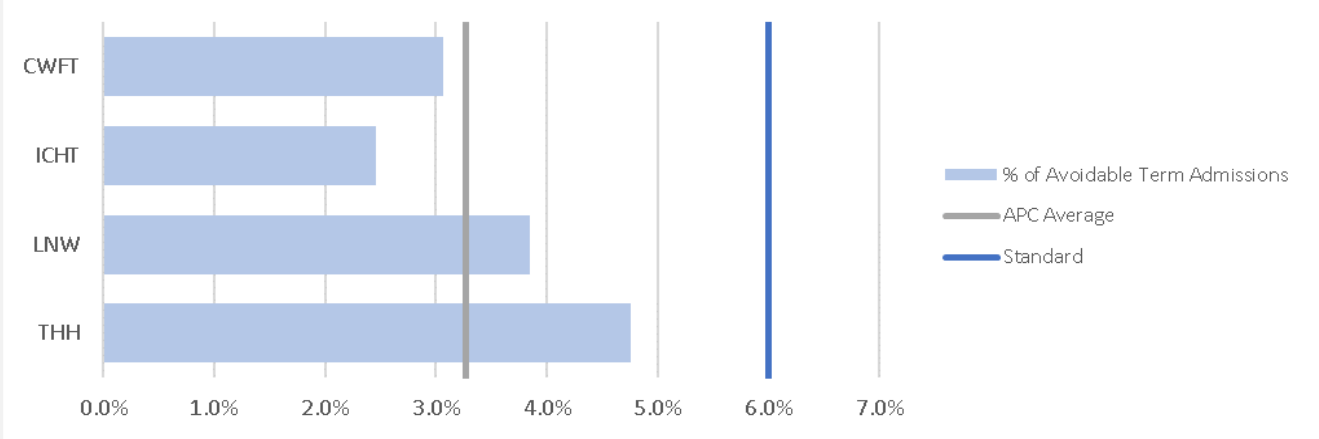
Improvements: Neonatal units co-producing standardised ATAIN and Transitional care audits to facilitate benchmarking and trend analysis across the sector to reduce separation of mother and baby. Findings reported to and discussed in LMNS board quarterly.

Forecast Risks: None identified

CURRENT PERFORMANCE

	Number of Avoidable Term Admissions	Number of Avoidable Term Admissions YTD	% of Avoidable Term Admissions	Difference from Threshold
CWFT	24	106	3.1%	
ICTH	17	86	2.5%	
LNW	12	46	3.8%	
THH	17	67	4.8%	
APC	70	305	3.3%	

STRATIFICATION

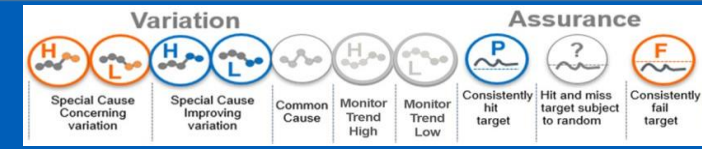


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

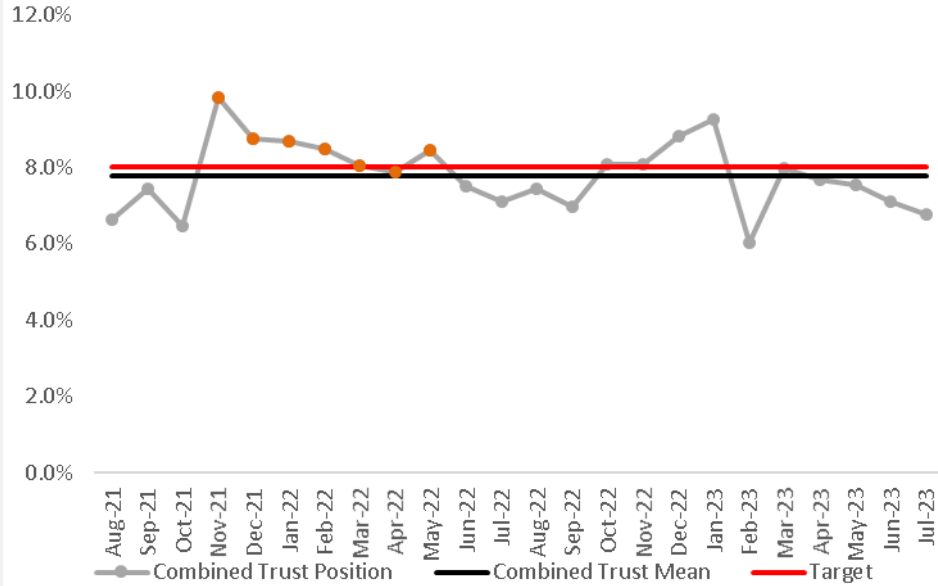
Committee: Acute provider collaborative executive management board

(Maternity) Preterm Births



TREND

Pre-term Birth Rate



8%

STANDARD

6.8%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: In July, NWL had a pre-term birth rate of 6.8% which is below the target. There has been an overall decrease over the last four months. There was a slight increase in the pre-term birth rate at WM in May and June, however the rate reduced in July to 6%.

Recovery Plan: N/A.

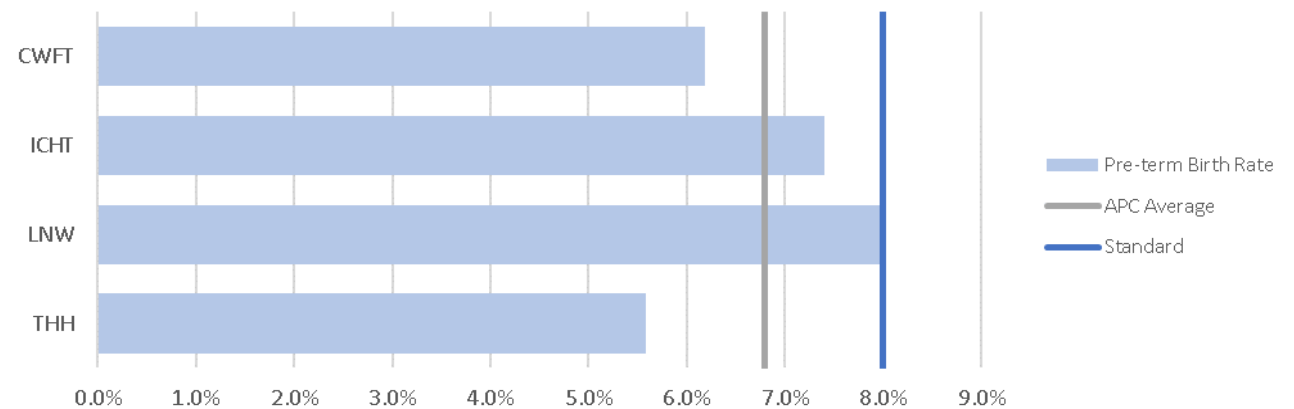
Improvements: The team will follow up the results of any investigation and work closely with the ATAIN team.

Forecast Risks: No risks identified.

CURRENT PERFORMANCE

	Number of Pre-Term Births	Total Births	Pre-term Birth Rate	Difference from Threshold
CWFT	49	792	6.2%	
ICTH	52	703	7.4%	
LNW	25	313	8.0%	
THH	20	358	5.6%	
APC	146	2166	6.8%	

STRATIFICATION

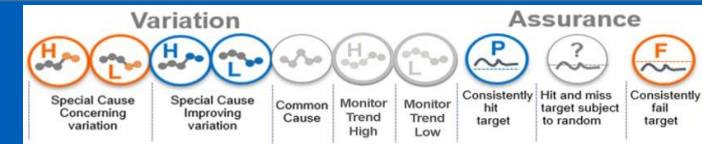


GOVERNANCE

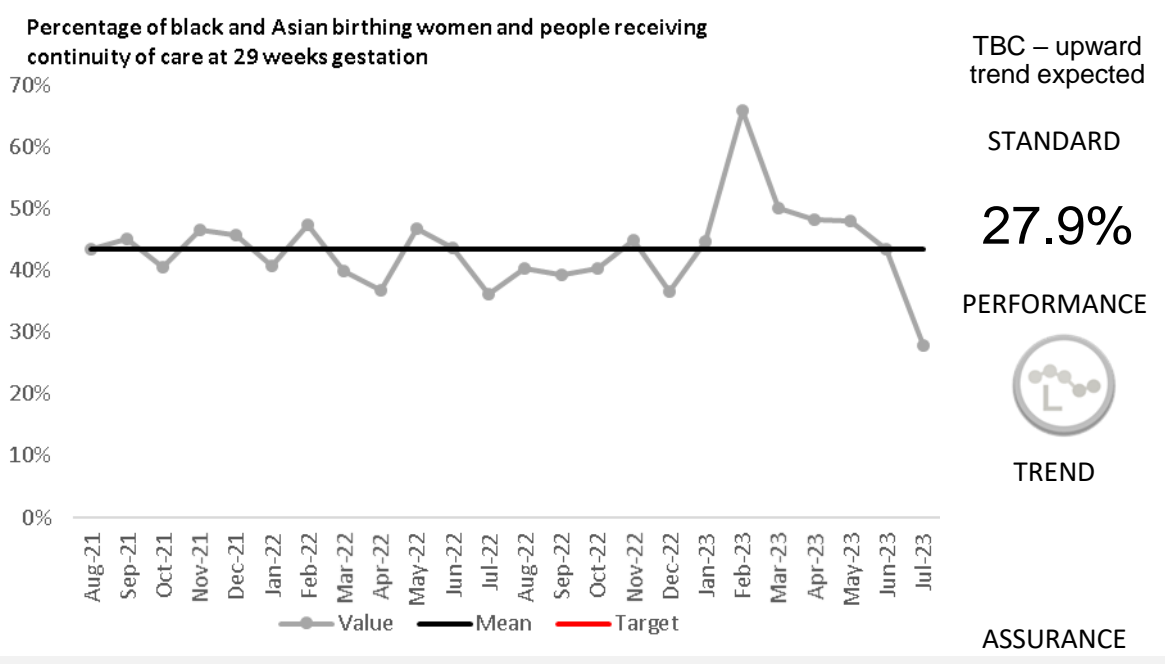
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

(Maternity) BAME Maternity Continuity of Care (MCoC)



TREND



NARRATIVE

Performance: In July, there was a significant reduction in the percentage of BAME birthing women and people receiving continuity of care at 29 weeks gestation at APC level (N.B. data is not available for LNW – CoC pathways remain suspended at LNW due to the vacancy position and need to prioritise safe staffing in clinical areas). The percentage at ICHT was 50.5%, 24.9% at THH and 11.4% at CWFT.

Recovery Plan: All services are working to improve their vacancy rates through local and international recruitment (this is the first building block before further MCoC teams can be implemented). Once achieved the next step will be to engage with the workforce (second building block).

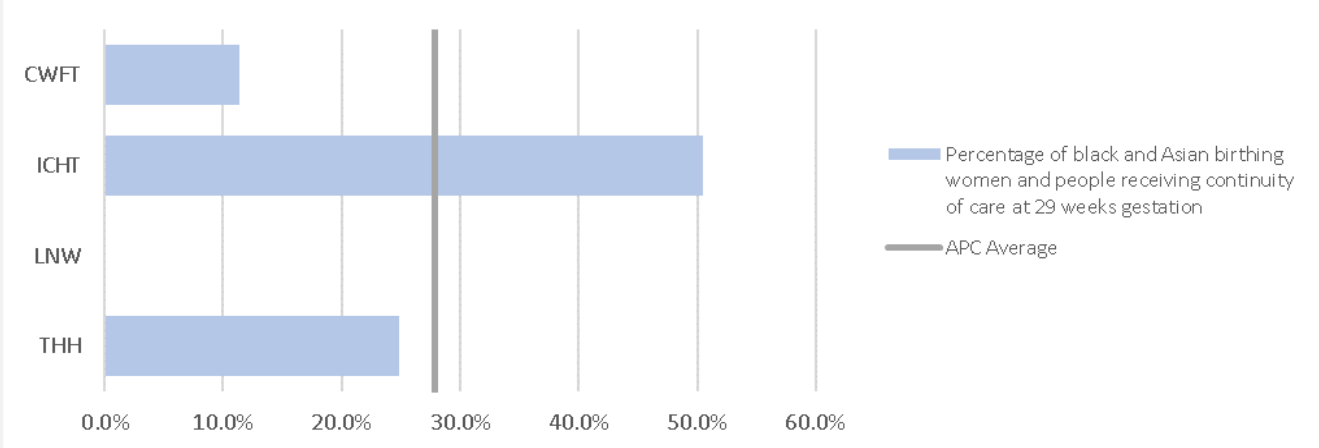
Improvements: In addition to local recruitment and the yearly pipeline of NQM's, NWL maternity providers are working with Capital Midwife to plan bespoke international recruitment.

Forecast Risks: There is a risk that maternity services in NWL will take a significant period of time to reach a vacancy rate that support implementation of further teams and a further risk that midwives may not want to work in MCoC models

CURRENT PERFORMANCE

	Number of birthing women and people marked as being on a CoC pathway and have a named lead midwife as part of care plan	Total number of birthing women and people who reach 29 weeks gestation	Percentage of black and Asian birthing women and people receiving continuity of care at 29 weeks gestation
CWFT	54	473	11.4%
ICHT	190	376	50.5%
LNW	-	-	-
THH	58	233	24.9%
APC	302	1082	27.9%

STRATIFICATION

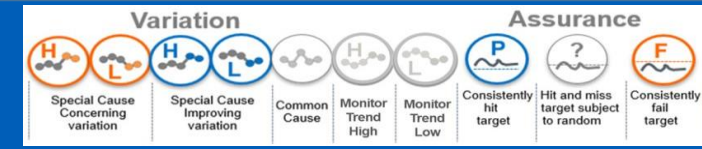


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

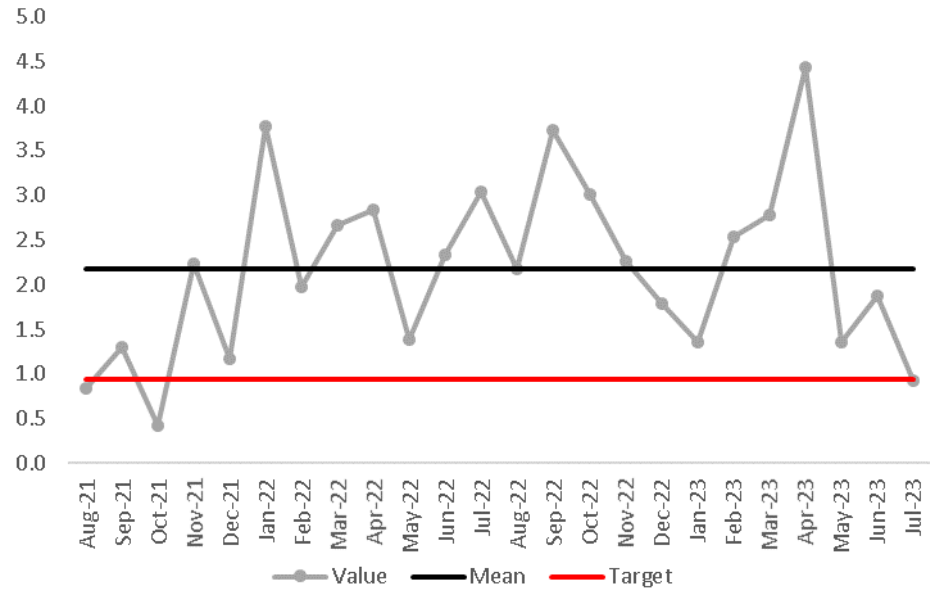
Committee: Acute provider collaborative executive management board

(Maternity) Neonatal Crude Deaths



TREND

Crude neonatal death rate (per 1000 birth rate)



0.94

STANDARD

0.92

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: The crude neonatal death rate at APC level was below target in July for the first time since October 2021. In July, there were 2 neonatal deaths, one at CWFT and one at ICHT. Both cases are being investigated.

Recovery Plan: N/A

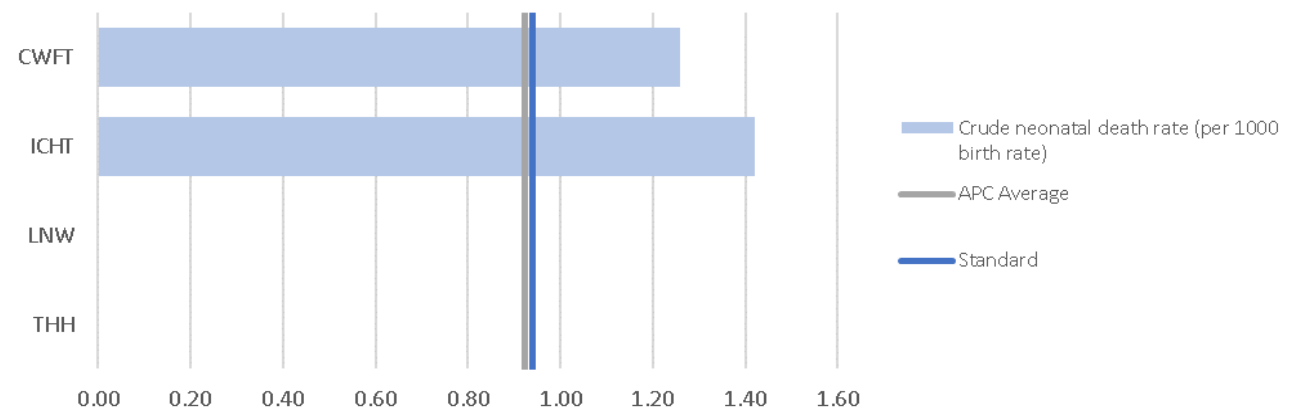
Improvements: The Neonatal CRG and the Trust teams will continue to monitor any new cases.

Forecast Risks: None identified.

CURRENT PERFORMANCE

	Number of Neonatal Deaths	Total Births	Crude neonatal death rate (per 1000 birth rate)	Difference from Threshold
CWFT	1	792	1.26	0.32
ICTH	1	703	1.42	0.48
LNW	0	313	0.00	
THH	0	358	0.00	
APC	2	2166	0.92	

STRATIFICATION

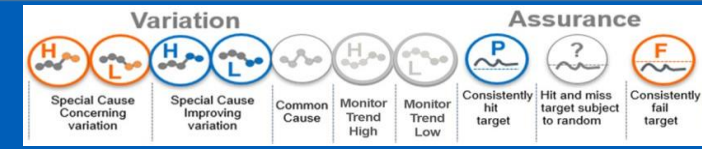


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

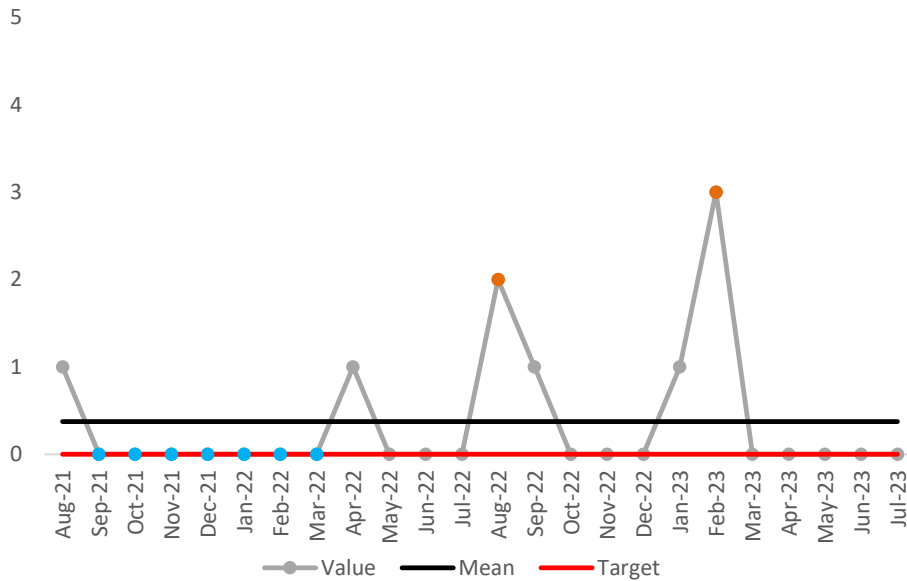
Committee: Acute provider collaborative executive management board

(Maternity) Maternal Deaths



TREND

Maternal Deaths



0
STANDARD

0
PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: In July 2023, there were no maternal deaths reported by APC trusts. There have been none so far this financial year.

Recovery Plan: N/A

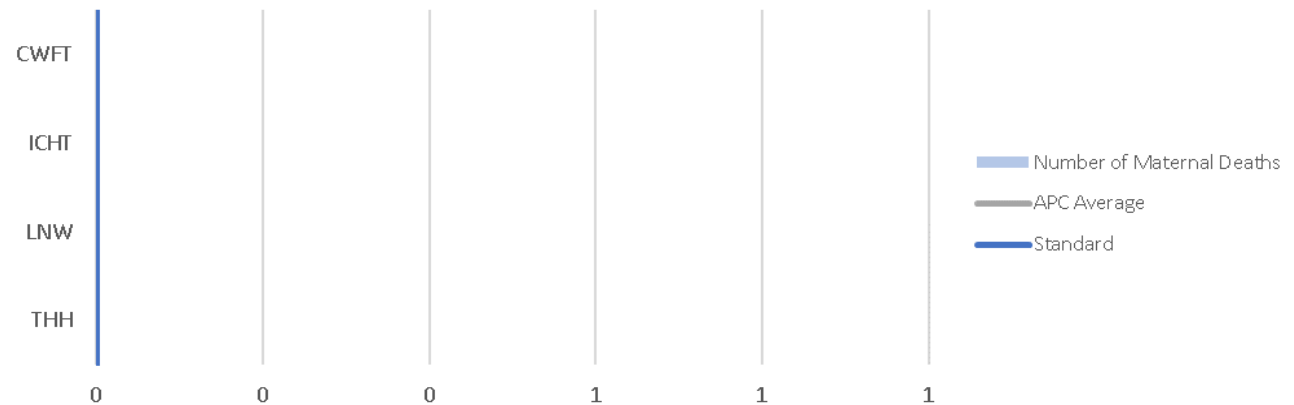
Improvements: N/A

Forecast Risks: No current risks.

CURRENT PERFORMANCE

	Number of Maternal Deaths	Total Births	Difference from Threshold
CWFT	0	792	
ICHT	0	703	
LNW	0	313	
THH	0	358	
APC	0	2166	

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

Operational Performance

Introduction:

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

Performance:

- Key metrics across UEC are mostly stable with a deterioration in patients staying over 12 hours in the emergency departments.
- Strike action is now impacting long waiting patients, but activity overall is still increasing, with all sites driving to do as many elective patients as they can as winter approaches. This includes continuing to improve productivity especially in Outpatients and Theatres.
- Diagnostics performance is statistically stable but remains fragile especially in Audiology and Non-obstetric ultrasound.

Some metrics were not available for this report for LNWUH due to the change over to Cerner and prioritising national reporting.

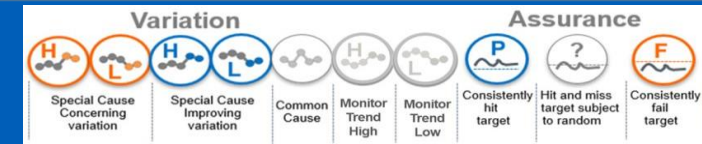
Key Actions:

- Continued focussed work on Discharge and UEC actions following peer reviews.
- Work on discharge metrics in the pack needs to be delivered post Cerner 'go lives'.
- Peer review has now started on Paediatric ED

Escalations:

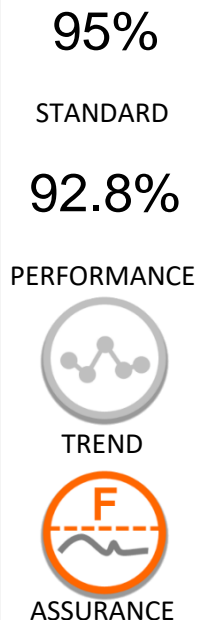
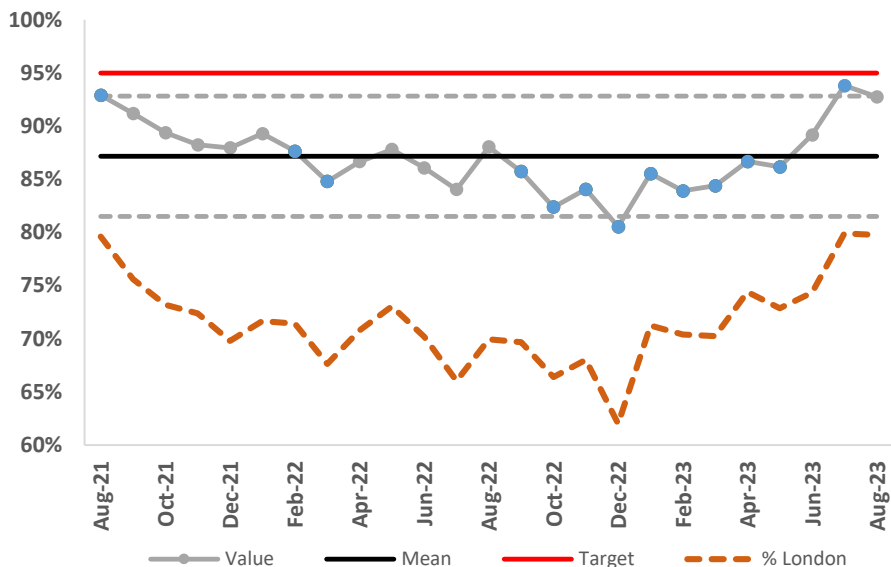
On-going Industrial action is high risk for all domains of performance.

Operations Ambulance Handover Waits



TREND

30 mins Breach Performance (LAS)

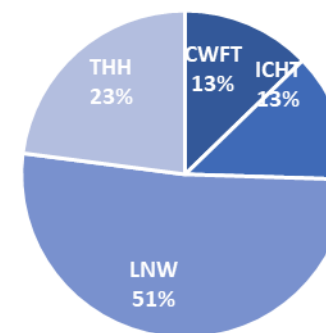


CURRENT PERFORMANCE

LAS Handover Waits within the thirty minute standard Aug-23

	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	3728	96.7%		124	0	1529	166
ICHT	2838	95.6%		124	0	966	119
LNW	4822	89.6%	-5.4%	501	19	1607	617
THH	2031	89.0%	-6.0%	223	5	820	149
APC	13419	92.8%	-2.2%	972	24	4922	1050

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: NWL has the best handover performance across London and on average in July 23, handover times were 10 minutes quicker in NWL than the average for the rest of London. NWL has the lowest average number of handovers over 15 minutes, with only 40% of handovers exceeding 15 minutes compared to 61% across London. NWL also achieved the lowest average number of handovers over 30 and 60 minutes, despite receiving the highest number of conveyances in London (27% of the total) and an increasing number of conveyances.

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

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

Forecast risks: Continued increases in the number of conveyances and industrial action

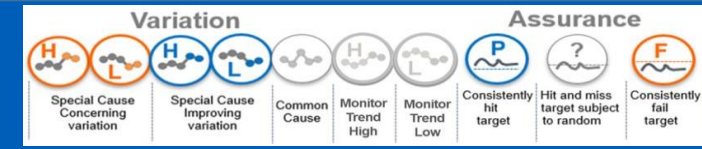
GOVERNANCE

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

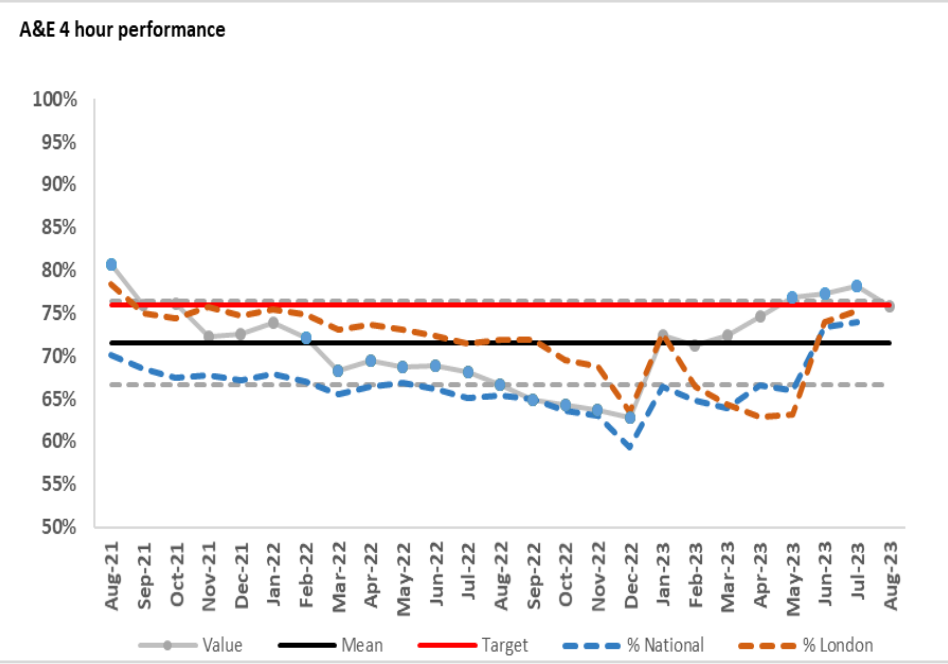
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL UEC Board (Chair: Claire Hook)

Data Assurance: These figures are provided by LAS

Operations Urgent & Emergency Department Waits



TREND



CURRENT PERFORMANCE

Time spend in Emergency Department: 4-Hour Standard Aug-23

	Total attendances (All Types)	4 hour Performance	Difference from target	4 hour + delays (All Types)	Of which (Number and Performance)			Impacted by Referrals to SDEC	
					Type 1 / 2 breaches	Type 3 breaches			
CWFT	25664	82.7%		4449	4424	74.6%	25	99.7%	1086
ICHT	22901	76.7%		5331	5262	67.2%	69	99.0%	4243
LNW	24935	70.9%	-5.1%	7259	6896	42.4%	363	97.2%	0
THH	11300	69.6%	-6.4%	3433	3352	39.5%	81	98.6%	1225
APC	84800	75.9%	-0.1%	20472	19934	60.9%	538	98.4%	6554

NARRATIVE

Performance: CWFT and ICHT achieved the 76% standard. Performance at LNW was challenged in August by the implementation of Cerner. THH has an improvement trajectory in place.

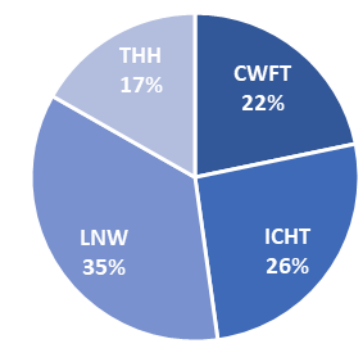
Recovery plan: A range of measures have been identified at each site to further improve performance and maintain safe levels of care, including expanding frailty and same day emergency care services. The peer review of paediatric emergency care has concluded.

Improvements: All EDs have completed a self-assessment to measure progress against the Patient First and FOCUSED best practice standards to inform further improvement.

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

*LNW SDEC data unavailable due to Cerner go-live

STRATIFICATION

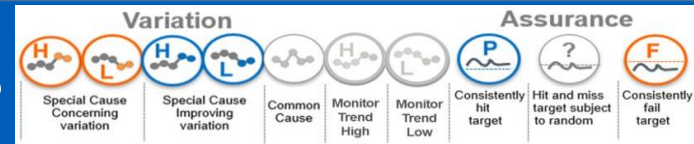


Trust share of APC waits longer than standard

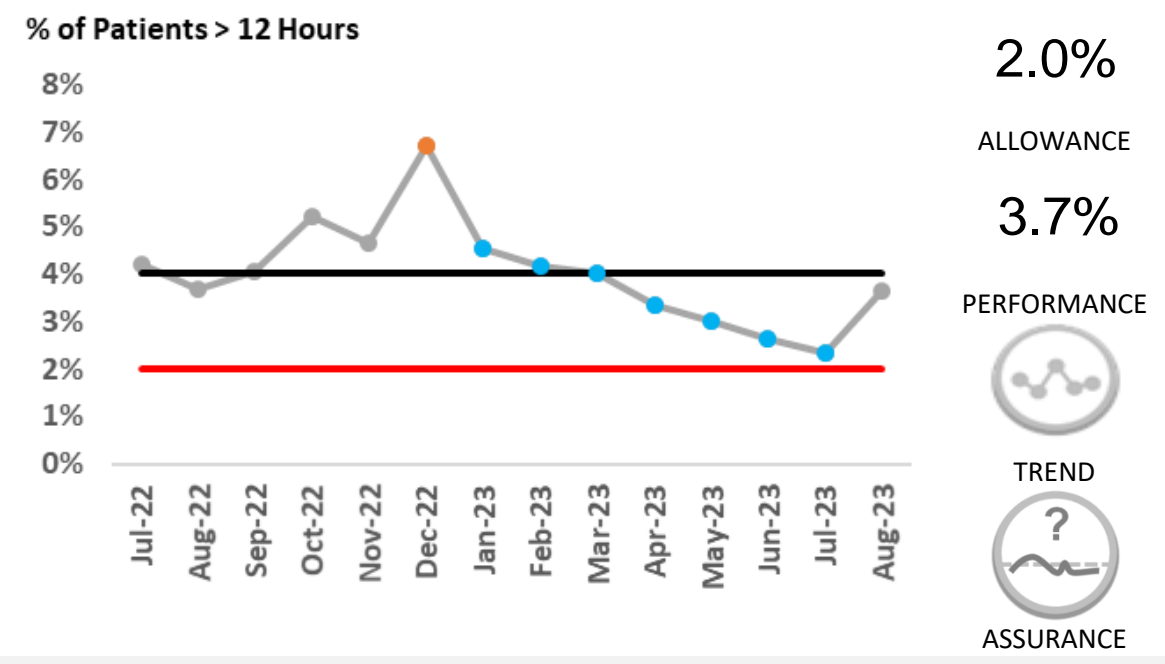
GOVERNANCE

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

Operations Urgent & Emergency Department Long Waits



TREND



NARRATIVE

Performance: Long waits in the ED are linked to flow through the hospital as well as those waiting for beds outside the hospital. Performance has improved since December 2022 but remains a key focus with LNW and THH performance deteriorating un August. All sites have plans to open additional bed capacity over winter.

Recovery plan: As with 4-hour performance, each site has identified a range of actions to further improve performance and maintain safe levels of care.

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

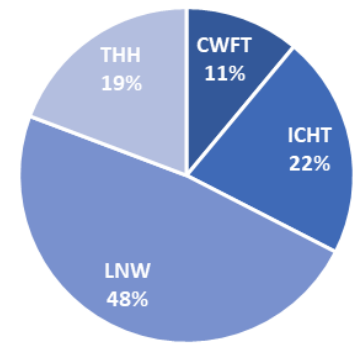
Forecast risks: Increases in demand, continued delays with discharge for medically optimised patients, continued delays for patients waiting for admission to mental health beds, industrial action.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 12-Hour waits Aug-23

	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	25664	1.3%		343	343	0	46
ICTH	22901	2.9%	-0.9%	664	664	0	71
LNW	24935	6.0%	-4.0%	1493	1493	0	253
THH	11300	5.3%	-3.3%	596	596	0	21
APC	84800	3.7%	-1.7%	3096	3096	0	391

STRATIFICATION



Trust share of APC waits longer than standard

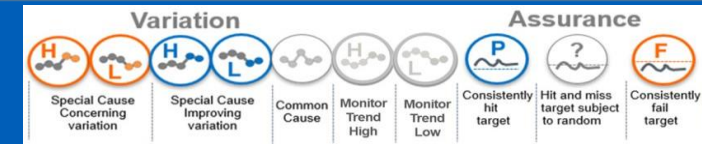
GOVERNANCE

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

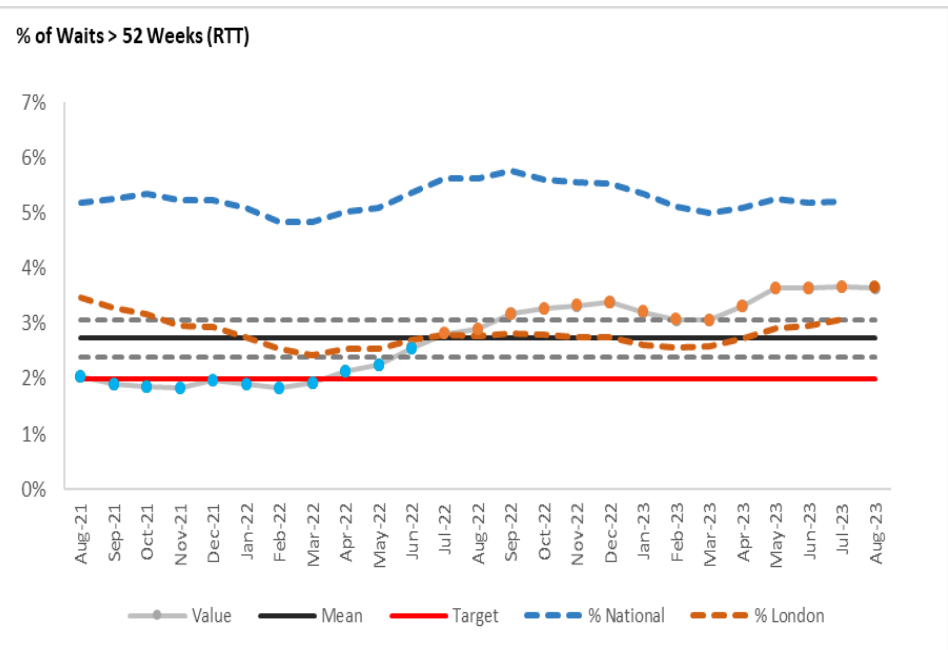
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL UEC Board (Chair: Claire Hook);

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

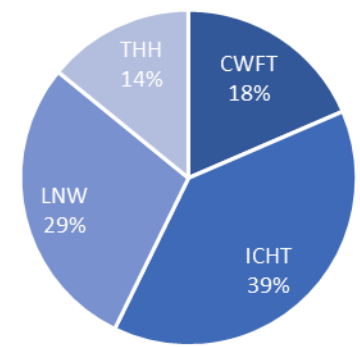


CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 18-Week Standard Aug-23

	Total Waiting List	Waits > 52 weeks	Difference from target	52 + weeks	Of which		Impacted by OTDCs not booked < 28 days	Impacts on Average wait (weeks)
					78 + weeks	104 + weeks		
CWFT	58626	3.2%	-1.2%	1855	76	0	11	17.39
ICHT	106192	3.7%	-1.7%	3878	22	0	0	19.41
LNW	80380	3.6%	-1.6%	2868	32	0	0	19.18
THH	29020	4.9%	-2.9%	1415	2	0	1	20.14
APC	274218	3.7%	-1.7%	10016	132	0	12	18.99

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

NWL's total PTL saw a marginal increase in August. Pathways over 52 weeks increased across all providers except THH. There was also an increase in 78 weeks pathways with no 104 weeks waiters reported in the sector.

NWL's most challenged specialities with backlogs included Vascular (CWFT), Neurology (ICHT), ENT (THH) and Gynaecology (LNW). ICHT's Allergy Service has achieved a significant backlog reduction since early 2023.

Key risks to delivering further backlog reduction include further industrial action.

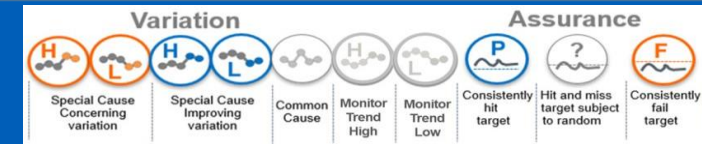
GOVERNANCE

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);

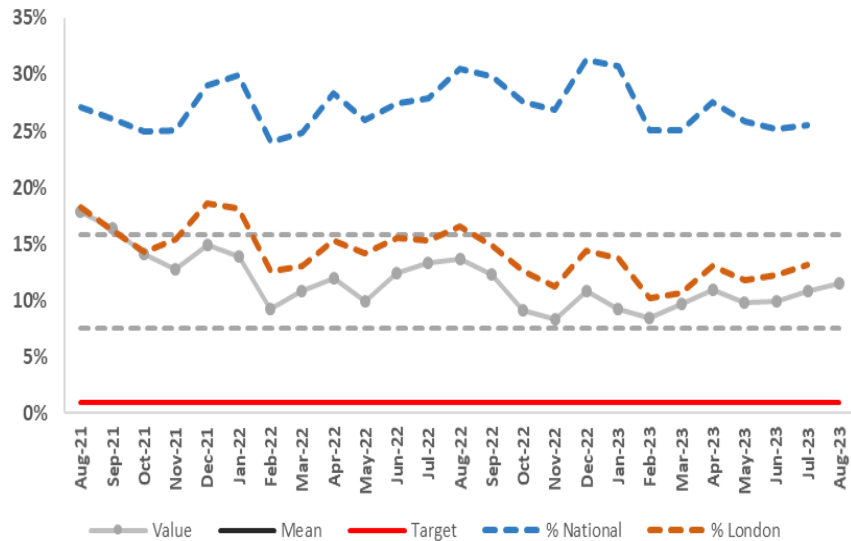
Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

Operations Access to Diagnostics



TREND

% of Breaches > 6 Weeks (Diagnostics)



1.0%

ALLOWANCE

11.5%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: The performance remains stable.

Recovery Plan: Capacity at all sites continues to be increased where possible, particular focus remains on non-obstetrics ultrasound at THH; CT recovery post new scanner at ICHT and Audiology at LNW.

Improvements: All sites alongside elective recovery are seeing increased demand.

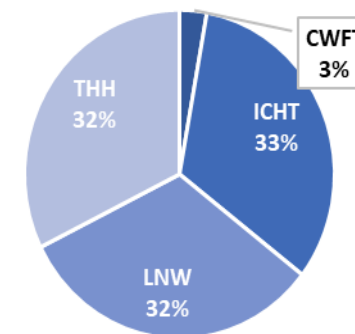
Forecast Risks: Likely significant industrial action.

CURRENT PERFORMANCE

Waits for Diagnostic Tests: 6-Week Standard Aug-23

	Total Waiting List	Waits > 6 weeks	Difference from target	6 + weeks	Of which 13 + weeks
CWFT	8258	1.5%	-0.5%	124	21
ICHT	12711	11.3%	-10.3%	1431	386
LNW	10843	13.0%	-12.0%	1412	212
THH	6162	23.0%	-22.0%	1416	475
APC	37974	11.5%	-10.5%	4383	1094

STRATIFICATION



Trust share of APC waits longer than standard

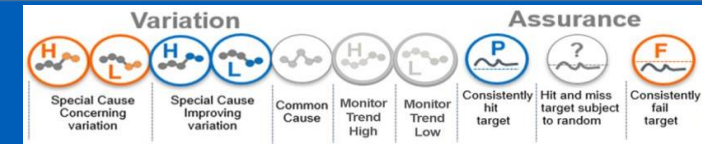
GOVERNANCE

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

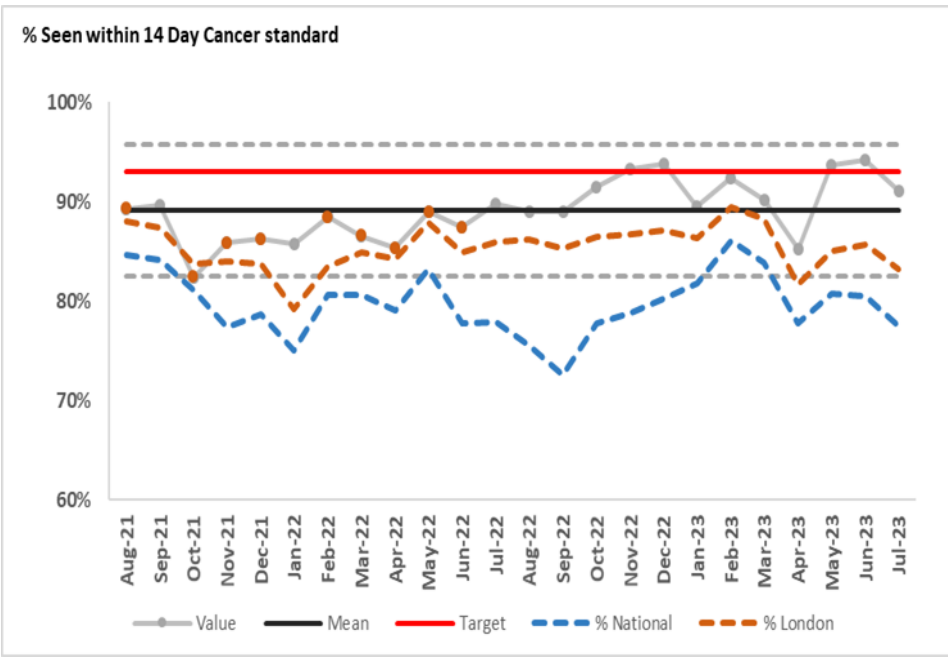
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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



TREND



93%
STANDARD

91.1%
PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: 2WW performance standard has been met overall with two organisations not meeting, mainly due to challenges seen in Dermatology and Gynaecology.

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

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

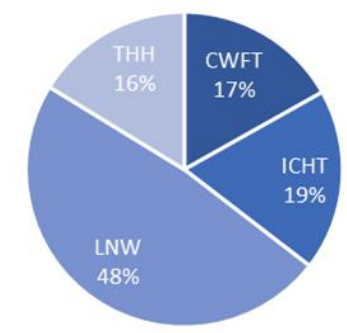
Forecast Risks: Ongoing planning remains crucial to mitigate risks and potential capacity loss resulting from Industrial Actions, which could lead to workforce challenges. Additional risk is the implementation of Cerner at LNW and planned at THH which will impact capacity and visibility of cancer patients on active pathways. Position likely to deteriorate in August.

CURRENT PERFORMANCE

Wait to be Seen by a Cancer Specialist following an urgent GP Referral: Two Week Wait Standard Jul-23

	Total Seen	Two-week wait performance	Difference from target	14 + days	Of which	
					28 + days	Breast referrals
CWFT	2729	94.9%	2.9%	139	6	98
ICHT	2551	94.0%	2.0%	154	0	87
LNW	2801	85.8%	-6.2%	399	27	199
THH	1190	88.7%	-3.3%	134	31	69
APC	9271	91.1%	-0.9%	826	64	453

STRATIFICATION



Trust share of APC waits longer than standard

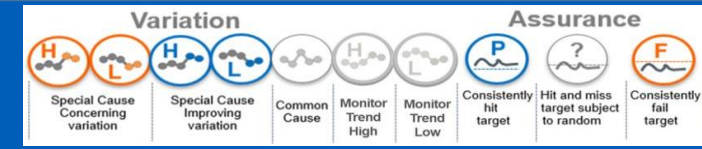
GOVERNANCE

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

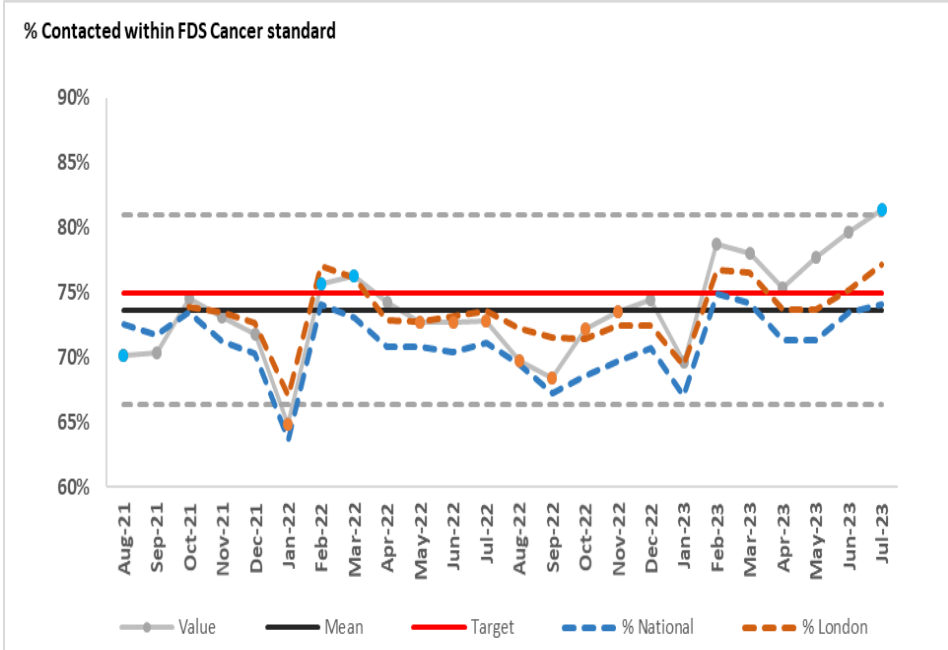
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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)



TREND



75%
STANDARD

81.4%
PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: NWL has met the FDS cancer standard for the fifth month consecutively, despite a very challenged month operationally due to strike action

Recovery Plan: July performance exceeds the target.

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

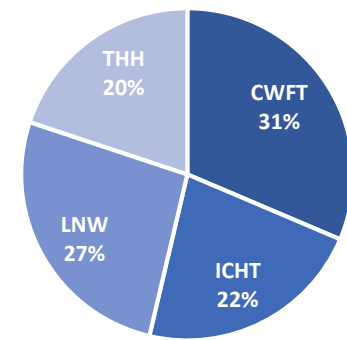
Forecast Risks: Continued planning of capacity for scheduled industrial action to protect cancer pathways as much as possible. Cerner implementation is a risk for tracking patients in a timely and proactive way through the diagnostic pathways.

CURRENT PERFORMANCE

Access to Cancer Care (Faster Diagnosis) Jul-23

	Total Contacts	Faster Diagnosis performance	Difference from target	28 + days	Of which 62 + days
CWFT	2684	80.3%		530	103
ICHT	2431	84.5%		376	0
LNW	2917	84.7%		446	62
THH	1059	68.3%	-6.7%	336	67
APC	9091	81.4%		1688	232

STRATIFICATION



Trust share of APC waits longer than standard

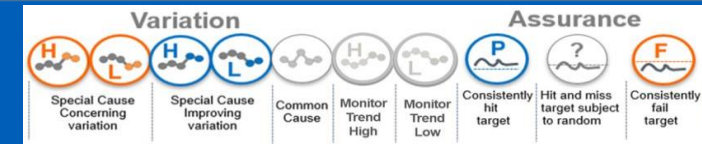
GOVERNANCE

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

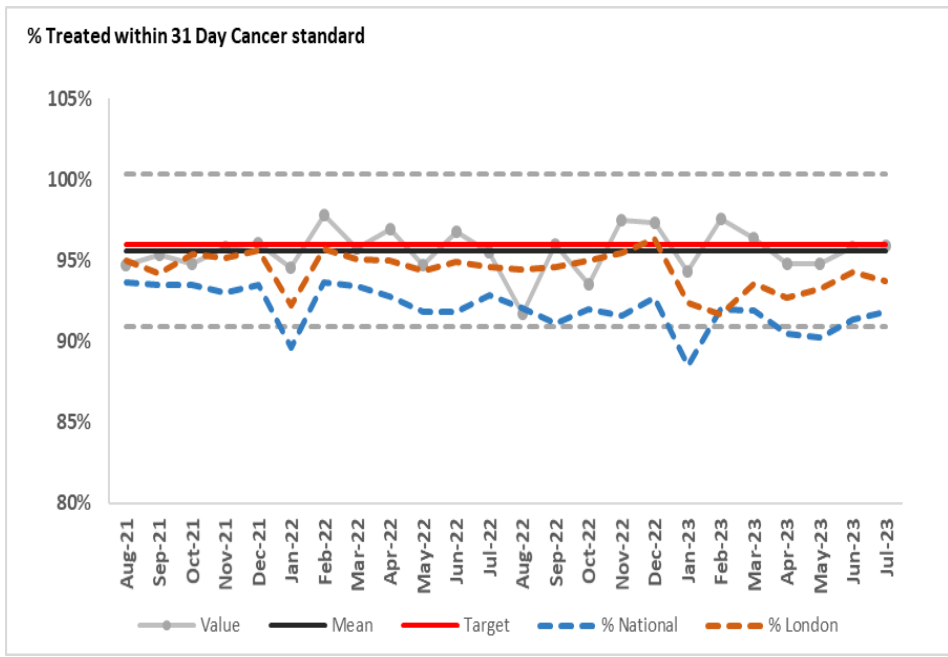
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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



TREND



96%
STANDARD

95.9%
PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: The rise in referral rates has resulted in a notable increase in cancer treatments. However, the planned capacity to meet this heightened demand has been affected by industrial action and annual leave planning over the summer, leading to a reduction in available resources. The impact of these challenges has been particularly noticeable in one Trust.

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

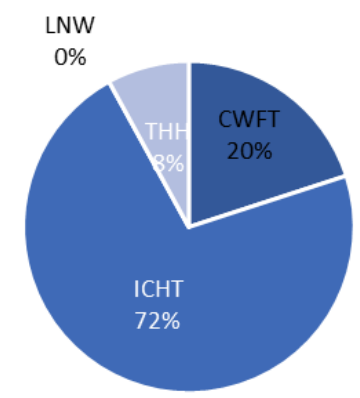
Improvements: Maintaining oversight and planning ahead of time for treatment pathways.

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

CURRENT PERFORMANCE

	Total Treated	31 day performance	Difference from target	31 + days	Of which 62 + days
CWFT	132	96.2%		5	0
ICHT	247	92.7%	-3.3%	18	0
LNW	146	100.0%		0	0
THH	88	97.7%		2	1
APC	613	95.9%	-0.1%	25	1

STRATIFICATION

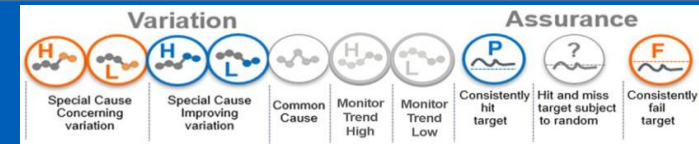


Trust share of APC waits longer than standard

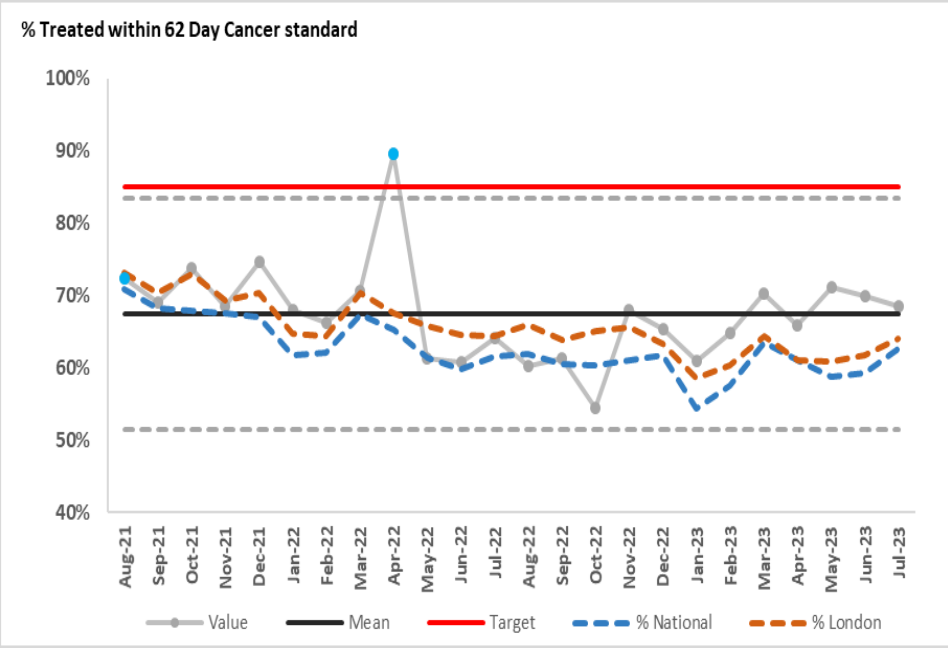
GOVERNANCE

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



TREND



CURRENT PERFORMANCE

Unacceptable Waits for the Treatment of Cancer: 62-day Standard Jul-23

	Total Treated	62 day performance	Difference from target	62 + days	Of which 104 + days	Impacts on Backlog 104 + days
CWFT	87	71.3%	-13.7%	25	8	25
ICHT	100.5	62.2%	-22.8%	38	0	51
LNW	96	70.3%	-14.7%	28.5	8	41
THH	61	72.1%	-12.9%	17	6	5
APC	344.5	68.5%	-16.5%	108.5	22	122

NARRATIVE

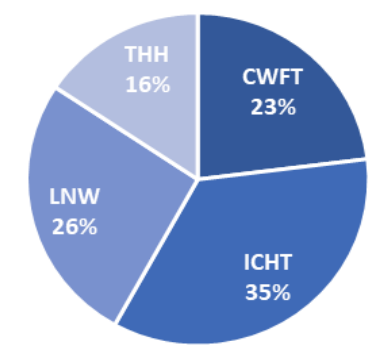
Performance: Performance against the 62-day standard remains challenged across NWL. There are system wide pressures that are contributing to this including delays in inter-trust transfers and capacity constraints for treatment pathways due to strikes and holidays.

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

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

Forecast Risks: Workforce pressures and the potential for continued periods of Industrial Action.

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

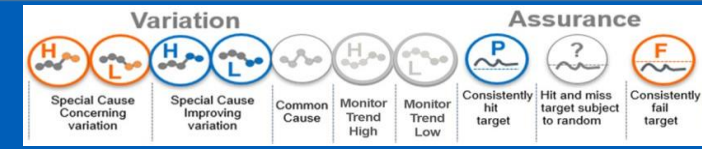
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

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

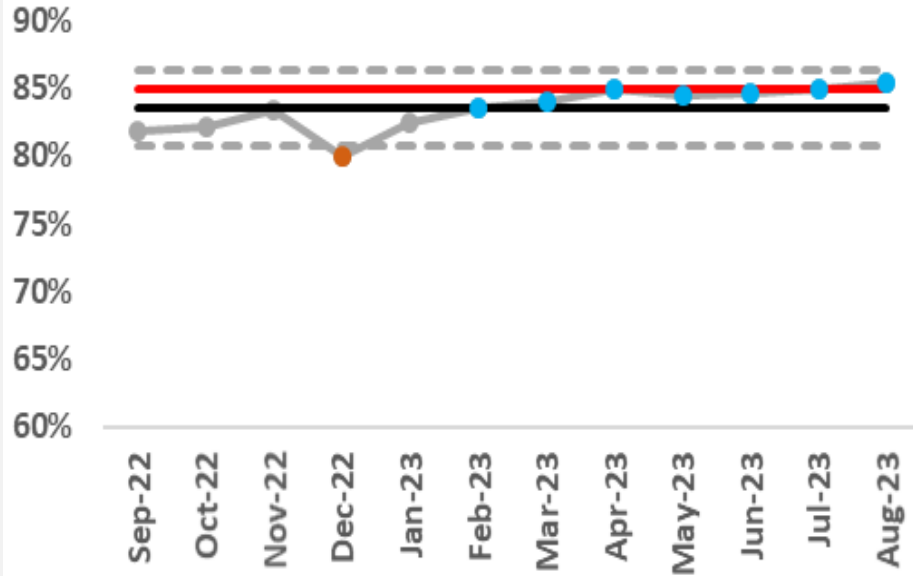
Demand and Capacity Measures

Operations Theatre Utilisation (Uncapped)



TREND

Theatre Utilisation



85%

STANDARD

85.5%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Theatre utilisation maintained an improvement trajectory since December. NWL currently has the highest rate in London. CWFT and THH are the strongest performers in the sector, whilst ICHT, though improving, remains marginally below the National target. ICHT's new timetable has gone live at SMH and HH and Western Eye theatres have now reopened. All are expected to drive further improvements at ICHT.

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.

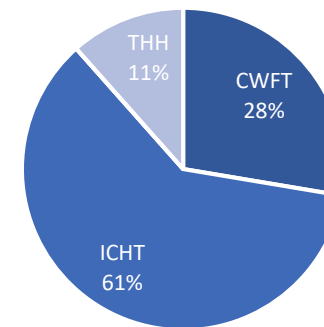
*LNW data unavailable due to Cerner go-live

CURRENT PERFORMANCE

Theatre Utilisation Aug-23

	Planned operating time (hours)	Theatre utilisation	Difference from target	Unused time (hours)
CWFT	2432	87.2%		312
ICHT	4329	84.2%	-0.8%	686
LNW	0			0
THH	1021	87.2%		130
APC	7782	85.5%		1128

STRATIFICATION



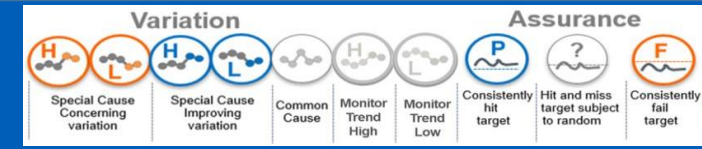
GOVERNANCE

Senior Responsible Owner: Rob Hodgkiss, Deputy CEO and Chief Operating Officer, CWFT

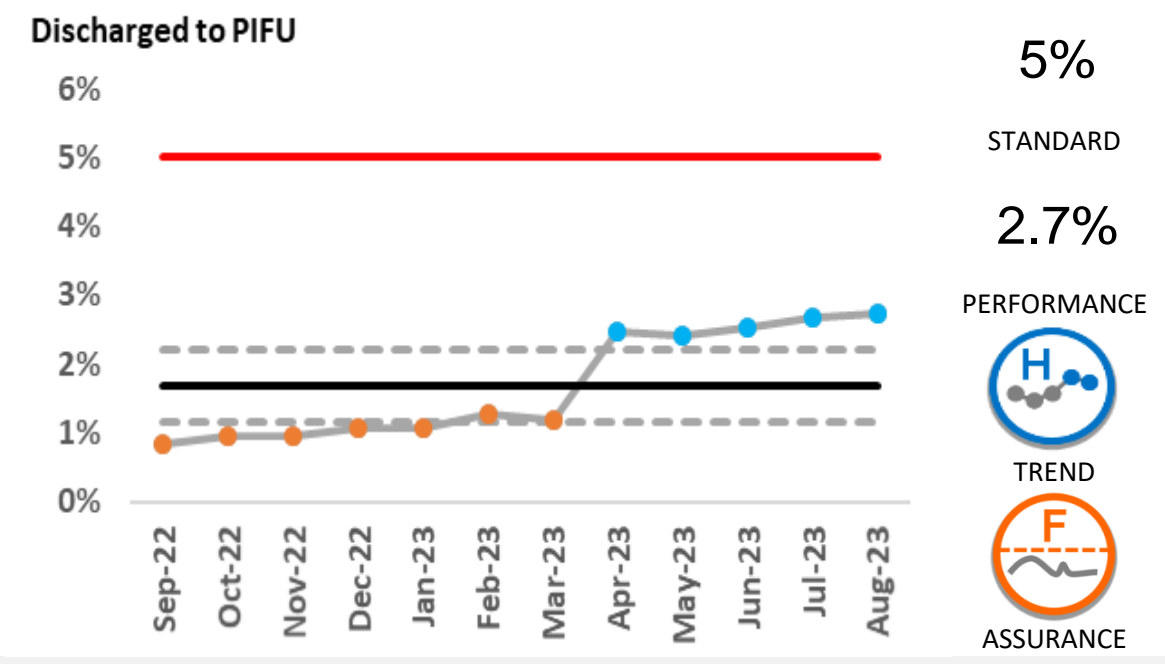
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Rob Hodgkiss);

Data Assurance: tbc

Operations Outpatient Transformation



TREND



NARRATIVE

PIFU rates have continued to improve with a large increase in April driven by further uptake at CWFT. NWL performance remains under the National target of 5%.

All Trusts are focused on continued PIFU rollout to more specialities and increasing uptake. Operational planning and improvement plans also support PIFU capacity increases into 2023/24. Learning from CWFT will be shared across the APC.

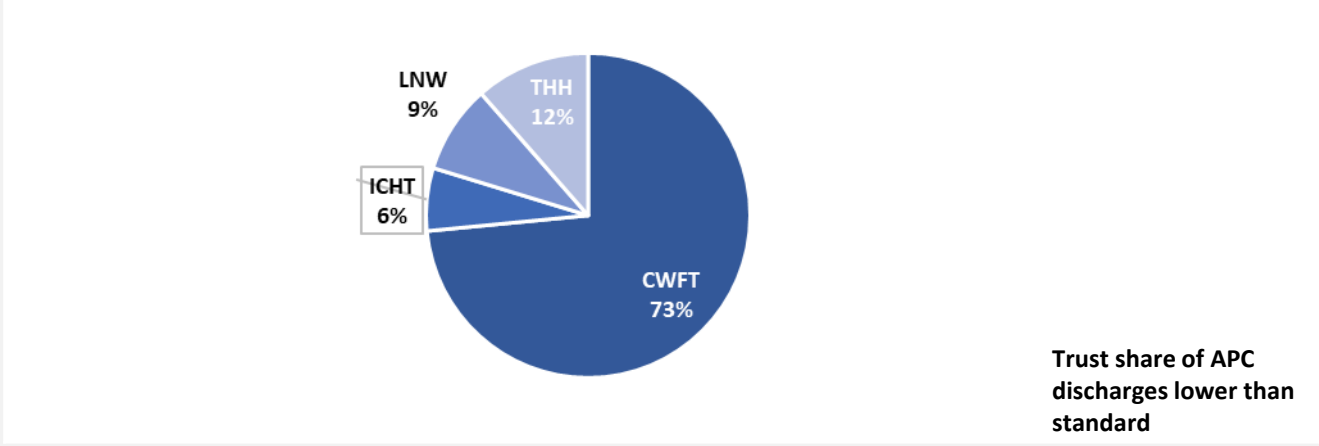
Key risks to delivery include implementation of digital infrastructure, LNW Cerner go-live and roll-out during planned industrial action.

CURRENT PERFORMANCE

Outpatient Transformation Aug-23

	Total OP contacts	Discharged to PIFU	Difference from target	Moved / Discharged to PIFU	Impacts on		
					OPFA DNAs	OPFU DNAs	Virtual contacts
CWFT	62484	7.3%		4558	12.4%	10.2%	7632
ICHT	92470	0.4%	-4.6%	388	13.3%	10.8%	18003
LNW	42225	1.3%	-3.7%	546	11.9%	11.8%	10068
THH	30004	2.4%	-2.6%	712	9.0%	8.6%	3507
APC	227183	2.7%	-2.3%	6204	12.1%	10.8%	39210

STRATIFICATION



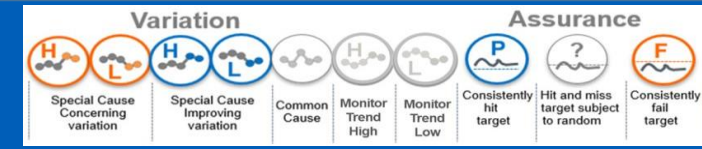
GOVERNANCE

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);

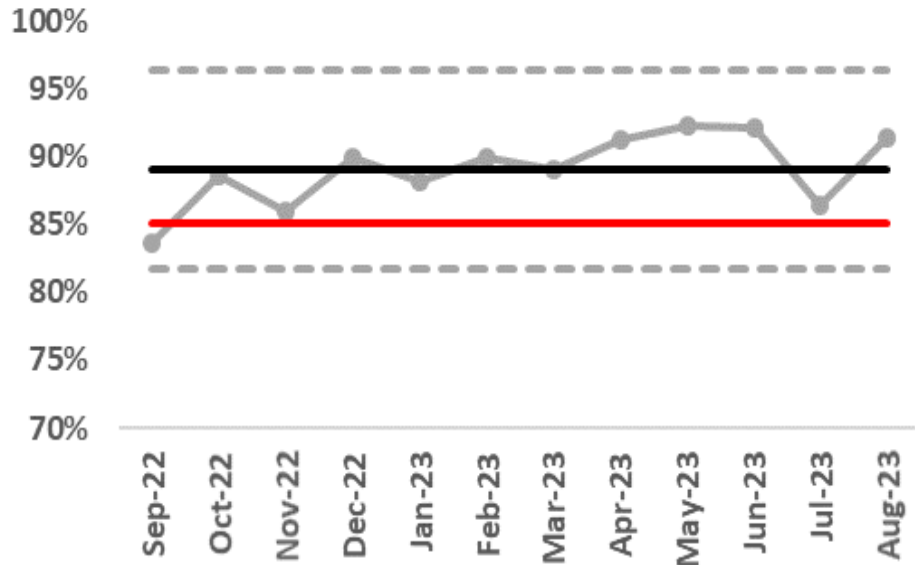
Data Assurance: tbc

Operations Critical Care



TREND

Critical Care Bed Occupancy



<85%

STANDARD

91.3%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Bed occupancy remains higher than target but operationally within tolerance.

Recovery Plan: Not required at this time

Improvements: Not required at this time.

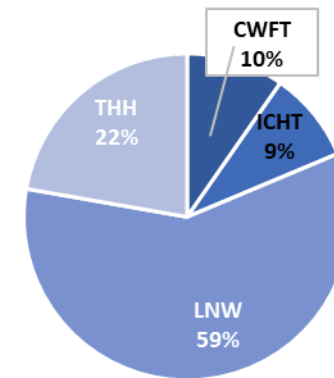
Forecast Risks: None.

CURRENT PERFORMANCE

Critical Care Aug-23

	Available critical care beds	Bed occupancy	Difference from target	Unoccupied critical care beds
CWFT	19	92.0%	7.0%	1.5
ICHT	94	98.5%	13.5%	1.4
LNW	56	83.4%		9.3
THH	12	71.0%		3.5
APC	181	91.3%	6.3%	15.7

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)

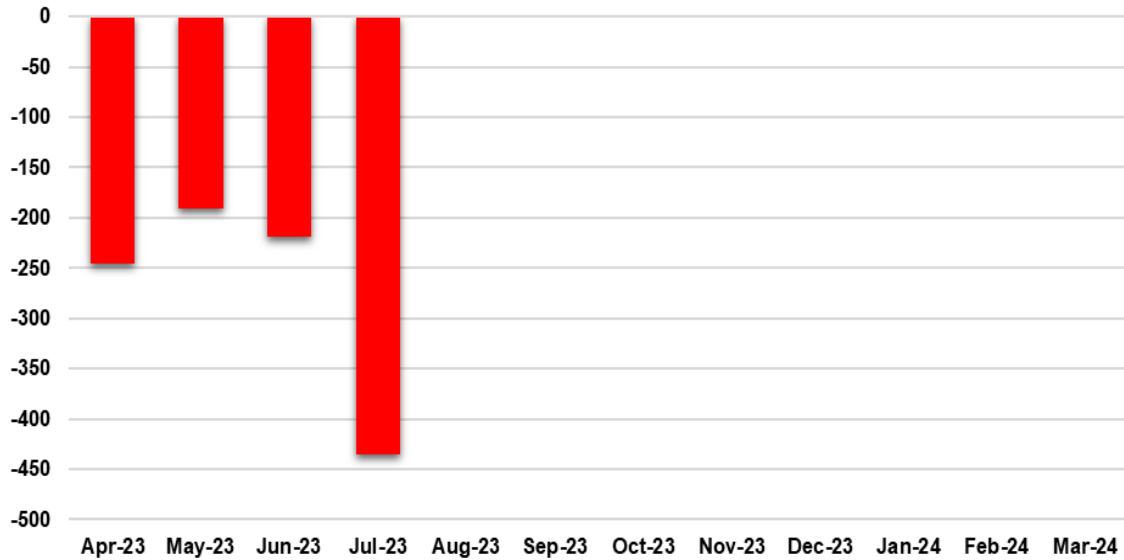
Data Assurance: tbc

Operating Plan Performance

Operating Plan Performance: Elective Inpatient

TREND

Elective Inpatients variance from Plan



NARRATIVE

Performance: Elective activity is challenged at all Trusts following industrial action in the month of July.

Recovery Plan: Not required at this time

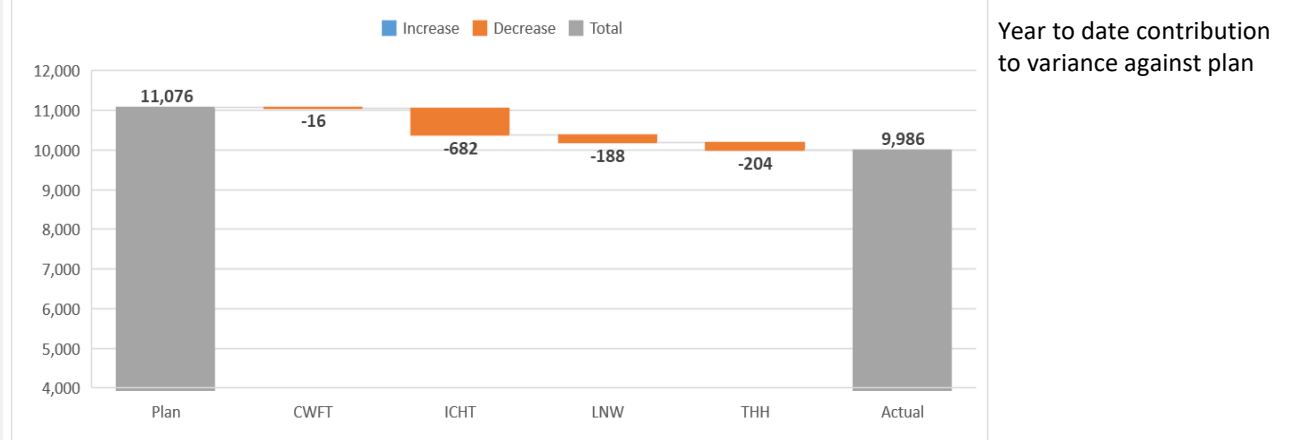
Improvements: Not required at this time.

Forecast Risks: Key risks to delivery include LNW Cerner go-live and planned industrial action.

CURRENT PERFORMANCE

	Current Month - Jul-23				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	488	480	-8	-1.7%	488	480	-8	-1.7%	1,992	1,976	-16	-0.8%
ICHT	1,378	1,133	-245	-17.8%	1,378	1,133	-245	-17.8%	5,286	4,604	-682	-12.9%
LNW	793	673	-120	-15.1%	793	673	-120	-15.1%	2,875	2,687	-188	-6.5%
THH	208	146	-62	-29.8%	208	146	-62	-29.8%	923	719	-204	-22.1%
APC	2,867	2,432	-435	-15.2%	2,867	2,432	-435	-15.2%	11,076	9,986	-1,090	-9.8%

STRATIFICATION



Year to date contribution to variance against plan

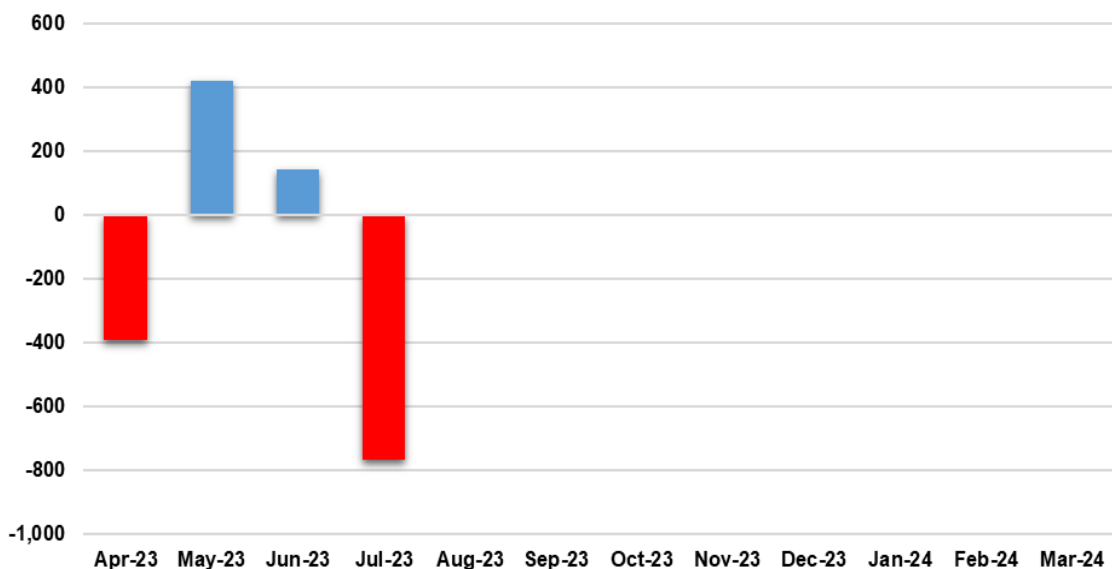
GOVERNANCE

The governance section will note 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

Operating Plan Performance: Day Case

TREND

Elective Daycase variance from Plan



NARRATIVE

Performance: Day case activity is showing variation across Trusts, with a challenged sector position following industrial action. CWFT and LNW are on plan whilst ICHT and THH are below plan.

Recovery Plan: Not required at this time

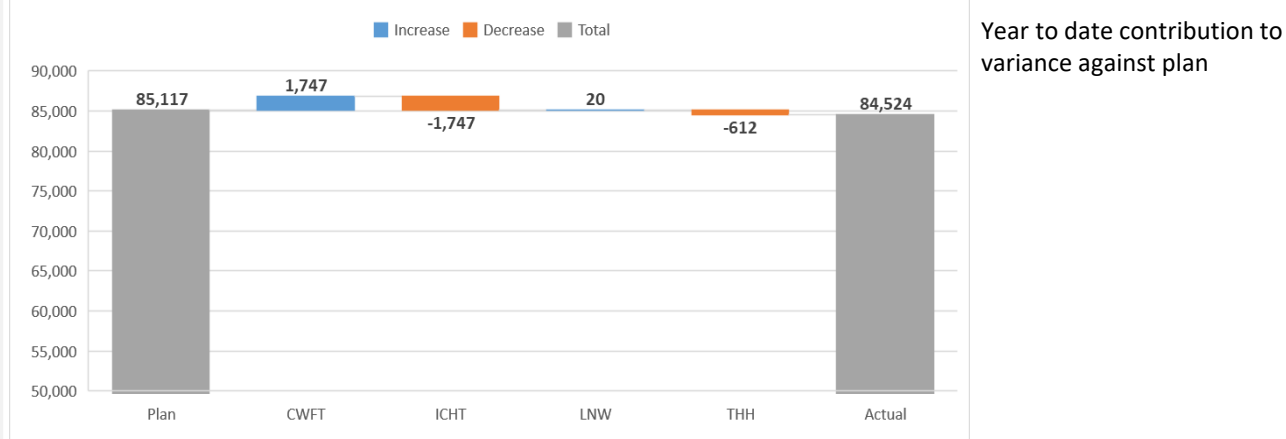
Improvements: Not required at this time.

Forecast Risks: Key risks to delivery include LNW Go-live and planned industrial action.

CURRENT PERFORMANCE

	Current Month - Jul-23				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	4,844	5,236	392	8.1%	4,844	5,236	392	8.1%	19,167	20,914	1,747	9.1%
ICHT	9,011	8,078	-933	-10.4%	9,011	8,078	-933	-10.4%	34,442	32,695	-1,747	-5.1%
LNW	5,889	5,904	15	0.3%	5,889	5,904	15	0.3%	23,247	23,267	20	0.1%
THH	2,095	1,852	-243	-11.6%	2,095	1,852	-243	-11.6%	8,260	7,648	-612	-7.4%
APC	21,839	21,070	-769	-3.5%	21,839	21,070	-769	-3.5%	85,117	84,524	-593	-0.7%

STRATIFICATION



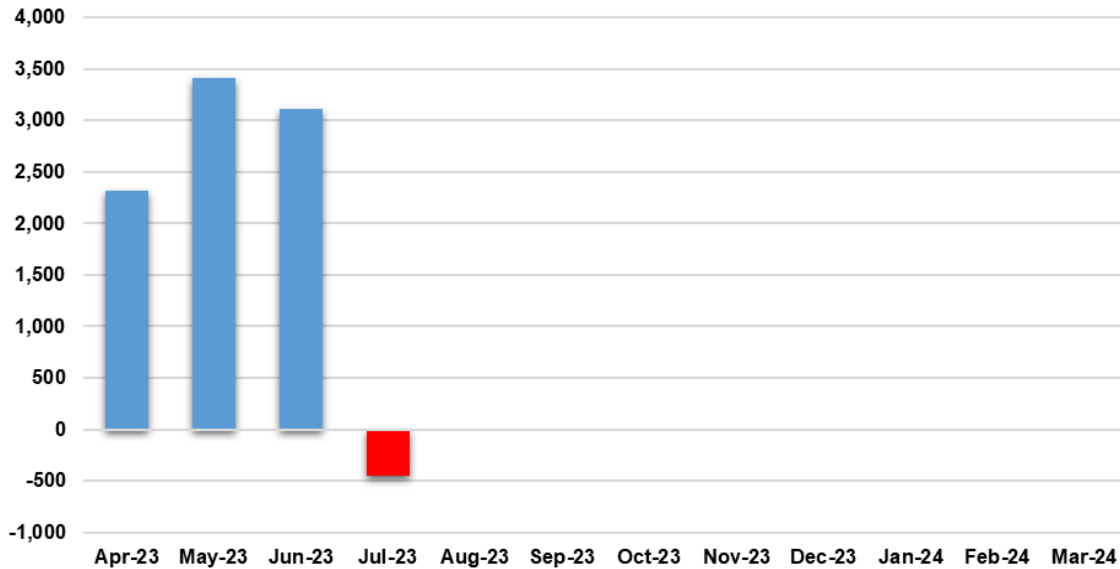
GOVERNANCE

The governance section will note 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

Operating Plan Performance: Outpatient New

TREND

Outpatient New variance from Plan



NARRATIVE

Performance: Outpatient New activity across the sector is on plan for all Trusts except LNW due to industrial action and planned Cerner roll-out in the Trust. The sector remains committed to deliver planned activity targets despite industrial action.

Recovery Plan: Not required at this time

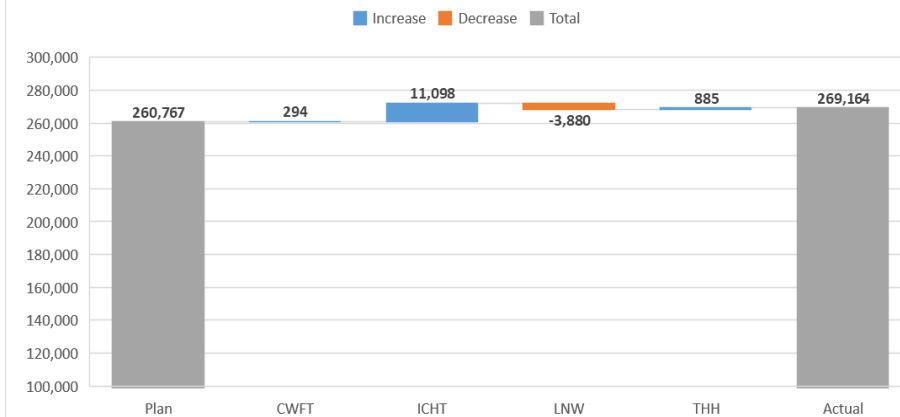
Improvements: Not required at this time.

Forecast Risks: Key risks to delivery include LNW Cerner go-live and planned industrial action.

CURRENT PERFORMANCE

	Current Month - Jul-23				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	16,806	17,439	633	3.8%	16,806	17,439	633	3.8%	66,855	67,149	294	0.4%
ICHT	18,194	19,526	1,332	7.3%	18,194	19,526	1,332	7.3%	69,597	80,695	11,098	15.9%
LNW	25,682	23,107	-2,575	-10.0%	25,682	23,107	-2,575	-10.0%	92,016	88,136	-3,880	-4.2%
THH	8,412	8,575	163	1.9%	8,412	8,575	163	1.9%	32,299	33,184	885	2.7%
APC	69,094	68,647	-447	-0.6%	69,094	68,647	-447	-0.6%	260,767	269,164	8,397	3.2%

STRATIFICATION



Year to date contribution to variance against plan

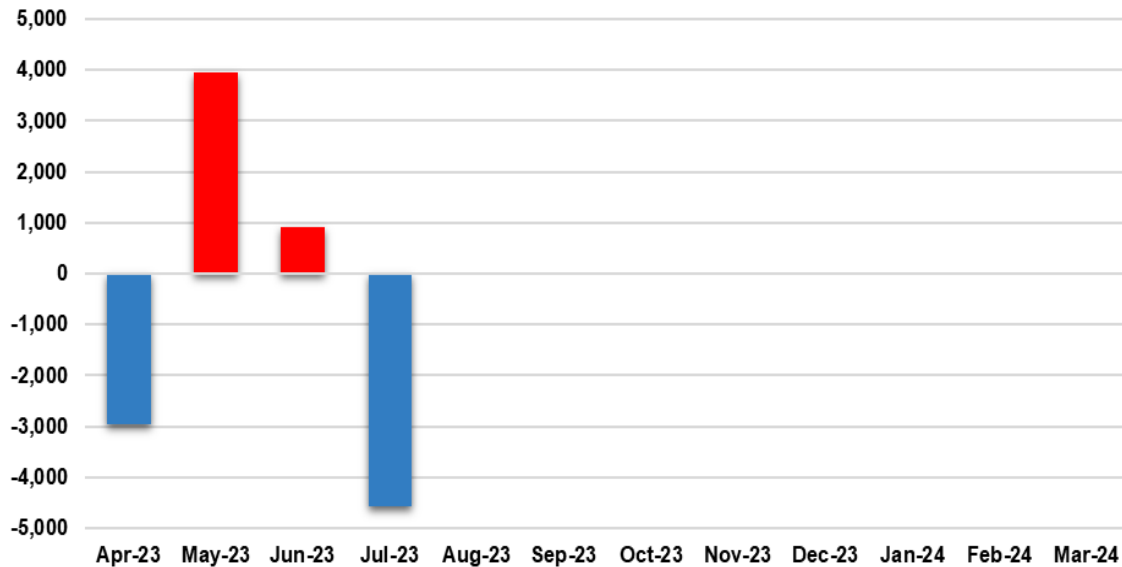
GOVERNANCE

The governance section will note 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

Operating Plan Performance: Outpatient Follow Up

TREND

Outpatient Follow-Up variance from Plan



NARRATIVE

Performance: Outpatient Follow-up activity across the sector is on plan for all Trusts with a continued focus on reducing follow-up activity in line with planned targets.

Recovery Plan: Not required at this time

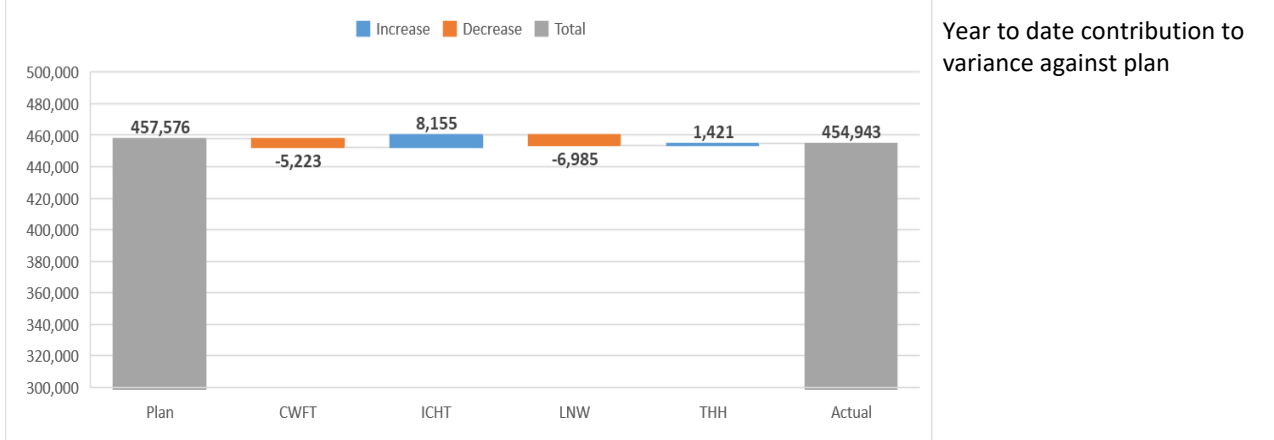
Improvements: Not required at this time.

Forecast Risks: Key risks to delivery include LNW Cerner go-live and planned industrial action.

CURRENT PERFORMANCE

	Current Month - Jul-23				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	27,615	26,468	-1147	-4.2%	27,615	26,468	-1147	-4.2%	110,813	105,590	-5223	-4.7%
ICHT	47,242	44,332	-2910	-6.2%	47,242	44,332	-2910	-6.2%	181,834	189,989	8155	4.5%
LNW	29,522	29,344	-178	-0.6%	29,522	29,344	-178	-0.6%	119,385	112,400	-6985	-5.9%
THH	11,828	11,509	-319	-2.7%	11,828	11,509	-319	-2.7%	45,543	46,964	1421	3.1%
APC	116,207	111,653	-4554	-3.9%	116,207	111,653	-4554	-3.9%	457,576	454,943	-2633	-0.6%

STRATIFICATION



GOVERNANCE

The governance section will note 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

Workforce Performance

Workforce Executive Summary

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

Collectively we are reporting a total staffing position (substantive, bank & agency) of 1,492 WTE above the 2023/24 **operating plan** (4.3%) in August 2023. Each of the Trusts are right-sizing staffing numbers to match the level of activity and income they are going to achieve.

Vacancy rates at collaborative level are a special cause improving variation and are below the collaborative target of 10%. Over the past year the collaborative vacancy level has been steadily reducing, reaching its lowest point in March 2023 at 9.3%. This reduction in vacancies is the result of targeted recruitment campaigns, both at home and abroad, with a continuing focus to drive further improvement. Collaborative action is focussed on the hard to fill vacancies, which remain a cause for concern for those service areas.

Voluntary turnover continues as a special cause improving variation as, over the last ten months, there has been a steady reduction from 13.2% to the current position of 11.3% which is below the APC target of 12.0%. All Trusts have active retention projects and / or programmes and are part of a retention programme, supported by national resource, being initiated across the NWL ICS. The main Collaborative initiative on retention is the creation of a career's hub and a proposal for a common career's platform.

After a year of high **sickness** rates, the past nine months have seen a steady decrease to the current rolling sickness absence rate of 4.1% which is a special cause improving variation. All Trusts have plans in place to manage absence, particularly long-term absence linked to Covid. Current absence levels are now within the expected seasonal range. Trusts continue to work locally to re-deploy staff and mitigate safe staffing risks as required, which can result in a higher reliance on temporary staff with increased numbers of bank and agency shifts being requested and filled to mitigate staffing gaps due to sickness absence.

Agency spend, as a proportion of overall pay bill, is our productivity measure with a collective target set at 2%. Current performance for August 2023 was 2.8% and is a common cause variation; driven by hard to fill vacancies, additional staffing requirement due to impacts of elective recovery activity and industrial action by healthcare workers. Reliance on agency workers is key for the delivery of some services, particularly where there is a national skills shortage such as for sonography and cardiac physiology and Trusts are working towards collective solutions in these areas. Continued collaborative work on temporary staffing remains the focus for reducing agency expenditure overall.

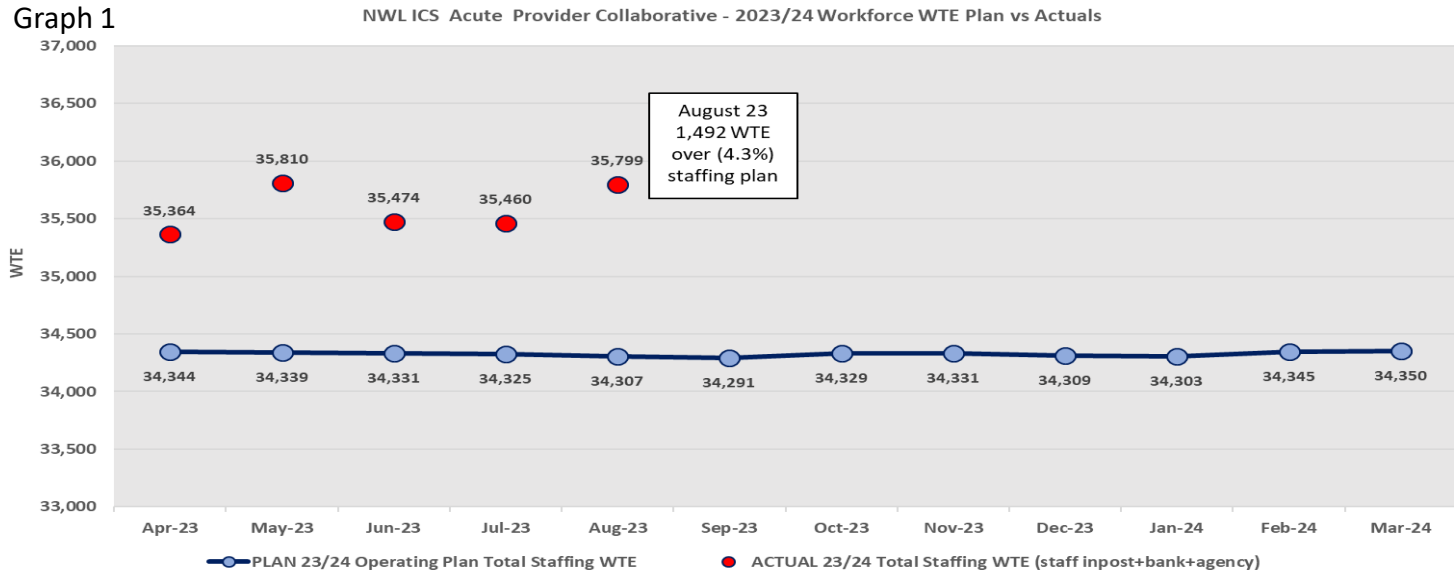
Completion rates for **non-medical Performance Development Reviews** (PDR), is an area of concern, albeit we have seen an improvement over the past five months with the metric currently at a special cause improving variation. With the exception of non-medical appraisals at Imperial (which have a set window for completion) all Trusts operate a rolling programme for PDRs and are working towards the common target of 95% to drive improvement. The People Committee in Common has requested each People Committee to review their Trust level plans with an expectation of improved performance by the September (26th) People Committee in Common.

It has been agreed that for **Equality, Diversity and Inclusion** there will be a quarterly update on progress towards the Model Employer Goals. At Acute Collaborative Provider (ACP) Level BAME employees represent 61% of total workforce. To enable the ACP to achieve its 2025 MEG goals, each senior pay band needs to reflect 61% of BAME staff within each pay band. Included are the targets for each of the Provider Trusts in this report. Additionally, metrics on inclusive recruitment will be added in quarter 3.

Escalations by Theme:

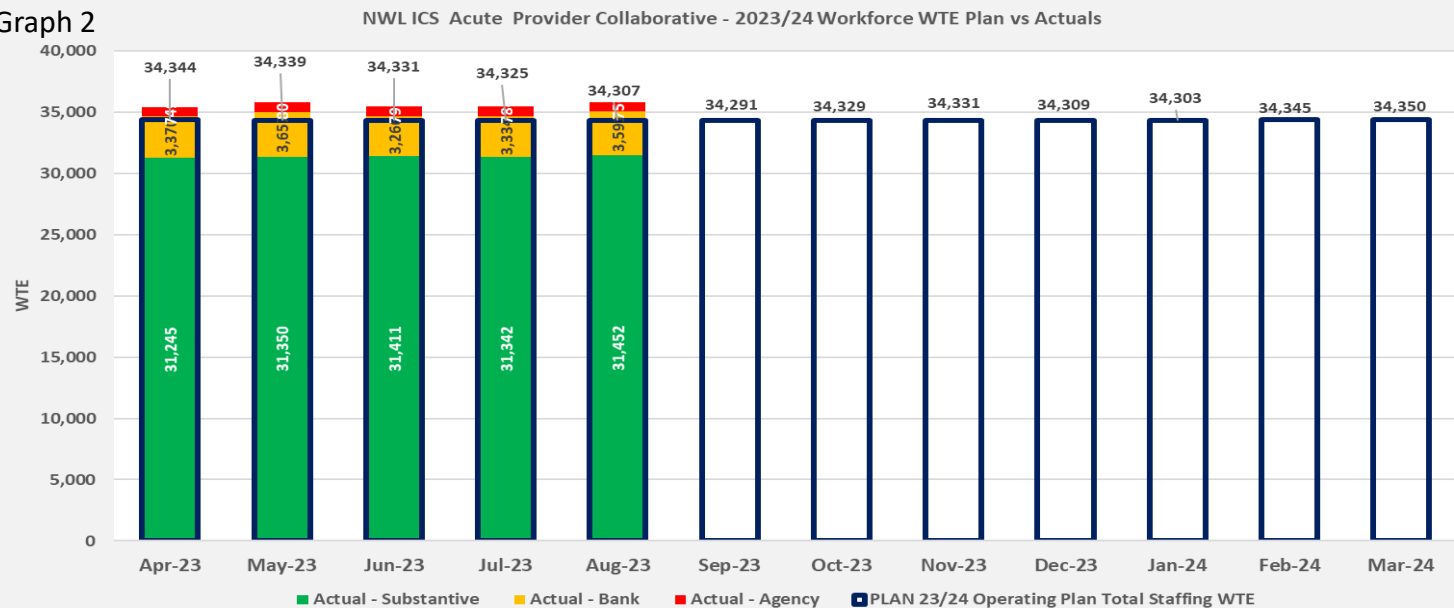
- Over-staffing against operating plan.
- EDI positive actions to address under-representation at senior levels.

Workforce 2023/24 Workforce Plan – Actual v Plan(WTE)



Graph 1 opposite shows the current overall workforce WTE (substantive + bank + agency) performance against the 2023/24 Workforce Plan for the Acute Provider Trusts (2023/24 Trust Operating Plans)

In August 2023, we planned to use a total of 34,307 WTE staff across, the four Acute Trusts, to deliver services and patient care. The actual reported staffing WTE was 35,799 WTE; 4.3% above plan (1,492 WTE).

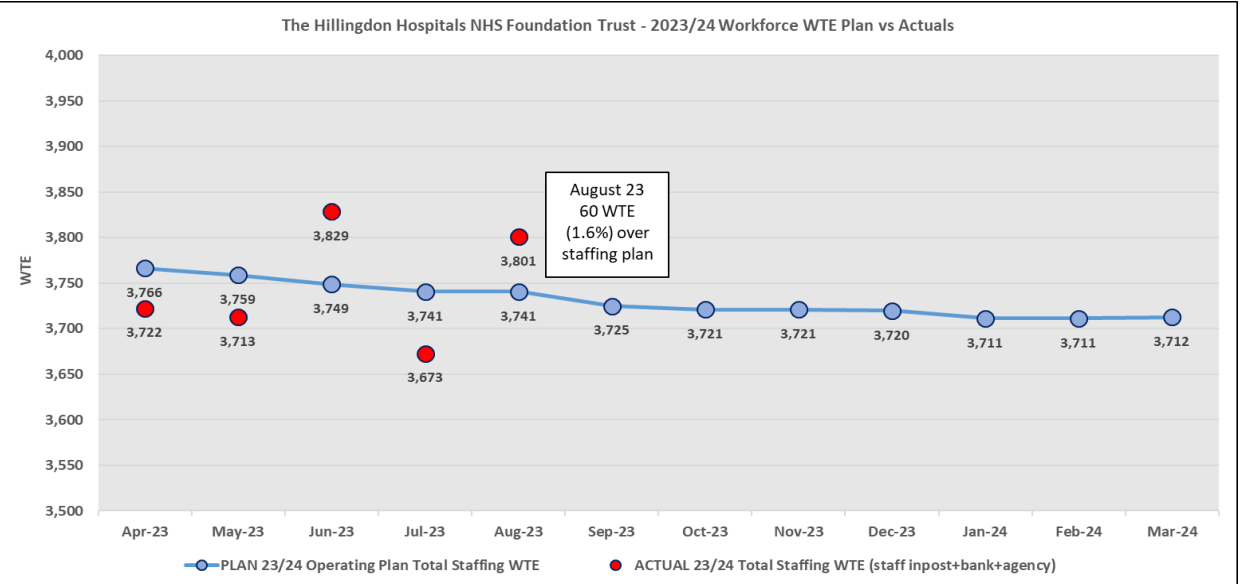
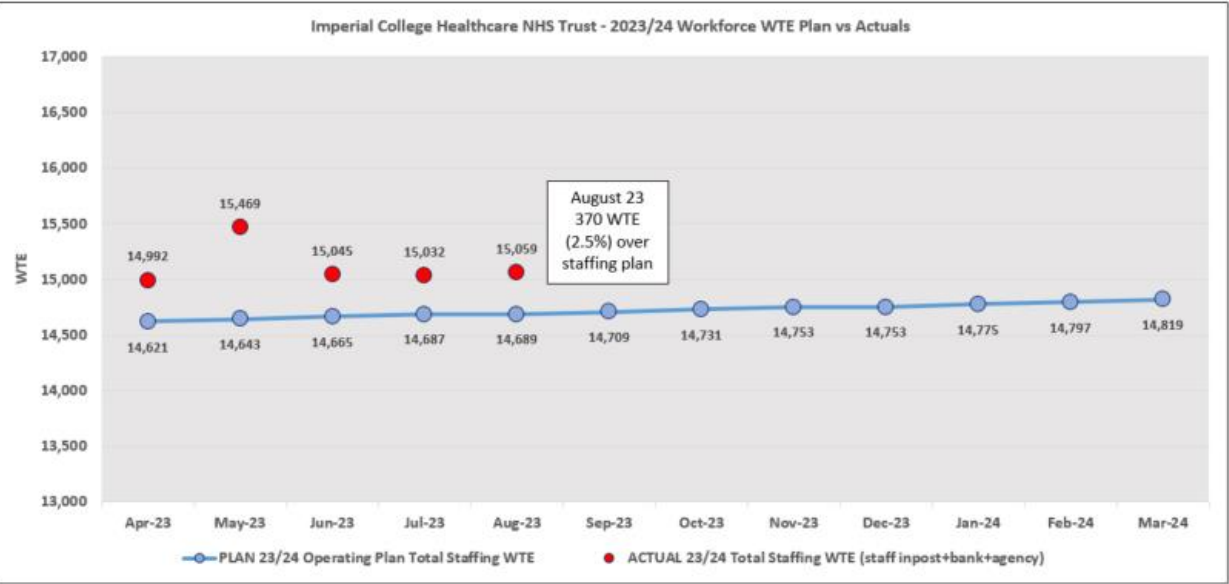
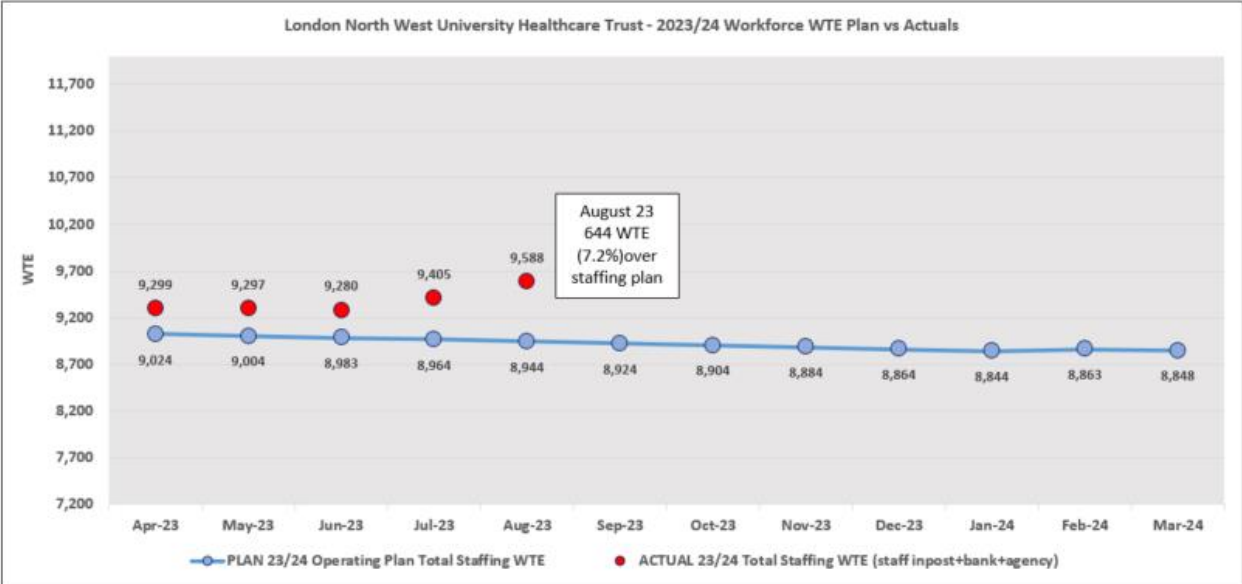
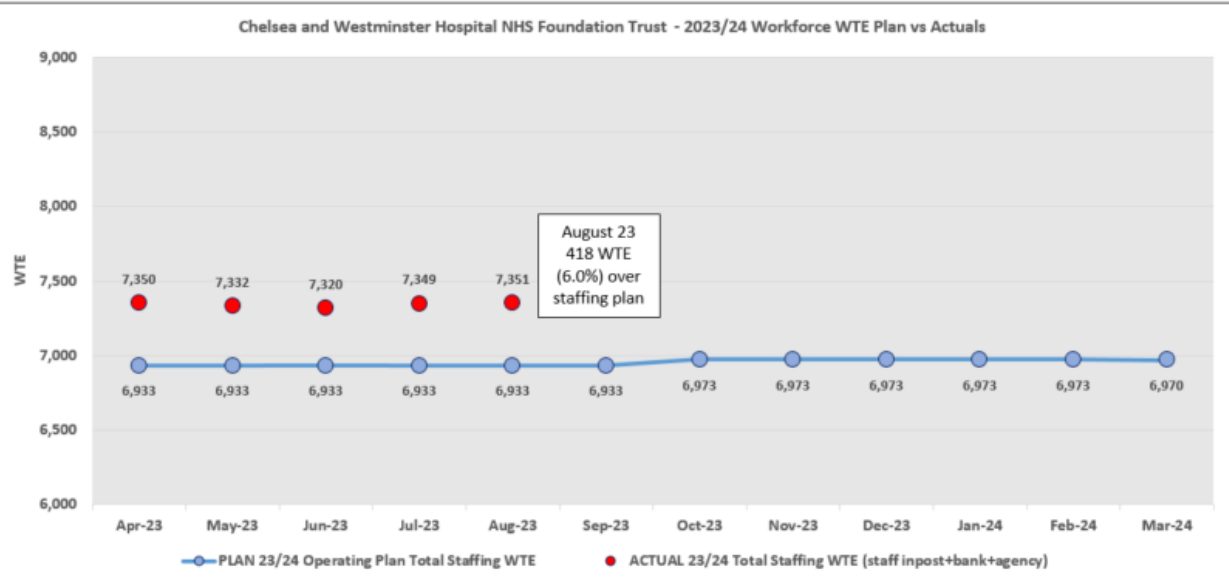


Graph 2 shows the staffing WTEs against plan by staffing type; substantive, bank or agency.

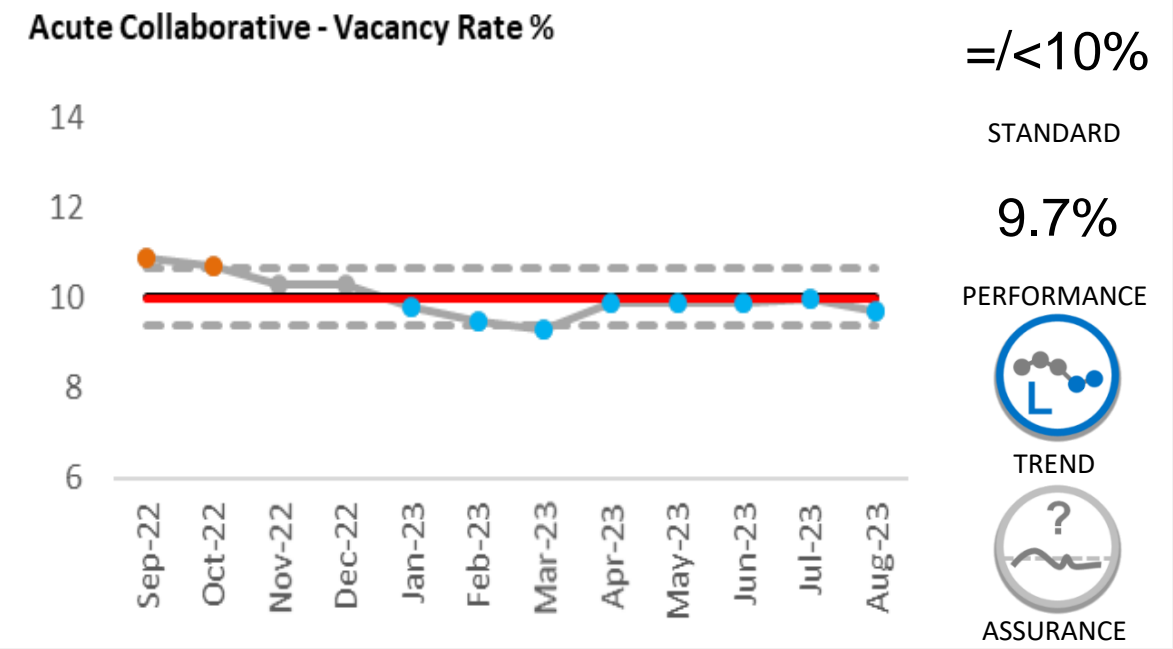
Understanding of the key drivers, for this over-plan position, are needed at organisation level, with triangulation to current financial and activity performance to deliver the 2023/24 Operating Plan.

Each of the Trusts are right-sizing staffing numbers to match the level of activity and income they are going to achieve.

2023/24 Workforce Plan – Actual v Plan(WTE)



TREND



NARRATIVE

Performance: Vacancy rates at collaborative level are a special cause improving variation and are below the collaborative target of 10%. Over the past year the collaborative vacancy level has been steadily reducing reaching its lowest point in March 2023 at 9.3%. This reduction in vacancies is the result of targeted recruitment campaigns, both at home and abroad, with a continuing focus to drive further improvement.

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

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

We continue to see increasing numbers of internationally appointed nurses 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 appointments to preceptorship roles, new obstetric nurse roles and scrub/theatre nurses.

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

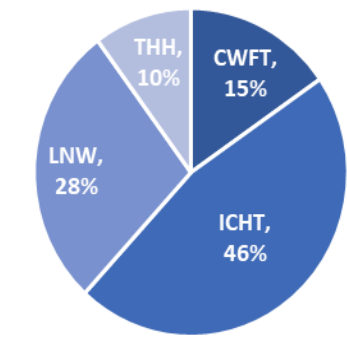
Forecast Risks: High levels of vacancies puts additional pressure on bank staffing demand at a time of increased activity (elective recovery) and industrial action.

CURRENT PERFORMANCE

Vacancies	Target %	Month 05 Vacancy Rate %	Variance to Target %	Vacancy WTE
CWFT	10%	7.4%	2.6%	519
ICHT	10%	10.3%	-0.3%	1,567
LNW	10%	10.4%	-0.4%	945
THH	10%	9.5%	0.5%	342
APC	10%	9.7%	0.3%	3,373

STRATIFICATION

Trust proportion of vacant WTE across the APC Month 05



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

Workforce Vacancies by Staff Group

Acute Trusts Staffing Group Vacancies - August 2023	Post WTE	Staff Inpost WTE	Vacant WTE	Vacancy Rate %
Admin & Clerical (bands 1/2/3/4/5/6)	4,919	4,415	504	10.3%
Allied Health Professional (Qualified bands 5+)	1,936	1,734	202	10.4%
Allied Health Professional (Unqualified bands 2/3/4)	312	255	57	18.3%
Ancillary	1,595	1,334	262	16.4%
Doctor (Career Grade)	261	224	37	14.2%
Doctor (Consultant)	2,219	2,095	124	5.6%
Doctor (Training & Trust Grade)	3,323	3,205	118	3.5%
Nursing & Midwifery (Qualified bands 5+)	11,722	10,478	1,244	10.6%
Nursing & Midwifery (Unqualified bands 2/3/4)	3,662	3,305	357	9.7%
Pharmacist	458	470	-12	-2.6%
Physician Associate	50	52	-1	-2.4%
Scientific & Technical (Qualified bands 5+)	1,332	1,200	132	9.9%
Scientific & Technical (Unqualified bands 2/3/4)	847	772	75	8.9%
Senior Manager (non-clinical bands 7/8/9/VSM)	2,161	1,883	278	12.9%
Other Staff	24	28	-4	-16.3%
Totals	34,823	31,450	3,373	9.7%

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

The overall vacancy rate is 9.7% which has reduced by 1.4 percentage points over the past twelve months; in August 2022 the collective vacancy rate was 11.1%.

Qualified nursing and midwifery roles have an 10.6% vacancy rate representative of 1,244 WTE vacancies. Within this staff group are mental health nursing roles which are one of our top recruitment priorities; temporary staff cover of these vacancies often attract high agency premia.

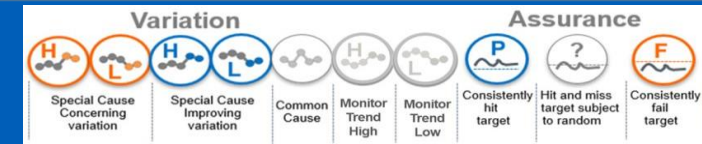
Just over 21% of current vacancies are non-clinical roles below band 7; 504 WTE admin & clerical and 202 WTE ancillary roles.

Qualified scientific, therapeutic and pharmacist vacancies (322 WTE) account for 10% of the APC vacancies.

Clinical support roles at bands 2, 3 & 4 total 489 WTE / 14% of current vacancies.

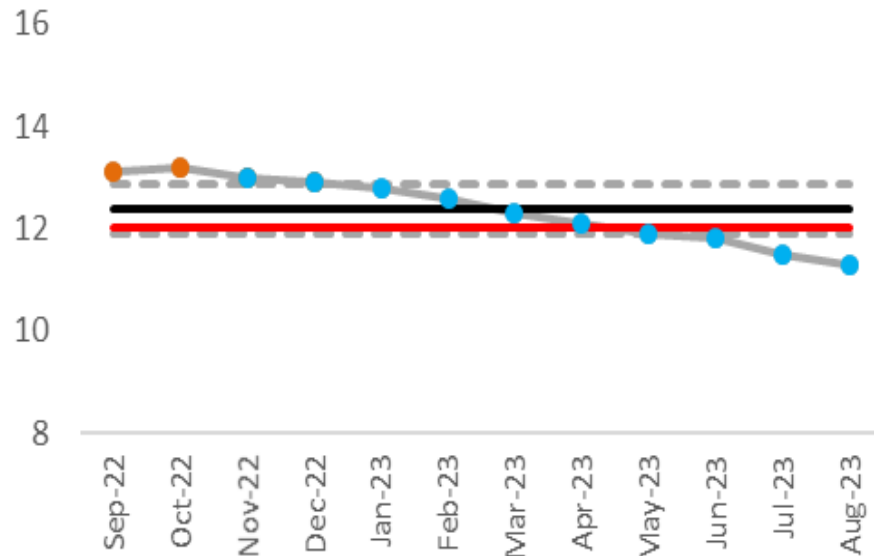
Medical vacancies totalled 279 WTE at the end of August 2023.

Workforce Voluntary Turnover



TREND

Acute Collaborative - Turnover Rate %



=/ \leq 12%

STANDARD

11.3%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Voluntary turnover continues as a special cause improving variation as, over the last ten months, there has been a steady reduction from 13.2% to the current position of 11.3% which is below the APC target of 12.0%.

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

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

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

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

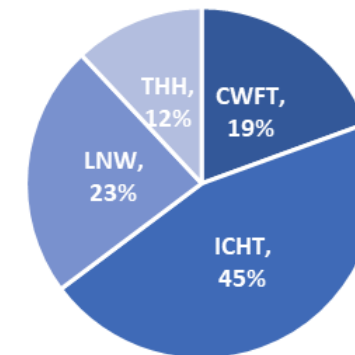
CURRENT PERFORMANCE

Voluntary Turnover

	Target %	Month 05 Turnover Rate %	Variance to Target %	Voluntary Leavers WTE (rolling 12 months)
CWFT	12%	13.0%	-1.0%	722
ICHT	12%	10.8%	1.2%	1683
LNW	12%	10.8%	1.2%	863
THH	12%	12.2%	-0.2%	445
APC	12%	11.3%	0.7%	3713

STRATIFICATION

Trust proportion of voluntary leavers wte (rolling 12 months) across the APC Month 05



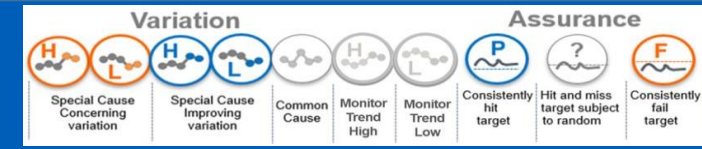
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

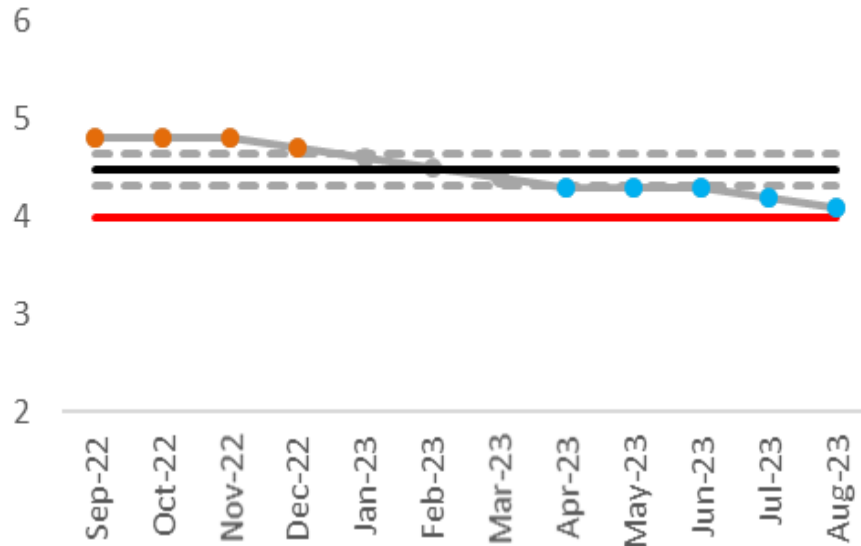
Data Assurance: tbc

Workforce Sickness Absence



TREND

Acute Collaborative - Rolling Sickness Rate %



= / < 4%

STANDARD

4.1%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: After a long period of high sickness levels, the past nine months have seen a steady decrease to the current rolling sickness absence rate of 4.1% which is a special cause improving variation. Sickness absence continues to be impacted by Covid-19 resurgences as well as seasonal illness and all Trusts have plans in place to manage absence, particularly long-term absence linked to Covid. Current absence levels are now within the expected seasonal range.

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

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

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

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

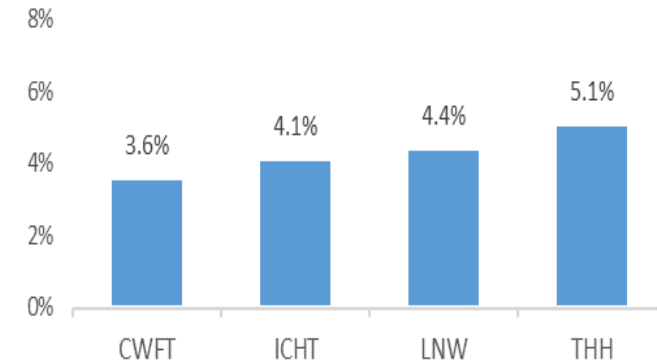
CURRENT PERFORMANCE

Rolling Sickness Absence

	Target %	Month 05 12 Month Rolling Sickness Absence Rate %	Variance to Target %	Month 05 In-Month Sickness Absence Rate %
CWFT	4%	3.6%	0.4%	3.6%
ICHT	4%	4.1%	-0.1%	3.9%
LNW	4%	4.4%	-0.4%	4.4%
THH	4%	5.1%	-1.1%	5.1%
APC	4%	4.1%	-0.1%	4.0%

STRATIFICATION

12 Month Rolling Sickness Absence Rate % across the ACC Month 05



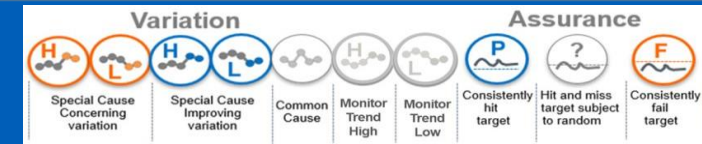
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

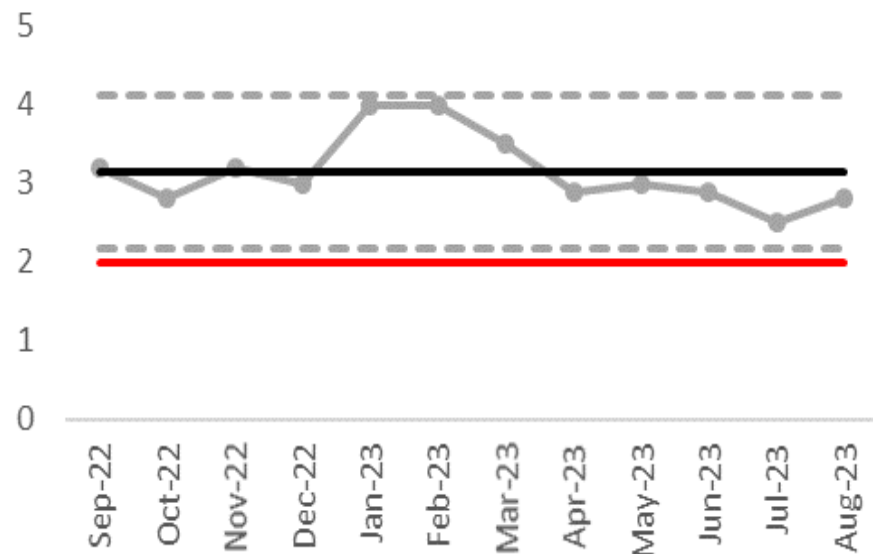
Data Assurance: tbc

Workforce Productivity - Agency Spend



TREND

Acute Collaborative - Agency Spend % of Paybill



= / < 2%

STANDARD

2.8%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Agency spend, as a proportion of overall pay bill, is our productivity measure with a collective target set at 2%. Current performance for August 2023 was 2.8% and is a common cause variation; driven by hard to fill vacancies, additional staffing requirement due to impacts of elective recovery activity and industrial action by healthcare workers.

Reliance on agency workers is key for the delivery of some services, particularly where there is a national skills shortage such as for sonography, mental health nursing and cardiac physiology and Trusts are working towards collective solutions in these areas. Continued collaborative work on temporary staffing remains the focus for reducing agency expenditure overall.

Harmonised and uplifted bank rates for AfC staff are in place across 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: Increased demand on both agency and bank workers continues in response to seasonal sickness levels and higher acuity and dependency of patients; requiring the continued focus on recruitment to minimise the underlying vacancy position and associated temporary staffing fill.

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

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

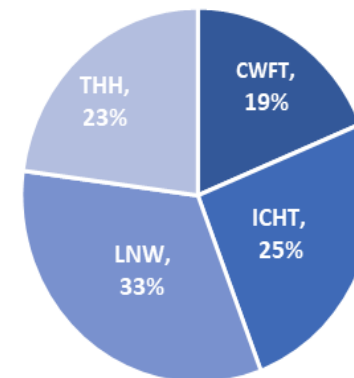
CURRENT PERFORMANCE

Productivity - Agency Spend

	Target %	Month 05 Agency Spend Rate %	Variance to Target %	Agency Spend £ (in Month)
CWFT	2%	2.5%	-0.5%	1,050,902
ICHT	2%	1.6%	0.4%	1,422,681
LNW	2%	3.4%	-1.4%	1,843,489
THH	2%	3.7%	-1.7%	1,281,604
APC	2%	2.8%	-0.8%	5,598,676

STRATIFICATION

Proportion of agency spend (£) by Trust across the APC For Month 05



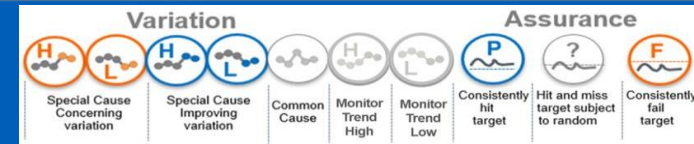
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

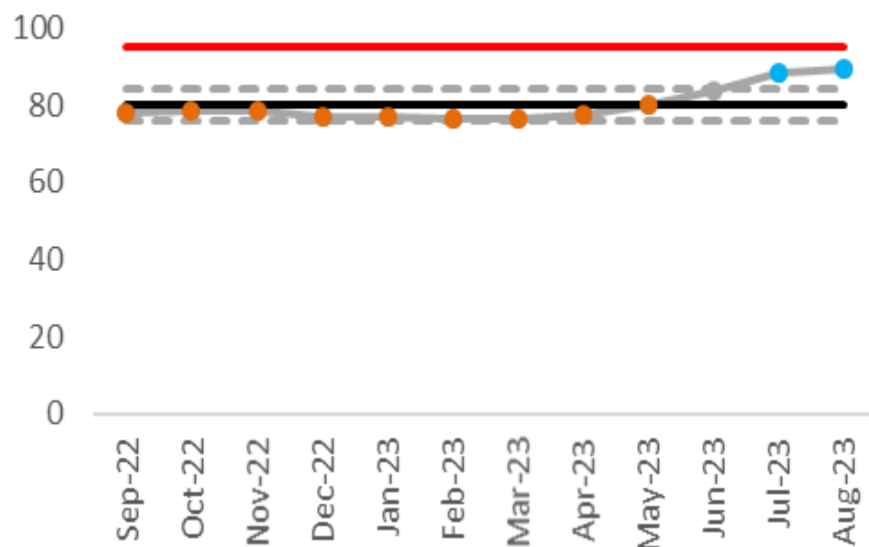
Data Assurance: tbc

Workforce Non-Medical PDR



TREND

Acute Collaborative - PDR Completion Rate %



= / < 95%

STANDARD

89.4%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

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

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

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

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

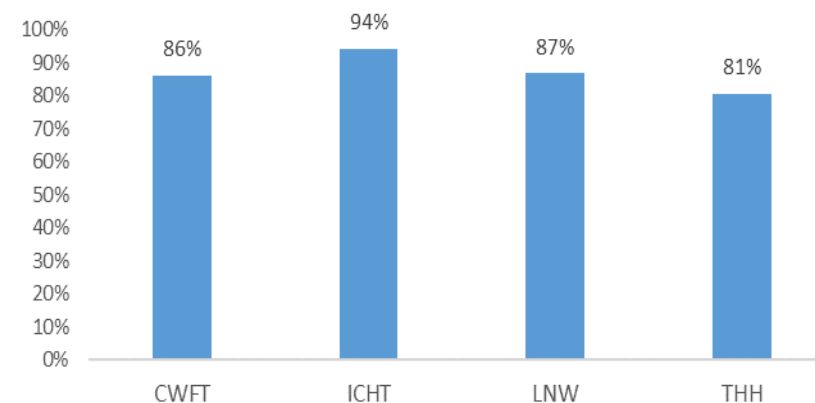
CURRENT PERFORMANCE

Non Medical PDR

	Target %	Month 05 PDR / Appraisal Rate %	Variance to Target %
CWFT	95%	86.2%	8.8%
ICHT	95%	94.3%	0.7%
LNW	95%	86.7%	8.3%
THH	95%	80.5%	14.5%
APC	95%	89.4%	5.6%

STRATIFICATION

Month 05 Non-Medical PDR Rate % by Trust across the APC



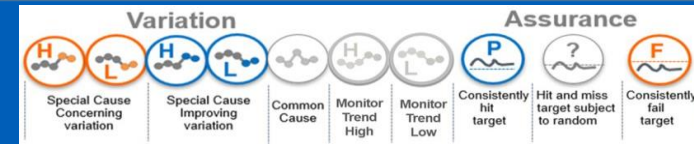
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

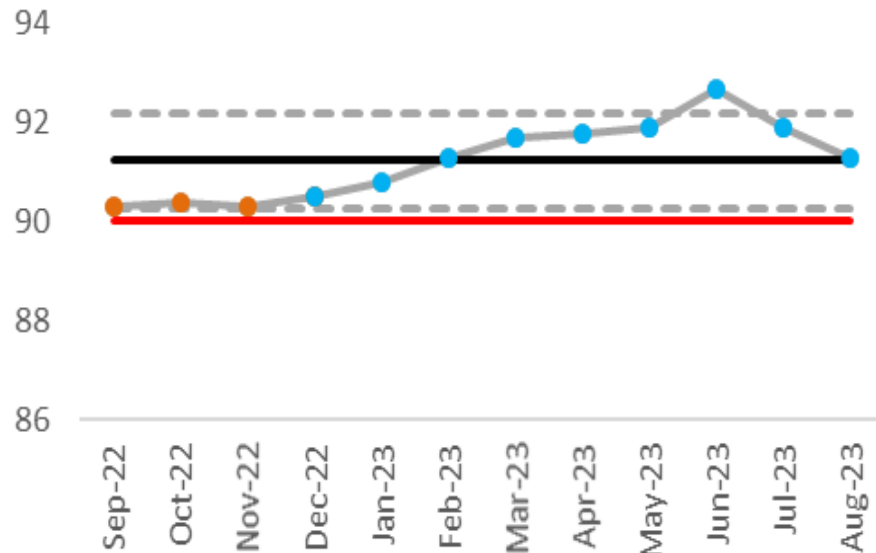
Data Assurance: tbc

Workforce Core Skills Compliance



TREND

Acute Collaborative - Core Skills Rate %



=/<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.

Apart from very temporary marginal reductions, all Trusts across the collaborative continue to perform well against the target for Core Skills compliance and it is not an area of concern at collaborative level.

Recovery Plan / Improvements: Topic level performance monitoring and reporting is key to driving continual improvement with current areas for focus.

The induction programmes for doctors in training includes time for them to complete the online elements of their core skills training, which is essential during high rotation activity including 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

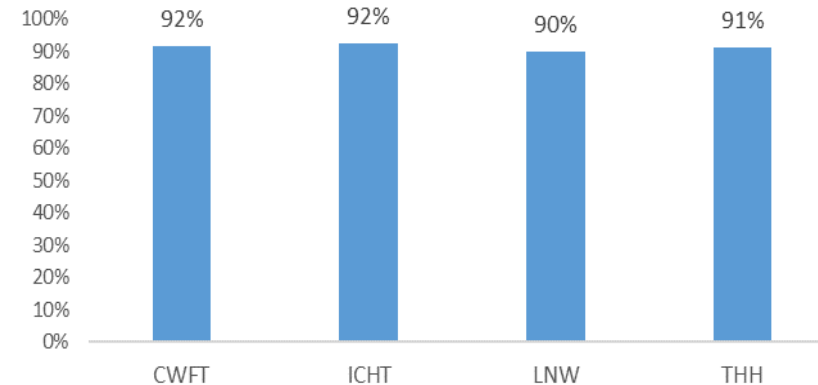
CURRENT PERFORMANCE

Core Skills Compliance

	Target %	Month 05 Core Skills Compliance Rate %	Variance to Target %
CWFT	90%	91.5%	1.5%
ICHT	90%	92.3%	2.3%
LNW	90%	90.0%	0.0%
THH	90%	91.2%	1.2%
APC	90%	91.3%	1.3%

STRATIFICATION

Month 05 Core Skills Compliance Rate % by Trust across the APC



GOVERNANCE

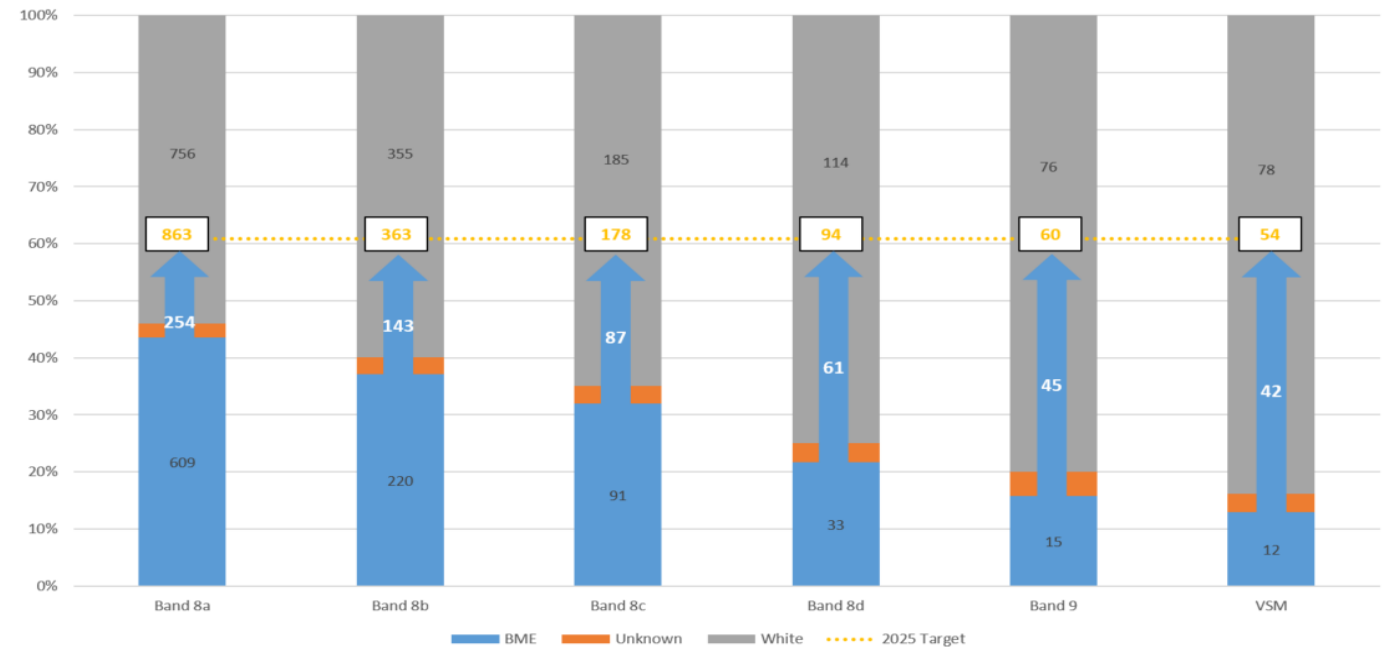
Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

Workforce Model Employer Goals - Overview

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

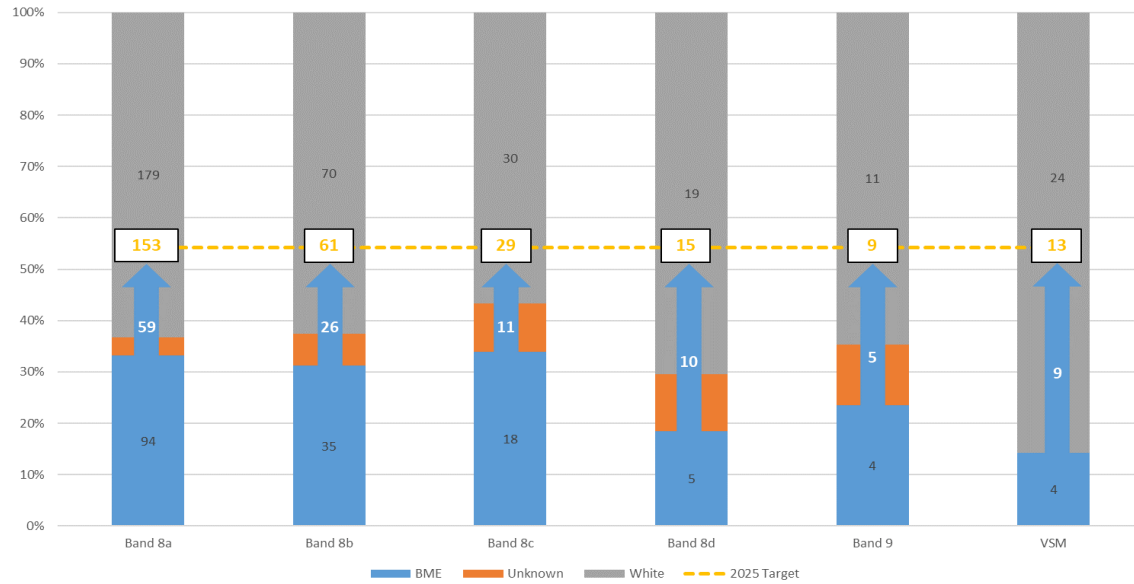


Actions being taken and developed to support MEG goals across the ACP at trust level are as follows (but not limited to);

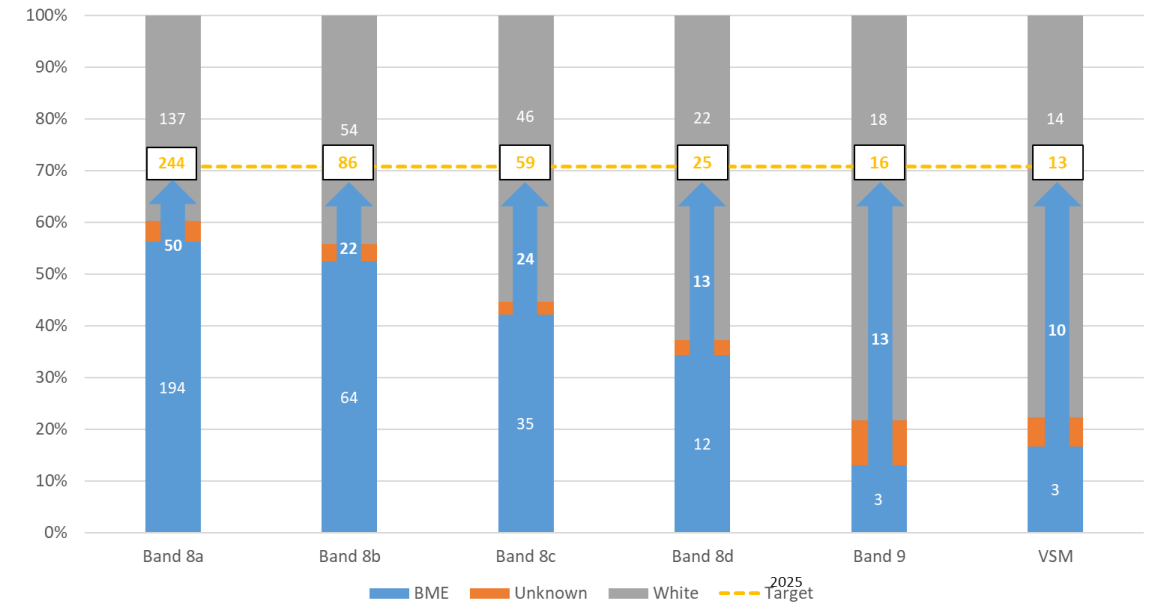
- Inclusive talent management strategies
- Succession planning to enable identifying, support and promotion of talent
- Inclusive recruitment means panels are gender-diverse and ethnically inclusive
- Diverse recruitment panels for all roles above band 7
- Regular monitoring and reporting on MEG targets

Workforce Model Employer Goals - Provider

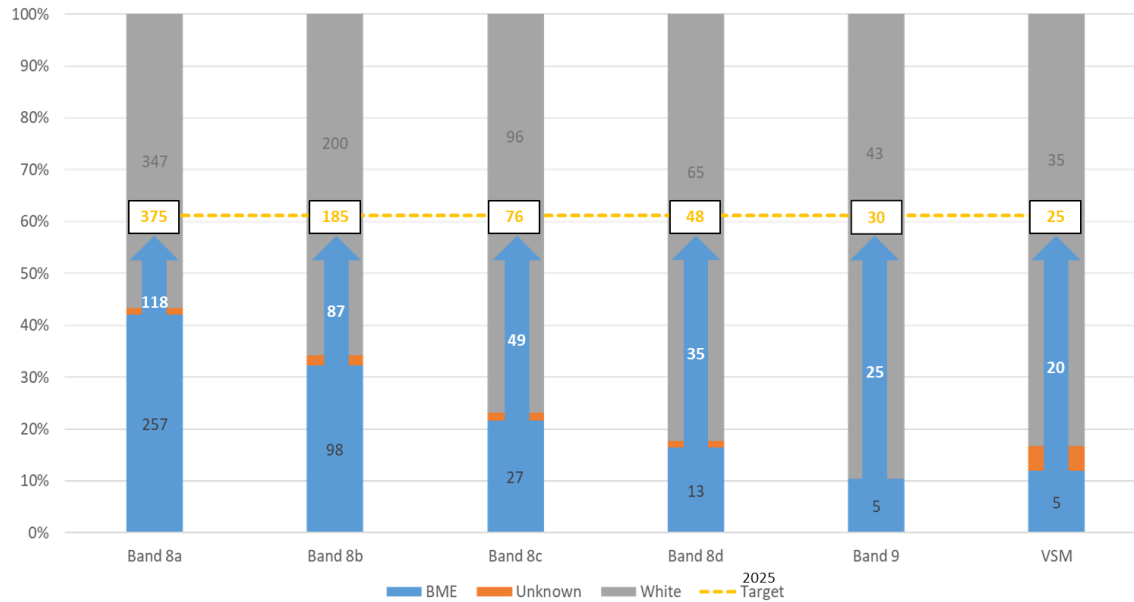
CWFT



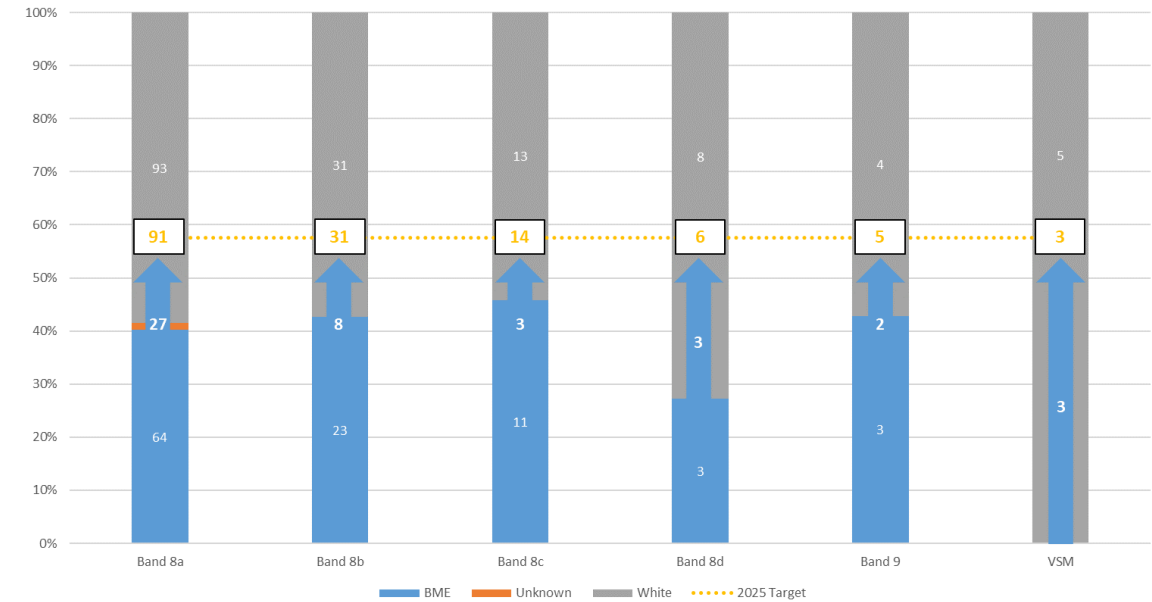
LNW



ICHT



THH



Finance

Introduction:

The detailed Finance Report for the APC (Acute Provider 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 5 (Aug).

Performance:

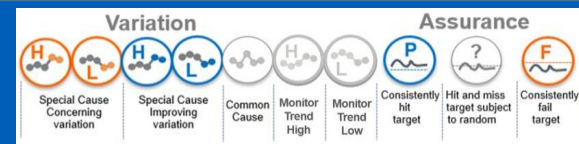
At Month 5, the APC reports a year-to-date deficit of £52.4m against a planned deficit of £13.4m, thus reporting a £39.1m adverse variance to plan. The key drivers of the variance are :

1. CIP programme is under delivered by £19.1m.
2. Junior Doctors and Consultants' industrial action has an impact on income (cancelled activity) of £15m and costs (paying for additional shifts to consultants and other medical staff), of £12.2m. In month 5, this has been partially mitigated by additional ERF income which aims to cover the impact of April strikes (£4.9m), meaning the overall impact to date of industrial action is £22.4m.
3. Inflation over funded levels caused a pressure of c£7.3m to date.
4. Elective income performance to month 5 is an over performance of £3.7m, comprising £0.3m favourable on ERF and £3.4m favourable on the non ERF element of the NWL variable contract. The impact of industrial action on ERF income is £9.2m, therefore without the industrial action ERF performance would be £12.9m over delivered.
5. Operational overspends in clinical areas caused a further pressure on the budgets; in part mitigated by some non-recurrent benefits.
6. Junior doctors pay award – the back dated pay award of 6% was paid in month 5. The tariff in contract income has been uplifted to fund the award; however there is a shortfall in income over costs of £3.4m to date. This is being discussed at a regional and national level.

Escalations:

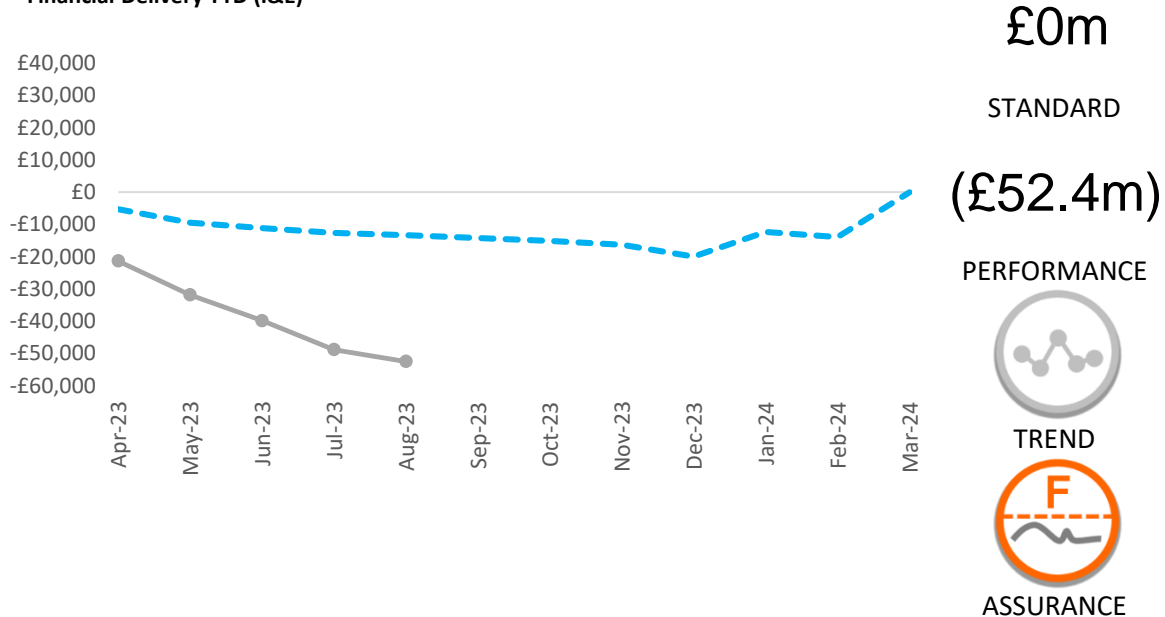
- To note the new financial performance management framework for 2023/24.
- A detailed forecast and recovery plan has been prepared (at month 4 and refreshed at month 5).

(Finance) Financial Delivery (I&E)



TREND

Financial Delivery YTD (I&E)



NARRATIVE

Performance: YTD deficit of £52.4m, against a YTD plan of £13.3m deficit, hence reporting a £39.1m adverse variance to plan.

Recovery Plan: 2023/24 performance management escalation process, including forensic review of performance via Peer to Peer CFO meetings. Forecast incl recovery plans to report in Sept F&P CIC.

Improvements: Receipt of YTD ERF income to account for a 2% reduction in the WWA annual target. – additional £4.9m.

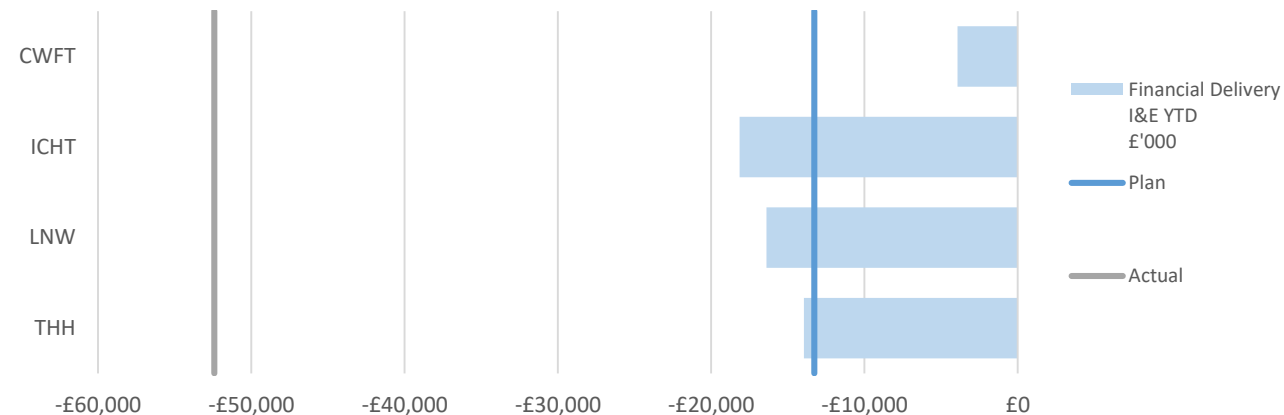
Forecast Risks: Detailed forecast and recovery has been prepared at month 4, updated for month 5. Main risks are excess inflation, industrial action, CIP delivery, run rate challenges and junior doctors pay award funding shortfall..

CURRENT PERFORMANCE

Financial Delivery (I&E)

	Financial Delivery I&E YTD £'000	Variance from target YTD £'000	FOT £'000
CWFT	(3930)	(4145)	0
ICHT	(18146)	(18146)	0
LNW	(16391)	(12067)	0
THH	(13942)	(4778)	0
APC	(52408)	(39135)	0

STRATIFICATION



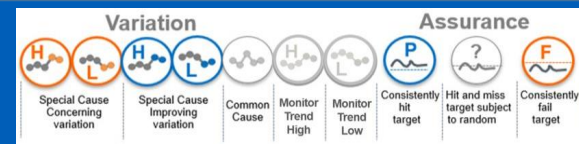
GOVERNANCE

Senior Responsible Owner: Jonathan Reid, Chief Financial Officer, LNW

Committee: NWL Collaborative Finance and Performance Committee

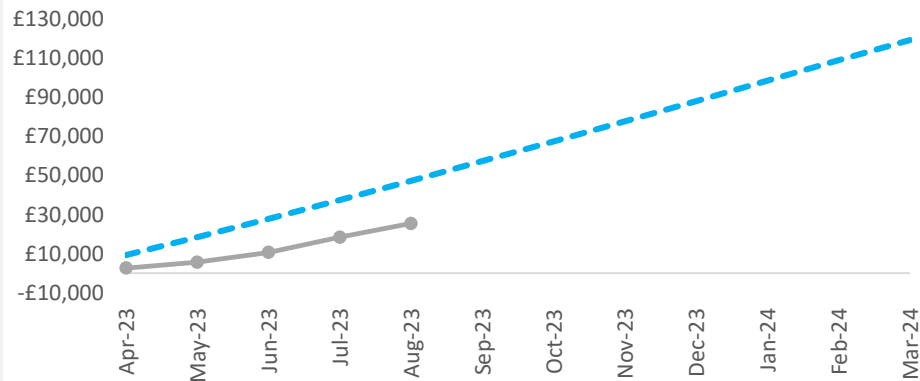
Data Assurance: Trust's Monthly Financial Monitoring Returns to ICB and NHSE.

(Finance) Financial Delivery (CIP)



TREND

Financial Delivery YTD (CIP)



£119.5m

STANDARD

£25.5m

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: CIP delivery is £25.5m against a YTD plan of £47.4m, thus reporting a YTD adverse variance of £21.9m.

Recovery Plan: the 23/24 APC financial performance management process has been enacted. Peer to Peer review meetings have taken place to review CIP programmes. Recovery plans and forecasts have been developed.

Improvements: Monthly CIP delivery has improved month on month from ave of £4.6m in for m1-m4 to £7m in m5..

Forecast Risks: Forecasts include risks against CIP delivery. Some delivery is via non recurrent means which impacts on the underlying position.

CURRENT PERFORMANCE

Financial Delivery (CIP)

	CIP YTD £'000	CIP Variance YTD £'000	FOT £'000
CWFT	9146	(654)	23520
ICHT	4820	(17437)	53421
LNW	9481	(3769)	31800
THH	2051	0	10757
APC	25498	(21860)	119498

STRATIFICATION



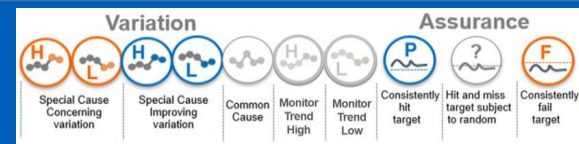
GOVERNANCE

Senior Responsible Owner: Jonathan Reid, Chief Financial Officer, LNW

Committee: NWL Collaborative Finance and Performance Committee

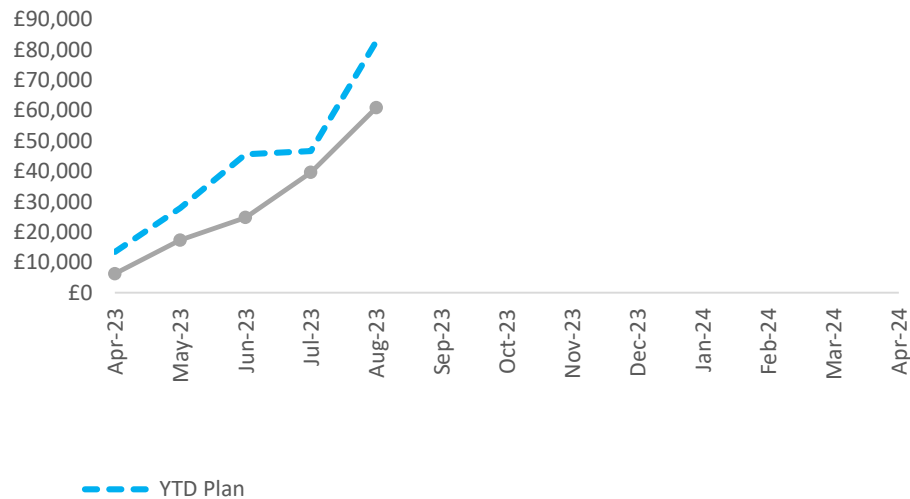
Data Assurance: Trust's Monthly Financial Monitoring Returns to ICB and NHSE.

(Finance) Capital Spend



TREND

Capital Spend YTD



£283m

STANDARD

£60.9m

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance:

Capital spend is £60.9m YTD against a YTD plan of £82.7m, therefore a £21.8m favourable variance reported.

Recovery Plan:

Trusts' capital spend is expected to ramp up as the year progresses and projects commence. Capital plans include nationally funded schemes under the national capital programme (£91.4m) and the Targeted Investment funds (20.1m). In addition LNW was granted additional funding to build a 32 bedded modular ward in June.

Forecast Risks:

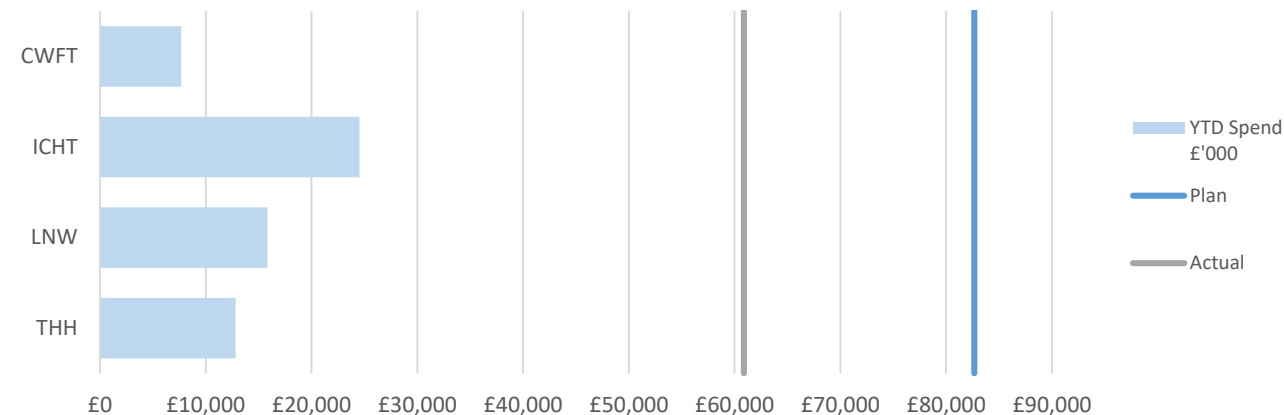
None to highlight at month 5

CURRENT PERFORMANCE

Capital Spend

	YTD Spend £'000	YTD Variance £'000	Forecast Spend £'000
CWFT	7688	9232	49311
ICHT	24523	174	77708
LNW	15840	9909	79968
THH	12824	2478	53972
APC	60875	21793	260959

STRATIFICATION



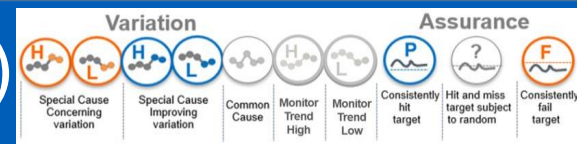
GOVERNANCE

Senior Responsible Owner: Jonathan Reid, Chief Financial Officer, LNW

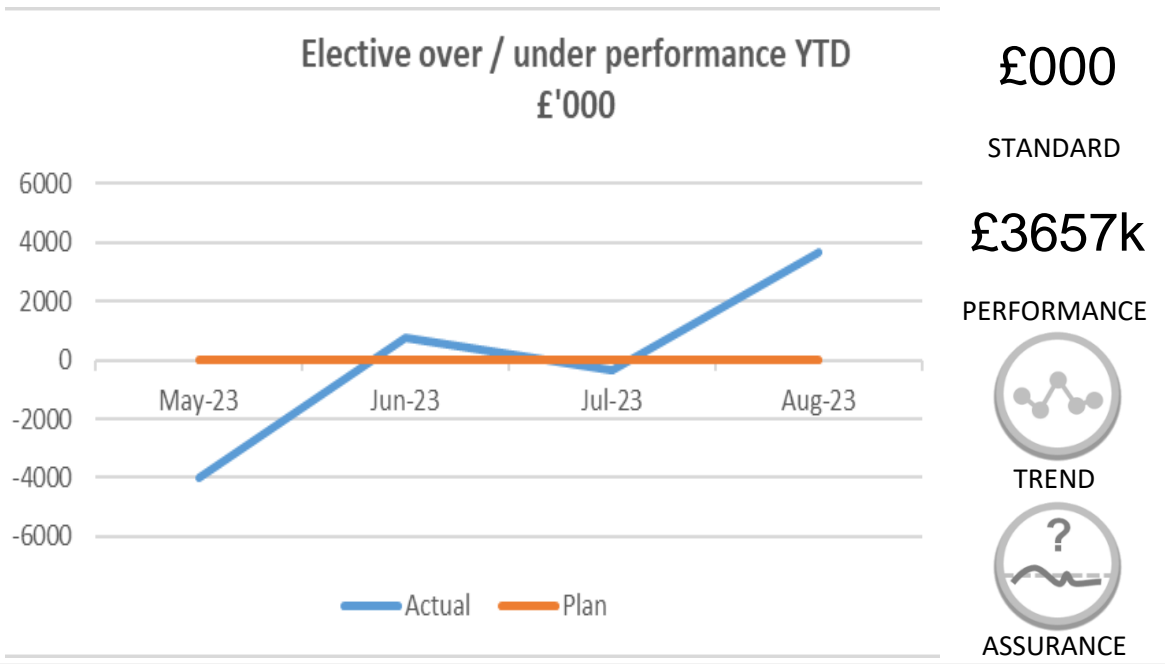
Committee: NWL Collaborative Finance and Performance Committee

Data Assurance: Trust's Monthly Financial Monitoring Returns to ICB and NHSE.

(Finance) Elective Recovery Performance (All Commissioners)



TREND



NARRATIVE

Performance:

Elective performance to the end of month 5 is a £3.7m over performance. This is against all commissioners and comprises an over performance of £0.3m on ERF PODs and a £3.3m overperformance on the other variable elements of the contract with NWL ICB.

Values are agreed between the APC and ICB by the APC ERF Working Group. Performance has been adversely impacted by doctors' industrial action which has caused reductions in activity over planned levels due to cancellations/[postponements. Removing the impact of this industrial action elective performance would be £9.9m over delivered to date.

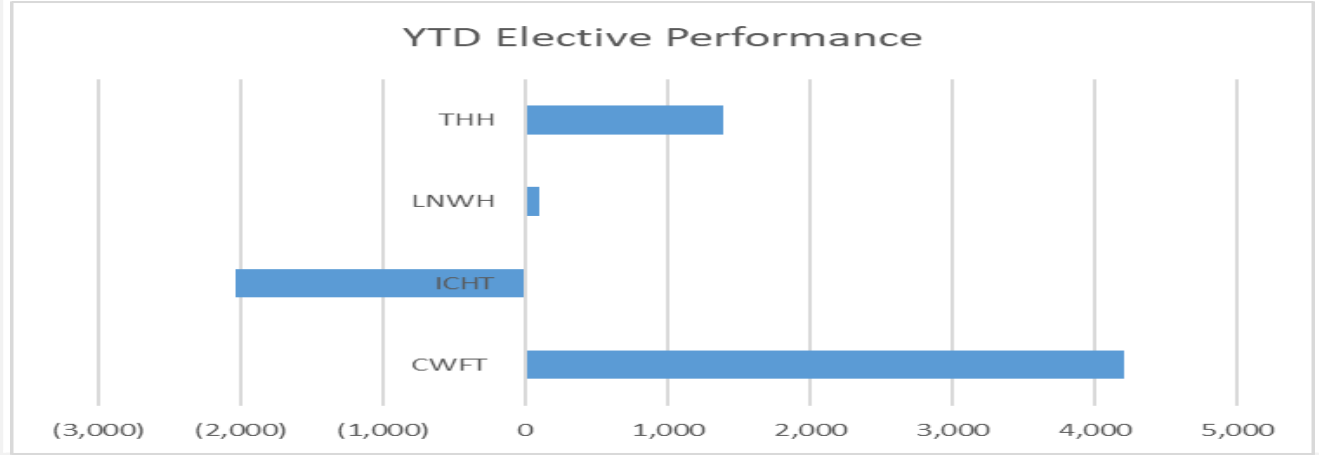
The target elective VWA for 2023/24 has been reduced by 2% to mitigate the impact of April's industrial action. This has returned £4.9m additional income into the position, included in the performance table here.

CURRENT PERFORMANCE

Elective Recovery Performance (All Commissioners)

	ERF Performance YTD Actual £'000	Other variable YTD elective performance £'000	Total Elective YTD Performance £000
CWFT	3930	280	4210
ICHT	(4473)	2431	(2042)
LNW	5	91	96
THH	865	529	1394
APC	327	3330	3657

STRATIFICATION



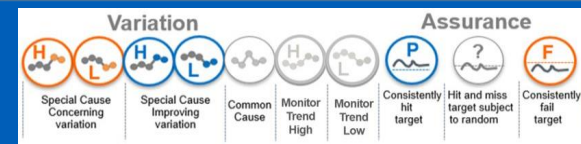
GOVERNANCE

Senior Responsible Owner: Jonathan Reid, Chief Financial Officer, LNW

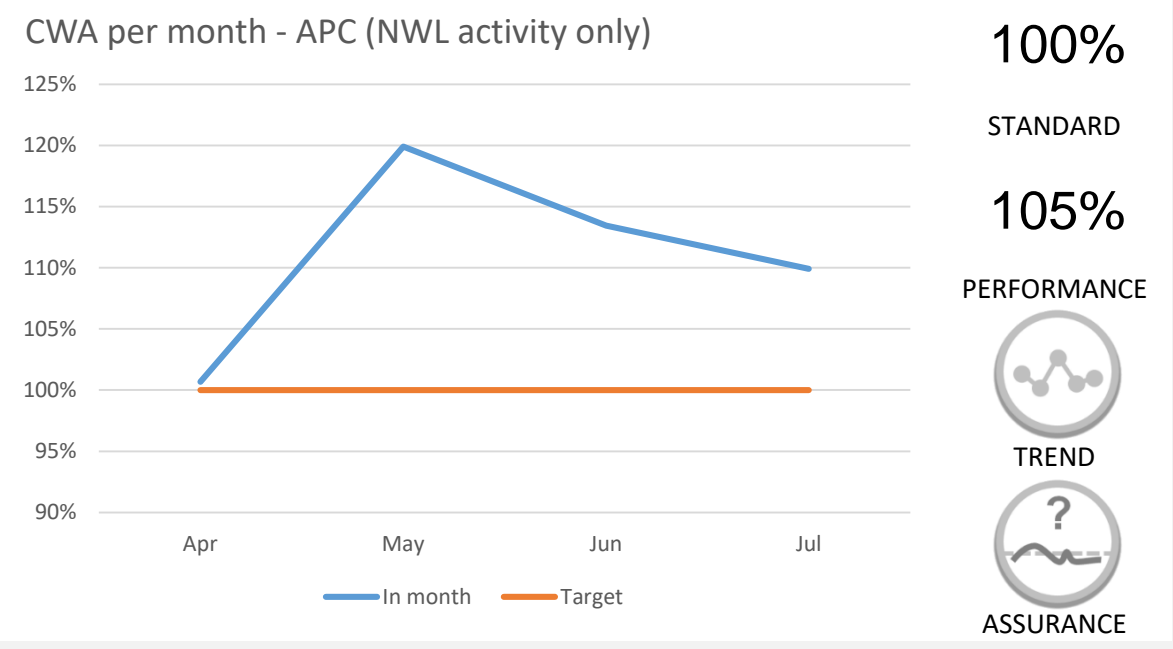
Committee: NWL Collaborative Finance and Performance Committee

Data Assurance:

(Finance) Cost Weighted Activity (NWL Only)



TREND



NARRATIVE

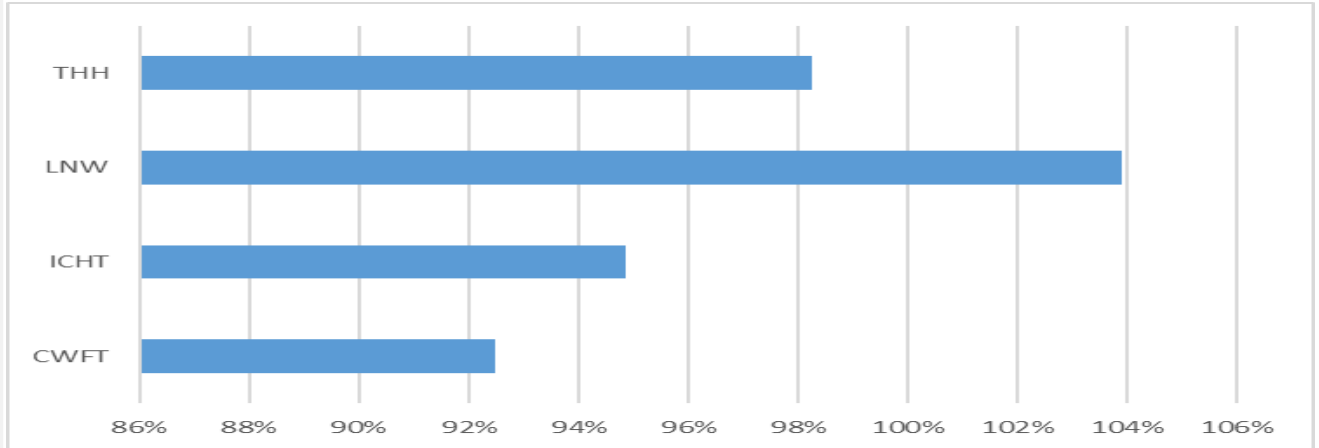
Performance:
 Cost Weighted Activity – the value of activity in 2023/24 compared to the same period in 2019/20 (adjusted for inflation) is 105%, or 5% higher than 2018/20 level for Aug.
 This is for NWL activity only.

CURRENT PERFORMANCE

Cost Weighted Activity YTD (NWL only)

	CWA Performance Actual YTD	CWA Performance Expected YTD	Difference from Target
CWFT	92%	100%	-8%
ICHT	95%	100%	-5%
LNW	104%	100%	+4%
THH	98%	100%	-2%
APC	102%	100%	2%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Jonathan Reid, Chief Financial Officer, LNW
Committee: NWL Collaborative Finance and Performance Committee
Data Assurance: Trust SLAM data reports.

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

Item number: 4.3

This report is: Public

2023/24 NWL APC Month 5 Finance Report

Author: Acute CFO Group, supported by Helen Berry
Job title: Associate Director of Finance, NWL APC

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

Purpose of report

Purpose: Assurance

This report sets out the financial position of the Collaborative at Month 5 (Aug 2023). 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.

Meeting: NWL Acute CFOs
25/09/2023
Outcome: Agreed

Executive summary and key messages

The report notes the Month 5 2023/24 financial performance for the NWL APC (Acute Provider Collaborative).

Key messages:

The NWL APC set a breakeven financial plan for 2023/24.

At the end of month 5 (Aug) the APC reports a deficit of £52.4m, against a year to date deficit

plan of £13.3m, therefore reporting a £39.2m adverse variance.

The key drivers are:

CIP programme is under delivered by £19.1m.

Junior Doctors and Consultants' industrial action has an impact on income (cancelled activity) of £15m and costs (paying for additional shifts to consultants and other medical staff), of £12.2m. In month 5, this has been partially mitigated by additional elective recovery fund (ERF) income which aims to cover the impact of April strikes (£4.9m), meaning the overall impact to date of industrial action is £22.4m.

Inflation over funded levels caused a pressure of c£7.3m to date.

Elective income performance to month 5 is an over performance of £3.7m, comprising £0.3m favourable on ERF and £3.4m favourable on the non ERF element of the NWL variable contract. The impact of industrial action on ERF income is £9.2m, therefore without the industrial action ERF performance would be £12.9m over delivered.

Operational overspends in clinical areas caused a further pressure on the budgets; in part mitigated by some non-recurrent benefits.

Junior doctors pay award – the back dated pay award of 6% was paid in month 5. The tariff in contract income has been uplifted to fund the award, however there is a shortfall in income over costs of £3.4m to date. This is being discussed at a regional and national level.

Escalation:

The NWL Acute CFO Group implemented a financial performance management framework for 2023/24 which includes escalation of performance management should the financial position and CIP delivery be adverse to plan. Peer to Peer CFO meetings have taken place throughout the financial year to address CIP delivery, risks, mitigations, prepare and review forecasts and ensure standard methodologies are in place across the APC.

Forecast:

At Month 5, the APC is forecasting to meet the annual breakeven plan, noting the risks (above). The detailed forecast produced at month 4 estimated a c£44m year-end deficit, factoring in additional ERF income (for April strikes) reduces this to c£33m. Forecasts built at month 4 are being reviewed in detail for month 5, and updated accordingly.

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

N/A



North West London
Acute Provider Collaborative

Four acute NHS trusts working together



Chelsea and Westminster
Hospital NHS Foundation Trust



The Hillingdon Hospitals NHS
Foundation Trust



Imperial College Healthcare
NHS Trust



London North West University
Healthcare NHS Trust

NWL APC

2023/24 Month 5 (August 2023)

Financial Performance

Helen Berry, Associate Director of Finance.

21 September 2023

Executive Summary

Financial Performance

At the end of month 5 the APC reports a deficit of £52.4m against a year-to-date deficit plan of £13.3m, thus reporting a £39.2m adverse variance to plan. The in-month deficit is £3.7m against a plan of £0.7m deficit, a £3m adverse variance to plan in the month. The APC's financial plan for the year is breakeven. The main drivers of the YTD variance to plan are:

Cost Improvement Programmes (CIP): The APC annual financial plan includes a CIP requirement of £119.5m. At month 5, the YTD target delivery is £47.4m, actual YTD delivery is £25.5m, of which £11.4m is non recurrent CIP. There is an adverse YTD variance of £21.9m. The rate of CIP delivery is on a par with last month at £7m and has improved since Q1 which saw an average monthly delivery of £3.1m. At this stage in the year, the expectation is full CIP will be delivered by the end of the year, although a significant element will be realised via non recurrent measures. The Financial Performance Management escalation process in place for 2023/24 continues and Peer to Peer CFO meetings are in place, which explore CIP programmes and processes to share learning across the APC. The APC business plan includes an objective to ensure CIP delivery is maximised and full CIP is met for 2023/24. Governance and reporting is through the new APC Executive Management Board and through to Finance & Performance Committees. In addition, all four trusts have CIP governance arrangements in place to monitor and manage the identification and delivery of CIP schemes. The Acute Productivity and Efficiency Leads Group continues to meet regularly to support delivery across the Collaborative by working in joint partnership on trust and ACP CIPs per the ACP business plan and a new CFO chaired APC Efficiency Board has been set up as the accountability vehicle to which CIP performance is reported.

Doctors' Industrial Action: Industrial action has taken place in each month of the financial year bar May, which has had a significant effect on the APC's ability to meet its financial plan to date. Contract income for planned care activity is reduced due to the postponement of elective care, at £14.2m; and other variable / private patient income by £1m. Pay expenditure increased due to the payment of additional shifts for cover, mitigated in part by the reduction in pay for the doctors' strike shifts; at £12.2m. In total the adverse impact on financial performance caused by this postponed activity and additional cost is £27.2m. In month 5, additional ERF income was realised due to the agreement to reduce the annual target elective activity value by 2%, to mitigate the impact of the April strikes and this returned £4.9m additional income to the APC which has been included in August's I&E. Including this mitigation, the overall impact on industrial action to date is therefore £22.4m.

Inflation: Included in the 2023/24 funding settlement is 5.5% to cover inflation. The 2023/24 AfC pay award is fully funded. A significant risk remains around contract inflation for services such as soft and hard FM utilities, and rates. The impact of unbudgeted inflation at month 5 is estimated at £7.3m to date. Inflationary pressures remains a significant unmitigated risk in 2023/24, currently estimated at c£20m FYE. The ICB has £6.7m funding (full year) for the ACP which will be distributed in month 6 to contribute to this cost pressure.

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

Cont'd overleaf.....

Executive Summary - continued

Contract Income Performance : The NHS payment mechanism for 2023/24 includes provision to pay for (most) planned care PODs as cost and volume (variable). In month 5, the APC has reported a favourable variance of £3.7m across the elective contracts. CWFT & THH report over performance, LNWH breakeven and ICHT reports under performance. Values include the additional income accounted for as a result of the 2% electivity activity value target adjustment. Excluding the impact of industrial action, the position would be a £12.9m overperformance on the elective contract.

Junior doctors pay award: the pay award of 6% was paid in August (backdated to April). The pay award had been accrued to month 4 but at 2% (per the original plan). Tariff income has been adjusted to reflect the additional cost, however for all trusts there is shortfall of income over cost. To date this is £3.4m for the APC, with an estimated full year impact of £8m, which contributes to the overall deficit.

2023/24 Financial Performance Management Process.

The NWL Acute CFO Group has implemented a financial performance management framework for 2023/24 comprising identification of a risk pool and additional measures to support the Collaborative in ensuring the financial plan is met. This includes escalation of performance management should the financial position and CIP delivery be materially adverse to plan.

Peer to Peer CFO meetings have taken place throughout the financial year to date, to review monthly financial performance in Trusts including the reasons for the adverse variance, ensuring standard methodology is used to account for material adjustments and CIP programme delivery, management and schemes.

Forecast

A detailed forecast at month 5 returned a c£44m deficit for the APC, This was based on a draft monthly trajectory of financial performance based on a set of assumptions regarding ERF performance, industrial action and inflation, plus additional local risks and mitigations. This draft year end deficit is almost entirely as a result of the adverse impact of excess inflation and industrial action. Factoring in the full year value of additional ERF income, the forecast reduces to c£33m deficit. Detailed work has been ongoing throughout month 5 to further to review forecasts, including assumed income increases, cost reductions needed, non-recurrent measures and other risks and mitigations Further detail is provided in the Financial Recovery paper.

APC Financial Performance at Month 5

NWL Acute Collaborative (Month 5 Financial Performance)

2023/24	In Month Plan £000	In Month Actuals £000	In Month variance £000	Year to date Plan £000	Year to date Actual £000	Year to date Var £000	YTD variance %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	303,520	327,853	24,333	1,497,875	1,552,100	54,225	3.6%	3,599,764	3,645,985	46,222
Pay	(184,188)	(207,265)	(23,076)	(910,719)	(974,852)	(64,133)	-7.0%	(2,183,972)	(2,226,922)	(42,951)
Non-Pay	(115,999)	(120,994)	(4,995)	(580,247)	(612,368)	(32,121)	-5.5%	(1,393,009)	(1,398,064)	(5,055)
Non Operating Items	(4,041)	(3,261)	780	(20,182)	(17,289)	2,893	14.3%	(22,783)	(20,999)	1,784
Total	(708)	(3,666)	(2,958)	(13,273)	(52,408)	(39,135)		0	0	0

The table shows the month 5 financial performance of the APC, by I&E category, a £39.1m YTD adverse variance to plan and an adverse in month variance of £2.9m. The main drivers are:

- Income – Doctors’ Industrial Action impacts on elective and other variable income compensated by income over budgeted levels for the UCCs at LNWH and THH (with corresponding costs in pay and non-pay) ; income to account for the higher cost of the AfC pay settlement (over tariff funded levels), some income overperformance on other patient care contracts. In the month there is a significant favourable variance (£24m) explained by additional income to account for the higher (than planned for) junior doctors’ pay award which was paid in month 5. The contract income tariff has been adjusted to account for the additional pay award.
- Expenditure (Pay and Non pay) – cost of doctors’ industrial action, CIP under delivery, operational pressures and inflation, incremental cost of the AfC pay award (over tariff funded level) and UCC expenditure (compensated by income as above). In the month, the junior doctors pay award of 6% was paid, to date 2% had been accrued in line with plan. The year-to-date impact of paying the additional 4% causes the adverse variance in the month.
- To note, for the junior doctors pay award, paid in August and backdated to April, there is a shortfall of income over costs which contributes to the monthly deficit, this is c £3.4m. The impact will be factored into refreshed forecasts at month 5.

APC Financial Performance at Month 5 by Trust

NWL Acute Collaborative (Month 5 Financial Performance by Trust)

2023/24	In Month Plan	In Month Actuals	In Month variance	Year to date Plan	Year to date Actual	Year to date Var	Year to date (deficit) / surplus as a % of YTD income %	Annual Plan	Annual Forecast	Forecast Variance
	£000	£000	£000	£000	£000	£000		£000	£000	£000
CWFT	13	485	472	215	(3,930)	(4,145)	-1%	0	0	0
ICHT	0	(1,232)	(1,232)	0	(18,146)	(18,146)	-3%	0	0	0
LNWH	719	(1,492)	(2,211)	(4,324)	(16,391)	(12,067)	-4%	0	0	0
THH	(1,440)	(1,428)	12	(9,164)	(13,942)	(4,778)	-10%	0	0	0
Total	(708)	(3,666)	(2,958)	(13,273)	(52,408)	(39,135)	-3%	0	0	0

The table shows the month 5 financial performance by Trust, all trusts report adverse variances to plan YTD. In month 5, CWFT and THH report favourable variances. As a percentage of the year-to-date turnover, the deficit is 3% (down from 4% at month 4).

At month 5, trusts are reporting an annual forecast of breakeven in line with the plan, however the draft forecast prepared at month 4 notes an estimated deficit of c£33m. Risks to delivery include :

- CIP performance
- Excess inflation pressure (over funded levels).
- Funding gap on junior doctors pay award
- Industrial action impact on costs and income.
- Other run rate pressures in operational budgets.

APC Financial Performance Month 5 – Doctors' Industrial Action

Month 5 - Monthly Junior Doctors & Consultants Industrial Action Impact

2023/24 M5	April				June				July				August				Total			
	Cost	Elective (ERF) Income	Other variable Income	Total	Cost	Elective (ERF) Income	Other variable Income	Total	Cost	Elective (ERF) Income	Other variable Income	Total	Cost	Elective (ERF) Income	Other variable Income	Total	Cost	Elective (ERF) Income	Other variable Income	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	(714)	(858)	(175)	(1,747)	(615)	(322)	(150)	(1,087)	(734)	(860)	(170)	(1,764)	(817)	(495)	(120)	(1,432)	(2,879)	(2,536)	(615)	(6,030)
ICHT	(707)	(1,619)	(300)	(2,626)	(630)	(760)	(100)	(1,490)	(1,381)	(1,704)	(120)	(3,205)	(1,815)	(2,205)	(120)	(4,140)	(4,533)	(6,287)	(640)	(11,460)
LNWH	(725)	(893)	0	(1,618)	(742)	(903)	0	(1,645)	(1,010)	(1,227)	0	(2,237)	(833)	(1,010)	0	(1,843)	(3,310)	(4,033)	0	(7,343)
THH	(410)	(351)	0	(761)	(354)	(400)	325	(429)	(382)	(347)	(27)	(756)	(288)	(178)	(25)	(490)	(1,434)	(1,276)	273	(2,436)
Total	(2,556)	(3,721)	(475)	(6,752)	(2,340)	(2,385)	75	(4,651)	(3,507)	(4,138)	(317)	(7,961)	(3,753)	(3,888)	(265)	(7,905)	(12,156)	(14,132)	(982)	(27,269)
Cost/ income loss per (working) strike day	(639)	(930)	(119)	(1,688)	(780)	(795)	25	(1,550)	(701)	(828)	(63)	(1,592)	(938)	(972)	(66)	(1,976)	(760)	(883)	(61)	(1,704)

- Industrial action has occurred each month except May: over 16 working days (20 calendar days) to date. The overall adverse impact is on average c£1.7m per working day.
- The impact on the cost base is £12.2m to date.
- The impact on income is a reduction of £14.1m elective income and £1m other variable income (private patient and other non-ERF variable income).
- The total cost and income impact of £27.3m is mitigated to month 5 by additional income granted to account for April strikes, of £4.9m. This reduces the overall impact of IA to £22.4m, per the table on the right.
- The calculation of the additional ERF income is explained on slide 9.

Month 5 YTD summary - net impact of Doctor's industrial action

2023/24 M5	Cost	Elective (ERF) Income	Other variable Income	Total	Add'l ERF to M5 (2% target)	Net impact of IA in I&E
	£000	£000	£000	£000	£000	£000
CWFT	(2,879)	(2,536)	(615)	(6,030)	1,028	(5,002)
ICHT	(4,533)	(6,287)	(640)	(11,460)	2,039	(9,421)
LNWH	(3,310)	(4,033)	0	(7,343)	1,307	(6,036)
THH	(1,434)	(1,276)	273	(2,436)	518	(1,918)
Total	(12,156)	(14,132)	(982)	(27,269)	4,892	(22,377)

APC Financial Performance Month 5 – Excess inflation

Inflation over funded levels	YTD M5 (est)
	£000
CWFT	(1,183)
ICHT	(2,814)
LNWH	(2,451)
THH	(868)
Total	(7,316)

The table notes the year to date estimate of excess inflation at £7.3m.

Excess inflation is the cost pressure caused by higher prices for services in excess of the amount funded in the national tariff (income). Tariffs were uplifted by 5.5% to account for inflationary pressures, which have fallen short of actual inflation for many goods and services, most notably soft and hard FM contracts, utilities, rates and rental.

Finance teams have reviewed the methodology of calculating excess inflation and the method is uniform across all trusts.

To note, the ICS will be distributing funding to contribute to the excess inflation cost pressure of £6.7m (full year). ICHT have included the year-to-date income (£0.8m) at month 5. The others will reflect from month 6.

APC Run rate - Month 5

Monthly actual run rate movement (stripping out industrial action impact & inflation)

2023/24	Month 1 run rate	less IA & excess inflation	Month 1 (net)	Month 2 run rate (No IA)	less excess inflation	Month 2 (net)	Month 3 run rate	less IA & excess inflation	Month 3 (net)	Month 4 run rate	less IA & excess inflation	Month 4 (net)	Month 5 run rate	* less IA & excess inflation	Month 5 (net)	M5 YTD Actual	M5 YTD IA&Infl	M5 YTD Actual Net of IA/IA 2%/ Infl	M5 YTD plan	M5 YTD variance exl; IA/ERF 2%/Infl impact
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	(1,616)	1,980	364	(24)	233	209	(1,210)	1,320	110	(1,565)	1,997	432	485	655	1,140	(3,930)	6,185	2,255	215	2,040
ICHT	(10,481)	3,294	(7,187)	(4,304)	668	(3,636)	(1,555)	2,158	603	(574)	3,872	3,298	(1,232)	2,243	1,011	(18,146)	12,235	(5,911)	0	(5,911)
LNWH	(6,418)	2,111	(4,307)	(3,331)	493	(2,838)	(1,820)	2,137	318	(3,331)	2,729	(602)	(1,492)	1,016	(476)	(16,391)	8,487	(7,904)	(4,324)	(3,580)
THH	(2,790)	978	(1,812)	(2,848)	217	(2,631)	(3,392)	646	(2,746)	(3,484)	973	(2,511)	(1,428)	(28)	(1,456)	(13,942)	2,786	(11,155)	(9,164)	(1,991)
Total	(21,305)	8,362	(12,942)	(10,507)	1,611	(8,896)	(7,977)	6,261	(1,716)	(8,954)	9,572	618	(3,666)	3,886	220	(52,408)	29,693	(22,715)	(13,273)	(9,442)

- The table notes the monthly run rate (actuals) for month 1 to month 5 and strips out the impact of industrial action and inflation. Note there are non-recurrent benefits that support the position, but these have not been removed. The additional YTD ERF income received in month 5 resulting from the 2% target reduction is also removed (from month 5).
- There is an improvement in the underlying monthly financial position for the APC, although the month 5 surplus is lower than month 4:
M1: (£12.9m deficit); M2 : (£8.9m deficit); M3 : (£1.7m deficit); M4 : £0.6m surplus; M5: £0.2m surplus
- To date, the actual I&E position, net of IA and inflation is £22.7m, and against a YTD plan of £13.3m, returns a year-to-date adverse variance of £9.4m. This can be explained in the main by CIP under delivery mitigated by some non-recurrent benefits.

APC Month 5 Elective Income – 2% baseline adjustment

In 2023/24 elective activity is paid for on a cost and volume (variable) basis. The elective activity plan includes “ERF” PODs - day case, elective, outpatient firsts and outpatient procedures. These are subject to national VWA targets and national pricing.

In addition, the NWL ICB elective contract includes other planned care PODs which are for local agreement, and paid for on a variable basis, these are outpatient unbundled; excluded drugs and excluded devices.

For the ERF PODs the 2023/24 target VWA %'s, against the (repriced) 19/20 baseline are:

2023/24 VWA % targets (ERF PODS)	LNWH	CWFT	ICHT	THH	NWL ICB
	%	%	%	%	%
NWL activity	108	115	104	106	109
ALL ICS activity	109	113	104	105	

In agreement with the ICB, up to month 5, trusts have estimated performance against the YTD VWA % targets, and calculated elective (“ERF”) income. In addition, performance against the “Non ERF” PODs is also calculated and included in the YTD position. Measured against the YTD baseline target this gives under or over performance. The VWA targets have been reduced by 2% in August, so the %'s in the above table are now 2% lower.

Elective - 2% target adjustment impact

	Annual VWA target pre adjustment	Revised annual VWA target less 2%	Annual Variance	YTD impact (based on working days)
Trust	£000	£000	£000	£000
CWFT	139,566	137,072	2,494	1,028
ICHT	339,882	334,933	4,949	2,039
LNWH	171,807	168,635	3,173	1,307
THH	65,689	64,431	1,258	518
Total APC	716,944	705,070	11,873	4,892

In month 5, NHSE amended the elective target VWA for 2023/24 , it is reduced by 2% to account for the impact of the doctors' industrial action in April.

This amends the whole year's VWA target. The table above notes that the impact over the whole year is additional ERF income of £11.8m. To month 5, a proportion of this has been included – based on the number of working days / calendar days to the end of August (103/250), £4.9m

The reason the year-to-date value is accrued is because April's strike action impacts on Trust's ability to reach elective targets over the whole of the rest of the financial year. This methodology is prescribed by NHSE.

APC Month 5 Elective Income – Performance

Elective under/overperformance to end of Month 5

	NWL ICB ERF	Non NWL ICB ERF	Spec Comm ERF	Total ERF	NWL Other variable	Total	Movement in performance M4 to M5
Trust	£000	£000	£000	£000	£000	£000	£000
CWFT	2,943	1,013	(26)	3,930	280	4,210	1,875
ICHT	(1,579)	(1,395)	(1,499)	(4,473)	2,431	(2,042)	619
LNWH	1,343	(139)	(1,199)	5	91	96	(1,483)
THH	1,524	(1,591)	932	865	529	1,394	3,016
Total APC	4,231	(2,112)	(1,791)	327	3,330	3,657	4,027

YTD performance includes 2% target reduction

The APC reports a £3.7m favourable impact caused by elective income performance to month 5. This comprises £0.3m over performance of ERF and £3.7m over performance on the locally agreed PODs.

Values include the £4.9m of additional ERF resulting from the 2% VWA target adjustment.

There is an improvement in overperformance of £4m compared to last month, mostly due to the 2% target adjustment, although THH also reports a marked improvement in its underlying ERF performance

In addition to the above performance, LNWH has included a further £4.1m elective income in the YTD position to mitigate against the impact of reduced activity reported due to Cerner implementation in the month.

Elective performance net of IA impact

	Elective perf reported	IA impact on elective income	IA addtl (2%)	Elective perf before IA impact
	£000	£000	£000	£000
CWFT	4,210	(2,536)	1,028	5,718
ICHT	(2,042)	(6,287)	2,039	2,206
LNWH	96	(4,033)	1,307	2,822
THH	1,394	(1,276)	518	2,152
Total	3,657	(14,132)	4,892	12,897

The table shows elective performance net of the impact of industrial income (which is a reduction of £14.1m elective income mitigated by the additional £4.9m for the 2% target reduction).

£12.9m overperformance would be reported without industrial action.

APC Month 5 CIP Summary

APC - Efficiency Delivery M5

2023/24	YTD plan			YTD actuals			YTD Var	Annual Plan			Annual Forecast			Fcast Variance
	R	NR	Total	R	NR	Total		R	NR	Total	R	NR	Total	
Efficiency Month 5	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	9,800	0	9,800	5,305	3,841	9,146	(654)	23,520	0	23,520	15,765	7,755	23,520	0
ICHT	22,257	0	22,257	2,582	2,238	4,820	(17,437)	53,421	0	53,421	20,270	33,151	53,421	0
LNWH	13,250	0	13,250	4,180	5,300	9,481	(3,769)	31,800	0	31,800	19,469	12,331	31,800	0
THH	2,051	0	2,051	2,051	0	2,051	0	10,757	0	10,757	10,757	0	10,757	0
Total	47,358	0	47,358	14,119	11,378	25,498	(21,860)	119,498	0	119,498	66,262	53,237	119,498	0
% delivery of plan				30%	24%	54%					55%	45%	100%	

- The CIP plan for the APC in 2023/24 is £119.5m or 3.2% of income. The CIP plan is profiled in equal 12ths at three trusts; THH has an increasing profile throughout the year.
- At Month 5 the APC is £21.9m under delivered at £25.5m against a year-to-date plan of £47.4m. £11.4m has been classed as non-recurrent CIP.
- To date 54% of the year-to-date plan is delivered. Month on month there is a step up in delivery at £7.0m in month 5 compared to £4.6m per month up to month 4.
- At month 5, the forecast expectation is to meet the annual CIP plan in full, noting risks in the forecast.

Actions to address CIP identification and delivery:

- APC Business plan CIP delivery workstream with CFO SROs.
- New strengthened governance arrangements regarding CIP delivery including a new Efficiency Board, chaired by CFOs.
- Collaborative and joint working throughout the APC by the Acute Collaborative Productivity & Efficiency group – sharing knowledge on schemes, identification, reporting and governance.
- A common methodology in place for measuring CIP across the collaborative in 2023/24 to ensure consistency of reporting.
- Financial Performance escalation in place in 2023/24.

APC Financial Performance Month 5 – variance breakdown

Month 5 - high level variance breakdown

2023/24 Month 5	YTD variance	Outside Trust's Control				Within Trust's Control			YTD variance
		YTD Drs IA impact (cost)	YTD Drs IA impact (Income)	YTD Add'l Elective Income (2% target adj)	Inflation > funded level (est)	CIP variance	Elective under/over (@M5) net of IA & 2% adj	Other	
	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	(4,145)	(2,879)	(3,151)	1,028	(1,183)	(654)	5,718	(3,023)	(4,145)
ICHT	(18,146)	(4,533)	(6,927)	2,039	(2,814)	(17,437)	2,206	9,320	(18,146)
LNWH	(12,067)	(3,310)	(4,033)	1,307	(2,451)	(3,769)	2,822	(2,633)	(12,067)
THH	(4,778)	(1,434)	(1,002)	518	(868)	0	2,152	(4,143)	(4,777)
Total	(39,135)	(12,156)	(15,113)	4,892	(7,316)	(21,860)	12,897	(479)	(39,135)
Total outside control					(29,693)	Total within control			(9,442)

The table shows the breakdown of the £39.1m YTD variance, split into reasons outside the control of Trusts (£29.7m) and within their control (£9.4m) :

- Doctors' industrial action – cost impact £12.2m
- Doctors' industrial action – income impact £15.1m, of which £14.1m is against elective and £1m is against other variable income including private patients at ICHT. This is mitigated by £4.9m additional elective income due to the 2% reduction in the VWA target for 2023/24.
- Inflation pressure (above funded level) £7.3m
- CIP under delivery of £21.9m
- Elective over performance (net of IA impact), £12.9m (see slide 10).
- Other - £0.04m favourable, comprising run rate pressures and operational overspends which are mitigated by non-recurrent benefits in some areas.

APC Month 5 Capital Summary

The APC Capital Plan for 2023/24 is £262.5m, comprising schemes funded from trust capital and national funding.

To note expenditure on capital might exceed the CRL (capital resource limit) where projects are funded from other sources such as additional grants and donations.

The national schemes are funded from the DHSC national capital programme and the Targeted Investment Fund, noted in the table below (as at the financial year beginning, to be updated):

National Programme	£000
Community Diagnostic Centres	31,679
Diagnostic Digital Capability Programme	387
Endoscopy - Increasing Capacity	6,247
Front Line Digitisation	972
New Hospital Programme (THH)	26,200
UEC Capacity	26,000
Total	91,485
Targeted Investment Fund	£000
Elective Recovery	20,141
Total	20,141
Total - DHSC programmes	111,626

Capital	M5 2023/24			Annual 2023/24		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	16,920	7,688	9,232	82,200	44,311	37,889
ICHT	24,697	24,523	174	76,448	86,784	(10,336)
LNWHT	25,749	15,840	9,909	55,404	84,968	(29,564)
THH	15,302	12,824	2,478	48,427	54,170	(5,743)
Total	82,668	60,875	21,793	262,479	270,233	(7,754)

At Month 5, the APC has spent £60.8m on capital, against the year-to-date plan of £82.7m, a £21.8m favourable variance.

The forecast variance to plan, is £7.7m overspent. This is due to additional projects being approved to date whereas the original capital plan remains per the original plan submission.

The overspend at LNWH is due to additional capital funding granted for a new 32 bed modular ward at LNWH and additional front line digital funding. reflect this. The underspend at CWFT reflects NWL ICS reserves held by the Trust at planning stage, now allocated out to relevant organisations.

APC Month 5 Cash

The APC cash balance stood at £355.1m at the end of August, which represents a decrease of £53.8m since the end of the previous financial year.

Three trusts reports decreases in their cash balances , one trust (CWFT) reports an increase:

- The increase in CWFT is due to an increase in NHS income receipts.
- The decrease at ICHT is line with the plan and results from movements in working capital and capital expenditure.
- The decrease at LNWH stems from the reported I&E deficit position plus payment of large year end capital creditors in the first quarter of the year.
- The decrease in THH is due to an increase in debtors and the I&E deficit position.

NWL APC Cash Balance			
Trust	31-Mar-23	31-Aug-23	Movement
	£m	£m	£m
CWFT	160.2	163.9	3.7
ICHT	179.2	148.9	(30.3)
LNWH	50.1	29.4	(20.7)
THH	19.4	12.8	(6.5)
Total	408.9	355.1	(53.8)

APC Trust Summary Narrative

THH:

At M5, the Trust is reporting a YTD deficit of £13.9m, an adverse variance to plan of £4.8m. The main drivers of the variance are the impact of the doctors strikes (£2.4m) and unfunded inflation on utilities (£0.9m). RMN costs remain exceptionally high and contribute £1.1m adverse to the I&E position.

Total income and activity is 6.2% above plan YTD. The Trust is overperforming in non-elective (which is under a block) and underperforming on elective activity which is being offset by higher income on OP 1st and A&G. Elective recovery has improved in month 5, both as a result of additional income accrued due to a 2% baseline reduction and an improvement in the underlying elective activity.

The efficiency target for 2023/24 is £10.8m and is phased to ramp up through the year. In addition, £7.7m efficiency target carried forward from 22/23 is in the plan. For Month 5 the 2023/24 plan is £0.8m and this has been achieved for August. Work continues on both delivery of developed schemes and to develop further opportunities. The current programme has identified opportunities of £21.5m.

LNWH:

The Income & Expenditure position to the end of August is a deficit of £16.4m, a variance to plan of £12.1m. The variance is driven by several factors: the impact of the industrial action £7.4m YTD (£4m income loss and £3.4m of additional costs) in addition to excess inflation (£2.3m) above planned levels.

ERF overperformance is £4.1m compared with £1.5m in month 4 (although this figure is derived without the benefit of accurate activity and income data for the period after Cerner implementation). The estimated surplus has grown substantially (£1.3m) due to 2% reduction in the ERF target to offset the loss of income arising from industrial action in April.

The YTD position assumes that all UTC related costs, (identified c.£6.7m YTD) are fully recovered. The NWL ICB has now formally awarded the contract for provision of UTC services to the Trust.

CIP delivery YTD is £9.7m against a plan of £13.3m (annual plan of £31.8m has been phased over an equal monthly profile). Identified schemes have been quantified to the value of £31.9m.

CWFT:

At month 5 the Trust is reporting an in-month surplus of £0.49m and a year-to-date deficit of £3.93m. This is £4.15m adverse against the YTD plan. The YTD variance is largely driven by the ongoing industrial action (£6.03m), which is a combination of additional cost (£2.89m) and loss of income (ERF (£2.54m), GUM (£0.59m) & Private Patients (£0.03m)). Also contributing is non-pay inflation above the funded levels (£1.2m). The Trust has also reported underachievement against CIP delivery (0.65m), Overall YTD slippage and inflationary pressures have been mitigated by over delivery of activity, the 2% target adjustment for elective activity (£1.0m) and other benefits, resulting in industrial action being the main driver of the adverse variance.

ICHT:

At Month 5 the Trust is reporting a 18.1m deficit YTD against a breakeven plan..

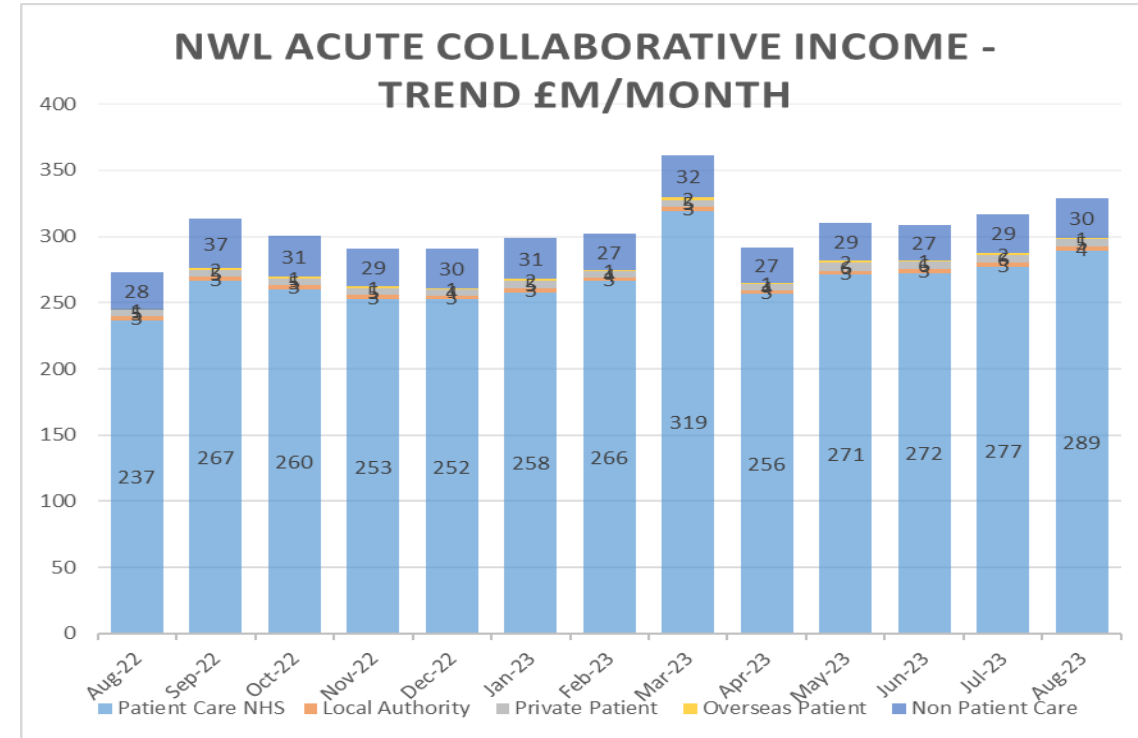
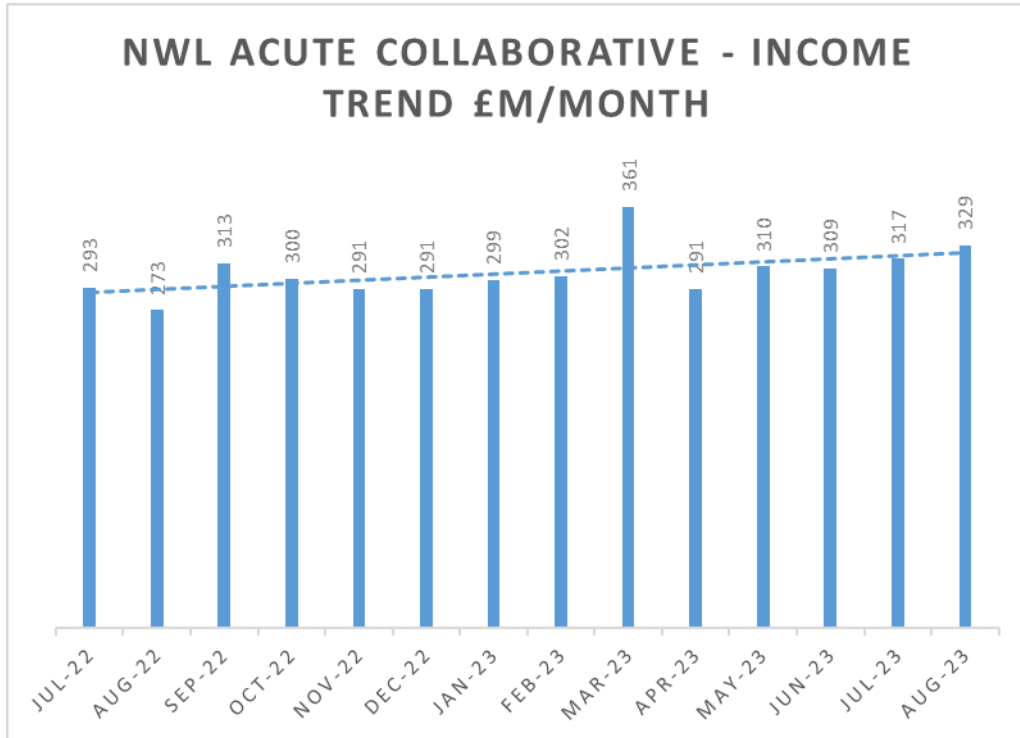
The material drivers of the variance remain the under achievement of efficiencies (£17.1m); assumed loss of income and costs incurred for industrial action (£11.4m); excess inflation above funded levels (£2.8m) with other overspends on operational budgets offset by £2m VWA target reduction, an upside on finance costs, non-recurrent benefits, and net other underspends mainly in Corporate areas.

As at Month 5, £20.55m of efficiency schemes have been planned and phased on TrakIt by services. £4.74m of efficiencies have been delivered YTD which is £17.51m adverse to plan. The Trust has a quantified pipeline of £5.74m (on Trakit), alongside £2.34m of additional "best case" measures still to be reflected on Trakit This brings the total programme value to £28.63m. A further set of transformational priority areas are being worked up, with a total potential benefit value of circa £19m.

Appendix 1

NWL APC Income & Expenditure Trends at Month 5

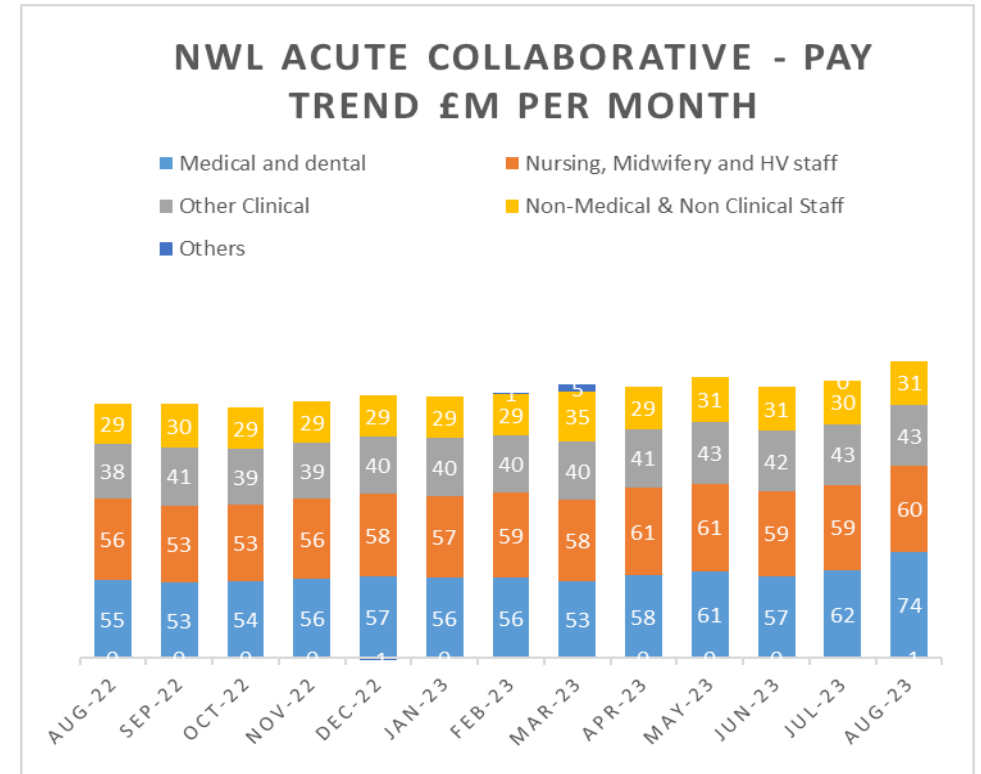
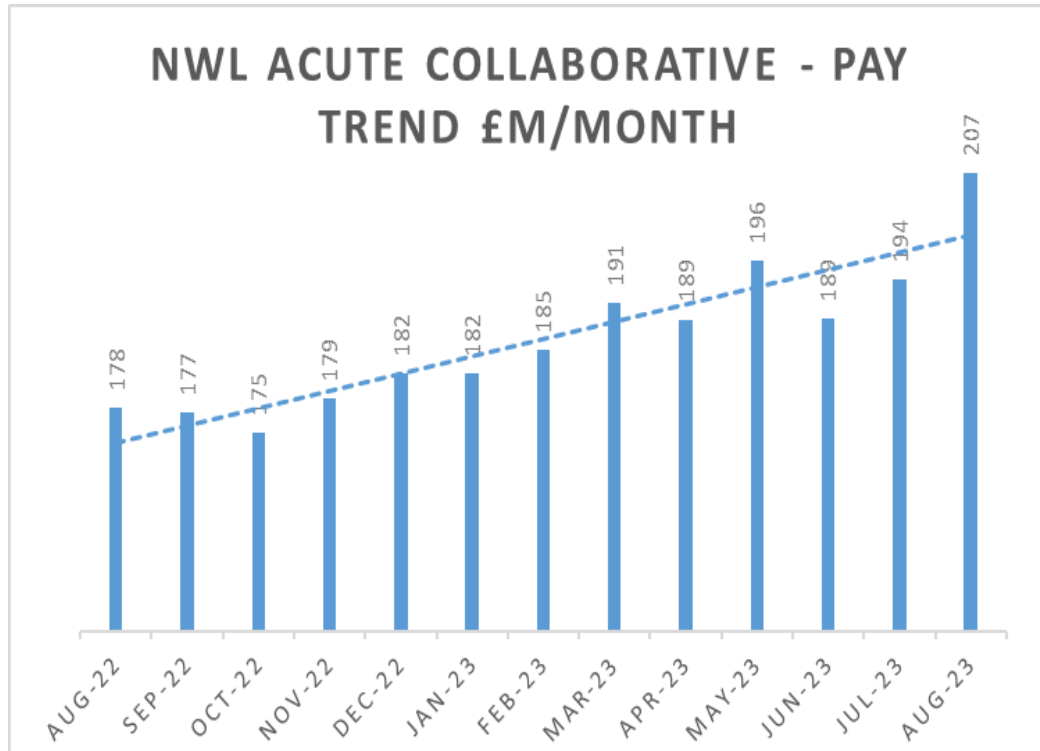
NWL APC Income Trend



The graphs show the monthly income trend for the APC. Figures are absolute; however, March 23 value has been adjusted to remove material one off income: income received for the non-consolidated AfC pay award and additional employers pension charges. The residual March 23 spike accounts for non-recurrent income received at the end of the year and other year-end adjustments made.

In Aug 2023/24, the medical pay award was paid (backdated from April), the corresponding YTD funding causes an increase in income in the month. Overall monthly income as increased by **5%** on average, over 2022/23.

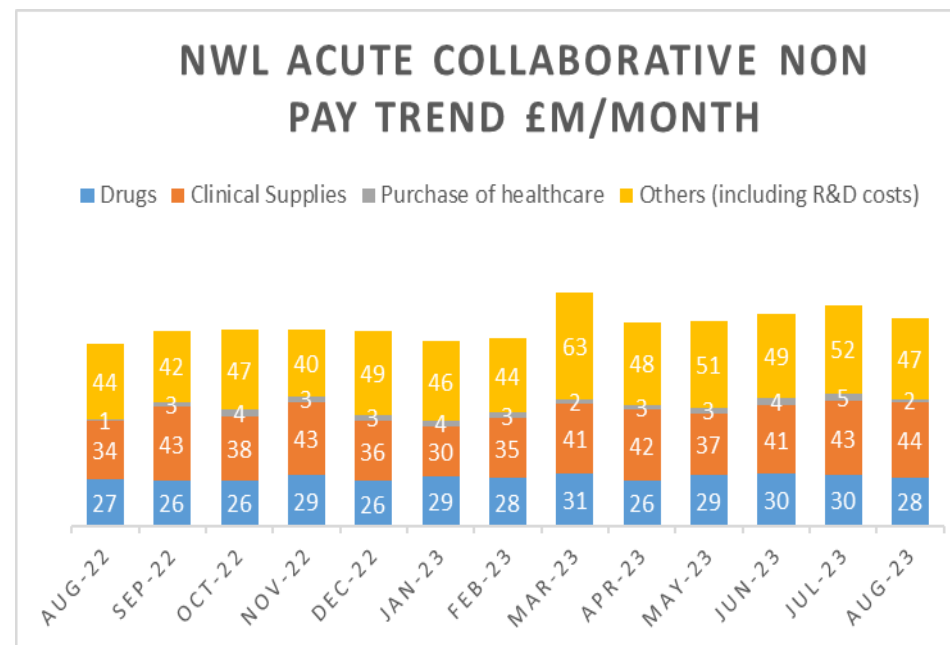
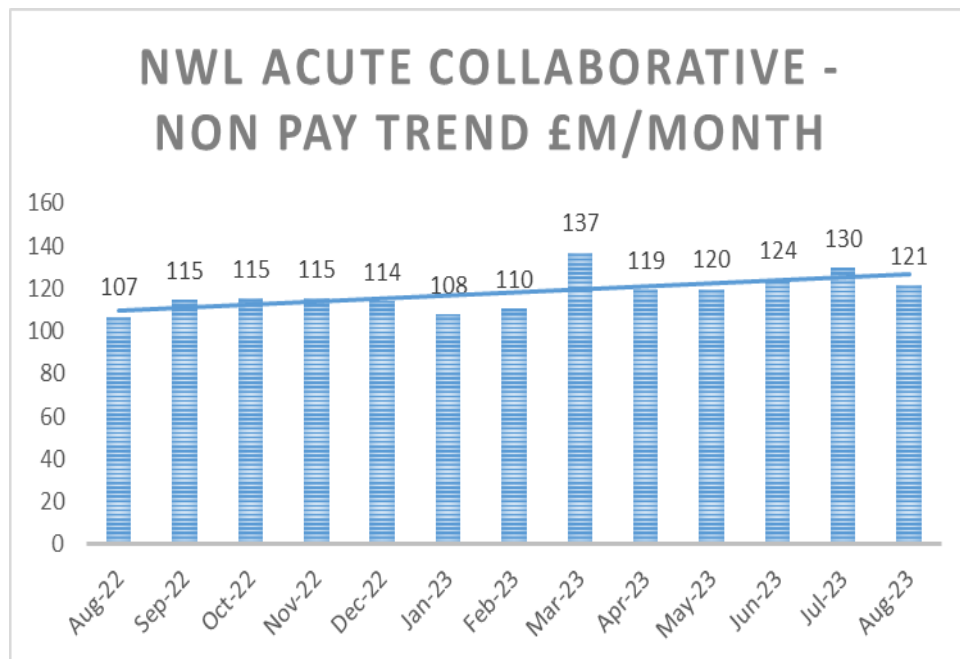
NWL APC Pay Trend



The graphs shows the pay trend of the APC. Figures are absolute; however March 2023 has been adjusted for material items: the non-consolidated AfC pay award and the additional employers pension charges.

Pay has increased by an average of 6.7%. To note AfC pay award of 5%, junior doctors pay award of 6% and pay costs of the THH and LNWH UCCs are new in 2023/24 contributing to the increase. In addition, pay pressure associated with industrial action, also contributes. In month 5 the junior doctors pay award was paid (backdated to April) which causes the spike here.

NWL APC – Non Pay Trend



The graphs show the non-pay trend of the APC.

Non pay has increased by 8% in 2023/24 compared to 2022/23 , a major factor is the continuing increases to inflation across utilities, rates, facilities management contracts (increase here is c8%), and drugs has also increased (by 10%).

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

Item number: 4.4

This report is: Public

Winter planning, including elective capacity plans

Author: Robert Hodgkiss, Deputy CEO and COO (CWT); James Walters, COO (LNW); Tina Benson (THHT); Claire Hook (Imperial)
Job title: NWL APC Chief Operating Officers

Accountable director: Lesley Watts
Job title: CEO, Chelsea and Westminster NHS Foundation Trust and lead acute provider collaborative CEO for finance and performance

Purpose of report

Purpose: Assurance

Each of the four acute trusts have developed comprehensive, individualised winter resilience plans, tailored to their specific physical estate and workforce challenges. At the time of writing all Acute Trust Winter resilience plans are in the process of going through their own internal governance arrangements for Executive sign off and assurance. The report outlines the key system-wide plans and investment for 2023/24 and focus on the additional bedded capacity within the Acute Trusts and the key, planned initiatives to support flow by site.

Report history

NWL APC Executive Management Board 04/10/2023 Considered and discussed.		
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Executive summary

North West London (NWL) Integrated Care System (ICS) submitted a Winter Plan to NHS England (NHSE) London on 11 September 2023 in response to the requirement signalled in the guidance 'Delivering Operational Resilience Across the NHS this winter'. The submission detailed performance and activity capacity that it is planned will meet the demands of winter 2023/24 and was accompanied by a narrative that responds to specific questions posed of Integrated Care Boards (ICBs).

Alignment with the NWL 'Winter Plan Update – 23/24' detailing the sources and applications of winter funding presented to ICS Leadership on 4 August has been confirmed. The key assumption made in the submission is that NWL ICS planned performance and activity has not changed from the 2023/24 Operating Plan unless otherwise subsequently agreed with NHSE.

Planned acute winter escalation beds total 178 general and acute beds. 104 of these beds were included within the 2023/24 Operating Plan and an additional 74 beds have been agreed through winter planning. There is sufficient funding within the available envelopes to cover the 178 beds. The requirement to ensure total beds (core and escalation) are no lower than plan numbers or those in place at March 2023 has been met.

General and Acute bed occupancy is now planned to meet the 92% national target surpassing the 95% agreed in the Operating Plan. The number of Critical Care beds remains at 195 beds through winter however the programme is currently developing a surge plan to accommodate a 10% increase in demand. This plan does not have associated funding.

The ICS is not meeting the plan to reduce the number of G&A beds occupied by patients not meeting the criteria to reside, with a revised plan in place to 336. (Current position is 494 – See Appendix A).

No additional escalation capacity has been agreed for 2-hour Urgent Community Response as the Operating Plan performance of 90% is in excess of the national requirement of 75% of referrals being responded to within 2 hours. The community bed plan maintains the same capacity through the winter with 181 beds opened during the winter period compared to 180 reported in June. The virtual ward capacity plan in agreement with NHSE has been revised, with an agreed and funded plan to open 550 virtual beds.

Funding previously notified to ICS Executives, allocated to Discharge Hubs, Admission Avoidance and Bridging Services, is in line with the service specifications detailed in this pack and have not changed. A description of Providing Assessment and Treatment for Children at Home (PATCH) service has been included in the appendices for completeness as it is separately funded through the NWL ICS Winter Plan. Primary Care winter plans have also been included.

The Mental Health, Learning Disability and Autism plan has been included in the appendices for completeness although not separately funded through the ICS Winter Plan.

Strategic priorities

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

Impact assessment

- Equity
- Quality
- People (workforce, patients, families or careers)

- Operational performance
- Finance
- Communications and engagement
- Council of governors

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

Winter planning, including elective capacity plans

October 2023



North West London Acute Provider Collaborative

Each of the four Acute trusts have developed comprehensive, individualised winter resilience plans, tailored to their specific physical estate and workforce challenges.

At the time of writing all Acute Trust Winter resilience plans are in the process of going through their own internal governance arrangements for Executive sign off and assurance.

The following slides describe the key system-wide plans and investment for 23/24 and focus on the additional bedded capacity within the Acute Trusts and the key, planned initiatives to support flow by site.

Key Messages (1)

North West London (NWL) Integrated Care System (ICS) submitted a Winter Plan to NHS England (NHSE) London on 11th September 2023 in response to the requirement signalled in the guidance 'Delivering Operational Resilience Across the NHS this winter'. The submission detailed performance and activity capacity that it is planned will meet the demands of winter 2023/24 and was accompanied by a narrative that responds to specific questions posed of Integrated Care Boards (ICBs). The submission does not cover funding however there are limited references to quality and workforce.

Alignment with the NWL 'Winter Plan Update – 23/24' detailing the sources and applications of winter funding presented to ICS Leadership on 4th August has been confirmed.

The key assumption made in the submission is that NWL ICS planned performance and activity has not changed from the 2023/24 Operating Plan unless otherwise subsequently agreed with NHSE.

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General and Acute bed occupancy is now planned to meet the 92% national target surpassing the 95% agreed in the Operating Plan.

The number of Critical Care beds remains at 195 beds through winter however the programme is currently developing a surge plan to accommodate a 10% increase in demand. This plan does not have associated funding.

Key Messages (2)

The ICS is not meeting the plan to reduce the number of G&A beds occupied by patients not meeting the criteria to reside, with a revised plan in place to 336. (Current position is 494 – See Appendix A)

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Funding previously notified to ICS Executives, allocated to Discharge Hubs, Admission Avoidance and Bridging Services, is in line with the service specifications detailed in this pack and have not changed.

A description of Providing Assessment and Treatment for Children at Home (PATCH) service has been included in the appendices for completeness as it is separately funded through the NWL ICS Winter Plan. Primary Care winter plans have also been included.

The Mental Health, Learning Disability and Autism plan has been included in the appendices for completeness although not separately funded through the NWL ICS Winter Plan.

NWL 2023/24 Winter Plan – Financial Plan

Main Winter Schemes/Initiatives - 2023/24

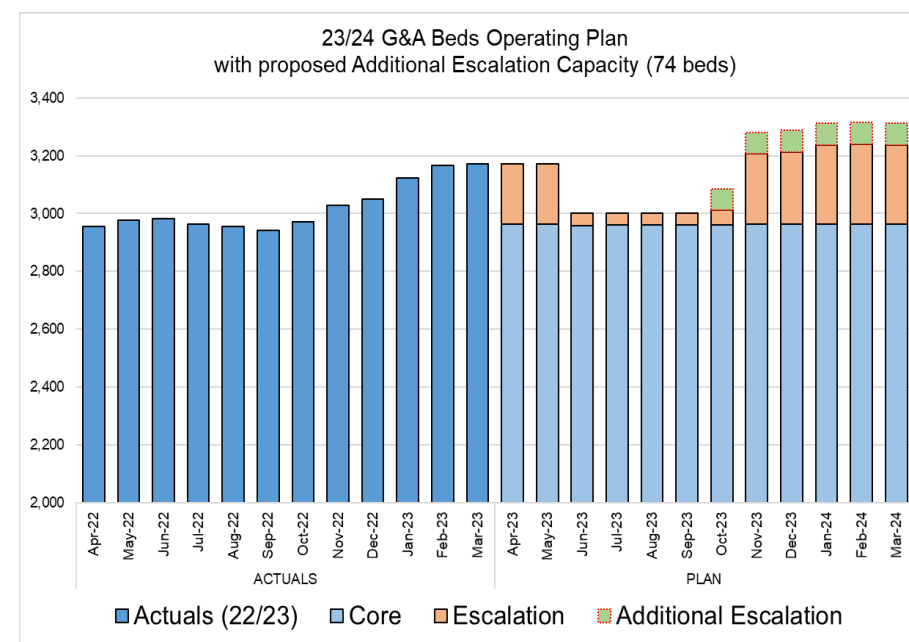
Scheme/Initiative	£m	Funding Source
Physical Bed Provision	14.5	ICB Winter Allocation & UEC Revenue Support
Virtual Wards	4.6	ICB Winter Allocation
PATCH	2.0	ICB Winter Allocation
Discharge Hubs	3.1	ICB Winter Allocation
Admission Avoidance (THH & LNWH – Frailty)	0.6	UEC Revenue Support
Bridging Service	5.1	Discharge Funding - BCF
Complex Care Initiatives	5.1	Discharge Funding - BCF
UCR	0.2	ICB Winter Allocation
Communications	0.2	ICB Winter Allocation
	35.4	

Winter Plan – Additional Bed Capacity

Winter plans agreed within the ICS include:

- **178** beds, of which:
 - **104** are already included within the 23/24 Operating Plan
 - **74** are escalation and will be added to ‘Additional Escalation Capacity’

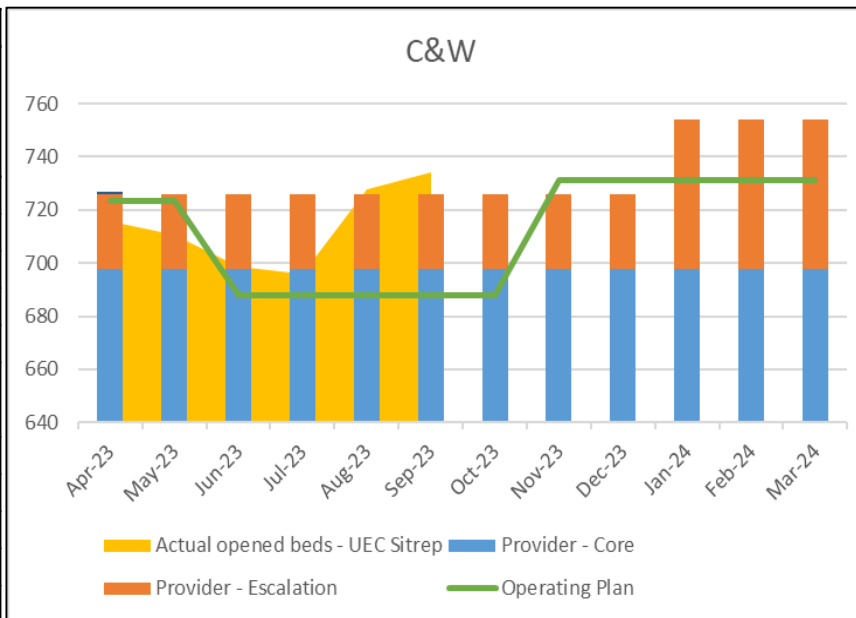
Trust	Site	Total Winter Funding Beds	Already Included within Ops Plan	Additional Escalation
ICHT	8S Charing Cross	14	14	
ICHT	Lillian Holland ward SMH	14		14
ICHT Total		28	14	14
C&W	Nightingale at C&W or interim arrangement	28		28
C&W	New ward at West Mid	28	28	
C&W Total		56	28	28
LNW	New ward at NPH or interim arrangements at other sites	32	32	
LNW	Capacity at Ealing if required	32		32
LNW Total		64	32	32
THH	THH	30	30	
NWL Total		178	104	74



G&A bed provision and reporting

- On the Chelsea site, the 28 bedded escalation ward (Nightingale) has carried over recurrently from winter 2022/23, and is now reported as core G&A capacity
- On the West Middlesex site, national capital funding has been received for an additional 24 bedded ward, due to come online at the beginning of Q4
- The Trust is reporting over the Operating Plan due to a national counting change where beds that are in principle available are reported as open even if not actively in use or staffed due to reduced demand
- Where beds have been delivered over the planned level a factor is the Trust using areas that are not suitable for long term G&A use

CW						
Month	Updated Core Bed position	Updated Escalation Bed plan	Provider - Total	Actual opened beds - UEC Sitrep	Var. from Core	Operating Plan
Apr-23	698	28	726	716	18	723
May-23	698	28	726	711	13	723
Jun-23	698	28	726	699	1	688
Jul-23	698	28	726	696	-2	688
Aug-23	698	28	726	728	30	688
Sep-23	698	28	726	734	36	688
Oct-23	698	28	726			688
Nov-23	698	28	726			731
Dec-23	698	28	726			731
Jan-24	698	56	754			731
Feb-24	698	56	754			731
Mar-24	698	56	754			731



Other planned initiatives to support flow

- Implementation of a front door frailty service on both sites
- UTC/ED demand management and flow
- Admission avoidance and earlier discharge (increased use of SDEC & Virtual Wards)
- Implementation of Discharge Ready Unit and increased use of discharge lounges
- Use of digital tools to support flow and discharge
- Increased 7 day working

ICHT

- The difference between the core bed position and the operating plan is due to counting changes where beds that don't fit the G&A criteria are no longer reported as G&A beds. This has the consequence that ICHT will report a higher and more realistic bed occupancy rate.
- 14 beds opened following the refurbishment of 8S ward at CXH were carried over recurrently and are now reported as core G&A capacity.
- Winter beds will be open from the 25th September at SMH, substituting beds previously proposed for D4 ward at HH.

ICHT						
Month	Updated Core Bed position	Updated Escalation Bed plan	Provider - Total	Actual opened beds - UEC Sitrep	Var. from Core	Operating Plan
Apr-23	1,021		1,021	1,066	45	1,064
May-23	1,021		1,021	1,076	55	1,064
Jun-23	1,021		1,021	1,021	0	1,056
Jul-23	1,021		1,021	1,026	5	1,056
Aug-23	1,021		1,021	1,019	-2	1,056
Sep-23	1,021	14	1,035	1,021	0	1,056
Oct-23	1,021	14	1,035			1,056
Nov-23	1,021	14	1,035			1,071
Dec-23	1,021	14	1,035			1,071
Jan-24	1,021	14	1,035			1,071
Feb-24	1,021	14	1,035			1,071
Mar-24	1,021	14	1,035			1,071

Other planned initiatives to support flow:

- ✓ Board round and ward routine improvement work
- ✓ Extended opening hours of discharge lounge
- ✓ Increased use of SDEC
- ✓ Boarding policies for each site
- ✓ Refresh of escalation process
- ✓ Internal LAS step 2 plan in place
- ✓ 24/7 critical care outreach service for each site
- ✓ New pathways to maximise use of capacity at HH

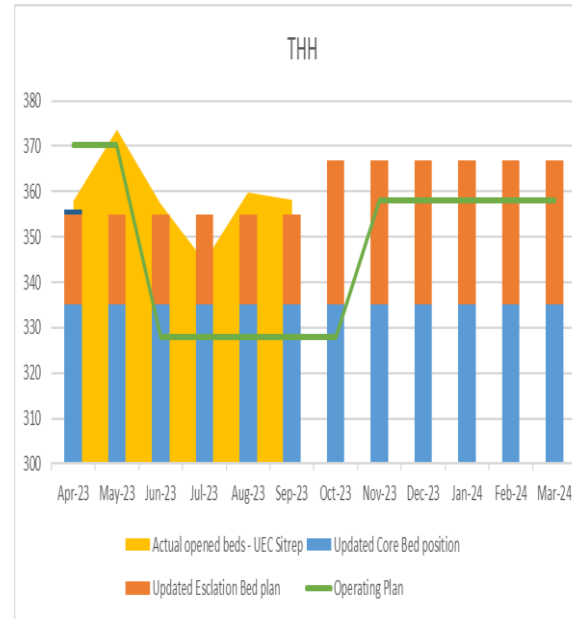
LNW						
Month	Updated Core Bed position	Updated Escalation Bed plan	Provider - Total	Actual opened beds - UEC Sitrep	Var. from Core	Operating Plan
Apr-23	954	12	954	1,014	60	1,015
May-23	954	12	954	1,017	63	1,015
Jun-23	954	12	954	1,008	54	929
Jul-23	954	12	954	986	32	930
Aug-23	954	12	954	991	37	930
Sep-23	954	12	954	1,009	55	930
Oct-23	954	45	999			939
Nov-23	954	45	999			1,047
Dec-23	954	45	999			1,053
Jan-24	954	45	999			1,077
Feb-24	954	45	999			1,080
Mar-24	954	77	1,031			1,077

Other planned initiatives to support flow if funding available:

- Additional MDT staff to support ED, ward and discharge flow
- Corridor cohorting to manage LAS handovers
- The LNW Flow Model for ward corridor care and overnight boarding remains in place

- LNW has increased their core bed base from an average of 942 beds (Apr – Dec 2022) to an average of 954 (Jan – Sept 2023). 12 NPH gastro beds were transferred from NPH to CMH in winter 22/23
- 12 escalation beds have remained open all year due to demand at Northwick Park (Crick/Darwin – 4, Fletcher – 4, Elliot – 4)
- 33 beds cumulatively will phase open in from October 2023
 - 12 at escalation beds at Northwick Park (Crick/Darwin – 4, Fletcher – 4, Elliot – 4)
 - 21 at Ealing (6North – 4, 8South – 7, 9North – 10)
- There are 12 beds to be created from October by a reconfiguration of the surgical bed base at Northwick Park
- 32 bed modular build at Northwick Park, funded by national capital monies, due to come on line in March 2024
- Plans are in place to protect elective capacity as much as possible, however like last year medical staffing may need to be redirected from outpatients to staff additional beds depending on temporary recruitment

THH						
Month	Updated Core Bed position	Updated Escalation Bed plan	Provider - Total	Actual opened beds - UEC Sitrep	Var. from Core	Operating Plan
Apr-23	335	20	355	358	23	370
May-23	335	20	355	374	39	370
Jun-23	335	20	355	357	22	328
Jul-23	335	20	355	345	10	328
Aug-23	335	20	355	360	25	328
Sep-23	335	20	355	358	23	328
Oct-23	335	32	367			328
Nov-23	335	32	367			358
Dec-23	335	32	367			358
Jan-24	335	32	367			358
Feb-24	335	32	367			358
Mar-24	335	32	367			358



Other planned initiatives to support flow if funding available:

- Additional paediatric and surgical registrar overnight to prevent admission.
- Increased Critical care outreach and staffing for full 12 beds as required.
- Increased medical SDEC hours and numbers
- Wound pathway to reduce length of stay (LoS)
- Increase in Pharmacy staff to reduce time for TTAs.

- Fleming is the main escalation ward with 20 beds that will be extended to 30 as pressure increases
- 4 escalation beds are available at Rockwood Ward
- Where beds are delivered over the normal capacity total this is due to THH using areas that are not suitable for long term G&A use

Risks

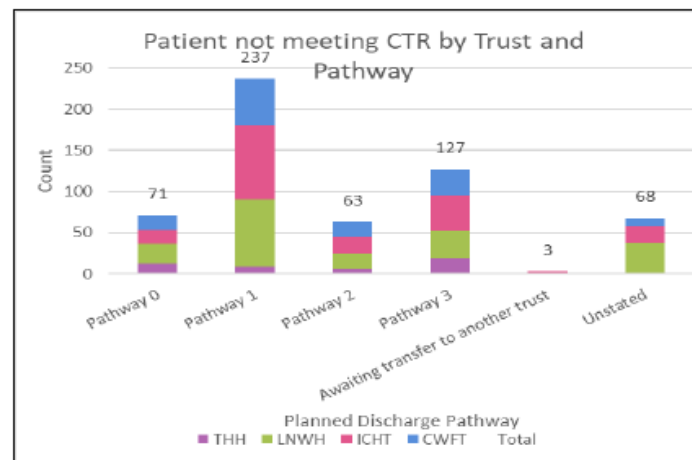
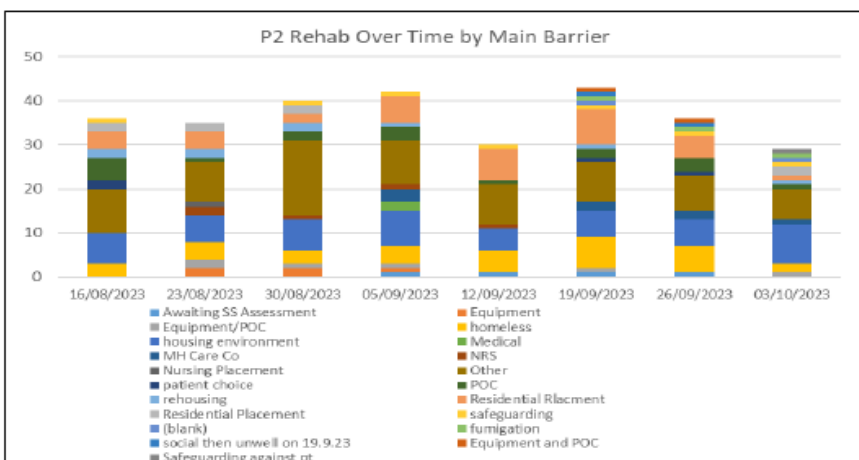
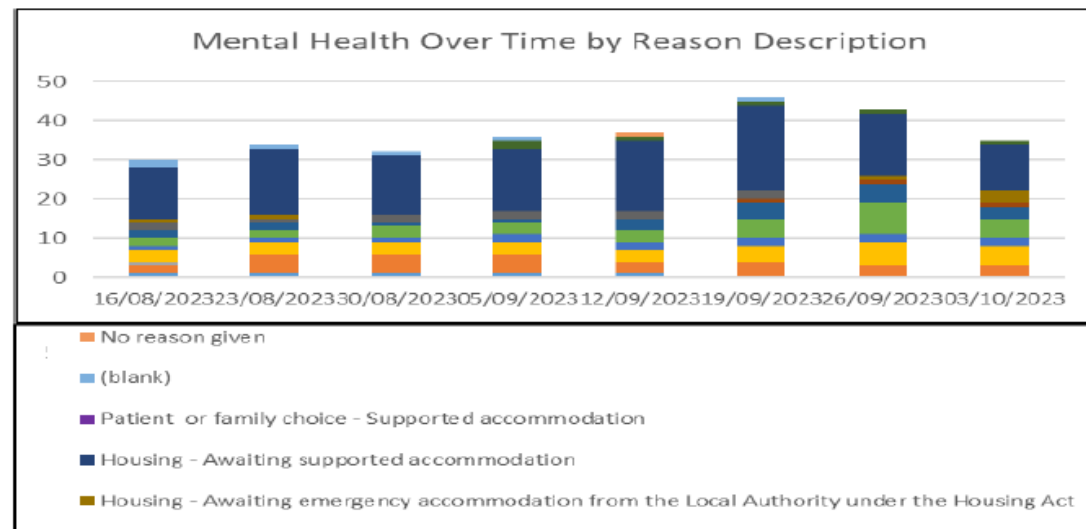
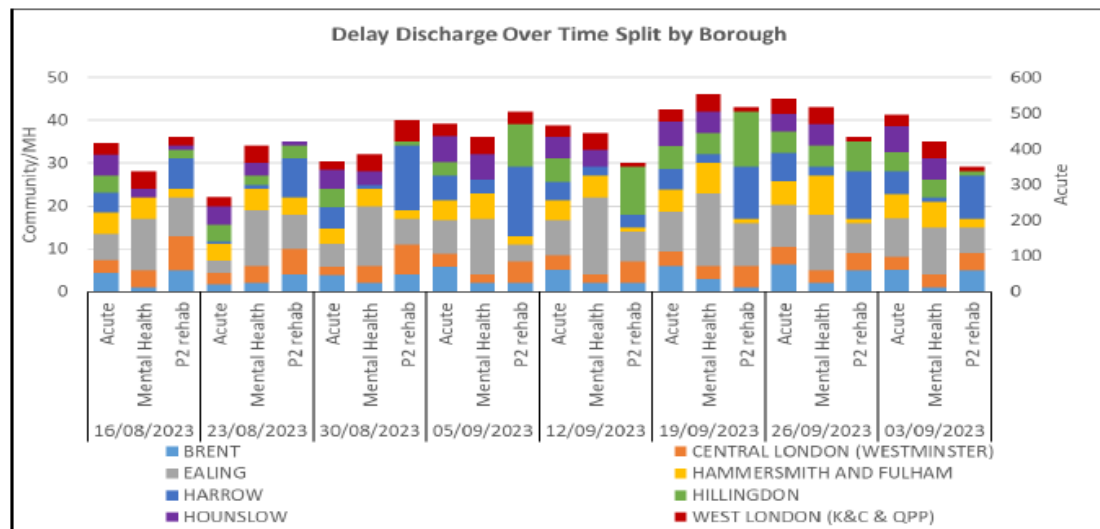
- Lack of clarity about allocation of discharge funding
- Delays for patients waiting for mental health beds
- Impact of further industrial action
- No funding to support surge planning for critical care
- Equipment delays with the new contract/provider (London-wide)
- Delivering agreed trajectories for bed occupancy and NCTR

Acute, Community and MH not meeting CTR and not discharged – NWL

As of 03/10, there are 35 discharge delays in MH (28% in Ealing), 494 in Acute (19% from Ealing) and 29 in P2 Rehab (31% from Harrow) in NWL. Biggest reasons for delays in Acute is in pathway 1. Biggest reason for delays in MH is Housing and biggest reason for delays in P2 rehab is other & Housing environment

Data source:

- MH – MH sitrep
- Community – Ice hub
- Acute – Optica



North West London Acute Provider Collaborative

Collaborative Finance and Performance Committee Chair's Highlight Report to the Board in Common – for discussion

September 2023

Highlight Report

1.0 Purpose and Introduction

- 1.1 The purpose of this report is to provide the Board in Common (BiC) with assurance of the work undertaken by the Collaborative Finance and Performance Committee at its last meeting held on 19 September 2023. The report is intended to provide any feedback to the BiC and request if further work within the Committee's remit is required.
- 1.2 The role of the Collaborative Committee is:
- To oversee and receive assurance that the Trust level Finance and Performance Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
 - To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium-term improvements.
 - To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and integrated care system (ICS) integrated improvements.
 - To draw to the BiC's attention to matters they need to agree or note.
- 1.3 The Committee's agenda was compressed to two hours given the operational pressures within the trusts and across the ICS with the consultant and junior doctor industrial action.

2.0 Key Highlights

2.1 Operational performance

The Committee considered month four performance and was updated on system arrangements for managing the current operational pressures give the dual industrial action. The committee was advised that this was through 'gold' calls across the system the previous day and just before the meeting, to ensure a joined up response across the NHS and local government. The committee was advised of the wider work underway with system partners to ensure resilience through the industrial action and more generally.

- 2.1.1 **Urgent and emergency care:** the Committee was updated on NHS England's (NHSE) July communications setting out the national approach to 2023/24 winter planning, building on the Emergency Care Recovery Plan. The plan includes targets of 76% patients being admitted, transferred or discharged within four hours by March 2024 and average category two ambulance response times of 30 minutes. Included is an incentive scheme for trusts with a Type 1 emergency department – to achieve an average of 80% for four hour performance in Q4 23/24 and at least 90% of ambulance handovers within 30 minutes in Qs 3 and 4. The Committee was advised that all emergency departments in the NWL acute provider collaborative (APC) are on track to meet the 76% standard and have stretch plans to deliver 80%. Ambulance handover performance continues to improve. Variation in usage of same day emergency care (SDEC) and urgent treatment centres (UTCs) was flagged as an area to explore in future. It was noted how the A&E performance across the collaborative showed on average good performance, that the target was within reach.

- 2.1.2 **Diagnostics:** performance across the APC remains stable overall, but non-obstetric ultrasound is a concern due to staffing gaps. The Committee heard about the funding made available nationally at short notice for implementation of an artificial intelligence (AI) project in imaging diagnostics. A case has been worked up across the collaborative for supporting reporting of chest x-rays. The final benefits will be worked through once the supplier and costs are understood during procurement. The Committee requested further detail on the finances and impact, alongside potential benefits given current cost pressures.
- 2.1.3 **Elective care:** performance across the collaborative is broadly in line with expectations given current pressures. The sector has seen small increases in the total patient tracking list (PTL) driven by industrial action and annual leave. Long waiting positions remain static driven by the impact of industrial action on overall activity in August. The committee reviewed the completed '*National Protecting and Expanding Elective Capacity Self-Certification Checklist*'. Trusts are fully assured on most areas and where partially assured, plans are in place to address any non-compliance. The committee heard that while ideally all would be fully assured, this was a realistic picture and colleagues across the collaborative were learning from and supporting each other.

More generally the point was made that industrial action was having a major impact, with the day of the meeting being the 29th day of action since March, and a further seven known dates through to December. The Committee was advised that while the waiting list had gone up by 1%, this was against a backdrop of 10% across London.

The Committee's attention was drawn to the segmented data noting there was no identified differential in wait time by ethnicity, but that further and wider work was underway to assess impacts for ethnicity, deprivation and other protected characteristics.

- 2.1.4 **Cancer:** June and July shows good progress in relation to two week waits and the faster diagnosis standard, with both compliant. Achieving the 62-day performance target remains a significant challenge, but there was a small improvement and overall well above the London average. The Committee was advised that with the transfer to Cerner (including the planned stepdown) there will be an adverse impact recorded for the next reporting period, but that this is a temporary issue.

2.2 Financial performance

- 2.2.1 The Committee heard that at the end of month 4 (July) the APC is reporting a deficit of £48.7m, against a year to date deficit plan of £12.6m, therefore reporting a £36.2m adverse variance. This is driven by under delivery of cost improvement programmes (CIPs) by £19.1m and impact of industrial action impacting on cancelled activity (£11m) and additional cover staffing costs (£7.7m). Inflation over funded levels also continued to add to cost pressures (£6.4m).

The Committee was advised of the work underway through the APC CFO group – with a focus on 'grip and control' and peer review and support. The Committee was updated on plans for an 'efficiency board' which would include HR and chief operating officers (COOs) as well as the CFOs. The Committee heard about capital expenditure being £7m behind plan but confirmed that the budget would be spent by year end and overall noted the pressures on capital budget.

The CFOs have been working on the development of a Financial Recovery Plan by Month 6, with overall financial planning starting in September – the Committee was advised on indicative planning assumptions for the 2024/25 financial year. The need to find £100m was highlighted, with £50m possible through CFOs/Finance (maximising

income, sales, technical work) and the other £50m would require particular focus from COOs and HR directors/chief people officers in terms of CIP proposals. Each organisation would need to work with their executive team colleagues to pull together the financial recovery plan.

Recovery of inflation and industrial action impacts: the Committee discussed the impact of both and the national/regional/ICB arrangements to date and planned. The strike impact was not currently fully reflected for year to date but it was anticipated this may well be forthcoming. The importance of this plus recognition and funding support for the impact of inflation was highlighted, with the Committee seeking a further discussion and decision on approach for the December meeting.

2.3 Business planning – progress and monitoring

The Committee received a summary of progress against the finance and operations objectives set out in the business plan agreed by the BiC in April. At month 4, the picture of performance against the key performance and finance objectives is mixed.

The performance against CIP was noted, with 1% currently but a step change of 3-5% required. The issue re differential costs of providing services across the trusts was raised, with agreement that this should be further explored in future to understand the issues and how to address collaboratively. The importance of early identification of CIPs, particularly on a recurrent basis, and need focus on the bigger transformational activities was highlighted.

2.4 Business cases

2.4.1 Elective Orthopaedic Centre (EOC) – the Committee was advised on the progress of the EOC noting the refreshed governance and progress, particularly re workforce and scheduling of work. The Committee was advised about the delay to the original timetable but assured that focussed work was underway to progress the development. There is further work underway re Hillingdon and financial impact, alongside ensuring confidence for clinicians scheduling patients for treatment given timing issues. An update on the transport issue was requested and the Committee was advised of the co-design work underway through the transport working group. This is comprised of patients, councillors, residents and other stakeholders and meets regularly to determine the support and accessibility needs of patients ahead of the EOC accepting its first patients.

2.5 Risk

The Committee was assured that the key risks has been covered through the agenda items discussed at the meeting. The Committee heard about developments regarding the new collaborative risk management /board assurance framework approach, which would ensure risk registers were developed and considered for each collaborative committee.

2.6 Equality, Diversity and Inclusion (EDI) Action Plan

The Committee discussed the paper and how EDI had been woven through several of the reports on the agenda today with segmented data. The discussion focussed on what the Committee could do in a meaningful way and it was agreed that there would be a further discussion at the APC executive management board (EMB) to explore the potential of the Cerner system, to understand and then agree which datasets to draw down – e.g. frail and elderly, learning disability and autism, ethnicity.

3.0 Positive Assurances Received

3.1 The Committee received assurance regarding completion of the elective capacity self-assessments, noting some elements of partial assurance which reflected a realistic picture.

4.0 Key Risks to Escalate

4.1 None specifically, but the continued impact of industrial impact in terms of performance and budget was highlighted.

5.0 Concerns Outstanding

5.1 None, in addition to the risks above.

6.0 Key Actions Commissioned

6.1 SDEC and UTCs – data and discussion on progress and plan once all are within collaborative ownership – to come back to the Committee in six months' time.

6.2 AI bid for imaging diagnostics (chest x-rays) was supported in principle, but the Committee want to see update re finances, impact on productivity and overall plan.

6.3 EDI - identify opportunities within the Cerner system for data by protected characteristics and deprivation – APC EMB to follow up and report back.

6.4 EOC – to ensure the BiC is updated specifically on the issue re patient transport.

7.0 Decisions Made

7.1 As above - AI bid supported in principle subject to some further analysis and working through by CFOs.

8.0 Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Integrated Performance Report and operational performance updates on UEC, diagnostics, elective care, cancer	To note	5.	Trust Level Committee Assurance Reports	To note
2.	Finance Report and cost improvement recovery	To note	6.	Collaborative Financial and Performance Risks and Assurance	To note
3.	Financial Recovery Report	To note	7.	Equality Diversity and Inclusion Next Steps	To note
4.	Elective Orthopaedic Centre	To note	8.	Draft Forward Agenda Planner	To note

9.0 Attendance

Members:	September attendance
Catherine Jervis, Non- executive director (NED) - (Chair)	N
Patricia Gallan, NED, Chair of CWT F&PC	Y
Bob Alexander, NED, Chair of Imperial F&PC	Y (acted as Chair)
David Moss, NED, Chair of LNW F&PC	Y
Lesley Watts, CEO, Chelsea and Westminster NHS FT and Collaborative Lead for Finance and Performance	Y

Attendees:	
Matthew Swindells, Chair of NWL Board in Common and Collaborative	Y
Jon Bell, Chief Financial Officer - Hillingdon	Y
Tina Benson, Chief Operating Officer – Hillingdon	Y
Rob Hodgkiss, Chief Operating Officer / DCEO - Chelwest	Y
Virginia Massaro, Chief Financial Officer - Chelwest	Y
Claire Hook, Chief Operating Officer - Imperial	Y
Jazz Thind, Chief Financial Officer - Imperial	Y
James Walters, Chief Operating Officer - LNW	Y
Jonathan Reid, Chief Financial Officer - LNW	Y
Peter Jenkinson, Director of Corporate Governance	Y
Tim Orchard, Chief Executive – Imperial	Y
Marie Price, Deputy Director Corporate Governance	Y

**North West London Acute Provider Collaborative (NWL APC)
Quality Committee Chair's Highlight Report to the NWL APC Board in
Common (BiC) – for discussion
September 2023**

Highlight Report

1. Purpose and Introduction

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

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

2. Key highlights

2.1. Deep Dive – Peer Reviews

2.1.1. The Committee undertook a deep dive into Paediatric Emergency Departments (ED) and Discharge peer reviews.

2.1.2. Nationally and locally available data has been analysed across Paediatric EDs and this has been benchmarked by department to identify variation. Six main themes have been identified: Data and Coding; Optimising Capacity, Space and Flow; Workforce; Same Day Emergency Care; Children and Young People's Mental Health; and the 16-17 year old 'lost tribe'. The themes will be used to produce actions for improvement which will be tracked through an overarching project plan.

2.1.3. The Committee noted the excellent work and positive engagement with the Paediatric community. Concerns were noted around safeguarding, particularly for children with disabilities, training of clinicians which has been a common theme, and ensuring that data is robustly captured, particularly in relation to paediatric emergency departments (EDs). The Committee were assured that many concerns will be addressed through the action plan and safeguarding issues will be taken forward by the Safeguarding Groups.

2.1.4. The Committee noted the report on the Discharge peer review.

2.1.5. The peer review programme will be paused until Spring 2024, due to Winter pressures and focus will be given to address the action plans that are already in place.

2.2. Review of Acute Provider Collaborative Quality Priority workstreams

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

- 2.2.2 **End of Life Care:** The Committee noted that the work stream will focus on priorities around the Universal Care Plan (UPC), Cerner and Data, and Education. There is eagerness to have consistency around education and training across the four trusts, as well as standardising the end of life schemes.
- 2.2.3 **Deteriorating Patients:** The Committee noted that the work stream will focus on improved recognition and response to the deteriorating patient, education and training for staff, collaborative working to standardise reporting, and collaborative learning and working to achieve 2023/24 Commissioning for Quality and Innovation (CQUIN) 07. The *Call 4 Concern* programme will enable anyone to raise a concern, and this will be encouraged through communications during implementation.
- 2.2.4 **User Insights/Patient Experience:** The Committee noted that focus has been given to the Friends and Family Test (FFT), complaints and concerns, and patient and public involvement, including the inclusion of lay partners and community engagement. Work will be done to achieve consistency of patient and public engagement across the four trusts and recommendations will be produced on this and on improving patient experience.
- 2.2.5 **Maternity Standards:** The Committee noted the self-assessment against the Maternity Incentive Scheme (MIS) year 5 requirements for Q1. All trusts are flagging a risk against Safety Action 8: training and compliance, which has largely been impacted by ongoing industrial action. LNWH have also flagged a potential risk around compliance to Safety Action 5: 1:1 labour care and supernumerary status of labour ward coordinator, due to staff and recruitment and this is being monitored. All four NWL APC trusts quarterly quality and workforce reports have been reviewed in detail at the local trust quality committees. RB outlined the requirements for Board oversight and reported that NHS Resolution have confirmed that this authority can be delegated by the NWL APC Board in Common (BiC) to each trust's local quality committee, providing this is reflected in the terms of reference and the scheme of delegation. SG asked whether the BiC needs to formally approve this delegation of authority at its next meeting. PN reported that DC has reviewed the scheme of delegation and it requires an adjustment to enable delegation to the local committees. Work will be done to progress this so the local committees can approve the CNST MIS report including the workforce element and an overarching report will be reviewed by the NWL APC Quality CiC every quarter. An annual report will be presented to the NWL APC BiC before final submission.
- 2.2.6 **Mortality:** The Committee noted the work stream have agreed the process for the review of the individual diagnostic groups, and the palliative care coding work is due to be completed in November. Deep dives are planned into Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).
- 2.2.7 **Clinical Harm Reviews and Inequality:** The Committee noted the work being undertaken to formulate a standard reporting process and to ensure better visibility of risks and incidents. This will be linked to operational data with the aim to enable more precise interventions and identification of problematic pathways and groups.
- 2.2.8 **Mental Health in Acute Trusts:** The Committee noted that the focus of the work stream over four main areas: process and pathways for mental health patients in the trusts, the environment and facilities for patients, staffing and training, and policy and procedures. Staff feedback has been received and training and

education is viewed as the most important.

2.2.9 **Quality Digital Outcomes:** The Committee noted the focus of this work stream as the electronic patient record, standardising and driving out variation, and improving quality of practice and integrating devices.

2.2.10 **Infection Prevention Control (IPC):** The Committee noted the initial priorities of the work stream as standardising winter planning, Healthcare Associated Infections (HAI) reduction, shared antimicrobial surveillance system, and a penicillin de-labelling programme. The workstream will also begin to incorporate horizon-scanning of issues that will affect local communities at collaborative level.

2.2.11 **Clinical Transformation:** The Committee noted that an established Patient Pathway Programme Board is in place which reports to the NWL APC Executive Management Board. The first three services are: the NWL APC Elective Orthopaedic Centre (EOC); Ophthalmology; Clinical Haematology. The next two services for review are Gynaecology and Dermatology, and work is underway on the 100-day challenge to establish the current state and to design its future. The Committee agreed that as Clinical Transformation will be an important ongoing Quality programme that in future this will be reported separately and not as part of the Quality Workstream updates.

2.3. National Patient Safety Strategy and Quality System Standardisation

2.3.1. The Committee received a progress update on the implementation of the NHS patient safety strategy across the NWL APC. A policy for the Patient Safety Incident Response Framework (PSIRF) has been agreed, alongside patient safety incident response plans. Governance structures for the ongoing monitoring, quality assuring and delivery of safety actions and improvement have been agreed for all trusts.

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

2.4.1. The Committee discussed the proposed EDI metrics to be delivered by the Committee as part of the overall action plan of the Board in Common. The Committee will take forward the EDI metrics arising from the quality improvement programmes but highlighted the need for the full and accurate recording of the patient ethnicity data.

2.5. Learning from Deaths quarterly report

2.5.1. The Committee reviewed the combined NWL APC Q1 report incorporating all four trusts which outlines the key themes and outcomes from the learning from deaths processes.

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

2.6. Review of Quality and Safety following the verdict of the Countess of Chester Case

2.6.1. The Committee received a report outlining the monitoring processes in place to identify potential issues related to patient safety and clinical outcomes. Assurance processes include PSIRF, the learning from deaths processes, Freedom to Speak Up (FTSU) and the coronial arrangements. The Committee noted the importance of triangulation and discussed how a supportive culture can be cultivated that will help staff to feel safe when raising concerns.

2.6.2. The creation of real-time data and algorithms for wider scrutiny will be investigated.

2.7. Trust Quality – Function Reports

2.7.1. The Committee received quality performance reports from each Trust, noting exceptions against key performance indicators and measures being taken to address areas of variance against target.

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

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

2.8. Annual Complaints report

2.8.1. The Committee received the combined NWL APC complaints summary annual report incorporating all four Trusts, which outlines the work undertaken by the Trusts in 2022/23.

2.8.2. The Committee received assurance that each Local Trust is compliant with the national complaint standard and the individual Trust Annual Complaints reports will be published on the respective website by end of October 2023.

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

2.9. Acute Collaborative Quality Performance Report

2.9.1. The Committee received the collaborative quality performance reports and general issues around Infection Prevention and Control were noted. There was an increase in serious incidents with harm in ICHT; this is being investigated and will be closely monitored.

3. Positive assurances received

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

3.2 Other key positive assurances received include:

- Good progress is being made with the agreed quality priorities for the NWL APC, with a focus on aligning reporting and processes to enable improvements in quality of patient care.
- Positive assurance was received following the review of the quality and safety processes in place to identify potential issues related to patient safety and clinical outcome following the verdict of the trial in relation to the Countess of Chester Hospital.
- All trusts are on track to transition to PSIRF within the agreed national timescales.

4. Key risks to escalate

4.1 The Committee noted common risks across Trusts in relation to the impact of industrial action on quality, the challenges with infection prevention and control, and with the volume and treatment of mental health patients.

4.2 The occurrence of a never event at CWFT in relation to a hip replacement. This is undergoing a serious incident investigation.

5. Concerns outstanding

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

6. Key actions commissioned

6.1 Work stream leads will consider how the available technology can be incorporated into the work that is being undertaken.

7. Decisions made

7.1 There were no items for approval presented to the committee this month, so no decisions made.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Deep Dive – Peer Reviews	To discuss	8.	Learning from deaths quarterly reports – Quarter one 2023/24	To note
2.	Acute Collaborative Quality Performance Report	To discuss	9.	Complaints Annual Report Acute Collaborative Themes and Actions	To note
3.	Workstream PIDS and Project Updates	To discuss	10.	Any Other Business: NED Walkabouts	To discuss
4.	National Patient Safety Strategy and Quality System Standardisation	To discuss	11.	Committee forward planner	To note
5.	Quality EDI metrics	To discuss			
6.	Review of Quality and Safety following the verdict in the trial of LL	To discuss			
7.	Trust Quality Committee – Function reports	To discuss			

9. Attendance

Members	September attendance
Steve Gill, Vice chair (CWFT), NED (THHT) (Chair)	Y
Peter Goldsbrough, Non-executive director (ICHT/CWFT)	-
Syed Mohinuddin, Non-executive director (LNWH/CWFT)	Y
Linda Burke, Non-executive director (THHT/ICHT)	Y
Carolyn Downs, Non-executive director (ICHT/CWFT)	Y
Pippa Nightingale, Chief executive (LNWH)	Y
Tim Orchard, Chief executive (ICHT)	-
Julian Redhead, Medical director (ICHT)	Y
Raymond Anakwe, Medical director (ICHT)	Y
Roger Chinn, Medical director (CWFT)	Y

Victoria Cook, Acting/Interim Medical director (THHT)	-
Alan McGlennan, Chief Medical Officer (THHT)	Y
Jon Baker, Medical director (LNWH)	Y
Sarah Burton, Chief nurse (THHT)	Y
Robert Bleasdale, Chief nurse (CWFT)	Y
Janice Sigsworth, Chief nurse (ICHT)	Y
Lisa Knight, Chief nurse (LNWH)	Y

**North West London Acute Provider Collaborative
Collaborative People Committee Chair's Highlight Report to the Board
in Common – for discussion
September 2023**

Highlight Report

1. Purpose and Introduction

1.1 The role of the People Collaborative Committee is:-

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

2. Key Highlights

- 2.1 The Committee received a progress update towards the opening of the NWL Elective Orthopaedic Centre (EOC) with a particular focus on the workforce priorities. The key headlines discussed:
- Pre-operative pathway approved at partnership board on 1 Sept 23 aligns with requirement of public consultation
 - NWL EOC transport working group co-design of three step transport provision on track. To be in place by end of November 2023. JHOSC updated at September committee
 - Job planning & theatre scheduling : ICHT and CWFT have agreed rota allocation for named consultants and job planning on that basis for full five theatre EOC. LNWH rota allocations are in progress
 - Nurse, OT & theatre recruitment + overseas recruitment progressing. Focus continuing on hard to recruit areas of scrub nurses and anaesthetists
 - Work to agree the EOC 'partnership agreement' continues to meet Gateway 4 with all partners engaging. Finance and activity remodelling continuing to progress via the task and finish group

Estates/construction delay confirmed at 12 weeks. Part opening (3 theatres) in November/December 2023 with full (5 theatre) capacity from February 2024.

The Committee were reassured that there were sufficient staff for the partial opening. A lot of the staffing will be via international recruitment and the Committee got assurance regarding the support package available to them.

A further update was requested on the transport solution.

2.2 The Committee received the Acute Collaborative Dashboard, and the following key highlights were noted and discussed:

- Collectively the Trusts are reporting a total staffing position (substantive, bank & agency) of 1,577 WTE above the 2023/24 operating plan (4.5%) in July 2023. Each of the Trusts are right-sizing staffing numbers to match the level of activity and income they are going to achieve.
- Vacancy rates at collaborative level are now at the collaborative target of 10.0%. Over the past year the collaborative vacancy level has been steadily reducing, reaching its lowest point in March 2023 at 9.3%.
- Voluntary turnover is an improving special cause variation with a steady reduction from 13.2% to the current position of 11.5% which is below the APC target of 12.0%.
- After over a year of increase, the rolling sickness absence rate is now an improving special cause variation; down from 4.8% in October 2022 to the current position of 4.2%.
- Agency spend, as a proportion of overall pay bill, is our productivity measure with a collective target set at 2%. Current performance for July 2023 was 2.5%; driven by additional staffing requirement due to impacts of industrial action and staffing requirements for Urgent Treatment Centre (LNWH).
- Completion rates, for non-medical Performance Development Reviews (PDR), is an area of concern with no Trust meeting target; hindered by operational pressures and episodes of industrial action.
- All Trusts are above target for Core Skills compliance, which collectively is now an improving special cause variation.
- It has been agreed that for Equality, Diversity and Inclusion there will be a quarterly update on progress towards the Model Employer Goals. At Acute Collaborative Provider (ACP) Level BAME employees represent 61% of total workforce. To enable the ACP to achieve its 2025 MEG goals, each senior pay band needs to reflect 61% of BAME staff within each pay band. Included are the targets for each of the Provider Trusts in this report. Additionally, metrics on inclusive recruitment will be added in quarter three.

The CPOs provided a verbal update in how they are right sizing staffing numbers to match the level of activity and income. The Committee noted that the Executive Management Board have also requested a deep dive into this issue. A written report from the CPOs was requested for the next meeting.

The CPOs updated the Committee on the PDR challenge as requested. The issue had according to the local people Committee minutes was discussed at CWFT and THHFT.

The CPOs were congratulated on the fact that vacancy rates had reached the target, as had voluntary turnover, as had core skills compliance. The rolling sickness absence rate was improving but was slightly above the target of 4%.

- 2.3 The Committee received the workforce priority objectives:
- Reduce premium rate temporary staffing
 - Elective Orthopaedic Centre workforce transition
 - Recruitment hub for hard to fill vacancies
 - Careers hub and staff transfer scheme
 - Increase apprenticeship levy uptake
 - Reduce violence, aggression, bullying and discrimination
 - Scaling up project

The Committee noted that the 2023/24 priorities have been converted into a business plan for delivering the priority programme across quality, people, finance/performance, and infrastructure. The Committee received quarter two update which focussed on the six in-year objectives as well as scaling people services. Metrics identified for each priority people, are measured against a confirmed baseline position. A set of deliverables have been identified to achieve improvement against the baseline position across the collaborative.

There has been a continuing focus on developing the workstreams in quarter 2 and progressing of initiatives identified in quarter 1.

Risks have been identified across the majority of programmes with mitigations, whilst leads will continue to update the position as the programmes develop.

The Committee discussed in particular:

- 1) The harmonisation of bank rates which now includes THHFT has shown a positive uplift in bank uptake and reduction in agency
- 2) That targets had been set for hard to fill vacancies and IMG ED middle grade recruitment had commenced.
- 3) A digital platform has been procured for career progression across the collaborative
- 4) The collaborative apprenticeship usage is now at 39% a 10% improvement. The Committee asked the CPOs to set stretching targets for this area and to especially use for HCA's and discuss at local people committees
- 5) The Scaling Up project is in the process of being launched and has been accepted as a national vanguard programme and the funding will be available at the end of December. The SOC to be signed by 31st December 2023 and the full business case by 1st March 2024.

- 2.4 The Committee received an Employee Relations Casework report which provided Board level oversight of quarter one baseline data for formal Employee Relations (ER) activity across the Collaborative. The report highlighted the number of formal ER cases including resolution which incorporates Grievance

and Bullying and Harassment Cases, Disciplinary cases and Maintaining High Professional Standards cases (MHPS). The report included ethnicity breakdown of those employees involved in these processes in accordance with our WRES3 indicator of the likelihood of BME staff entering the formal disciplinary process. The report also provided the average time that formal ER cases have been open within the Trust at the point of reporting.

The Committee noted the need to standardise the policy across the collaborative to resolve conflict proactively and on a timely basis and where possible through informal routes such as mediation. The Committee agreed that each Trust Workforce Committee should receive and scrutinize employee relations casework data every quarter which should include number of staff and timescales of the investigation and proposed end date. A further analysis of the data was requested and that there should be frequent chase ups of external parties and escalations as necessary to NHSE.

- 2.5 The Committee received the Guardian of Safe Working report which summarised key findings and themes from the Guardian of Safe Working reports. It will also outline a set of recommendations to be taken forward across the four Trusts. The report was based on the most recent available report that has been taken through trust executive committees, this has resulted in the data and information available being taken from different reporting periods. Exception reports have been raised at similar levels across CW, ICH, and THH, with a higher number at LNW (one of two trusts to provide an annual report), and no consistent peak throughout the year. The majority of exceptions raised have been at junior level (FY1 – CT3), and the division where the most exceptions have been raised is Medicine and Integrated Care (69% across the four trusts).
- 2.6 The Committee considered the APC Equality, Diversity and Inclusion report, which reviewed the annual workforce EDI reports for the AC Trusts and to identify common themes, development and improvement priorities. Each trust produces annual workforce equality reports in line with our responsibilities ‘public sector duties’ under the Equality Act 2010. The reports included. The Committee was asked to approve the following recommendations:
1. That the Committee note the shared annual workforce EDI outcomes and actions identified for the Collaborative. This was noted the outcomes and the two key metrics with a recommendation that the metrics relating to the NHS improvement plan needed to be clearer and outlined in an action plan
 2. That the Committee endorse the proposal to sign up to the Race at Work Charter to be agreed by Trust Committees. The Committee was not convinced as to the value of signing up to another initiative. What was needed was demonstrable action/outcomes in the EDI area that staff could see. The Committee agreed that further discussion is required at

local Trust Workforce Committee level about what the race charter means for each Trust.

3. That the Committee endorse the proposal to produce a joint collaborative EDI action and improvement plan based on the EDI Improvement Plan and the shared EDI priorities outlined in this report. This Committee endorsed the proposal which will be discussed in detail at the next Board in Common meeting.

- 2.7 The Committee received key findings and themes from the annual NHS Staff survey which took place between September and November 2022. The report outlined the actions and recommendations across the four Trusts, and how this linked to both Trust People priorities and the Acute Collaborative People Priorities. The Committee noted that there were some common areas of strength across the Trusts, notably in the theme “We are always learning.” The Acute Care Collaborative People Priority programmes are very closely aligned to the areas for development coming out of the survey, and where this is not the case, there are improvement programmes of work at Trust or ICS level. The report also included the four Trusts approach to action planning, on their People Priority programmes developed in response to the survey.
- 2.8 The Committee received a report on Review of Workforce Processes following the verdict on the trial of the Lucy Letby and the new Fit and Proper Test framework. Further to the discussion, it was agreed that the Committee had limited assurance and there was a request for improvements made to strengthen freedom to speak process is reported to the Committee. The Committee also noted that there is ongoing collaborative work to implement the new fit and proper person framework in order to be compliant by the deadline stipulated by NHS England.
- 2.9 The Committee received and noted the Local Trust People Committee reports.
- 2.10 The Committee noted that new risks requested at the last meeting were now included in the NWL Workforce report. It was requested that mitigations should be added.

3. Positive Assurances Received

- 3.1 The Committee received positive assurance in the following areas:
 - Vacancy rates
 - Voluntary turnover
 - Sickness absence
 - Core skills compliance

4. Key Risks to Escalate

- 4.1 Covid-19 & Flu Vaccination: increasing cases of the new covid-19 strain which is impacting staff and increasing sickness absence rate. The Flu and Covid-19 vaccination campaign have commenced across the collaborative. Further details to be provided at the next meeting.
- 4.2 The Committee agreed to bring to the attention of the Board in Common, potential risks of industrial action as we progress into winter and the importance of proactive mitigations.

5. Concerns Outstanding

None.

6. Key Actions Commissioned

- 6.1 The Model Employer Goals (MEG) data to include length of time staff spend across the bands to provide more intelligence on progression.
- 6.2 The Committee requested that the Race at Work Charter to be discussed at local Trust Workforce Committees to determine what the Charter means for each Trust with a recommendation to the Collaborative Committee.

7. Decisions Made

- 7.1 The Committee discussed the scaling up project and it was agreed that while there are still ongoing discussions with NHS England on resourcing for the pilot areas. Work will commence to progress this item as quickly as possible within the people priorities.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Elective Orthopaedic Centre Workforce	Discussion	6.	APC EDI Report	Discussion
2.	Acute Collaborative Dashboard	Discussion	7.	Review of Workforce Processes following verdict of Lucy Letby Fit and Proper Person Test Framework Update	Discussion
3.	Workforce Priority Objectives	Discussion	8.	Local Trust People Committee reports Actions and Escalations	Noting
4.	Employee Relations Casework	Discussion	9.	NWL Workforce Risk Register	Noting
5.	Guardian of Safe Working Report	Discussion	10.	Committee Forward Planner	Noting

9. Attendance

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

North West London Acute Provider Collaborative
Digital and Data Committee Chair's Highlight Report to the Board in
Common – for discussion
September 2023

Highlight Report

1. Purpose and Introduction

The role of the Digital and Data Committee is:-

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

2. Key Highlights

Terms of Reference

The Committee reviewed and updated the terms of reference re the membership of the committee:

- The inclusion of additional members representing their cohorts across the 4 Trusts.
- The addition of specific specialist expertise, as and when required, to be agreed by the Committee Chair, Lead CEO and NWL APC Chair in Common.
- The inclusion of information around working with the ICB to ensure transformation programs are digitally enabled.

Stocktake of 2022-23

The Committee was provided with a paper on the historical context of the Digital & Data work of the NWL APC Infrastructure and Capital Committee from its inception in September 2022 until June 2023 to ensure all members reached a level of common understanding.

Forward View

A presentation on the forward view provided a scan of the horizon looking at what will need to be delivered in 2024 and beyond. This was on the assumption that we have robust and funded plans in place for the current financial year. The presentation covered:

- A review of the 7 steps in the digital and data strategy and in addition looked at corporate systems, sustainability, and digital inclusion.

- It set out what it is that we aim to deliver, what we need to do to ensure delivery and how we are planning to do it.

The Committee agreed that as the timing of the business planning process will be a first cut to the Board in Common in January 2024, at the next committee meeting in December 2023 there will be a need to focus on a clear set of priorities for 2024/5.

Digital and Data Strategy

The Committee noted the Digital and Data strategy and the Digital and Data programme deliverables for 2023/24.

Care Co-ordination Solution

The Committee received a presentation on the progress of the Care Co-ordination Solution. They noted that there will be a decision by NHSE in the coming weeks on the preferred bidder for the national Federated Data Platform for which CCS has been a test-bed and that a workshop will be taking place to determine the plans for adoption across the NWL APC. There is an expectation that once NHS England announces the national FDP supplier, whoever this is, this will be the Collaborative's data platform and workflow engine and we will expect to continue to be the national development and reference site.

Equality and Diversity

The committee discussed their contribution to the EDI action plan that will be taken to the NWL APC Board in Common in October 2023 and confirmation of the agreed EDI priorities for each sub-committee are required to finalise these.

The committee agreed that their initial priority would be ensuring that the data collected on core systems to support the equity analysis and reporting required by the workforce, quality and performance committees. This will particularly require enhancing the recording of ethnicity and other protected characteristics and bringing to together this data where it exists of disparate systems.

Further work will be needed to imbed equity within our digital strategies addressing issues such as the digital divide in access to technology amongst our population, the multiple languages that are used by our population, differing levels of digital skills amongst our population and the particular needs of people with disabilities and illnesses to ensure that the widening use of technology does not exacerbate inequalities in care.

The Committee discussed the suggested draft priorities for 2023-2025 and agreed to do further iterative work outside the meeting.

2.1 Positive Assurances Received

Cerner EPR project

The committee received assurance that LNWHT is now live on the CernerEPR after a tremendous amount of hard work over the cutover weekend and following weeks from all of those involved. There remains some work to complete around stabilisation and some off plan items but the cutover over and go live for LNWHT is now largely complete. There are some lessons learnt and these will be taken forward to the THHFT go-live.

2.2 Key Risks to Escalate

Digital staff are stretched thinly across the stabilisation of the LNW-Cerner implementation and the preparation for the Hillingdon-Cerner go live.

2.3 Concerns Outstanding

None

2.4 Key Actions Commissioned

- 1) To undertake a review of the data strategy in the context of the national FDP contract award which is expected imminently.
- 2) To prepare a paper for the next meeting on digital and data priorities to inform the business planning round.
- 3) To undertake a review of underlying network, data centre and security infrastructure to assured the committee on risk and mitigations across the four trusts.
- 4) Link needs to be made with the digital quality programme led by Janice Sigsworth with an ambition of putting the collaborative at the leading edge of using data and emerging analytics tools to identify, predict and prevent clinical quality variation.

2.5 Decisions Made

None

3. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Terms of Reference	For Agreement	7.	Future of the Committee	Verbal Update
2.	Stocktake of 2022-23 and forward view	For Information	8.	Care co-ordination Solution (CCS)	For Information
3.	APC Digital and Data Strategy – update and next steps	For Information	9.	Equality and Diversity – proposed approach	For Discussion
4.	Digital and Data Programme Deliverables 2023/24	For Information	10.	APC Digital Governance	For Information
5.	Progress on Cerner EPR Programme	For Assurance	11.	Forward Plan 2022/23	For noting
6.	Cerner Optimisation programme	For Information			

4. Attendance

Members	September attendance
Steve Gill (NED Chair)	Y
Bob Alexander (NED)	Y
Syed Mohinuddin (NED)	Y
Simon Morris (NED)	Y

Patricia Wright (Lead CEO)	Y
Simon Crawford (Director of Strategy – LNWH & Senior Information Risk Owner (SIRO) Representative)	Y
Kevin Jarrold (Joint Chief Information Officer – ICHT/CWFT)	Y
Robbie Cline (Joint Chief Information Officer – LNWH/THHT)	Y
Sanjay Gautama (Consultant anaesthetist & Chief Clinical Information Officer (CCIO) Representative)	Y
Bruno Botelho (NWL APC Programme Director & Operations Representative)	Y
Mathew Towers (Business Intelligence (BI) Representative)	Y
Nick Gash (NED)	N
Neena Modi (NED)	N
In Attendance	
Matthew Swindells (NWL APC Chair in Common)	Y
Alexia Pipe (Chief of Staff to the Chair in Common)	Y
Janine Combrinck (BDO – Internal Auditor)	Y
Jack Crouch (KPMG – Internal Auditor)	Y
Peter Jenkinson (Director of Corporate Governance)	Y
Leigh Franklin (Assistant Trust Secretary - THHFT (minutes)	Y

**North West London Acute Provider Collaborative (NWL APC)
Strategic Estates and Sustainability Committee Chair's Highlight Report to
the NWL APC Board in Common (BiC) – for discussion
September 2023**

Highlight Report

1. Purpose and Introduction

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

- To oversee and receive assurance that the Trust level processes governing estates 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 in estates optimisation and usage, and sustainability.
- To prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements in the management of estate and sustainability.
- To receive assurance regarding capital planning and prioritisation across the Collaborative.
- To oversee the development of the strategic direction of estates across the Collaborative, including site optimisation and redevelopment.

2. Key highlights

2.1 Welcome

2.1.1 The Chair welcomed members to the inaugural meeting of the Strategic Estates and Sustainability Collaborative Committee. The main duties of this new committee were previously discharged via the Collaborative Digital and Infrastructure Committee but, as agreed at the Board in Common meeting in July, two separate committees have been established to focus on strategic estates and sustainability, and digital and data, respectively. Some of the work of the previous Committee would carry forward into this committee, including the consideration of the Integrated Care System (ICS) estates strategy, and the consideration of development of collaborative expertise to support other major developments in the future.

2.2 Terms of Reference

2.2.1 The Terms of Reference had been presented and approved at the July 2023 meeting of the Board in Common. The Terms of Reference had since been updated to reflect agreed membership and the Committee considered other amendments, including the need to include a duty relating to ensuring that equity is considered in all strategic estates development. The Committee approved the Terms of Reference, subject to some minor additions. It was agreed to review them again in 6 months.

2.3 Update on green plan and sustainability plans

2.3.1 The Committee received an update on green plans across the acute provider collaborative, including priorities for the four Trusts and areas which could be delivered collaboratively. Key achievements included delivery of anaesthetic gas switch targets across NWL, development of electric vehicle (EV) charges across sites, waste programmes and infrastructure works (such as decommissioning of nitros-oxide

manifold at Charing Cross Hospital), IT projects such as PC power off and Escosia search engine.

2.3.2 Next steps include the development of a consistent carbon reporting tool, development of an ACP estates decarbonisation plan, various infrastructure projects including replacement / efficiency of boilers, solar panel installation and continuation of waste reduction programmes.

2.3.3 Green plans to get to net zero were noted and highlighted the important link between efficiency and cost / energy reductions.

2.3.4 The Committee noted the progress made to date from the baseline around commonality for the four Trusts and noted the need for communications to staff / consistent messaging. The Committee agreed the need for reporting to include performance metrics, as well as progress in actions.

2.4 Update on redevelopment plans

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

2.5 Charing Cross and Hammersmith Hospitals Strategic Outline Case update

2.5.1 The Committee noted the updated on the Strategic Outline Case for Charing Cross and Hammersmith hospitals.

2.6 Development of Acute Provider Collaborative estates strategy

2.6.1 The Committee noted the need to develop an APC estates strategy, which would be informed by the development of an overall APC strategy and clinical strategy. The first step in this process would be a stock-take of the estate across the NWL APC, to evaluate the current estate and to develop contingency plans. The estates strategy would also link to the ICS estates strategy.

2.7 Premises Assurance Model 2022/23

2.7.1 The NHS Premises Assurance Model (NHS PAM) is an annual reporting tool referred to as 'the workbook', that became mandatory this year having previously been a voluntary data gathering exercise.

2.7.2 The NHS PAM has been developed to provide a nationally consistent basis for assurance for provider boards on regulatory and statutory requirements relating to their estate and related services, and the NHS Constitution right "To be cared for in a clean, safe, secure and suitable environment".

2.7.3 NHS Trusts were required to submit their scoring outcome to NHS England by 8 September. Each Trust completed their own self-assessment. No Trust had rated any areas as inadequate, however a number of areas were rated as 'requires minimal improvement' or 'requires moderate improvement'.

2.7.4 The Committee considered whether the PAM returns were reflective of the condition of some of the estate in Trusts, but noted that the focus of the PAM return was on estates related governance processes rather than on the fabric of the actual estate, which would be included in other reporting such as Estates Returns Information Collection (ERIC) returns.

2.7.5 It was agreed each Trust would review their return and include a bridging statement to make clear what the return does / does not include and ensure appropriate context around the condition of the estate.

2.7.6 Following new guidance published by the Department for Education regarding the approach to the presence of reinforced aerated autoclaved concrete (RAAC), NHS England wrote to all Trusts reminding them of the existing approach to management of RAAC in healthcare sites and asked Boards to ensure appropriate assurance

mechanism regarding identification of RAAC.

2.7.7 All four Trusts have completed a review of their respective sites and have found no evidence of RAAC to date; however, work continued across all Trusts to provide additional assurance.

2.8 Committee forward plan

2.8.1 A discussion took place around equality, diversity and inclusion (EDI) metrics for the Committee's consideration. It was agreed the committee report template should be revised to include what consideration had been given to impact on equity of access, including areas of deprivation or disadvantage to specific disabilities.

2.8.2 From an estates point of view Premises Assurance Model (PAM), Patient-led Assessments of the Care Environment (PLACE) and Estates Returns Information Collection (ERIC) would help to bring a full picture of the estate and would inform the estates stock-take.

2.8.3 It was suggested that stakeholder engagement (Foundation Trusts' Council of Governors and NHS Trust Strategic Lay Forum) could be approached to consider areas of reporting to the Board.

3. Positive assurances received

3.1 The Committee noted the submission of mandatory returns in relation to the Premises Assurance Model, and the self-certification in relation in RAAC.

4. Key risks to escalate

4.1 The Committee noted the existing risk to patient experience, operational effectiveness and financial sustainability from the condition of estate across the Collaborative.

5. Key actions commissioned

5.1 The Committee agreed to commission a stocktake of estate across the Collaborative, including data such as the PAM, PLACE and ERIC returns, as the first step towards developing a collaborative estates strategy.

6. Decisions made

6.1 The Committee Terms of Reference were approved subject to minor additions.

7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Terms of Reference	To approve	5.	Development of APC estates strategy	To note
2.	Update on green plan and sustainability plans	To note	6.	Premises Assurance Model 2022/23	To note
3.	Update on redevelopment programmes - THHFT - ICHT	To note	7.	Committee forward planner	To note
4.	Charing Cross and Hammersmith Hospitals Strategic Outline Case	To note			

8. Attendance Matrix

Members:	September Meeting
Bob Alexander, Vice chair (ICHT) (Chair)	Y
Aman Dalvi NED (CWFT/ICHT)	Y
Neville Manual, NED (THHFT/CWFT)	Y
David Moss, NED (LNWH/ICHT)	Y
Tim Orchard, Chief executive (ICHT)	Y
Bob Klaber, Director of Strategy, Research and Innovation (ICHT)	Y
Virginia Massaro, CFO (CWFT)	Y
Jonathan Reid, CFO (LNWH)	Y
Jason Seez, Deputy CEO (THHFT)	N
Janice Sigsworth, Chief Nurse (ICHT)	Y
Steve Wedgwood (THHFT)	Y
In attendance:	
Huda As'ad, Associate NED (LNWH)	N
Rachel Benton, Redevelopment Programme Director (THHFT)	Y
Peter Jenkinson, Director of Corporate Governance (ICHT and CWFT)	Y
Alexia Pipe, Chief of Staff – Chair's office	Y
Matt Tulley, Redevelopment Director (ICHT)	Y

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

Item number: 4.6

This report is: Public

Collaborative Complaints Annual Report 2022-23

Author: Peter Hare
Job title: Patient Services Manager, LNW

Accountable director: Robert Bleasdale
Job title: Chief Nursing Officer, CWT

Purpose of report

Purpose: Decision or approval

To approve the summary of the Complaints Annual Report for the Collaborative covering period 1 April 2022 to 31 March 2023.

Receive assurance that each Local Trust Quality Committee has scrutinised the detailed Complaints Annual Report for its respective Trust.

Note that each local Trust will publish their detailed Complaints Annual Report on their website by no later than 30 October 2023.

Report history

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

NWL APC Quality Committee, September 2023 – approved		
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Executive summary and key messages

This paper summarises the key findings of the statutory annual complaints reports for the period 1 April 2022 to 31 March 2023 for the four Trusts comprising the North West London Acute Provider Collaborative. The four Trusts (in alphabetical order) are:

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

Each individual Trust has submitted its own Annual Complaints Report to its Board Quality Committee who have scrutinised the content and associated learning. Each Trust will publish its own Annual Report on its own website by 30 October 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

North West London Acute Provider Collaborative Complaints Annual Report 2022-23

1. The Governance of Complaints across the Collaborative

Each of the four Trusts within the Collaborative can provide assurance that:

- They have a Complaints Policy that is in date and reflects national legislation and regulatory requirements
- They have a dedicated and established Complaints Department to support implementation of the complaints management and learning process
- They have a named Executive Director responsible for the Complaints function and process
- Learning from Complaints is considered at local Divisional Levels across the 4 Trusts and is also reported at Executive and sub Board Level
- Learning from complaints forms an integral part of the role of the Quality Committee operating within each Trust
- Learning from complaints forms part of the duties of the Collaborative Quality Committee

2. Formal Complaints Received

The table below shows the number of formal complaints received by each Trust during the period 1 April 2022 to 31 March 2023.

For future reporting, the number of complaints received as a percentage of activity in each Trust will be included. For example, in 2022/23, activity figures for London North West showed that for all episodes of care recorded, a complaint was received for 0.08% of them.

Name of Trust	Total Number of Formal Complaints Received	% increase/decrease compared to 21/22
Chelsea and Westminster	481	+7
Imperial College Healthcare	1009	+12
LNWH	906	-2
Hillingdon Hospital	268	-26
Total	2,664	

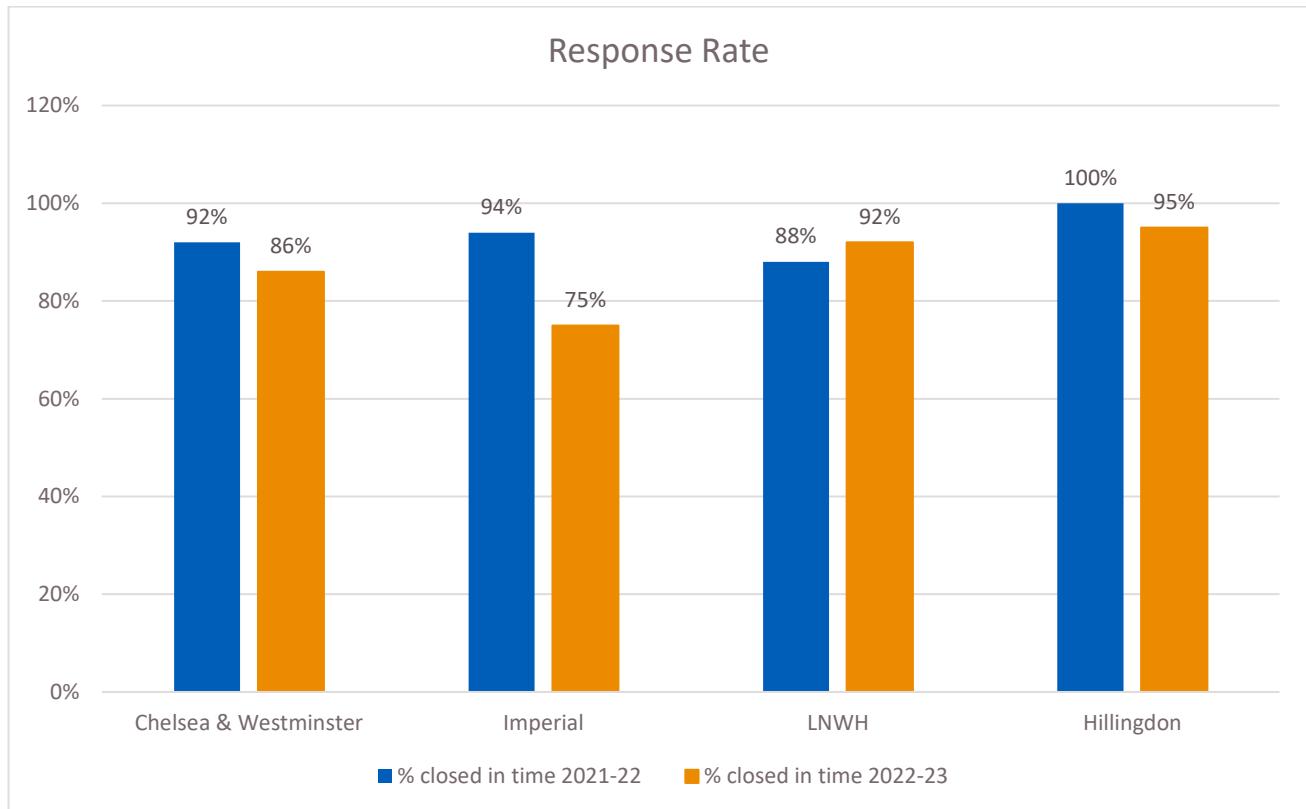
3. Acknowledging complaints.

The Complaints Regulations require NHS organisations to acknowledge all formal complaints within three days of receiving them. The table below shows as a percentage the number of complaints that were acknowledged within this time frame by Trust:

Name of Trust	Total Number of Formal Complaints Received	% of those acknowledged within 3 days
Chelsea and Westminster	481	95% (measured by 2 days)
Imperial College Healthcare	1009	95%
LNWH	906	98.5%
Hillingdon Hospital	268	99.3%
Collaborative Average	2,664	97%

4. Responding to complaints.

The following graph demonstrates the percentage of complaints that were closed during 2022/23, with 2021/22 for a comparison.



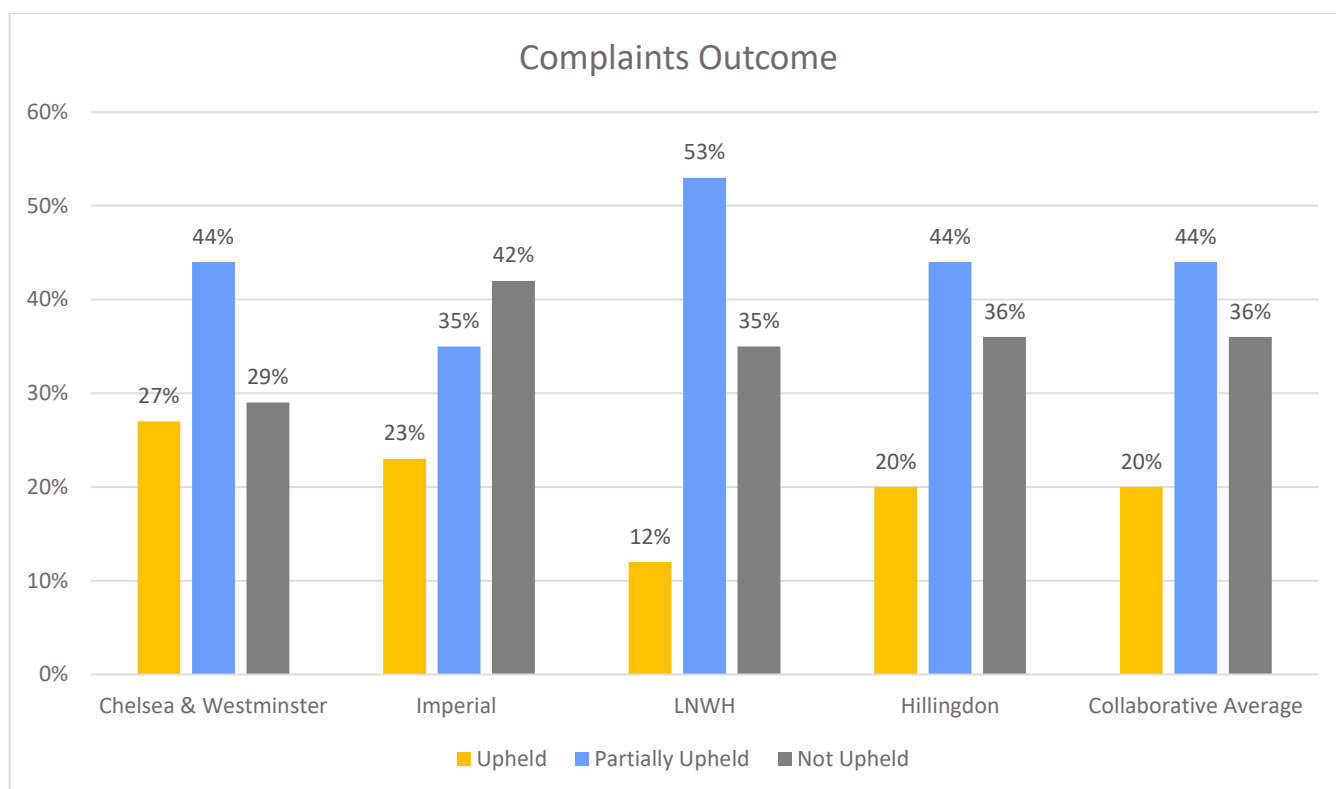
5. Reopened complaints

The complaints regulations allow for complainants to contact the Trust again should they feel the response they have received has not fully addressed their concerns. These complaints are then reopened and a further investigation carried out, with resolution either by letter or a meeting. The chart below details the number of complaints reopened by Trust during 2022/23

Name of Trust	Total Number of Formal Complaints Received	Total number of reopened complaints	% of complaints reopened
Chelsea and Westminster	481	34	7%
Imperial College	1009	33	3%
LNWH	906	74	8%
Hillingdon Hospital	268	4	1.5%
Total	2,664	145	5.5%

6. Outcome of complaints closed

Each complaint that is closed is recorded as to whether the complaint was fully upheld, in that all the concerns identified required action, partially upheld or not upheld. Each NHS organisation reports these criteria nationally as well in the annual complaints report to NHS Digital. The graph below shows the complaint closed by outcome for each of the four Trusts.



7. Complaint Themes

Each formal complaint that is received is categorised using one of a pre-set of subjects. These are called KO41 codes, and are nationally set so that complaints data submitted to NHS Digital each quarter can be compared across all NHS organisations. The graph below demonstrates the top 5 themes reported for each Trust during 2022/23. Collecting this data shows there are some differences in the way Trusts categorise complaints, with the disparity between Clinical Treatment and Patient Care an example. Complaints leads are coming together to align the coding of complaints to support greater consistency where there is current variation.

Name of Trust	Clinical Treatment	Values & Behaviour	Appointments	Communications	Patient Care
Chelsea and Westminster	32%	8%	5%	27%	16%
Imperial College Healthcare	27%	16%	14%	12%	7%
LNWH	24%	12%	11%	20%	9%
Hillingdon	0.7%	26%	6%	13%	43%
Collaborative Average	24%	14%	11%	17%	13%

8. The Parliamentary and Health Service Ombudsman

Should a complainant be dissatisfied with the attempts to resolve their complaint, they can ask the Parliamentary and Health Service Ombudsman (PHSO) to carry out an independent investigation.

Complainants refer their complaint to the PHSO direct, and should the PHSO decide they wish to investigate, they will request copies of the complaints investigation and correspondence from the relevant Trust.

The table below shows the number of complainants who contacted the PHSO during 2022-23 and the PHSO's decision on the resultant outcome of those enquiries.

It is worth noting that the PHSO can take up to a year from deciding to investigate a complaint to producing their final report. Enquiries received in one financial year will therefore often have the final report produced during the following year.

Enquiries usually result in the Trust sharing their complaints file and any relevant medical records with the PHSO for them to do an initial review. Should the PHSO then decide they are going to investigate, they will write to the Trust and advise as such.

Name of Trust	Total Number of Enquiries Received	Total Progressed to Investigation	Total Upheld	Total Partially Upheld	Total Not Upheld	Awaiting Report
Chelsea and Westminster	15	1	1	0	0	1
Imperial College	25	4	1	1	0	1
LNWH	18	4	0	1	1	1
Hillingdon	2	1	0	1	0	1
Totals	60	10	2	3	1	4

9. Learning from complaints

One of the key components of a complaints investigation is identifying actions and learning. This forms the final principle in the Parliamentary and Health Service Ombudsman's complaints handling guide, seeking continuous improvement.

Examples of actions identified from complaints during 2022/23 are set out below:

Importance of ordering appropriate blood tests included in junior doctors newsletter	Folding privacy screen introduced to x-ray viewing room for additional privacy for patients undressing for scan.	Additional step for take home medications put in place as part of discharge process
Rolling works programme to replace trolleys in ED and measures in place to check any defective trollies are not in use	Information sign introduced to UCC at CMH advising patients can ask to speak to a nurse in private	Implementation of Purple Butterfly project aimed at improving experience of patients and families during end of life.

Ward team meetings set up to reinforce good communication with patients and families to prepare for discharge	Additional training for staff on the correct process for booking an interpreter	More robust system introduced to wards to make notes of telephone calls received
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10. Complainant Demographics

During 2023/24 all four Trusts will work to understand the demographics and socio-economic profile of complainants. This is part of our aim to reduce health inequalities across North West London. During 2022/23, Imperial College Healthcare NHS Trust took the lead in starting to explore such data and this demonstrated that people who describe themselves as having a 'white British, Irish and other white background' are most 'over-represented' in terms of making complaints to the Trust (48 per cent of complainants vs 38.5 per cent of registrations) and people from 'black Caribbean, African and other black background' are slightly over-represented (10.7 per cent vs 7.8 per cent).

Meanwhile, people from 'mixed' backgrounds are very slightly 'under-represented' (3.1 per cent vs 4.2 per cent) and people from Asian backgrounds are more under-represented (14.6 per cent vs 17.7 per cent).

There appears to be a clear correlation between deprivation and likelihood of making a complaint, with people from the area with the highest deprivation most 'under-represented' in complaints and people from the area with least deprivation most 'over-represented'.

During 2023/24 much more analysis is required to understand and act on this data, including research to find out why some groups are complaining less than may be expected, whether there are on any particular complaint themes amongst specific groups. We also want to expand analysis into other protected characteristics. This approach will be taken across all four Trusts in the Collaborative.

11. Plans for the year ahead

All four Trusts have committed to meeting regularly in order to work towards aligning their complaints processes and reporting mechanisms. We will discuss and share our practices, agree on what is good practice, and look to further improve the complaints process across the collaborative.

A prime example of this will be to report on the time taken to resolve complaints by Trust and as a collaborative. Future reporting will include those complaints closed within a timescale of three months, and then between three and six months. Also included will be those complaints that have exceeded their proposed due date and remain outstanding, with the timeframe of the delay included in the report.

Complaints teams across the collaborative are coming together shortly to ensure alignment of the classification and categorisation of complaints moving forward. This will support greater comparison and learning across the collaborative

As mentioned in section 8, each Trust will also look to start and build upon what Imperial College Healthcare have already initiated in understanding the demographics of those that do submit a complaint, and feeding into the work that is being carried out to reduce health inequalities across North West London.

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

Item number: 4.7

This report is: Public

Acute provider collaborative Learning from Deaths Quarter one 2022/23 summary report

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

Accountable directors: Jon Baker, Alan McGlennan, Raymond Anakwe, Julian Redhead & Roger Chinn
Job title: Medical Directors

Purpose of report

Purpose: Information or for noting only

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

Report history

Trust Quality Committees

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

Acute Provider Collaborative mortality surveillance meeting

14/08/2023
Draft trust reports were reviewed and the contents of this paper discussed and agreed.

Acute Provider Collaborative Quality Committee

27/09/2023
This report was discussed, the on-going actions endorsed and the report approved for onward submission to the Board-in-common.

Executive summary and key messages

- 1.1. In line with national guidance each Trust provides a quarterly report to their quality committee on mortality surveillance and other learning from deaths processes. This report provides a summary of the quarter one 2022/23 reports. Individual trust reports are provided in the reading room.
- 1.2. A shared learning from deaths report template has been designed by the acute provider collaborative (APC) mortality task and finish group with a focus on learning and improvements. Trusts are transitioning to using this template with a standardised data set, these will be fully in use for the quarter two reports.
- 1.3. The reports provide assurance that deaths are being scrutinised in line with requirements, and learning being shared and acted upon through Trust governance processes.
- 1.4. A consistent theme relates to the opportunity to improve care at the end of life, with local actions in place and joint work through the APC quality priority workstream.
- 1.5. Changes have been made to standardise mortality review triggers and the Level 2 death review grading system used which will support improved comparison of outcomes and identification of cross-trust learning. These will be reflected in the data in the Q2 reports.
- 1.6. Trust mortality rates remain similar to the previous quarter. The Hillingdon Hospitals NHS Foundation Trust (THH) have an “as expected” hospital standardised mortality ratio (HSMR) and standardised hospital mortality indicator (SHMI) with all others remaining “lower than expected”.
- 1.7. All Trusts are investigating variations between observed and expected deaths by diagnostic group and also where there is variance between HSMR and SHMI (above 100 and where statistically significant). Reviews will be presented to the next APC mortality surveillance group which will discuss themes and trends identified and agree actions to be taken forward including linking the data to peer reviews.

Strategic priorities

Tick all that apply

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

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

Impact assessment

Tick all that apply

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

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

Main report

2. Learning and Improvements

- 2.1. Each Trust has processes in place to ensure learning from deaths happens after all in-hospital deaths and that this is shared and actions implemented where required.
- 2.2. There are no issues for escalation to this committee.
- 2.3. The key theme for improvement from mortality reviews undertaken in quarter one 2022/23 relates to care at the end of life, including recognition and timely referral to palliative care, agreement and documentation of advanced care planning/treatment escalation plans and involvement of patients and families in these processes.
- 2.4. In addition to the local work in place within all Trusts, improving end of life care is a shared priority across the APC, an update on progress is provided separately to this committee.
- 2.5. Other themes/actions for improvement identified by individual Trusts are set out below:
 - 2.5.1. **CWFT:** improvement work is underway in the emergency department regarding wait times for patients with mental health conditions, local induction of guidelines, clinical handovers and clinical staffing levels.
 - 2.5.2. **ICHT:** improvements noted in communication, team working and involvement of palliative care, which may be linked to the work of the priority programmes.
 - 2.5.3. **LNW:** rheumatology reviews found patients with higher rates of cancer, multi-morbidity, and progressive neurological disorders, which would be greatly supported by more advanced care planning within the community. Additionally in this quarter, well-coordinated liaison and support between colleagues across disciplines and specialties, enabling the timely transfer to patients, has been identified.
 - 2.5.4. **THH:** reviews completed demonstrated good MDT communication and collaborative co-ordination with other teams which included prompt response from specialties and early involvement of the palliative care team. There were examples of timely completion of DNACPR forms following effective communication with patients/families. One case identified issues around end of life planning and the use of Comfort Care plans.

3. Thematic Review

3.1. A shared core data set has been created for use in all learning from death reports but there have been challenges around the collection and reporting of some data items. Trusts are reporting the data that they have available and work continues to report any outstanding data in the next local reports. The APC mortality surveillance group will continue to monitor the roll out of this shared data set.

3.2. The scorecard forms part of local reports and will be monitored through local governance and the APC mortality surveillance group on a quarterly basis. Reviewing a standard dataset will allow for more straightforward comparison between our organisations that will support the identification of shared learning and insights.

3.3. Mortality rates and numbers of deaths

3.3.1 HSMR and SHMI data shows that each Trust continues to have a rolling-12 month HSMR below the national benchmark of 100. CWFT, ICHT and LNW are 'lower than expected'. THH remains 'as expected', but both measures are on a downward trajectory and are now below 100.

3.3.2 Trend and funnel plot visualisations of HSMR and SHMI mortality rates are included in the board in common clinical outcomes performance report and can be found in the appendix of this report. These show data at Trust level. Site level mortality data will be included in the quarter two reports. It is important to note that these show the most recently available data, which will be different from that reported in the individual Trust reports.

3.3.3 HSMR and SHMI diagnostic group data is under review by the APC mortality surveillance group to identify any shared themes or learning. The group have identified variation in HSMR and SHMI diagnostic group scores across our organisations. Further work is required to understand the differences in the data and identify areas for improvement. The outputs of local reviews will be monitored through the APC mortality surveillance group and reported to APCQC in December.

3.3.4 An example of the SHMI diagnostic group data being reviewed by the APC mortality surveillance group is in the table below. NHSE only provide a breakdown of these nine SHMI diagnostic groups.

3.3.5 Scores shown in green text are significantly lower than expected mortality rates whereas those shown in black text are within the expected range. A significantly higher than expected relative risk would be shown in red text but there are currently no diagnostic groups with in this risk category.

3.3.6 The statistical model applied means that scores over 100 in a particular diagnostic group does not necessarily indicate a significantly higher than expected relative risk which is why scores over 100 in the table below are still within expected range in each group.

SHMI Diagnosis group	HH	CWFT	LNW	ICHT
Cancer of bronchus, lung	89.05	76.63	103.85	62.7
Fluid and electrolyte disorders	52.67	43.77	66.34	44.29
Fractured neck of femur	116.23	111.05	112.32	56.81
Gastrointestinal haemorrhage	115.11	60.63	79.8	54.72

Pneumonia	77.18	76.66	98.55	72.88
Secondary malignancies	151.31	61.64	80.67	63.85
Septicaemia (excluding labour)	94.24	83.05	79.46	86.08
Acute Myocardial Infarction	82.17	89.51	89.23	113.15
Urinary Tract Infection	125.67	49.99	82.54	76.4

3.3.7 Although local review of the data occurs within each Trust, the processes are not currently standardised. The group have therefore agreed a process for each Trust to identify and investigate diagnostic groups that meet agreed thresholds and report outcomes through local Trust learning from death governance and escalate for discussion at APC mortality surveillance group meetings.

3.3.8 This process involves completion of a coding review for each diagnostic group and then review of each observed death to identify if clinical concerns had been raised through local mortality review processes or if concerns not previously reported have now been identified.

3.3.9 Reviews already undertaken by Trusts for deaths during this period include:

- CWFT have identified an error in their data upload process to NHS Digital which meant cases were processed without the primary diagnosis group coding. This has been corrected and does not impact the overall risk mortality rating for HSMR and SHMI.
- ICHT have investigated increasing HSMR trends in Gynaecology and Stroke and Neurosciences. Gynaecology had a HSMR score of 114.9 in March 2023 (data for the period November 2021-October 2022) compared to 93.5 in the previous month, and the score had steadily increased over the preceding 12 months. There were three deaths recorded on Datix which is higher than usual. In this low death specialty, small numbers can result in larger fluctuations in mortality rates. The cases have been reviewed and there are no clinical concerns; all three had advanced cancer. Telstra Health have confirmed that the HSMR model adjusts for palliative care cases and this adjustment will be contributing to the subsequent reduction in HSMR which fell back below 100 in May 2023. Stroke and Neurosciences continue to carry out a deep-dive into the steady increase in their HSMR rate over the preceding 12 months despite their mortality rate returning to lower than expected in quarter one. Outcomes from this review will be reported in quarter two report.
- An on-going review into the high HSMR in neonatology and maternity at ICHT is being undertaken with Imperial College. Initial internal reviews did not identify a clear reason for the high rate. 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.

3.4. **Medical examiner reviews**

3.4.1 All Trusts have a medical examiner service in place who scrutinise in-hospital deaths.

3.4.2 Trusts continue to work collaboratively to expand medical examiner scrutiny to all non-coronial deaths occurring in NWL boroughs. A task and finish group with representation from the NWL Integrated Care Board (ICB) and primary care borough directors have worked together to implement this new pathway. The original date for the community pathway

becoming a statutory requirement was April 2023 and the new NWL pathway went live ahead of this date to ensure readiness across the sector. However, the legislation was delayed and the Department of Health and Social Care have now confirmed that it will pass in April 2024.

3.4.3 The task and finish group continues to meet to embed the new pathway and encourage primary care organisations to refer deaths ahead of the statute date. Medical examiner offices in NWL are in receipt of additional funding from NHSE so that they are resourced to manage the increase in demand on our services that the community pathway will create.

3.4.4 Collaborative work between all four providers also continues with the aim to establish weekend medical examiner services later this year.

3.5. Level 2 reviews

3.5.1 Deaths where there are concerns, or which meet certain agreed criteria, are referred on by the medical examiner for a case note 'Level 2' review. A shared set of 'triggers' for these reviews was implemented across Trusts at end of quarter one which will allow consistent reporting on themes from this data going forward.

3.5.2 The percentage of deaths referred for a level 2 review during 2022/23 varies across each Trust, from 6% at LNW, 13% at THH, and 9% at ICHT (not currently reported for CWFT).

3.5.3 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 however the systems are different making comparison difficult. In quarter one, all trusts implemented the CESDI scoring system which will be used to identify whether a death was avoidable in order to produce standard outputs from Level 2 reviews. Comparative data will be available in quarter two reports.

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

- **CWFT:** One case of sub-optimal care that might have made a difference to the patient's outcome was identified; this case was declared as a serious incident.
- **ICHT:** No cases of poor or very poor care were identified in all 38 Level 2 referrals, the first time this has happened since 2020/21.
- **LNW:** 11 / 33 cases referred for a Level 2 reviews were completed in this quarter and review did not find any cases of sub-optimal care.
- **THH:** Two Level 2 cases have been completed and found no sub-optimal care. The 17 remaining cases are in the process of being completed.

3.6. Other mortality reviews

3.6.1 A number of other national processes are in place for review of deaths for specific cohorts of patients. These include the Perinatal mortality review tool (PMRT), Learning disability mortality review (LeDeR) and Child death overview panels (CDOP), which are described in the glossary below. There are gaps in some Trusts' reporting on data and outcomes for these processes and work is underway to rectify this. We will provide an update on timelines in the Q2 report.

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

3.6.3 LNW are reviewing their internal processes for capturing, monitoring and learning from PMRT, CDOP and LeDeR reviews.

3.6.4 Through PMRT processes, both ICHT and THH have identified challenges with language and communication barriers due to difficulty of accessing interpreters for diverse local communities who access maternity services. Both Trusts have improvement plans in place.

4. Areas of focus

- 4.1. Work continues to align our learning from deaths processes and reporting of outcomes through the new APC mortality surveillance group. This will further improve how the collaborative uses data to identify and share learning from deaths.
- 4.2. The focus in quarter one has been to align on a standard set of triggers for Level 2 reviews and grading system for these reviews, as described above in this report.
- 4.3. The APC mortality surveillance group will now commence a review into the palliative care coding processes and the accuracy of mortality coding processes in Trusts. Improvement recommendations will be identified following this review.
- 4.4. Local areas of focus have also been identified by each Trust:
 - ICHT continue to review processes and functions of Specialty Mortality and Morbidity (M&M) reviews. Areas of best practice have been identified, local guidelines have been produced and a process of tracking being developed.
 - THH continue to work with Medicine and Surgery divisions to recruit mortality leads for those divisions.
 - LNW have identified that more action needs to be taken within the community to support the completion of Advanced Care Planning. With increasing numbers of frail patients living at home, the trust needs community partners to be more pro-active.
 - CWFT is engaged in significant recruitment activities and resource allocation programmes to ensure clinical staffing levels are maintained.

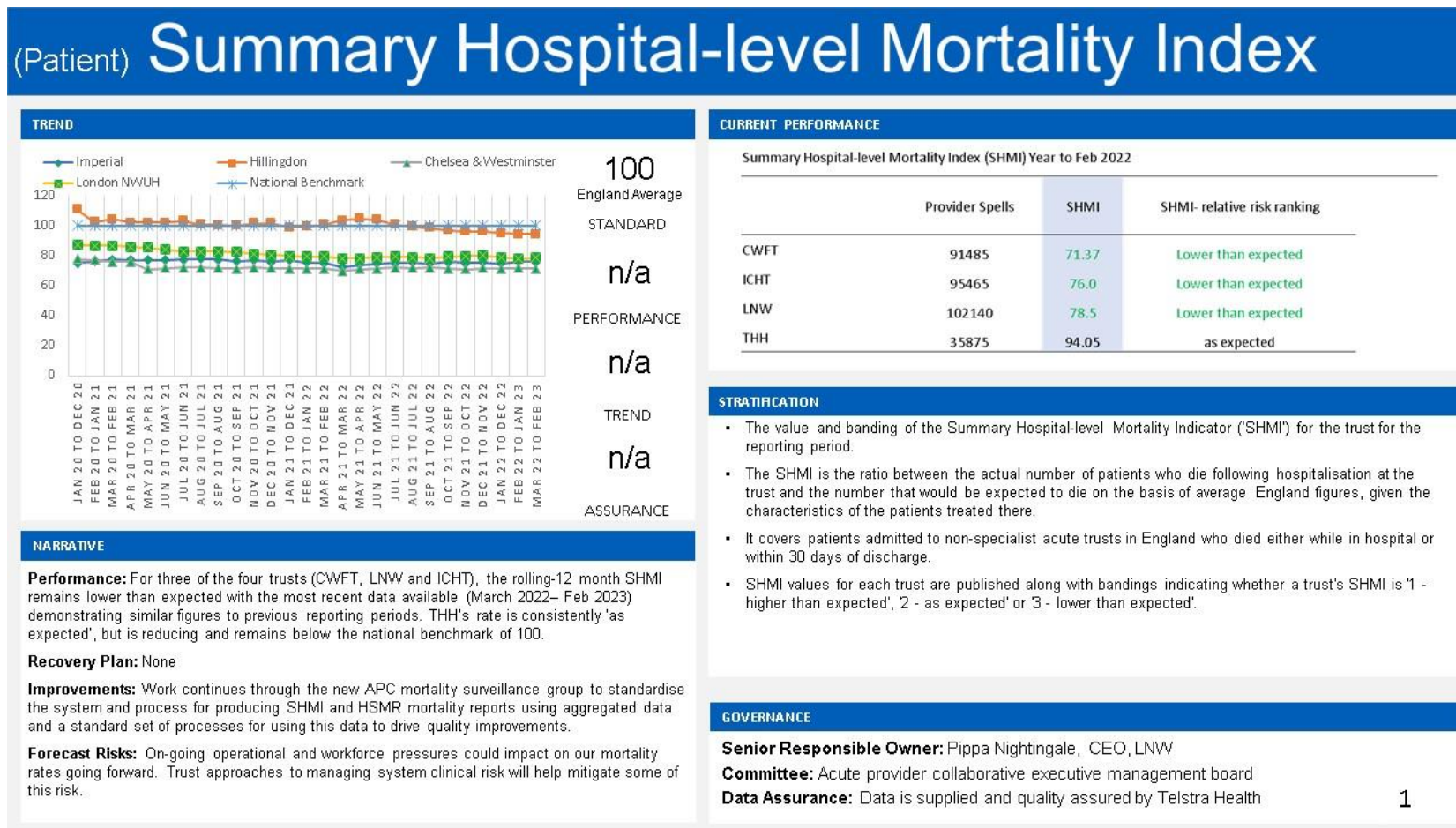
5. Conclusion

- 5.1. The individual Trust reports provide assurance regarding each Trust's processes to ensure scrutiny of, and learning from, deaths in line with national guidance, with actions in place where the need to improve these further has been identified.
- 5.2. Across the APC our mortality rates are lower than, or as expected, when compared nationally, with regular review of these occurring both internally and through the APC quality committee.
- 5.3. Low numbers of cases are identified through level 2 reviews where clinical concerns are identified however review processes and grading are different making comparison difficult. This will be rectified from Q2 making analysis more meaningful.
- 5.4. Implementation of agreed changes to processes for recording and reporting outcomes will improve how the collaborative uses data to identify and share learning from deaths.
- 5.5. Local reviews into HSMR and SHMI scores will be monitored through the APC mortality surveillance group and reported in APC learning from death reports going forward. There is variance that would benefit from comparative analysis and will be linked to the APC peer review process going forward.
- 5.6. The APC mortality surveillance group will provide assurance to the APC Quality committee and the Board in Common that there is a strategic approach to reviewing mortality and learning from deaths across the collaborative on an ongoing basis.

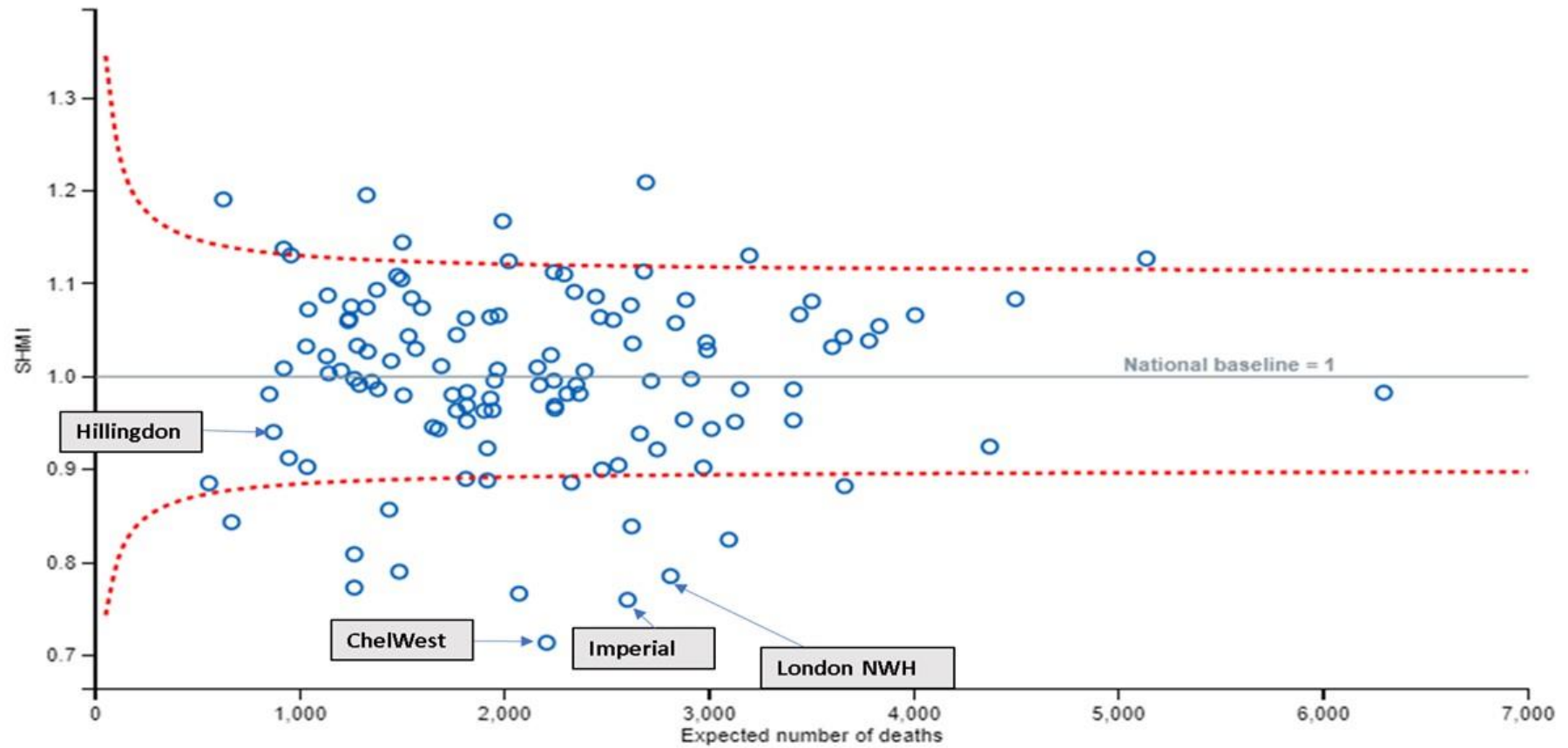
6. Glossary

- 6.1. **Medical Examiners** are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.
- 6.2. **Level 2 reviews** are additional clinical judgement reviews carried out on cases that meet standard criteria and which provide a score on the quality of care received by the patient during their admission.
- 6.3. **Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.
- 6.4. **Child Death Overview Panel (CDOP)** is an independent review process managed by Local integrated care boards (ICBs) aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.
- 6.5. **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.
- 6.6. **Learning Disabilities Mortality Review (LeDeR)** is a review of all deaths of patients with a learning disability. The Trust reports these deaths to NHSE who are responsible for carrying out LeDeR reviews. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

Appendix – Clinical outcomes performance report mortality data

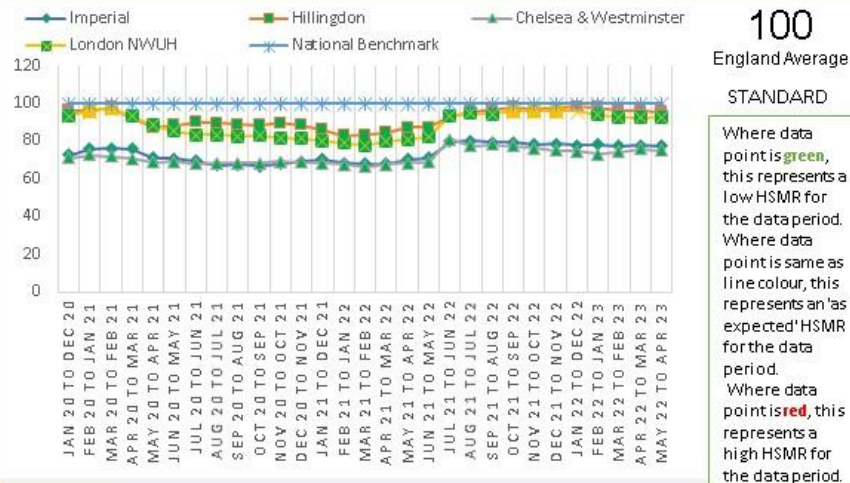


(Patient) Summary Hospital-level Mortality Index



(Patient) Hospital Standardised Mortality Ratio

TREND



NARRATIVE

Performance: The most recent data (for the year May 2022–April 2023) shows that each trust has a rolling 12-month ratio below the national benchmark. THH's rate remains as expected.

Recovery Plan: N/A

Improvements: Work continues through the new APC mortality surveillance group to standardise the system and process for producing SHMI and HSMR mortality reports using aggregated data and a standard set of processes for using this data to drive quality improvements.

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 April 2023

	Provider Spells	HSMR	SHMI- relative risk ranking
CWFT	43766	74.9	Lower than expected
ICHT	68403	77.6	Lower than expected
LNW	59961	92.6	Lower than expected
THH	15854	95.42	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: Pippa Nightingale, CEO, LNW

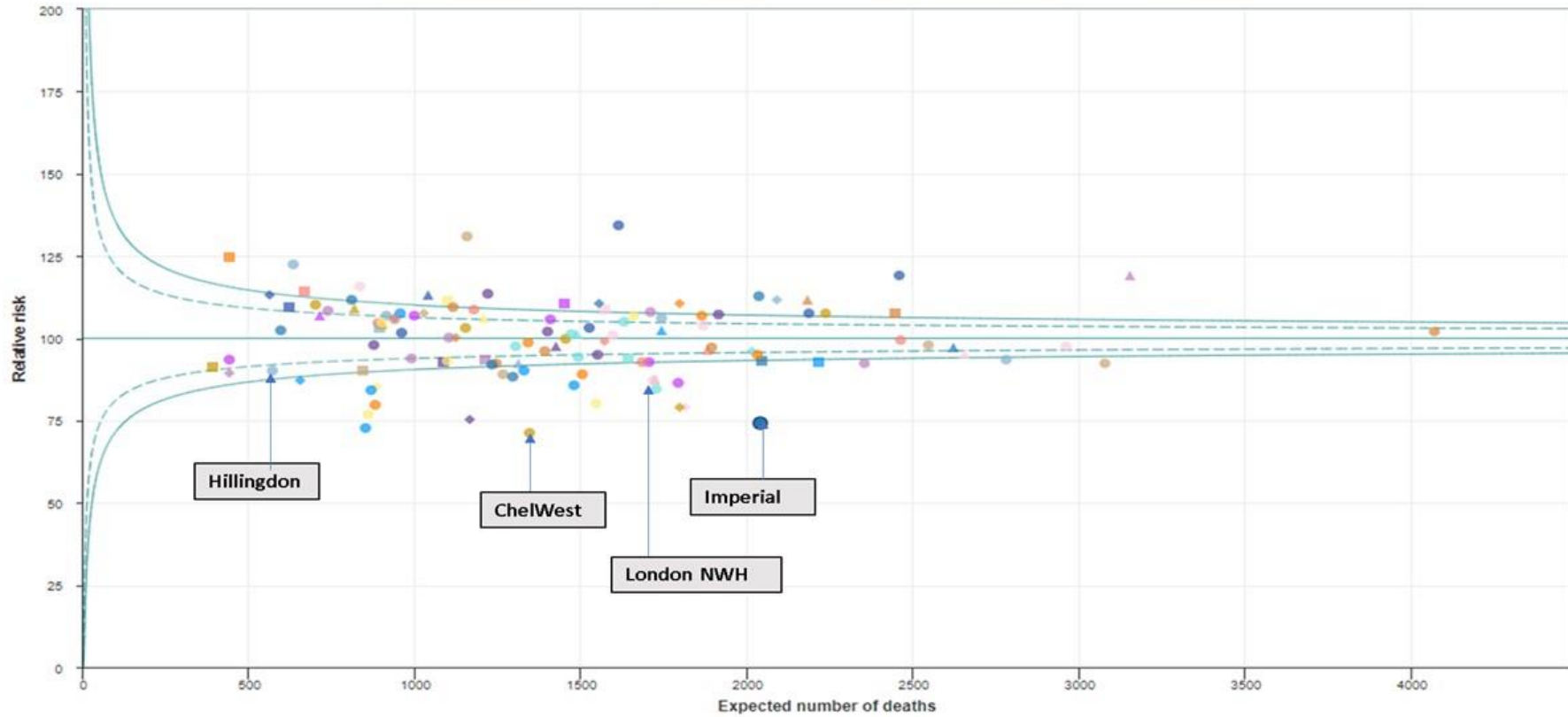
Committee: Acute provider collaborative executive management board

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

(Patient) Hospital Standardised Mortality Ratio

Diagnoses - HSMR | Mortality (in-hospital) | May-22 to Apr-23 | ALL (acute, non-specialist)

Peers # Measure Benchmarks Group by Show



Audit and Risk Committee (ARC) Chair's Highlight Report to the Board in Common

Date of Audit and Risk Committee: 11 September 2023

Highlight Report

1. Key Highlights

Internal Audit

1.1.1 The Committee has received five Internal Audit Progress reports. Of the two audits completed, the committee noted the rating, findings and recommendations as follows:

Name	Design rating	Effectiveness Rating
Patient Discharge	Moderate	Moderate
Stock and Stores Management – Estates and Facilities	Moderate	Moderate

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 and noted that the 2023/24 Internal Audit programme was progressing to plan.

1.1.4 The committee also received and noted the Internal Audit Annual Benchmarking Report 2022/23 and the Environmental Sustainability Report.

Review and Learning from the Annual External Audit process 2022/23

1.2.1 The committee received a report from the Trust and External Audit perspective which outlined the factors that contributed to the late completion of the external audit of the annual accounts for 2022/23. The committee discussed and noted the findings, noted the remedial actions to be completed and by when. The committee will closely and regularly monitor the action plan and seek assurance that these have been addressed ahead of the 2023/24 audit.

Finance

The committee noted:

1.3.1 Review of losses and special payments: No write offs in quarter 1 of 2023-24 (April to June 2023), or the approval of any special payments were requested.

1.3.2 Review of non-compliance with SFIs: Waiver usage, both from a value and volume perspective, has continued to fall during 2023-24 to date after a peak at the 2021-22 year end. Procurement record, track and report any non-compliance monthly to the finance team.

1.3.3 Debtors and creditors: Significant progress has been made in managing creditors. Aged debtor balances have grown throughout the year to date, reflecting resourcing issues within the team. The Finance team is putting in place some additional resource to manage the issues arising and ensure the Trust is chasing and collecting debts efficiently.

Aged debtor balances are £3.3m higher than the level at the last year end and have increased steadily during the year. After increases during the current year, NHS organisations account for 44% of the total debt, overseas visitors 39% and non-NHS organisations approximately 19%. The Trust still has high levels of bad and doubtful debt provision in place against all of these debts, particularly against overseas visitors' debt.

Reductions in creditor balances have continued for the majority of this financial year, and Better Payment Practice Code performance has remained high, with 92% of all invoices (by value) being paid within 30 days.

Grip and Control

1.4.1 The committee received an update against the delivery of the Grip and Control Programme noting good progress with the programme through regular reviews taking place on a monthly basis with category leads. The committee noted that positive feedback was received by NHSE following the review of the Grip and Control programme that was included in their assessment of the National Oversight Framework Level 4 exit criteria.

Counter Fraud Progress Report

1.5.1 The committee received and noted the Counter Fraud progress report covering activity between July – August 2023. In this period the team has received four new referrals and three cases have been closed. There are five open cases under active investigation by the Local Counter Fraud Service (LCFS) and a further two being led by another NHS body.

1.5.2 The committee noted ongoing proactive work being undertaken by the LCFS.

1.5.3 The committee noted the NHS Counter Fraud Authority quarter 1 Strategic Threat Assessment which provides strategic intelligence on current, or emerging TVEs, (threats, vulnerabilities, and enablers), key areas highlighted include staff, patient exemption fraud, fraudulent access and data manipulation.

Health and Safety Report

1.6.1 The committee received a summary of the work of the Health, Safety and Environment Committees (HSEC). The committee noted that work has started on developing and implementing a Health and Safety assurance dashboard, the committee

welcomed this approach and will receive an outline position against a range of Health and Safety indicators at its next meeting.

Board Assurance Framework

1.7.1 The committee received and noted the Board Assurance Framework and Corporate risks scoring 12 and above for quarter 1 2023/24.

Report from the Risk Management Group

1.8.1 The Committee received assurance and noted:

- The Trust's Risk Management KPIs
- The Trust's Risk Management Training arrangements.
- Progress against the recommendations from the KPMG Strategic Risk Governance Review, noting all actions have been completed
- A Summary of work undertaken by the Trust Risk Management Group

2. Positive Assurances Received

Internal Audit

2.1.1 The Committee noted positive feedback on the two completed Internal Audit reports as per section 1.1 above and positive progress on closing down recommendations from audits.

3. Key Risks to Escalate

None

4. Concerns Outstanding

None

5. Key Actions Commissioned

Review and Learning from the Annual External Audit process 2022/23

5.1.1 The committee will closely and regularly monitor the action plan and seek assurance that these have been addressed ahead of the 2023/24 audit.

6. Decisions Made

6.1.1 **Fixed Asset Policy** –The committee approved the Fixed Asset Policy, subject to further amendments to be added following discussion and input from committee members and external audit.

6.1.2 **Risk Management Strategy** – The committee approved the Trust Risk Management Strategy, and will review progress against delivering the strategy in the next 6-12 months.

6.1.3 **Risk Management Policy** – The committee approved the Trust Risk Management Policy.

7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Fixed Asset Policy	Approve	7.	Finance Report	Assurance
2.	Risk Management Strategy	Approve	8.	Grip and Control Programme Update	Assurance
3.	Risk Management Policy	Approve	9.	Health and Safety Report	Assurance
4.	Learning from the Annual External Audit process 2022/23	Assurance	10.	Board Assurance Framework	Assurance
5.	Internal Audit Reports	Assurance	11.	Report from the Risk Management Group	Assurance
6.	Counter Fraud Report	Assurance			Assurance

3 Attendance

Members	September attendance
Neville Manuel – Chair	N
Nick Gash – NED (acted as Chair)	Y
Patricia Gallan - NED	Y
Attendees	
Patricia Wright (CEO)	Y
Jon Bell (CFO)	Y
Naeem Udin (Deputy CFO)	Y
Jonathan Gooding (Exetrnal Audit)	Y
Grace Quist- Therson (External Audit)	Y
Janine Combrinck (Internal Audit)	Y
Simon Lane (Counter Fraud)	Y
Nicole McLaughlin (Counter Fraud)	Y
Vikas Sharma (Trust Secretary)	Y

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: 13 September 2023

Highlight Report

1. Key Highlights

External Audit

- 1.1 The Committee received a verbal update, noting that the Trust completed the annual report and accounts for 2022/23 and submitted these on time.
- 1.2 There had been a number of recommendations from the 2022/23 audit and Trust management had drafted an action plan in response to those recommendations.
- 1.3 The Committee noted the action plan to address the recommendations with a project style approach, including the set-up of a working group to monitor progress and manage any issues.

Internal Audit Progress report

- 1.4 The Committee received the report and noted good progress against the annual plan.

Counter Fraud Progress report

- 1.5 The Committee received the report and noted the progress of the plan.

Redevelopment Committee Annual Report / Deep Dive

- 1.6 The Committee received the report to provide assurance on the effectiveness of the Redevelopment Committee in its oversight of delivery of all aspects of the redevelopment programme.
- 1.7 It was highlighted that, as well as oversight of the redevelopment programme for St. Mary's, Charing Cross and Hammersmith hospitals, the redevelopment committee had focused on contingency and estate management updates; contingency planning; Samaritan Hospital and Western Eye Hospital estate issues and refurbishment funding.
- 1.8 The RAAC inquiry was discussed and the committee were informed that a report would then be formed, and presented to the Board in Common on 17 October 2023.
- 1.9 The CEO assured the Committee that the Estates team had been, and were still in the process of carrying out inspections; however, of the inspections already completed, there was no evidence of RAAC.

Risk and Assurance Report

- 1.10 The Committee received the report providing an update on the corporate risk register, the corporate risk profile and board assurance framework process.
- 1.11 The Committee noted that the corporate risk profile changed in July due to the re-definition of a corporate risk. This change would enable us to focus more on the extreme risks within the organisation via the corporate risk report.
- 1.12 The Committee also noted that the Board Assurance Framework had been established to capture strategic risks at Trust level.
- 1.13 The Committee noted the number of extreme risks, and that the majority of these sit under Estates or Operational pressures following Covid and more recent Industrial Action. Following an initial review by the Executive Team Meeting, it had been agreed that an Executive Risk Committee would be established to focus on the extreme risks and monitor the BAF and this would report into the executive management board.

Cyber Security Dashboard

- 1.14 The Committee received the report outlining the ongoing steps that were being taken by the Trust to mitigate and manage cyber security related risks and incidents, providing an overview of the core activities that were undertaken between June 2023 and August 2023 to manage cyber risks, which were predominately focused on infrastructure and application remediation.

Losses and Compensation report

- 1.15 The Committee received and noted the report detailing all losses and special payments approved in Quarter 1 of the 2023/24 financial year

2. Positive Assurances Received

Internal Audit Update

- 2.1 The Committee noted that three assignment reports; Medical Devices, Outsourced Contracts and Safeguarding Adults had been completed, and all of these reports had received ratings of Amber/Green - Significant assurance with minor improvement opportunities.

Annual Fire Safety Report

- 2.2 The Committee received the report providing assurance of the Trust's annual fire safety compliance.
- 2.3 The Committee noted that the Trust have now completed all actions related to the Western Eye Notice of Deficiency (NoD) from the London Fire Brigade, and the site had reopened earlier this year.

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	Purpose	No.	Agenda Item	Purpose
1.	External Audit Report	To note	5.	Risk and Assurance report	To note
2.	Internal Audit progress report	To note	6..	Annual Fire Safety Report	Assurance
3.	Counter Fraud progress	To note	7.	Cyber Security Dashboard	To note
4.	Redevelopment Committee Annual Report / Deep Dive	Assurance	8.	Losses and Compensation report	To note
		To note	9.	Committee forward planner	To note

8. Attendance

Members:	September Attendance
Nick Gash, Chair (ICHT)	Y
Bob Alexander, Non-executive Director (ICHT)	Y
Linda Burke, Non-executive director (THHFT)	Y
David Moss, Non-executive director (LNWT)	Y
Tim Orchard, Chief executive (ICHT)	Y
Attendees:	
Julian Redhead, Medical director (ICHT)	Y
Jazz Thind, Chief Finance Officer (ICHT)	Y
Janice Sigsworth, Chief Nurse (ICHT)	Y

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: 26 July 2023

Highlight Report

1. Key Highlights

Audit

Internal Audit Report

- 1.1 Two audits are in progress: Patient Transport Services and Cancer Data Set, and three are planned to start in August. The Committee noted concern that little fieldwork had been undertaken in Q1 which may result in additional pressures on teams later in the year. It was requested that the Internal Auditors address this in future years.
- 1.2 Two changes were noted to the Internal Audit Programme. The Consultant Job Planning audit has been replaced with an audit of Nurse Rostering and the Cerner Implementation audit has moved from Q1 to Q4.

External Audit Report

- 1.3 The external audit of the Trust has been completed and an unmodified opinion was issued on 30 June 2023. The Auditor's Annual Report has also been issued and published on the Trust website.
- 1.4 The team have commenced the plan and risk assessment of the year end audit of the LNWH Charity's accounts.

External Audit Recommendations Tracker

- 1.5 The Committee received a tracker detailing the progress being made on the ISA260 recommendations. One new recommendation was received following the recent audit on journals authorisation.

Counter Fraud Report

- 1.6 The Committee received a summary of work that has taken place since the last meeting.

Risk

Board Assurance Framework

- 1.7 A new risk on mental health will be included and this follows a number of serious incidents at the Trust. This has been discussed by the Quality and Safety Committee and Lisa Knight (CNO) is leading on the mental health quality workstream for the Acute Collaborative.

Risk Report

- 1.8 The Committee reviewed the longstanding risks. Many overdue risks relate to Estates and Facilities and Women and Children's. The report has been reviewed at local Trust

committees and good progress is being made to reduce this number, particularly those related to Women and Children's.

Governance

EPRR NHS England Assurance Process 2023/2024

1.9 The Committee received the Trust's self-assessment against the minimum standards of the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR). All Trusts must submit their self-assessment by 8 September 2023 and the Trust's peer review will take place on 26 October 2023.

Policy Tracker

1.10 The Corporate and Clinical Governance teams have undertaken an initial cleansing review of the schedule of policies. Each policy will be assigned to a local committee; the forward plans will be updated to ensure timely reviews and the Chairs will be advised on expiry dates.

Losses and Compensation Report

1.11 The Committee received the losses and compensation claims processed up until 30 June 2023.

Review of Debtors and Creditors

1.12 The Committee received the Trust's debtor and creditor position as at 20 June 2023.

2 Positive Assurances Received

External Audit Recommendations Tracker

2.1 The introduction of the tracker provides assurance to the Committee that the ISA260 recommendations are addressed in a timely manner. The External Auditors have confirmed they are satisfied with the progress and action plan.

Policy Tracker

2.2 Following the initial cleansing review of the policies, a second cleanse will take place with subject matter experts. The exercise has demonstrated that just over 70% of policies are in date. The team will seek to secure a confirmed date by which out of date policies will be reviewed in order to have a trajectory for full policy compliance moving forward.

EPRR NHS England Assurance Process 2023/2024

2.3 The Trust self-assessment indicates that the Trust is fully compliant, with 64 out of 64 green ratings against the core standards for EPRR arrangements. This follows a full review and is identical to last year's submission.

3 Key Risks to Escalate

3.1 None

4 Concerns Outstanding

4.1 None

5 Key Actions Commissioned

Board Assurance Framework

5.1 The Chair will share learning around the inclusion of a mental health related risk with Audit Committee Chairs across the Acute Collaborative for consideration locally.

Policy Tracker

5.2 Future iterations of the policy tracker will provide assurance on compliance and areas of concern, with regular updates presented to the Committee.

6 Decisions Made

EPRR NHS England Assurance Process 2023/2024

6.1 The Committee approved the Trust's 2023/24 self-assessment submission against the NHS England Core Standards for Emergency Preparedness, Resilience and Response.

External Audit – Re-appointment of KPMG

6.2 The Committee agreed that the external audit contract with KPMG should be extended for 1+1 years subject to satisfactory conclusion to discussions concerning the annual external audit fees for the extension period.

7 Summary Agenda

26 July 2023

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Internal Audit Report	Approval	6.	Board Assurance Framework	Assurance
2.	External Audit Report	Approval	7.	Risk Report	Assurance
3.	External Audit – Re-appointment of KPMG	Approval	8.	Policy Tracker	Assurance
4.	External Audit Recommendations Tracker	Assurance	9.	EPRR Standards - Compliance	Approval
5.	Counter Fraud Report	Assurance	10.	Losses and Compensation Report	Assurance
			11.	Review of Debtors and Creditors	Assurance

8. Attendance

Members:	September attendance
Bob Alexander, NED (Chaired meeting)	Y
Ajay Mehta, NED	N
Baljit Ubhey, NED (Chair from Oct)	Y
Attendees	
Pippa Nightingale, Chief Executive Officer	Y
Jonathan Reid, Chief Financial Officer	Y
Lisa Knight, Chief Nurse	Y
Dawn Clift, Director of Corporate Affairs	Y
Dominic Sharp, Associate Director of Finance – Financial Control	Y
Rachit Babbar, External Audit Manager (KPMG)	Y
Arpit Sarraf, External Audit Manager (KPMG)	Y
Janine Combrink, Internal Audit Manager (BDO)	Y
Colin McDonnell, Head of Emergency Preparedness, Resilience and Response	Y
Nikki Walcott, Corporate Governance Manager	Y

North West London Acute Provider Collaborative Chelsea and Westminster NHS Foundation Trust - Audit and Risk Committee Chair's Highlight Report to the Board in Common

Highlight Report of the meeting held on 15 September 2023

1.0 Purpose and Introduction

- 1.1 The purpose of this report is to update the Board in Common (BiC) about the meeting of the Trust's Audit and Risk Committee held on 15 September 2023.

2.0 Key Highlights

2.1 Local Counter Fraud Service (LCFS) Update

- 2.1.1 The Committee was updated on the local proactive exercise reviewing processes in relation to recruitment and pre-employment checks. The arrangements in place were reported as largely sound, with some control gaps and improvements to be made to fully mitigate any risk of fraud. An action plan has been developed and shared for implementation by the Trust.
- 2.1.2 The Committee was advised on the fraud risks currently affecting the sector and an update on types of investigations taken across LCFS's client base.
- 2.1.3 The Committee heard about the progress in training staff, with two of the four contracted sessions delivered. The Committee discussed what happens when there is a need to recruit staff urgently vs the need to ensure all appropriate checks are adhered to.
- 2.1.4 The Committee considered the benchmarking data which showed an increase of 21 referrals, which will this placed the trust nearer the high end of trusts with referrals, but noted that this demonstrated good awareness of and confidence in reporting potential fraud.

2.2 Internal Audit

- 2.2.1 The Committee was updated on the action underway to close down actions from internal audits, with the Committee seeking a strong push to do given the time some had been outstanding. Members were advised that this is in progress.
- 2.2.2 The Committee was advised on the positive position of the Trust in benchmarking data with peers on internal audit assurance opinions – with the Trust being at the higher end given the amount of 'substantial' assurance outcomes. Data on level and number of recommendations also showed the trust benchmarked well against peers.
- 2.2.3 The Committee welcomed the environmental sustainability report, showing the positive progress and suggested this go to the estates and sustainability committee for consideration of activity to spread across the collaborative.
- 2.2.4 **Single Tender Waiver (STW) Internal Audit Report:** the Committee received a report on STWs which was a positive report, demonstrating how the STW requirement had reduced and noting that the trust benchmarks well against others. The Committee discussed the findings and issues with the reasons given for a STW (often due to sole supplier) and the low financial level of some STWs – both aspects are to be further addressed through local and collaborative action.

2.2.5 The Committee heard about the plans for wider work across the acute provider collaborative (APC) through the shared service for procurement to procure more simply. The Committee was also advised on the annual review of current standing financial instructions (SFIs) to check that the levels were appropriate – with benchmarking across peers to take place ahead of developing proposals for change.

2.3 External Audit

2.3.1 The Committee received a verbal report, noting that this was a ‘quiet’ quarter given the past quarter’s work in relation to the annual report and accounts, with the completion of the audit and issuing of the clean audit opinion and certificate. The annual report and accounts were completed in time to be laid before Parliament before summer recess.

2.4 Debtors and creditors

2.4.1 A report on this was presented following a request from a previous committee meeting. The report showed a significant improvement on last year on the Better Payment Practice Code, but noted the position was still slightly below target. Assurance was provided on the close working across divisions and teams with local statistics, updates and engagement with budget holders to improve the position.

2.5 Risk and board assurance framework

2.5.1 The Committee received a report on current board assurance (BAF) risks, considered at the key trust committees. The wider risk register and strategy was also shared. The Committee noted where a number had passed their target mitigation dates or had overdue action plans. The Committee was updated on the new extreme risk regarding power supply at West Middlesex and the risk to the current Ambulatory Diagnostics Centre build project and the site more generally.

2.5.2 The Committee discussed the next steps overall for risk at a local and collaborative level, and requested a broader discussion on risk appetite. The Committee was advised about the development of a collaborative wide process and BAF alongside planned training which would complement local risk strategies, development sessions and training for board/executives.

2.6 National Cost Collection Submission

2.6.1 The Committee confirmed assurance that the correct process and resources were in place in relation to the National Cost Collection submission to NHS England (NHSE) and agreed to delegate authority to the Chief Financial Officer to approve the nation submission to NHSE.

2.7 Cyber Security

2.7.1 The Committee received a detailed update on the good progress in relation to cyber security, with a substantial assurance rating from internal audit on trust data security and protection controls.

2.7.2 The issue regarding medical devices such a televue monitors was discussed and work underway to ensure this is embedded within the broader cyber security focus given upgrades work differently than for IT devices.

2.8 Losses and special payments

2.8.1 The Committee was updated on the first quarter figures for special payments and losses, which largely related to private and overseas patients debt, and expired pharmacy drugs. Comparatively performance is better for quarter one in 2023/24 than it was in 2022/23, so the trend is improving.

2.9 Single tender waivers (STWs) – standing report

2.9.1 The Committee welcome the improved position and was advised on the work across the collaborative to share best practice to support a decrease in the need for STWs.

2.10 Clinical Audit

2.10.1 The Committee received the report on the national clinical audits including timetable and outcomes of the 49 which took place during 2022/23. The Committee heard that the trust didn't participate in nine due to a number of barriers, but that several of these had been addressed and were included in the forward plan for 2023/24. The Committee heard that the reporting and oversight takes place through the executive management board (EMB), clinical effectiveness group (CEG) and through the Quality Committee. The work will be linked through to the refresh of the clinical strategy, focussing on better access, experience and outcomes for patients.

3.0 Positive Assurances Received

3.1 The Committee received assurance on the following:

- Internal Audit NHS Annual Report Benchmarking 2022/23: Showing the Trust performs relatively well in relation to peers in terms of assurance opinions, level and number of recommendations

4.0 Key Risks to Escalate

4.1 No specific risks to escalate.

5.0 Concerns Outstanding

5.1 None.

6.0 Key Actions Commissioned

6.1 CFO to sign off the national cost collection submission (NCCS).

7.0 Decisions Made

7.1 As above – to agree the CFO approves and submits the NCCS.

8.0 Summary Agenda

No.	Agenda Item	Purpose
1.	Counter Fraud Progress Report	Noting
2.	Internal Audit 2023/24 Progress Report against Work Plan <ul style="list-style-type: none">• Recommendation follow up report• NHS Annual Reports 2022/23 benchmarking report• Environmental sustainability – carbon neutrality and net zero: Considerations for Audit Committees	Noting
3.	External Audit Update	Noting
4.	Debtors and Creditors report	Noting
5.	Board Assurance Framework	Noting
6	Risk Assurance Framework, including Risk Management Policy and Risk Appetite and Statement Review	Noting
7.	National Cost Collection Board Assurance	Noting/agreement
8.	Cyber Security Report	Noting
9.	Clinical Audit Update	Noting
10.	Losses and Special Payments including Write Offs	Noting
11.	Waiver of SFIs	Noting
12.	Audit Committee Forward plan	Noting

9.0 2023 / 24 Attendance Matrix

Meeting held on 15 September

Members::	September attendance
Aman Dalvi, Non-executive director (NED) and Committee Chair	Y
Catherine Jervis, NED	Y
Syed Mohinuddin, NED	Y
Attendees:	
Virginia Massaro, Chief Financial Officer - Chelwest	Y
Lesley Watts, Chief Executive Officer (for part of meeting)	Y
Peter Jenkinson, Director of Corporate Governance	Y
Marie Price, Deputy Director Corporate Governance	Y
Alex Bolton, Associate Director of Quality Governance	Y
Peter Chapman Deputy Director of Finance	Y
Kathy Lanceley Director of IT	Y
Janine Combrinck, BDO	Y
Matthew Wilson, RSM	Y
Natalie Nelson, RSM	Y
Laura Rogers, Deloitte	Y

NWL Acute Provider Collaborative Board in Common (Public)

17/10/2023

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 19 September 2023. There was no urgent business for discussion in August and, noting the summer annual leave period, the meeting was stepped down.

Report history

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

**Board in Common
Cabinet**
19/09/2023

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

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

1. Business case: Cross-site rolling Endoscope replacement programme (Chelsea and Westminster NHS Foundation Trust (CWFT))

- The business case sought capital funding for phases 1-5 of the endoscopy rolling replacement programme and represented a direct replacement of existing equipment as part of a rolling programme and as part of the medical equipment capital programme.

- Total estimated capital costs (subject to procurement) were £4.5m across 5 years with associated maintenance costs of £1.6m over 5 years. Costs were budgeted within the Trust's capital programme.
- The business case had been approved by CWFT's Finance and Performance Committee and the CWFT Capital Programme Board.
- A brief discussion took place around reliance on one supplier and impact on pricing. This was acknowledged however equipment was not interchangeable between suppliers and would impact on the ability to flex theatre lists. On balance it was agreed this was the right decision.
- Members of the CWFT Board approved the business case.

2. Business Case: Additional bed capacity (Chelsea and Westminster NHS Foundation Trust (CWFT))

- The business case requested capital and revenue funding to convert an existing outpatient area into an additional general medical ward at the West Middlesex site, plus associated decant and enabling works. The released capacity would provide the site with additional care of the elderly / general medicine beds (28), which is where the shortfall of capacity in the bed base lies, and would protect surgical capacity during peak activity by reducing outliers.
- The case requested £5m of capital funding (of which £2.9m would be funded by NHS England), £1m of non-recurrent revenue and £3.6m of recurrent revenue costs to run the new ward (of which £3.7m is recurrently funded by NHS England).
- The business case had been approved by CWFT's Finance and Performance Committee and the CWFT Executive Management Board.
- Members of the CWFT Board approved the business 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 19 September 2023 were:

CEO Update on significant issues

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

- A&Es across all four Trusts remained under pressure and there had been an upsurge in Covid.
- The Hillingdon Hospitals NHS Foundation Trust had received formal notification that it would move from National Oversight Framework level 4 to 3.
- London North West Healthcare NHS Trust had received a Prevent Future Deaths notification from the Coroner's office and gave a confidential verbal brief on the difficult case. The Cabinet was also briefed on potential CQC investigation into a previous incident regarding the treatment of patients with mental health needs.

Financial recovery update

The Cabinet noted an improvement in the month 5 financial position, though noted a continued overspend due mainly to costs related to industrial action and inflation, and under-delivery of the Cost Improvement Programmes (CIP). A meeting would take place in the near future around mitigations to deliver year-end. Central funding was anticipated to ameliorate costs related to

inflation and industrial action, which could reduce overspend further; however, Trusts needed to concentrate efforts on CIPs.

Countess of Chester Hospital – assurance update

The Cabinet noted that more detailed recommendations were expected from NHS England in the next few weeks. A paper would be presented to the Collaborative Quality Committee detailing clinical governance processes in place across the Collaborative and a separate paper would be presented to the People Collaborative Committee detailing ongoing work to develop a culture where staff were not afraid to raise concerns. A combined assurance paper would then be brought to the Board in Common in October 2023. The Cabinet noted monitoring across the four Trusts was in place but more could be done around triangulation of data for quality and workforce.

Integrated Performance, Quality and Workforce Report

The Board in Common Cabinet reviewed the monthly performance report by exception. It was agreed further commentary would be added around referral to treatment times for cancer metrics. Further work was taking place around the performance detail which should be seen at Trust, Collaborative Committee and Board in Common level and triangulation for commentary.

Elective Orthopaedic Centre (EOC) Progress

The Board in Common Cabinet received a brief update on progress and noted recruitment was progressing well. Work was continuing to progress the phased opening of the EOC from November 2024. The Cabinet asked to see the revised transport plan.

Protecting and expanding elective capacity

The Board in Common Cabinet noted a recent letter from NHS England around a set of activities to drive outpatient recovery at pace. A Board self-certification process, signed off by Trust Chairs and CEOs, was required by 30 September. Oversight would be provided by the Finance and Performance Collaborative Committee, and would be reported to the Board in Common via the committee chair's report.

The Board in Common Cabinet noted that work was being undertaken across the collaborative and within the Trusts such as productivity of theatres and managing day case rates. Following industrial action, it was noted there was more understanding around building in resilience. A brief discussion took place around stronger action around Did Not Attend (DNA) to help manage the waiting list however recognised this needed to be done carefully to ensure health inequalities were not exacerbated.

Board in Common draft agenda

The Board in Common Cabinet noted the draft agenda for the Board in Common and agreed a number of minor changes.

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

N/A