North West London
Acute Provider Collaborative

NORTH WEST LONDON (NWL) ACUTE PROVIDER COLLABORATIVE (APC) BOARD IN COMMON - PUBLIC

NORTH WEST LONDON (NWL) ACUTE PROVIDER COLLABORATIVE (APC) BOARD IN COMMON - PUBLIC

29 April 2025

10:00 GMT+1 Europe/London

The Oak Suite, W12 Conference Centre, Hammersmith Hospital

AGENDA

0. AGENDA NWL APC BOARD IN COMMON - PUBLIC 29 APRIL 2025

REFERENCES

Only PDFs are attached

0. Agenda 29 April Board in Common 2025 FINAL.pdf

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

North West London Acute Provider Collaborative
Board in Common - Public
Tuesday 29 April 2025, 10:00 – 13:00
The Oak Suite, W12 Conference Centre, Hammersmith Hospital

Members of the public are welcome to join this meeting in person or by Microsoft Teams, via the following link: Click here to join the meeting *(please do not join on any previous meeting teams links)* The Chair will invite questions at the end of the meeting. It would help us to provide a full answer if you could forward your questions in advance to thh.corporatemanagement@nhs.net but this is not a requirement, you can ask new questions on the day. Any questions that are submitted in writing but due to time are not addressed in the meeting will be answered in writing on the Acute Provider Collaborative website.

A G E N D A

Time	Item No.	Title of Agenda Item	Lead	Enc
10:00	1.0	Welcome and Apologies for Absence	Chair in Common Matthew Swindells	Verbal
	1.1	Declarations of Interest	Matthew Swindells	1.1
	1.2	Minutes of the previous NWL Acute Provider Collaborative Board Meeting held on 21 January 2025 and action log	Matthew Swindells	1.2
10:05	1.3	Staff Story – Equity – Outpatient initiative *To note the staff story*	Vineeta Manchanda Carolyn Downs Pippa Nightingale	1.3
2. Report from the Chair in Common				
10:20	2.1	Report from the Chair in Common – *To note the report*	Matthew Swindells	2.1
	2.2	Board in Common Cabinet Summary *To note any items discussed at the Board in Common Cabinet meetings*	Matthew Swindells	2.2
3. Decision Making and Approvals				
10:30	3.1	APC Financial, Operational and Workforce Business Plans 2025/26 *To approve the plans*	Lesley Watts/Jazz Thind	3.1
10:45	3.2	Delegated Authorities to Provider Trust Committees 2024/25 To approve the recommended delegated authorities to provider Trust committees for the financial year ending 2024/25. • Self-certifications for Non Foundation Trusts	Peter Jenkinson	3.2

		• Self-certifications for Foundation Trusts • Modern Slavery Act Statement		
4. Integrated Quality and Performance Report				
-	4.0	Integrated Quality, Workforce, Performance and Finance Report *To receive the integrated performance report*	Pippa Nightingale Lesley Watts	4.0
4.1. Quality				
10:50	4.1.1	Quality – IQPR – anything by exception	Pippa Nightingale	4.0
	4.1.2	APC Equity Improvement Plan – BiC action plan *To note the report*	Pippa Nightingale Carolyn Downs Vineeta Manchanda	4.1.2
	4.1.3	Learning from deaths quarter 3 report For BiC members, individual Trust reports can be found in the TeamEngine Reading Room. For members of the public these can found in the appendix document on the NWL APC website *To note the report*	Jon Baker	4.1.3
	4.1.4	Elective Orthopaedic Centre (EOC) update *To note the report*	Pippa Nightingale	4.1.4
	4.1.5	Collaborative Quality Committee Chair Report *To note the report*	Patricia Gallan	4.1.5
4.2 Workforce				
11:20	4.2.1	Workforce – IQPR – anything by exception	Pippa Nightingale	4.0
	4.2.2	Collaborative People Committee Chair Report *To note the report*	David Moss	4.2.2
4.3 Finance and Performance				
11:35	4.3.1	Performance – IQPR – anything by exception	Lesley Watts	4.0
	4.3.2	Performance report • Emergency 4.3.2a • Elective 4.3.2b • Cancer 4.3.2c • Diagnostics 4.3.2d *To receive the performance report*	James Walters	4.0

	4.3.3	Finance – IQPR – anything by exception	Lesley Watts	4.0
	4.3.4	Financial performance report *To receive the financial performance report*	Jazz Thind	4.3.4
	4.3.5	Collaborative Finance and Performance Committee Chair Report *To note the report*	Carolyn Downs	4.3.5
5. Data and Digital				
11:55	5.1	Collaborative Digital and Data Committee Report *To note the report*	Matthew Swindells	5.1
6. Estates and Sustainability				
12:05	6.1	Collaborative Strategic Estates, Infrastructure and Sustainability Committee Report *To note the report and approve the updated terms of reference*	Bob Alexander	6.1
7. Chief Executive Officers				
12:15	7.1	Acute Provider Collaborative Executive Management Board (EMB) Summary *To note any items discussed at the APC EMB meetings*	Tim Orchard	7.1
	7.2	Reports from the Chief Executive Officers and Trust Standing Committees *To note the reports* • London North West University Healthcare NHS Trust • Imperial College Healthcare NHS Trust • The Hillingdon Hospitals NHS Foundation Trust • Chelsea and Westminster Hospital NHS Foundation Trust	Pippa Nightingale / David Moss Tim Orchard / Bob Alexander Lesley Watts / Carolyn Downs Lesley Watts / Patricia Gallan	7.2a 7.2b 7.2c 7.2d
8. Reports for Information Only				
12:30	8.1	Use of the Trust Seal	Peter Jenkinson	8.1
Any Other Business				
	9.1	Nil Advised		
10. Questions from Members of the Public				
12:35	10.2	The Chair will initially take one question per person and come back to people who have more than one question when	Matthew Swindells	Verbal

		everyone has had a chance, if time allows.		

Close of the Meeting
Date and Time of the Next Meeting
15 July 2025, 09:30 – 12:30, W12, Hammersmith Hospital
Representatives of the press and other members of the public will be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admissions to Meetings) Act 1960)

1.0 WELCOME AND APOLOGIES FOR ABSENCE (MATTHEW SWINDELLS)

1.1 DECLARATIONS OF INTEREST (MATTHEW SWINDELLS)

REFERENCES

Only PDFs are attached

1.1a. NWL APC BiC Register of Interest - front cover - April 2025.pdf

1.1b. Board in Common Register of Interests - April 2025.pdf

NWL Acute Provider Collaborative Board in Common (Public)
29/04/2025
Item number: 1.1
This report is: Public

NWL Acute Provider Collaborative Board in Common Register of Interests

Author: Peter Jenkinson
Job title: Director of Corporate Governance

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

Purpose of report

Purpose: Information or for noting only

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

Report history

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

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

Executive summary and key messages

This is the annual presentation of the Board in Common Register of Interests. Following presentation to the NWL Acute Provider Collaborative Board in Common, the Register of Interests will be published on the microsite and individual Board Register of Interests will be published on respective Trust websites. At the commencement of each Board in Common, Collaborative and local Committee members, members are required to declare any revisions to their declared interests and any interests relating to agenda items.

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

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

Reason for private submission

Tick all that apply

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

If other, explain why

NORTH WEST LONDON ACUTE PROVIDER COLLABORATIVE
BOARD IN COMMON - REGISTER OF INTERESTS 2025-26

Date last updated: 7 April 2025 (PH)

NAME	ROLE	TYPE OF INTEREST				DESCRIPTION OF INTEREST	DATE INTEREST OPENED	DATE INTEREST CLOSED	ACTIONS TO BE TAKEN TO MITIGATE RISK	BOARD MEMBER			
		Financial	Non-Financial Professional	Non-Financial Personal	Indirect					CWFT	ICHT	LNWH	THHFT
Non-Executive Directors													
Matthew Swindells	Chair in Common	x				Founder / Owner: MJS Healthcare Consulting	Aug-19	Ongoing	Exclusion from any discussions that could lead to conflict.	x	x	x	x
				x		Chair: Citizens Advice	Mar-24	Ongoing	Exclusion from any discussions that could lead to conflict.				
		x				Non-Executive Director: Prism Improvement Limited (Prism Improvement owns a stake in another NHS consulting firm Four Eyes Consulting)	Apr-22	Ongoing	Exclusion from any discussions that could lead to conflict.				
		x				Senior Advisor: Global Council	Sep-19	Ongoing	Exclusion from any discussions that could lead to conflict.				
			x			President: Health Care Supply Association (HCSA)	Jan-23	Ongoing	Exclusion from any discussions that could lead to conflict.				
		x				Chair: Carnall-Farrar Consulting	Feb-25	Ongoing	Exclusion from any discussions that could lead to conflict.				
		x				Internal Advisor: Carnall-Farrar Consulting	Feb-22	Jan-25					
		x				Advisor: Akeso	Oct-23	Jan-25					
Bob Alexander	Vice Chair - Imperial College Healthcare NHS Trust	x				Non-Executive Director: London Ambulance Service NHS Trust	Aug-21	Ongoing			x	x	
		x				Advisor: CHKS Ltd	Nov-18	Ongoing					
			x			Trustee: Imperial Health Charity	Dec-23	Ongoing					
			x			Trustee: London Ambulance Charity	Aug-21	Ongoing					
		x				Associate Non-Executive Director: South West London ICB	Nov-24	Ongoing					
		x				Strategic Advisor: Health Spaces Ltd	Mar-25	Ongoing					
		x				Non-Executive Director: Community Health Partnership Ltd	Apr-19	31-Mar-25					
Linda Burke	Non-Executive Director			x		Medical Justice Charity	May-20	May-27			x		x
		x				Non-Executive Director: Frimley Health	Apr-22	Apr-25					
Aman Dalvi	Non-Executive Director	x				Owner: Aman Dalvi Limited	2017	Ongoing		x	x (designate NED)		
		x				Non-Executive Chair: Goram Homes (Bristol)	2019	Ongoing					
		x				Non-Executive Chair: Kensington & Chelsea TMO Residuary Body	2019	Ongoing					
		x				Non-Executive Chair: Aspire Housing (Staffordshire)	Jan-21	Ongoing					
		x				Non-Executive Chair: Newlon HT	Jan-21	Ongoing					

		x				Board member: Old Oak Development Corporation	Mar-22	Ongoing					
Carolyn Downs	Vice Chair - The Hillingdon Hospitals NHS FT	x				Senior Advisor: Newton Europe	Sep-23	Ongoing		x			x
		x				Non-Executive Director: States of Jersey Health and Care Advisory Board	Sep-23	Ongoing					
		x				Non-Executive Advisor / Member: London Policing Board	Sep-23	Ongoing					
Patricia Gallan	Vice Chair - Chelsea and Westminster Hospital NHS FT	x				Non-Executive Director: HMRC	Jul-19	Ongoing	Permanent Secretary HMRC has given formal approval to Patricia's appointment	x			x
				x		Chair of Governors: Drapers' Brookside Infant and Junior School. Member of	Aug-21	Ongoing					
			x			Vice Chair: Trade Remedies Authority	Mar-25	Ongoing					
				x		Council of Queen Mary University of London	Jan-23	Ongoing					
Nick Gash	Non-Executive Director	x				Self-employed: Public Affairs Consultant	Sep-04	Ongoing			x		x
		x				Associate: Westbrook Strategy Ltd	Feb-20	Ongoing					
			x			Trustee: CW+ Charity	Nov-17	Ongoing					
			x			Chair Audit and Risk Committee: Royal Society of Medicine	Nov-21	Ongoing					
		x				Independent member: Risk and Audit Committee of Office for Students	Feb-24	Ongoing					
					x	Spouse: Member of Parliament for Brent and Isleworth	May-15	Ongoing					
		x				Chair: London North West Advisory Committee for Clinical Impact Awards	Nov-18	Mar-25					
Loy Lobo	Non-Executive Director	x				Owner: Wegyanik Ltd	Apr-14	Ongoing			x	x	
		x				Non-Executive Director: Essex Partnership University Trust (EPUT)	Mar-21	Ongoing					
		x				Visiting Lecturer: Imperial College Business School	Sep-14	Ongoing					
		x				Advisor: Dama Health Ltd (includes an equity option)	Apr-23	Ongoing					
		x				Advisor: Juul Labs Inc	Nov-23	Ongoing					
		x				Business Advisor: Radiant Science UG, Berlin (includes an equity option)	Apr-24	Ongoing	To be recused from discussing matters where the company may be a financial				
		x				Wegyanik - consulting partner to Salesforce.com	Jun-24	Ongoing					
					x	Palantir: personal friend of MD of Global Health and Life Sciences	Feb-25	Ongoing	To be recused from discussing matters where the company may be a financial beneficiary				
					x	Accenture: personal friend of MD responsible for Accenture Oracle	Apr-25	Ongoing	To be recused from discussing matters where the company may be a financial				
				x		Member of the Digital Health Council and Past President of the Council: Royal Society	Mar-15	Mar-25					
		x				Advisor: No Suffering Ltd	Apr-23	Feb-25					
Martin Lupton	Non-Executive Director					Nothing to declare						x	x
Vineeta Manchanda	Non-Executive Director	x				NEM and Audit Chair: NHS Bedfordshire, Luton and Milton Keynes ICB Board	Jul-23	Ongoing		x			x
		x				NED & Audit Chair: Essex Cares Limited (ECL)	Oct-20	Ongoing					
		x				Independent Adviser: London Borough of Brent Audit Committee	Mar-19	Ongoing					
		x				Director: IBDMS Ltd	Dec-11	Ongoing					
			x			Independent Audit Committee Member: Worcester College, Oxford University	Sep-22	Ongoing					

		x				NED and Audit Chair: RTOP PLC	Aug-23	09/01/2025					
Ajay Mehta	Non-Executive Director		x			Trustee - Together for Mental Wellbeing	Nov-24	Ongoing		x		x	
Dr Syed Mohinuddin	Non-Executive Director	x				Director: NeoMate Ltd	Jan-23	Ongoing		x		x	
		x				Director: Evolve Coaching Solutions Ltd	Jan-23	Ongoing					
Simon Morris	Non-Executive Director	x				Chair-elect: North London Hospice	Jun-11	Ongoing				x (designate NED)	x
		x				Director: Crisis Homes Ltd	Oct-23	Ongoing					
David Moss	Vice Chair of London North West University Healthcare NHS Trust					Nothing to declare					x (designate NED)	x	
Mike O'Donnell	Non-Executive Director	x				Non-Executive Director/Senior Advisor: Westbrook Partners	Apr-24	Ongoing		x			x
		x				Non-Executive Director/Independent Finance Advisor: City of Stoke On Trent	May-24	Ongoing					
		x				Non-Executive Director: Local Pensions Partnership Administration Ltd	Apr-24	Ongoing					
		x				Non-Executive Director/Senior Advisor: XTP UK Ltd	Apr-24	Ongoing					
		x				Non-Executive Director: Public Sector Audit Appointments Ltd	Apr-24	Ongoing					
		x				Founder/Director: Mike OD Consulting Ltd	Apr-24	Ongoing					
Sim Scavazza	Non-Executive Director	x				Acting Chair: Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	Apr-23	Ongoing			x	x (designate NED)	
			x			Chair: The Seacole Group; BAME NHS Chairs and NEDs	Apr-24	Ongoing					
				x		Fellow: Royal Society for Arts, Manufacturers and Commerce	2018	Ongoing					
				x		Trustee: Smartworks	May-22	Ongoing					
				x		Trustee: National Saturday Club	Sep-22	Ongoing					
		x				Chair: Office of the Independent Adjudicator	Oct-23	Ongoing					
			x			EDI Advisor: NHS Providers	Mar-24	Ongoing					
					x	Spouse: CTO Newcross Healthcare	Aug-21	Ongoing					
Helen Stephenson	Non-Executive Director	x				Non-Executive Director: The National Lottery Community Fund	Jul-22	Ongoing	Exclusion from any discussions that could lead to conflict.	x	x		
		x				Non-Executive Director: ECB Regulatory Board	Apr-24	Ongoing	Exclusion from any discussions that could lead to conflict.				
				x		Governance and People Committee: Royal Academy of Dance	Jun-24	Ongoing	N/A				
			x			Trustee: Board of the King's Foundation (charity)	Jan-25	Ongoing					
Baljit Ubhey	Non-Executive Director					Nothing to declare						x	x
Catherine Williamson	Non-Executive Director (Academic)	x				Consultant to Mirum Pharmaceuticals	May-19	Dec 22 (may continue to		x	x		
		x				Consultant to Ipsen Global	Oct-24	Ongoing					
		x				Honorary consultant Obstetric Physician at St Thomas' Hospital	Aug-23	Ongoing					
		x				Director: Obstetric Medicine Company	Jul-20	Ongoing					
			x			Council member: Academy of Medical Sciences	Feb-25	Ongoing					
			x			Panel member: MRC Rare Disease Grant Patel	2021	Ongoing					
			x			Maternal Medicine Representative: RCOG Genomic Medicine Committee	2024	Ongoing					

			x			Patron: ICP Support (charity)	2012	Ongoing					
			x			Patron: Lauren Page Trust (charity)	2008	Ongoing					
			x			Medical researcher	1994	Ongoing					
				x		Member: Labour party (no donations nor roles)	1997	Ongoing					
Executive Directors													
Lesley Watts	Chief Executive - Chelsea and Westminster Hospital NHS FT and The Hillingdon Hospitals NHS FT		x			Trustee: CW+ Charity	Apr-18	Ongoing		x			x
			x			Director: Imperial College Health Partners	Sep-15	Ongoing					
					x	Daughter: member of staff at Chelsea and Westminster NHS FT	Apr-18	Ongoing					
					x	Son: Director of Travill construction	Apr-18	Ongoing					
				x		Honorary member: Chelsea Arts Club	Aug-23	Ongoing					
Robert Bleasdale	Chief Nursing Officer - Chelsea and Westminster Hospital NHS FT		x			Trustee: CW+ Charity	Apr-22	Ongoing		x			
Roger Chinn	Chief Medical Officer - Chelsea and Westminster Hospital NHS FT	x				Private consultant radiology practice is conducted in partnership with spouse.	1996	Ongoing		x			
			x			Provide support to The Hillingdon Hospitals NHS FT Executive Team	Aug-20	Ongoing	Current and ongoing as part of NWL Integrated Care System mutual aid				
			x			Trustee of CW+ Charity	Mar-21	Ongoing	4 year term with option to stand for re-election for further 4 years				
Virginia Massaro	Chief Financial Officer - Chelsea and Westminster Hospital NHS FT and The Hillingdon Hospitals NHS FT			x		Director: Cafton Lodge Limited	Mar-14	Ongoing		x			x
			x			Member: Healthcare Financial Management Association London Branch Committee	Jun-18	Ongoing					
			x			Finance Director of CW Medicines Limited	Sep-21	Ongoing	CW Medicines Ltd is a wholly owned subsidiary outpatient pharmacy which has been operational from 1 April 2022				
Sarah Burton	Chief Nurse - The Hillingdon Hospitals NHS FT					Nothing to declare							x
Alan McGlennan	Chief Medical Officer - The Hillingdon Hospitals NHS FT					Nothing to declare							x
Jason Seez	Deputy Chief Executive and Director of Strategy - The				x	Spouse: Works in NHSE	Feb-19	Ongoing					x
Tim Orchard	Chief Executive - Imperial College Healthcare NHS Trust		x			Professor: Imperial College London	N/A	Ongoing			x		
			x			Member of the Board of the Office for Strategic Co-ordination of Health Research	Jan-24	Jan-27					
			x			Director: Imperial College Health Partners	Nov-18	Ongoing					
Raymond Anakwe	Joint Medical Director - Imperial College Healthcare NHS Trust	x				Self Employed: Imperial Private Healthcare	Jan-13	Ongoing			x		
		x				Self Employed: Hospital of St John and St Elizabeth Hospital	Jan-13	Ongoing					
		x				Self Employed: Cromwell Hospital	Jan-13	Ongoing					
Claire Hook	Deputy Chief Executive / Chief Operating Officer - Imperial	x				Director: Hook Medico Legal Ltd	Apr-20	Ongoing			x		
Julian Redhead	Joint Medical Director - Imperial College Healthcare	x				Club Doctor: Chelsea Football Club	2000	Ongoing			x		

	NHS Trust	x				Medical Director: Fortius Clinic	2005	Ongoing					
			x			Private Clinic: Imperial College Private Healthcare	2004	Ongoing					
			x			Secretary: British Association Immediate care (London)	2003	Ongoing					
			x			Trustee to Chelsea Football Club Players Trust	2024	Ongoing					
			x			National Clinical Director: Urgent and Emergency Care	2020	Ongoing					
			x			Non-Executive Director: Royal Society Prevention of Accidents	2014	2024					
Janice Sigsworth	Chief of Nursing - Imperial College Healthcare NHS Trust		x			Honorary Professional Appointment: King's College London	Jan-13	Ongoing			x		
			x			Honorary Professional Appointment: Bucks New University	Jan-13	Ongoing					
			x			Honorary Professional Appointment: Middlesex University	Jan-00	Ongoing					
			x			Clinical Adviser: NMC of Pre-Registration Midwifery Standards	Mar-20	Ongoing					
			x			Member: Shelford Safer Care Nursing Toot (SNCT) Committee	Nov-23	Ongoing					
			x			National Professional Lead: Nursing and Midwifery Genomics	Jan-19	Ongoing					
Jazz Thind	Chief Financial Officer - Imperial College Healthcare NHS Trust			x		Non-Trustee Member: Cancer Research UK Audit Committee	Jan-23	Ongoing			x		
				x		Trustee: Medway Towns Gurdwara Sabha Ltd	Apr-24	Ongoing					
Pippa Nightingale	Chief Executive Officer - London North West University Healthcare NHS Trust		x			Trustee: Rennie Grove Hospice Board	Apr-19	Ongoing				x	
		x				Non-Executive Director: Birth Rate+ Midwifery safe staffing	Jun-21	Ongoing					
Jon Baker	Chief Medical Officer - London North West University Healthcare NHS Trust	x				Freelance screenwriter	2019	Ongoing				x	
Simon Crawford	Deputy Chief Executive - London North West University Healthcare NHS Trust		x			Director: Imperial College Health Partners	2018	Ongoing				x	
Lisa Knight	Chief Nursing Officer - London North West University Healthcare NHS Trust					Nothing to declare						x	
Bimal Patel	Chief Financial Officer - London North West University Healthcare NHS Trust	x				Director: Greenside Court Management Ltd	Nov-19	Ongoing				x	
				x		Independent Governor: Board of Kingston University	Mar-22	Ongoing					
James Walters	Chief Operating Officer - London North West University Healthcare NHS Trust					Nothing to declare						x	

1.2 MINUTES OF THE PREVIOUS NWL APC PUBLIC BOARD MEETING HELD ON 21 JANUARY 2025 AND ACTION LOG (MATTHEW SWINDELLS)

REFERENCES

Only PDFs are attached

1.2.0. Draft BiC public minutes 21 January 2025 v1.pdf

1.2.1. BiC (public) - Action Log Jan 25 final.pdf

North West London Acute Provider Collaborative Board in Common
Meeting in Public
Tuesday 21 January 2025, 13:00-16:00
The Oak Suite, W12 Conferences Centre, Hammersmith Hospital

Members Present

Mr Matthew Swindells	Chair in Common
Mr Robert Alexander	Vice Chair (ICHT) & Non-Executive Director (LNWH)
Mrs Carolyn Downs CBE	Vice Chair (THHFT) and Non-Executive Director (CWFT)
Mr Loy Lobo	Non-Executive Director (LNWH & ICHT))
Mr David Moss	Vice Chair (LNWH) & Non-Executive Director (ICHT)
Mr Nick Gash	Non-Executive Director (ICHT & THHFT)
Mr Aman Dalvi	Non-Executive Director (CWFT & ICHT)
Ms Vineeta Manchanda	Non-Executive Director (CWFT & THHFT)
Mr Ajay Mehta	Non-Executive Director (CWFT & LNWH)
Mr Simon Morris	Non-Executive Director (THHFT & LNWH)
Ms Sim Scavazza	Non-Executive Director (ICHT & LNWH)
Mr Mike O'Donnell	Non-Executive Director (CWFT & THHFT)
Dame Helen Stephenson	Non-Executive Director (CWFT &ICHT)
Professor Tim Orchard	Chief Executive Officer (ICHT)
Ms Pippa Nightingale	Chief Executive Officer (LNWH)
Ms Lesley Watts CBE	Chief Executive Officer (CWFT & THHFT)
Ms Tina Benson	Chief Operating Officer (THHFT)
Ms Lisa Knight	Chief Nursing Officer (LNWH)
Ms Jazz Thind	Chief Financial Officer (ICHT)
Ms Lindsey Stafford-Scott	Chief People Officer (CWFT)
Mr Raymond Anakwe	Medical Director (ICHT)
Ms Virginia Massaro	Chief Financial Officer (CWFT)
Ms Jazz Thind	Chief Financial Officer (ICHT)
Mr Bimal Patel	Chief Financial Officer (LNWH)

Members present via Teams

Ms Patricia Gallan	Vice Chair (CWFT) & Non-Executive Director (THHFT)
Mr Martin Lupton	Non-Executive Director (LNWH & THHFT)
Dr Syed Mohinuddin	Non-Executive Director (LNWH & CWFT)
Mr Robert Bleasdale	Chief Nursing Officer (CWFT)
Ms Sarah Burton	Chief Nursing Officer (THHFT)
Mr Simon Crawford	Deputy Chief Executive (LNWH)
Ms Claire Hook	Chief Operating Officer (ICHT)
Ms Virginia Massaro	Chief Financial Officer (CWFT)
Mr Alan McGlennan	Chief Medical Officer (THHFT)
Professor Janice Sigsworth	Chief Nursing Officer (ICHT)
Professor Julian Redhead	Chief Medical Officer (ICHT)
Mr Jason Seez	Deputy Chief Executive (THHFT)
Ms Baljit Ubhey	Non-Executive Director (LNWH & THHFT)
Dr Jon Baker	Chief Medical Officer (LNWH)
Dr Roger Chinn	Chief Medical Officer (CWFT)

Mr James Walters	Chief Operating Officer (LNWH)

In Attendance

Mr James Biggin-Lamming	Director of Strategy and Transformation (LNWH)
Mr Gavin Newby	Deputy Chief Financial Officer (THHFT)
Mr Peter Jenkinson	Director of Corporate Governance (ICHT & CWFT)
Ms Jessica Hargreaves	Deputy Director of Corporate Governance (ICHT)
Ms Alexia Pipe	Chief of Staff to the Chair (APC)
Ms Amrit Panesar	Corporate Governance Officer (CWFT)

Present via Teams

Ms Tracey Connage	Chief People Officer (LNWH)
Ms Dawn Clift	Director of Corporate Governance (LNWH)
Mr Robbie Cline	Chief Information Officer (APC)
Mr Kevin Croft	Chief People Officer (ICHT)
Ms Michelle Dixon	Director of Engagement & Experience (ICHT)
Ms Emer Delaney	Director of Communications (CWFT)
Mr Philip Spivey	Chief People Office (THHFT)

Apologies for Absence

Ms Tracey Cotterill	Interim Chief Financial Officer (THHFT)
Ms Linda Burke	Non-Executive Director (THHFT & ICHT)
Ms Catherine Williamson	Non-Executive Director (ICHT & CWFT)

Minute Ref		Action
1.0 1.0.1	**Welcome and Apologies for Absence** Matthew Swindells (MS), the Chair, welcomed everyone to the meeting and advised the meeting was being recorded and would be published online. A warm welcome was extended to Catherine Williamson, Mike O'Donnell and Bimal Patel.	
1.1 1.1.1	**Declarations of Interest** No declarations were noted further to those listed on the public register.	
1.2 1.2.1	**Minutes of the Meeting held on 15 October 2024.** The minutes from the meeting held on 15 October 2024 were **approved** as an accurate record subject to minor amendments to the job titles of Simon Crawford and Loy Lobo.	
1.3 1.3.1	**Matters Arising and Action Log** The updates to the action log were noted.	
1.4 1.4.1 1.4.2	**Staff Story** Kevin Croft (KC) introduced the staff story which focused on violence and aggression, which was told by Jezel Lewis, an ICHT senior staff nurse in A&E on the St Mary's site. It was noted that tackling violence and aggression was a huge issue in the NHS and is the highest health and safety risk for staff with the 2023 staff survey demonstrating that an average of 15% of staff had personally	

	experienced physical violence at work over the previous 12 months and an average of 30% experienced verbal violence and aggression from patients or visitors.	
1.4.3	Board members noted that tackling violence and aggression is a key collaborative workstream which is overseen by the Collaborative People Committee and heard of the initiatives that have been introduced to mitigate the instances of violence and aggression and the impact cases have on staff. In particular, the staff story highlighted the work of the violence and aggression steering group that is in place at ICHT, chaired by Tim Orchard (TO) and Board members noted the further work to do for a wider collaborative group. Responding to a query from Patricia Gallan (PG), KC confirmed that police support was strong and there had been a number of successful prosecutions.	
1.4.4	Board members reflected on the powerful staff story and extended thanks to Jezel Lewis for taking the time to talk about her experiences.	
1.4.5	**The Board in Common noted the report and story.**	
2.1	**Report from the Chair in Common**	
2.1.1	MS presented his report extending thanks to all staff that had worked over the Christmas period and acknowledged the huge winter pressures with an extraordinary demand on services, particularly from flu and Norovirus which was leading to extended waits in A&E departments, handover delays and a general strain on most services.	
2.1.2	Acknowledging the change in leadership at THHFT, MS extended thanks to Patricia Wright (PW) for her contribution as CEO to patients and staff of THHFT over the past four years.	
2.1.3	MS welcomed Mike O'Donnell, a new Non-Executive for CWFT and THHFT from 1 November 2024, from this month Catherine Williamson, new academic NED for ICHT and CWFT and Bimal Patel, new CFO for LNWH.	
2.1.4	Reflecting on the very recent outcome of the revised New Hospital Programme, MS noted that the redevelopment at the Hillingdon Hospital was extremely positive both for staff and patients. However, it was noted that the outcome for ICHT was very disappointing.	
2.1.5	TO stated that the St Mary's site quite simply would not last until 2040, confirming the need to progress schemes more quickly and explore alternative funding approaches, leveraging the value of land that will be surplus to requirements and noting the significant contribution the life science partnerships to local and national economic growth. Noting the responsibility to patients and local communities, TO reaffirmed that the Trust would work with existing partners and the Government to determine a way to complete a detailed design and achieve planning consent as soon as possible.	
2.1.6	MS extended thanks to the redevelopment teams at both THHFT and ICHT.	
2.1.7	**The Board in Common noted the report.**	

2.2 2.2.1 2.2.2	**Implementation of shared leadership model for CWFT and THHFT - update** PJ noted the conclusion to the process of appointing a single Accountable Officer (AO), Lesley Watts, for both CWFT and THHFT, following approval by the Trust Boards of THHFT and CWFT in October 2024 noting that the appointment of a single AO sought to address immediate and longer-term risks regarding the viability of THHFT. **The Board in Common noted the update.**	
2.3 2.3.1 2.3.2 2.3.3 2.3.4	**Board in Common Cabinet Summary** MS presented the summary of the Board in Common Cabinet meeting held on 11 December 2024. Board members noted that the Cabinet had approved the business case and contract award for pathology modernisation for sexual health clinics at CWFT as well as the terms of reference for the meeting. Updates had been received from the CEOs and the Acute Provider Collaborative Executive Management Board (APC EMB) as well as updates on the financial position of each of the four Trusts and the recovery plan in the Elective Orthopaedic Centre (EOC) which was in place to address the financial deficit and improve activity levels. **The Board in Common noted the report.**	
3.1 3.1.1 3.1.2	**Evolving the Collaborative governance arrangements – revision to the scheme of delegated authority** Peter Jenkinson (PJ) presented a proposal to revise the Scheme of Delegated Authority for the four Trusts within the collaborative to reflect agreed amendments to the APC governance arrangements including the introduction of the Trust Standing Committees. **Board members approved the proposed changes to the Scheme of Delegated Authority.**	
4.1 4.1.1	**Integrated Quality, Workforce, Performance and Finance report** Board members received the Collaborative performance report which outlined quality, workforce, performance and finance metrics. [Updates provided below]	
5.2 5.2.1 5.2.2	**Collaborative Safeguarding Annual Report 2023/24** Janice Sigsworth (JS) presented the Collaborative Safeguarding Annual Report, summarising the four trust safeguarding annual reports and confirming that all four trusts had taken their individual annual reports through their respective Quality Committees and all reports had since been published on trust websites. Board members noted the assurance that all four trusts' safeguarding frameworks and practices were compliant with the national statutory duties	

	and mandatory requirements required to safeguard adults and children.	
5.2.3	It was agreed that further alignment and standardisation of the safeguarding reports would be helpful and a review as to whether the four safeguarding services could be more collaborative would be undertaken; Board members reflected on the importance of ensuring each trust maintained the detailed scrutiny of cases and agreed that this needed to be a key consideration when looking at more collaborative processes.	**JS**
5.2.4	**The Board in Common noted the report.**	
5.3	**Learning from Deaths Report**	
5.3.1	Jon Baker (JB) presented the learning from deaths summary report. Board members were pleased to note that all organisations had either lower than or as expected mortality rates. JB highlighted the upcoming change to the methodology for Hospital Standardised Mortality Ratio (HSMR) which would likely affect the data slightly, but acknowledged that the data would continue to be scrutinised and any care issues would be escalated appropriately.	
5.3.2	**The Board in Common noted the report.**	
5.4	**Collaborative Quality Committee Chairs report**	
5.4.1	The Board in Common received the report from the Collaborative Quality Committee noting in particular that Martha's rule had been implemented across all four trusts, noting this would take time to embed but acknowledging the positive clinical engagement in the process.	
5.4.2	**The Board in Common noted the report.**	
6.1	**Workforce IQPR**	
6.1.1	PN reported that workforce metrics were positive across the collaborative including lower vacancy and turnover rates, reduced agency spend and compliance with core skills and appraisal standards. Board members noted that there was a continued focus on workforce planning and workforce equality data.	
6.1.2	**The Board in Common noted the update.**	
6.2	**Collaborative People Committee chairs report**	
6.2.1	The Board in Common received and noted the report from the Collaborative People Committee noting the focus on tackling violence and aggression as well as the work on the people services improvement programme. David Moss (DM) noted that the workforce review needed to include detail around productivity and not just be focused on numbers; LW confirmed that each trust was challenging itself around productivity, noting the importance of system productivity as a key part of the business plan for 2025/26.	
6.2.2	**The Board in Common noted the report.**	
7.1	**Finance IQPR**	
7.1.1	LW highlighted the finance metrics noting the continuing challenges with finance and operational performance across all four Trusts. Board members	

	were pleased to note the improved faster diagnostics performance but agreed that this still needed to be improved further for patients across the sector. Each trust had improvement plans in place with a focus on achieving the required trajectories and these were monitored both locally and through the Collaborative Finance and Performance Committee.	
7.1.2	**The Board in Common noted the update.**	
7.2	**Financial performance report**	
7.2.1	Jazz Thind (JT) provided an update on the financial position, highlighting a deficit of £35.2 million as of November and discussing ongoing recovery plans to address the challenges. She detailed the Investigation & Intervention (I&I) process, which involved reviewing the financial position and planning for 2025-2026, with a goal of achieving a break-even position. JT also outlined the timeline for this process, expected to conclude by the end of January or early February, alongside ongoing discussions with the ICB and national team. Additionally, JT mentioned the need for cash support for some organisations to meet their commitments and ensure smooth cash flow.	
7.2.2	Looking ahead to 2025-2026, Board members reflected on the importance of aligning activity, financial, and workforce plans to ensure a comprehensive approach. This included a need to address contractual issues with the ICB to establish clear funding arrangements and avoid uncompensated over performance. Efficiency targets were also discussed, focusing on initiatives to manage costs within financial constraints. Board members also noted the significance of capital planning, including the revenue implications of investments, to align with overall financial strategies.	
7.2.3	**The Board in Common noted the report.**	
7.3	**APC financial planning 25/26**	
7.3.1	JT provided an update on the 2025/26 planning process noting that whilst the guidance had not yet been shared by NHSE, teams across the four trusts were working on their business plans aligning activity, financial and workforce. Board members discussed the importance of addressing contractual issues, efficiency targets and capital planning.	
7.3.2	PJ outlined the proposed governance process for sign off and submission noting that these would be confirmed once the guidance had been received from NHSE.	
7.3.3	**The Board in Common noted the report.**	
7.4	**Collaborative Finance and Performance Committee Chair's report**	
7.4.1	Board members received and noted the report from the Collaborative Finance and Performance Committee.	
7.4.2	**The Board in Common noted the report.**	
8.1	**Collaborative Data and Digital Committee Report**	
8.1.1	Board members received and noted the report from the Collaborative Data and Digital Committee. MS extended thanks to PW for her efforts in leading	

	this work and noted that TO would be the lead CEO for digital and data going forwards.	
8.1.2	**The Board in Common noted the report.**	
9.1 9.1.1	**Collaborative Estates and Sustainability Committee Report** Board members received and noted the report from the Collaborative Estates and Sustainability Committee. Bob Alexander (BA) highlighted that the terms of reference of the Committee had been updated to extend the scope to include strategic investment in major infrastructure/equipment across the APC. The Committee name would therefore be changed to the Collaborative Strategic Estates, Infrastructure and Sustainability Committee. Membership had also been extended to include one Chief Operating Officer to support the correlation with performance.	
9.1.2	BA also highlighted that the condition of the estate across the Collaborative and the cost of backlog maintenance remained a significant risk.	
9.1.3	**The Board in Common noted the report.**	
10.1 10.1.1	**Acute Provider Collaborative EMB summary** TO presented the summary from the recent APC EMB meetings highlighting the positive work around clinical pathways of which there was very positive clinical engagement and collaborative working.	
10.1.2	Responding to queries from Nick Gash (NG) and Vineeta Manchanda (VM) regarding the reporting mechanisms for joint projects, TO confirmed that these should come through APC EMB but highlighted the importance of the responsibilities remaining within each statutory organisation and governance process.	
10.1.3	**The Board in Common noted the report.**	
10.2	**Reports from the Chief Executive Officers and Trust Standing Committees**	
10.2.1	<u>London North West Hospital NHS Trust</u> PN highlighted the flow and discharge focus during a two week programme at the Trust which had been very successful; the new emergency department had opened at Northwick Park for patients up to 18 years old linked to St Giles Trust which offer psychological support to children; PN also highlighted that the Ealing Hospital site had achieved Joint Advisory Group on Gastro Intestinal Endoscopy (JAG) accreditation and Getting it Right First Time (GIRFT) accreditation at the Elective Orthopaedic Centre. PN welcomed Bimal Patel, the new CFO at LNWH and extended thanks to all staff for their hard work over the Christmas period.	
10.2.2	David Moss presented the report from the LNWH Standing Committee highlighting the positives of 2024/25 noting the continuing pressures that staff deal with, and extended thanks to the executive team for leading the Trust through this.	

10.2.3	Imperial College Healthcare NHS Trust TO highlighted the progress with the Fleming Centre with architects recently appointed. TO highlighted the positive performance particularly in the emergency department and thanked staff for their hard work in maintaining this during the winter period. TO noted that the Trust had reduced the number of referrals into the maternity services from outside of North West London. Whilst patient safety had been maintained, the large out of area numbers was affecting patient experience and these measures were in place to improve this. TO highlighted recent research updates and senior leadership changes and staff and service awards.	
10.2.4	BA presented the report from the ICHT Standing Committee highlighting the maternity pressures and reflecting on his observations relating to these increasing operational pressures in the service as the Trusts non-executive maternity champion. There had been a helpful focus on risk and the board assurance framework at the recent Committee.	
10.2.5	Chelsea and Westminster NHS Foundation Trust LW highlighted research and innovation work including the national Generation study, deploying AI in dermatology, and cultural inclusivity work. LW noted that the Trusts maternity services were recognised in the national CQC report on maternity services for best practice and also highlighted other staff awards that had recently been achieved.	
10.2.6	PG presented the report from the CWFT Standing Committee highlighting that performance overall was very good with a focus on further improvement in A&E. PG reflected on the hard work of all staff to achieve this and thanked LW for her continued leadership whilst taking on the CEO role at THHFT.	
10.2.7	The Hillingdon Hospitals NHS Foundation Trust LW highlighted the positive news regarding the redevelopment in the New Hospitals Programme and the challenges this would bring. LW extended thanks to the staff at THHFT for embracing the recent changes in leadership, acknowledging further changes to come in terms of senior leadership and corporate consolidation across the Trusts. LW thanked Patricia Wright for her support during the handover of the CEO role.	
10.2.8	Carolyn Downs (CD) presented the report from the THHFT Standing Committee and welcomed LW to her new role as CEO and thanked PW for her support. CD reflected on the positive news relating to the redevelopment and extended thanks to Jason Seez (JS) and the redevelopment team for their hard work to get to this point. LW noted that the CQC report was expected over the following 4-6 weeks. CD noted her disappointment in the time it had taken for the Trust to receive this report. LW confirmed that the Trust was not waiting for the report to begin addressing issues that had arisen during the inspections. _	
11. 11.1	**Any other business** Nil advised.	

12.1 12.1.1	**Questions from members of the public** A member of the public asked about better ways of working, noting the positive impact that the clinical pathways work would have and whether there was anything that the four trusts in the APC were resistant to change. TO responded that the APC was responsive to change and innovation, noting the importance of ensuring staff were equipped to be able to adapt to the rapidly changing environment in which they work.	
12.1.2	A member of the public thanked TO for the statement about the New Hospital Programme and asked whether this could be published online. TO confirmed that this would be done.	**TO**
12.1.3	A member of the public asked PN about progress with the Ealing Hospital refurbishment. PN confirmed that the new centre at Ealing, and the Willesden and Wembley Community Diagnostics Centres were all open and fully functional. The Meadow House strategy, which was an NHS funded hospital with new model of care was progressing well.	
12.1.4	A member of the public reflected on a recent experience and asked if there are staff available if patients need a third person to look after a patient if anxious and PN confirmed that healthcare assistants are available to provide this care.	
	The Chair drew the meeting to a close and thanked the Board in Common and members of public for joining the meeting.	

North West London Acute Provider Collaborative

Board in Common (public) Action Log

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

Meeting Date: 29 April 2025 **Lead Responsibility and Paper Author: Matthew Swindells**

Purpose

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

Part 1: Actions from Previous Meetings Remaining Open

Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
4.1.9 (15/10/24)	IQPR	The Board asked for a further focus on where the APC is performing well, where there is improvement required, where there is variation – so the focus should be on exceptions and where attention and action is needed rather than all of the detail covered in committee and other meetings.	TO	IQPR is on the agenda and will be picked up in the meeting. To note the IQPR is currently under review to align with the 2025/26 business planning priorities from NHSE.	July 2025
10.1.1	EMB report	The Board noted the positive progress on	TO	Update provided in item 7.1.	

Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
(15/10/24)		clinical pathways and inquired about non-clinical pathways. There was a question about whether the non-clinical pathways were operating at their full potential, or whether there was a need for further expansion. It was agreed this would be sent out for discussion.			April 2025
5.2	APC Improvement Plan – EDI Action Plan	The Board discussed the need to set challenging and measurable targets and ensure we address unconscious bias. Carolyn Downs (CD) suggested that we include the issue of measurement of local populations to ensure effective measurement of data.	Pippa Nightingale	Action complete re stage one of EDI plan. Stage two - included on the agenda item 4.1.2.	April 2025
5.2.3 (21/01/25)	Collaborative Safeguarding Annual Report 2023/24	To standardise the safeguarding reports across all four Trusts.	Janice Sigworth	We have had discussions about how we further align the services & reports with safeguarding leads. The safeguarding teams already share good practice & policies and have an informal network. We decided before further work was undertaken we would await the outcome of the statutory & mandatory	TBC following ICB review

Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
				training review (which reported in March 25) and changes to the ICB role & function. The ICB play a key role in safeguarding assurance. The ICB CNO is undertaking a review to ensure statutory & regulatory responsibilities are discharged whilst removing duplication and streamlining processes. The APC is supporting this review which should be completed by the Autumn. We will then further align our safeguarding services to meet the needs of the new model.	

Part 2: Actions previously outstanding but now completed

Meeting Date	Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes & Status
21/01/25	12.1 – Questions from members of the public	ICHT NHP	Statement about the New Hospital Programme to be published online	TO	Completed, statement published on the ICHT website.

1.3 STAFF STORY: EQUITY - OUTPATIENT INITIATIVE (VINEETA MANCHANDA / CAROLYN DOWNS / PIPPA NIGHTINGALE)

REFERENCES

Only PDFs are attached

1.3. B2H_Collaborative Report_v1.2.pdf

NWL Acute Provider Collaborative Board in Common (Public)
29/04/2025
Item number: 1.3
This report is: Public

Brent Back to Health: Community-Based, Volunteer-Led Appointment Reminders

Author: Piers Milner; Emma Edwardson
Job title: Head of Strategy; Head of Elective & Digital Transformation

Accountable director: James Walters
Job title: Chief Operating Officer

Purpose of report

Purpose: Information or for noting only

Report history

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

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

Executive summary and key messages

Context

London North West University Healthcare NHS Trust (LNWH) serves some of the most diverse and deprived communities in the NHS. Equity of access is a strategic priority—and missed appointments (DNAs) highlight stark inequalities:

- Patients from the most deprived areas are almost twice as likely to miss appointments (20%) as those in the least deprived areas (11%)
- Black patients have higher DNA rates (21%) than White British patients (14%)

The Project

To tackle this challenge, LNWH—working in partnership with Brent CVS and the NWL ICB—launched the Brent Back to Health Programme: a community-based, volunteer-led call centre located at the Brent Carers Centre. Every week, volunteers call 400 patients in the most deprived Primary Care Networks in Brent (Harness South and K&W West), across four high-DNA specialties:

- Ophthalmology
- Maxillofacial & Oral Surgery
- Cardiology
- Endocrinology & Diabetes

Using a behavioural-science-informed script, volunteers make friendly, supportive calls from people within the local community—not from a faceless service. They confirm attendance and explore barriers to attendance. These small but personal interventions are helping to rebuild trust and reduce missed care. Updates are shared directly with service teams.

Emerging Impact

- 0.9% absolute reduction in DNAs (6% relative reduction), particularly among more deprived patients
- Low-cost model: £1.50 per patient, 93p per call
- Volunteers gain valuable skills, and Brent Carers Centre furthers its mission to support local people

This initiative supports national Core20PLUS5 priorities and the proposed access improvement theme of the APC Equity programme.

Hear from the team

The video captures reflections from Funmi, Volunteers & Befriending Coordinator, and Alexia, one of 30 volunteers involved in the programme. Together, they offer a powerful insight into how a simple, compassionate phone call—from someone local and relatable—can transform patient engagement, improve access, and make healthcare feel more personal.

Their stories also highlight the mutual benefits: patients feel heard and supported, while volunteers gain confidence, skills, and a sense of purpose. It's a reminder of the potential when acute providers collaborate meaningfully with Voluntary, Community, and Social Enterprise (VCSE) partners to build more inclusive, connected care.

Note: This initiative is also referenced in the Health Equity item later in the agenda item 4.1.2.

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

2. REPORT FROM THE CHAIR IN COMMON

2.1 REPORT FROM THE CHAIR IN COMMON (MATTHEW SWINDELLS)

REFERENCES

Only PDFs are attached

2.1. Chairs Report NWL APC Public BiC 29 April 2025 v2.pdf

NWL Acute Provider Collaborative Board in Common (Public)
29/04/2025
Item number: 2.1
This report is: Public

NWL Acute Collaborative Chairs Report

Author: Matthew Swindells
Job title: Chair in Common

Accountable director: Matthew Swindells
Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

The Board in Common is asked to note the report.

Report history

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

N/A

Executive summary and key messages

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

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

The Acute Provider Collaborative

As this is the first Board meeting of the new financial year, I'd like to take a moment to look back to the end of the last financial year. Firstly, congratulations to the four Trusts that make up the Acute Provider Collaborative (APC) for finishing the financial year by hitting the £50m deficit target that we had agreed. The past year has been one of the toughest I have experienced in my 35 years in the NHS and the efforts to bring finances back under control after a difficult first 6 months have been tremendous. In the strange way that NHS funding works, our Trusts, absorbed a huge amount extra activity during the year, particularly non-elective, for which income was fixed at the start of the year and therefore over-performance funding wasn't received in year but was calculated as part of a "true-up" for the new financial year. Once that played through it amounted to £75m in unfunded activity, making it clear how well our Trusts had done.

We have also shown the largest growth in elective activity in London compared to the pre-COVID baseline, hit our A&E targets, have some of the best ambulance handover times to hospital staff across London and have met the cancer 28 days' faster diagnosis' standard (people referred on an urgent suspicion of cancer having their diagnosis of cancer confirmed or clear within 28 days) across the APC.

I am proud we continue to deliver care as the safest group of hospitals in the NHS as measured by Summary Hospital-level Mortality Indicator (SHMI), with three of our four Trusts in the top 10 nationally on the SHMI and all four Trusts better than the NHS benchmark.

The four Trusts have had a focused approach to tackling health inequalities and improving equity of access across all North West London, improving access to outpatient services, particularly for populations facing barriers to care, further details of this work will be highlighted at today's Board in Common (BiC) meeting.

The APC is now on a single Electronic Patient Record (EPR), the largest single record in the NHS, so patients can move between hospitals confident that their records will move with them. I am also delighted that over the last two years all the People Promise elements in the NHS staff survey have seen improvements, in some areas there have been significant improvements in our results. The APC strives to be an employer of choice, and we could not deliver all of the achievements above without our fantastic staff, volunteers and partners.

NHS England and Integrated Care Boards (ICBs) changes, impact on the APC

As people will have seen in the newspapers, the Government recently announced that NHS England (NHSE), the organisation that oversees the NHS in England, will shed staff and merge into the Department of Health and Social Care (DHSC). While this doesn't affect our hospitals directly, the move is part of a wider cost saving programme that all NHS organisations are facing.

NHSE has formed a new top leadership team with the departure of the Chair, the Chief Executive, the Chief Finance Officer and several other senior officials. Penny Dash has left as Chair of the North West London Integrated Care Board to become Chair of NHS England. The new Chief Executive is Sir Jim Mackey, most recently Chief Executive of Newcastle University Hospital and the new CFO is Elizabeth O'Mahoney, formally Regional Director for the South West of England. Sir Jim has recently announced changes for Integrated Care Boards (ICBs) and Trusts. ICBs are required to reduce their running costs

by 50% by December this year.

As we start the new financial year, each of the Trust Boards have approved their business plans for 2025/26, with the Acute Provider Collaborative (APC) agreeing a balanced budget for 2025/26. There has been some further discussion with ICB and NHSE regarding the operational plans, in particular the planned elective activity, and these revised plans are on today's Board in Common agenda for final approval. The plans set out what we have to deliver operationally and financially to meet the requirements of NHSE and NWL ICB, there are three key parts to the NHS business planning guidance for acute Trusts, planned care, emergency care and living within our means. This year will be challenging, as there is a requirement to reduce costs by 1% on last year's baseline, achieve a 4% improvement in productivity overall and improve performance against key operational standards.

The plans we are setting out are designed to meet this ambitious challenge, but it require significant work by both the Trusts and the wider health system. The Trusts will need to make big changes to reduce cost whilst improving quality, without putting an unreasonable burden on our hard working staff. The wider health system will need to put in place the plans that have been in gestation for the past couple of years to avoid unnecessary A&E attendances, manage more patients in the community, and reduce the number of patients in hospital who would be better cared for elsewhere. The ICB has set the Trusts' funding based on no growth in emergency or elective demand. This won't happen by magic and failure to make the changes in neighbourhood care to manage demand growth down to zero will make our plans to deliver shorter waiting and better quality within our budget increasingly hard to achieve.

As we look into the coming year, the challenge will be great, but with our strengthened leadership team and tighter collaboration between our Trusts, we are as well placed as any hospitals to face the future.

Board changes

This month Tina Benson the Chief Operation Officer (COO) at THHFT has left the Trust and has moved to Frimley Park Hospital as their COO. Tracey Cotterill has also left THHFT after several months as interim Chief Financial Officer. On behalf of the Board, I would like to thank them for their hard work and dedication to the Trusts and APC. This will also be the last Board in Common meeting for Claire Hook, COO and Deputy Chief Executive at ICHT, as she will leave the Trust in June 2025 to take up a new role as COO at the Francis Crick Institute. Claire has made an outstanding contribution to the NHS through her long career and has made a huge contribution to the improvements we can all see at ICHT over the past few years. She leaves Imperial as one of the top Trusts in the country and we will all miss her.

At an Executive level there have been some changes at CWFT and THHFT to further strengthen and enhance collaboration. Virginia Massaro has been appointed as the Chief Finance Officer for both CWFT and THHFT, Jason Seez has been appointed as the Chief Infrastructure and Redevelopment Officer for both CWFT and THHFT. Alan McGlennan has been appointed as the Managing Director for THHFT, this is a new post which has been created to take on accountability for the management and leadership of the hospital sites. Alan will also maintain his role as the Chief Medical Officer. Further Executive changes can be found in Lesley Watts' Chief Executive report.

Redevelopment Update

In February this year, the New Hospital Programme (NHP) confirmed that Imperial College

Healthcare NHS Trust can proceed to the next phase of the redevelopment of St Mary's Hospital in Paddington. This phase will focus on detailed design and planning, with the aim of securing full planning consent for a new hospital within a redeveloped life sciences campus by 2027/28. A first tranche of funding is expected imminently, forming part of an anticipated £50 million total required to complete this phase of work. In the meantime, ICHT is establishing a joint taskforce with Westminster City Council to accelerate the St Mary's redevelopment by identifying and securing additional funding.

Following the NHP's confirmation that Charing Cross Hospital and Hammersmith Hospital sites are also part of Wave 3 (i.e. not beginning until 2035), ICHT has submitted a bid for funding to continue master planning efforts. We are actively exploring options for how best to support life sciences around these hospital sites in particular how the Imperial West Tech corridor will support the case for redevelopment of both hospitals, particularly given their strategic links with the White City Innovation District.

ICHT has received funding to address significant maintenance backlogs at both Hammersmith and Charing Cross hospitals. This investment will also contribute to the Trust's decarbonisation goals, supporting the delivery of more sustainable and energy-efficient facilities.

ICHT redevelopment team continues to work closely with the NHP team to take forward the schemes and will continue to engage with colleagues across the Trust and our stakeholders as this progresses.

Stanton Williams has been appointed as the architect for the new Fleming Centre following a competitive RIBA process. The research and public engagement facility will be built on the St Mary's Hospital campus in Paddington and is due to open in 2028, marking the centenary of the discovery of penicillin by Sir Alexander Fleming at the hospital.

The next phase will involve detailed design, public consultation (scheduled for May/June), and submission of a planning application in partnership with Westminster City Council.

Following the government's recent review of the NHP, on 10 January 2025 the Secretary of State for Health and Social Care published his report and announced that the new Hillingdon Hospital will proceed as a wave 1 scheme, with construction expected to start 2027/28 and a capital envelope of £1-£1.5bn.

Alongside the seven high priority RAAC (reinforced autoclaved aerated concrete) hospitals which were outside the scope of the review, we are one of a small number of schemes that have been selected to proceed in wave 1. This is a significant milestone for THHFT and the community we serve. The redevelopment will allow us to create a modern, state-of-the-art facility designed to meet the needs of our patients, staff, and visitors for generations to come.

The next phase of the journey will now begin, focusing on planning and construction and are committed to keeping everyone informed as we progress at every stage. Immediate next steps include agreeing the detailed programme of work with the NHP and the THHFT redevelopment team will soon start work on progressing the design for the new hospital and aligning it to the NHP's standardised design approach.

The enabling works for the Hillingdon scheme continue to progress including the Furze project which is due to complete September 2025. Business cases for the remaining schemes are going through assurance with NHP and NHSE London and are expected to be approved in the new financial year. This will deliver a cleared site for construction to

begin on the new hospital in 2027/8.

Acute Provider Collaborative Visits

On 28 January I visited the Paediatric Emergency Department (ED) at THHFT, thanks to Katrina Warkcup, ED Matron, who showed me the department and walked me through the pathway at the site. It was good to see the close working with the adult ED and the streaming taking place to ensure patients are being seen as quickly and effectively as possible to help the flow from the front door.

On 30 January I visited the Dean Street Clinic, which houses the sexual health services CWFT provides in the heart of Soho, Dr Tara Suchak, Clinical Lead for Dean Street and Jon Clark, Clinic Manager with their team gave me a tour of the centre, showing the wider range of services they deliver and highlighting the community outreach work they do to support all of the community to access their services.

On 8 April I visited the Oncology Outpatient service at Charing Cross hospital, I went with a group of ICHT NEDs to meet some of the team, thanks to Eleanor Ewers, Trust lead SACT Nurse & Matron, Vicky Kidner, Oncology lead nurse and Harr Monaghan, General Manager for walking us through the service and highlighting the partnership work across our cancer network.

2.2 BOARD IN COMMON CABINET SUMMARY (MATTHEW SWINDELLS)

REFERENCES

Only PDFs are attached

2.2. BiC Cabinet Committee Summary 12 February and 12 March 2025 -final.pdf

NWL Acute Provider Collaborative Board in Common (Public)
29/04/2025
Item number: 2.2
This report is: Public

Board in Common Cabinet – Committee Summary

Author: Philippa Park
Job title: Executive Assistant to the Chair

Accountable director: Matthew Swindells
Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

This paper provides an update on items discussed at the Board in Common Cabinet committees held on 12 February and 12 March 2025.

Report history

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

Board in Common Cabinet 12/02/2025 What was the outcome?	Board in Common Cabinet 12/03/2025 What was the outcome?	Committee name Click or tap to enter a date. What was the outcome?

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

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

1. **Business Case and Contract Award Short form business case for Development Manager and master planning team for St Mary's Hospital in the Redevelopment Directorate at Imperial College Healthcare NHS Trust (ICHT).**

Members of the ICHT Board approved the short form business case for Development Manager (DM) role & master planning team for St Mary's Hospital rebuild.

2. **Imperial College Healthcare NHS Trust (ICHT) Waste Management Contract.**

Members of the ICHT Board approved the business case for ICHT Waste Management Contract.

3. **Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) Hard Facilities Management Business Case.**

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 are provided in this report.

The key items to note from the Board in Common Cabinet Committees held on 12 February and 12 March 2025 were:

Planning and Strategy

Business Planning 2025/26. At the February meeting, the Chief Executives updated the Cabinet on the work each of the Trusts had been doing to develop their business plans for the coming year. The Cabinet had a detailed discussion on what work was needed to deliver the finalised business plans for the 27 March deadline, it was noted that NHSE required a 4% productivity gain and 1% reduction in baseline costs for 2025/26. The Cabinet agreed the Trusts needed to ensure all work that is carried out is paid for and also had a discussion on where risks sit in the system. The Cabinet noted the importance of agreeing and having the right metrics to track productivity in 2025/26, such as value weighted activity (VWA), Chief Financial Officers and Chief Operating Officers are working on a list of metrics. The Cabinet agreed to write formally to the ICB on 2025/26 Business Plans.

At the March meeting, Cabinet members were informed that the Board Assurance Statements, which needed to be submitted alongside Trust business plans, had now been published by NHSE. Discussions were taking place with the ICB around the submission date for the assurance statements. The assurance statements also included a requirement to ensure equality impact assessments (EQIA) were developed against Trust plans and that these were reviewed by the Board. The Board had a robust discussion about the targets needed to deliver achievable plans.

The Cabinet emphasised the first quarter of the year was of paramount importance and immediate and non-recurrent action and reduction of spend may be required to aid Cost Improvement Plans (CIPs) to ensure the financial year was not lost in the first few months. The Cabinet were clear that the Board would not sign off a business plan which could not be

delivered. Members also stated that they were not prepared to sign off board assurance statements if the information was not available to qualify the statements.

Progress Report on the Clinical Pathways Programme. A progress update on the Clinical Pathways Programme was provided to the Cabinet in the February meeting; across the 28 joint specialties in the APC, clinical leads were tasked with identifying one pathway and aligning to best practice by April 2025. The Cabinet noted good clinical engagement across the pathways and progress being made in agreeing their respective pathway, the benefits and metrics to be used to measure the outcomes, with the aim being for all pathways to be ready for implementation by 1 April 2025. The Cabinet had a brief discussion on the approach to non-clinical pathways, via the corporate transformation board, which needs to be reviewed and the programme confirmed including understanding the baseline data. A refresh of the Board and programme needs to be carried out.

Delivery and Assurance

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

LNWH

- The Medirest contract is up for tender, the Trust is working through the procurement process. The potential risk of industrial action by Medirest employees was highlighted
- A routine targeted CQC inspection would take place on 19 March 2025 on Ionising Radiation (Medical Exposure) Regulations (IRMER).
- A peer review on sickle cell service (ICHT and LNWH) would be taking place.
- Griffin land sale negotiations continued around the value of the land, which now included planning approval. The Trust needed to get maximum value, which may move into the next financial year.

THHFT

- The factual accuracy checks on the draft Care Quality Commission (CQC) reports from the recent inspection would be submitted shortly. The final reports would then be publicly released, date to be confirmed. The Trust continued to make internal improvements.

- Discussions were taking place about the incinerator, which was likely to worsen the financial position. Negotiations were taking place. However, there was a risk for the sector around the financial reward.

ICHT

- An incident at the Cleveland Clinic was reported on with next steps to be taken internally and with the Cleveland Clinic to investigate.

- The Trust had temporarily stopped undertaking brain tumour operations via the Trust neuro-oncology service, likely to be for a period of two weeks, to enable the trust to undertake an external review due to safety concerns. The Chair of the Quality Committee and Vice Chair would be kept up to date.

- The Trust had agreed mediation with regard to Ravenscourt Park dilapidations and an agreement had been signed. Provision, held on the balance sheet, would be released.

CWFT

- There had been challenge discussions at EMB around a few business cases which would not be funded this year.

- Discussions had also taken place on rotas with ED consultants and an agreement had been reached.

Acute Provider Collaborative Executive Management Board

The Cabinet received a brief update from the Acute Provider Collaborative Executive Management Board and noted the items discussed, which included:

- The North West London Elective Orthopaedic Centre (EOC) was delivering to plan and was now ahead of where it was expected to be.
- A brief discussion took place around the significant cost of the Investigation and Intervention (I&I) regime. If the reports had no merit a letter would be sent to the ICB.

Any Other Business.

The soft Facilities Management tender at LNWH had now been approved by the Treasury. Shortlisting had been undertaken and a tender would be offered. The contract was due to

commence on 1 October 2025. However, the GMB Union raised objections that an in-house option had not been offered. Unfortunately, this was not possible as there was no available capital. The GMB may take strike action unless contracts are aligned. Discussions were taking place, however, it was not possible to align the contracts truly (NHS pension, annual leave etc).

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

3. DECISION MAKING AND APPROVALS

3.1 APC FINANCIAL, OPERATIONAL AND WORKFORCE BUSINESS PLANS 2025/26 (LESLEY WATTS / JAZZ THIND)

REFERENCES

Only PDFs are attached

3.1 APC Plan 202526 BIC 29.04 v4.pdf

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

NWL APC Plan 2025/26

Board In Common Meeting

29th April 2025

Executive summary

- This paper presents the Acute Provider Collaborative (APC) trusts' final plans for 2025/26 as approved by the Trust Standing Committees (week commencing 24th March) and the Board in Common on 27th March.
- Plans comprise of:
    1. Finance – income & expenditure plan, efficiencies, capital plan, cash plan.
    2. Operational activity and performance.
    3. Workforce – establishment, staff in post, substantive, bank and agency.
    4. Productivity & Efficiency checklists (noting key delivery actions to improve productivity and Elective and Urgent and Emergency care performance).
- <u>The key highlights include:</u>
    - A break-even income and expenditure plan, after the inclusion of £121.3m of additional non-recurrent funding from the North West London Integrated Care Board and £49m of income linked to the outcome of the 'true up' and 'local price' review (with validation underway to confirm the latter). Cost inflation assumptions have been modelled against national guidance uplifts as per slide 4.
    - Delivery of £178m of efficiencies with schemes focussing on cost reductions rather than income growth. This level of efficiency is 31% higher than that delivered in 2024/25.
    - APC capital plan of £283.5m – funded through internal cash generation, and national cash backed public dividend capital. This excludes charitable donations and grant funding.
    - Cash forecast plan at 31.03.2026 is £184.8m.
    - A 1,260 whole time equivalent reduction in workforce.
- Operational plans submitted on 27th March have subsequently been updated to reflect higher than previously planned Referral To Treatment trajectories, these revised and final operational performance plans are shown in the **Appendix (slide 19)**.
- The financial plan includes a significant degree of risk and the APC is required to develop a medium-term financial plan that sets out the path to financially sustainability during 2025/26.
- The main non-financial risks relate to patient waiting times, patent experience and the impact of not achieving some quality standards (e.g. birth rate +), with the impact to be assessed through the existing Quality Impact Assessment processes at each Trust.

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Income and Expenditure Plan

Finance Plan – summary

	Plan 25/26 (27.03.25)							
	Income	Pay	Non pay	Non op exp	Total exp	Total Plan	Efficiency	Efficiency
	£m	£m	£m	£m	£m	£m	£m	%
CWFT	1,022.9	-586.9	-402.3	-33.7	-1,022.9	0.0	33.4	3.3%
ICHT	1,814.8	-1,126.4	-673.2	-15.1	-1,814.8	0.0	80.4	4.4%
LNWH	1,084.6	-671.9	-388.1	-24.6	-1,084.6	0.0	48.5	4.5%
THH	408.3	-268.9	-130.7	-8.6	-408.3	0.0	15.7	3.8%
APC	**4,330.6**	**-2,654.2**	**-1,594.4**	**-81.9**	**-4,330.6**	**0.0**	**178.0**	**4.1%**

- Headline plans include cost uplift factor (CUF) for 2025/26 as per the table published in the planning guidance:
  - Income uplift of 2.15%.
  - Expenditure inflationary funding according to the % per cost item.

Cost item	Estimate	Cost Weight	Weighted estimate
	%		%
Pay	4.72	70.45	3.33
Drugs	0.83	2.34	0.02
Capital	2.39	7.35	0.18
Unallocated CNST	0.31	2.09	0.01
Other	3.51	17.76	0.62
Total uplift			4.15
efficiency			-2
Net CUF			2.15

  - The pay cost change of 4.72% includes: pay award of 2.8%, 0.1% pay drift, and other pay related cost pressures on NHS services including the increase in employer's national insurance from April.
  - The efficiency factor of 2% adjusts cost downwards and encourages providers to continually improve their use of resources

Finance Plan : Efficiency

Efficiency plan 2025/26							
	27.03.25 Final Efficiency Target	%		Identified %	Unidentified %	22.04.24 Identified £	Unidentified £
	£m	%		%	%	£m	£m
CWFT	33.4	3.3%		70%	30%	23.5	9.9
ICHT	80.4	4.4%		72%	28%	58.0	22.4
LNWH	48.5	4.5%		60%	40%	29.0	19.5
THH	15.7	3.8%		76%	24%	12.0	3.7
APC	**178.0**	4.1%		**69%**	**31%**	**122.5**	**55.5**

- The APC efficiency target is £178.0m.
- Set against the forecast efficiency delivery in 2024/25 of £135.4m, this is a 31% increase in efficiency requirement in 2025/26.
- To date £122.5m (69%) has been reported as being identified, with further work in train to close the remaining gap of £55.5m.
- Any under-delivery against identified plans (e.g. due to phasing) / gap to target, will need to be offset by other non-recurrent mitigations and further in-year grip and control measures.

Capital Plan

Capital Plan Detail

- The 25/26 provider system capital allocation equates to £316.1m. This is £30.2m greater than the previously advised allocation of £285.9m and is fully attributable to the incentive bonus allocation receivable on the back of achieving the 24/25 system income and expenditure plan (breakeven). CWFT will as in 24/25, hold this on its books as the 'system capital reserve' and providers will be required to put in bids/business cases to access this systems bonus.
- The table sets out the breakdown of the APC capital plan by APC Trusts excluding ''yet to be confirmed' allocations, donations and grants.
- This forms the basis of the opening Capital Resource Limit (CRL) and is made up of:
  - £189.9m of core capital;
  - £62.4m of indicative critical estates safety risks and constitutional standard programmes funding, final formal approval of which is due to be provided by NHSE upon submission of the 25/26 income and expenditure plans (NWL ICS allocation value was £69.5m). Bids against this pot were scored by the ICB programme leads with collaboration from operational leads and the regional NHSE team; and
  - £31.5m of other national funding for schemes in train from prior years.
- Cash affordability remains a key aspect of cash planning.

2025/26 TOTAL CAPITAL - APC trusts

CRL APPORTIONMENT	CWFT £'000	ICHT £'000	LNWHT £'000	THH £'000	TOTAL £'000
Core CRL	26,701	61,991	28,998	13,701	131,391
Impact of IFRS 16	1,880	21,302	1,500	1,077	25,759
Additional Core CRL Request	2,000				2,000
Reserves - Transfer from NWL to NCL iCB	500				500
System Bonus Reserves	***30,228***				30,228
Total Charge against Capital Allocation (including impact of IFRS 16)	**61,309**	**83,293**	**30,498**	**14,778**	**189,878**
NATIONAL CAPITAL - ALLOCATED					
Estates Safety (CIR)		25,250		8,000	33,250
Constitutional Standards:					
Electives	5,000	4,000			9,000
UEC	5,000	10,290	100	1,500	16,890
Diagnostics		3,000			3,000
Sub-Total National Capital	**10,000**	**42,540**	**100**	**9,500**	**62,140**
OTHER NATIONAL PDC SCHEMES					-
New Hospital Programme				28,280	28,280
PFI capital charges (e.g. residual interest)	2,202		1,032	1	3,235
Net CDEL	**73,511**	**125,833**	**31,630**	**52,559**	**283,533**

NHS North West London Acute Provider Collaborative

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Operational Plan

National Operational Targets key points

Reduce elective care waits

- Improve the **percentage of patients waiting <18 weeks for treatment to 65%** and for the first appointments to 72% nationally with every trust delivering a 5% improvement
- Reduce the proportion of people waiting > 52 weeks for treatment to less than 1% of the total waiting list.
- Improve performance against 62 cancer **standard to 75%-and 28-day faster access standard to 80%**
- The Elective Reform plan specifies a requirement to deliver elective activity levels at 118% VWA.

Improve A&E waiting times and ambulance response times

- Reach minimum of **78% patients admitted, discharged and transferred from ED within 4 hours**.
- Improve Cat 2 ambulance response times to an average of 30 minutes across 2025/26.
- Reduce avoidable ambulance conveyances and handover delays by delivering hospital handovers within 15 minutes and improving access to urgent care services at home or in the community.
- Improve and standardise urgent care by using the principles of same day emergency care (SDEC).

Planning Guidance states "Operational plans must be set consistent with the available resource, rather than the resource set to meet any specified goal. This means that any affordability challenges must be addressed in the initial plan and as part of discussions with NHS England".

Operational plan : Key performance targets

Note : activity & performance plans have been subsequently amended – see Appendix (slide 19)

	ICHT		CWFT		LNWH		THH	
Measure	**March 2026 position**	**Compliant Y/N**	**March 2026 position**	**Compliant Y/N**	**March 2026 position**	**Compliant Y/N**	**March 2026 position**	**Compliant Y/N**
Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against November 2024 baseline – all Trusts to deliver 60% minimum	55.52%	No- reach 60% minimum No - 5% improvement	60.00%	Yes reach 60% minimum No - 5% improvement	52.64%	No – reach 60% minimum No - 5% improvement	51.75%	No – reach 60% minium No - 5% improvement
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against November 2024 baseline – all Trusts to deliver 67% minimum.	64.91%	No - reach 67% minimum No - 5% improvement	58.00%	No - reach 67% minimum No - 5% improvement	55.60%	No – reach 67% minimum Yes - 5% improvement	55.60%	No – reach 67% minimum No - 5% improvement)
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	3.15%	No	1.00%	Yes	1.58%	No	1.00%	Yes
Improve performance against the headline 62-day cancer standard to 75% by March 2026	85%	Yes	85%	Yes	84%	Yes	75%	Yes
Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	80%	Yes	80%	Yes	79%	No	77%	No
Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	78% 1.8% decrease on T1 12-hour waits	Yes Yes	78% 0.3% decrease on T1 12-hour waits	Yes Yes	78% 0.03% decrease on T1 12-hour waits	Yes Yes	78% 2.6% decrease on T1 12-hour waits	Yes Yes

Operational plan : Activity Summary

APC : Summary activity plan 27.03 submission

	ICHT				CWFT				LNWH				THH				APC			
Measure	2024/25	2025/26	Var	% var	2024/25	2025/26	Var	% var	2024/25	2025/26	Var	% var	2024/25	2025/26	Var	% var	2024/25	2025/26	Var	% var
Ist OP	279,648	282,561	2,913	1%	253,887	217,103	(36,784)	-14%	345,438	314,171	(31,267)	-9%	117,835	111,065	(6,770)	-6%	996,808	924,900	(71,908)	-7%
FU OP	636,124	661,780	25,656	4%	364,036	343,673	(20,363)	-6%	387,155	351,929	(35,226)	-9%	173,430	163,882	(9,548)	-6%	1,560,745	1,521,264	(39,481)	-3%
OP Procedures (ERF definition)	186,727	206,163	19,436	10%	111,183	90,434	(20,749)	-19%	152,478	132,134	(20,344)	-13%	60,534	56,902	(3,632)	-6%	510,922	485,633	(25,289)	-5%
Electives	15,265	13,998	(1,267)	-8%	7,093	7,000	(93)	-1%	8,984	9,131	147	2%	2,773	2,605	(168)	-6%	34,115	32,734	(1,381)	-4%
Day Cases	116,690	115,454	(1,236)	-1%	71,895	65,502	(6,393)	-9%	104,084	96,761	(7,323)	-7%	35,889	33,700	(2,189)	-6%	328,558	311,417	(17,141)	-5%
Total - Elective & Day cases	131,955	129,452	(2,503)	-2%	78,988	72,502	(6,486)	-8%	113,068	105,892	(7,176)	-6%	38,663	36,305	(2,358)	-6%	362,673	344,151	(18,522)	-5%
A&E (Type 1,2 & 3)	279,971	282,804	2,833	1%	313,647	313,648	1	0%	341,744	358,832	17,088	5%	151,317	158,884	7,567	5%	1,086,679	1,114,168	27,489	3%
SDEC	29,216	34,746	5,530	19%	19,652	25,364	5,712	29%	19,918	20,914	996	5%	19,176	20,087	911	5%	87,963	101,111	13,148	15%
Non Electives 0 LOS	20,796	22,654	1,858	9%	29,976	18,856	(11,120)	-37%	34,689	36,418	1,729	5%	6,459	6,276	(183)	-3%	91,920	84,204	(7,716)	-8%
Non Electives >1 day LOS	43,307	41,348	(1,959)	-5%	38,286	35,818	(2,468)	-6%	45,400	47,662	2,262	5%	19,425	20,110	685	4%	146,419	144,938	(1,481)	-1%

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together

Chelsea and Westminster Hospital NHS Foundation Trust

The Hillingdon Hospitals NHS Foundation Trust

Imperial College Healthcare NHS Trust

London North West University Healthcare NHS Trust

Workforce Plan

Workforce key points

Trust submissions are based on bottom-up planning and submissions from divisions, directorates and departments, but where this has not been fully possible a plan needs to be submitted based on setting a challenging, but deliverable staffing and pay reduction plan, with the final position taking account of the following.

National planning guidance:

- **Reduce spend on temporary staffing and support functions:**
  - Achieving close to 100% delivery of planned core capacity before accessing premium capacity (use of agency and premium bank rates, waiting list initiatives, and insourcing arrangements, managing to tariff prices as a guide)
  - Depending on performance, deliver a minimum 30%-40% reduction in agency expenditure based on current spending (with further reductions over the Parliament) as part of optimising cost and productivity
  - Depending on current performance, deliver a 10-15% reduction in bank use. Bank rates should be optimised as far as possible with collaborative arrangements in place across and between systems
  - Conduct a robust review of establishment growth and reduce spend on support functions to April 2022 levels
- **Drive improvement in operational and clinical productivity, providers are expected to:**
  - Develop plans that address the activity per WTE gap against the pre-Covid level
  - Systematically implement all elements of the People Promise to improve the working lives of all staff and increase staff retention and attendance.
  - Implement the 6 high impact actions to improve equality, diversity and inclusion. The evidence is clear that engaged, motivated staff improve productivity and patient outcomes
- Subsequent to the submission of plans on 27th March, a letter was received (1st April) from NHSE Chief Executive Sir Jim Mackey setting out the requirement to reduce corporate pay cost growth by 50% during Quarter 3 (from 2019/20 to 2024/25). This was however followed by a further letter (NHSE London) which defined the expected target reductions in corporate spend when comparing 2018/19 to 2023/24 at c£25m across the APC.

Generic / APC-wide strategies and actions

- Given all APC Trusts have underlying financial deficits this requires reductions in pay run rate; Taking out vacant posts that are not being used to reduce the establishment will not affect the pay run-rate and deliver a cost improvement. Unless a vacancy arises or a fully-funded mutually-agreed resignation scheme is agreed, reducing substantive staffing will have a transition cost of redundancy payments that, in some cases, could be as high as the full-year effect of the savings.
- Currently temporary staffing (bank and agency) is between 7-10% with agency in some Trusts at or below 1%, achieving the 30% reduction in agency may be challenging to achieve.
- Whilst it is theoretically possible to achieve the required pay savings without reducing substantive posts, there are likely to be opportunities in substantive areas that are being taken and some temporary staffing that is unavoidable in the short term.
- Addressing the drivers of 'excess' staffing not previously recognised as core acute staffing – system optimisation, medically fit for discharge, specials, use of RMNs.
- Reviewing micro-system productivity deficiencies (e.g. theatre late starts and early finishes, outpatient Do Not Attends, first to follow up rates) driving unwarranted pay costs through sub-optimal productivity.
- Recognising and funding the core staffing requirements for non-elective activities operating over previous block contracts (e.g. maternity, emergency care, critical care) but part of the future demand.
- Addressing the root causes of premium-rate pay expenditure and/or out of hours working – targeted and collaborative efforts to recruit into hard to fill vacancies (e.g. anaesthetists, emergency care), developing future pipelines (IMGs, locally-employed doctors, CESR programmes) and growing our own (e.g. sonographers, theatre practitioners, OTs).
- Continuing the improvement in grip, control and scrutiny on temporary staffing bookings and approvals through sharing best practice and tools from the best in the APC.
- Corporate services programme to reduce back-office costs.
- Review of business cases not drawn down.

Workforce Plan WTE

The APC workforce submission (27.03) is summarised in the table below and highlights:

- Planned reduction in total staff deployed including substantive, bank and agency, of 1,260 whole time equivalents (down by 3.3%)
- Establishments planned to reduce by 339 whole time equivalents (down 1%)

Workforce (WTE) *	SIP Outturn	Establishment	SIP Outturn	Establishment	Staff In Post Change	Establishment Change	Staff-in-Post % Change	Establishment % Change
	Year End Mar - 25	Year End Mar-25	Year End Mar-26	Year End Mar - 26	Year End Mar-26	Year End Mar - 26	Year End Mar-26	Year End Mar - 26
CWFT	8,188	7,663	7,944	7,674	-243	11	-3%	0.1%
ICHT	16,327	15,740	15,876	15,581	-451	-159	-3%	-1%
LNWH	10,068	9,532	9,630	9,298	-438	-234	-4%	-2%
THH	4,183	3,914	4,055	3,958	-128	44	-3%	1%
NWL APC	**38,766**	**36,849**	**37,506**	**36,510**	**-1,260**	**-339**	**-3%**	**-1%**

* SIP = Staff in Post, includes substantive, agency and bank

Risks

Key Risks -1

Risks	Mitigation (where known)	Accountable Lead
Impact on quality of care and quality standards (e.g. Non-compliance with birth rate + and NICU BAPM standards)	The Trusts' Quality Impact Assessment processes will be applied to all cost improvement schemes (CIPs), service developments and elective recovery fund (ERF) reduction plans.	Chief Medical Officers & Chief Nurses
Impact on waiting lists due to non-compliance of RTT and diagnostic waiting times targets resulting from ERF cap.	A risk assessment will be undertaken for each impacted area to ensuring that there is a plan that focuses prioritisation based on clinical need for RTT and diagnostics. The ICB has retained ERF funding for targeted approach during the year.	Chief Medical Officers & Chief Nurses
Impact on staff morale and staff experience	Clear and transparent approach to communications with staff. Recognition that there will be challenging and less palatable decisions that will need to be taken through which staff will need to be supported.	Chief Executives
Failure to deliver 2025/26 financial plan	Engagement through planning round to ensure senior leaders are aware of the financial pressures and the necessary cost/workforce reductions to deliver the plan. A well-developed CIP plan with schemes identified that can deliver early in the year. Non-recurrent savings to bridge any gap whilst the transformative schemes are developed. Close monitoring of variance to budget to identify mitigations immediately. Non-Pay controls and further review of non-pay opportunities e.g. pathology Reserve flexibilities Opportunity to further increase private patient activity and income	Chief Finance Officers
Failure to achieve reduction in WTE within 2025/26	Delivery of workforce plan to be monitored at monthly divisional performance meetings, CIP efficiency programme boards and through budgetary management. Governance through the Trusts' Workforce Committees.	Chief People Officers

Key Risks -2

Risks	Mitigation (where known)	Accountable Lead
Ability to achieve CIP target / required run rate reduction	Non-recurrent savings will help to mitigate the unidentified gap. Grip and control measures - to mitigate CIP gap e.g. vacancy control, temporary staffing measures, non-pay controls, strict compliance with no PO, no pay policy, stopping subscriptions etc will be in place from 1st April. Monitored through budgets and CIP/Efficiency programmes.	Chief Financial Officers
Ability to achieve operational requirements/targets	Trajectories have been developed to support the delivery of the operational and performance commitments in the plan. The APC will not be compliant against all indicators. Maximise core capacity through improved productivity and measures such as expanding PIFU, reducing DNAs and Remote Monitoring. Explore opportunities to reduce demand through community pathways.	Managing Directors / Chief Operating Officers
No contingency has been built into the plan for unknown items	The APC has agreed not to fund contingency as that would lead to an increase in deficit requiring additional CIP targets to mitigate. However, each Trust has a small number of reserves to mitigate the required run-rate reductions in e.g. escalation beds.	Chief Finance Officers
Inflation	The plan includes national inflation assumptions only. Any inflation above the assumed level would result in a cost pressure.	Chief Finance Officers
Ability to achieve productivity and efficiency targets as outlined in Planning Checklist	Other areas for improved productivity will be identified on an ongoing basis. This will be supported through the service/ward Deep Dives, which are highlighting areas of opportunity.	Directors of Transformation

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Appendix
Updated 2025/26 Operational Performance Plans

Updated Operational Performance and Activity plans

- Following review by NHS England of the 2025/26 operational performance and activity plans submitted on 27th March, all APC trusts were asked to review their submissions with the request to improve RTT and review any other standards which were not compliant with national expectations.
- The tables on the next slides (21 and 22) sets out the updated positions and is deemed to be the final 2025/26 performance & activity plans.
- This will now form the basis of the resubmission due to NHS England on the 30th April.

Updated Operational Performance

	ICHT		CWFT		LNWH		THH	
Measure	**March 2026 position**	**Compliant Y/N**	**March 2026 position**	**Compliant Y/N**	**March 2026 position**	**Compliant Y/N**	**March 2026 position**	**Compliant Y/N**
Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against November 2024 baseline – all Trusts to deliver 60% minimum	60.24%	Yes - reach 60% minimum No - 5% improvement (from baseline)	60.00%	Yes reach 60% minimum No - 5% improvement (from baseline)	60.10%	Yes reach 60% minimum Yes - 5% improvement (from baseline)	60.00%	Yes – reach 60% minium Yes - 5% improvement (from baseline)
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against November 2024 baseline – all Trusts to deliver 67% minimum.	64.91%	No - reach 67% minimum No - 5% improvement (baseline 64%)	67.00%	Yes reach 67% minimum No - 5% improvement (baseline 65.8%)	55.60%	No – reach 67% minimum Yes - 5% improvement (baseline 49%)	55.60%	No – reach 67% minimum No - 5% improvement (baseline 52.4%)
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	3.15%	No	1.00%	Yes	1.00%	Yes	1.00%	Yes
Improve performance against the headline 62-day cancer standard to 75% by March 2026	85%	Yes	85%	Yes	84%	Yes	75%	Yes
Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	80%	Yes	80%	Yes	80%	Yes	80%	Yes
Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	78% 0.3% decrease on T1 12-hour waits	Yes Yes	78% 0.3% decrease on T1 12-hour waits	Yes Yes	78% 0.03% decrease on T1 12-hour waits	Yes Yes	78% 2.6% decrease on T1 12-hour waits	Yes Yes

NHS North West London Acute Provider Collaborative

Updated Activity

APC : Summary activity plan - FINAL (22.04 submission)

	ICHT				CWFT				LNWH				THH				APC			
Measure	**2024/25**	**2025/26**	**Var**	**% var**	**2024/25**	**2025/26**	**Var**	**% var**	**2024/25**	**2025/26**	**Var**	**% var**	**2024/25**	**2025/26**	**Var**	**% var**	**2024/25**	**2025/26**	**Var**	**% var**
Ist OP	279,648	282,561	2,913	1%	253,887	217,103	(36,784)	-14%	343,953	345,571	1,618	0%	117,835	111,065	(6,770)	-6%	995,323	956,300	(39,023)	-4%
FU OP	636,124	661,780	25,656	4%	364,036	343,673	(20,363)	-6%	383,113	344,537	(38,576)	-10%	173,430	163,882	(9,548)	-6%	1,556,703	1,513,872	(42,831)	-3%
OP Procedures (ERF definition)	186,727	206,163	19,436	10%	111,183	90,434	(20,749)	-19%	150,081	156,155	6,074	4%	60,724	56,902	(3,822)	-6%	508,715	509,654	939	0%
Electives	15,265	13,998	(1,267)	-8%	7,093	7,000	(93)	-1%	9,422	9,131	(291)	-3%	2,773	2,605	(168)	-6%	34,553	32,734	(1,819)	-5%
Day Cases	116,690	115,454	(1,236)	-1%	71,895	65,502	(6,393)	-9%	103,502	96,761	(6,741)	-7%	35,889	33,700	(2,189)	-6%	327,976	311,417	(16,559)	-5%
Total - Elective & Day cases	131,955	129,452	(2,503)	-2%	78,988	72,502	(6,486)	-8%	112,924	105,892	(7,032)	-6%	38,663	36,305	(2,358)	-6%	362,529	344,151	(18,378)	-5%
A&E (Type 1,2 & 3)	279,971	282,804	2,833	1%	313,647	313,648	1	0%	342,932	358,832	15,900	5%	151,317	158,884	7,567	5%	1,087,867	1,114,168	26,301	2%
SDEC	29,216	34,746	5,530	19%	19,652	25,364	5,712	29%	19,918	20,914	996	5%	19,176	20,087	911	5%	87,963	101,111	13,148	15%
Non Electives 0 LOS	20,796	22,654	1,858	9%	25,577	18,856	(6,721)	-26%	34,869	36,743	1,874	5%	6,459	6,276	(183)	-3%	87,701	84,529	(3,172)	-4%
Non Electives >1 day LOS	43,307	41,348	(1,959)	-5%	37,869	35,818	(2,051)	-5%	45,934	47,985	2,051	4%	19,425	20,110	685	4%	146,536	145,261	(1,275)	-1%

Activity Change 27.03 to 22.04 submissions

Activity changes : 27.03 submission to 22.04 submission

	ICHT			CWFT			LNWH			THH			APC		
Measure	**27.03**	**22.04**	**Var**	**27.03**	**22.04**	**Var**	**27.03**	**22.04**	**Var**	**27.03**	**22.04**	**Var**	**27.03**	**22.04**	**Var**
Ist OP	282,561	282,561	0	217,103	217,103	0	314,171	345,571	31,400	111,065	111,065	0	924,900	956,300	31,400
FU OP	661,780	661,780	0	343,673	343,673	0	351,929	344,537	(7,392)	163,882	163,882	0	1,521,264	1,513,872	(7,392)
OP Procedures (ERF definition)	206,163	206,163	0	90,434	90,434	0	132,134	156,155	24,021	56,902	56,902	0	485,633	509,654	24,021
Electives	13,998	13,998	0	7,000	7,000	0	9,131	9,131	0	2,605	2,605	0	32,734	32,734	0
Day Cases	115,454	115,454	0	65,502	65,502	0	96,761	96,761	0	33,700	33,700	0	311,417	311,417	0
Total - Elective & Day cases	129,452	129,452	0	72,502	72,502	0	105,892	105,892	0	36,305	36,305	0	344,151	344,151	0
A&E (Type 1,2 & 3)	282,804	282,804	0	313,648	313,648	0	358,832	358,832	0	158,884	158,884	0	1,114,168	1,114,168	0
SDEC	34,746	34,746	0	25,364	25,364	0	20,914	20,914	0	20,087	20,087	0	101,111	101,111	0
Non Electives 0 LOS	22,654	22,654	0	18,856	18,856	0	36,418	36,743	325	6,276	6,276	0	84,204	84,529	325
Non Electives >1 day LOS	41,348	41,348	0	35,818	35,818	0	47,662	47,985	323	20,110	20,110	0	144,938	145,261	323

RTT Performance update (27.03 to 22.04 submissions)

ICHT:

RTT performance reported on 27.03: 55.52%

RTT performance reported on 22.04: 60.24%

CWFT:

RTT performance reported on 27.03: 56.4%

RTT performance reported on 22.04: 60.00%

LNWH:

RTT performance reported on 27.03: 52.64%

RTT performance reported on 22.04: 60.10%

THH:

RTT performance reported on 27.03: 51.75%

RTT performance reported on 22.04: 60.00%

All trusts have now committed to delivering individual performance of 60% by March 2026. This has been reflected in the final submission of the operating plan.

The required performance improvement will be delivered through a combination of streamlining pathways, front-loading diagnostic tests, reducing DNAs, converting follow up capacity to new appointments and consistent application of guidance about evidence-based interventions.

3.2 DELEGATED AUTHORITIES TO PROVIDER TRUST COMMITTEES 2024/25

(PETER JENKINSON)

REFERENCES

Only PDFs are attached

3.2. Delegated authorities to provider Trust Committees Apr 25.pdf

NWL Acute Provider Collaborative Board in Common (Public)
29/04/2025
Item number: 3.2
This report is: Public

Delegated Authorities to provider Trust Committees

Author: Jessica Hargreaves
Job title: Deputy Director of Corporate Governance

Accountable directors: Peter Jenkinson, Director of Corporate Governance (ICHT, CWFT, THHFT)
Dawn Clift, Director of Corporate Affairs (LNWH)

Purpose of report

Purpose: Decision or approval

The latest Scheme of Delegation (approved by the Board in Common in January 2025) already gives delegated authority to Audit Committees to sign off Trust annual reports and Quality Committees to sign off Trust Quality Accounts, however there remain a couple of other required documents that need to be completed as part of the year end processes. This paper seeks approval of the proposed delegated authorities from the respective Trust Boards to the local Board Committees as per the schedule within the report. Schedule 1: The Board of Chelsea and Westminster Hospital NHS Foundation Trust is asked to approve. Schedule 2: The Board of Imperial College Healthcare NHS Trust is asked to approve. Schedule 3: The Board of London North West University Healthcare NHS Trust is asked to approve. Schedule 4: The Board of The Hillingdon Hospitals NHS Foundation Trust is asked to approve.

Report history

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

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

Executive summary and key messages

The following items would usually be reserved for local Trust Board approval ahead of submissions/publication as required as part of the NHS year end process:

- Self-certifications for Non Foundation Trusts
- Self-certifications for Foundation Trusts
- Modern Slavery Act Statement

We are now seeking to delegate sign off of these documents to the relevant Trust Audit Committee's as laid out in the schedules below. This is aligned to the year end processes with the Annual Reports and Quality Accounts which are signed off by Audit Committees and Quality Committees as per the Scheme of Delegation that was approved at the Board in Common in January 2025.

This request for delegation is consistent with the process undertaken in recent years (prior to the establishment of the NWL Acute Provider Collaborative) where delegated authority was supported by the Trust Boards. The expectation of delegation has been discussed at the recent meetings of the relevant Board Committees.

<u>Schedule 1:</u> The Board of Chelsea and Westminster Hospital NHS Foundation Trust is asked to approve the following delegations:

Item	Board Committee	Submission	By when
Self-certification: General Condition 6 (GC6) & Continuity of services condition (CoS7) of the NHS Provider License	Audit & Risk Committee	Publication to Trust website	30 June 2025
Self-certification: Condition 4 Corporate Governance Statement	Audit & Risk Committee	Publication to Trust website	30 June 2025
Modern Slavery Act Statement	Audit & Risk Committee	Publication to Trust website	30 September 2025

<u>Schedule 2:</u> The Board of Imperial College Healthcare NHS Trust is asked to approve the following delegations

Item	Board Committee	Submission	By when
Self-certification: General Condition 6 (GC6) of the NHS Provider License	Audit Committee	Publication to Trust website	30 June 2025
Self-certification:	Audit Committee	Publication to Trust	30 June 2025

Condition 4 Corporate Governance Statement		website	
Modern Slavery Act Statement	Audit Committee	Publication to Trust website	30 September 2025

<u>Schedule 3:</u> The Board of London North West University Hospitals NHS Trust is asked to approve the following delegations

Item	Board Committee	Submission	By when
Self-certification: General Condition 6 (GC6) of the NHS Provider License	Audit & Risk Committee	Publication to Trust website	30 June 2025
Self-certification: Condition 4 Corporate Governance Statement	Audit & Risk Committee	Publication to Trust website	30 June 2025
Modern Slavery Act Statement	Audit & Risk Committee	Publication to Trust website	30 September 2025

<u>Schedule 4:</u> The Board of The Hillingdon Hospitals NHS Foundation Trust is asked to approve the following delegations

Item	Board Committee	Submission	By when
Self-certification: General Condition 6 (GC6) & Continuity of services condition (CoS7) of the NHS Provider License	Audit & Risk Committee	Publication to Trust website	30 June 2025
Self-certification: Condition 4 Corporate Governance Statement	Audit & Risk Committee	Publication to Trust website	30 June 2025
Modern Slavery Act Statement	Audit & Risk Committee	Publication to Trust website	30 September 2025

Strategic priorities

Tick all that apply

☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity
☐ Support the ICS's mission to address health inequalities

☐ Attract, retain, develop the best staff in the NHS
☐ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
☐ Achieve a more rapid spread of innovation, research, and transformation

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

4.0 INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR) (PIPPA NIGHTINGALE / LESLEY WATTS)

REFERENCES

Only PDFs are attached

4.0. April BIC Performance Report IQPR v3.pdf

NHS
North West London
Acute Provider Collaborative

Integrated Performance Report

February 2025 data

(Cancer, Maternity & Op Plan Performance = January 2025)

received by EMB and BIC April 2025

Integrated Performance Report Update

The Integrated Quality and Performance Report (IQPR) provides a metrics, overview of performance across the Acute Provider Collaborative (APC). The IPQR currently tracks indicators across three areas of quality, workforce and performance providing Trust level data and an aggregated APC position.

The report is currently under review to ensure it aligns with the NHS Planning Guidance and the priority areas for the four Trusts this year.

Slide 3 gives an overview of the metrics the APC plans to track in 2025/26, the report will split into four sections:

Section 1 – Performance Targets, Section 2 – Productivity and Flow Metrics , Section 3 – APC Priority Metrics, Section 4 – Statutory Reports. Plans are in place to map these metrics, and work is underway to bring together for the performance report.

APC Performance Forward Look – 2025/26

	Section 1 | Performance | KPI	Expected	Actual	Notes
	Elective Care			
*	Referral to treatment waits > 18 weeks	≥60%	TBC	25/26 Operating Plan Priority; minimum standard, 65% expected nationally
	Referral to treatment waits > 52 weeks	</=1%	2.4%	25/26 Operating Plan Priority; 2/4 Trusts compliant in period
	Access to Cancer Care (Faster Diagnosis) < 28 days	≥80%	75.3%	25/26 Operating Plan Priority; 1/4 Trusts compliant in period
	Referral to Cancer Treatment Pathways < 62 days	≥75%	75.3%	25/26 Operating Plan Priority; 4/4 Trusts compliant in period
	Emergency Care			
	Waits in urgent and emergency care > 4 hours	≥78%	73.9%	25/26 Operating Plan Priority; 0/4 Trusts compliant in period
	Waits in urgent and emergency care > 12 hours vs 24/25	-ve	5.8%	25/26 Operating Plan Priority; Performance to be confirmed
	Maternity and Neonatal Care			
	Neonatal Crude Deaths (per 1,000 births)	<0.94	2.2	
	Crude still birth rate (per 1,000 births)	<3.3	3.5	
	Pre-Term births (per 1,000 births)	<80	90	
*	Maternity and Neonatal Safety Investigation Referrals	TBC	TBC	Including Maternal Deaths, neonatal brain injuries and intrapartum still births
	Equity/Access to Healthcare			
*	Wait in emergency care for mental health consult/bed	TBC	TBC	25/26 Operating Plan Priority; ICB 51% (Jan-25) in worst quartile
*	Additional indicators to be considered	TBC		
	Finance			
*	System Financial Performance	Balance	TBC	
*	Temporary Staff Cost Performance	£TBC	TBC	Composite metric including Agency (-30%) and Bank (-15%) spending analysis
*	Corporate Headcount reduction progress	50%	TBC	Baseline position: £228m (23/24 costs uplifted to 25/26)
*	Elective Value Weighted Activity	118%	TBC	Elective Reform plan; Composite metric including DC, EL IP, OPFA and OP Procedures

* New indicators to be included as part of this pack. Full scope to be confirmed.

	Section 2 | Productivity and Flow	Expected	Actual	Notes
	Access and Flow			
	Outpatient Transformation – PIFU Performance	≥5%	3.8%	25/26 Operating Plan Priority; 1/4 Trusts compliant in period
*	Wait for first Outpatient appointment	67%	TBC	25/26 Operating Plan Priority; minimum standard, 72% expected nationally
*	Ambulance handover waits > 15 mins	≥65%	40.1%	25/26 Operating Plan Priority
*	Discharge Planning Performance (delays)	TBC	TBC	25/26 Operating Plan Priority; monitoring to be harmonised
*	Length of Stay > 7 days	TBC	TBC	25/26 Operating Plan Priority; monitoring to be harmonised
*	Readmission Rate	TBC	TBC	25/26 Operating Plan Priority; monitoring to be harmonised
	Productivity			
*	Productivity Opportunity Performance	4.2%	TBC	25/26 Operating Plan Priority; ICB 4.7% (Dec-24) in highest quartile
*	Workforce Productivity Growth vs 19/20	+ve	TBC	25/26 Operating Plan Priority; ICB: -5.5% (Dec-24) but 3/4 Trusts compliant

	Section 3 | Collaborative Priorities	Expected	Actual	Notes
	Capacity			
	Access to diagnostics > 6 Weeks	</=5%	15.5%	
	Theatre Utilisations (Hrs)	≥85%	85.4%	
	Sickness Absence Rate	≤4%	4.1%	
	Voluntary Turnover Rate	≤12%	8.2%	

	Section 4 | Safety and Statutory Reports	Expected	Actual	Notes
	Safety			
	Healthcare associated c. Diff Infections (per 100,000 bed days)	n/a	29.00	
	Healthcare associated E. coli BSIs (per 100,000 bed days)	n/a	43.50	
	Healthcare associated MRSA BSI (per 100,000 bed days)	0	1.04	
	Pressure ulcers (per 1,000 bed days)		0.04	
	Inpatient falls (per 1,000 bed days)		0.07	Amend to 'falls with fractures'
	SHMI (as expected or better)	<100	4 / 4	

Performance Summary

▲ ▼	**Statistically significant** improvement or deterioration in monitored trend
✓ !	**Statistically likely or very unlikely** to meets the desired level of performance

Link to Slide	Section | KPI	Expected	Actual	Improvement Trend	Assurance
	Patient Safety and Experience				
	Reporting rate of patient safety incidents (per 1,000 bed days)	≥54.9	56.08	▲	○
	Serious Incidents (Sis/PSIIs) (per 1,000 bed days)	n/a	0.21	▲	○
	Pressure ulcers (per 1,000 bed days)		0.04	○	○
	Inpatient falls (per 1,000 bed days)		0.07	○	○
	Healthcare associated c. Diff Infections (per 100,000 bed days)	n/a	29.00	○	○
	Healthcare associated E. coli BSIs (per 100,000 bed days)	n/a	43.50	○	○
	Healthcare associated MRSA BSI (per 100,000 bed days)	0	1.04	○	○
	Formal complaints received (per 1,000 bed days)	n/a	2.82	○	○
	Good experience reported by inpatients	≥94%	95.3%	○	✓
	Good experience reported for emergency depts.	≥74%	78.6%	○	✓
	VTE Risk Assessments Completed	≥95%	97.2%	▲	✓
	Mortality				
	SHMI (as expected or better)	<100	4 / 4	○	○
	HSMR (as expected or better)	<100	3 / 4	○	○
	Maternity				
	Crude still birth rate (per 1,000 births)	<3.3	3.5	○	○
	Rate of suspected neonatal intrapartum brain injuries	<1.8	0.00	○	○
	Pre-Term births (per 1,000 births)	<8%	9%	○	○
	Neonatal Crude Deaths (per 1,000 births)	<0.94	2.2	○	○
	Maternal Deaths	0	0	○	○
	Good experience reported for maternity services	≥90%	93.9%	○	○

Link to Slide	Section | KPI	Expected	Actual	Improvement Trend	Assurance
	Patient Access				
	Ambulance handover waits	≥65%	40.1%	○	!
	Waits in urgent and emergency care > 4 hours	≥78%	73.9%	▲	!
	Waits in urgent and emergency care > 12 hours	</=2%	5.8%	▼	!
	Referral to treatment waits > 52 weeks	</=2%	2.4%	▼	!
	Access to diagnostics > 6 Weeks	</=5%	15.5%	○	!
	Access to Cancer Care (Faster Diagnosis) < 28 days	≥75%	75.3%	○	✓
	Cancer First Treatment from Diagnosis < 31 days	≥96%	96.8%	▲	!
	Referral to Cancer Treatment Pathways < 62 days	≥85%	75.3%	▲	!
	Operating Plan and Capacity				
	Elective Inpatients (variance from target)	n/a	-10.1%	-	-
	Day Cases (variance from target)	n/a	17.6%	-	-
	Outpatient New Appointments (variance from target)	n/a	7.3%	-	-
	Theatre Utilisations (Hrs)	≥85%	85.4%	○	○
	Outpatient Transformation - PIFU	≥5%	3.8%	○	!
	Critical Care – Unoccupied Beds	≤85%	90.9%	○	○
	Patients Not meeting Criteria to Reside	n/a	688	-	-
	Workforce				
	Vacancy Rate	≤10%	6.0%	▲	✓
	Voluntary Turnover Rate	≤12%	8.2%	▲	✓
	Sickness Absence Rate	≤4%	4.1%	○	○
	Agency spend	≤2%	1.4%	○	○
	Non-medical appraisals	≥95%	91.6%	○	!
	Core skills compliance	≥90%	91.9%	○	○

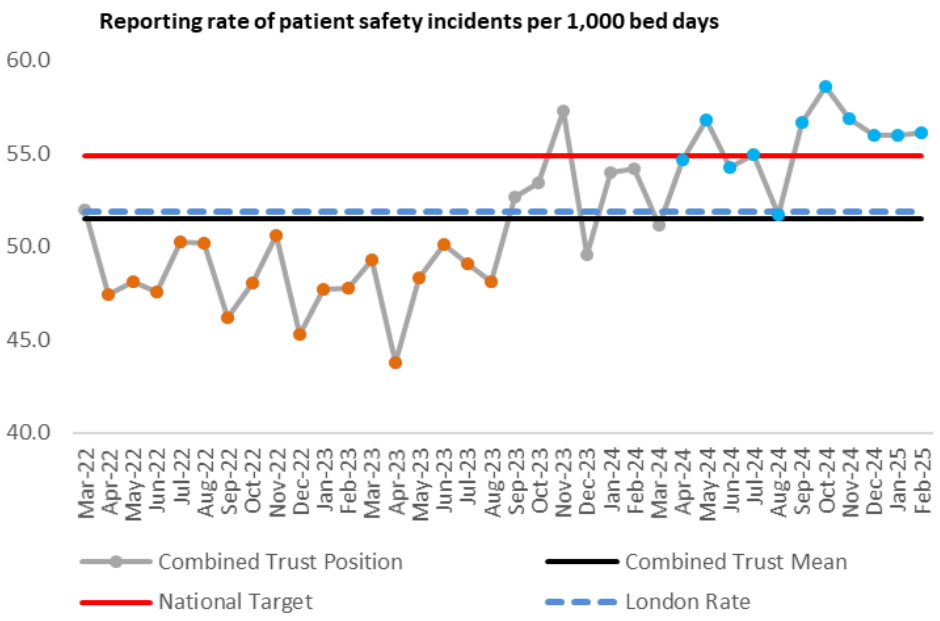
Patient Safety and Experience

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 narrative within this report has been updated to reflect February 2025 data.

Patient Safety Incidents

TREND



≥54.9

STANDARD

56.08

PERFORMANCE

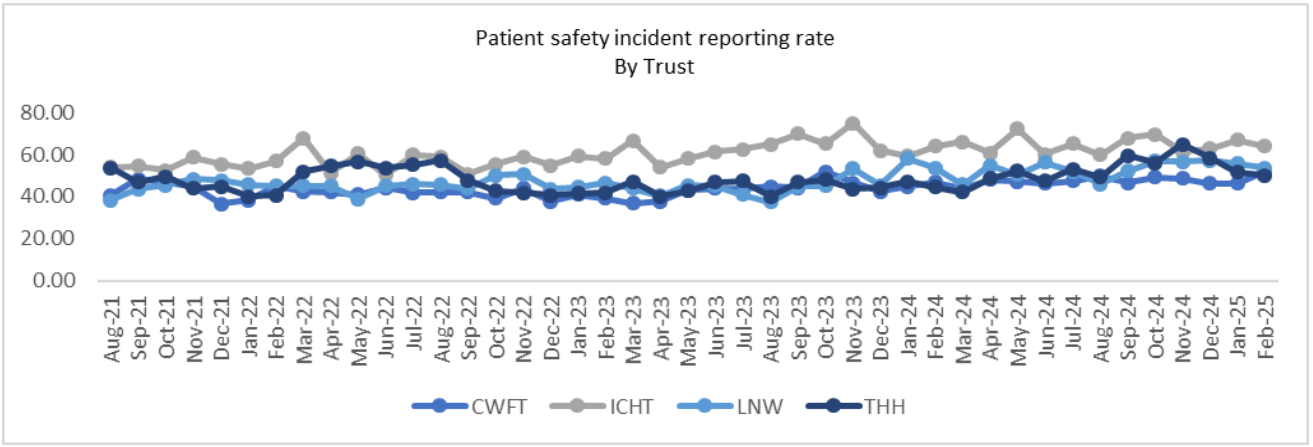
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total bed days (in month)	Patient safety incident reporting rate (in month)	Difference from Standard	Patient safety incidents reported (in month)	Number of severe and extreme harm incidents reported (in month)	% severe and extreme harm incidents (in month)	12 month rolling patient safety incident reporting rate	12 month rolling % of severe and extreme harm incidents
CWFT	23,709	51.88	-3.02	1,230	4	0.02%	48.08	0.18%
ICHT	30,752	64.09		1,971	5	0.02%	64.70	0.18%
LNW	29,335	53.69	-1.21	1,575	1	0.00%	53.07	0.06%
THH	12,757	50.09	-4.81	639	1	0.01%	52.64	0.30%
APC	**96,553**	**56.08**		**5,415**	**11**	**0.01%**	**55.30**	**0.19%**

STRATIFICATION



NARRATIVE

Performance: Incident reporting is an indicator of the safety culture, higher rates pointing to a willingness to speak up. The rate is variable, but showing improvement, and is above the standard (national average) in month and on the 12 month rolling data. ICHT met the standard in month. Increases have been reviewed and are partly linked to operational pressures. The percentage causing severe or extreme harm is below national average (0.40%) at APC level (in-month and rolling 12 month). Trusts continue to identify areas for improvement in response to themes and have examples of positive changes made. See following slide for examples.

Recovery Plan: All trusts are committed to increasing incident reporting by supporting staff to feel confident and comfortable to do so through various methods, including delivery of national and local training programmes in response to PSIRF, improved identification and sharing of learning, championing via local team meetings, safety huddles and relevant committees. At CWFT, the Safety Culture survey launched at the end of January to capture attitudes towards reporting and perceptions of safety culture to inform further improvements, this has been completed at other trusts in the past..

Improvements: Implementation of the new incident management system, recently approved, will support standardisation of processes and ensure the system is as user-friendly as possible. Staff regularly feedback that current systems are barriers to reporting.

Forecast Risks: Not applicable.

GOVERNANCE

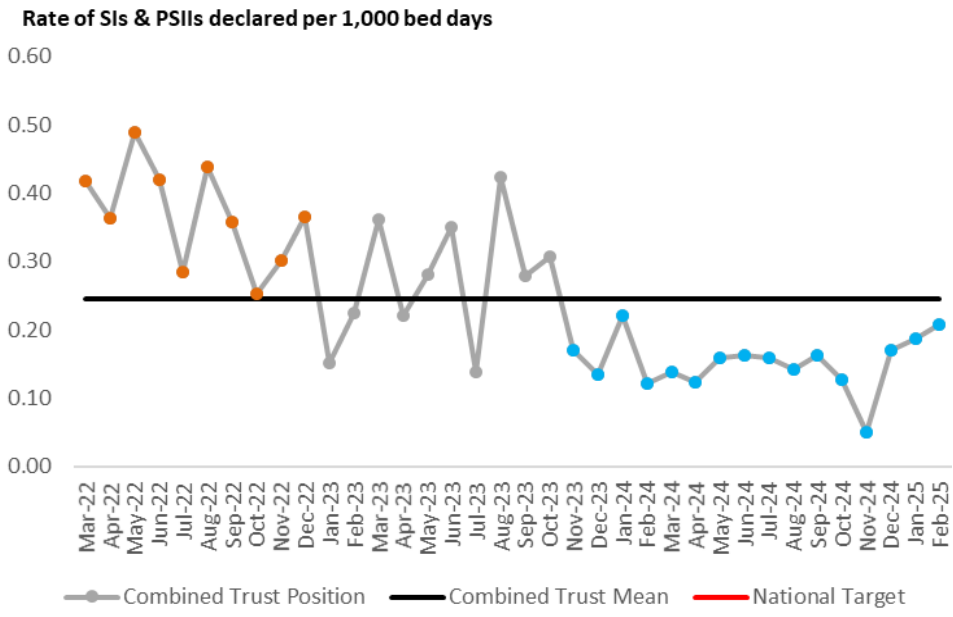
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Incidents reported on STEIS (SIs/PSIIs)

TREND



n/a

STANDARD

0.21

PERFORMANCE

L

TREND

ASSURANCE

NARRATIVE

Performance: The trend shows a reduction in the number declared as expected with PSIRF encouraging proportionate responses focused on opportunities for learning, with an increase in January and February driven largely by ICHT. Since this report was last presented to BiC 4 never events- have been reported, three wrong site procedures in ophthalmology (2 at THH and 1 at CWFT) and 1 retained swab in maternity at CWFT. PSIIs have been declared with immediate actions underway.

Recovery Plan: N/A

Improvements: Themes are regularly reviewed and used to identify local priorities and inform our Patient Safety Incident Response Plans (PSIRPs), which are currently being updated for 2025/26. Recent themes include:

- CWFT: in-month increase in falls with harm and pressure ulcers – being reviewed via the relevant safety improvement groups with oversight of actions through the Patient Safety Group.
- ICHT: Emerging themes include discharge medication accuracy and time critical medication administration which are being considered as possible safety improvement priorities for 25/26.
- LNW: treatment delays as a result of bed pressures. Improvement plans in place.
- THH: falls, pressure ulcers and bed availability due to site pressures. Improvement plans in place.

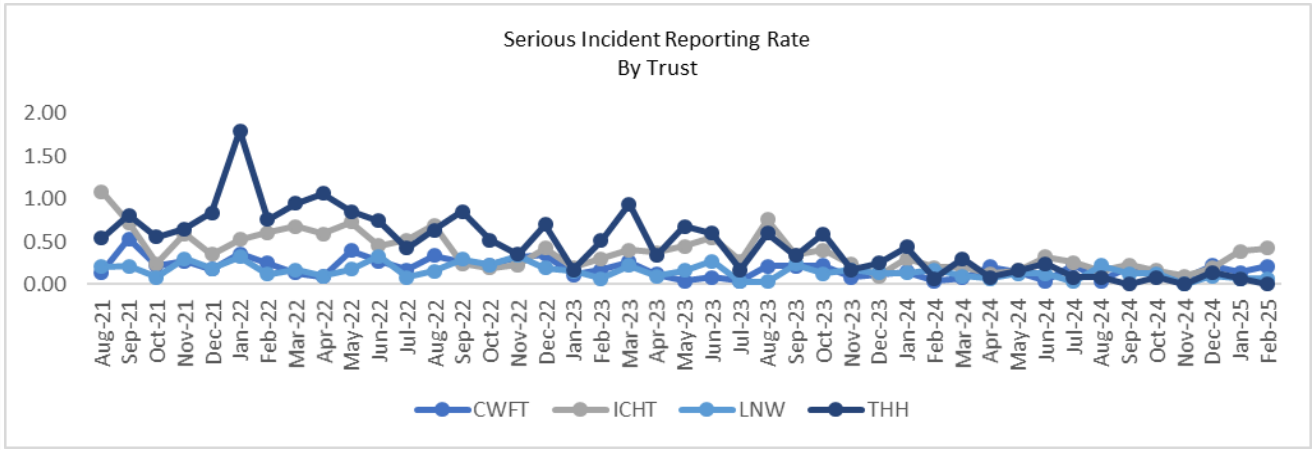
APC work streams continue for priority areas including care of the deteriorating patient and implementation of the new national safety standards for invasive procedures (which supports never event improvement).

Forecast Risks: Trusts are seeing delays in the learning response processes which are partly being caused by the learning curve and culture change that PSIRF requires. Local actions are underway with a focus on training and support for staff.

CURRENT PERFORMANCE

	Total bed days (in month)	In Month SIs & PSIIs	Reporting Rate	12 Month Rolling SIs & PSIIs	12 Month Rolling Reporting Rate
CWFT	23,709	5	0.21	44	0.14
ICHT	30,752	13	0.42	83	0.23
LNW	29,335	2	0.07	35	0.10
THH	12,757	0	0.00	16	0.11
APC	**96,553**	**20**	**0.21**	**178**	**0.15**

STRATIFICATION



GOVERNANCE

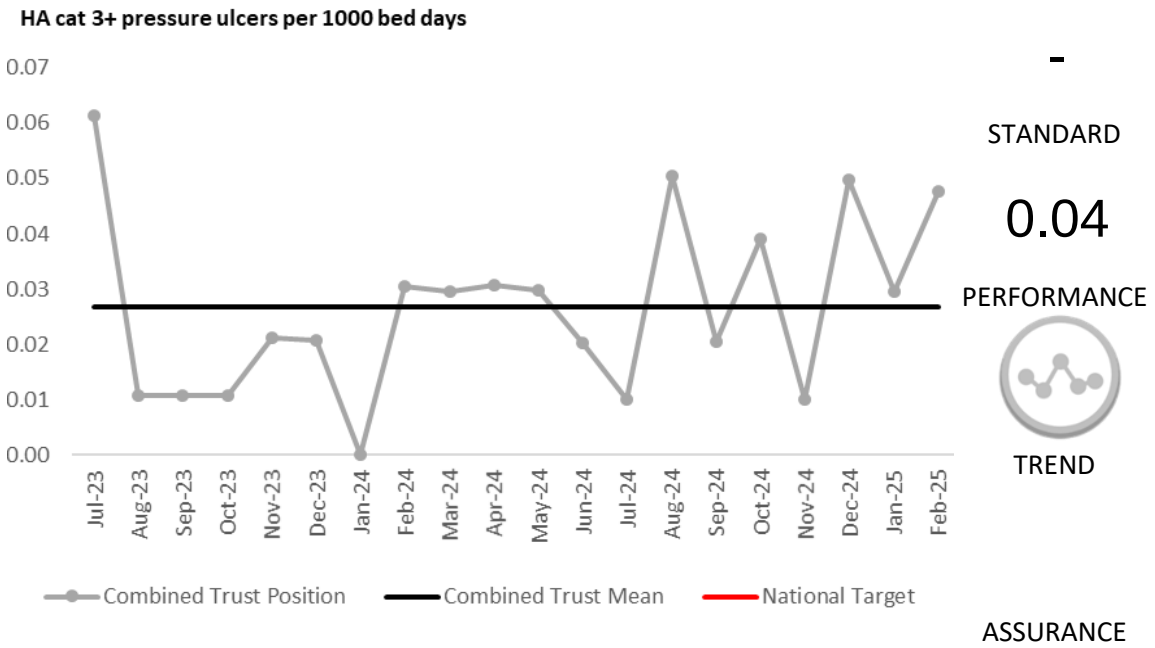
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Pressure Ulcers

TREND



-

STANDARD

0.04

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: This metric shows the rate of hospital acquired (HA) pressure ulcers graded as category 3 and 4. The figures are based on data reported in the Trusts' incident reporting systems, and the data is not risk adjusted. There were four reported in February 2025, 2 at CWFT and 2 at ICHT. No risks identified for escalation.

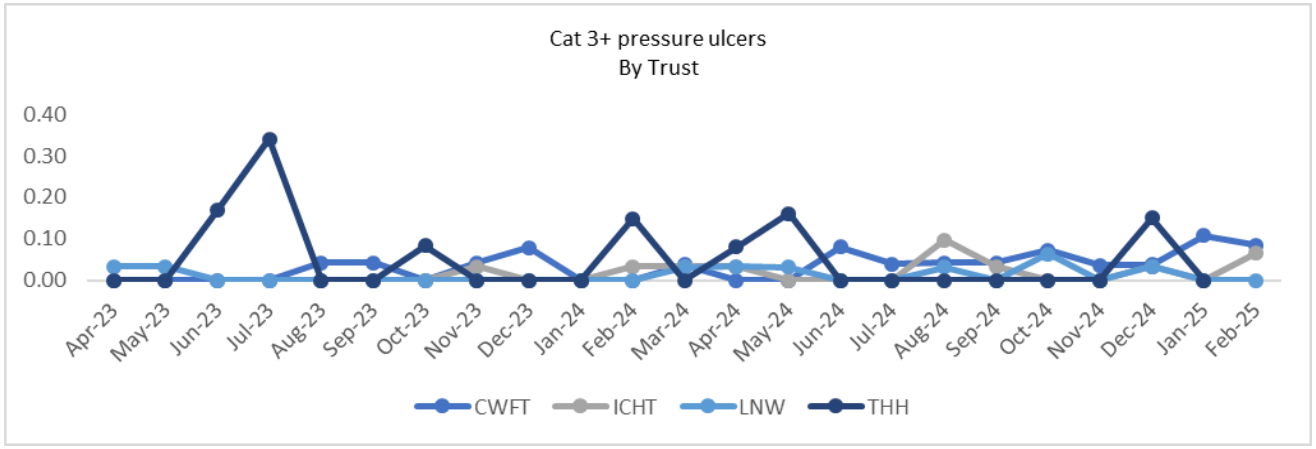
Improvements: The APC have reviewed and refreshed processes for pressure ulcer risk assessment. In quarter four all trusts completed the implementation of a single, evidence based risk assessment tool. Reducing variation will support portability of skills and knowledge.

Forecast Risks: There is on-going outreach underway with community services and borough partners.

CURRENT PERFORMANCE

	Total bed days	HA cat 3+ pressure ulcers per 1000 bed days (in month)	Number of HA cat 3+ pressure ulcers (in month)	12 month rolling number of HA cat 3+ pressure ulcers	12 month rolling rate of HA cat 3+ pressure ulcers per 1000 bed days
CWFT	23,709	0.08	2	15	0.05
ICHT	30,752	0.07	2	9	0.02
LNW	29,335	0.00	0	7	0.02
THH	12,757	0.00	0	5	0.04
APC	**96,553**	**0.04**	**4**	**36**	**0.03**

STRATIFICATION



GOVERNANCE

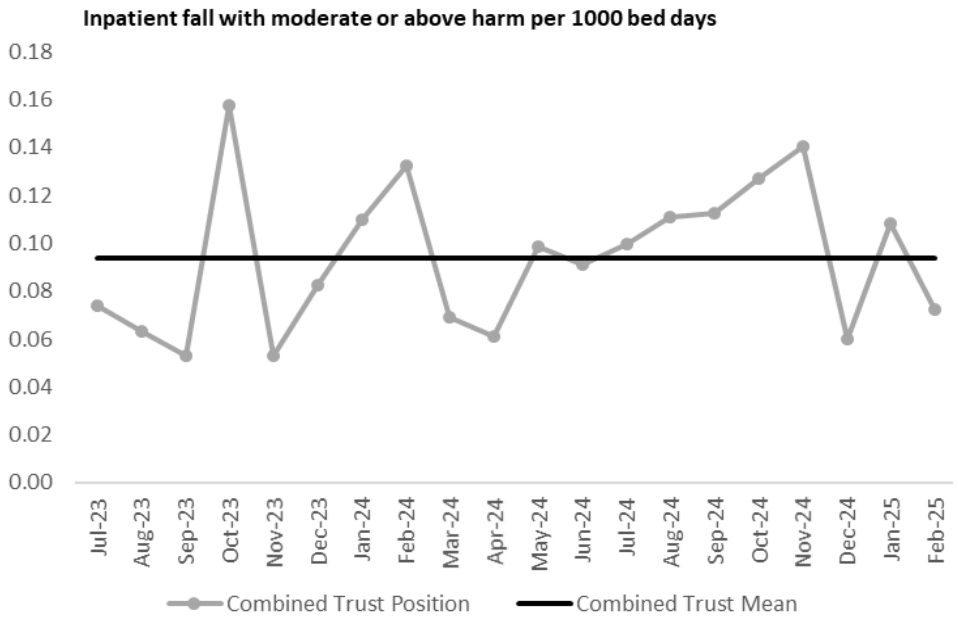
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Patient falls

TREND



-

STANDARD

0.07

PERFORMANCE

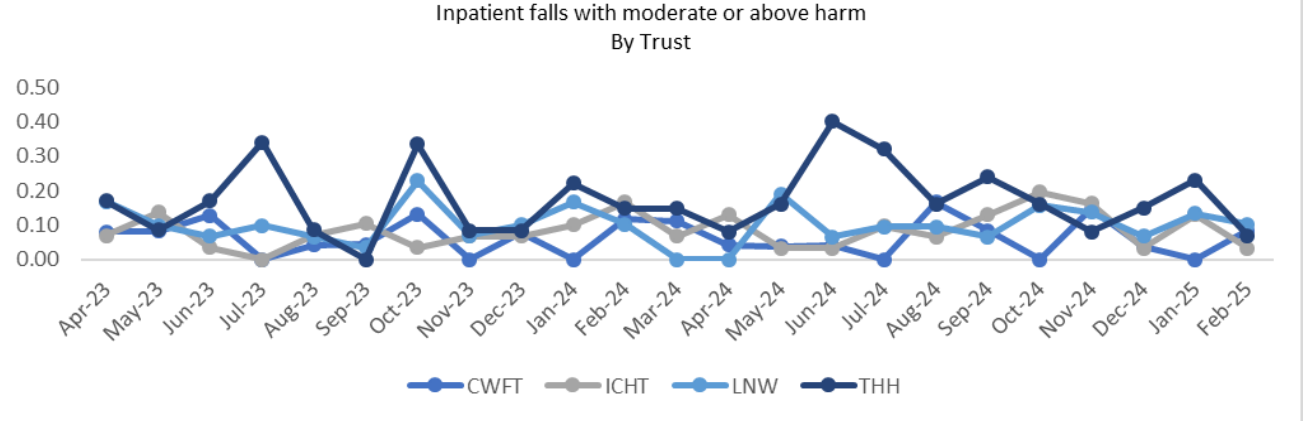
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total bed days (in month)	Inpatient falls with moderate or above harm per 1000 bed days (in month)	Number of inpatient falls with moderate or above harm (in month)	12 month rolling number of inpatient falls with moderate or above harm	12 month rolling rate of inpatient falls with moderate or above harm per 1000 bed days
CWFT	23,709	0.08	2	19	0.06
ICHT	30,752	0.03	1	34	0.09
LNW	29,335	0.10	3	34	0.09
THH	12,757	0.08	1	28	0.19
APC	**96,553**	**0.07**	**7**	**115**	**0.10**

STRATIFICATION



NARRATIVE

Performance: This new metric shows the rate of incidents reported where falls caused moderate or above harm to patients per 1000 bed days, which is consistently below 0.2 with small numbers overall. Data is not risk adjusted. National benchmarking data is not currently available. There was a small reduction in February, with 7 cases reported.

Recovery Plan: The cases are currently being reviewed via each organisation's PSIRP to identify learning which will feed into local safety improvement programmes.

Improvements: All Trusts have safety improvement programmes in place to support prevention of falls with harm, including specific projects with high falls frequency areas, thematic reviews and improvements to risk assessments. The APC deputy directors of nursing group are overseeing changes to the workflow in the electronic patient record so that this aligns to policy.

Forecast Risks: Not applicable.

GOVERNANCE

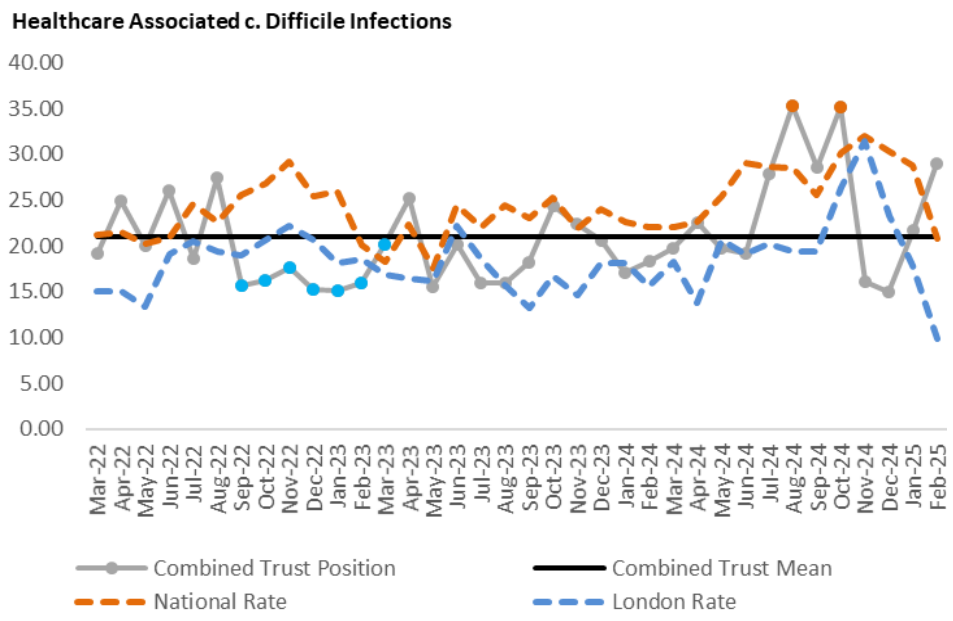
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Healthcare Associated C.Difficile Infections

TREND



Trust Specific

STANDARD

29.00

PERFORMANCE

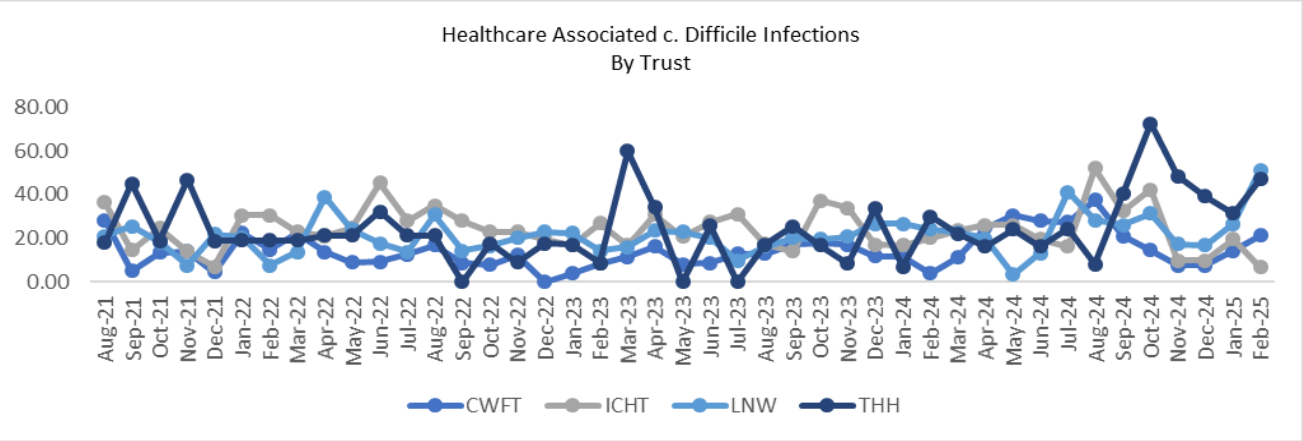
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total bed days (in month)	Count of c.Diff cases (in month)	Rate of c. Difficile Infections per 100,000 bed days (in month)	12 Month rolling rate of c. Difficile Infections per 100,000 bed days	Count of c.Diff cases in year (FY 24/25)	Trust Threshold (FY 24/25)	Difference from Threshold
CWFT	23,709	5	21.09	20.04	59	33	-26.0
ICHT	30,752	2	6.50	23.63	80	81	
LNW	29,335	15	51.13	24.71	84	75	-9.0
THH	12,757	6	47.03	32.39	46	26	-20.0
APC	**96,553**	**28**	29.00	**24.14**	**269**	**215**	**-54.0**

STRATIFICATION



NARRATIVE

Performance: In month there was an increase in cases reported across the APC (n=28). All Trusts except ICHT have exceeded their annual thresholds set by NHSE. All Trusts noted a period of significant increase during the summer. The drivers for this are not clear but there has been a general increase in cases reported across London, in hospitals and the community. There were more than twice as many cases reported in London in August 2024 compared to the same time last year.

Recovery Plan: All Trusts undertake **a** case review to determine if there have been any lapses in care or opportunities for improvement, this includes peer and ICB review. The recent increase at THH has been reviewed and there was no evidence of cross-transmission. Improvement work is underway using learning from case reviews. At ICHT the related policy has been reviewed to improve clarity on the actions to take when a case is suspected or identified, and the process for data collection and documentation in Cerner is being redesigned.

Improvements: There is ongoing work across all four trusts, as a collaborative and with system /ICB partners. Work is focussing on timeliness and appropriateness of sampling, isolating patients and strengthening guidance and policies. In addition there is further work to be done around completion of stool charts and early recognition and testing of cases.

Forecast Risks: The national annual epidemiological commentary (published 26/09/24) notes cases have increased by 33% since 2020/21. Given the rising infection rates nationally, all Trusts are likely to exceed their NHSE set IPC thresholds for 2024/25.

GOVERNANCE

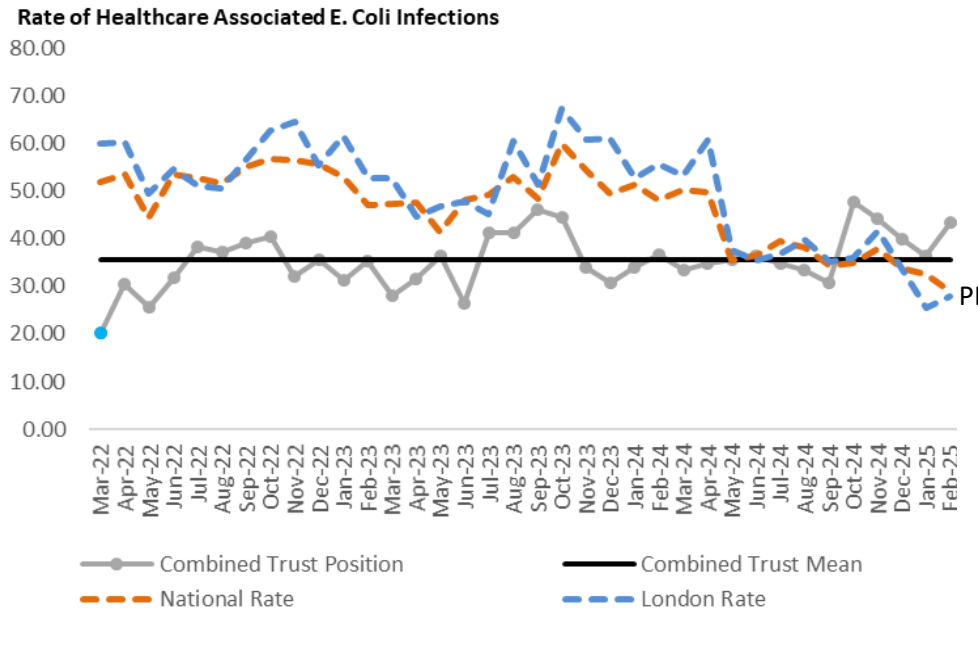
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Healthcare Associated E. coli Infections

TREND



Trust Specific

STANDARD

43.50

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: At APC level, the chart shows a small increase in February, with 42 cases reported. LNW and THH have now exceeded the annual threshold set by NHSE. Some of the increases have been linked to urinary tract infections with working groups in place in both trusts in response.

Recovery Plan: The ICB is focused on reduction of E.coli BSIs in line with the NHS Long Term Plan. A regular ICS-led Gram-negative blood stream infection meeting is in place to drive improvement as a significant proportion are attributed to community acquisition. It is important that there is a greater understanding of the risk factors for those attributed to acute organisations. Reduction therefore requires a whole health economy approach. Each organisation reviews their Gram-negative blood stream infections, with some organisations having a working group in place, and present their improvement plan at the ICS group, analysing trends and local risk factors that they are working on with clinical colleagues. There is also a project underway in conjunction with NWLP to review urinary tract infection and pathogen epidemiology.

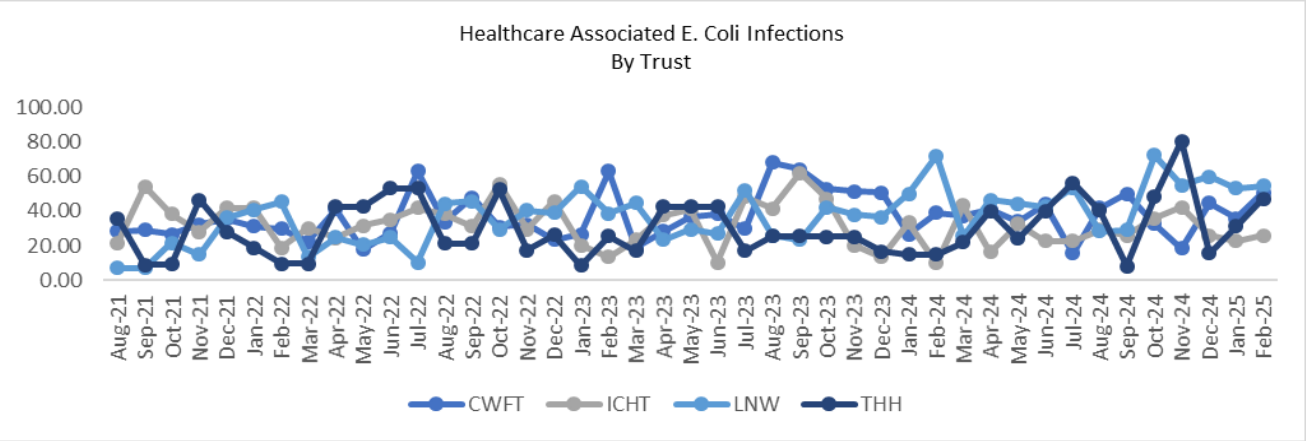
Improvements: Impact of actions taken through local and ICS reduction plan are monitored in each Trust and reported through the GNB BSI ICS group and APC group.

Forecast Risks: Between 2022/23 and 2023/24, national rates of E. Coli saw the largest annual increase since surveillance began. Given the rising infection rates nationally, all Trusts are likely to exceed their NHSE set IPC thresholds for 2024/25.

CURRENT PERFORMANCE

	Total bed days (in month)	Count of E.Coli BSIs in month	Rate of E. Coli Infections per 100,000 bed days (in month)	12 Month rolling rate of E. Coli Infections per 100,000 bed days	Count of E.Coli BSIs in year (FY 24/25)	Trust Threshold (FY 24/25)	Difference from Threshold
CWFT	23,709	12	50.61	36.85	104	120	
ICHT	30,752	8	26.01	28.79	93	116	
LNW	29,335	16	54.54	46.99	165	132	-33.0
THH	12,757	6	47.03	37.68	54	39	-15.0
APC	**96,553**	**42**	43.50	**37.60**	**416**	**407**	**-9.0**

STRATIFICATION



GOVERNANCE

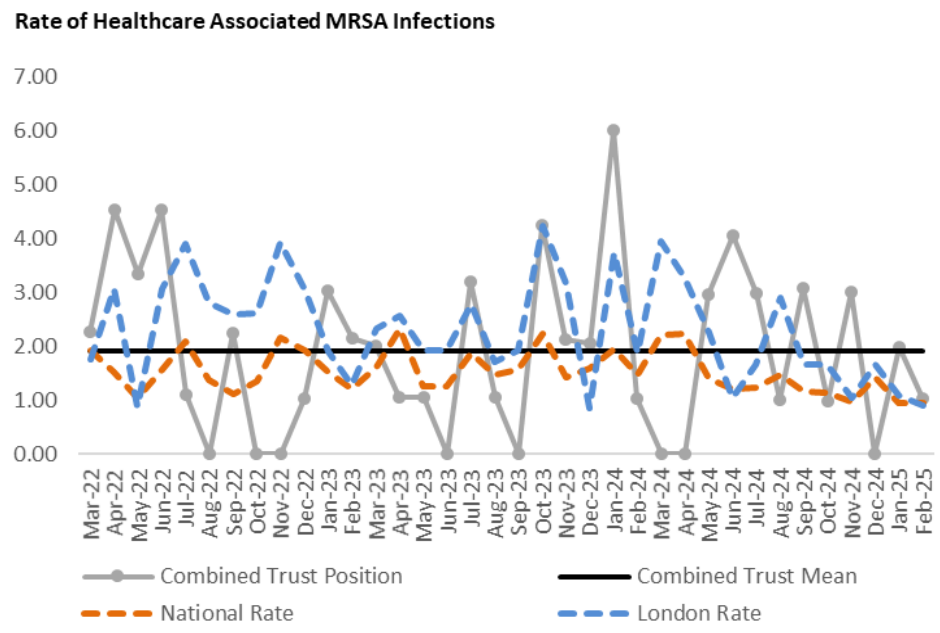
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Healthcare Associated MRSA Infections

TREND



0

STANDARD

1.04

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: There was one MRSA BSIs reported in February across the APC. The total number this financial year is 21 against a threshold of 0. The largest number of cases (n=8) have been reported at ICHT. The national annual epidemiological commentary (published 26/09/24) shows that nationally rates have increased incrementally by 14.3% since 2019/20 after a sustained period of stability, with rates in 2023/24 reaching levels last seen in 2013/14.

Recovery Plan: Robust processes for managing and investigating cases, and on-going improvement work are in place, with a focus on improving routine IPC practice, audits, screening and decolonisation. All cases are reviewed to identify any lapses in care or learning opportunities. All organisations are focussing on improving line care and hand hygiene compliance, with a new bacteraemia reduction group set up at ICHT focusing on effective MRSA eradication post surveillance, practice auditing, feedback and improvement plans focused on care of invasive lines. The APC group is also reviewing MRSA screening to understand where there are opportunities for standardisation.

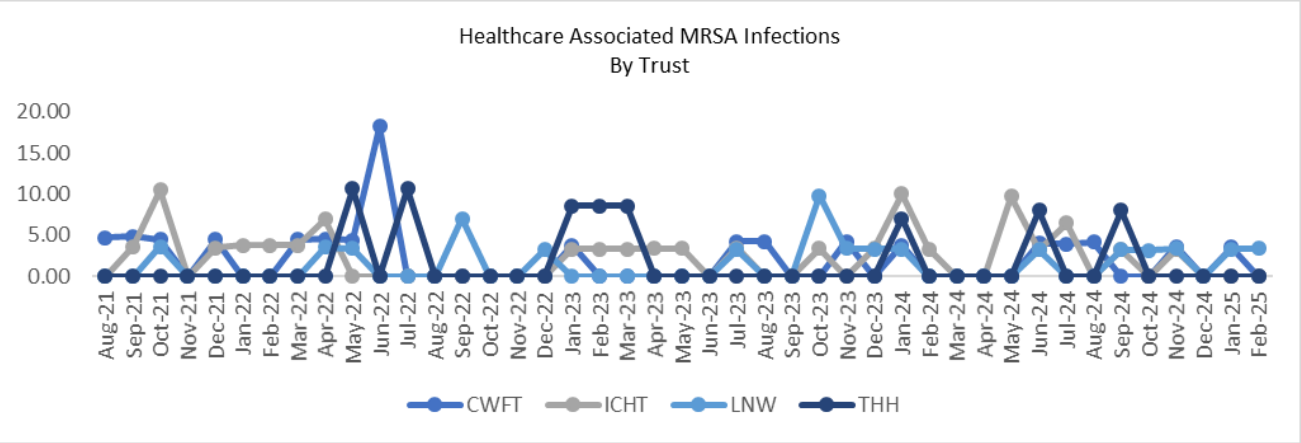
Improvements: A review of these cases will feed into the APC priority workstream to support identification of collective action or learning. Each trust has improvement work in place in response to these infections, the outcomes of which will report into the APC workstream and any shared learning planned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

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Total bed days (in month)	Count of MRSA BSIs in month	Rate of MRSA Infections per 100,000 bed days (in month)	12 Month rolling rate of MRSA Infections per 100,000 bed days	Count of MRSA BSIs in year (FY 24/25)	Trust Threshold (FY 24/25)	Difference from Threshold
CWFT	23,709	0	0.00	1.62	5	0	-5.0
ICHT	30,752	0	0.00	2.17	8	0	-8.0
LNW	29,335	1	3.41	1.63	6	0	-6.0
THH	12,757	0	0.00	1.32	2	0	-2.0
APC	**96,553**	**1**	1.04	**1.75**	**21**	**0**	**-21.0**

STRATIFICATION



GOVERNANCE

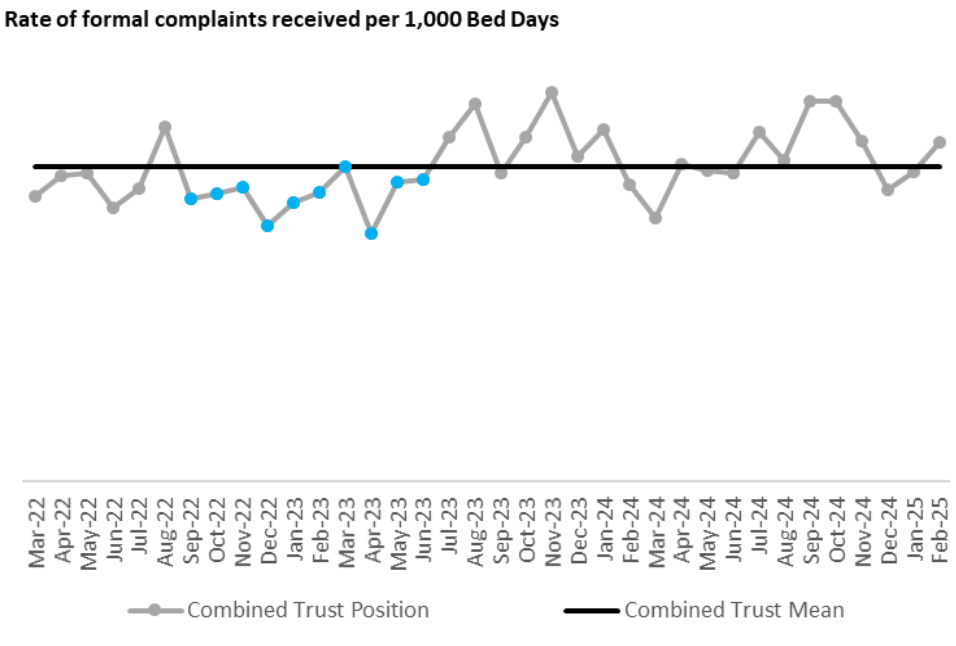
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Formal Complaints

TREND



n/a

STANDARD

2.82

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: The trend graph shows a small increase in month, in line with standard variation. Rates have been calculated per 1,000 bed days following agreement at APC quality committee and to bring this in line with other metrics reported in this dashboard. Rates vary at trust level, with ICHT having the highest rate in month and across the last 12 months. Each trust monitors complaint performance and activity. Data on completion of responses has been added to this dashboard to allow closer monitoring of performance. This demonstrates that currently ICHT takes the longest time to complete responses and has the highest number open for more than 90 working days (N.B. CWFT, LNW and THH report to first response while ICHT reports to final response, taking into account any re-opened complaints).

Recovery Plan: Not applicable

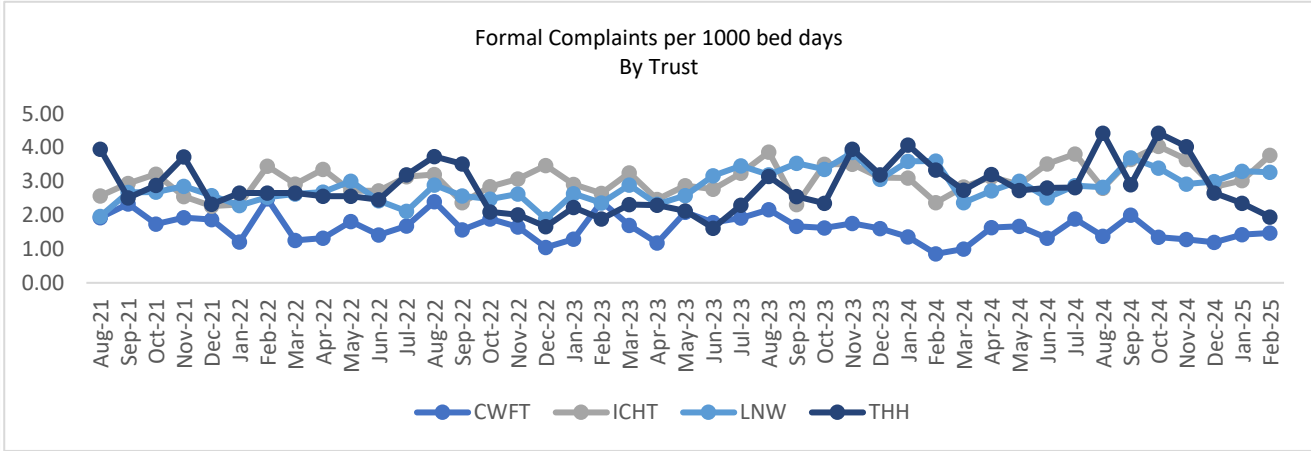
Improvements: Quarterly reporting on APC level complaints data and themes to APCQC is in place. This continues to demonstrate differences between how individual trusts are reporting performance, outcomes and themes from complaints making comparison difficult. This is under review and will be standardised where possible to allow for identification of APC level learning and actions.

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Total bed days (in month)	Rate per 1,000 bed days	Count of Patient Complaints	12 Month Rolling Rate per 1,000 bed days	Average days to complete responses	Number of open complaints >90 days
CWFT	23,709	1.48	35	1.46	27	2
ICHT	30,752	3.77	116	3.33	43	6
LNW	29,335	3.27	96	2.99	39	3
THH	12,757	1.96	25	3.08	35	N/A
APC	**96,553**	**2.82**	**272**	**2.71**	**36**	**11**

STRATIFICATION



GOVERNANCE

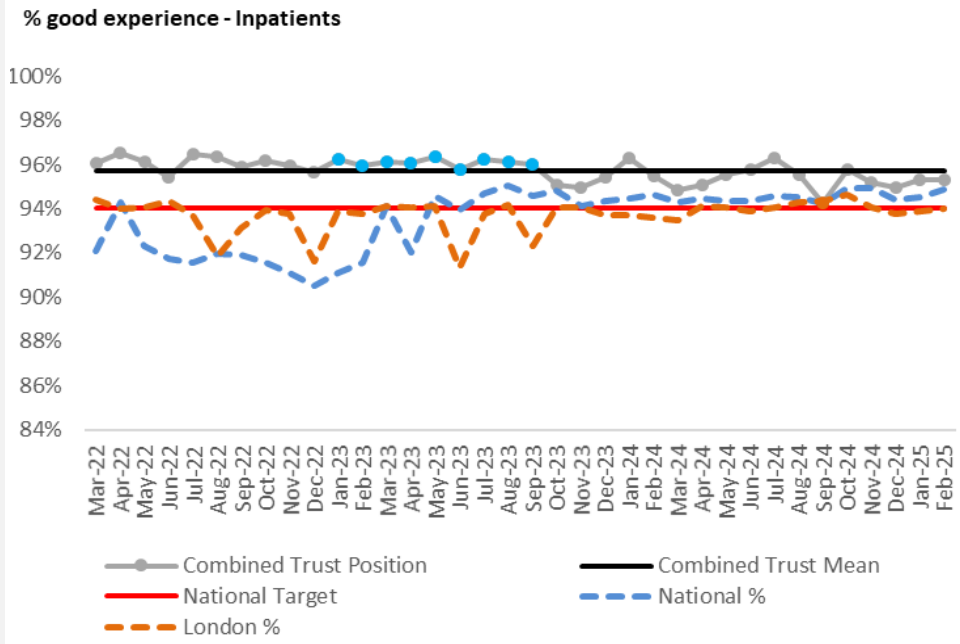
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Inpatient Friends & Family Test

TREND



94%

STANDARD

95.3%

PERFORMANCE

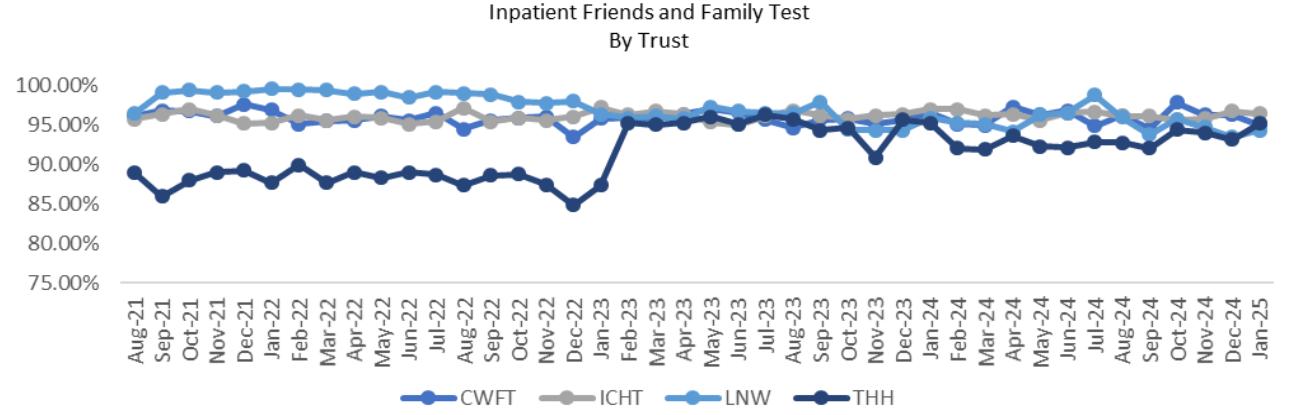
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	869	95.3%		828	96.0%
ICHT	2,790	96.8%		2,702	96.3%
LNW	3,135	94.4%		2,960	95.3%
THH	1,009	93.7%	-0.3%	945	93.2%
APC	**7,803**	**95.3%**		**7,435**	**95.3%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of inpatients reporting a good experience has consistently been above target and above national and London average. All trusts except THH were above the standard in month.

Recovery Plan: Not applicable

Improvements: A joint procurement plan for a patient survey platform is now in place, which will support better identification of areas for collaborative improvement once implemented.

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

GOVERNANCE

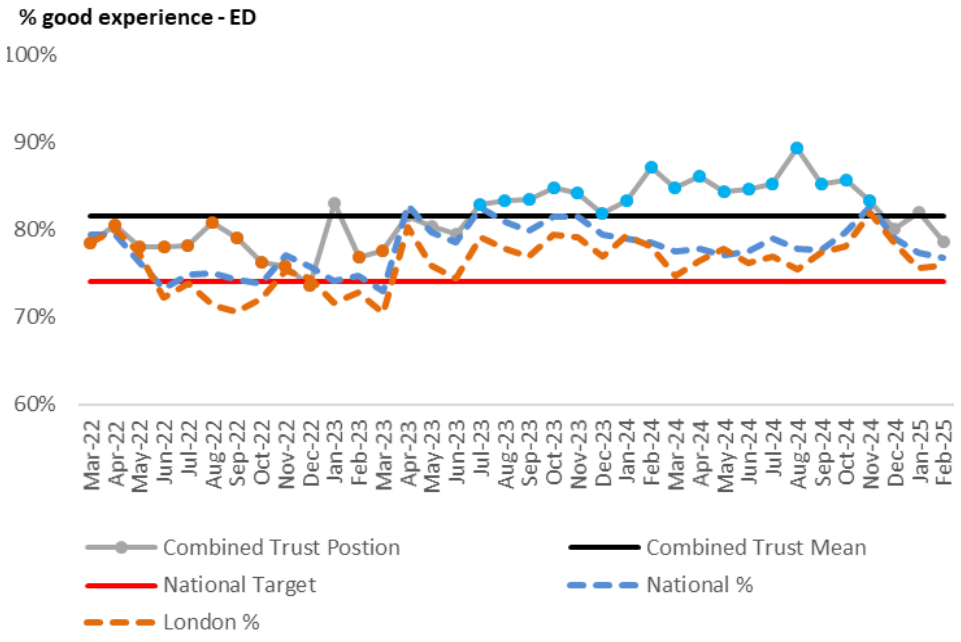
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Emergency Dept Friends & Family Test

TREND



74%

STANDARD

78.6%

PERFORMANCE

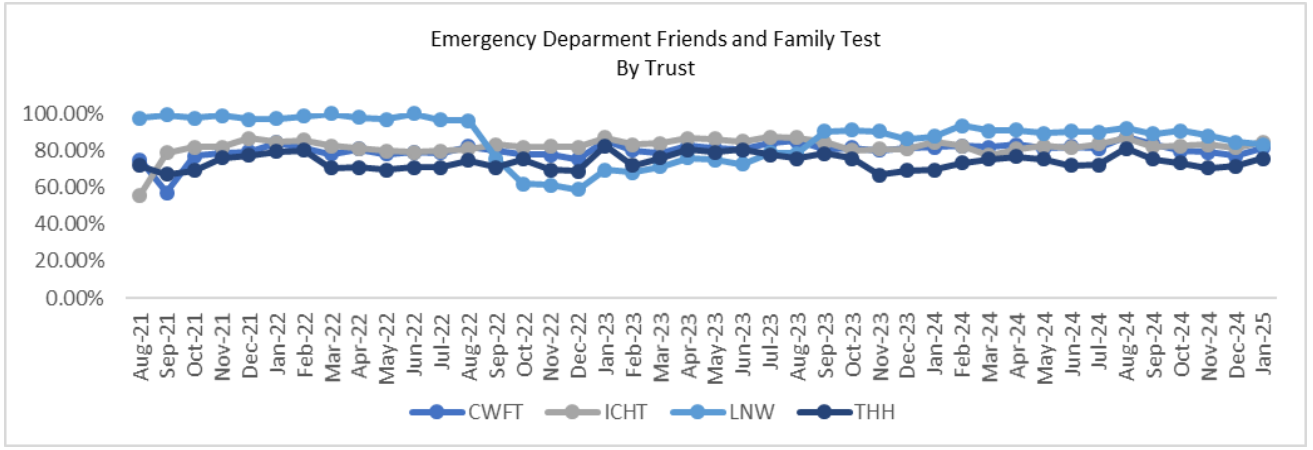
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	1,661	78.3%	[illegible]	1,301	81.5%
ICHT	1,278	82.9%	[illegible]	1,060	82.5%
LNW	1,723	78.8%	[illegible]	1,358	89.3%
THH	714	70.7%	-3.3%	505	74.2%
APC	**5,376**	**78.6%**	[illegible]	**4,224**	**84.5%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of patients accessing our emergency departments who report a good experience has been consistently above standard since January 2023, with a long recent period of special cause improving variation. There has been a slight reduction over the last three months, likely linked to operational pressures. All Trusts except THH met the standard in February 2025.

Recovery Plan: Not applicable.

Improvements: N/A

Forecast Risks: Continued operational pressures resulting in longer waits in ED may have a detrimental impact on patient experience.

GOVERNANCE

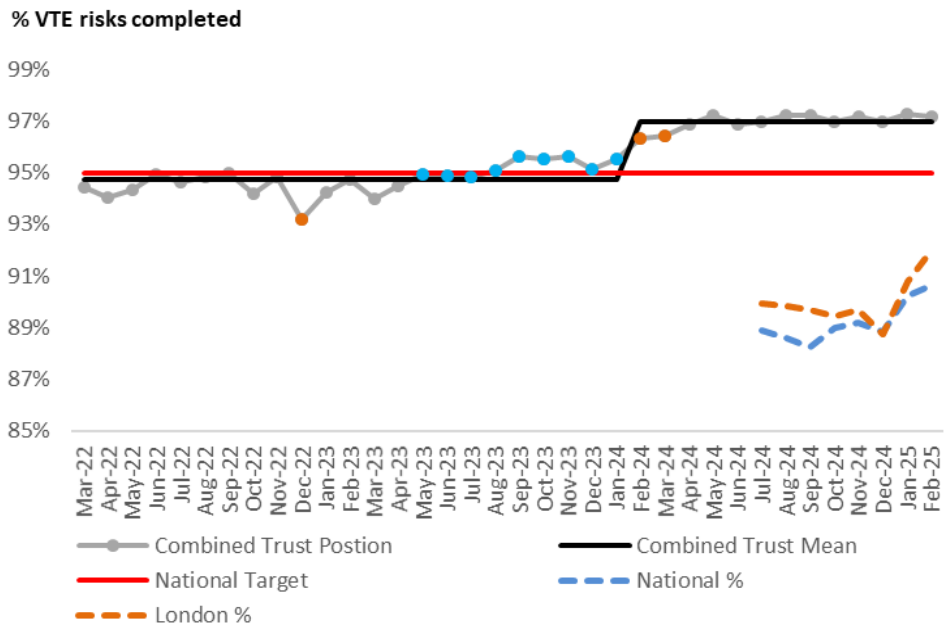
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

VTE Risk Assessments Completed

TREND



95%

STANDARD

97.2%

PERFORMANCE

H

TREND

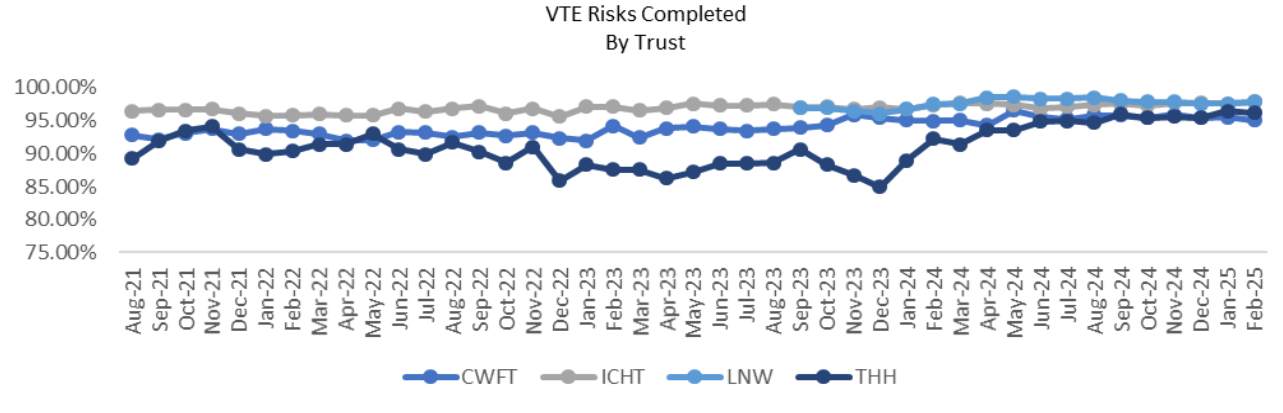
P

ASSURANCE

CURRENT PERFORMANCE

	Total Inpatient Admissions	VTE Risk Assessments	Difference from Target	Count of Inpatients With Completed Risk Assessments	12 Month Rolling VTE Risk Assessments
CWFT	6,825	95.0%		6,487	95.4%
ICHT	15,410	97.8%		15,074	97.4%
LNW	12,632	97.8%		12,353	98.0%
THH	3,494	96.2%		3,361	95.0%
APC	**38,361**	**97.2%**		**37,275**	**97.0%**

STRATIFICATION



NARRATIVE

Performance: Benchmarking data from June 2024 onwards is now available for this metric and shows we are performing considerably better than the London and national rates.

LNW and THH are now reporting directly from Cerner which had resulted in an improvement at APC level. We are above the standard in month and across the last 12 months in all Trusts.

Recovery Plan: Not applicable

Improvements: Not applicable

Forecast Risks: Not applicable

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.

Mortality

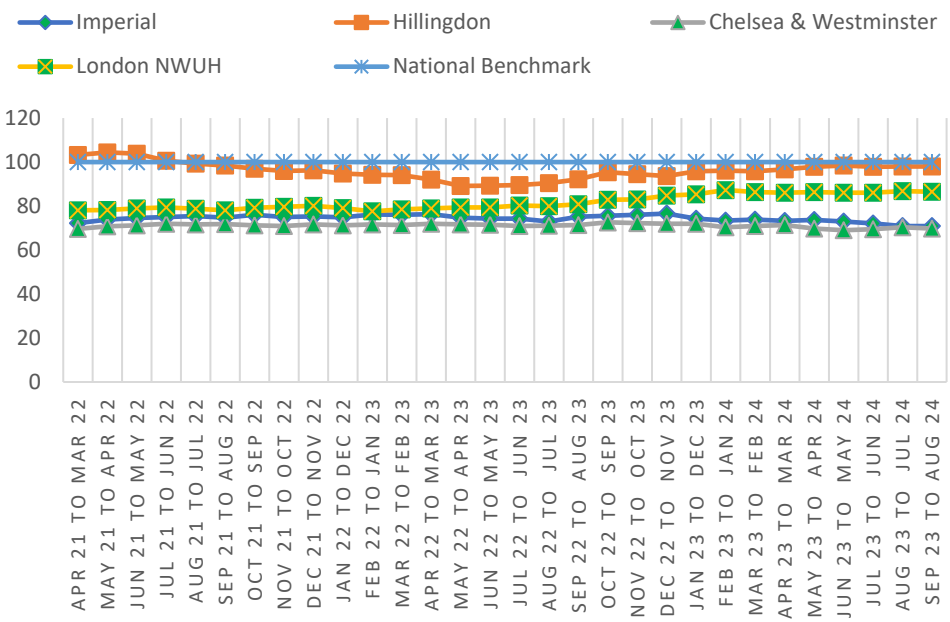
Two separate statistical models are monitored: the Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Rate (HSMR).

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'.

HSMR is a summary mortality indicator. It is based on a subset of 41 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, deprivation, month of admission, method of admission, admission source, number of previous emergency admissions and discharge year. The indicator no longer adjusts for palliative care within the model (in line with SHMI). 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.

Summary Hospital-level Mortality Index

TREND



100
England Average

STANDARD

98.02

PERFORMANCE

n/a

TREND

n/a

ASSURANCE

NARRATIVE

Performance: For three of the four trusts (CWFT, LNW and ICHT), the rolling 12-month SHMI remains lower than expected with the most recent data available (August 2023 – July 2024). THH's rate is consistently 'as expected'.

Recovery Plan: Not applicable.

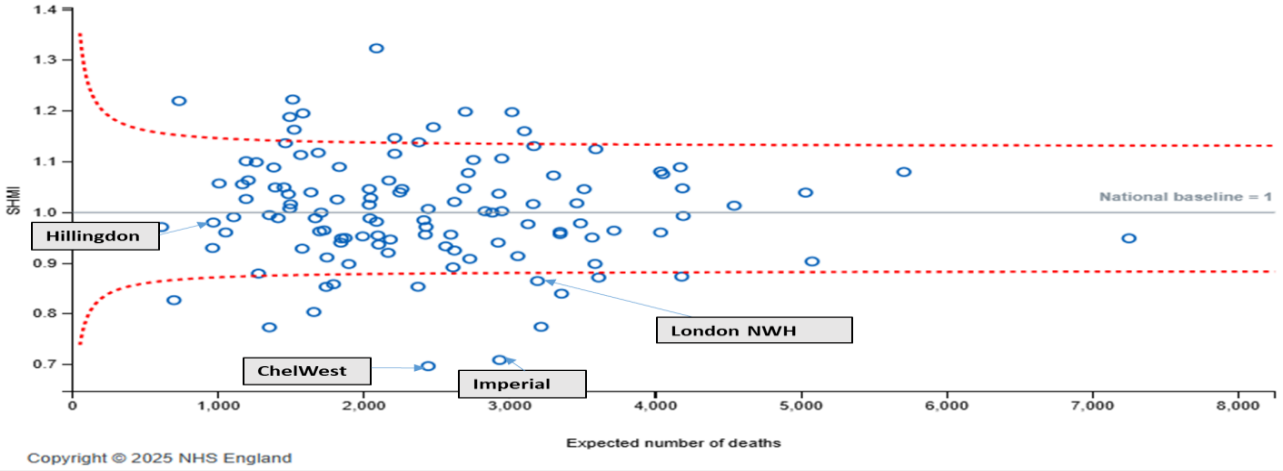
Improvements: All Trusts investigate variations between observed and expected deaths by diagnostic group. Reviews for quarter three were summarised in the learning from deaths report presented to APCQC and BiC with no issues to escalate.

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	102805	69.70	Lower than expected
ICHT	115340	70.91	Lower than expected
LNW	106505	86.49	Lower than expected
THH	49685	98.02	as expected

STRATIFICATION

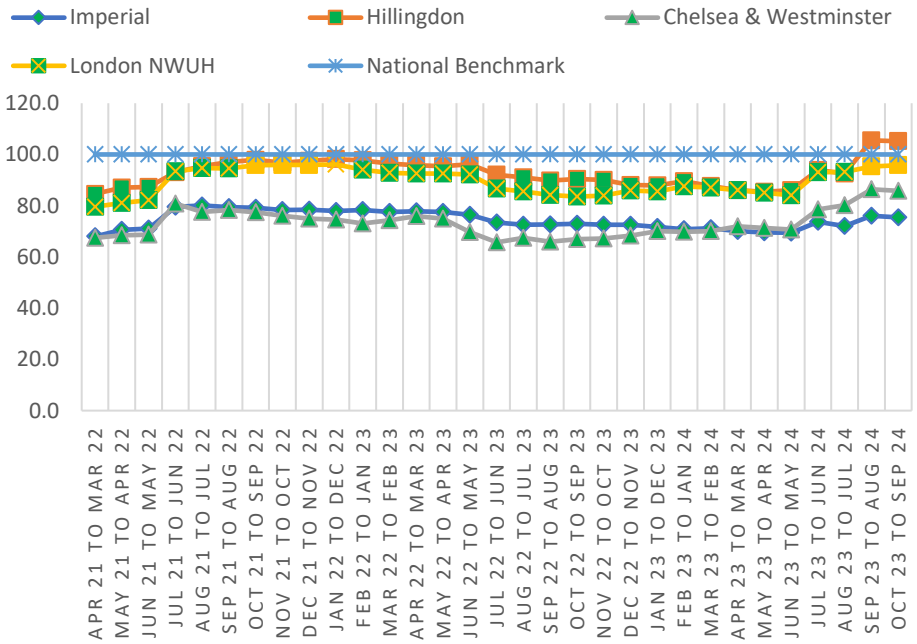


GOVERNANCE

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

Hospital Standardised Mortality Ratio

TREND



100

England Average

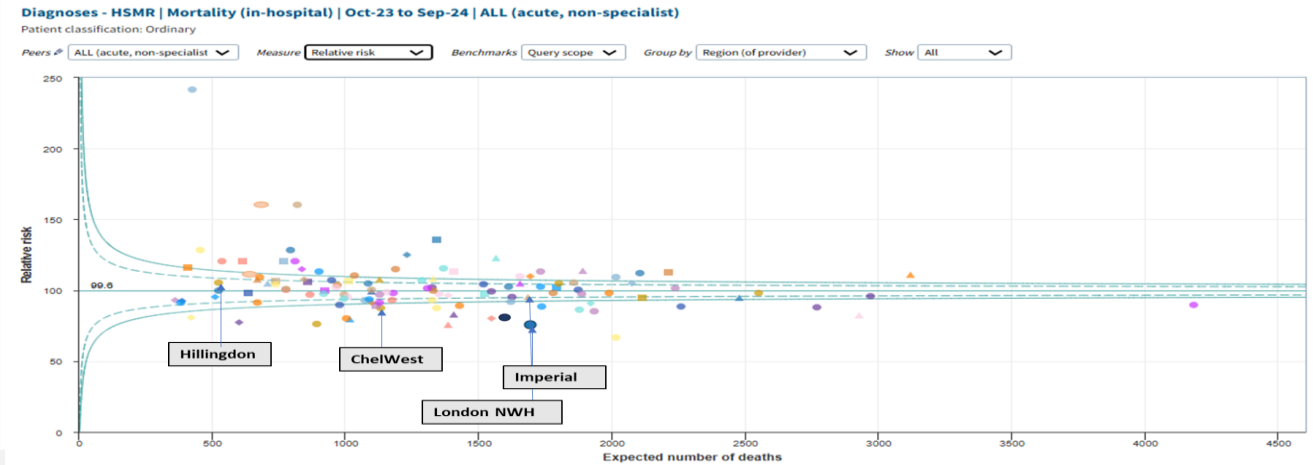
STANDARD

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

CURRENT PERFORMANCE

	Provider Superspells	HSMR	HSMR- relative risk ranking
CWFT	43595	85.8	Lower than expected
ICHT	49047	75.4	Lower than expected
LNW	47863	95.8	as expected
THH	19613	105.2	as expected

STRATIFICATION



NARRATIVE

Performance: Changes have been made nationally to the HSMR methodology which includes removal of the adjustment for palliative care coding and changes in the diagnostic groupings which make up the ratio. As expected this has resulted in increases in HSMR in all four trusts, and in most providers nationally. THH has increased above the national benchmark of 100, and LNW has moved to 'as expected'. CWFT and ICHT remain lower than expected. Rankings for CWFT, ICHT and LNW have not changed significantly, however THH has dropped to 78th.

Recovery Plan: The impact of the changes is being reviewed by each Trust, and within the APC mortality surveillance group. Potential issues with coding have been identified by LNW and THH. This is being reviewed to ensure accuracy.

Improvements: All Trusts investigate variations between observed and expected deaths by diagnostic group. Reviews for quarter three were summarised in the learning from deaths report presented to APCQC and BiC with no issues to escalate.

Forecast Risks: N/A

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Maternity

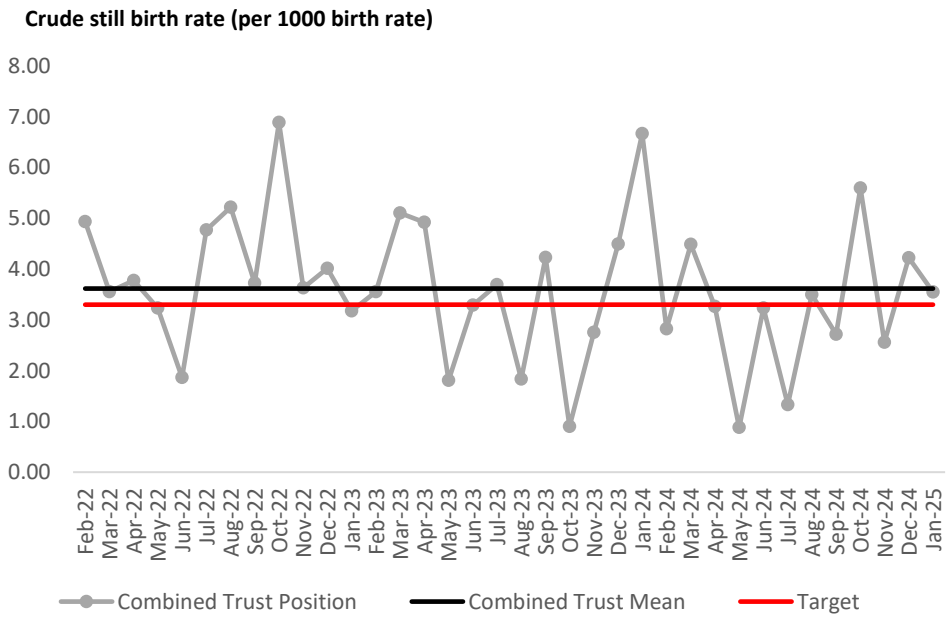
January 2025

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.

Following agreement at the APC quality meeting, which is chaired by the CEO for LNW as executive lead for quality across the APC, changes have been made to the narrative for this section to focus more on themes and learning across the APC, rather than on individual cases. This will support improved reporting on progress with actions underway to make improvements going forward.

Crude still birth rate (per 1000 births)

TREND



3.3

STANDARD

3.5

PERFORMANCE

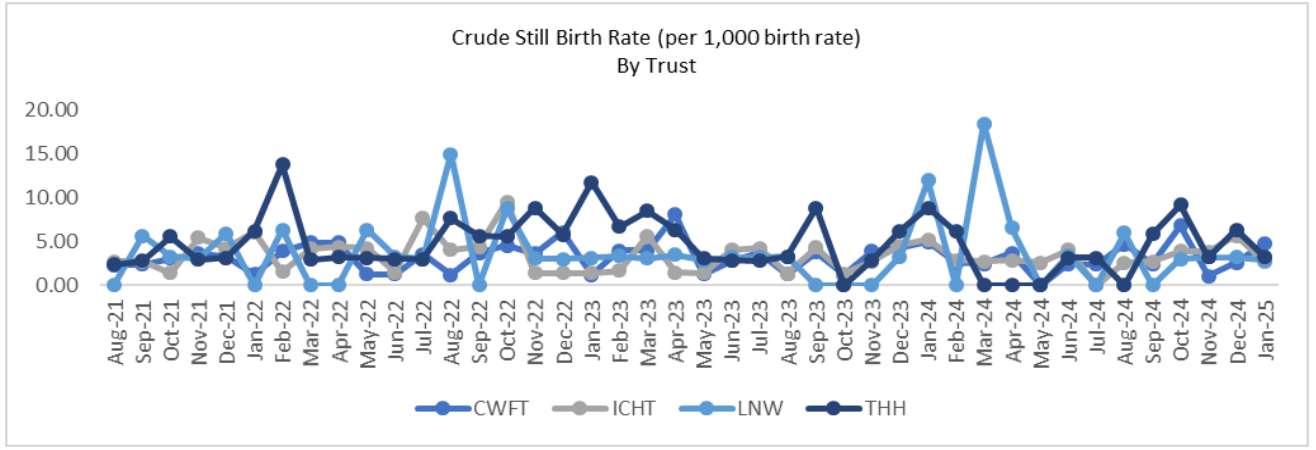
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total Births	Total Still Births & Late Fetal Losses	Total Still Births	Total Late Fetal Losses	Crude Still Birth Rate	Crude Still Birth Rate FYTD	Difference from Standard
CWFT	835	4	4	0	4.8	3.1	1.49
ICHT	759	2	2	0	2.6	3.1	
LNW	349	1	1	0	2.9	2.8	
THH	312	2	1	1	3.2	3.4	
APC	**2255**	**9**	**8**	**1**	**3.5**	**3.1**	**0.25**

STRATIFICATION



NARRATIVE

Performance: The rate is based on stillbirths at 24+ weeks. Data on late fetal losses (between 22+ and 23+6 weeks) is included in the table for information and monitoring. The APC stillbirth rate was above the standard in month but is below financial year to date.

Recovery Plan: All cases are investigated via the Perinatal Mortality Review Tool (PMRT) to identify local learning & actions. Service level reviews of 23/24 stillbirths & local action plans are in place. From the combined review across the APC the following improvement actions are in place as agreed at the January Q&S meeting which include further screening for those at greatest risk (review of the fetal medicine foundation tools), review of translation tools and implementing the maternal reducing inequalities care bundle with 4 areas of focus (interpretation/translation, vitamin D, timely access to antenatal care and response to RFM) which is being developed for London and will be launched in June 2025. THH implemented Interpreter on Wheels 4 months ago to support the language needs of their local population. Evaluation at 4 months positive - 99 video calls/1246 audio calls (39 languages used) staff feedback positive.

Improvements: All trusts are working towards full achievement of Saving Babies' Lives Care Bundle version 3 (ICB assessed position in March at the time of submitting MIS was 86% for CWFT and THH 43%, 93% for LNW and 86% for ICHT- working group across the LMNS defining progress trajectories with each organisation). The NWL fetal growth restriction guidance has recently been updated to include an updated risk assessment for Aspirin.

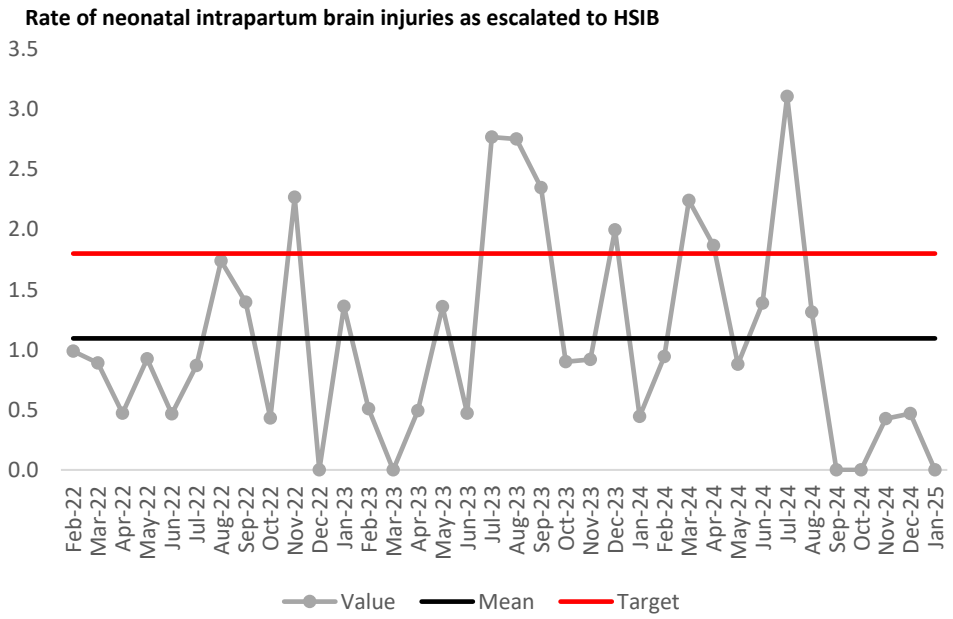
Forecast Risks: N/A

GOVERNANCE

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

Rate of suspected neonatal intrapartum brain injuries

TREND



1.8

STANDARD

0.00

PERFORMANCE

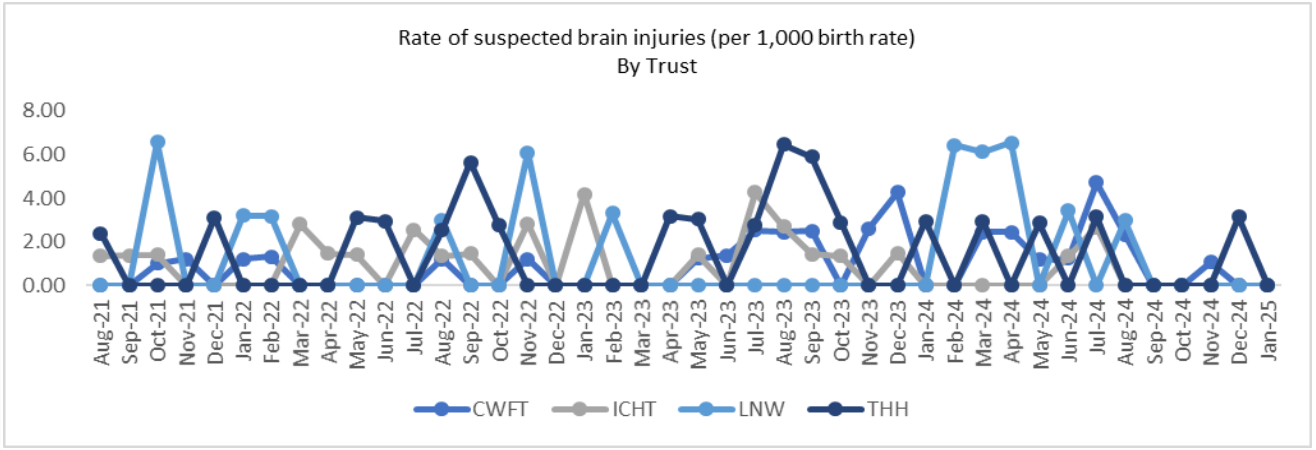
TREND

ASSURANCE

CURRENT PERFORMANCE

	Total Births	Suspected Brain Injuries in Month	Rate of suspected brain injuries	Suspected Brain Injuries FYTD	Rate of Suspected Brain Injuries FYTD
CWFT	835	0	0.00	11	1.30
ICHT	759	0	0.00	3	0.40
LNW	349	0	0.00	4	1.25
THH	312	0	0.00	3	0.93
APC	**2255**	**0**	**0.00**	**21**	**0.94**

STRATIFICATION



NARRATIVE

Performance: At APC level we are below the standard financial year to date. There were no cases of suspected intrapartum brain injury meeting the definition in January 2025. Of the 11 cases across CWFT 5 babies have had normal MRIs, 2 have moderate Hypoxic Ischaemic Encephalopathy (HIE) and 4 have severe HIE (5 of these cases went on to be reported as neonatal deaths).

Recovery Plan: Phase 2 of embedding the escalation quality improvement project at CWFT is in progress and is being rolled out to the neonatal services with a launch date of April 25. In addition, a change in practice to move to physiological fetal monitoring interpretation will be implemented in Spring 2025 and the digital tool has now been set up to support physiological testing and is going through the UAT process.

Improvements: All services have undertaken a review of their cases for 23/24**.** The top three themes identified are: clinical care and decision making, escalation / situational awareness and fetal heart monitoring and escalation. Actions have been agreed at the January's MNQPSG meeting. The areas of focus for the system are streamlining fetal monitoring practices and reviewing the escalation toolkit from CWFT with the aim to implement on all sites.

Forecast Risks: N/A

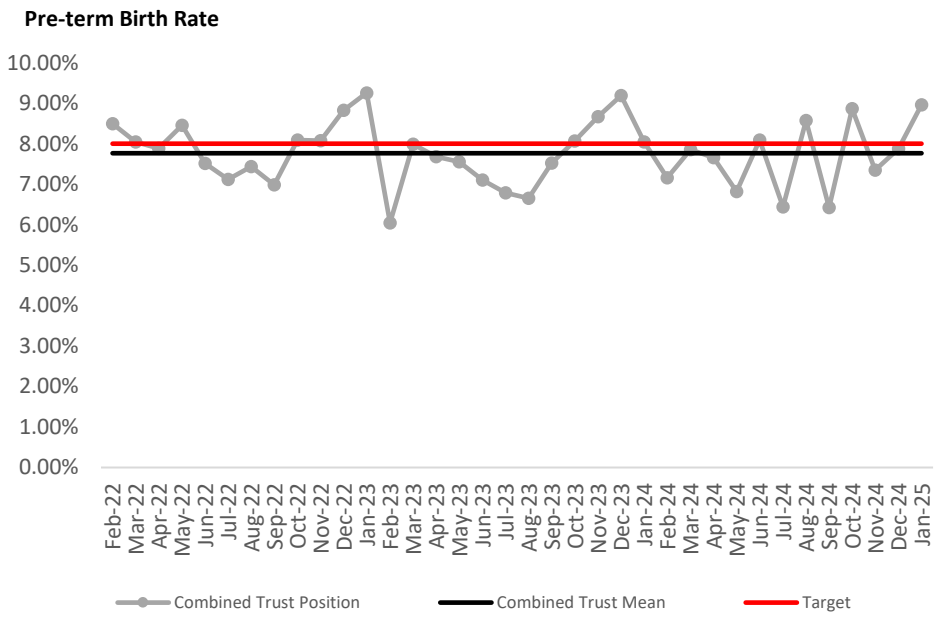
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

Preterm Births

TREND



8%

STANDARD

9.0%

PERFORMANCE

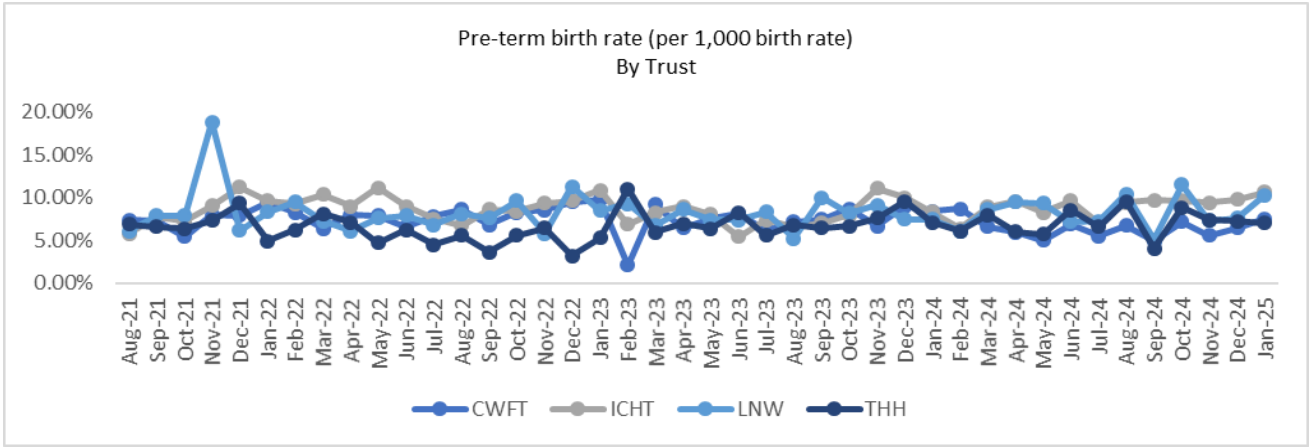
TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Pre-Term Births	Early Preterm births	Late Preterm births	Total Births	Pre-term Birth Rate	Difference from Threshold	Pre-Term Births FYTD	Pre-Term Births rate (per 1000 birth rate) FYTD
CWFT	63	10	53	835	7.5%		521	6.2%
ICHT	81	19	62	759	10.7%	2.67%	701	9.3%
LNW	36	5	31	349	10.3%	2.32%	275	8.6%
THH	22	0	22	312	7.1%		228	7.1%
APC	**202**	**34**	**168**	**2255**	**9.0%**	**0.96%**	**1725**	**7.7%**

STRATIFICATION



NARRATIVE

Performance: In month, the APC had a pre-term birth rate of 9% which is above the standard. ICHT and LNW were above the standard. ICHT are a net importer of all categories of preterm In-Utero Transfers and Ex-utero Transfers due to their status as a medical level 3 NICU. There are no concerns to escalate. In Q3 LNW appointed dedicated obstetric and midwifery pre-term birth leads. Monthly MDT improvement meetings were established

Recovery Plan: Not applicable.

Improvements: At LNW weekly MDT Preterm birth clinics embedded; registrars are being trained in cervical length scanning. Peri-prem passport in pilot phase with good service user feedback, official launch event planned April 2025. Sector-wide PTB training hosted by LNW in February well received, internal staff training commenced. The APC is undertaking a review of all preterm births and IUT across both sites at CWFT as part of the business case development to support service redesign of the level 2 NICU as well as the preterm birth antenatal service at WM site. WM has a newly appointed pre-term birth lead MW to work as part of the MDT.

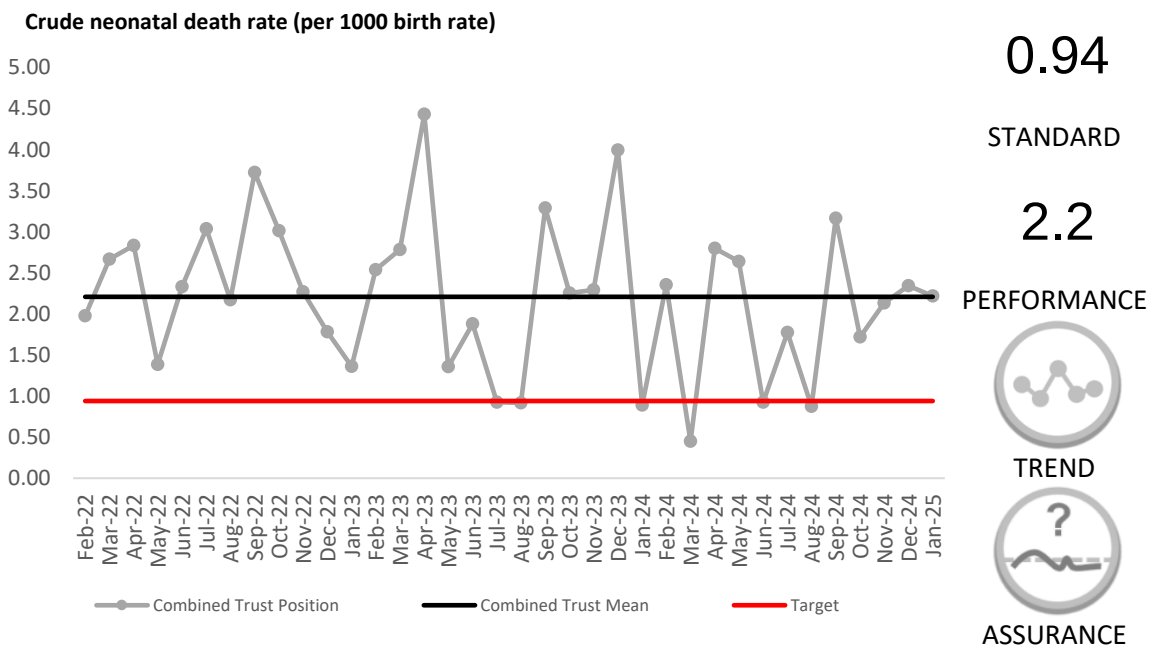
Forecast Risks: No risks identified.

GOVERNANCE

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

Neonatal Crude Deaths

TREND



0.94

STANDARD

2.2

PERFORMANCE

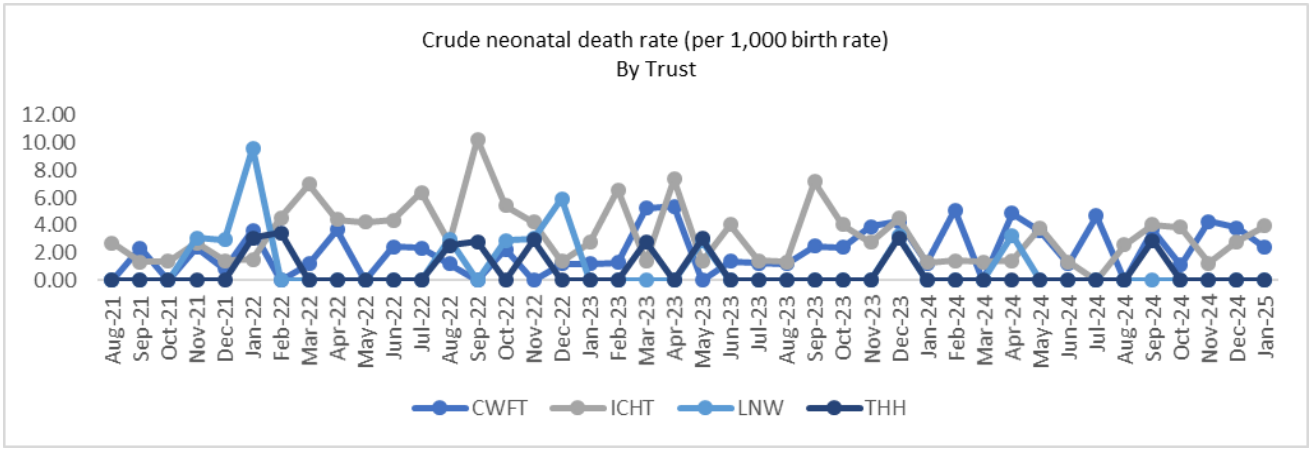
TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Neonatal Deaths	Number of neonatal deaths (22+0- 23+6 weeks)	Number of neonatal deaths (24+0 - 40+ weeks)	Total Births	Crude neonatal death rate (per 1000 birth rate)	Difference from Threshold	Neonatal Deaths FYTD	Crude neonatal death rate (per 1000 birth rate) FYTD
CWFT	2	0	2	835	2.4	1.5	25	2.96
ICHT	3	0	3	759	4.0	3.0	19	2.52
LNW	0	0	0	349	0.0		1	0.31
THH	0	0	0	312	0.0		1	0.31
APC	**5**	**0**	**5**	**2255**	**2.2**	**1.3**	**46**	**2.06**

STRATIFICATION



NARRATIVE

Performance: The crude neonatal death rate at APC level is above the standard in January and for this financial year. There were 5 cases across the APC in January. All cases are being appropriately investigated.

Recovery Plan: A review of neonatal deaths cross-site in 23/24 has been completed at CWFT. No recurrent themes were identified in addition to those identified via the PMRT process. Actions are tracked via the Maternity and Neonatal Safety Investigation Branch (MNSI) or PMRT processes and updates are provided in the quarterly Q&S report. A combined report is being produced for all services to understand any system wide themes and trends for action and will be presented at the Q&S meeting in March.

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

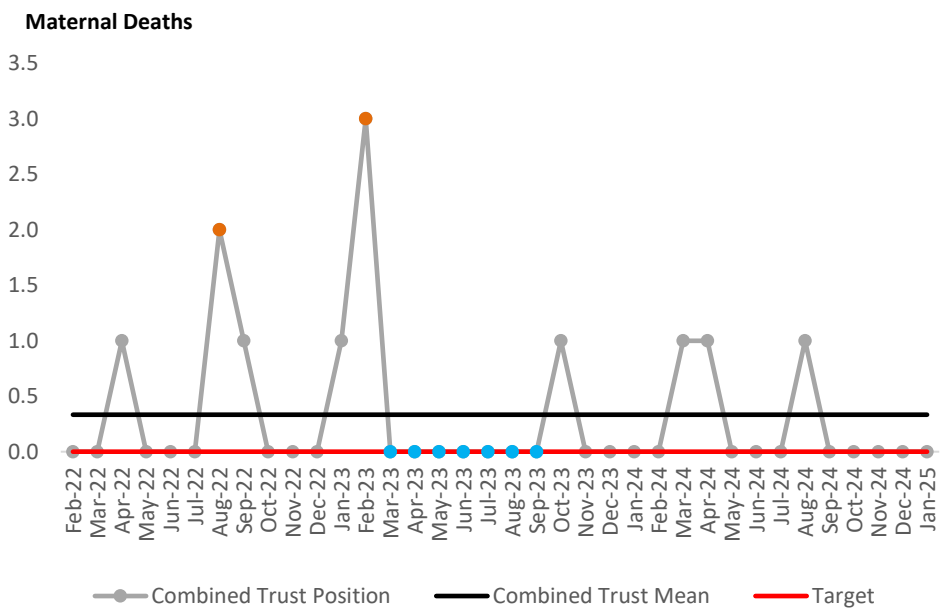
Forecast Risks: None identified.

GOVERNANCE

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

Maternal Deaths

TREND



0

STANDARD

0

PERFORMANCE

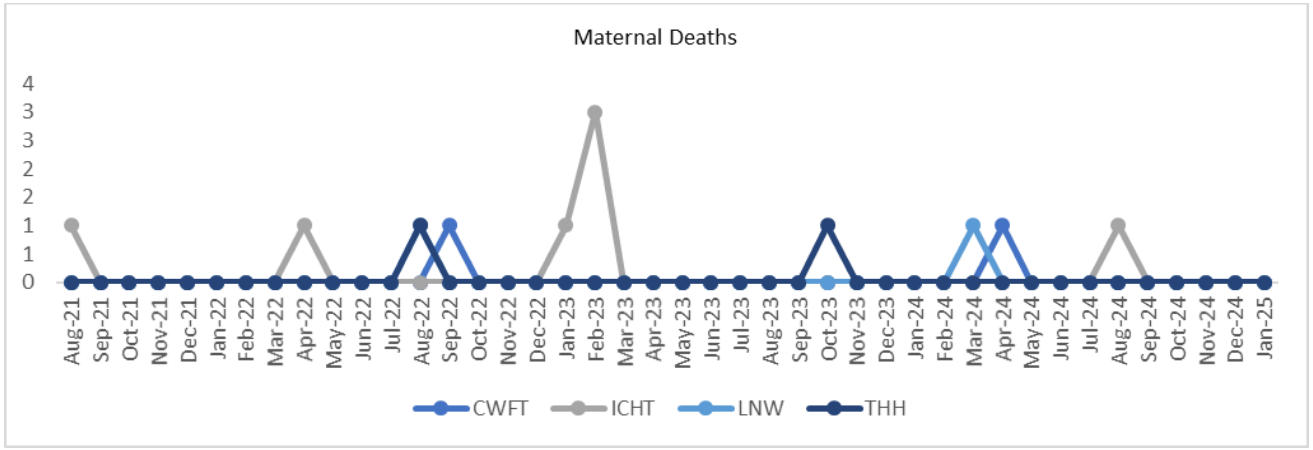
TREND

ASSURANCE

CURRENT PERFORMANCE

	Number of Maternal Deaths	Total Births	Difference from Threshold	Number of maternal Deaths FYTD
CWFT	0	835		1
ICHT	0	759		1
LNW	0	349		0
THH	0	312		0
APC	**0**	**2255**		**2**

STRATIFICATION



NARRATIVE

Performance: There were no maternal deaths reported in January 2025. There have been two indirect cases reported so far this financial year, 1 at ICHT and 1 at CWFT.

Recovery Plan: N/A

Improvements: A review by the ICB has looked at the 16 maternal deaths of birthing people who were residents of NWL in the last 5 years this has now been presented at the London Perinatal Quality and Safety Surveillance Group with all other systems to understand themes and trends for London and identify areas for focus. A spreadsheet of all the recommendations from cases in NWL is being complied and reviewed by the Maternal Medicine Network clinical director with the aim to make sure all services are compliant with the recommendations.

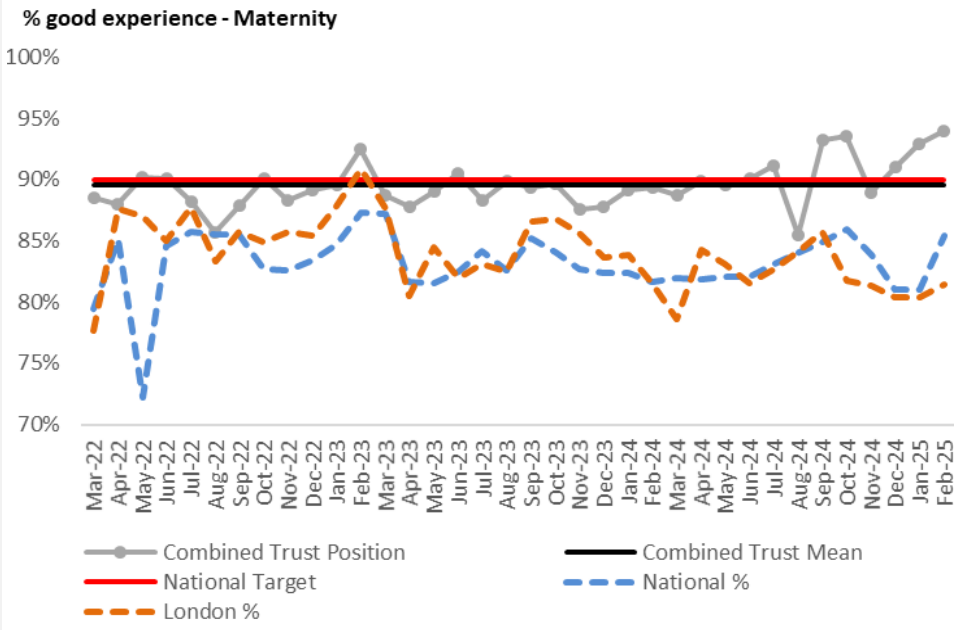
Forecast Risks: No current risks.

GOVERNANCE

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

Maternity Friends & Family Test

TREND



90%

STANDARD

93.9%

PERFORMANCE

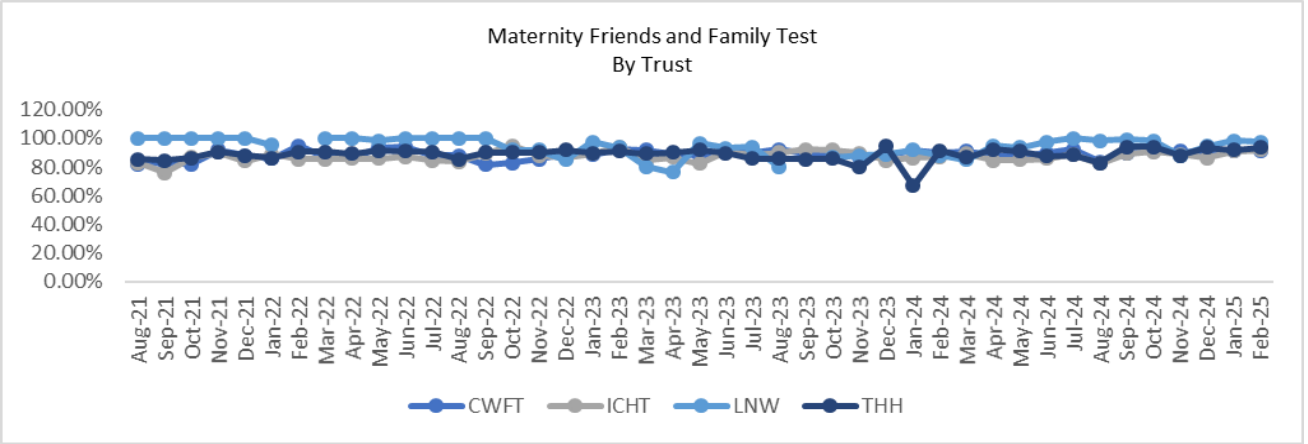
TREND

ASSURANCE

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	154	91.6%		141	90.0%
ICHT	229	92.1%		211	88.1%
LNW	222	97.7%		217	95.6%
THH	221	93.7%		207	90.8%
APC	**826**	**93.9%**		**776**	**90.8%**

STRATIFICATION



NARRATIVE

Performance: At APC level, the percentage of maternity patients who report a good experience varies. We are consistently above national and London averages, and above the 90% standard in-month and across the last 12 months of data.

Recovery Plan: LNW- note previous reporting of a low response rate was a reporting error that has been rectified. Response rate now broadly in line with sector partners. The service has developed a patient experience action plan as a wider response to the CQC national maternity survey. At ICHT, user feedback is showing the pressure that current high activity levels is having on experience, a plan for improvement is being developed. THH is working to improve experience of our women, birthing people and their families particularly in times of high activity. CWFT has seen improvements in the CQC survey based on improvements from last year and the action plan has been further updated.

Improvements: The work to improve maternity care and patient experience within each organisation is ongoing. All services have a detailed Maternity and Neonatal Voices Partnership (MNVP) workplan in place to co-produce improvements in their services based on the results of the CQC maternity survey.

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

GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Patient Access

February 2025, except Cancer service metrics January 2025

Operations Summary

This is a report on the operational performance of the APC for the period ending February 2025 except for cancer which is January 2025. The key points are:

Performance:

- UEC pathways have shown a very small improvement in February despite the ongoing pressure, London Ambulance conveyances have been high.
- Long-waiting patients are reducing in line with the National reductions, the APC is predicting a number of 65ww at the end of March 2025 whilst still working through all mitigations to the risks.
- Theatre utilisation is high but late starts and early finishes remain a productivity opportunity. PIFU (Patient Initiated follow up) is improving. Follow ups attendances need to reduce significantly across all Trusts as we move into 25/26, this will be a key area of focus for all Trusts.
- Cancer performance reduced in January post the festive season, however this is on a recovery trajectory.
- Diagnostics performance has stabilised below target, this will now not be met in 24/25.

Key Actions:

- To improve UEC (Urgent Emergency Care) targets to 78% by March 2025.
- To monitor the impact of unachieved diagnostic target on Cancer services

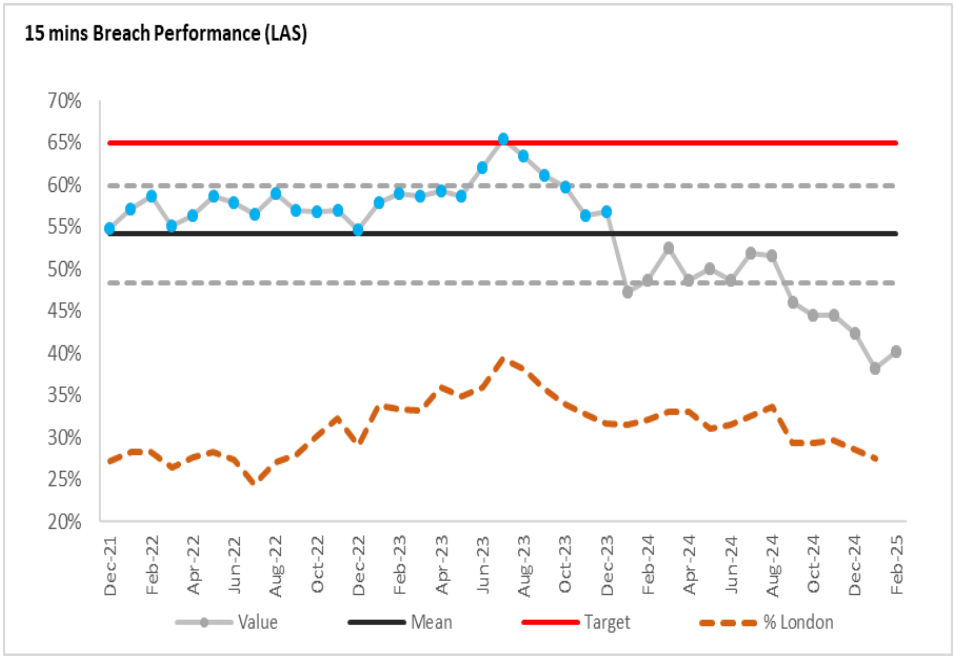
Escalations:

- DM01 (*Definitive Measure 01*) will not be achieved in 2024-25 due to numerous issues including the current financial run rate.

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

Ambulance Handover Waits

TREND



65%

STANDARD

40.1%

PERFORMANCE

TREND

F

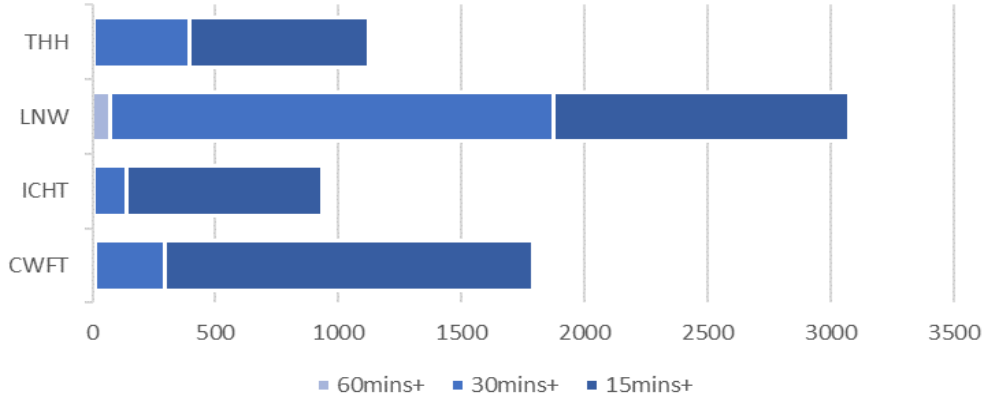
ASSURANCE

CURRENT PERFORMANCE

LAS Handover Waits within the fifteen minute standard Feb-25

	Total Handover	15mins Performance	Difference from target	15 min + delays	Of which	Impacts on	
					30min + delays	60 min + delays	LAS time lost (hours)
CWFT	2993	40.2%	-24.8%	1791	295	10	286
ICHT	2816	66.8%		935	141	4	127
LNW	3969	22.4%	-42.6%	3079	1877	70	2204
THH	1795	37.5%	-27.5%	1122	396	5	274
APC	**11573**	**40.1%**	**-24.9%**	**6927**	**2709**	**89**	**2892**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: NWL continues to have some of the best Ambulance handover times across London. In February, combined performance of completed handovers within 15 and 30 minutes improved following several months of increased delays.

Recovery plan: The sector is participating in transformation work to maximise the use of alternatives to ED, avoid conveyancing, and increase direct referral routes and direct booking. We have also revised the system escalation process during peak pressure and have agreed on new arrangements to support LAS as part of their winter plan. Northwick Park Hospital remains an outlier regarding the number of handover delays. To assist, the other APC Trusts will take 10 - 12 patients between them over two hours each afternoon as a temporary measure while seeking more sustainable solutions for managing peaks in demand.

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 embedded as business as usual.

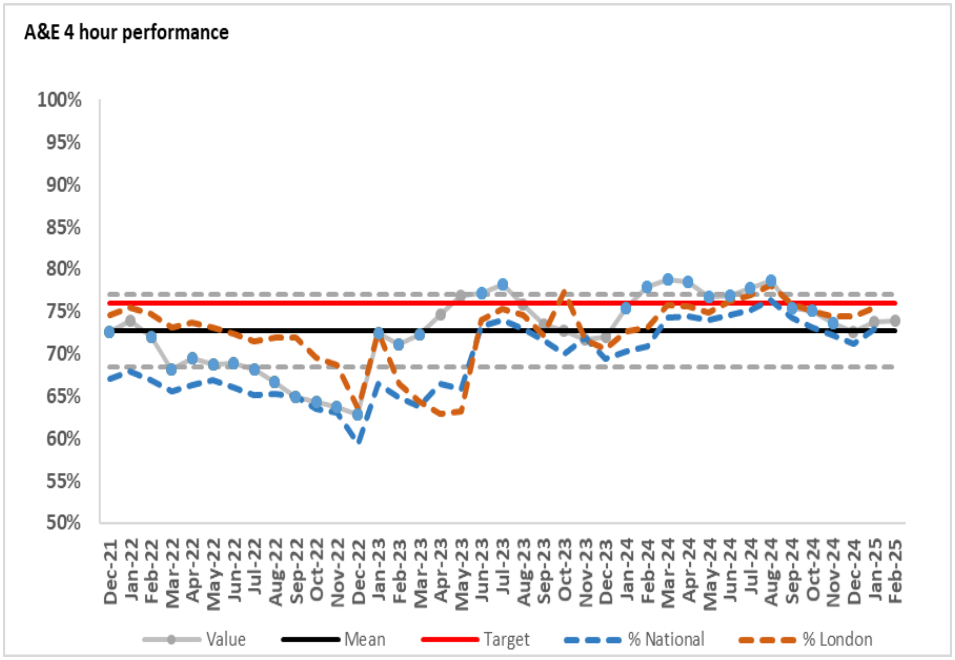
Forecast risks: Continued increases in the number of conveyances.

GOVERNANCE

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

Urgent & Emergency Department Waits

TREND



76%

STANDARD

73.9 %

PERFORMANCE

H

TREND

F

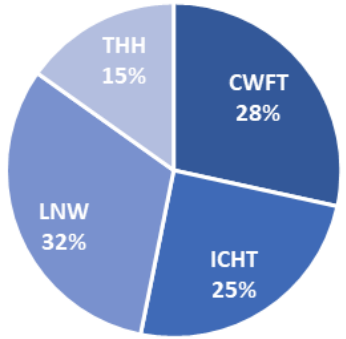
ASSURANCE

CURRENT PERFORMANCE

Time spend in Emergency Department: 4-Hour Standard Feb-25

	Total attendances (All Types)	4 hour Performance	Difference from target	4 hour + delays (All Types)	Of which (Number and Performance)				Impacted by
					Type 1 / 2 breaches		Type 3 breaches		Referrals to SDEC
CWFT	23922	74.11%	-1.9%	6194	6091	66.6%	103	98.2%	1455
ICHT	21334	74.8%	-1.2%	5382	5021	65.2%	361	94.8%	4571
LNW	26414	73.9%	-2.1%	6895	6764	47.1%	131	99.0%	1973
THH	11608	71.6%	-4.4%	3298	3210	43.6%	88	98.5%	2348
APC	**83278**	**73.9%**	-2.1%	**21769**	**21086**	**58.8%**	**683**	**97.9%**	**10347**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: In February, 73.9% of A&E patients were admitted, transferred, or discharged within four hours. Efforts continue to improve performance and meet the national standard of 78%.

Recovery plan: Each Trust has a comprehensive action plan to improve four-hour performance and maintain safe levels of care. These plans align with the wider North West London UEC program, which aims to reduce demand and waits across the entire care system. In addition to the measures implemented as part of the winter plan, all Trusts have introduced further actions in March to meet the four-hour performance standard. As a result, there has been some improvement, based on data up until mid-March.

Improvements: The improvement plans are built on progress made during 2023/24 as well as the NHSE best practice guidance for Urgent and Emergency Care issued earlier this year.

Forecast risks: Further increases in demand, rising levels of respiratory infection, continued delays with discharge for medically optimized patients.

GOVERNANCE

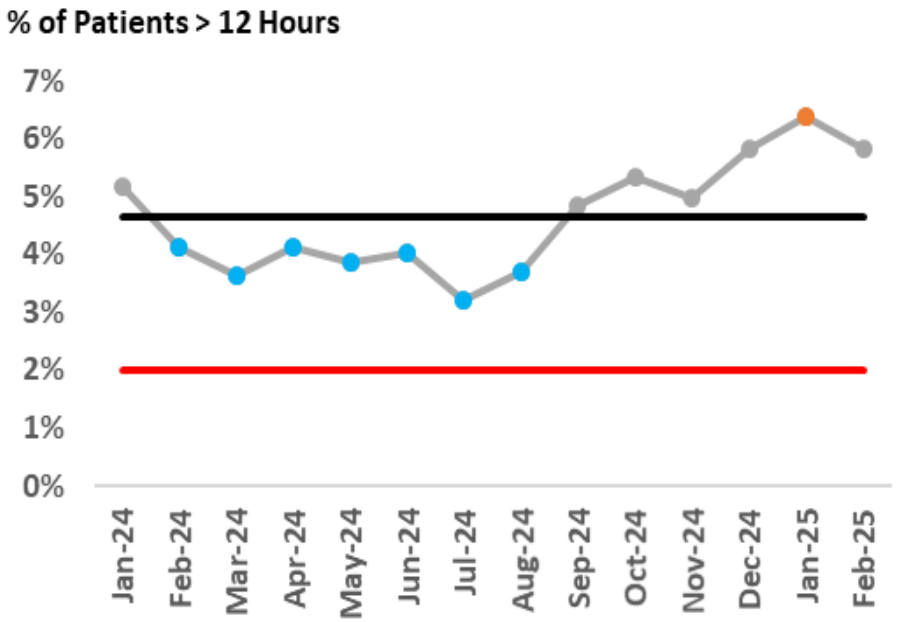
Senior Responsible Owner: Claire Hook, Chief Operating Officer, ICHT

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

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

Urgent & Emergency Department Long Waits

TREND



2.0%

ALLOWANCE

5.8%

PERFORMANCE

H

TREND

F

ASSURANCE

NARRATIVE

Performance: In February 2025, there is an improvement in performance for the proportion of patients waiting 12-hours or more following arrival to the Emergency Department. Flow through the hospital , increased demand and mental health delays are factors impacting the length of time spent in ED.

Recovery plan: Each site, through local protocols, continue to manage flow through a range of actions to recover performance and maintain safe levels of care.

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

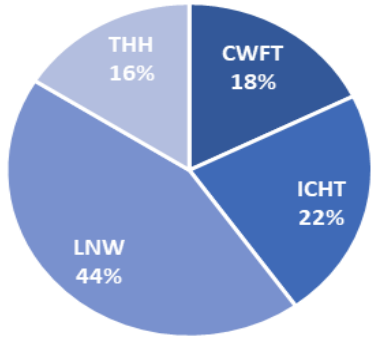
Forecast risks: Increases in demand, continued delays with discharge for medically optimised patients and continued delays for patients waiting for admission to mental health beds.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 12-Hour waits Feb-25

	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	23922	3.6%	-1.6%	858	858	0	43
ICHT	21334	5.1%	-3.1%	1088	1088	0	364
LNW	26283	8.1%	-6.1%	2127	2127	0	547
THH	11608	6.7%	-4.7%	776	776	6	94
APC	**83147**	**5.8%**	**-3.8%**	**4849**	**4849**	**6**	**1048**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

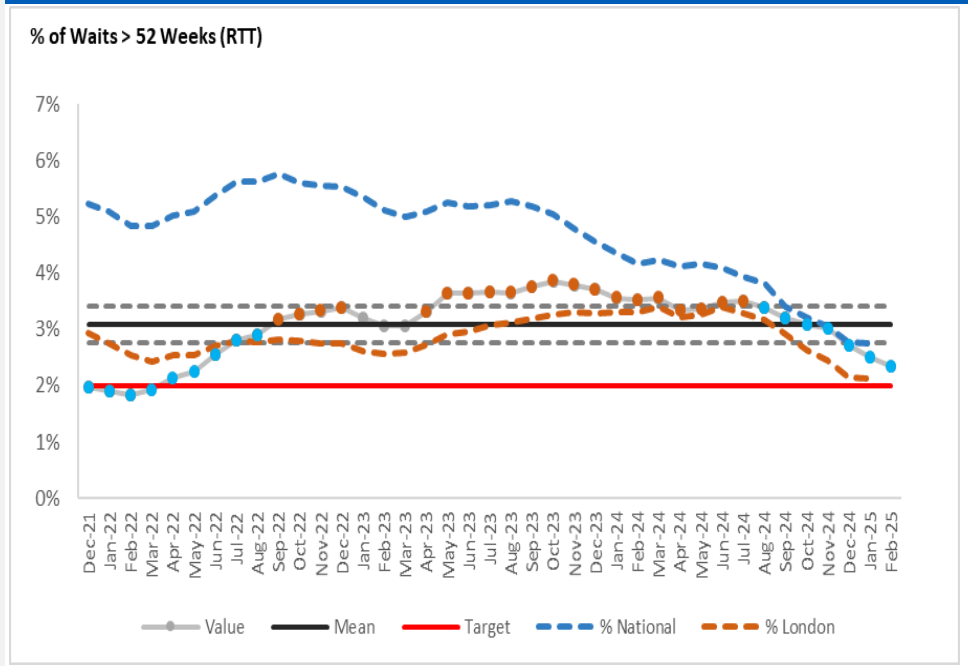
Senior Responsible Owner: Sheena Basnayake, Deputy Chief Operating Officer,

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

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

Referral to Treatment Waits

TREND



2.0%

ALLOWANCE

2.4%

PERFORMANCE

H

TREND

F

ASSURANCE

NARRATIVE

Performance: Long waits are being monitored at the patient level. All Trusts are committed to the operating plan targets and % of waits >52 weeks remains a special cause improvement for the sector with a 7-month improvement trajectory.

Recovery: Trusts are enhancing productivity whilst some insourcing has been stopped due to the uncertainty of ERF for the remainder of 24/25. Mutual aid is active across the APC meaning that some breaches will be reported at the treating organisation. Neuro-surgery (ICHT) is a challenge nationally and will continue to see long waiting patients into next year.

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

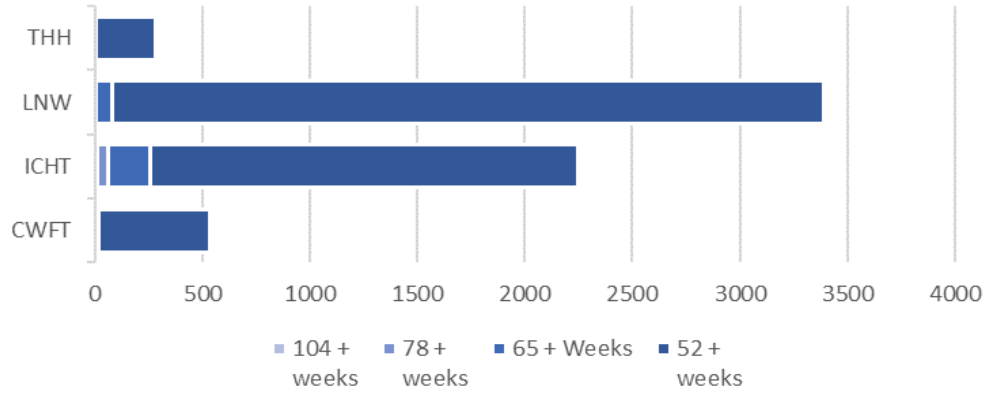
Forecast Risks: Risks to RTT reduction include overall capacity shortfalls, anaesthetic staffing shortages and high volumes of trauma and priority 2 patients.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 18-Week Standard Feb-25

	Total Waiting List	Waits > 52 weeks	Difference from target	52 + weeks	Of which		Impacted by	Impacts on	Average wait (weeks)
					65 + Weeks	78 + weeks	104 + weeks	OTDCs not booked < 28 days	
CWFT	64944	0.8%		537	19	1	0	7	16.42
ICHT	88834	2.5%	-0.5%	2251	258	65	11	11	18.60
LNW	92052	3.7%	-1.7%	3389	81	1	0	0	21.05
THH	28476	1.0%		283	6	1	0	0	18.61
APC	**274306**	**2.4%**	**-0.4%**	**6460**	**364**	**68**	**11**	**18**	**18.91**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

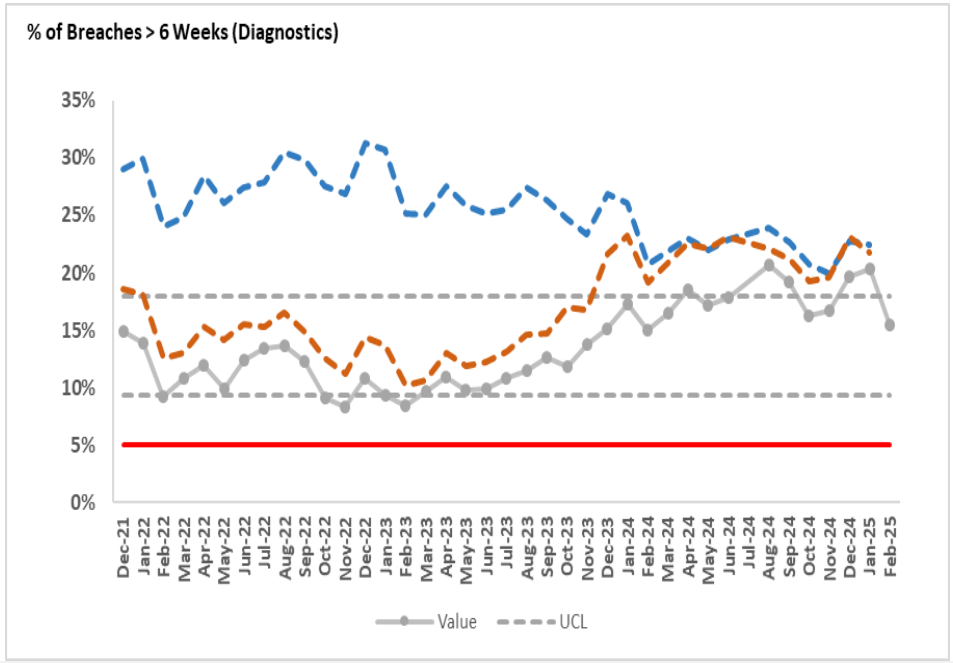
Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

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

Access to Diagnostics

TREND



5.0%

ALLOWANCE

15.5%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: Overall delivery remains below target. Recovery plans are in place but the APC will not meet target this financial year due to financial constraints across the sector and data quality at LNW.

Recovery Plan: LNW have some external support to correct the data flows driving the poor performance. Winter pressures combined with reduction in operational days saw capacity shortfalls and associated performance deterioration in December and January.

Improvements: Additional capacity being created through WLI's, insourcing and the use of CDC's where possible.

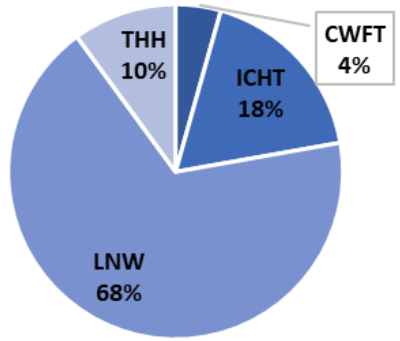
Forecast Risks: MRI capacity continues to be a risk across the sector. Other challenged modalities include Neurophysiology, Echocardiography and Ultrasound which face capacity challenges due to staffing shortages and ageing equipment.

CURRENT PERFORMANCE

Waits for Diagnostic Tests: 6-Week Standard Feb-25

	Total Waiting List	Waits > 6 weeks	Difference from target	6 + weeks	Of which 13 + weeks
CWFT	11159	3.5%		396	110
ICHT	18267	8.9%	-3.9%	1617	327
LNW	20679	29.7%	-24.7%	6138	2888
THH	8448	10.8%	-5.8%	910	50
APC	**58553**	**15.5%**	**-10.5%**	**9061**	**3375**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

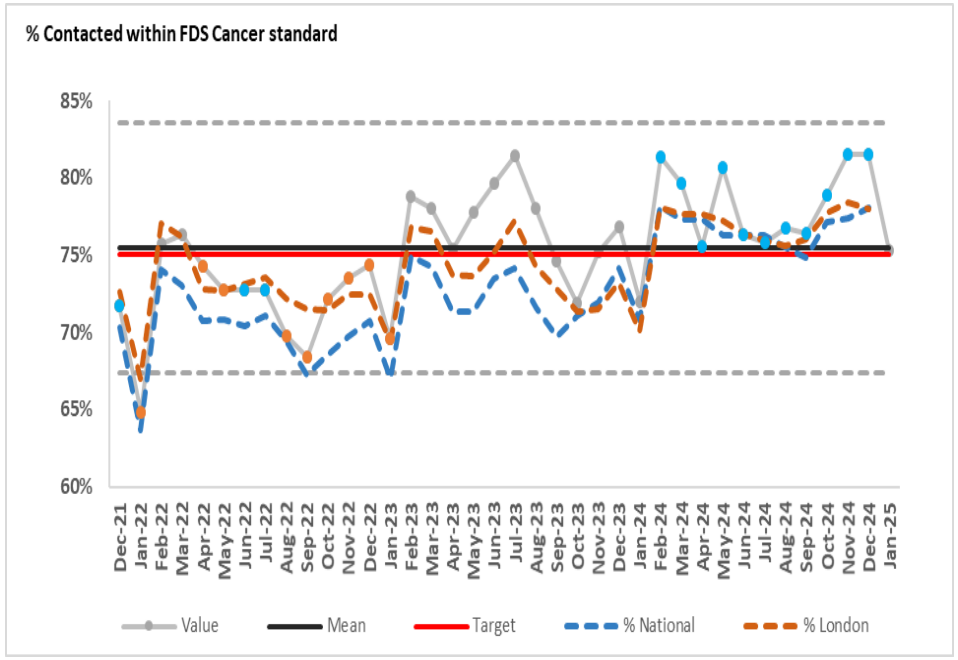
Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

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

Access to Cancer Care (Faster Diagnosis)

TREND



75%

STANDARD

75.3%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: NWL overall exceeded the FDS standard again in January, with a whole provider position being posted of 75.3% against 75% target. LNW and Hillingdon did not meet the standard for the month. Both Trusts performance dipped due to capacity challenges during the Christmas holiday period.

Recovery Plan: Continue collaborating with all Trusts to enhance the delivery of cancer pathways in line with the standard.. Both Hillingdon and LNW have added additional capacity in Q4 which will see big improvements to performance in February.

Improvements: Whilst the overall FDS performance was negatively affected in January, big improvement to capacity is expected in February.

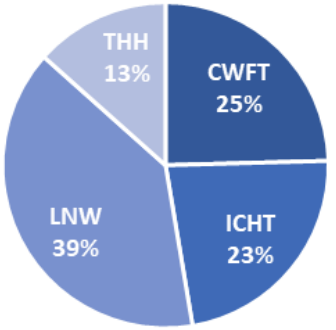
Forecast Risks: Continued planning of capacity for pinch points in pathways to protect cancer delivery as much as possible. Winter months and higher emergency admissions may lead to delays/restricted capacity, RMP to support with resilience funding to mitigate Easter impacts.

CURRENT PERFORMANCE

Access to Cancer Care (Faster Diagnosis) Jan-25

	Total Contacts	Faster Diagnosis performance	Difference from target	28 + days	Of which 62 + days
CWFT	2500	76.9%		577	123
ICHT	2694	80.1%		535	0
LNW	3126	70.5%	-4.5%	922	134
THH	1177	73.2%	-1.8%	315	38
APC	**9497**	**75.3%**		**2349**	**295**

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

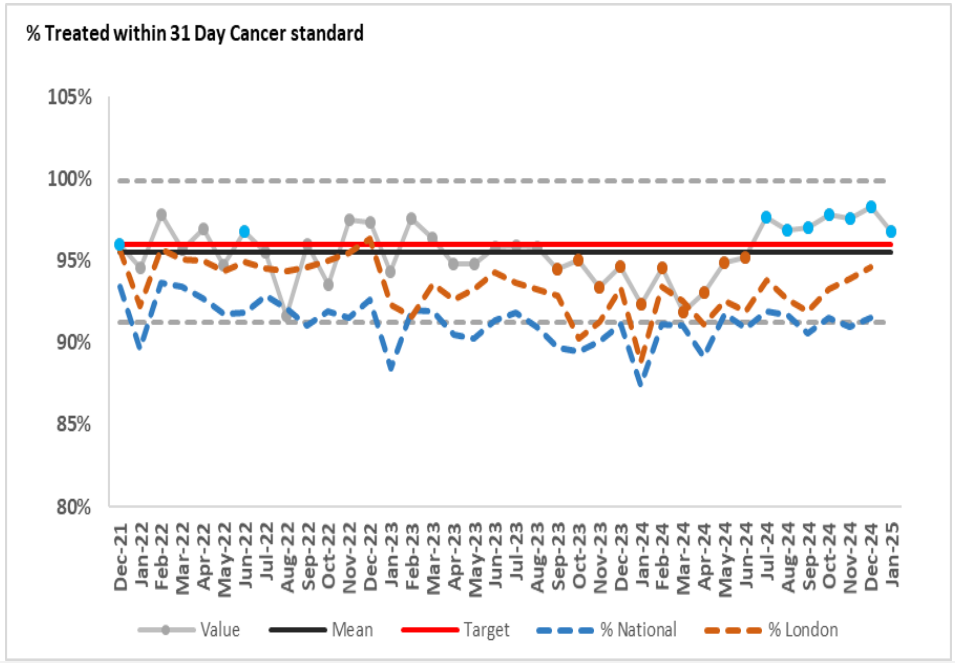
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

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

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

Cancer 31-Day Decision to treatment Combined Standard

TREND



96%

STANDARD

96.8%

PERFORMANCE

TREND

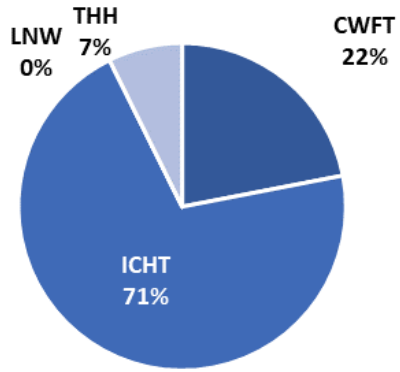
ASSURANCE

CURRENT PERFORMANCE

Cancer 31-day decision to treatment combined standard Jan-25

	Total Treated	31 day performance	Difference from target	31 + days	Of which 62 + days
CWFT	177	94.9%	-1.1%	9	0
ICHT	835	96.5%		29	0
LNW	184	100.0%		0	0
THH	98	96.9%		3	1
APC	**1294**	**96.8%**		**41**	**1**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: 31-day standard met for the seventh month in a row with all Trusts (except CWFT) individually meeting the standard. RMP and NWL are consistently the best performing against peers nationally.

Recovery Plan: The Trusts are working closely with RM Partners to conduct audits and develop targeted, tumour-specific action plans, with a particular focus on skin and Head and Neck at LNW. These audits will provide valuable insights into current performance, enabling the development of targeted, tumour-specific action plans designed to enhance diagnostic efficiency and treatment outcomes.

Improvements: Improvements at Imperial have seen their performance stabilise in the past 6 months.

Forecast Risks: As referral rates continue to stay high, there is a continued risk of a significant gap between demand and capacity due to workforce challenges. Increased lung treatments (as a result of TLHC) will also mean surgical capacity is more challenged

GOVERNANCE

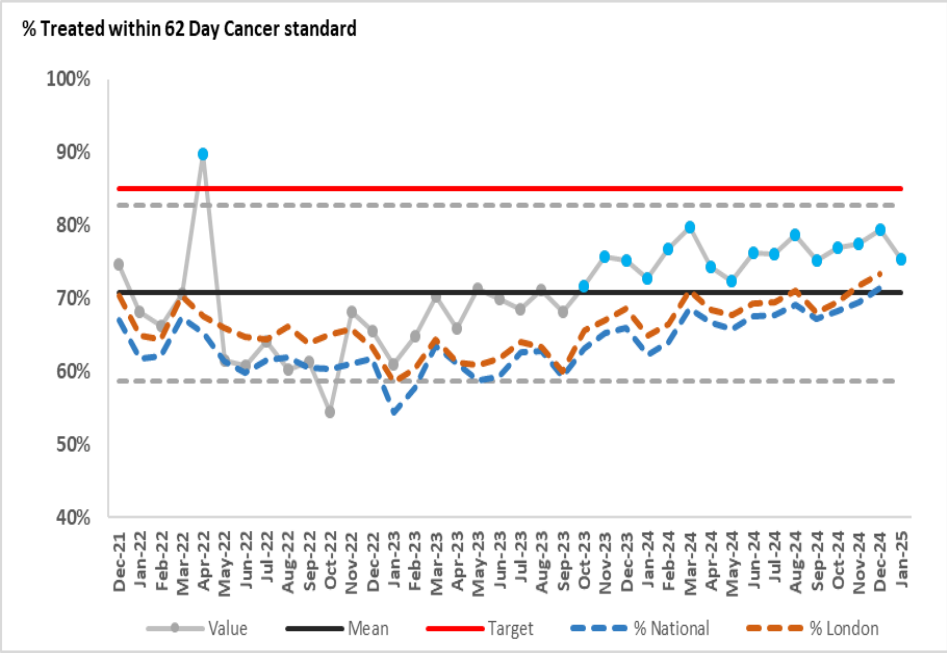
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

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

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

Referral to Cancer Treatment Pathways

TREND



85%

STANDARD

75.3%

PERFORMANCE

H

TREND

F

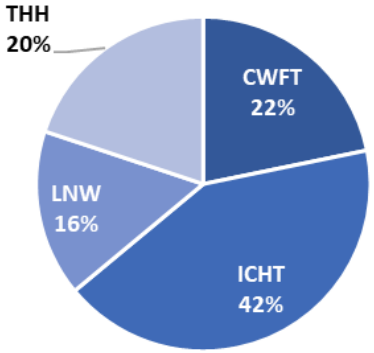
ASSURANCE

CURRENT PERFORMANCE

Unacceptable Waits for the Treatment of Cancer: 62-day Combined Standard Jan-25

	Total Treated	62 day performance	Difference from target	62 + days	Of which	Impacts on
					104 + days	Backlog 104 + days
CWFT	179.5	77.4%	-7.6%	40.5	14	0
ICHT	279	71.9%	-13.1%	78.5	0	61
LNW	188.5	84.1%	-0.9%	30	7.5	12
THH	107	65.4%	-19.6%	37	6	6
APC	**754**	**75.3%**	**-9.7%**	**186**	**27.5**	**79**

STRATIFICATION



Trust share of APC waits longer than standard

NARRATIVE

Performance: Performance against the 62-day standard remains challenged against the 85% standard (70% national expectation). There are system-wide pressures that are contributing to this including delays in inter-Trust transfers. Imperial and THH have issues in breast and urology and the whole sector struggles with lung. However, NWL still remains one of the best performing ICBs nationally.

Recovery Plan: Efforts continue to enhance inter-trust transfers, with a particular focus on Urology. Demand-reduction pathways—including those for breast, pain, and gynaecology—are being implemented. There are plans to address specialist diagnostic capacity for lung through EBUS, CTGB and Nav Bronc.

Improvements: Whilst performance dipped in January, some improvements expected in February with further improvements due to be seen in March – particularly at Imperial.

Forecast Risks: . Lung diagnostics demand (particularly EBUS and navigational bronchoscopy) is likely to see additional challenges in this pathway.

GOVERNANCE

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

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

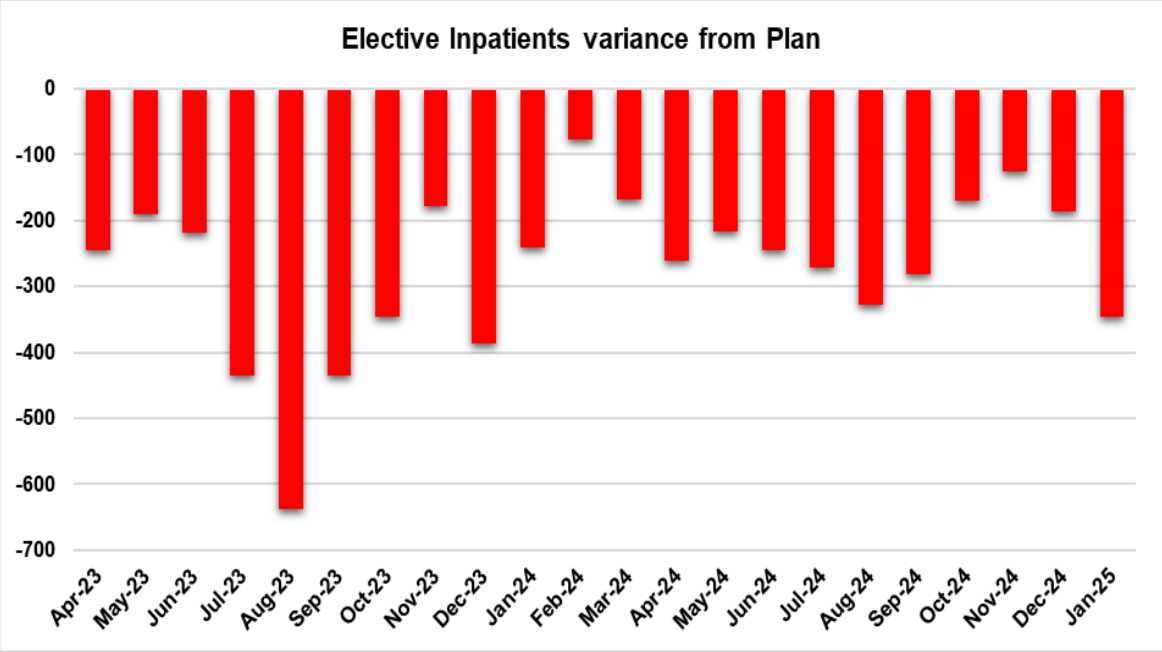
Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

Operating Plan and Capacity

December 2024

Operating Plan Performance: Elective Inpatient

TREND



NARRATIVE

Performance: Elective activity improved following industrial action earlier in the year. ICHT and LNW are currently under target.

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

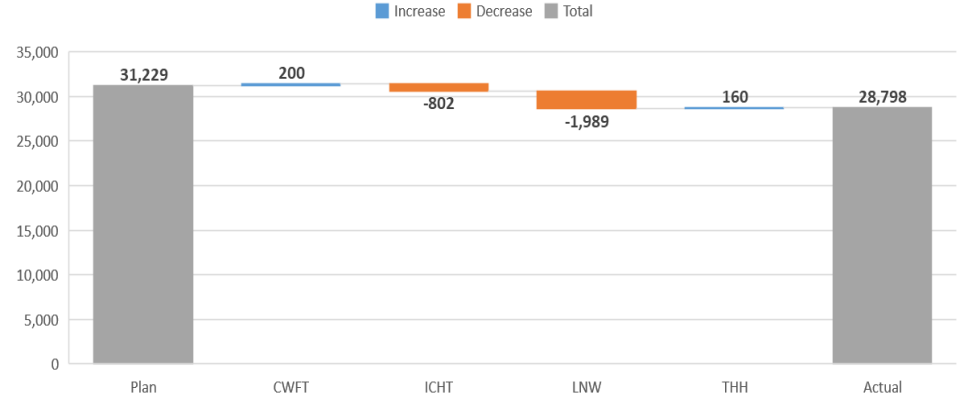
Improvements: CWFT/ THH are over-delivering.

Forecast Risks: None

CURRENT PERFORMANCE

	Current Month - Jan-25				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	724	537	-187	-25.8%	724	537	-187	-25.8%	5,603	5,803	200	3.6%
ICHT	1,472	1,340	-132	-9.0%	1,472	1,340	-132	-9.0%	13,778	12,976	-802	-5.8%
LNW	1,017	978	-39	-3.8%	1,017	978	-39	-3.8%	9,845	7,856	-1,989	-20.2%
THH	207	218	11	5.3%	207	218	11	5.3%	2,003	2,163	160	8.0%
APC	**3,420**	**3,073**	**-347**	**-10.1%**	**3,420**	**3,073**	**-347**	**-10.1%**	**31,229**	**28,798**	**-2,431**	**-7.8%**

STRATIFICATION



Year to date contribution to variance against plan

GOVERNANCE

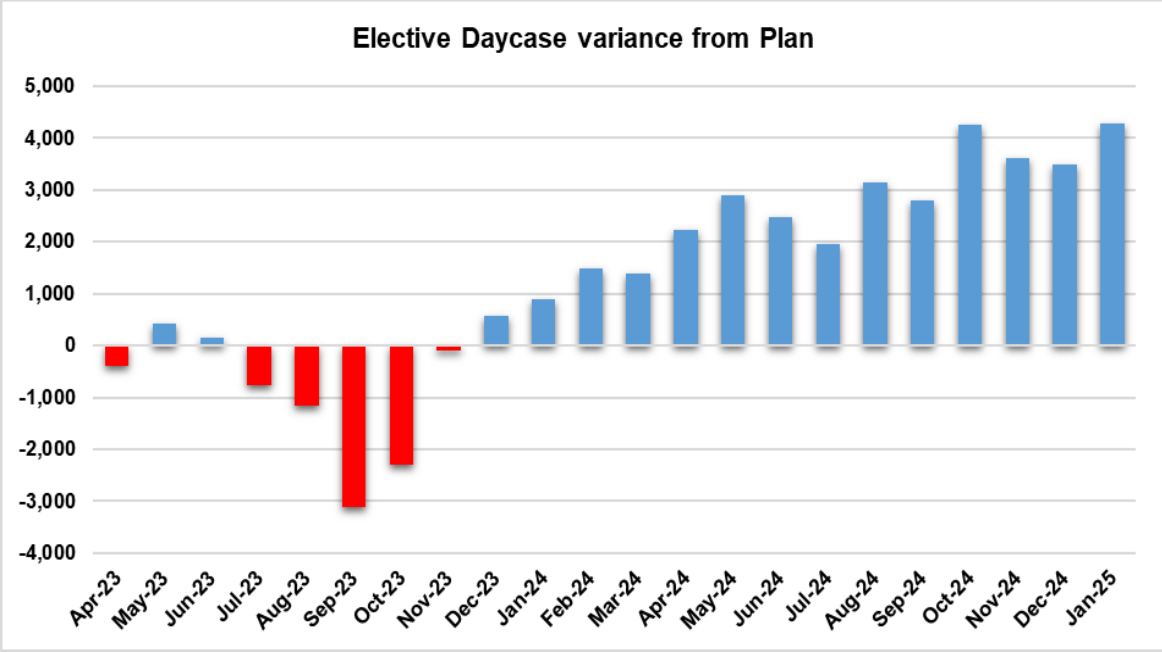
Senior Responsible Owner: Tina Benson, COO, THH

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

Data Assurance: tbc

Operating Plan Performance: Day Case

TREND



NARRATIVE

Performance: Day case activity is showing over performance in all Trusts.

Performance: Day case activity is showing variation across Trusts with all Trusts over performing year to date.

Recovery Plan: Insourcing is supporting delivery

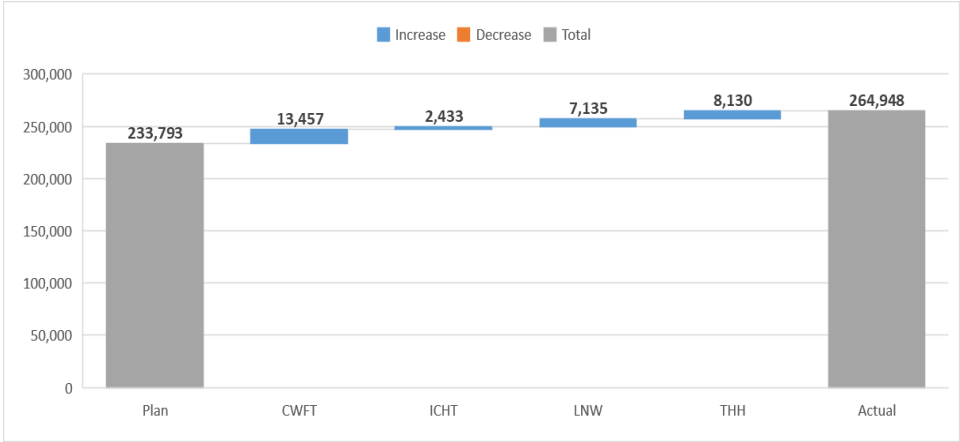
Improvements: LNW are still in a recovery process with weekly oversight meetings which has improved performance this quarter.

Forecast Risks: None forecast

CURRENT PERFORMANCE

	Current Month - Jan-25				Quarter to Date				Year to Date			
	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var	Plan	Actual	Var	% Var
CWFT	4,684	6,163	1,479	31.6%	4,684	6,163	1,479	31.6%	46,694	60,151	13,457	28.8%
ICHT	10,217	10,680	463	4.5%	10,217	10,680	463	4.5%	95,979	98,412	2,433	2.5%
LNW	7,182	8,682	1,500	20.9%	7,182	8,682	1,500	20.9%	69,540	76,675	7,135	10.3%
THH	2,212	3,048	836	37.8%	2,212	3,048	836	37.8%	21,580	29,710	8,130	37.7%
APC	**24,295**	**28,573**	**4,278**	**17.6%**	**24,295**	**28,573**	**4,278**	**17.6%**	**233,793**	**264,948**	**31,155**	**13.3%**

STRATIFICATION



Year to date contribution to variance against plan

GOVERNANCE

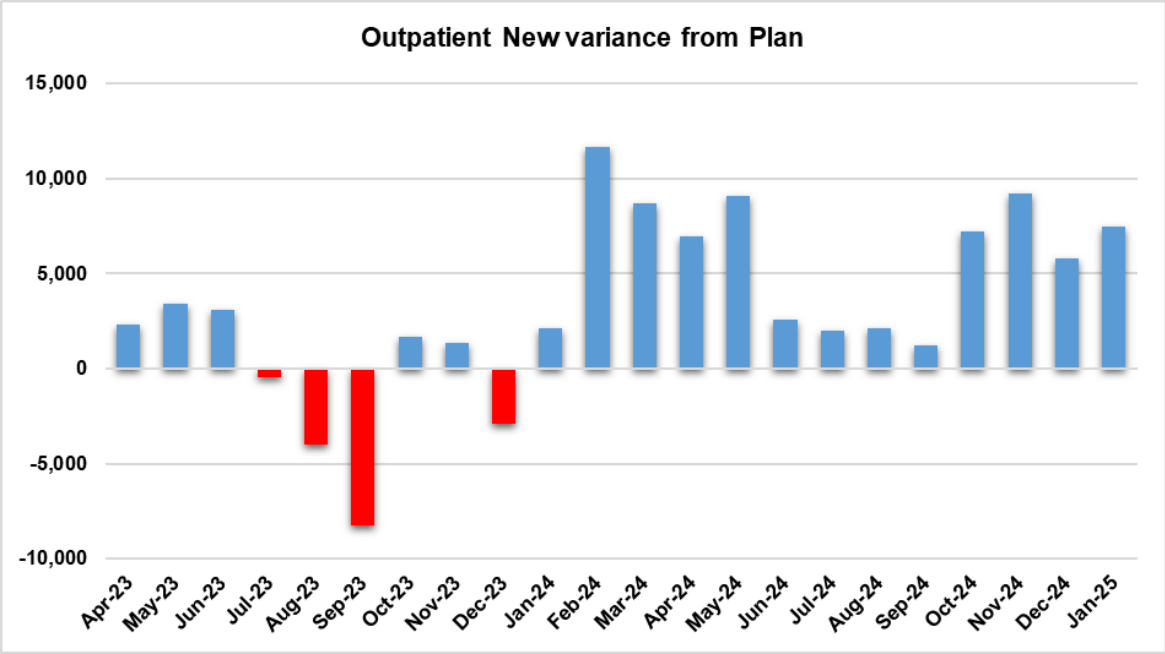
Senior Responsible Owner: Tina Benson, COO, THH

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

Data Assurance: tbc

Operating Plan Performance: Outpatient New

TREND



NARRATIVE

Performance: Outpatient New activity across the sector is above plan in-month and is on plan at year-end.

Recovery Plan: THH are investigating a reporting/mapping issue affecting both outpatient new and procedures

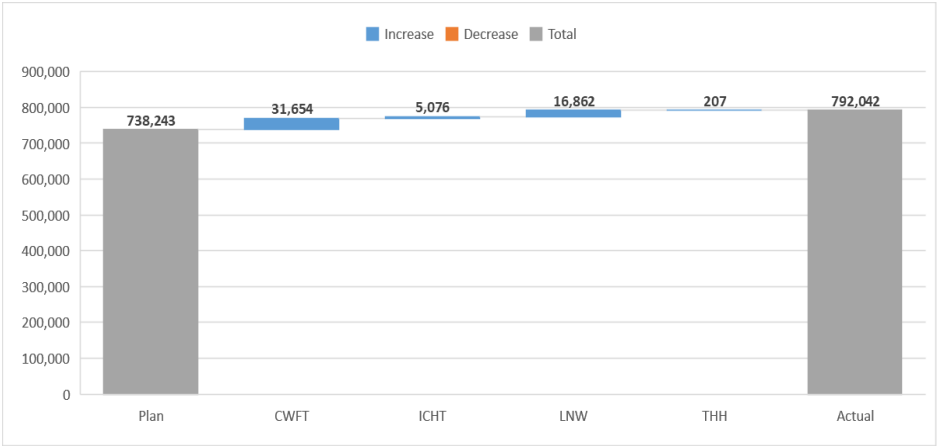
Improvements: All other sites have seen significant improvement in-month, bringing the APC very close to target.

Forecast Risks: None forecast

CURRENT PERFORMANCE

	Year to Date: Jan-25					
	Plan	**Actual**	**Var**	**% Var**	**Follow ups**	**FU Rate**
CWFT	169,897	201,551	31,654	18.6%	307,680	1.5
ICHT	232,935	238,011	5,076	2.2%	536,049	2.3
LNW	247,346	264,208	16,862	6.8%	336,970	1.3
THH	88,065	88,272	207	0.2%	154,342	1.7
APC	**738,243**	**792,042**	**53,799**	**7.3%**	**1,335,041**	**1.7**

STRATIFICATION



Year to date contribution to variance against plan

GOVERNANCE

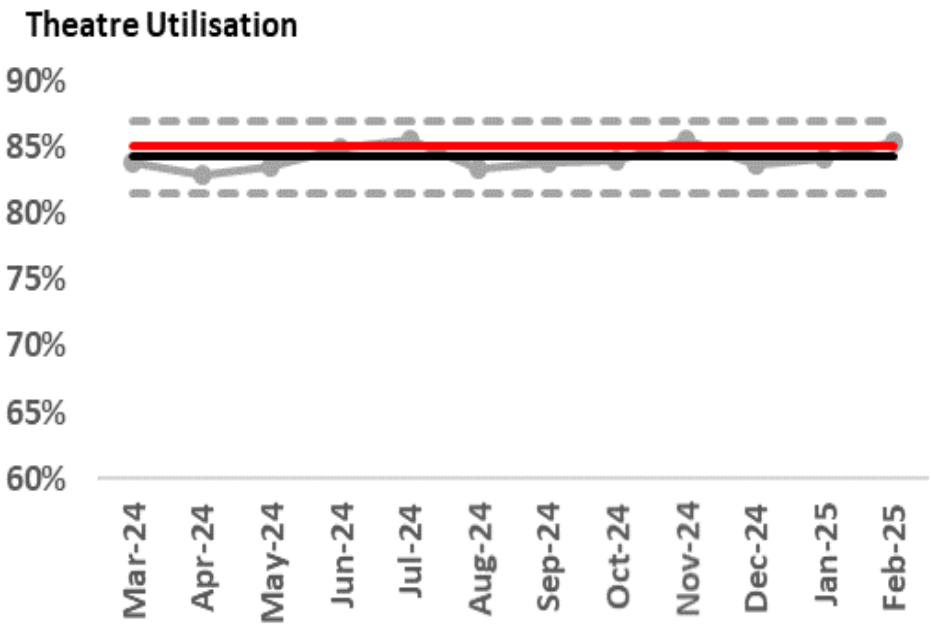
Senior Responsible Owner: Tina Benson, COO, THH

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

Data Assurance: tbc

Theatre Utilisation *(Uncapped)*

TREND



85%

STANDARD

85.4%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Theatre utilisation is stable with THH, LNW and CWFT above standard in February.

Recovery plan: At ICHT right sizing of the theatre schedule and the 6-4-2 process is being more rigorously followed to help enhance operational efficiency.

Improvement: At ICHT scheduling improvements have been realised through improved communications and more proactive and frequent flexing of staff. Further implementation of the digital preoperative assessment questionnaire is reducing the clinical time required to clear the patients as fit for surgery.

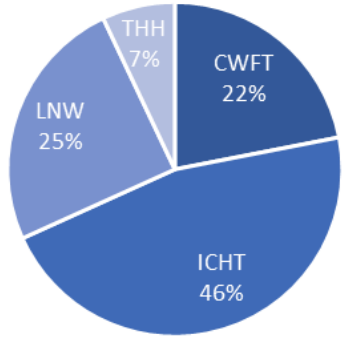
Future risk: Shortages in critical staffing groups.

CURRENT PERFORMANCE

Theatre Utilisation Feb-25

	Planned operating time (hours)	Theatre utilisation	Difference from target	Unused time (hours)
CWFT	2724	85.4%		399
ICHT	5196	83.8%	-1.2%	841
LNW	3536	87.3%		449
THH	1014	87.4%		128
APC	**12470**	**85.4%**		**1817**

STRATIFICATION



GOVERNANCE

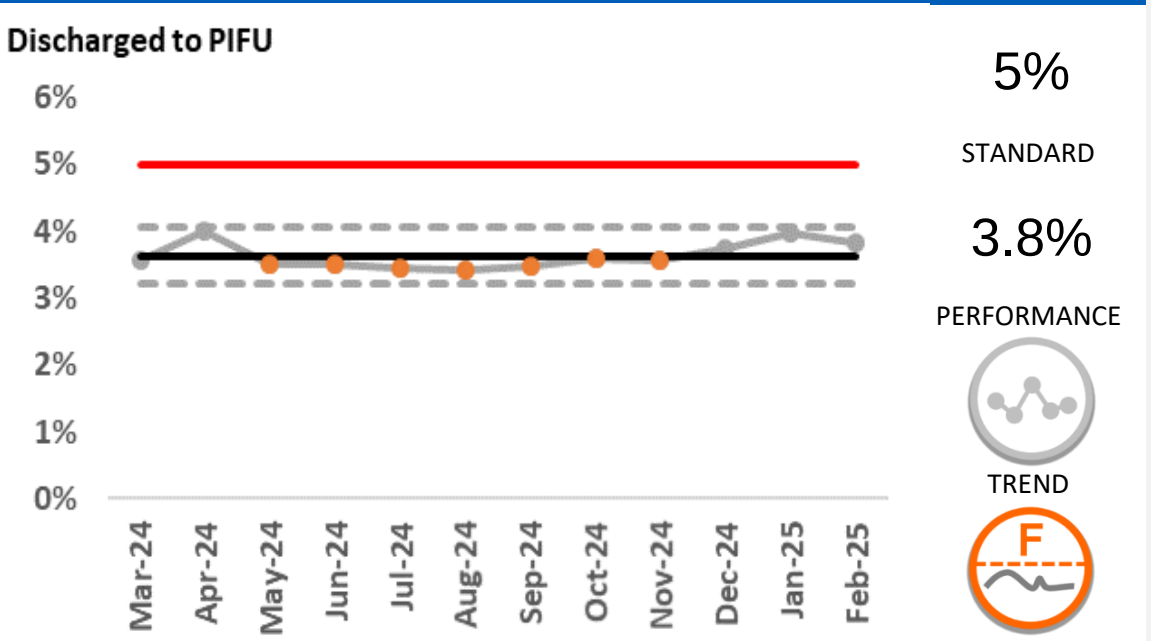
Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

Data Assurance: tbc

Outpatient Transformation

TREND



5%

STANDARD

3.8%

PERFORMANCE

TREND

F

ASSURANCE

NARRATIVE

Performance: Pathways discharged to PIFU are under target. A programme of work has commenced looking at those services with the greatest opportunity to utilise PIFU using GIRFT as a guide. PIFU usability on Cerner is to be improved to support clinical decisions. A clinical audit is being undertaken currently, with variation between specialities being reviewed.

Recovery plan: Outpatient improvement lead group is in place to standardise practice and increase PIFU to above the 5% target

Improvement: The APC is above the peer average of 1.8% and is above the national average of 3.1%

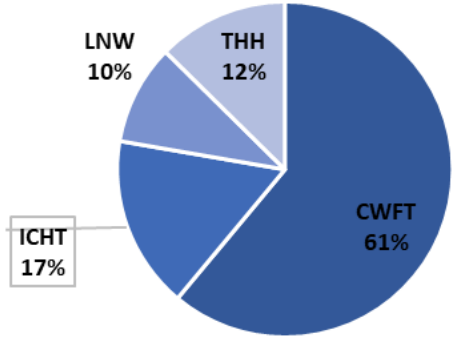
Future risks: Stability, usability and interoperability of digital infrastructure

CURRENT PERFORMANCE

Outpatient Transformation Feb-25

	Total OP contacts	Discharged to PIFU	Difference from target	Moved / Discharged to PIFU	Impacts on		
					OPFA DNAs	OPFU DNAs	Virtual contacts
CWFT	66707	7.8%		5202	9.6%	7.4%	7424
ICHT	51321	2.8%	-2.2%	1419	11.4%	9.1%	18943
LNW	70546	1.2%	-3.8%	823	9.8%	9.1%	13594
THH	33326	3.2%	-1.8%	1075	7.3%	8.1%	4673
APC	**221900**	**3.8%**	**-1.2%**	**8519**	**10.0%**	**8.6%**	**44634**

STRATIFICATION



Trust share of APC discharges lower than standard

GOVERNANCE

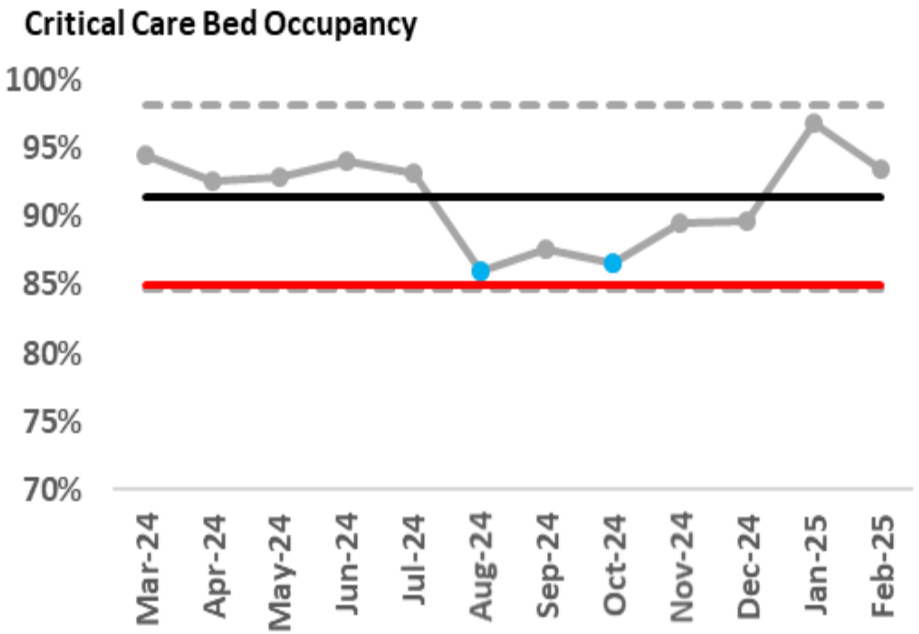
Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

Data Assurance: tbc

Operations Critical Care

TREND



<85%

STANDARD

90.9%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Critical Care bed occupancy is affected by seasonal variation. ICHT and CWFT have been flexing extra critical beds above normal capacity due to acuity.

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

Improvements: Not required at this time.

Forecast Risks: None.

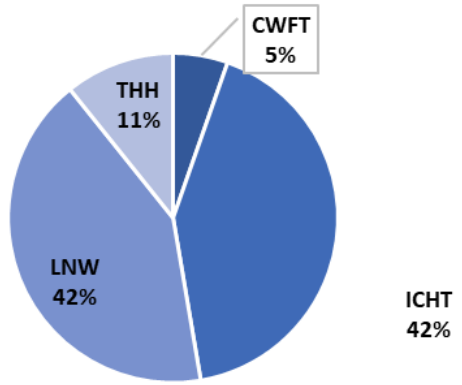
Note: There is a review in progress to ensure alignment of occupancy reporting

CURRENT PERFORMANCE

Critical Care Feb-25

	Available critical care beds	Bed occupancy	Difference from target	Unoccupied critical care beds
CWFT	25	96.4%	11.4%	0.9
ICHT	94	92.6%	7.6%	7.0
LNW	56	87.6%	2.6%	7.0
THH	9	79.2%		1.8
APC	**183**	**90.9%**	**5.9%**	**16.6**

STRATIFICATION



GOVERNANCE

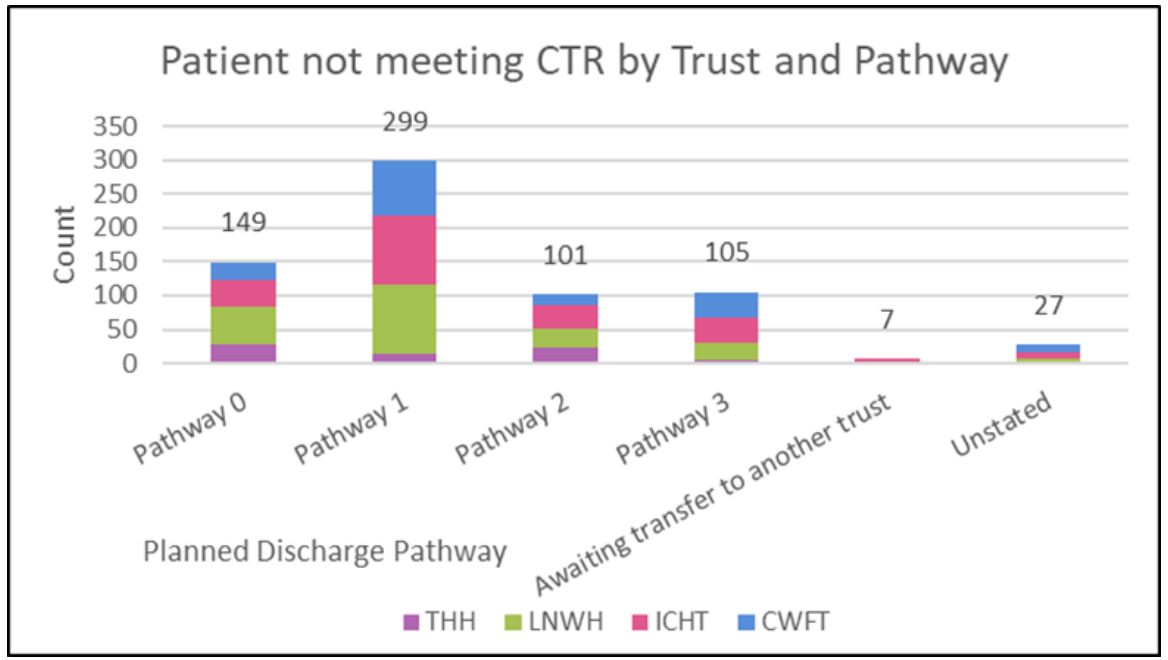
Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

Data Assurance: tbc

Discharge – patients not meeting the criteria to reside

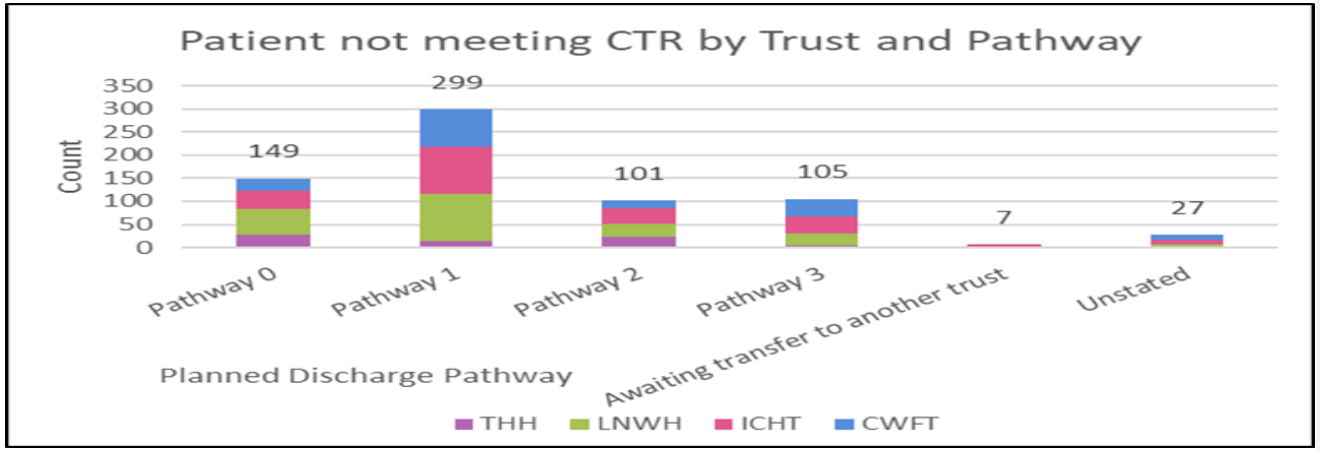
TREND



CURRENT PERFORMANCE

Local Authority	CWFT	ICHT	LNW	THH	Total	List Size	Rate r per 10,000
Brent	0	30	51	1	82	388,755	2.11
Ealing	10	27	69	3	109	433,858	2.51
H&F	20	43	0	0	63	224,022	2.81
Harrow	1	1	59	2	63	256,630	2.45
Hillingdon	0	4	19	55	78	324,843	2.4
Hounslow	68	14	5	2	89	327,779	2.72
Kensington & Chelse	22	37	1	0	60	268,576	2.23
Westminister	4	44	1	0	49	253,186	1.94
Out of area	45	29	13	8	95		
Total	170	229	218	71	688		

STRATIFICATION



NARRATIVE

Performance: There has been an overall sector-level increase in bed occupancy by non-CTR patients since November 2024. The prolonged increase in NCTR patients reached 14.5%, making NWL ICB the highest in London. This has been driven by CWFT and LNW which are particularly showing increased levels of occupancy. P1 and P3 pathway delay days performance to target varies by borough. THH and LNW data challenges are being worked through for historic data, but a fix is imminent. Resolution will support baseline setting new targets for 25/26.

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

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

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

GOVERNANCE

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

Workforce

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 no workforce metrics currently performing as special cause concern variation with four meeting the Acute Provider Collaborate agreed targets; vacancy, agency spend, turnover & core skills.

Vacancy rates at collaborative level are consistently hitting target and are special cause improving variation. Since January 2024, the collaborative vacancy level has maintained below the agreed target of 10.0% and in February 2025 was 6.0% (London position 8.4%). This performance is the result of targeted recruitment campaigns, both at home and abroad, with a continuing focus to drive further improvement. Collaborative action is focussed on the hard to fill vacancies, which remain a cause for concern for those service areas.

Voluntary turnover continues as a special cause improving variation as, over the past year, there has been a steady reduction from 10.6% to the current position of 8.2% (London position 11.4%) which is below the APC target of 12.0%. All Trusts have active retention projects and / or programmes and are part of a collaborative retention programme, supported by national resource, across the NWL ICS. The main Collaborative initiative on retention is the creation of a careers hub and a proposal for a common careers platform.

S**ickness levels** have increased but are within seasonal normal range and for February 2025 are collectively at 4.1% (London 5.0%); which slightly above the agreed 4.0% target and a common cause variation. All Trusts have plans in place to manage absence, particularly long-term absence. Trusts continue to work locally to re-deploy staff and mitigate safe staffing risks as required, which can result in a higher reliance on temporary staff with increased numbers of bank and agency shifts being requested and filled to mitigate staffing gaps due to sickness absence.

Agency spend, as a proportion of overall pay bill, is our productivity measure with a collective target set at 2%. Current performance for February 2025 was 1.4% and is a common cause variation; agency spend has been steadily reducing for the past year. 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 and eliminating all off-framework shifts (zero in February).

Completion rates for non-medical **Performance Development Reviews** (PDR), is an area of focus, albeit we have seen an improvement over the past twelve months with the metric continuing 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; current APC position is 91.6%.

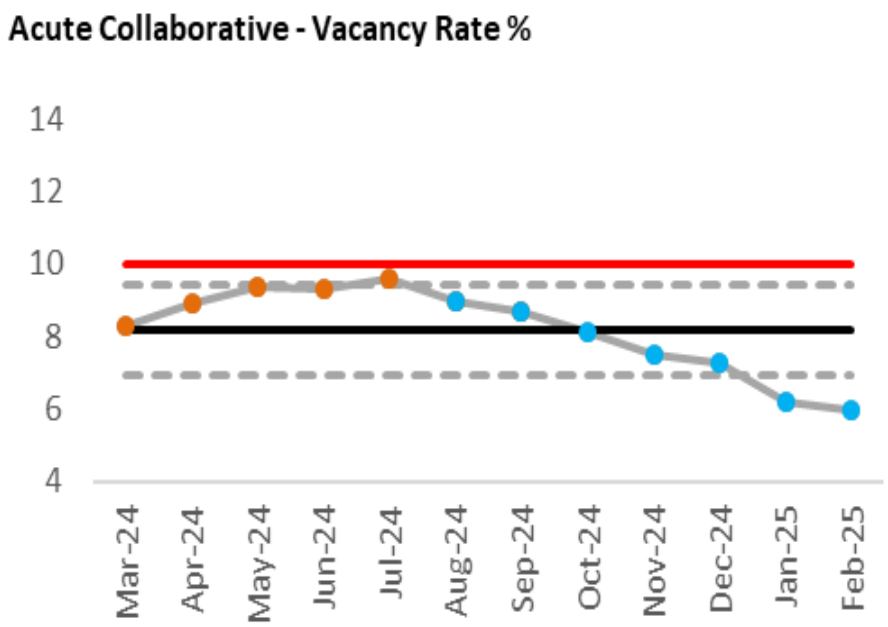
It has been agreed that for **Equality, Diversity and Inclusion** there will be a quarterly update on progress towards the Model Employer Goals. At Acute Collaborative Provider (ACP) Level BAME employees represent 62% of total workforce. To enable the APC to achieve its 2025 MEG goals, each senior pay band needs to reflect 61% of BAME staff within each pay band. Included in this report is the latest quarterly update.

Escalations by Theme:

- EDI positive actions to address under-representation at senior levels.
- Planning for remaining winter months and associated pressures.
- Triangulated planning for 2025/26 – financial / activity / workforce.

Vacancies

TREND



=/<10%

STANDARD

6.0%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Vacancy rates at collaborative level are consistently hitting target. Since February 2025, the collaborative vacancy level has maintained below the agreed target of 10.0% and in February 2025 was 6.0%. This performance is the result of targeted recruitment campaigns, both at home and abroad, with a continuing focus to maintain levels.
Collaborative action is focussed on the hard to fill vacancies. Our top areas of concern are those hard to recruit roles due to a national shortage of qualified staff; Operating Department Practitioners, Sonographers, Occupational Therapists, Middle Grades for Emergency Medicine and Mental Health Nurses. With a continuing reliance on agency staffing and locums to fill the vacancy gaps and support service delivery and both local and collaborative work continues to improve this position.

Recovery Plan / Improvements: Hard to recruit roles continue to receive focus with planned international recruitment campaigns, rolling recruitment and targeted recruitment campaigns to reduce vacancies.
We continue to see increasing numbers of internationally appointed nurses, and this continues to have a positive impact on general nursing vacancies, and we have a strong pipeline to over the coming months. Also of continued focus is the recruitment of midwives and maternity staff, with appointments to preceptorship roles, new obstetric nurse roles and scrub/theatre nurses.

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

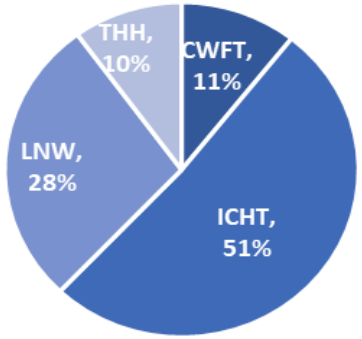
CURRENT PERFORMANCE

Vacancies

	Target %	Month 11 Vacancy Rate %	Variance to Target %	Vacancy WTE
CWFT	10%	3.1%	6.9%	233
ICHT	10%	7.2%	2.8%	1,123
LNW	10%	6.4%	3.6%	609
THH	10%	5.8%	4.2%	219
APC	**10%**	**6.0%**	**4.0%**	**2,185**

STRATIFICATION

Trust proportion of vacant WTE across the APC Month 11

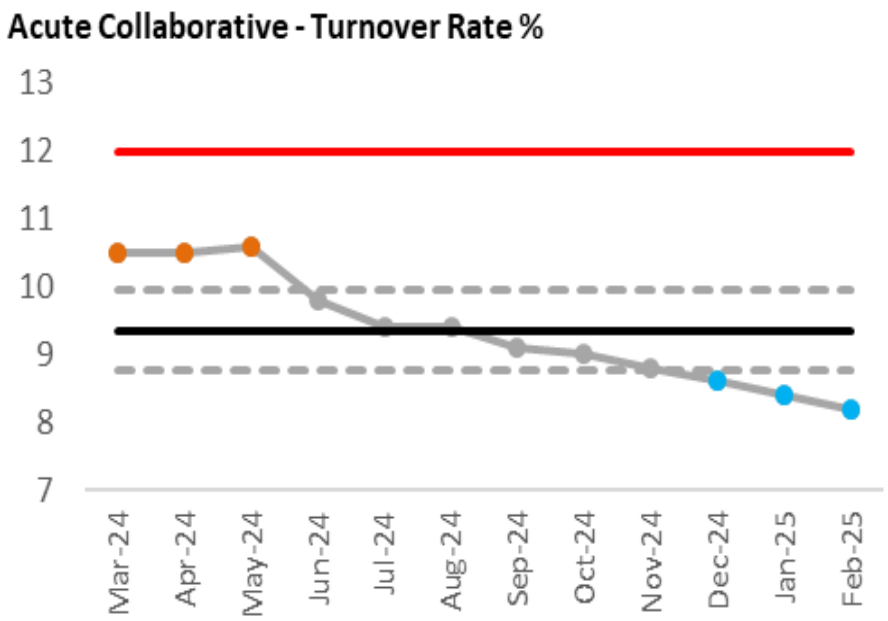


GOVERNANCE

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

Voluntary Turnover

TREND



=/<12%

STANDARD

8.2%

PERFORMANCE

L

TREND

P

ASSURANCE

NARRATIVE

Performance: Voluntary turnover continues as a special cause improving variation as, over the past year, there has been a steady reduction from 10.6% to the current position of 8.2% which is below the APC target of 12.0% and a special cause improving variation.
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.

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

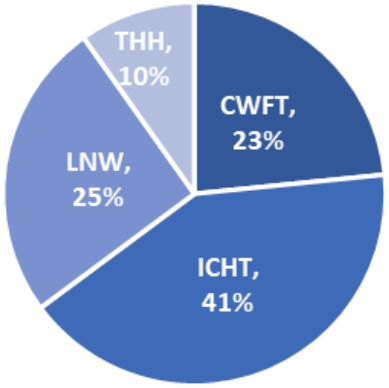
CURRENT PERFORMANCE

Voluntary Turnover

	Target %	Month 11 Turnover Rate %	Variance to Target %	Voluntary Leavers WTE (rolling 12 months)
CWFT	12%	9.2%	2.8%	540
ICHT	12%	8.0%	4.0%	956
LNW	12%	7.6%	4.4%	584
THH	12%	8.9%	3.1%	227
APC	**12%**	**8.2%**	**3.8%**	**2,306**

STRATIFICATION

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

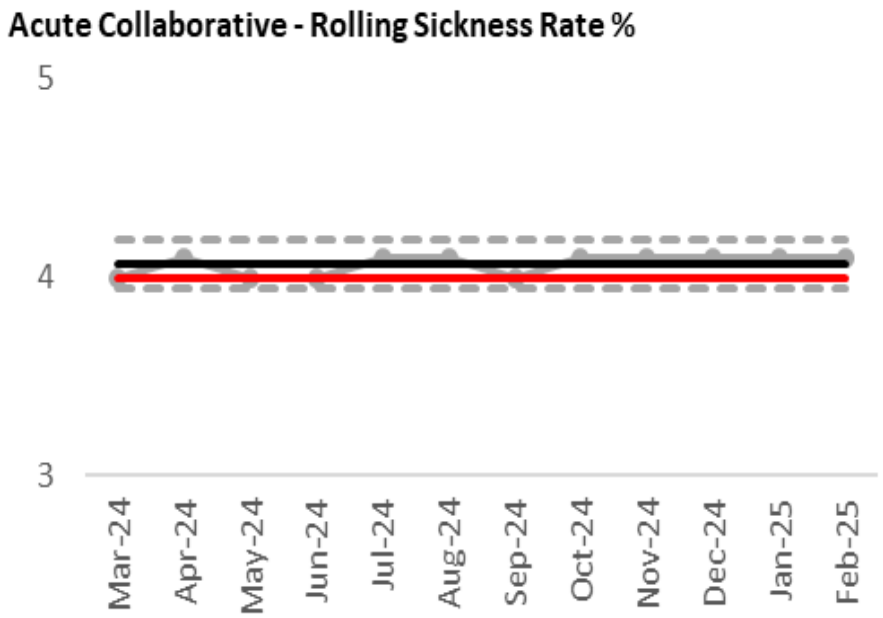


GOVERNANCE

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

Sickness Absence

TREND



=/<4%

STANDARD

4.1%

PERFORMANCE

TREND

ASSURANCE

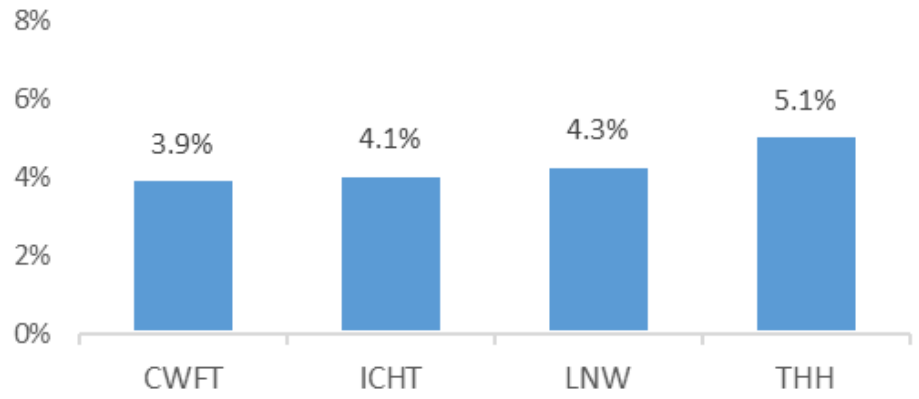
CURRENT PERFORMANCE

Rolling Sickness Absence

	Target %	Month 11 12 Month Rolling Sickness Absence Rate %	Variance to Target %	Month 11 In-Month Sickness Absence Rate %
CWFT	4%	3.9%	0.1%	3.8%
ICHT	4%	4.1%	-0.1%	4.4%
LNW	4%	4.3%	-0.3%	4.8%
THH	4%	5.1%	-1.1%	5.3%
APC	**4%**	**4.1%**	**-0.1%**	**4.4%**

STRATIFICATION

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



NARRATIVE

Performance: Within seasonal normal range and for February 2025 we are collectively at 4.1%; slightly above the agreed 4.0% target and a common cause variation.

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

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

Forecast Risks: Sickness absence levels which could be impacted by seasonal illness waves.

GOVERNANCE

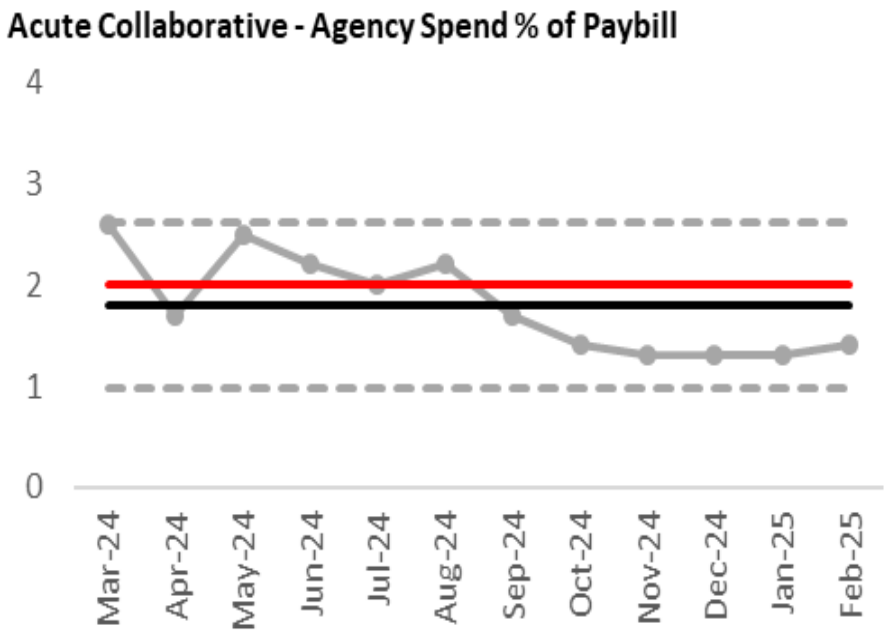
Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

Productivity - Agency Spend

TREND



=/<2%

STANDARD

1.4%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Agency spend, as a proportion of overall pay bill, is our productivity measure with a collective target set at 2%. Current performance for February 2025 was 1.4% and within target and is a common cause variation.
Reliance on agency workers is key for the delivery of some services, particularly where there is a national skills shortage such as for sonography, mental health nursing and cardiac physiology and Trusts are working towards collective solutions in these areas. Continued collaborative work on temporary staffing remains the focus for reducing agency expenditure overall.
Harmonised and uplifted bank rates for AfC staff are in place across all four Trusts to attract more staff to work on the bank.

Recovery Plan / Improvements: Increased demand on both agency and bank workers continues in response to seasonal sickness levels and higher acuity and dependency of patients; requiring the continued focus on recruitment to minimise the underlying vacancy position and associated temporary staffing fill.
Agency workers, whilst costing more than bank or substantive staffing, are essential for the delivery of some services where staff vacancies are nationally hard to recruit such as sonography, cardiac physiologists and pathology.

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

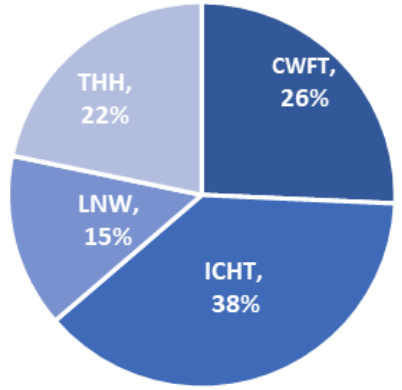
CURRENT PERFORMANCE

Productivity - Agency Spend

	Target %	Month 11 Agency Spend Rate %	Variance to Target %	Agency Spend £ (in Month)
CWFT	2%	1.7%	0.3%	823,100
ICHT	2%	1.3%	0.7%	1,215,931
LNW	2%	0.8%	1.2%	466,970
THH	2%	3.0%	-1.0%	696,031
APC	**2%**	**1.4%**	**0.6%**	**3,202,032**

STRATIFICATION

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

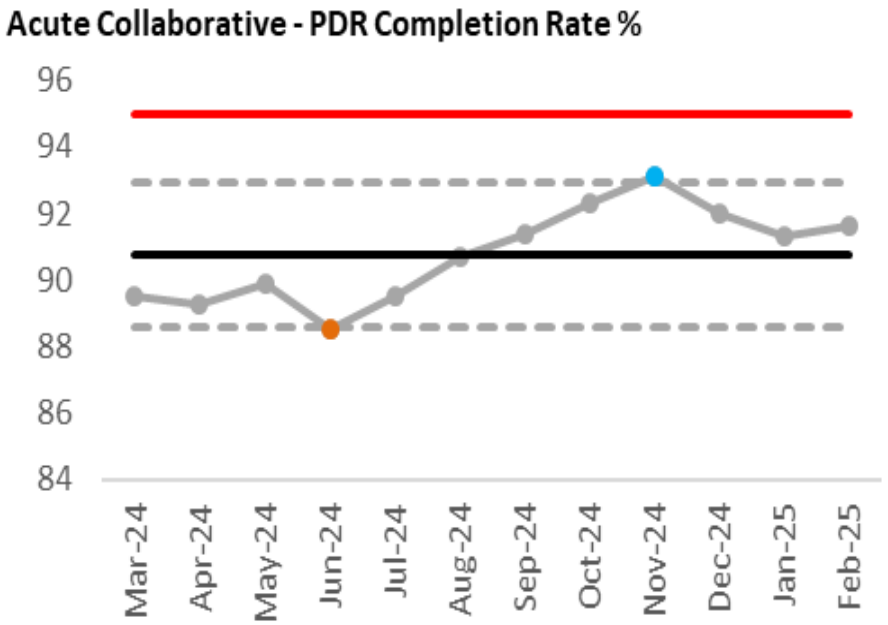


GOVERNANCE

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

Non-Medical PDR

TREND



=/<95%

STANDARD

91.6%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Completion rates for non-medical **Performance Development Reviews** (PDR), is an area of focus, albeit we have seen an improvement on the performance of this metric over the past ten months.

The APC at Month 11 has a medical PDR rate of 93.5%, which is split as follows CWFT 89.4%; ICHT 96.3%; LNW 94.3% & THH 89.3%.

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

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

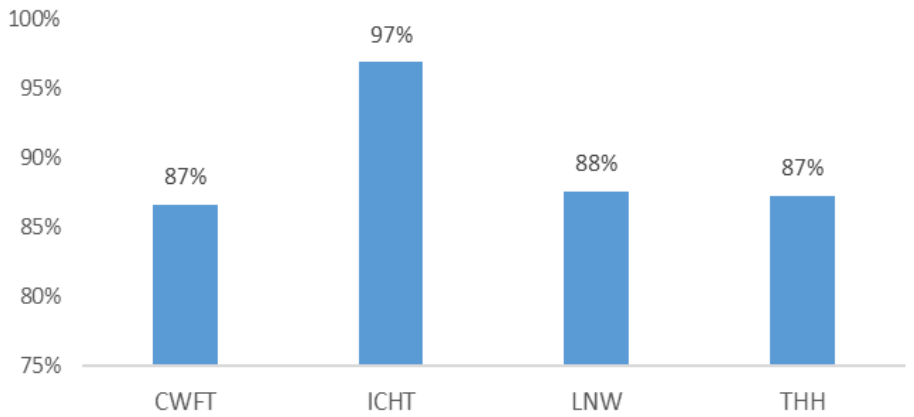
CURRENT PERFORMANCE

Non Medical PDR

	Target %	Month 11 PDR / Appraisal Rate %	Variance to Target %
CWFT	95%	86.7%	-8.3%
ICHT	95%	96.9%	1.9%
LNW	95%	87.6%	-7.4%
THH	95%	87.3%	-7.7%
APC	**95%**	**91.6%**	**-3.4%**

STRATIFICATION

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

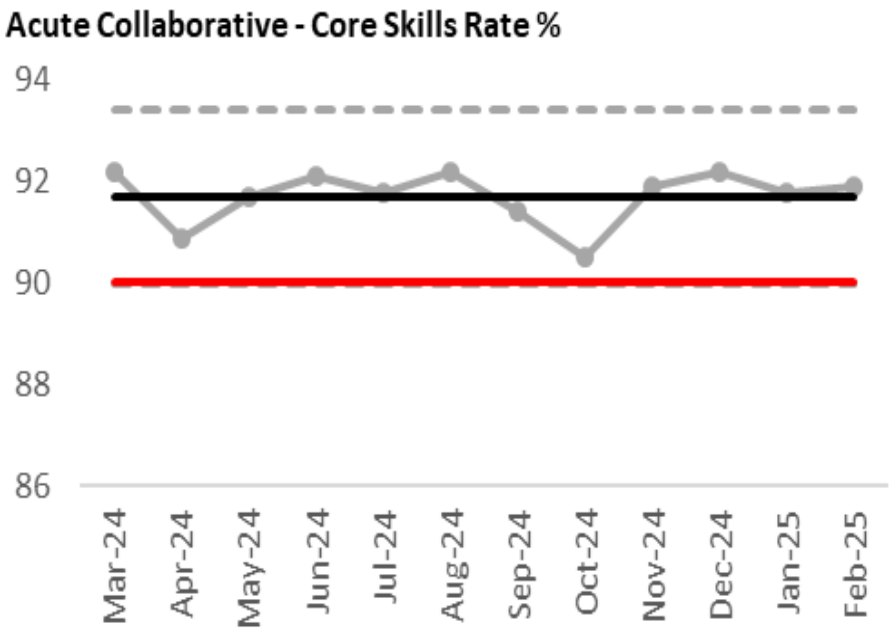


GOVERNANCE

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

Core Skills Compliance

TREND



=/<90%

STANDARD

91.9%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Core Skills (statutory & mandatory training) compliance is essential in the delivery of safe patient care as well as supporting the safety of staff at work and their ability to carry out their roles and responsibilities in an informed, competent and safe way.
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 February and February.
Where possible, auto-reminders are in place for both employees and their line managers to prompt renewal of core skills training as are individual online compliance reports as well as previous mandatory training accredited for new starters and doctors on rotation to support compliance.

Forecast Risks: None

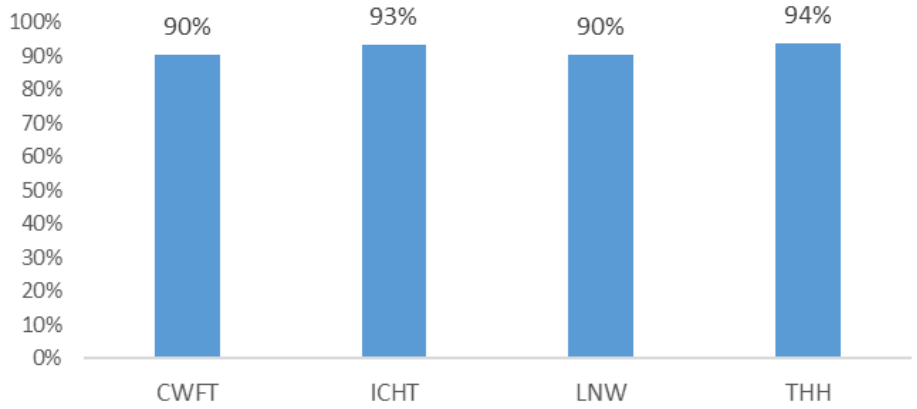
CURRENT PERFORMANCE

Core Skills Compliance

	Target %	Month 11 Core Skills Compliance Rate %	Variance to Target %
CWFT	90%	90.9%	0.9%
ICHT	90%	92.4%	2.4%
LNW	90%	91.1%	1.1%
THH	90%	93.8%	3.8%
APC	**90%**	**91.9%**	**1.9%**

STRATIFICATION

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



GOVERNANCE

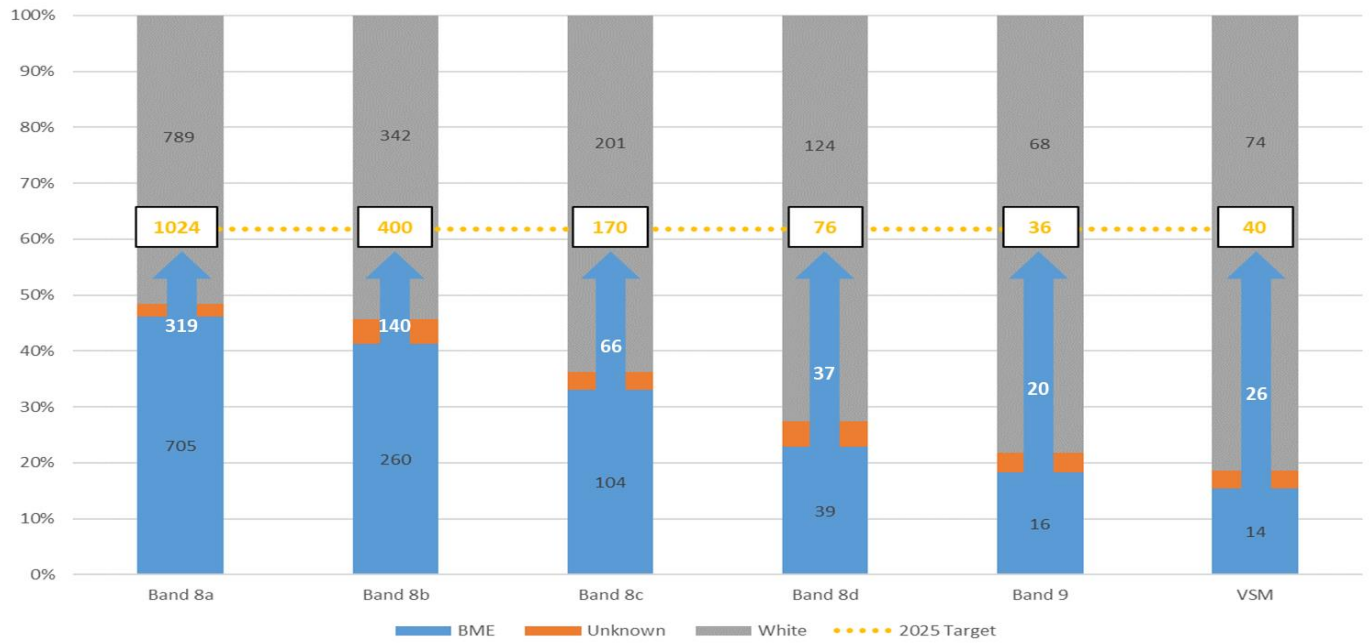
Senior Responsible Owner: Pippa Nightingale
Committee: APC People Committee
Data Assurance: tbc

Workforce Equity

It has been agreed that for Equality, Diversity and Inclusion there will be a quarterly update on progress towards the Model Employer Goals. At Acute Collaborative Provider (ACP) Level BAME employees represent 62% of total workforce. To enable the ACP to achieve its 2025 MEG goals, each senior pay band needs to reflect 61% of BAME staff within each pay band. Included in this report is the latest quarterly update.

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 February 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 February 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 February require focus on external recruitment and internal progression routes including secondment opportunities to gain exposure and leadership trials.

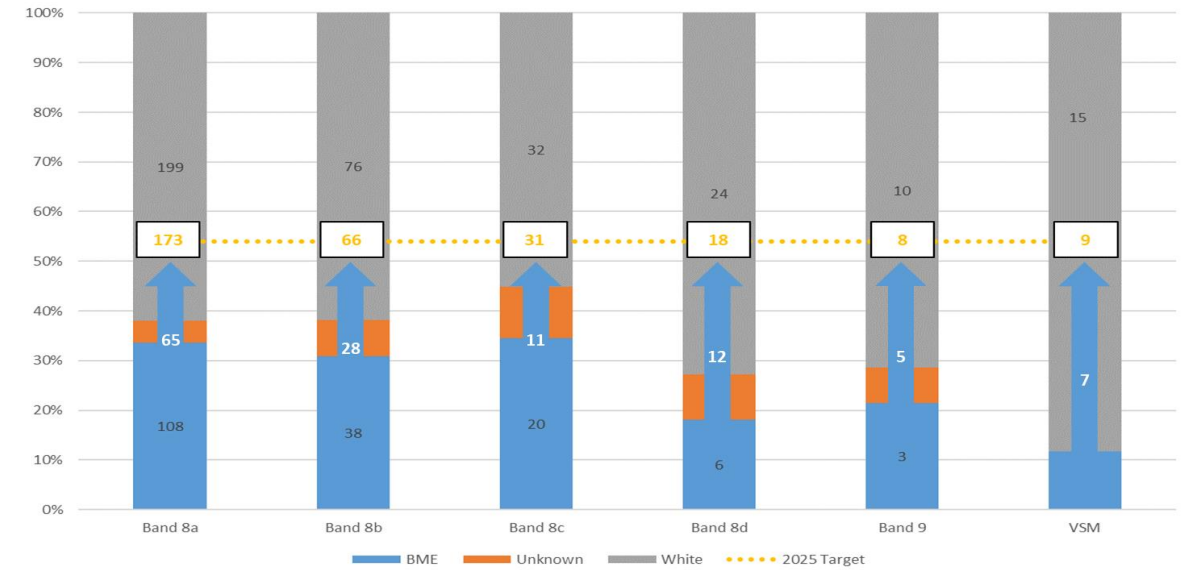


Actions being taken and developed to support MEG goals across the ACP at trust level are as follows (but not limited to);

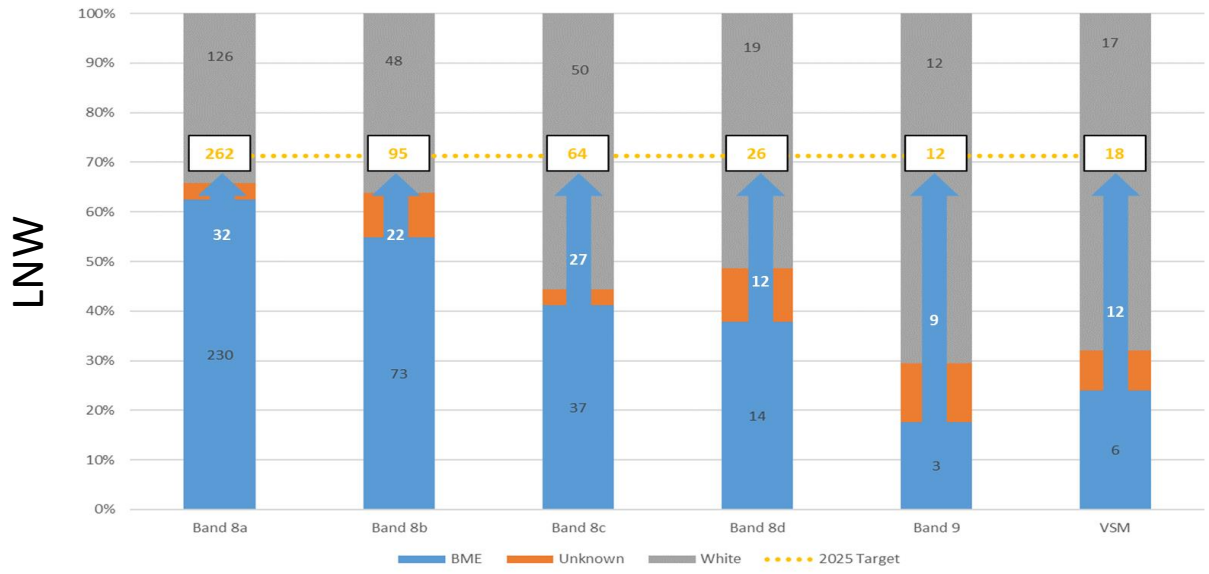
- Inclusive talent management strategies
- Succession planning to enable identifying, support and promotion of talent
- Inclusive recruitment means panels are gender-diverse and ethnically inclusive
- Diverse recruitment panels for all roles above band 7
- Regular monitoring and reporting on MEG targets

Workforce Model Employer Goals - Provider

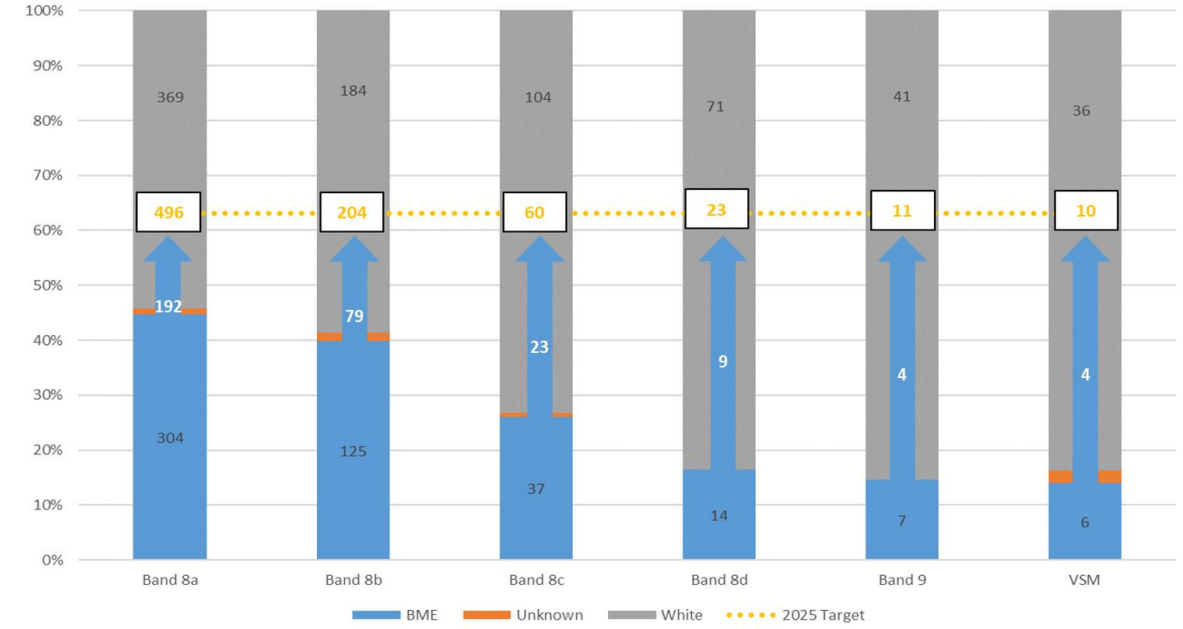
CWFT



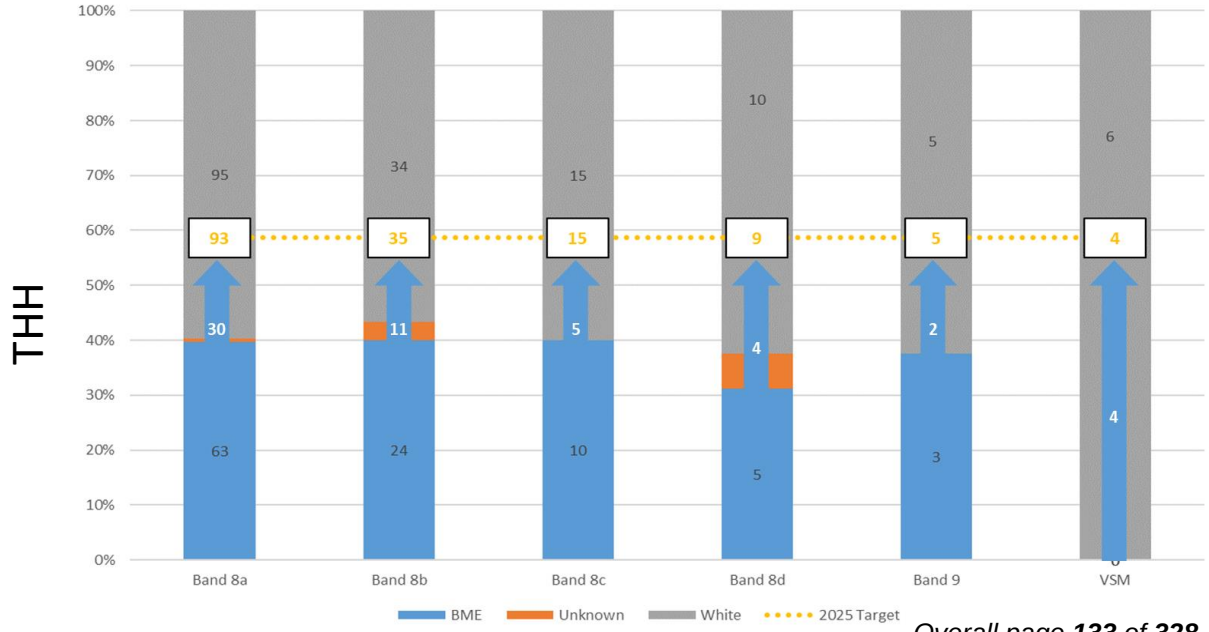
LNW



ICHT



THH



4.1 QUALITY

4.1.1 QUALITY IQPR - ANYTHING BY EXCEPTION (PIPPA NIGHTINGALE)

4.1.2 APC EQUALITY IMPROVEMENT PLAN - BOARD IN COMMON ACTION PLAN (PIPPA NIGHTINGALE / CAROLYN DOWNS / VINEETA MANCHANDA)

REFERENCES

Only PDFs are attached

- 4.1.2a. Equity Improvement Plan Steering Group cover sheetSSFINAL_MS.pdf
- 4.1.2b. 2025-04-29_APC Equity Improvement Plan Steering Group_Presentation for Board FINALV2.pdf

NWL Acute Provider Collaborative Board in Common (Public)
29/04/2025
Item number: 4.1.2
This report is: Public

Equity Improvement Plan Steering Group Recommendations

Author: Hannah Franklin, Tina Benson, Piers Milner,
Job title: Health Equity Programme Manager, Imperial College Healthcare NHS Trust; COO, The Hillingdon Hospitals NHS Foundation Trust; Head of Strategy, London North West University Healthcare Trust

Accountable director: Pippa Nightingale
Job title: Chief Executive Officer, London North West University Healthcare NHS Trust

Purpose of report

Purpose: Decision or approval

The purpose of this report is to provide the board with set of recommendations to improve equity in healthcare access, outcomes and experience across the 4 acute providers, based on an assessment of health inequalities priorities across NWL. The Board are asked to consider and approve the 5 recommendations being put forward in the attached slide deck, as well as the proposed governance of the plan.

Report history

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

Monthly APC EDI Improvement Plan Task and Finish Group Various Several variations of the presentation have been	consulted on by the group before the attached was approved for onward submission to this committee.

Executive summary and key messages

In 2023, the Board agreed that the 4 NWL Trusts would address the EDI and inequality agenda as a collaborative. This work was separated into two phases; Phase 1 was people focussed, and a workforce plan reflecting the High Impact Actions was proposed to the Board and endorsed in October 2023.

This report concludes Phase 2, implemented to focus on Patient and population health related inequalities. In November 2024, a Task and Finish Group was established to review all the initial work being performed across the sector and identify further opportunities to reduce variances in health outcomes amongst our NWL community. Following several in-depth discussions and reviews of available data, the below recommendations and metrics are now being put forward:

1. Focus APC attention on access to acute care (outpatient appointments and wait times for treatment)

2. Formalise support to CORE20PLUS5 clinical priority areas across the ICB, including an enhanced prevention offer

3. Remain sighted on existing equity improvement work across sickle cell and maternity

4. Develop a shared tool across all 4 providers to identify and measure healthcare inequalities, embedding this in business as usual to guide future priority setting

5. Adopt 4 equity focussed performance metrics across the APC, measuring progress by provider against agreed benchmark:
    1. Do-not-attend (DNA) rate of 1st outpatient appointments for patients from the most deprived areas (IMDQ1) brought down to Trust average DNA rate
    2. Eliminate waits over 40 weeks for patients from the most deprived areas (IMDQ1)
    3. Reduce proportion of bookings made later than 9+6w gestation by mothers of black, mixed and other ethnicity
    4. Analgesia offered within 30 minutes of presentation to all patients with an acute painful sickle cell episode. *(This metric is new and may need to be adapted)*

Given the focus on access and performance, the recommendation is that metrics 1 and 2 report through the APC Finance & Planning Committee. Metrics 3 and 4 will therefore report through to the APC Quality Committee given their focus on experience and outcome.

These metrics will be added to the Board Integrated Quality and Performance Report and through this be reported quarterly to the Board in Common.

The Task and Finish Group will now be stood down, and the Trust Standing Committees will take over the responsibility for oversight and regular monitoring.

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

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

APC Equity Improvement Plan steering Group

29/04/2025

North West London (NWL) has significant health and healthcare inequalities which the APC has a role in addressing

270,000 people in NWL are part of the **most deprived** populations in the UK

In some areas of NWL, **life expectancy is 20 Years lower** compared to others within the same Borough

In NWL the more deprived groups, on average, **become multi-morbid 10-15 years earlier** than the least deprived groups

Black, Asian and Mixed ethnicity mothers in NWL are **2.8 times more likely to experience a still birth** compared to white mothers (and **1.4 times more likely for a pre-term** birth)

c. 2,000 sickle cell patients across NWL have historically faced **systemic discrimination and limited access** to required health information and services

Patients from our most deprived communities are over **50% more likely to miss an outpatient appointment** compared to the least deprived due to **additional barriers** they face

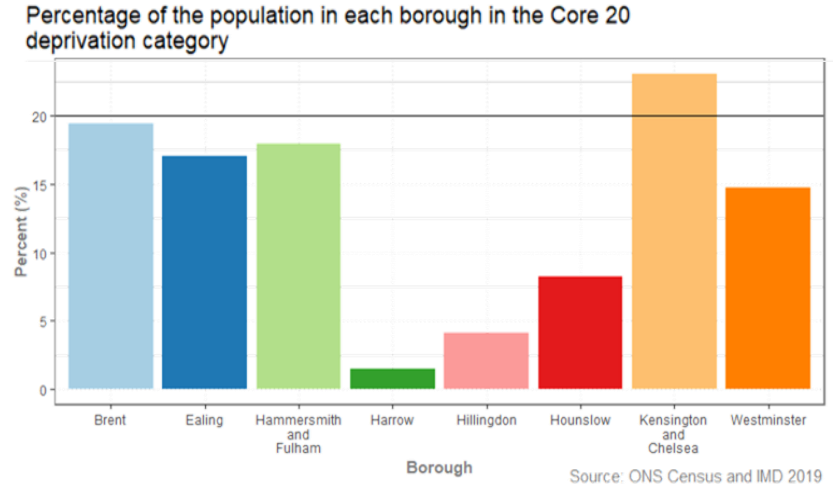
Sources:
- *NWL shared needs assessment*
- *Annual review of healthcare inequalities in North West London*

NW London has pockets of deprivation and affluence often within walking distance of each other

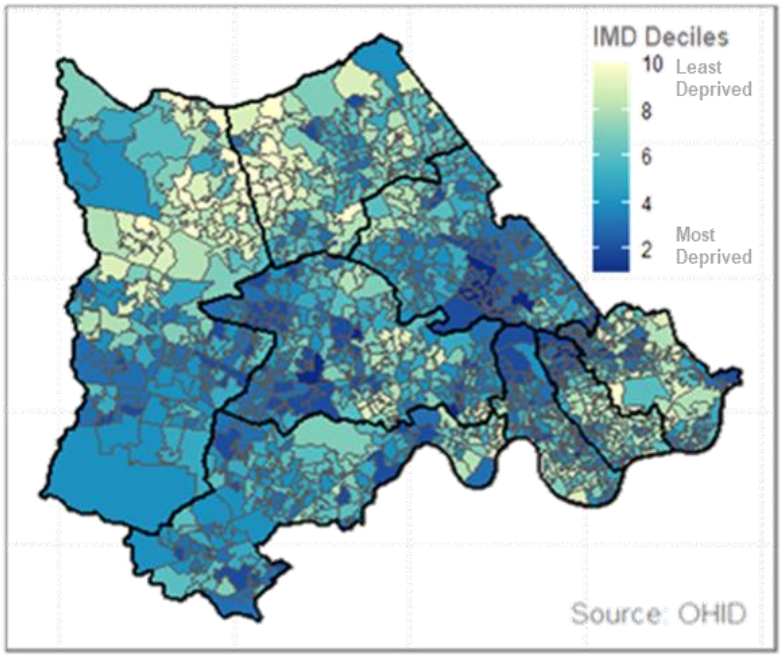
Deprivation is represented by the index of multiple deprivation (IMD); the lower the rank the higher the levels deprivation in an area.

The 'Core20' population live in the 20% most deprived areas of England.

- 12.7% of the NW London population live in a Core20 area.
- Brent has the lowest mean IMD decile suggesting it has the most deprivation, but Kensington and Chelsea has the greatest proportion of their population in the Core20 group (23%).



Indices of multiple deprivation deciles

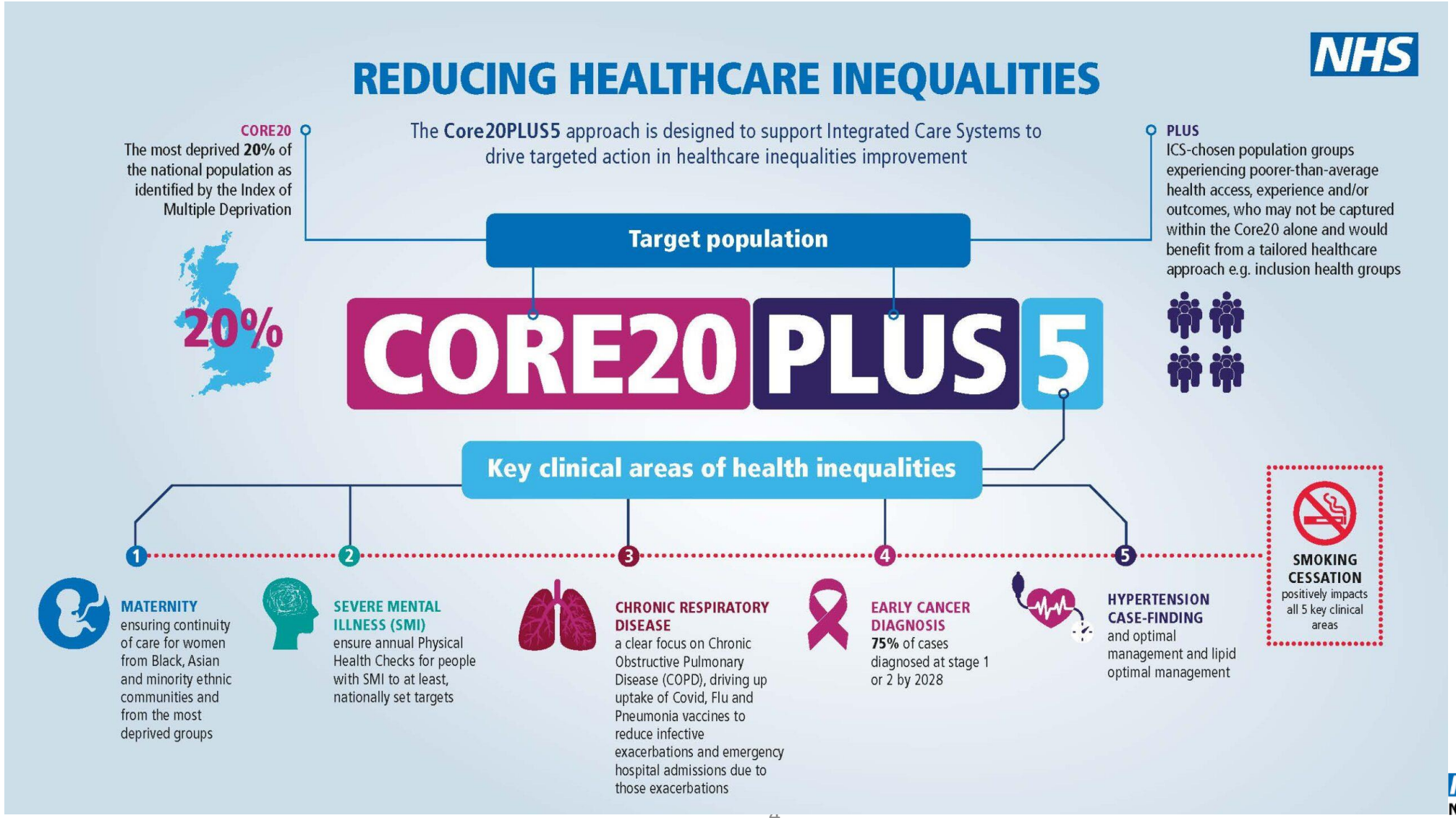


The index of deprivation is made up of seven factors: income, employment, education, health, crime, barriers to housing, and living environment.

Compared to the England average, in NW London:

- Air pollution is higher across all boroughs.
- Violent crime is higher in seven boroughs, and especially for men across all boroughs.
- Employment rates are significantly lower in three of our eight boroughs.
- Rates of homelessness where a child is involved are higher in five of eight boroughs.

CORE20PLUS5 is the national NHS approach to reducing healthcare inequalities



The APC EDI Improvement Group is committed to advancing health equity and reducing health inequalities across the NWL population

Our suggested approach includes leading key initiatives, supporting broader efforts, and maintaining oversight on critical areas of work.

Key focus areas	APC Equity Group Role	Detail Slides
Access: Improving equity of access to our outpatient services, supported through volunteer-led DNA calls	Lead	Slides 6-10
Access: Identifying and addressing disparities in the patient tracking list (PTL) to improve fairness in care access.	Lead	Slide 11
Outcomes: Embedding the shared tool as a core strategic measure for tracking and improving healthcare equity.	Lead	Slide 13
National Alignment: Supporting APC-led alignment and support of CORE20PLUS5 clinical priorities	Lead, support & sighted	Slides 15-21
Maternity & Sickle Cell: Monitoring and evaluating NWL's maternity transformation initiative and Staying informed on regional sickle cell health priorities	Sighted	Slide 22

Recommendations and ongoing oversight

Recommendations:

1. Focus APC attention on access to acute care (outpatient appointments and wait times for treatment)
2. Formalise support to CORE20PLUS5 clinical priority areas across the ICB, including an enhanced prevention offer
3. Remain sighted on existing equity improvement work across sickle cell and maternity
4. Develop a shared tool across all 4 providers to identify and measure healthcare inequalities, embedding this in business as usual to guide future priority setting
5. Adopt 4 equity focussed performance metrics across the APC, measuring progress by provider against agreed benchmark:
    1. Do-not-attend (DNA) rate of 1st outpatient appointments for patients from the most deprived areas (IMDQ1) brought down to Trust average DNA rate
    2. Eliminate waits over 40 weeks for patients from the most deprived areas (IMDQ1)
    3. Reduce proportion of bookings made later than 9+6w gestation by mothers of black, mixed and other ethnicity
    4. Analgesia offered within 30 minutes of presentation to all patients with an acute painful sickle cell episode. *(This metric is new and may need to be adapted)*

- These recommendations are anticipated to remain in place across 25/26 with a stock take through Trust standing committee as part of 26/27 operational planning.
- The programme for maternity has a well functioning governance and we are recommending this remains. The board will get site of the work through the recommended metric
- The metrics should be reported to each Trust standing committee, quarterly and twice a year to the Board in common. Metrics 1&2 will be monitored through the APC F&P committee and metric 3&4 measured through the APC quality committee.

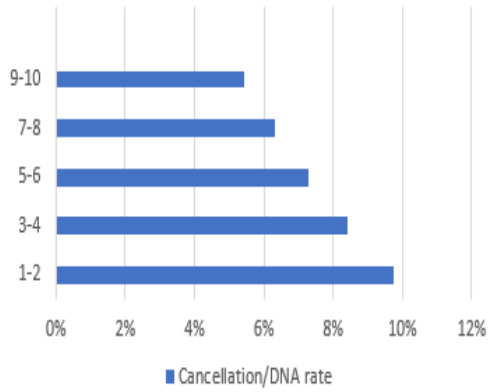
Appendix

DNA's

When considering the Index of Multiple Deprivation (IMD), it is anticipated that individuals from areas of high deprivation would exhibit higher Did Not Attend (DNA) rates compared to those from lower deprivation areas

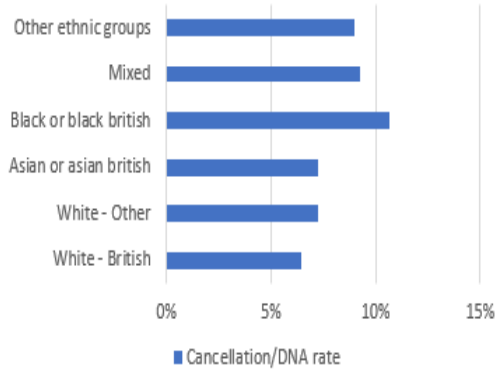
Breakdown of DNA rate by Index of Multiple Deprivation (IMD)

	Cancellations/DNAs	Total OP appts	Cancellation/DNA rate
1-2	8,309	85,442	9.72%
3-4	15,002	178,479	8.41%
5-6	10,692	146,722	7.29%
7-8	5,626	89,069	6.32%
9-10	2,133	39,298	5.43%
Total (excl not known)	41,762	539,010	7.75%
Unknown	1,705	17,590	9.69%
Total (inc not known)	43,467	556,600	7.81%



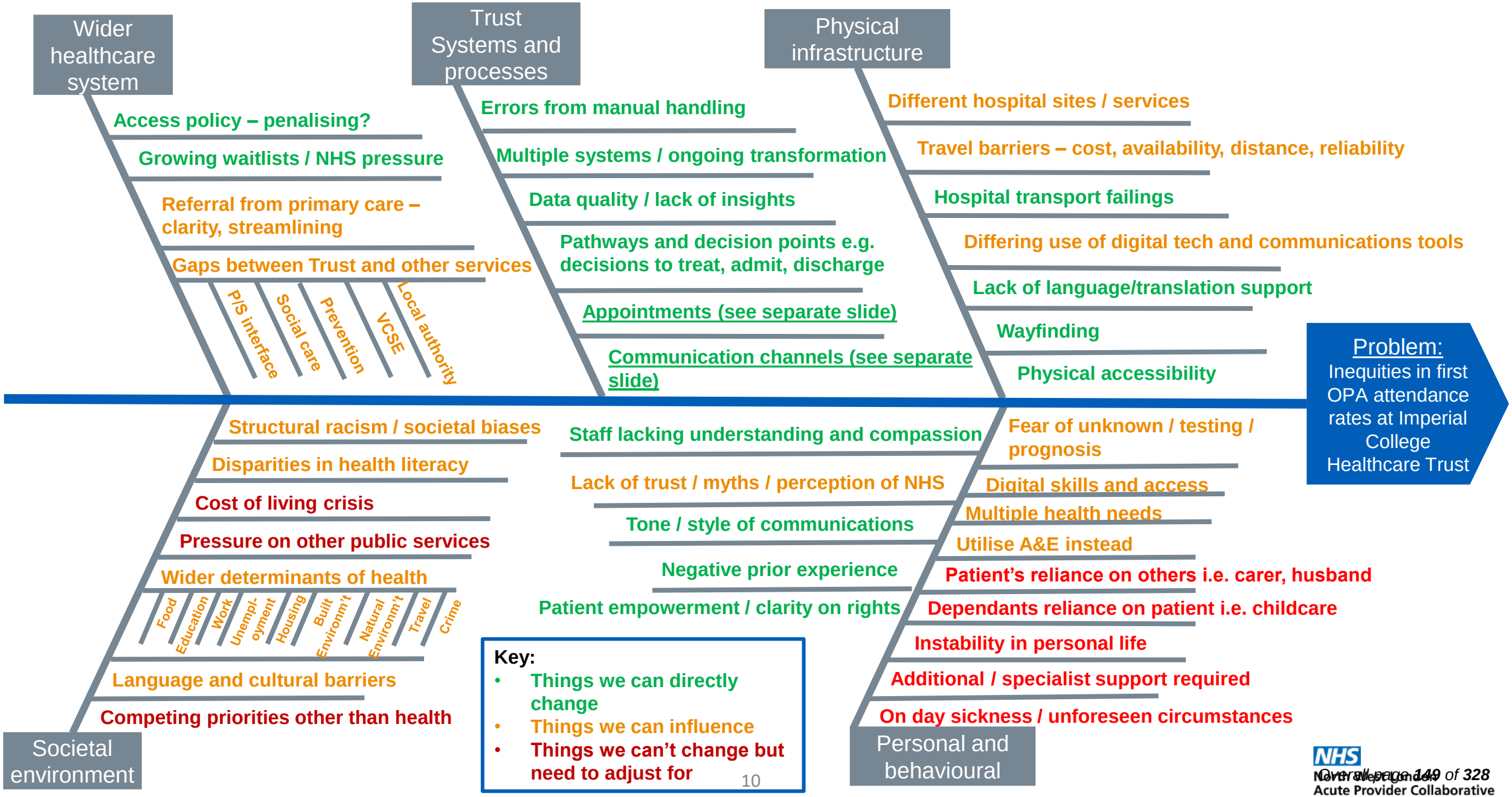
Breakdown of DNA Rate by Ethnicity

	Cancellations/DNAs	Total OP appts	Cancellation/DNA rate
White - British	8,360	130,353	6.41%
White - Other	7,167	99,152	7.23%
Asian or asian british	11,104	153,106	7.25%
Black or black british	7,084	66,433	10.66%
Mixed	1,577	17,026	9.26%
Other ethnic groups	4,441	49,537	8.97%
Total (excl not known)	39,733	515,607	7.71%
Not Known	3,734	40,993	9.11%
Total (inc not known)	43,467	556,600	7.81%



- Patients who live in the leaser deprived areas, (IMD 9–10) appointments show a lower DNA rate compared to those with who live in the most deprived areas (IMD 1–2).
- DNA rates remain high among black and mixed race ethnicities compared to white and Asian patients

The reasons for appointment non-attendance are complex and wide ranging



Improving equity of access of access to our outpatient services (volunteer appointment reminders)| NWL Acutes piloted similar models to reduce DNAs in deprived areas, with varying positive impact.

Trust	Volunteer Source	Services	Patients Reached	DNA Rate	Equity Index	Detail
THHT	External (via H4All)	• Ophthalmology	584	▼Better (12.8 vs. 10.0%)	Not Measured	Link
LNWH	External (via Brent Carers Centre)	• Ophthalmology • Maxillofacial & Oral Surgery	1,515	▼Slightly Better (15% vs. 14.1%)	▼Better (0.36 to 0.29)	Link
ICHT	Internal (via Imperial Health Charity)	• Respiratory (asthma) • Therapies • Gastroenterology • Breast Surgery	1,103	▼Better (17.6% vs. 10.6%, but inconsistent)	Not Measured	Link
CWFT	DoctorDr (Text message service)	• ENT • Rheum		13.7% vs 12.3% 12.7% vs 11.2%	Not Measured	

Initial evaluation shows promise but would benefit from enhanced rigor and control to validate outcomes. We are scoping options for scale and spread alongside a single robust evaluation approach agreed and coordinated across all providers

Identifying, understanding and addressing inequities in our Patient Treatment List (PTL)

Inequities in our PTL: Current State | Differing approaches & capacity across ICB teams & acute trusts mean this issue is not currently well defined or understood

To resolve, we have agreed to adopt a shared methodology across the four acute trusts to analyse inequity in waitlists, following the approach used in the equity index (see above from LNWH data and slide 16 for context). Early analysis shows several statistically significant differences for some demographics in terms of the proportion of the waitlist they make up or time spent waiting compared to a reference group which is being further looked at.

Elective Care Reform Paper | The paper highlights key initiatives, practical improvements, and expected outcomes to drive equity which we will also aim to implement as individual providers following steer from the ICB

⚙️ Key Actions for Equity

- 🏥 **Reduce Health Inequalities**:
  - ICBs develop plans for underserved groups
  - Acute board-level equity performance reviews
- 📍 **Focus Resources**:
  - Expand diagnostics and surgical hubs in deprived areas
  - Improve patient transport services for disadvantaged groups.
- 📊 **Improve Equity Related Data**:
  - Ensure accurate recording of ethnicity, housing, and other demographics.
  - Regularly review waiting list data to identify inequities.
- 📣 **Inclusive Communication**:
  - Use accessible formats and alternative languages.
  - Tailor messaging and outreach in underserved communities..
- 📱 **Digital Access**:
  - Expand NHS App functionality to manage appointments.
  - Provide non-digital alternatives for those excluded digitally.

📈 Practical Improvements

- 🛠️ **Equity Tools & Training**:
  - Use tools like e Health Equity and Referral to Treatment tool to prioritise vulnerable groups.
  - Train staff on equity-focused patient engagement and care.
- 🏆 **Leadership Accountability**:
  - Assign a director for equity and patient experience by April 2025.
  - Embed equity metrics in trust performance monitoring.

🎯 Expected Outcomes

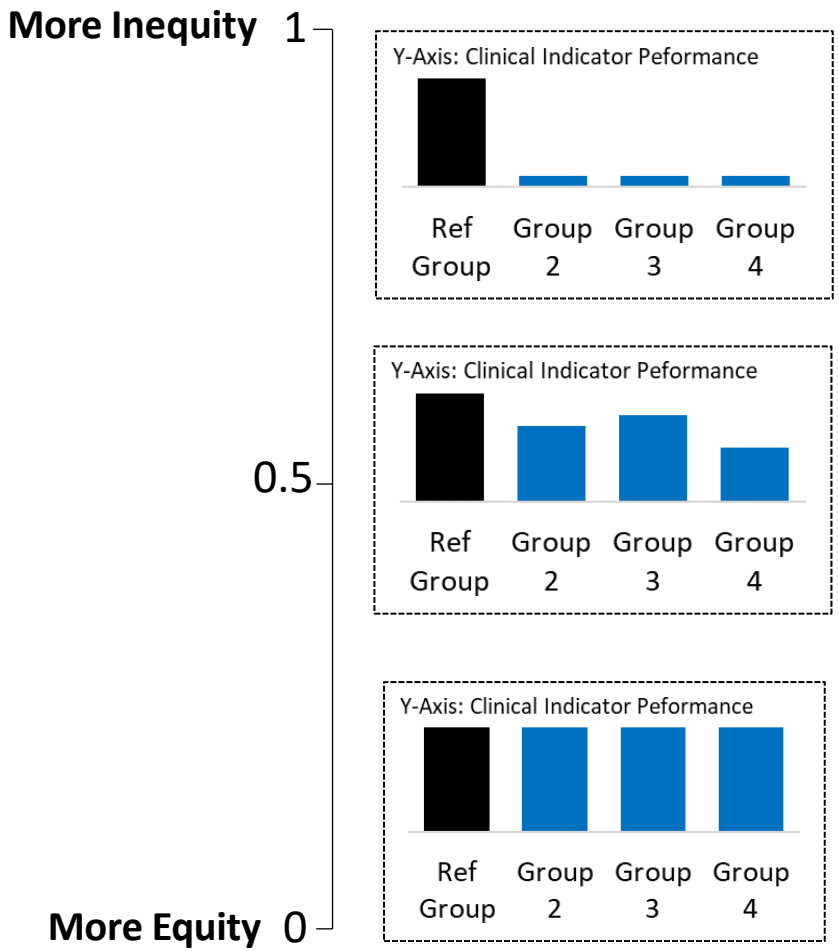
- 🚪 **Better Access:**
  - Reduce waiting time gaps between regions and socioeconomic groups.
  - Improve patient access to diagnostics and surgical pathways.
- 😊 **Improved Patient Experience:**
  - Ensure equitable, inclusive care pathways tailored to diverse needs.
  - Enhance transparency and patient choice through digital tools.

Source: NHS England; Reforming elective care for patients; January 2025 (https://www.england.nhs.uk/wp-content/uploads/2023/04/reforming-elective-care-for-patients.pdf

Equity Index

What is the Equity index? | The Equity Index measures clinical equity, comparing outcomes across demographics, time, and organisations, aligned with Core20Plus5

- A composite measure of clinical equity (0 = more equity, 1 = more inequity).
- Accounts for key factors such as deprivation, race, and other personal characteristics.
- Co-designed with staff, patients, and partners
- Enables comparative insights across:
  - **Outcomes** – *""Which clinical performance indicator has the most inequity?"*
  - **Demographics within an outcome** – *"Is inequity driven by race, deprivation, or both?"*
  - **Time** – *"Have our interventions improved equity?*
  - **Organisations or geographies** – ***"****Which organisation leads in equity, and what can we learn?"*
- Aligned with Core20Plus5, the national equity framework.



Equity Index: Progress Update | Work is progressing to advance from Beta Version to a Final Implementation version

Progress Update:

- **Beta Test Version:** Currently in use at LNWH, shaping local equity priorities.
- **Expert Review:** Reviewed by a statistics professor with positive feedback positive (see next slide).
- **Publication Plan:** Targeted for submission to a peer-reviewed journal following the review.
- **Final LNWH Release:** Development of the stable Equity Index version for LNWH is planned for Q1/2 25/26

Expert Review Outcomes | A robust, transparent tool for tracking organisation-wide inequity — with recognised limitations and mitigations

Expert Review by:

PROFESSOR

Alex Bottle

Professor of Medical Statistics
School of Public Health - Faculty of Medicine

Professional Experience:

BMJ Quality & Safety: Editorial Board

NIHR: Risk Adjustment & Machine Learning

NIHR: Acute Care Use & Mortality (NIHR)

NICE: Guideline Compliance in Heart Failure

BHF: Mortality Prediction

Strengths

- ✓ **Statistically rigorous:** Built on robust, evidence-based statistical methods.
- ✓ **Simplifies complexity:** Offers a single, benchmarkable outcome metric to track equity.
- ✓ **Actionable insights:** Breaks down into components to highlight key disparities.

Challenges of Composite Measures like the Equity Index

- ! **Masks detail:** Aggregation can obscure specific issues, making root cause diagnosis more difficult.
- ! **Subjective indicator choice & weightings**: Indicator choices and weightings may bias results.
- ! **Hides trade-offs:** Strong performance in one area can offset weaker areas.
- ! **Lacks transparency**: Drivers of the score may be unclear.

Mitigations Built into the Index

- **Inclusive development:** Co-designed with staff, patients, and partners.
- **Component-level visibility:** Users can access sub-scores and raw data.
- **Enhanced data governance:** Helps identify and address gaps in data collection.

Limitations & Future Enhancements

- **Data Quality** – Relies on consistent, high-quality inputs.
- **Descriptive only –** Shows where inequities exist but doesn't explain why or account for other possible influences
- **Statistical uncertainty –** Future versions will quantify sensitivity and confidence.

Equity Index in Action | Informing priorities, measuring progress, closing data gaps

Equity Index Use Cases and Emerging Benefits Realisation

Local Equity Focus Prioritisation

Approach:

- Mapped all clinical metrics using the Equity Index

Insight:

- Priority areas identified due to low Equity Index scores:
  - Access & Did Not Attends (DNAs)
  - Bowel Cancer Screening
  - Patient Experience Representation

Next Steps:

- LNWH Equity Group progressing targeted actions
- Ongoing tracking of the Equity Index in priority areas

Outcomes and Equity Benefit Realisation

Approach:

- Equity Index used as a KPI for volunteer-led pre-appointment calls

Insight:

- **DNA rate** reduced: 15% → 14.1%
- **Specialty Equity Index:** 0.36 → 0.29
  - Smaller-than-expected improvement
  - Triggered scale-up and review of equity levers
- **Trust Equity Index:** No change
  - Signals need for larger scale action

Next Steps:

- Pilot impact review
- Reassess drivers and consider expansion

Identifying Data Gaps

Approach:

- Meadow House Hospice: Strategic Equity Index KPI on representation of access to services

Insight:

- **0% ethnicity data** in SystemOne
- Cerner data linkage raised this to 60%
- Led to a change in how ethnicity data is captured across services

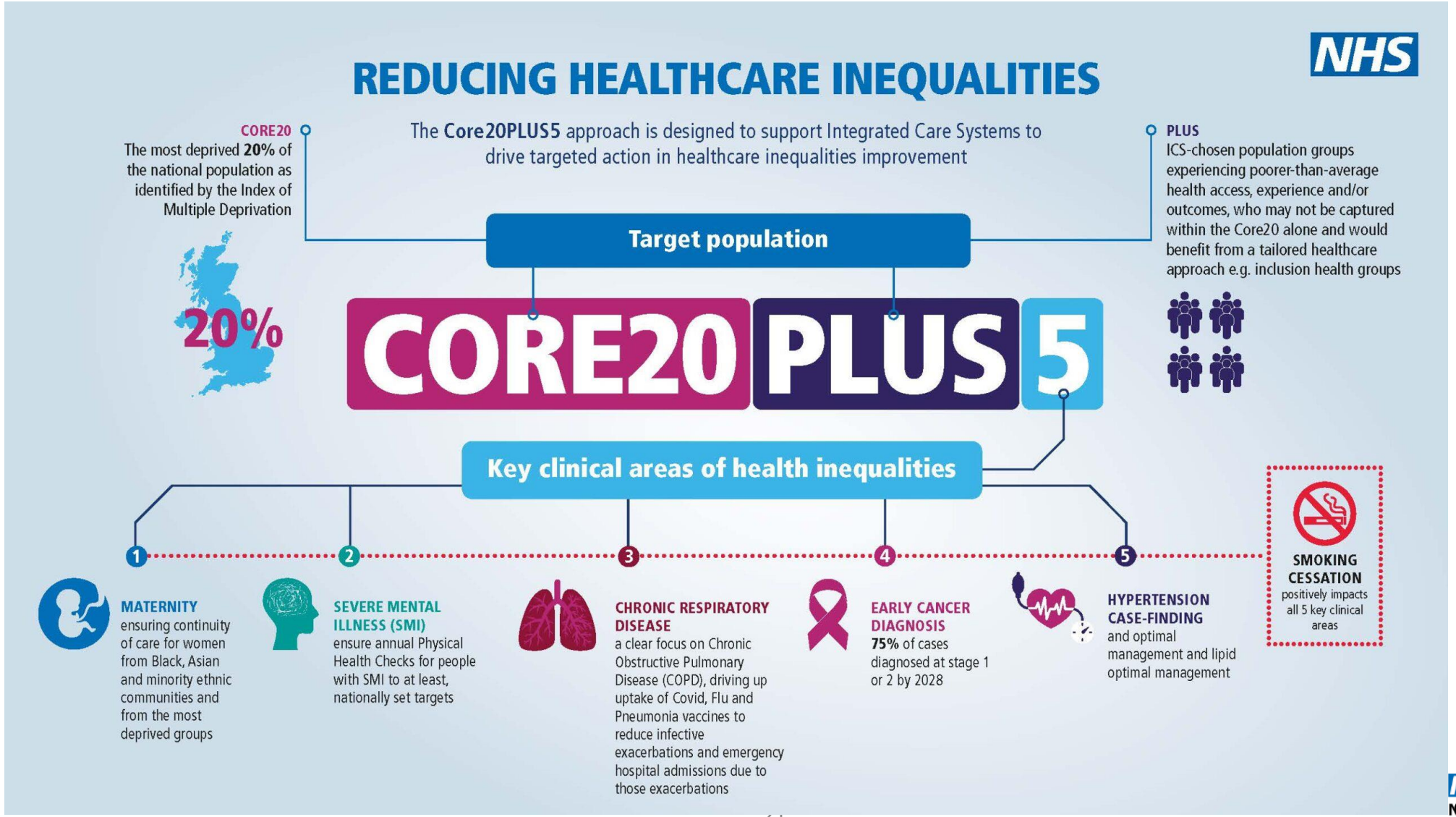
Next Steps:

- Review barriers to Specialist Palliative Care access
- Continue to improve capture of demographic data locally

Aligning with the Core20Plus5

National Clinical Priority Areas

CORE20PLUS5 is the national NHS approach to reducing healthcare inequalities



National Equity Priority Areas: Our Role | Each clinical area has been assigned a role — Lead, Support or Stay Sighted — based on our ability to drive change

Role Definitions

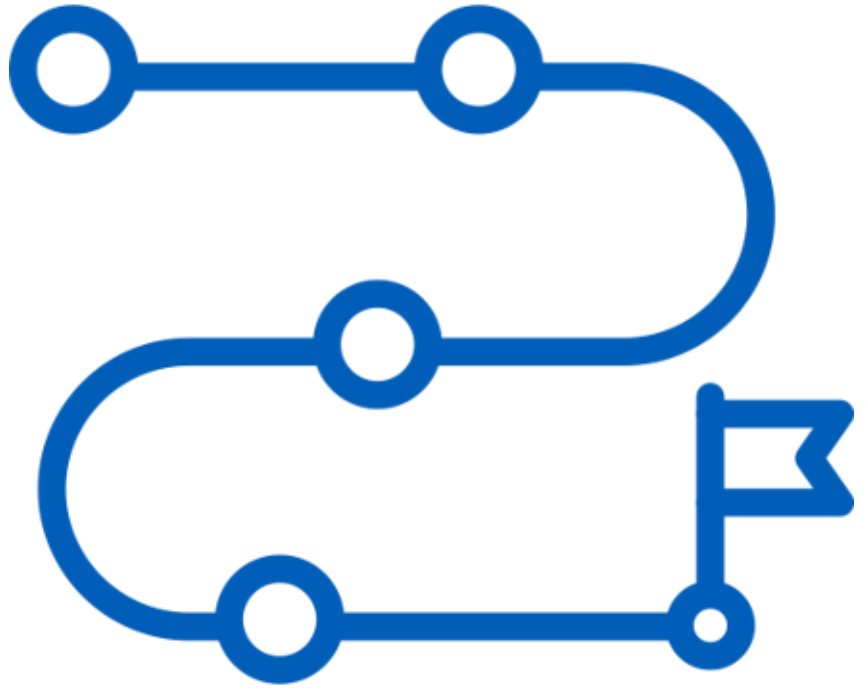
APC Role	Description	What might this look like?
Lead	Own equity delivery	• Targeted programmes, governance, APC coordination
Support	Collaborate locally/regionally	• Co-design, align, prevent
Stay Sighted	Monitor & stay ready	• Track trends, maintain alignment

Assignment of Roles to Clinical Focus Areas

National Focus Area	National Definitions	Proposed Role
Maternity	Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups	**Support**
Severe Mental Illness	Ensure annual physical health checks for people with SMI	**Sighted**
Chronic Respiratory Disease	Driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.	**Support**
Early Cancer Diagnosis	75% of cases diagnosed at stage 1 or 2 by 2028.	**Support**
Hypertension	Allow for interventions to optimise BP and minimise the risk of myocardial infarction and stroke	**Support**
Smoking Cessation	Positively Affects the above	**Support**

Five Clinical priorities: Proposed Next Steps | Follow a structured approach to embedding high-impact equity initiatives into APC-wide service improvement efforts

1. **Mapping & Alignment (Complete)**
   - Map existing initiatives across **APC Trusts**.
   - Identify gaps and opportunities for **scaling high-impact equity interventions**.
   - Ensure alignment with **national and local equity priorities**.
2. **Prioritisation & Proposal Development**
   - Ask relevant working groups & Clinical Reference Groups to review for any additional opportunities
   - **Evaluate proposals** under each clinical priority based on **equity impact** and **feasibility** for APC-wide implementation.
   - Leverage Transformation teams to **scope initiatives and resource.**
3. **Delivery & Oversight**
   - Assign ownership for implementation within **APC working groups / CRGs**.
   - Establish a structured **oversight framework** via the **APC Governance Group**.
   - Track progress through **data-driven insights and real-time reporting**.



NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Maternity & Sickle Cell

Maternity & Sickle Cell: Maternity | A Key Equity Priority for NWL with an existing programme of work and governance oversight

Maternity: A Key APC Equity Priority

- **High Inequity Area:** High proportion of still births attributed to Black, mixed and other ethnicity women (2.8 times more likely than white mothers) along with increased likelihood of pre-term births (1.4 times more likely)
- **Historical Failures:** Comprehensive NWL Maternity Equity and Equality report outlines systemic issues and resulting action plans NW_London_Maternity_Equity__Equality_report.pdf

Governance Considerations

- **Current Oversight:** All 4 acute trusts feed up into the Acute Quality Board in Common and the ICB performance committee via the Local Maternity and Neonatal System (see appendix H)
- **Maternity inequalities dashboard**: Already in use across acutes and ICB tracking monthly progress (appendix I)

Prevention opportunity

- **Poor health of mother pre-conception**: A key driver of still birth and preterm disparities, increased role for acute trusts to proactively feedback on health status and health promotion opportunities to primary care for future expectant mothers

Recommendation for Equity Oversight

- **Track roll out of Regional Care Bundles** (fetal movements, translation, improving access and vitamin D uptake) by each trust once available to support improved equity of maternal outcomes (still birth and pre-term birth)
- Proposed improvement metric to be measured across APC by provider given late booking poses delays to putting appropriate care plans in place **Proportion of bookings made later than 9+6w gestation by mothers of black, mixed and other ethnicity and from IMDQ1**.

Maternity & Sickle Cell: Sickle Cell | A Key Equity Priority for NWL with an Emerging Dedicated Governance Approach for Oversight and Delivery

Sickle Cell: A Key APC Equity Priority

- **High Inequity Area:** Sickle cell care disproportionately impacts Global Majority communities, with persistent disparities in access, experience, and outcomes.
- **Historical Failures:** National reports highlight systemic issues, reinforcing the need for sustained equity oversight.
- **Standardisation & Trust:** Embedding equity in governance ensures consistent care and builds trust with affected communities.

Governance Considerations

- **Current Oversight:** Sickle cell care has a joint clinical and operational lead, but governance remains split between LNWH & ICHT.
- **Planned Change:** The Sickle Cell Strategy proposes a joint North West London Specialist Haemoglobinopathy Service (NWL SHT) with unified governance.

Recommendation for Equity Oversight

- Equity considerations will be embedded within the new NWL SHT governance, ensuring aligned oversight without duplication

4.1.3 LEARNING FROM DEATHS - QUARTER 3 REPORT (JON BAKER)

REFERENCES

Only PDFs are attached

4.1.3. BiC learning from deaths Q3 v2.pdf

NWL Acute Provider Collaborative Board in Common (Public)
29/04/2025
Item number: 4.1.3
This report is: Public

Acute provider collaborative Learning from Deaths quarter three 2024/25 summary report

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

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

Purpose of report

Purpose: Information or for noting only

Trusts are required to report data to their public board on the outcomes from their learning from deaths process. This is achieved through a detailed quarterly report to individual Trust quality committees, 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.	26/02/2025 Trust reports were reviewed and the contents of this paper discussed and agreed.	Acute Provider Collaborative Quality Committee 18/03/2025 The committee noted the findings within the report. The report was approved for onward submission to Board-in-common.
Acute Provider Collaborative mortality surveillance meeting		

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 presents a summary of the findings from the quarter three reports of 2024/25.

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

1.3. In December 2024, changes were made nationally to the HSMR methodology. As expected, this has resulted in increases in HSMR in all four trusts, and in most providers nationally. The Hillingdon Hospitals NHS Foundation Trust (THH) has increased above the national benchmark of 100, and London North West NHS Trust (LNW) has moved to 'as expected'. Chelsea and Westminster NHS Foundation Trust (CWFT) and Imperial College Healthcare NHS Trust (ICHT) remain lower than expected. The impact of the changes is being reviewed by each Trust, and within the APC mortality surveillance group. Potential issues with coding have been identified by LNW and THH. This is being reviewed with data being updated accordingly.

1.4. The SHMI methodology has not changed. THH remains 'as expected' with all other Trusts 'lower than expected' for this indicator.

1.5. There continue to be low numbers of cases where clinical concerns are identified through Level 2 reviews. There were seven instances of sub-optimal care where different care might have made a difference compared to six last quarter. No common themes were identified across these cases.

1.6. Work to improve care at the end of life, a consistent theme across most quarters, continues with local actions in place. Care at the end of life is now included in the APC pathway improvement work.

1.7. All Trusts continue to investigate variations between observed and expected deaths by diagnostic group. Reviews undertaken in quarter three were presented to the APC mortality surveillance group in February, with no clinical concerns identified.

Impact assessment

☒ Quality

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

Strategic priorities

☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation

Key risks arising from report

Each Trust has processes in place to ensure learning happens after all in-hospital deaths, this is shared and actions implemented where required. There are no issues for escalation to this committee.

Main report

2. Learning and Improvements

2.1. The key theme for improvement from reviews undertaken in this quarter relates to care at the end of life, including recognition and timely referral to palliative care, agreement and documentation of advanced care planning/treatment escalation plans and the involvement of patients and families in these processes. This theme is consistent with previous quarters with local trust work in place. End-of-life care is a focus of the APC pathway improvement work, looking to standardise the discharge process for patients, which should support improvements in the number of patients who are able to die at the location of their choice.

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

- **CWFT:** reviews continue to highlight areas for improvement around timely and accurate documentation of treatment escalation plans (TEP) and DNAR discussions. This includes communication with families and supporting understanding of the patient care plan and expectations. The Trust recognises the importance of delivering high quality end of life care and has laid out key areas of focus around earlier identification, advance care planning, timely discharge planning to patient's preferred place of care and death.
- **ICHT:** reviews have identified examples of excellent team working and communication with families. An area for improvement identified in a small number of cases is around the importance of effectively responding to patient deterioration. This is a safety improvement priority with a focus on management of patients with sepsis and implementing the new NICE guidance and the pilot work to implement all stages of Martha's rule.
- **LNW:** reviews have identified examples of good utilisation of treatment escalation plans in collaboration with palliative care teams. Work continues to focus on supportive care guidelines for haematological malignancies receiving systemic anti-cancer therapy, and proactive clinical decision making with a case-by-case approach to feeding in frail and palliative patients. Improvement plans are in place/development through appropriate governance processes.
- **THH:** reviews identified excellent end-of-life care in several cases with early involvement from the palliative care team. There were some cases which identified areas for improvement relating to documentation, timeliness for completion of a death certificate out of hours. Findings have been shared for further review at specialty mortality and morbidity meetings (M&M) which will in turn inform improvement work.

3. Thematic Review

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

3.2. Mortality rates and numbers of deaths

3.2.1 In December 2024, changes were made nationally to the HSMR methodology which included removal of the adjustment for palliative care coding, changes to the comorbidity framework and deprivation scoring, and in the diagnostic groupings which make up the ratio. These are reflected in the board in common clinical outcomes dashboard for the data period of September 2023 to August 2024 as presented to APC quality committee (included in appendix 1).

3.2.2 As expected, this has resulted in increases in HSMR in all four trusts, and in most providers nationally. THH has increased above the national benchmark of 100, with their ranking remaining 'as expected' and LNW has moved to 'as expected'. CWFT and ICHT remain lower than expected. Rankings for CWFT, ICHT and LNW have not changed significantly, however THH has dropped to 81st. Coding is being reviewed to ensure accuracy.

3.2.3 The SHMI methodology has not changed. THH remains 'as expected' for SHMI with all other Trusts 'lower than expected' for this indicator.

3.2.4 HSMR and SHMI diagnostic group data is reviewed by the APC mortality surveillance group, with variation noted. Trusts continue to regularly review HSMR and SHMI diagnostic groups with a score above 100, or where HSMR is increasing, to understand the differences. Reviews undertaken in quarter three include:

- **ICHT:** Review of Asthma and Acute Myocardial Infarction (AMI) diagnostic groups are underway. A review of non-AMI deaths in Cardiology has also begun following an increase in HSMR above the national benchmark of 100 in August 2024, although this is still within the expected range. All reviews will be presented to the Learning from Death forum and details included in the Q4 report.
- **THH:** In Q3, diagnostic group alerts were triggered for Allergic Reactions, Appendicitis & Other Appendiceal Conditions, and Multiple Myeloma, with patient reviews underway. Additional CUSUM alerts for Cardiac Arrest & Ventricular Fibrillation and Gout & Other Crystal Arthropathies are under review, with completion expected in Q4.
- **LNWH:** This quarter, a review of Cardiac Arrest & Ventricular Fibrillation cases found that most of the cases (82%, n=31) were out-of-hospital cardiac arrests, appropriately treated and escalated to ITU. All cases were graded CESDI 0, with no sub-optimal care identified.
- **CWFT:** There were no diagnostic groups requiring review in quarter 3.

3.2.5 Site level HSMR data has been provided by Telstra Health UK with and was discussed at the APC mortality surveillance group. The table below shows most recent data available; this is prior to the changes made to HSMR outlined above. All sites except Northwick Park are below 100 and sites shown in green have a low relative risk.

Provider Rolling 12 month HSMR	Aug 23 to July 24
ICHT (St Mary's)	77.1
ICHT (Charing Cross)	75.2
ICHT (Hammersmith)	86.3
CWFT (ChelWest)	77.9
CWFT (West Middx)	95.7
THH (Hillingdon)	92.6
LNW (Northwick)	101.0
LNW (Ealing)	90.6
LNW (St Mark's)	52.1
National Benchmark	100.0

3.2.6 Queen Charlotte's and Chelsea Hospital (ICHT) and Mount Vernon (THH) have been removed from reporting as the numbers of deaths are very low which causes too much variation for the data to be used effectively. Deaths at these sites are still reviewed through standard learning from deaths processes.

3.2.7 There had been a period of recent increase at Hammersmith Hospital which is being reviewed by ICHT. This would be linked to the rising HSMR in Cardiology and recent alerts for the acute myocardial infarction diagnostic group due to the services operating on that site. Findings will be included in the quarter four report.

3.3. Medical examiner reviews

3.3.1 Following the new statutory requirements for death certification introduced in September 2024, all Trusts have expanded medical examiner scrutiny beyond in-hospital deaths to include all non-coronial deaths across the respective NWL boroughs in quarter three.

3.3.2 All four Trusts continue to provide out of hours/weekend ME scrutiny, prioritising urgent cases i.e. deaths requiring urgent body release. Learning from each Trust continues to feed into collaborative work with an aim to improve working relationships with referrers and other stakeholders.

3.4. Level 2 reviews

3.4.1 Deaths where there are concerns, or which meet agreed criteria, are referred by the medical examiner for a case note 'Level 2' review. The percentage of deaths referred during quarter three were 16% at LNW, 7% at THH, 18% at ICHT and 44% at CWFT.

3.4.2 A shared set of 'triggers' for these reviews were implemented at the end of quarter one to allow consistent reporting on themes. CWFT have also retained local triggers to be used where potential learning was identified at initial screening by consultants or for other local reasons such as requests from divisional mortality review groups, this explains the higher percentage referral data there.

3.4.3 All Trusts have implemented the CESDI scoring system to identify whether a death was avoidable in order to produce standard outputs from Level 2 reviews. Outcomes show low numbers of cases where definite issues are confirmed through Level 2 review which aligns with the lower-than-expected mortality ratios in most Trusts. Seven cases where sub-optimal care might have contributed to the patient's outcome were identified from completed reviews for deaths in this quarter which is similar to the previous quarter.

3.4.4 For deaths which occurred in quarter three:

- **CWFT**: 101 Level 2 reviews completed with no cases of sub-optimal care that might have made a difference to the patient's outcome.
- **ICHT**: 45 Level 2 reviews completed with five cases of sub-optimal care that might have made a difference to the patient's outcome, being managed through the incident process.
- **LNW**: 88 Level 2 reviews completed with one case of sub-optimal care that might have made a difference to the patient's outcome.
- **THH**: 7 Level 2 reviews have been completed, with one case of sub-optimal care that might have made a difference to the patient's outcome.

3.5. Other mortality reviews

3.5.1 A number of other national processes are in place for review of deaths for specific cohorts of patients. These include the Perinatal mortality review tool (PMRT), Learning disability

mortality review (LeDeR) and Child death overview panels (CDOP), which are described in the glossary below. Work has continued to align reporting of cases and outcomes from these processes in each Trust and data is now being presented in scorecards.

3.5.2 ICHT and THH have identified areas for improvement in the care and early identification of patients with learning disabilities and autism (LeDeR) this quarter, with enhancements already underway. Meanwhile, CWFT, LNWH, and ICHT continue to strengthen network support for non-English-speaking patients in the community, addressing a recurring theme that remains a priority for improvement.

3.5.3 Additionally, THH and ICHT have highlighted discrepancies in the use of aspirin for high-risk pregnancies through PMRT reviews. Sector-wide guidance has now been implemented in line with *Saving Babies' Lives v3*, ensuring a standardised pathway across all trusts.

4. Areas of focus

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

4.2. At ICHT, ethnicity data from the NWL Whole System Integrated Care (WSIC) platform has been integrated to improve data quality and reduce unknown records, leading to a decrease from 17% in Q1 to 6% in Q3. Work continues with the Health Inequalities programme team to analyse this data from a population health perspective and identify service inequalities.

4.3. At CWFT, as part of the implementation of the Patient Safety Incident Response Framework (PSIRF), the mortality review template is being utilised as a learning response tool, with the follow-up of safety action plans now managed through the Divisional Mortality Review Groups and the Mortality Surveillance Group moving forward. Additionally, any cases escalated as CESDI 2 and 3 are presented to the weekly Initial Incident Review Group, where a proportionate decision on the learning response is made and subsequently approved by the executive team.

4.4. THH launched a trial of a monthly Divisional Mortality Review Group (DMRG) meeting to review outcomes of completed SJRs graded as CESDI 1 or 2. The meeting aimed to enhance scrutiny of mortality cases, validate grading, identify key themes, and escalate concerns. It also facilitated timely divisional approval of actions. The trial was successful and will be presented at the next Mortality Surveillance meeting.

5. Conclusion

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

5.2. Despite the recent changes in HSMR methodology, all Trusts mortality rates remain either as expected or lower than expected. This aligns with the continued low numbers of cases where clinical concerns are identified through Level 2 reviews and small numbers of incidents reported overall where the harm to patients is confirmed as severe or extreme/death.

5.3. Local reviews into HSMR and SHMI diagnostic groups are overseen through trust governance process with themes shared at the APC mortality surveillance group and will continue to be summarised in this report going forward.

6. Glossary

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

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

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

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

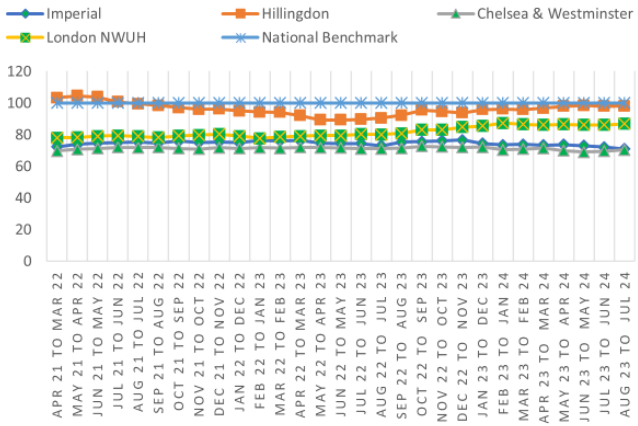
6.5. **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety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

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

Appendix – Clinical outcomes performance report mortality data

(Patient) Summary Hospital-level Mortality Index

TREND



100
England Average

STANDARD

n/a

PERFORMANCE

n/a

TREND

n/a

ASSURANCE

NARRATIVE

Performance: For three of the four trusts (CWFT, LNW and ICHT), the rolling 12-month SHMI remains lower than expected with the most recent data available (August 2023 – July 2024). THH's rate is consistently 'as expected'.

Recovery Plan: Not applicable.

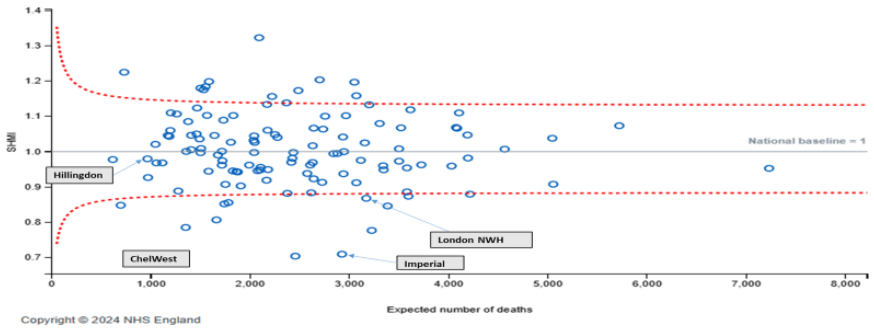
Improvements: All Trusts investigate variations between observed and expected deaths by diagnostic group. Reviews for quarter two were summarised in the learning from deaths report presented to APCQC and BiC, with no issues to escalate.

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	102500	70.39	Lower than expected
ICHT	114400	70.94	Lower than expected
LNW	105905	86.77	Lower than expected
THH	49465	97.95	as expected

STRATIFICATION



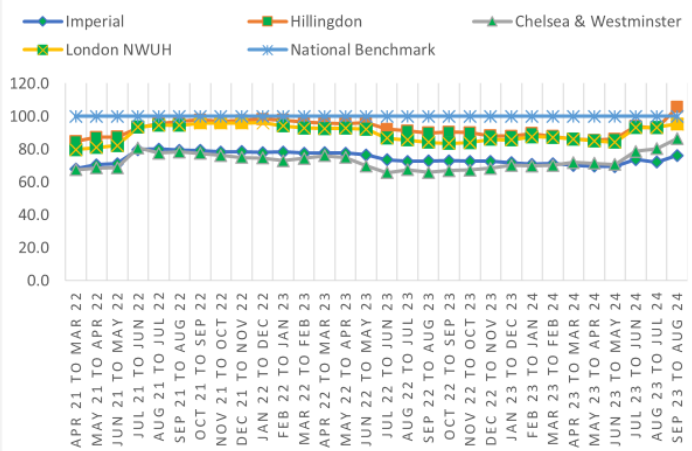
GOVERNANCE

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

17

(Patient) Hospital Standardised Mortality Ratio

TREND



100
England Average

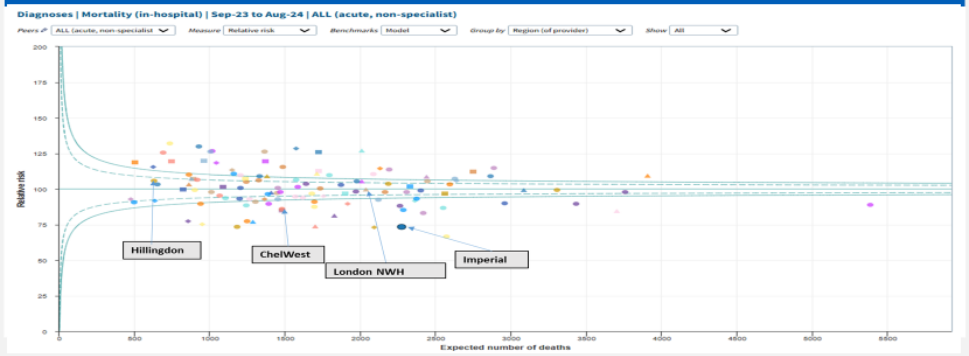
STANDARD

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

CURRENT PERFORMANCE

	Provider Superspells	HSMR	HSMR- relative risk ranking
CWFT	43094	86.4	Lower than expected
ICHT	48652	76.1	Lower than expected
LNW	47228	95.3	as expected
THH	19230	105.5	as expected

STRATIFICATION



NARRATIVE

Performance: Changes have been made nationally to the HSMR methodology which includes removal of the adjustment for palliative care coding and changes in the diagnostic groupings which make up the ratio. As expected this has resulted in increases in HSMR in all four trusts, and in most providers nationally. THH has increased above the national benchmark of 100, and LNW has moved to 'as expected'. CWFT and ICHT remain lower than expected. Rankings for CWFT, ICHT and LNW have not changed significantly, however THH has dropped to 81st.

Recovery Plan: The impact of the changes is being reviewed by each Trust, and within the APC mortality surveillance group. Potential issues with coding have been identified by LNW and THH. This is being reviewed to ensure accuracy.

Improvements: All Trusts investigate variations between observed and expected deaths by diagnostic group. Reviews for quarter three will be summarised in the learning from deaths report presented to APCQC and BiC.

Forecast Risks: N/A

GOVERNANCE

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

18

4.1.4 ELECTIVE ORTHOPAEDIC CENTRE (EOC) UPDATE (PIPPA NIGHTINGALE)

REFERENCES

Only PDFs are attached

4.1.4a. NWL EOC BIC Cover Collaborative Report template v3.pdf

4.1.4b. NWL EOC BIC 25 report.pdf

NWL Acute Provider Collaborative Board in Common (Public)
29/04/2025
Item number: 4.1.4
This report is: Public

NWL Elective Orthopaedic Centre (EOC) update

Author: Mark Titcomb
Job title: Managing Director NWLEOC, Central Middlesex and Ealing Hospitals

Accountable director: James Walters
Job title: COO LNWH

Purpose of report

Purpose: Information or for noting only

BiC is requested to discuss and note the content of the report

Report history

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

NWLEOC Partnership Board Committee name	APC Exec Management Board	Committee name
28/03/2025	09/04/2025	Click or tap to enter a date.
Noted	Noted	What was the outcome?

Executive summary and key messages

The report provides an overview of the NWL EOC as it approaches the first year of being open to full capability, focussing primarily on the qualitative aspects of the centre of excellence.

The paper includes statistics and activity levels for 2024/25 and a high-level view of the clinical outcomes and patient experience being achieved. Additionally, it covers, the governance of the EOC, the 2025/26 operating plan, and an extract from a paper produced for the APC that assessed the lessons learned during implementation of the centre.

The NWL EOC opened on 4th December 2023. Following a slow initial uptake, the centre expanded and was operating 5 theatres by April 2024. This centre is designed specifically to operate on for high volume, routine elective orthopaedic procedures (eg. Hips and knee replacements) for non-complex patients.

The benefits of this centre improves equity of access by significantly reducing waiting times for surgery. Reliability has also improved with fewer last minute cancellations as the centre operates as a ring-fenced, high efficiency model that is set away from acute/emergency pressures.

With focus on high quality care, the centre has achieved a reduction in length of stay. The absence of acute/emergency pressures means that the centre has the ability to treat more patients at lower cost. Feedback from both patients and staff have been very positive contributing to a stronger team culture.

There is a significant risk that the centre may not achieve or sustain full capacity due to inconsistent referral practices across partner organisations. The variability in key processes such as pre-operative assessments, bookings processes, management of waiting lists and surgical kit usage could limit the flow of appropriate (non-complex) patients into the centre. Additionally, if the case mix is not expanded to include a broader range of low-complex orthopaedic procedures, there is a risk of under-utilisation, which may in turn impact the retention of a skilled workforce and undermine the centre's ability to deliver cost-effective, high quality care.

To optimise capacity and maintain low operating costs, the centre has introduced a 2-week rule; under filled lists are stood down 2 weeks in advance and staff are redeployed. Additionally there has been a slight shift in the types of procedures accepted at the EOC, with new surgeons bringing more day cases to the centre.

Whilst this helps maximise the use of available capacity within the centre, continued support is recommended to sustain and further grow activity levels. This will help ensure the centre consistently delivers high-quality care and achieves optimal performance, generating shared benefits across the collaborative.

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

NWL Elective Orthopaedic Centre (NWL EOC) – BiC update report

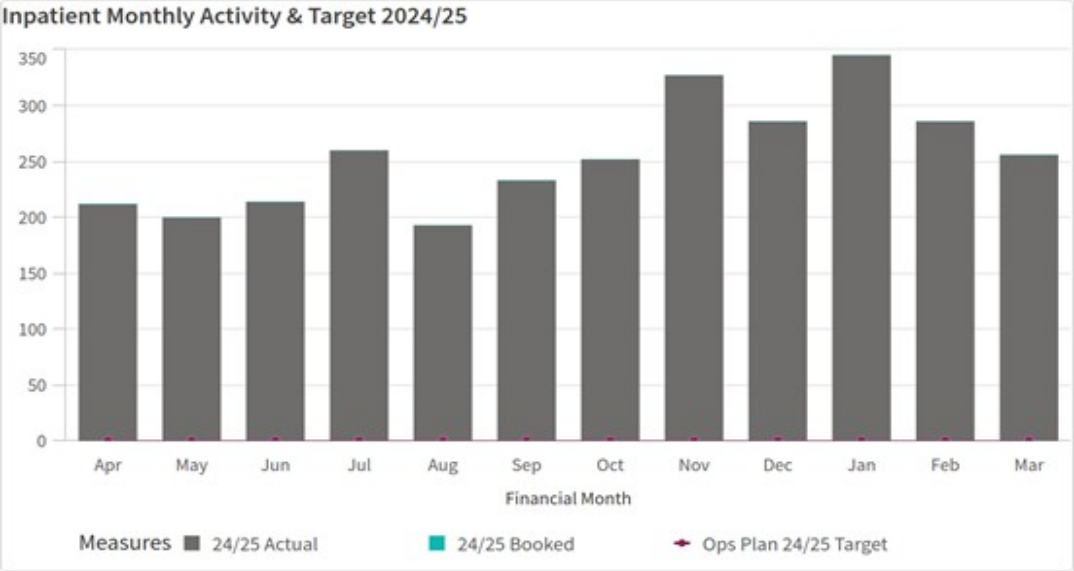
Overview

The NWL EOC programme opened on 4 December 2023 with an initial operating capability and then moved to full capacity on 30 April 2024 with 5 operating theatres, recovery and ringfenced ward beds. The centre is designed to deliver an improved inpatient pathway for adults who need routine, planned orthopaedic procedures, such as a hip or knee replacement, who are otherwise generally well, with the following benefits:

- faster and fairer access to surgery
- reduced cancellation/postponement of surgery
- improved consistency and higher quality of surgery, with reduced length of stay
- improved efficiency & productivity, enabling more patients to be treated at a lower cost
- improved staff experience & retention underpinned by increased opportunities to develop

NWLEOC – 2024/25 statistics

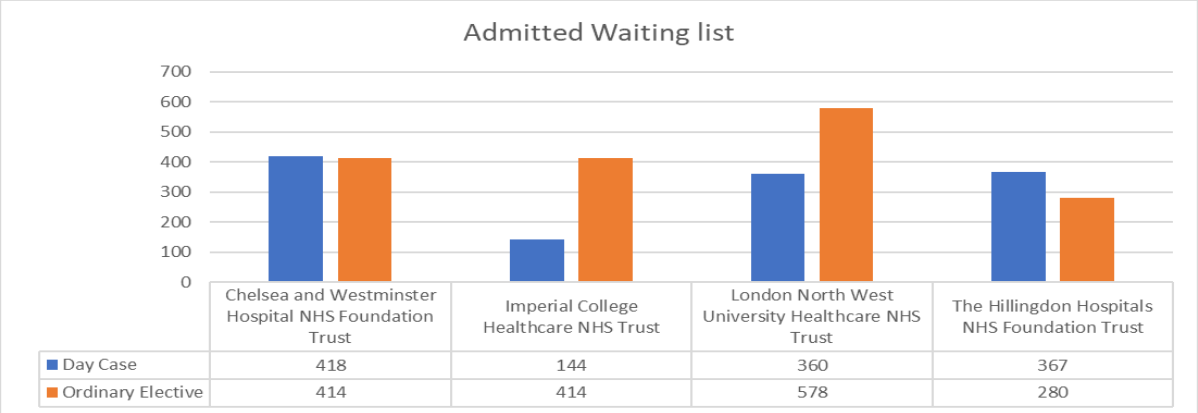
- 3063 patients had surgery at EOC during 2024/25, of which 774 were from partners (ICHT, CW and THH) and the remainder from LNWH.
- 28 ICHT, CW and THH surgeons have worked at CMH and have EOC operating lists included within their job plans.
- patient length of stay (achieving the GIRFT standard at 2.4 days) and patient experience has been excellent with further details provided below.
- zero complaints regarding transport provision across all eight boroughs.
- zero patient cancellations due to winter pressures or shortage of beds.
- activity levels were constrained in Q1/Q2 24/25 due to rectification of theatre ventilation defects, industrial action and a sub-optimal pre-op process. An improvement trajectory was implemented mid-year which delivered an improved level of activity during Q3 & Q4.



Q1 & Q2 total activity = 1312 patients, Q3 & Q4 total activity = 1752 patients

Waiting list impact, Clinical outcomes & GIRFT accreditation

The EOC benefits realisation plan identifies a number of clinical outcome measures over the 1, 2 and 5 year time scale. Monitoring and assurance is provided to the monthly partnership board within a clinical quality agenda item. Some of the key metrics for 24/25 are included further below:



	Chelsea and Westminster Hospital NHS Foundation Trust	Imperial College Healthcare NHS Trust	London North West University Healthcare NHS Trust	The Hillingdon Hospitals NHS Foundation Trust
Day Case	418	144	360	367
Ordinary Elective	414	414	578	280

Alongside the four acute Trusts, the EOC is contributing to an overall decrease in the north-west London orthopaedic waiting list and a reduction in the number of long-waiting patients.

In April 2024, there were 3300 patients on the NWL orthopaedic admitted waiting list and this has reduced now to a total of 2900 patients; the greatest number of these being from LNWH as shown above. To reduce this number more quickly, surgeons from THH have been operating on long waiting LNWH patients at the EOC during the winter months, and in doing so have demonstrated that sharing/pooling of patients can be safely achieved.

Clinical outcome measures for Apri 24 to March 25 are described below, with serious incidents, complaints and surgical site infections **all below the national average for this number of cases.**

KPI/metric	Outcome
Admitted PTL (waiting list)	• EOC significant contribution to reduction in NWL ortho PTL since September 2024 • LNWH has majority of long waiting patients – partner (THH) support to reduce backlog

Serious incidents	• 2 x SI
	  • abductor canal block on incorrect patient
	  • retained wire post op

Complaints	• 2 x complaints • (1 x medication query & 1 x scheduling issue)
Surgical site infections	• data below national average for NWLEOC TKR & THR since April 2024

Getting It Right First Time (GIRFT) accreditation

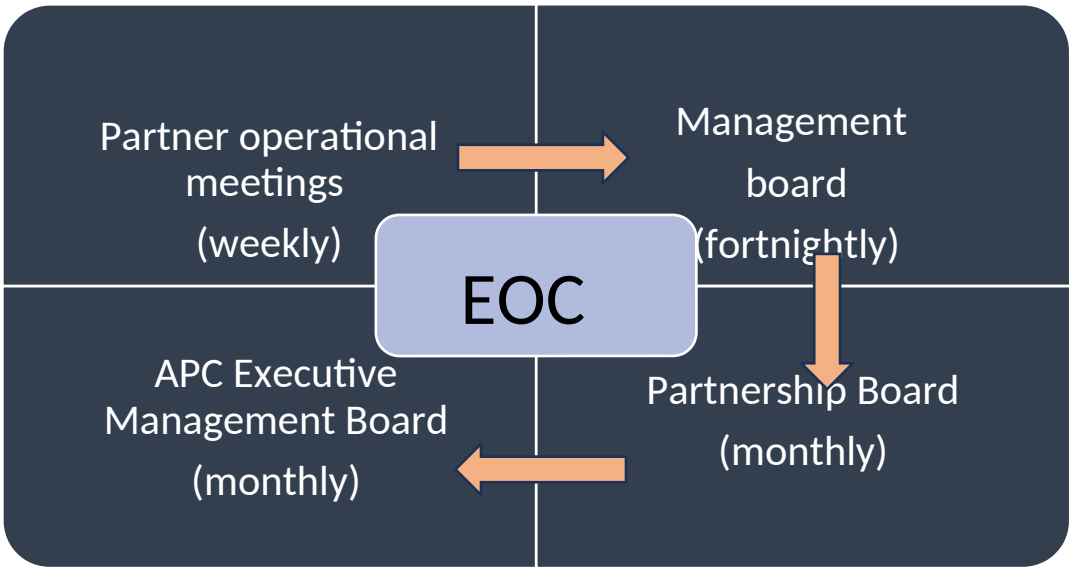
Following a period of onboarding, data submission and analysis, and a site visit, the GIRFT accreditation panel sat on 13th November 2024 and formally accredited the centre as an elective surgical hub. The executive summary of their report is here:

The unit was felt by all assessors to be a fabulous building with excellent facilities for patients. Staff were happy and excited to share information about the hub. The senior team was very engaged and passionate and keen to share their achievements and tell the assessor team about the recent successes. The progress that the hub has made since opening is commendable and the management team at all levels are to be congratulated on the culture that they are developing within the hub. The staff are clearly ready for the challenge and need to be supported and nurtured along the way. They are full of ideas, solutions and innovations and harnessing these will pay dividends.

The accreditation included 14 recommendations for further improvements to the centre which are being monitored by the partnership board and report back every six months to the GIRFT programme team. The next GIRFT site visit is scheduled for 2027.

NWL EOC Governance

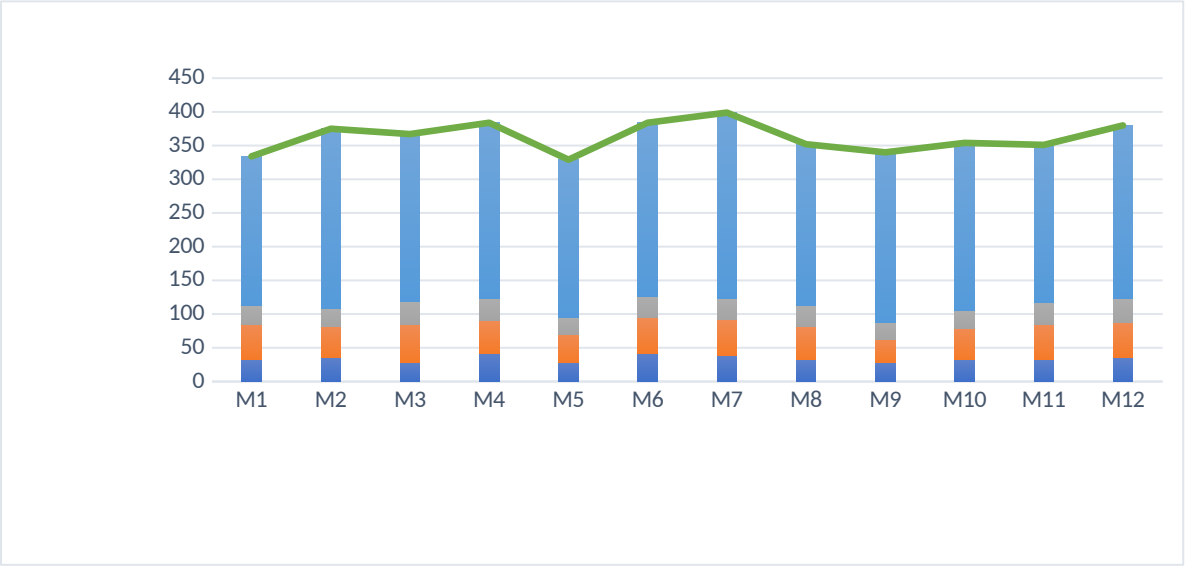
The EOC is governed by a Partnership Agreement and underpinning SLAs and SOPs. A monthly partnership board is chaired by the EOC medical director, has senior clinical representation from all partners, and reports to the APC Executive Management Board. The operational battle rhythm of the centre is described below:



2025/26 NWL EOC operating Plan

The operating plan has been developed using a series of planning assumptions supported by the intelligence and experience gained from the first full year of operating. The EOC partnership board have supported the proposed plan, however financial agreement and income assumptions between partners for the EOC have yet to be agreed.

A key part of the plan is to continue tight cost control of the centre, such that staffing numbers, bed numbers and equipment costs are adjusted to match the planned activity and the length of stay. The proposed 25/26 activity plan is here:



Lessons identified, NWLEOC case study and current challenges

A lessons identified paper was produced for the APC to share the learnings of the development and implementation of the EOC and to inform future shared service models.

The key findings are summarised here:

	Challenges	Take aways:
1	**Digital enabling limitations**	• Expectation when moving to Cerner that accessibility and collaboration across the APC would be significantly easier than initially proved. Eg: currently only a "view only" approach is established and therefore the EOC is not able to support partners with the administrative burden of ordering and actioning tests. • Patient pathway was initially set up with automated rules in FDP - resulting in the unnecessary rejection of some patients from the EOC until resolved. No 'test' environment in FDP - resulting in the EOC module needing additional testing/support to be clinically safe to use.
2	**Achieving fully shared involvement and ownership**	• Surgical leads were identified very early in the development of the EOC (which made clinical decision making for complex issues less of a challenge), but anaesthetic leads were engaged much later despite the importance of the pre-op processes (resulting in difficulty implementing pathway changes). • Shared partner resource for various workstreams worked well: eg: ICHT (digital), LNWH (transport/accessibility), THH (joint school) etc
3	**External events may disproportionally impact progress/activity**	• Industrial action and contractor delays (April – July 24) - are the examples
4	**Fully understand the implications of the chosen pathway & external best practice**	• Following the outcome of the public consultation, it was agreed that patients would only attend the EOC on the day of their surgery – a very different model to other EOCs; this then required several novel solutions to be developed • EOC was planned and implemented to GIRFT recommendations – this helped achieve a rapid and successful accreditation once fully open
5	**BC activity and financial assumptions & risk appetite**	• Some key BC assumptions proved highly challenging and could have been more fully tested? (eg: four joints per surgeon/per all day list from day one of opening) • Constantly review the levels of optimism in the BC against the risk appetite and external where assumptions about activity levels and financial outcomes are challenged.

Matt Bartlett & Mark Titcomb

EOC Medical Director and Managing Director

4.1.5 COLLABORATIVE QUALITY COMMITTEE CHAIR REPORT (PATRICIA GALLAN)

REFERENCES

Only PDFs are attached

4.1.5. Collaborative Quality Committee Chair's Report - March 2025 - PG.pdf

North West London Acute Provider Collaborative (NWL APC) Quality Committee Chair's Highlight Report to the NWL APC Board in Common (BiC) – for discussion March 2025

Highlight Report

1. Purpose and Introduction

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

- 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 – Clinical Pathways Review

2.1.1. The Committee commenced a deep dive into the Clinical Pathways programme which was a key component of the Acute Provider Collaborative Strategy, with each of 28 specialties across the Acute Provider Collaborative choosing one pathway to align to best practice. Committee members noted that all pathways had been approved and work had commenced with metrics and implementation plans being established to align best practices across clinical teams to improve quality and relationships. Committee members noted the importance of focusing on quality & efficiency gains through standardisation and the potential costs for saving. Progress updates for each pathway was reported through the Acute Provider Collaborative Executive Management Board.

2.2. Acute Collaborative Quality Performance Report

2.1.2. The Committee received the collaborative quality performance reports. Performance at acute provider collaborative level was similar to previous months with standards being met for the majority of metrics. Committee members noted that three of the four Trusts were within target however the fourth Trust's data had risen above the national average; an analysis was underway to identify the cause of this. The Committee were assured that all areas of variance were being managed through action plans to support improvement.

2.2 Work Stream Project Initiation Documents (PIDs) and Project updates

2.2.1 **Deteriorating patients**

Committee members received an update on the deteriorating patients work stream noting that there was a continued focus on the implementation of Martha's Rule with all four Trusts now live within the adult and paediatric services, though at different stages of implementation. Committee members noted the development of a standardised guideline for responding to deteriorating patients, which had been agreed across the four Trusts; Committee members noted that the workstream had agreed changes to improve and clarify wording for the Cerner Sepsis alert.

2.2.2 **Mental Health in Acute Trusts**

The Committee received an update from the work stream noting that the group had continued to meet and refine the work stream. Committee members noted that all four Trusts were expecting a rise in patients attending the emergency departments with mental ill health. Committee members noted that there was a rise in clinical incidents associated with mental health patients as feedback from staff outlined that they felt ill equipped to manage challenging behaviours. Committee members noted that the mental health strategy was near completion and the group were reviewing restraint policies and procedures.

2.2.3. **National Safety Standards for Invasive Procedures version 2 (NatSSIPs2)**

Committee members received a progress update against the priority work stream to implement the recently revised national safety standards for invasive procedures. Committee members noted that whilst good progress had been made on the initial priorities, significant work was required. Committee members noted that an induction training package reflecting the NatSSIPs2 had been agreed and work to design the e-module was underway.

2.2.4. **National Patient Safety Strategy – The Joint Procurement and Implementation of a Joint reporting and Learning System**

The Committee received an update on the progress of the implementation of a new Incident and Risk Management System. The Committee noted the business case for a single data platform for all quality data, which was expected to go live in December 2025.

2.3 Collaborative Quality Priorities 2025/26

2.3.1. The Committee noted the three main quality priorities for the APC: implementing the new quality system, completing the work on deteriorating patients, and focusing on clinical pathways.

2.4. Maternity Incentive Scheme Year 6 Final Position

2.4.1. The Committee received the report which summarised the changes and reporting timescales for the Maternity Incentive Scheme Year 6, and the position of each Trust against 10 of the safety actions. Committee members noted that three out of the four Trusts within the collaborative had finalised full compliance against the 10 safety actions. Action plans are in place to address the non-compliance at THHFT, monitored through nursing and midwifery improvement group.

2.5. Quality & Equality Impact Assessments across the NWL APC

2.5.1. The Committee received the report which informed the Committee of the progress made across the four Trusts to establish a common approach to Quality & Equality Impact Assessments across the Acute Provider Collaborative. Committee members noted the standardisation of quality impact assessments across the system and the importance of monitoring high-risk changes.

2.6. Combined Risk Escalation Report from Local Trust Quality Committees

2.6.1. Committee members received the report which highlighted key points to note or areas of risk identified by each of the four Trust's Quality Committees where collaborative-wide interventions would speed up and improve the response.

2.6.2. Chelsea & Westminster Hospital NHS Foundation Trust highlighted that the Committee had received a copy of the Regulation 28 (Prevention of Future Deaths) Report issued to the Trust from the Senior Coroner in December 2024.

2.6.3. The Hillingdon Hospitals NHS Foundation Trust highlighted that the Committee had discussed the progress in the Emergency Department (ED) and noted the improvements made, but also highlighted the need for continued focus and monitoring. Risks around Maternity, Infection Prevention & Control, Duty of Candour and staffing levels in the financial plan were highlighted.

2.6.4. The Imperial College Healthcare NHS Trust Quality Committee highlighted the on-going operational pressures in the EDs resulting in an increase in long lengths of stay for patients with mental health needs, and having a negative impact on patient experience. The Trust's executive team had agreed a temporary suspension of its neuro-oncology surgical service (initially 2 weeks) due to concerns raised internally and following an invited review by the Royal College of Surgeons (RCS) and Society of British neurosurgeons (SBNS). Continuing pressures across the maternity services were also highlighted.

2.6.5. London North West University Healthcare NHS Trust highlighted risks across the maternity department, infection prevention & control and acutely unwell complex patients in the emergency departments.

2.6.6. The Committee noted that there were no issues escalated through this round of meetings however, noted that themes identified within the report were common across all four Trusts.

2.7. Acute Provider Collaborative Learning from Deaths Quarter 3 summary report

2.7.1. The Committee reviewed the combined NWL APC Q3 report incorporating all four Trusts which outlined the key themes and outcomes from the learning from deaths process.

2.8. Quarterly Complaints report for Q3 2024/25

2.8.1. Committee members received the quarter three complaints report noting that there had been progress towards the target metrics agreed for all four Trusts and actions were in place that would deliver further progress which would be reported in the next quarter. Committee members noted the trends within the report and noted the importance of triangulating data to identify areas for improvement.

2.9. APC EDI patient equity work stream update

2.9.1. Committee members received the report noting that the workstream was progressing, focusing on reducing inequalities in healthcare access and improving communication with patients.

3. Positive assurances received

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

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

The Committee agreed to escalate the following to the Board in Common:

- Recognition that all 4 Trusts are above the KPIs for all IPC metrics not out of line with the national picture and each trust QC will monitor actions and process locally along with the APC work the IPC group are leading.
- Recognition that the Martha's law (call for concern) pilots are in operation now in all 4 Trusts for paediatrics and adult care.
- 3 out of the four Trusts had submitted full compliance against the year 6 Maternity incentive scheme.

5. Concerns outstanding

- There were no significant additional APC level concerns outstanding which required escalation to the Board.

6. Key actions commissioned

- None noted.

7. Decisions made

- There were no agenda items for approval within the agenda.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Deep dive: Clinical Pathways Review	For discussion and noting	10.	Quarter 3 Complaints report	For noting
2.	Acute Collaborative Quality Performance Report	To discuss	11.	APC EDI Patient equity work stream update	For noting
3.	Work Stream PIDs and Project Updates:	To discuss	12.	Any Other Business	To discuss
4.	National Patient Safety Strategy – The Joint	To discuss	13.	Committee forward planner	For noting

	Procurement and Implementation of a Joint reporting and learning system				
5.	Collaborative Quality Priorities 25/26	To discuss	14.		
6.	Maternity Incentive Scheme Year 6 final position	To discuss	15.		
7.	Quality & Equality Impact Assessments across the NWL APC	To discuss and noting	16.		
8.	Combined Risk Escalation report from local Trust Quality Committees	For approval	17.		
9.	Acute Provider Collaborative Learning from Deaths Quarter 3 summary report	To discuss			

9. Attendance

Members	September attendance
Patricia Gallan, Vice chair (CWFT), Non-executive director (THHT) (Chair)	**Y**
Syed Mohinuddin, Non-executive director (LNWH/CWFT)	**Y**
Linda Burke, Non-executive director (THHT/ICHT)	**Y**
Helen Stephenson, Non-executive director (ICHT/CWFT	**Y**
Pippa Nightingale, Chief executive (LNWH)	**Y**
Julian Redhead, Medical director (ICHT)	**Y**
Raymond Anakwe, Medical director (ICHT)	**Y**
Roger Chinn, Medical director (CWFT)	**N**
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**

4.2 WORKFORCE

4.2.1 WORKFORCE - IQPR - ANYTHING BY EXCEPTION (PIPPA NIGHTINGALE)

4.2.2 COLLABORATIVE PEOPLE COMMITTEE CHAIR REPORT (DAVID MOSS)

REFERENCES

Only PDFs are attached

4.2.2. Collaborative People Committee Chair's Report March 25.pdf

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

25 March 2025

Highlight Report

- **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.

- **Key Highlights**

- The Committee heard of a staff member's apprenticeship journey, highlighting the challenges and successes they experienced while balancing work, family, and academic commitments. They emphasised the importance of effective time management, support from family and colleagues, and the valuable skills gained through the apprenticeship. They explained their decision to pursue the apprenticeship programme, stating that they wanted to challenge themselves and improve their skills and knowledge. They sought advice from their manager and the learning and development team, ultimately choosing a business and management course. They encouraged others to enjoy the journey and learn as much as possible, emphasising the benefits of learning on the job and applying new skills in real-life situations.
- The apprenticeship levy paper highlighted the achievements and challenges faced in increasing apprenticeship usage. There was a discussion on the focus on healthcare support workers, data technicians, and leadership apprenticeships while awaiting further government guidance. The Committee discussed the challenges faced by staff in meeting functional skills requirements for apprenticeships, particularly for those with English as a second language, emphasising the need for investment in supporting staff to pass these skills and the potential impact of recent government changes.
- The Committee received an overview of the workforce performance report, noting that key HR KPIs were in a good place but highlighted ongoing challenges in some trusts. The committee discussed the importance of tracking medical PDRs and the need for additional metrics on workforce productivity and living within means.
- The EDI Action Plan highlighted progress made in various areas and the challenges faced in aligning the EDI leads' work with the board-approved plan. The committee emphasised the need for a more focused and impactful approach to EDI initiatives.

- The Committee noted improvements in the staff survey response rates and performance across the APC. There was a discussion on the need for targeted campaigns to address areas of concern, such as flexible working, discrimination, and bullying and harassment.
- There was a review on the progress of the People Services Improvement Programme with highlights on key achievements and challenges. The Committee noted the priorities for the next year, focusing on delivering the workforce plan, recruitment, and HR admin automation.
- The Annual Workforce Plan detailed the key demands and proposed reductions in staff usage and establishment. The committee discussed the importance of tracking progress by month and ensuring that the plan aligns with financial targets.

Positive Assurances Received

The Committee received positive assurance in the following areas:

- Positive metrics were reported in vacancies, turnover, sickness, agency spend, PDRs, and core skills across the collaborative.
- Improved staff survey response rates at all four trusts, with strong performance across the nine themes.
- Significant progress was made in standardising processes and systems, such as ESR, centralised bank, and single learning management platforms.
- An 8% increase in apprenticeship levy usage and a focus on gifting levy to support health inequalities.

Key Risks to Escalate

- The challenge of achieving the planned workforce reductions and ensuring that the reductions align with the financial targets. There was a risk that the current workforce numbers may not be sufficient to meet the break-even targets, necessitating further CIP delivery and potential impact on WTEs.
- The lack of sufficient resources and capacity to implement the EDI action plan effectively across all trusts. The varying levels of EDI resources among the trusts pose a risk to the successful execution of the plan.
- The challenge of increasing apprenticeship levy usage and addressing functional skills requirements. There was a risk that without targeted investment and collaboration, the full potential of the levy may not be realised.
- The Staff Survey Results highlighted persistent issues with flexible working, discrimination, violence and aggression, and bullying and harassment. These areas scored consistently lower than the acute average, indicating ongoing risks to staff satisfaction and engagement.
- There is a risk associated with achieving the 50% corporate reduction target without merging back-office functions. There is a need for a strategic approach to ensure that the reductions do not negatively impact operational efficiency.

Concerns Outstanding

- Concerns that the current headcount continues to exceed plan/budget.

- ## Key Actions Commissioned

- to accelerate the apprenticeship levy usage and explore further opportunities to achieve 100% usage.
- to include medical PDRs and workforce establishment numbers in future reports.
- to provide a succinct one-page summary of the six approved EDI actions, including delivery timeframes and outcomes.
- to explore external expertise for HR automation and consider a no-cost value risk share approach to expedite the process.
- to verify and correct Hillingdon's workforce reduction numbers and ensure accurate submission.
- to track the workforce element of CIP delivery by month and ensure alignment with financial targets.

- ## Decisions Made

The Committee recommended to include productivity metrics in the terms of reference for the committee and to bring back to the Committee for approval.

• Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Workforce Performance Report	Assurance	5.	People Strategy/Strategic Priorities 25/26	Noting/ Information
2.	Update on APC Board Workforce EDI Plan	Assurance	6.	Annual Workforce Plan Submission	Noting
3.	24/25 Staff Survey Highlights	Noting/ Information	7.	Collaborative workforce Risk Report (risks with a score of 15+)	Noting
4.	Collaborative People Priority Workstream Programme Updates 24/25	Noting/ Information	8.	Terms of Reference	Decision/ Approval

• Attendance

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

4.3 FINANCE AND PERFORMANCE

4.3.1 PERFORMANCE - IQPR - ANYTHING BY EXCEPTION (LESLEY WATTS)

4.3.2 PERFORMANCE REPORT (JAMES WALTERS)

4.3.3 FINANCE - IQPR - ANYTHING BY EXCEPTION (LESLEY WATTS)

4.3.4 FINANCIAL PERFORMANCE REPORT (JAZZ THIND)

REFERENCES

Only PDFs are attached

4.3.4a. APC M11 Finance BIC 29.04 Cover.pdf

4.3.4b. NWL APC M11 financial performance BIC 29.04 (1).pdf

NWL Acute Provider Collaborative – Board In Common

29/04/2025

4.3.4

This report is: Public

2024/25 NWL APC Financial Performance & Forecast (Month 11)

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

Accountable director: Jazz Thind
Job title: Chief Financial Officer, ICHT – on behalf of the Acute CFOs

Purpose of report

Purpose: Assurance

Report history

This paper was considered by the Acute CFOs.

NWL Acute CFOs	NWL Acute Executive Management Board
04/04/2025	09/04/2025
Noted and approved	Noted and Approved

Executive summary and key messages

I&E performance to date:

- At the end of February, the APC reported a year to date (YTD) actual deficit of £72.7m, which is £68.9m adverse to plan (£7.5m surplus), and £1.5m favourable to the YTD financial recovery plan (£74.2 deficit).
- In-month, the APC reported a surplus of £2.2m, which is an adverse in-month variance of £5.3m against plan and £0.15m above the expected position for February as per the month 7 recovery forecast.

Performance against the Financial Recovery Plan

- CWFT - £753k adverse in-month variance to FRP, due to the phasing of a material non recurrent benefit (CNST incentive scheme funding). In the FRP phasing was assumed equally over M10-M12, however the benefit will now be reported in M12.

- THH - £847k favourable in month variance to FRP, due primarily to the accounting and settlement of NHSE environmental controls dispute in month 11, ahead of the expected date which was assumed to occur in M12 in the FRP.

- LNWH and ICHT - marginal variances to FRP in month.

- YTD the performance is a favourable variance of £1.5m against the FRP, driven by the above M11 results and the prior month performance: LNWH noted overperformance above plan for ERF and ICHT noted an adverse variance on divisional improvement schemes. The latter has been mitigated by other additional benefits.

Forecast

- The latest updated APC forecast (as reported to the BiC (21.01)) is a deficit of £50.1m with detailed discussion on the drivers, mitigations, improvement opportunities discussed at Trust, APC and ICB wide meetings over recent months: CWFT - £0m; ICHT – planned £0m; LNWH - £23m deficit ; THH - £27.1m deficit.

Strategic priorities

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

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

Impact assessment

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

Reason for private submission

N/A

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

2024/25
NWL APC Financial Performance
Month 11 (February 2025)

Helen Berry, Associate Director of Finance

For NWL APC Board in Common 29 April 2025

Executive Summary

- This paper presents the NWL APC Month 11 (February '25) financial position including income and expenditure, capital and cash.
- At the end of February, the APC reported a year to date (YTD) actual deficit of £72.7m, which is £68.9m adverse to plan (£7.5m surplus), and £1.5m favourable to the YTD financial recovery plan (£74.2 deficit).
- In-month, the APC reported a surplus of £2.2m, which is an adverse in-month variance of £5.3m against plan and £0.15m above the expected position for February as per the month 7 recovery forecast.
- The main drivers of the year-to-date adverse variance include:
    - **Efficiencies:** YTD delivery is £16.4m adverse to plan (£111.7m delivered against £128m plan), 32% (£40.4m) is achieved via non recurrent means. Trusts are expecting full delivery of efficiency plans except THH, where a £5.2m undershoot is anticipated.
    - **Resident Doctors Industrial Action (IA):** (3 days in June, 1 day in July) - funding to cover the costs of IA of £4.6m has been included in the year-to-date position. Income loss estimated at £1.5m in not funded and is a (small) driver of the adverse variance.
    - **System Optimisation (planning item):** task force groups for both workstreams (1. Focus on discharges & medically optimised patients and 2. Mental Health Models of Care) are now merged with regular meetings convened and progress reported to both the APC Finance & Performance Workstream Meeting and the ICB Productivity Improvement Meeting. The programme is not expected to return a financial benefit in 2024/25.
    - **Operational pressures** including winter and supporting mental health patients continue.
    - **Excess inflation**: c£16.8m of inflation over funded levels has been identified as contributing to the overall adverse variance.

Executive Summary - continued

- **Elective Recovery Funding (ERF)** 2024/25 plan submissions assumed additional ERF income above contractually funded values (£817.9m Vs £739.7m). Overperformance against the financial plan to date is £70.8m, with a forecast overperformance of £78.3m at month 11.

- **YTD capital** spend is £153.7m against an £183.4m plan, £29.7m underspend to date. The key drivers of this position are: IFRS 16 related costs not yet in the position (timing issue) and underspends against nationally funded schemes.

- The combined **cash balance** at the 28th February is £232.2 a decrease of £106.2m (31%) since the end of the financial year and lower than the planned cash balance at the end of the month by £92.6m. Cash resilience in 2024/25 has been a key area of concern for at least two acute Trusts (LNWH & THH) throughout 2024/25.

Escalation & Forecast

- The latest updated APC forecast (as reported to the BiC (21.01)) is a deficit of £50.1m with detailed discussion on the drivers, mitigations, improvement opportunities discussed at Trust, APC and ICB wide meetings over recent months : CWFT - £0m; ICHT – planned £0m; LNWH - £23m deficit ; THH - £27.1m deficit.

- At month 11, the above forecasts (totalling £50.1m deficit) were reported to NHSE on the Monthly Financial Monitoring Return.

- Note: The financial performance escalation process implemented in 2023/24 is in place in 2024/25 due to the high risk in the financial plan. A set of escalation metrics are in place whereby a breach enacts escalation. This tests the variation from YTD plan, CIP delivery, ERF performance and annual plan. At Month 11, three trusts breached all or some of the escalation metrics. Appendix 3 details the escalation metrics.

Note on THH forecast:

- THH is expecting a downward fair value adjustment in relation to its incinerator investment property. This is due to ongoing negotiations with potential future operators which have indicated a significant drop in annual income against previous assumptions
- In addition, there is a need for further investment in the incinerator before it is operational, which is also expected to impact current value.
- The Trust's external valuer is currently completing the annual valuation for year end. As this asset is held as an investment property there will be a “fair value adjustment” rather than an “Annually Managed Expenditure impairment” associated with this operational asset.
- The asset is currently held on the asset register with a value c. £29m, and the Trust expects a significant impairment impact against that value.
- This adjustment will appear above the line for financial reporting purposes and will be supported by additional income to maintain the overall forecast deficit position of £50.1m for the APC.

I&E Performance tables

NWL Acute Collaborative (Month 11 Financial Performance)

2024/25	In Month Plan £'000	In Month Actuals £'000	In Month variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Var £'000	YTD variance %	Annual Plan £'000	Annual Forecast £'000	Forecast Variance £'000
Income	339,042	347,597	8,555	3,652,565	3,860,840	208,275	5.7%	3,984,265	4,218,962	234,697
Pay	(207,399)	(220,890)	(13,491)	(2,281,026)	(2,409,087)	(128,061)	-5.6%	(2,488,421)	(2,627,618)	(139,197)
Non-Pay	(119,680)	(120,030)	(350)	(1,327,832)	(1,477,209)	(149,377)	-11.2%	(1,449,418)	(1,590,023)	(140,605)
Non Operating Items	(4,435)	(4,431)	4	(47,533)	(47,267)	266	0.6%	(46,426)	(51,422)	(4,996)
Total	**7,528**	**2,246**	**(5,282)**	**(3,826)**	**(72,723)**	**(68,897)**		**0**	**(50,101)**	**(50,101)**

NWL Acute Collaborative (Month 11 Financial Performance by Trust)

2024/25	In Month Plan £'000	In Month Actuals £'000	In Month variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Var £'000	Year to date (deficit), surplus/income %	Annual Plan £'000	Annual Forecast £'000	Forecast Variance £'000
CWFT	284	(389)	(673)	(297)	(1,050)	(753)	0%	0	0	0
ICHT	268	4,473	4,205	219	(11,606)	(11,825)	-1%	0	0	0
LNWH	7,464	(1,239)	(8,703)	1,308	(30,713)	(32,021)	-3%	0	(23,000)	(23,000)
THH	(488)	(599)	(111)	(5,056)	(29,354)	(24,298)	-8%	0	(27,101)	(27,101)
Total	**7,528**	**2,246**	**(5,282)**	**(3,826)**	**(72,723)**	**(68,897)**	**-2%**	**0**	**(50,101)**	**(50,101)**

- The tables show the in-month, YTD and forecast performance by I&E category and by Trust.
- At Month 11, reporting to NHSE (monthly financial performance returns) notes a £23m deficit forecast for LNWH and £27.1m deficit forecast for THH. CWFT and ICHT report breakeven.
- The total APC forecast is £50.1m deficit as previously reported – but noting there will be a change to the THH forecast for income and cost in respect of the impairment and additional funding.

Performance against the FRP

NWL Acute Provider Collaborative : Variance to Recovery Plan

2024/25 Month 11	In month plan £'000	In month actual £'000	In month FRP £'000	In month var to plan £'000	In month var to FRP £'000	Year to date plan £'000	Year to date actual £'000	YTD FRP £'000	YTD variance to plan £'000	YTD var to FRP £'000
CWFT	284	(389)	364	(673)	(753)	(297)	(1,050)	(364)	(753)	(686)
ICHT	268	4,473	4,402	4,205	70	219	(11,606)	(11,130)	(11,825)	(477)
LNWH	7,464	(1,239)	(1,226)	(8,703)	(13)	1,308	(30,713)	(32,473)	(32,021)	1,760
THH	(488)	(599)	(1,446)	(111)	847	(5,056)	(29,354)	(30,252)	(24,298)	898
APC	**7,528**	**2,246**	**2,095**	**(5,282)**	**151**	**(3,826)**	**(72,723)**	**(74,218)**	**(68,897)**	**1,495**

- In month, overall, the APC met the target per the Financial Recovery Plan (£151k favourable variance).
- CWFT - £753k adverse in-month variance to FRP, due to the phasing of a material non recurrent benefit (CNST incentive scheme funding). In the FRP phasing was assumed equally over M10-M12, however the benefit will now be reported in M12.
- THH - £847k favourable in month variance to FRP, due primarily to the accounting and settlement of NHSE environmental controls dispute in month 11, ahead of the expected date which was assumed to occur in M12 in the FRP.
- LNWH and ICHT - marginal variances to FRP in month.
- YTD the performance is a favourable variance of £1.5m against the FRP, driven by the above M11 results and the prior month performance: LNWH noted overperformance above plan for ERF and ICHT noted an adverse variance on divisional improvement schemes. The latter has been mitigated by other additional benefits.

Performance : run rate

NWL APC IN MONTH		M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	M10 £000	M11 £000	M12 £000	Annual
CWFT	*Actual*	(1,668)	(680)	1,120	(535)	(1,021)	1,085	1,585	(408)	(425)	285	(389)		
	Plan	(195)	(195)	(203)	(45)	(6)	(47)	(56)	37	(15)	144	284	297	0
	FRP	(1,790)	(816)	1,379	(535)	(1,021)	1,085	1,586	(489)	(489)	364	364	364	0
	Variance to plan	(1,473)	(485)	1,323	(490)	(1,015)	1,132	1,641	(445)	(410)	141	(673)		
	Variance to FRP	122	136	(259)	0	0	0	(0)	82	64	(79)	(753)		
ICHT	*Actual*	(766)	(3,319)	(3,448)	(7,367)	(6,971)	(3,566)	(1,700)	9,218	(310)	2,150	4,473		
	Plan	(766)	(1,819)	(375)	18	595	448	645	224	157	824	268	(219)	0
	FRP	(766)	(3,319)	(3,410)	(7,404)	(6,972)	(3,566)	(1,739)	9,139	333	2,173	4,402	11,130	0
	Variance to plan	0	(1,500)	(3,073)	(7,385)	(7,566)	(4,014)	(2,345)	8,994	(467)	1,326	4,205		
	Variance to FRP	0	1	(38)	36	1	(0)	40	79	(643)	(22)	70		
LNWH	*Actual*	(4,302)	(4,230)	(6,479)	(3,471)	(3,075)	(2,624)	(4,345)	(1,809)	1,301	(441)	(1,239)		
	Plan	(769)	(1,471)	(1,626)	1,773	(94)	(53)	879	(1,149)	(2,858)	(788)	7,464	(1,308)	0
	FRP	(4,302)	(4,232)	(6,478)	(3,471)	(3,075)	(2,624)	(4,343)	(1,809)	(1,742)	830	(1,226)	9,473	(23,000)
	Variance to plan	(3,533)	(2,759)	(4,853)	(5,244)	(2,981)	(2,571)	(5,224)	(660)	4,159	347	(8,703)		
	Variance to FRP	0	2	(1)	(1)	1	(0)	(2)	0	3,043	(1,270)	(13)		
THH	*Actual*	(3,367)	(5,594)	(2,637)	(1,693)	(3,790)	(2,654)	(4,236)	(2,463)	(380)	(1,941)	(599)		
	Plan	(441)	(456)	(467)	(459)	(469)	(455)	(459)	(461)	(413)	(488)	(488)	5,056	0
	FRP	(3,389)	(5,571)	(2,638)	(1,693)	(3,790)	(2,632)	(4,258)	(1,444)	(1,445)	(1,946)	(1,446)	3,152	(27,100)
	Variance to plan	(2,926)	(5,138)	(2,170)	(1,234)	(3,321)	(2,199)	(3,777)	(2,002)	33	(1,453)	(111)		
	Variance to FRP	22	(23)	1	(0)	0	(22)	22	(1,019)	1,065	5	847		
APC	*Actual*	(10,103)	(13,823)	(11,445)	(13,067)	(14,856)	(7,759)	(8,695)	4,538	185	54	2,246	0	
	Plan	(2,171)	(3,941)	(2,671)	1,287	26	(107)	1,009	(1,349)	(3,129)	(308)	7,528	3,826	0
	FRP	(10,247)	(13,938)	(11,148)	(13,103)	(14,858)	(7,737)	(8,755)	5,397	(3,344)	1,421	2,095	24,119	(50,100)
	Variance to plan	(7,932)	(9,882)	(8,774)	(14,354)	(14,882)	(7,652)	(9,704)	5,887	3,314	362	(5,282)		
	Variance to FRP	144	116	(296)	36	2	(22)	60	(858)	3,529	(1,367)	151		
	YTD var to FRP	144	260	(36)	(0)	2	(20)	39	(819)	2,710	1,344	1,495		

- Table shows the in-month performance against plan and the recovery plan and the projected monthly performance in M12 to meet the FRP. Note the forecast is £50.1m deficit.
- Overall, there is a £1.5m favourable variance against the forecast recovery plan YTD and £0.15m favourable in month.
- There is an expected surplus of £24.1m in Month 12 to meet the annual FRP.
- There are material one off adjustments scheduled in M12 such as the land sale at LNWH.

M11 ERF Performance

ERF Income under/overperformance YTD - M11 in I&E | **Total ERF (incl 23/24 adj**

	NWL ICB ERF	Spec Comm ERF	Non NWL ICB ERF	Total ERF		Forecast ERF	Annual plan (finance plan)	Total Forecast
Trust	£'000	£'000	£'000	£'000		£'000	£'000	£'000
CWFT	28,899	99	(679)	**28,319**		**31,200**	161,674	192,874
ICHT	10,871	5,602	1,163	**17,636**		**19,669**	285,299	304,968
LNWH	19,746	(5,069)	771	**15,448**		**16,841**	220,855	237,697
THH	13,002	248	(3,886)	**9,365**		**10,557**	71,853	82,410
Total APC	**72,519**	**881**	**(2,632)**	**70,768**		**78,267**	**739,682**	**817,949**

- ERF performance at M11 is £70.8m over the ERF YTD financial plan.
- The impact of ERF 23/24 closedown is included in the YTD (£7.1m) and forecast performance (£8.5m).
- The Month 11 forecast is an overperformance of £78.3m against the financial plan, resulting in a total of £817.9m ERF income (including the 23/24 adj).
- Performance £ data has been provided by the Trust Income Teams.

M11 Efficiency

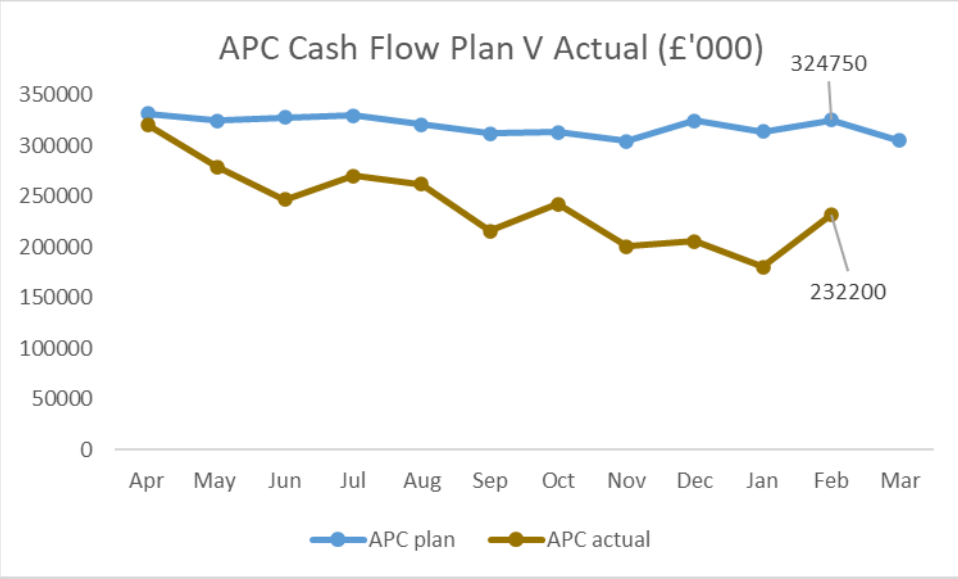
Month 11

Efficiency Month 11	YTD plan			YTD actuals			YTD Var	In Month Plan	In Month Actuals	in Month Variance	Annual Plan			Annual Forecast			Fcast Variance
	R	NR	Total	R	NR	Total		Total	Total	Total	R	NR	Total	R	NR	Total	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	16,297	4,904	21,201	15,479	5,722	21,201	(0)	2,398	2,287	(111)	17,926	5,594	23,520	16,801	6,719	23,520	0
ICHT	57,996	0	57,996	22,493	25,787	48,279	(9,717)	5,280	11,888	6,608	63,400	0	63,400	24,616	38,784	63,400	0
LNWH	25,872	5,853	31,725	28,278	2,708	30,986	(739)	3,039	4,989	1,950	28,494	6,352	34,846	31,858	2,988	34,846	(0)
THH	17,117	0	17,117	5,065	6,139	11,204	(5,913)	1,782	1,896	114	18,900	0	18,900	6,356	7,317	13,673	(5,227)
Total	**117,282**	**10,757**	**128,039**	**71,314**	**40,356**	**111,670**	**(16,369)**	**12,499**	**21,060**	**8,561**	**128,720**	**11,946**	**140,666**	**79,632**	**55,807**	**135,439**	**(5,227)**
% delivery of plan				**56%**	**32%**	**87%**								**57%**	**40%**	**96%**	

- The APC efficiency plan is £140.7m FY, an increase of £21.2m or 18% compared to 2023/24 CIP plan.
- M11 YTD delivery is £111.7m (87% of YTD plan), split 56% recurrent and 32% non-recurrent schemes. YTD variance against plan is £16.4m adverse.
- M11 in-month delivery is £21.1m, which is £12m better than the average in month delivery to date, due to some non-recurrent benefits supporting the position.
- The forecast was revised (in month 7) from showing full achievement of efficiencies to £5.2m under delivery, all at THH.
- Efficiency plans are profiled fairly evenly across the year according to plan profile agreed by the APC CFOs.

M11 Cash

- The APC combined cash balance at the end of February 2025 stood at £232.2m (up from £180m at the end of Jan). This is a decrease of £106.2m (31%) from the end of the previous financial year; and £92.6m lower than the February cash plan.
- All trusts are reporting lower balances than planned, driven primarily by the movement in working capital and I&E deficits which are partially compensated for by the underspend on capital.
- THH and LNWH have reported challenges with their cash flow and have been in discussion with the ICB and NHSE.



NWL APC Cash Balance					
Trust	31-Mar-24	28-Feb-25	Movement to YTD	28 Feb Cash plan	Variance from plan
	£m	£m	£m	£m	£m
CWFT	161.6	139.4	(22.2)	164.9	(25.5)
ICHT	136.7	83.3	(53.4)	132.6	(49.3)
LNWH	19.8	3.9	(15.9)	13.7	(9.8)
THH	20.3	5.6	(14.7)	13.6	(8.0)
Total	**338.4**	**232.2**	**(106.2)**	**324.8**	(92.6)
			-31%		-30%

M11 Capital

APC capital plan for 2024/25 is £228.7m, comprising schemes funded from trust cash and national funding.

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

Year to Date : At Month 11, the APC's capital spend is £153.7m against a £183.4m plan; a £29.7m underspend YTD. In month there was an overspend of £0.9m:

- Core CRL - underspend of 14.8m reflects the postponement / delays of some major capital schemes including the ADC in CWFT, and a slowdown of expenditure in THH.
- IFRS 16 Impact - underspend is due to phasing of the plans and delays in signing leases.
- National Schemes underspend of £9.0m stems from the NHP (New Hospital Programme) at THH.

Forecast : The full year forecast variance is £2.1m overspend at M11. The underspend on CRL is primarily at CWFT where there is an agreed £5m underspend.
The ICS flexibility capital budget (£2.6m) held at CWFT will underspend by £0.3m. The national schemes overspend is driven by ICHT; however, this is an approved variance to plan linked to the additional NHP MOU approvals received in- year. This is compensated by an underspend on the NHP at THH. ICHT is in discussion with NHP on the deferral of underspends into 2025/26.

Capital (net CDEL)		M11 2024/25 Plan	M11 2024/25 Actual	M11 2024/25 Variance	Annual 2024/25 Plan	Annual 2024/25 Forecast	Annual 2024/25 Variance
		£'000	£'000	£'000	£'000	£'000	£'000
CWFT	Core CRL	28,100	19,665	8,435	43,077	37,519	5,558
	IFRS 16 impact	8	116	(108)	95	342	(247)
	Nat schemes	22,151	23,340	(1,189)	22,332	23,520	(1,188)
	Total	**50,259**	**43,121**	**7,138**	**65,504**	**61,381**	**4,123**
ICHT	Core CRL	60,275	60,615	(340)	78,703	81,146	(2,443)
	IFRS 16 impact	11,573	7,307	4,266	11,573	9,130	2,443
	Nat schemes	610	4,661	(4,051)	2,091	22,289	(20,198)
	Total	**72,458**	**72,584**	**(126)**	**92,367**	**112,565**	**(20,198)**
LNWHT	Core CRL	19,933	20,331	(398)	25,073	25,073	0
	IFRS 16 impact	1,500	213	1,287	1,500	1,300	200
	Nat schemes	2,146	2,226	(80)	2,312	5,910	(3,598)
	Total	**23,579**	**22,770**	**809**	**28,885**	**32,283**	**(3,398)**
THH	Core CRL	14,806	7,697	7,109	14,636	13,250	1,386
	IFRS 16 impact	897	449	448	1,197	2,165	(968)
	Nat schemes	21,424	7,106	14,318	26,101	9,141	16,960
	Total	**37,127**	**15,252**	**21,875**	**41,934**	**24,556**	**17,378**
Total	Core CRL	123,114	108,308	14,806	161,489	156,988	4,501
	IFRS 16 impact	13,978	8,085	5,893	14,365	12,937	1,428
	Nat schemes	46,331	37,333	8,998	52,836	60,860	(8,024)
	Total	**183,423**	**153,727**	**29,696**	**228,690**	**230,785**	**(2,095)**

National Schemes	CWFT	ICHT	LNWH	THH	Total
	£'000	£'000	£'000	£'000	£'000
Diagnostic Digital Capability Programme	-	810	500	-	1,310
Elective Recovery/Targeted Investment Fund	20,206	-	-	-	20,206
Front Line Digitisation	-	-	780	-	780
NHP	-	1,281	-	26,100	27,381
PFI capital charges (e.g. residual interest)	2,126	-	1,032	1	3,159
Total	**22,332**	**2,091**	**2,312**	**26,101**	**52,836**

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Appendix 1

NWL APC Trust I&E at M11

I&E Performance : CWFT

2024/25 M11	In Month Plan £'000	In Month Actuals £'000	In Month variance £'000	YTD Plan £'000	YTD Actuals £'000	YTD variance £'000	YTD variance %	Annual Plan £'000	Annual Forecast £'000	Forecast Variance £'000
Income	77,533	76,861	(672)	849,189	914,740	65,551	8%	926,768	997,066	70,298
Pay	(45,898)	(48,546)	(2,648)	(502,074)	(530,409)	(28,335)	-6%	(547,968)	(578,560)	(30,592)
Non-Pay	(30,450)	(27,677)	2,773	(338,510)	(374,972)	(36,462)	-11%	(369,028)	(407,091)	(38,063)
Non Operating Items	(901)	(1,027)	(126)	(8,902)	(10,409)	(1,507)	-17%	(9,772)	(11,415)	(1,643)
Total	**284**	**(389)**	**(673)**	**(297)**	**(1,050)**	**(753)**		**0**	**0**	**0**

Key Messages :

- The Trust is reporting a YTD deficit of £1.05m, which is a £0.75m adverse variance to plan.
- The month 11 in-month position was a £0.39m deficit, which is an £0.8m adverse in-month variance to FRP, this is due to the phasing of a material non recurrent benefit (CNST incentive scheme funding). In the FRP phasing was assumed equally over M10-M12, however the benefit will now be reported in M12.
- CIP delivery has improved month on month and is reporting a YTD breakeven position against plan. Current CIP forecast shows full delivery for the year against the Trust's £23.5m target.
- Key drivers of the YTD position are escalation beds remaining open in Q1 net of any funding (£0.57m); RMN/ Specialling increase (£0.79m); non-pay inflation above the funded levels (£3.6m); which is partially offset by non-recurrent benefits YTD relating to the CNST Maternity Incentive Scheme and prior year over-performance income.
- Total ERF performance YTD equates to 146% compared to the target of 117% (19/20 baseline), which is an income over-performance of £31m (against the financial plan) and is largely offset against additional costs.
- Forecast remains unchanged at breakeven.

I&E Performance : ICHT

2024/25 M11	In Month Plan £'000	In Month Actuals £'000	In Month variance £'000	YTD Plan £'000	YTD Actuals £'000	YTD variance £'000	YTD variance %	Annual Plan £'000	Annual Forecast £'000	Forecast Variance £'000
Income	139,774	151,850	12,076	1,534,509	1,622,896	88,387	6%	1,674,278	1,770,156	95,878
Pay	(87,515)	(93,488)	(5,973)	(964,679)	(1,010,670)	(45,991)	-5%	(1,052,164)	(1,101,225)	(49,061)
Non-Pay	(51,065)	(53,067)	(2,002)	(559,425)	(615,983)	(56,558)	-10%	(610,999)	(660,143)	(49,144)
Non Operating Items	(926)	(822)	104	(10,186)	(7,849)	2,337	23%	(11,115)	(8,788)	2,327
Total	**268**	**4,473**	**4,205**	**219**	**(11,606)**	**(11,825)**		**0**	**0**	**0**

Key Messages :

- The month 11 in-month position was a surplus of £4.4m, £70k above the forecast outlined in the financial recovery plan (FRP)
- The in-month surplus position of £4.4m actuals includes the following key highlights:
  - clinical and corporate divisions underachieving against their respective control totals by £4.6m
  - £5.2m release of the onerous lease provision (£3.0m of which was as per FRP)
  - Additional funding of £2.2m
- ERF VWA forecast reaming steady at 121.2%, reflecting an over-performance of c £18m (in-line with M8 forecast). Internal and ICB calculations show this value is in line with the 24/25 ERF performance month 8 cap value issued by NHSE as part of the updated ERF conditions.
- This brings the Trust YTD positon to a deficit of £11.1m, which is a £11.8m adverse variance to plan.
- Appropriate mitigations exist to enable the achievement of a break-even forecast outturn for the year.

I&E Performance : LNWH

2024/25 M11	In Month Plan £'000	In Month Actuals £'000	In Month variance £'000	YTD Plan £'000	YTD Actuals £'000	YTD variance £'000	YTD variance %	Annual Plan £'000	Annual Forecast £'000	Forecast Variance £'000
Income	91,159	86,651	(4,508)	932,550	971,870	39,320	4%	1,016,324	1,068,332	52,008
Pay	(53,949)	(55,360)	(1,411)	(593,829)	(620,270)	(26,441)	-4%	(647,808)	(676,870)	(29,062)
Non-Pay	(27,859)	(30,623)	(2,764)	(316,674)	(361,341)	(44,667)	-14%	(345,904)	(391,779)	(45,875)
Non Operating Items	(1,887)	(1,907)	(20)	(20,739)	(20,972)	(233)	-1%	(22,612)	(22,683)	(71)
Total	**7,464**	**(1,239)**	**(8,703)**	**1,308**	**(30,713)**	**(32,021)**		**0**	**(23,000)**	**(23,000)**

Key Messages

- The Trust is reporting a YTD deficit of £30.7m, £32m adverse to plan. The deterioration in performance against plan is linked to a delay in accounting for profit on land sale. For planning purposes receipt of £9m was assumed in February, but there have been delays in finalising the deal. Receipt is assumed in forecast, £23m deficit.
- CIP delivery is £0.7m behind plan.
- Other key drivers include system factors, including winter beds, EOC, CDC and the system optimisation plan where activity / delivery is behind plan in addition to non-pay inflationary pressures.
- Balance sheet benefits of £5m, assumed in the Financial Recovery Plan assumptions are included in the YTD position.
- Total 2024/25 ERF income YTD exceeds plan by £15m reflecting successful implementation of income recovery measures aimed at redressing post-Cerner issues with recording and reporting activity.
- The Trust forecast has been revised, in agreement with NWL ICB, to a forecast deficit of £23m. The Trust continues to look for mitigations to improve this position

I&E Performance : THH

2024/25 M11	In Month Plan £'000	In Month Actuals £'000	In Month variance £'000	YTD Plan £'000	YTD Actuals £'000	YTD variance £'000	YTD variance %	Annual Plan £'000	Annual Forecast £'000	Forecast Variance £'000
Income	30,576	32,235	1,659	336,317	351,334	15,017	4%	366,895	383,408	16,513
Pay	(20,037)	(23,496)	(3,459)	(220,444)	(247,738)	(27,294)	-12%	(240,481)	(270,963)	(30,482)
Non-Pay	(10,306)	(8,663)	1,643	(113,223)	(124,913)	(11,690)	-10%	(123,487)	(131,010)	(7,523)
Non Operating Items	(721)	(675)	46	(7,706)	(8,037)	(331)	-4%	(2,927)	(8,536)	(5,609)
Total	**(488)**	**(599)**	**(111)**	**(5,056)**	**(29,354)**	**(24,298)**		**0**	**(27,101)**	**(27,101)**

Key Messages:

- At Month 11 of 2024/25, the trust reports a position of £24.3m adverse to plan.
- The drivers of the YTD position are:
  - Income is in total overperforming by 15.0m, largely due to overperformance in elective recovery and on Drugs & Devices, however there are adverse income variances in some elements due to a contractual dispute with NHS England, reduced activity from non NWL patients and planned support from ICB not being received.
  - The YTD income includes elective recovery funding which is potentially in excess of the national cap. This cap was set prior to Cerner related data quality issues being resolved, which resulted in a catch up of funding.
  - Under achievement of savings of c£6m compared to the submitted YTD plan.
  - Operational variances to Budget for pay and non-pay is below:
  - Pay £27m adv driven by urgent care pathways, RMNs and costs associated with ERF overperformance
  - Non-Pay £12m adv due to increased patient activity – including insourcing, costs associated with temporary staffing and estates and facilities.
  - Overperformance against plan for block activity is driving higher costs, particularly on the UEC pathway.
- Cashflow continues to be a concern for the Trust, although some cash support and other receipts have started to alleviate the pressure and allow for increased supplier payments

NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Appendix 2

NWL APC Run Rates

Run Rates

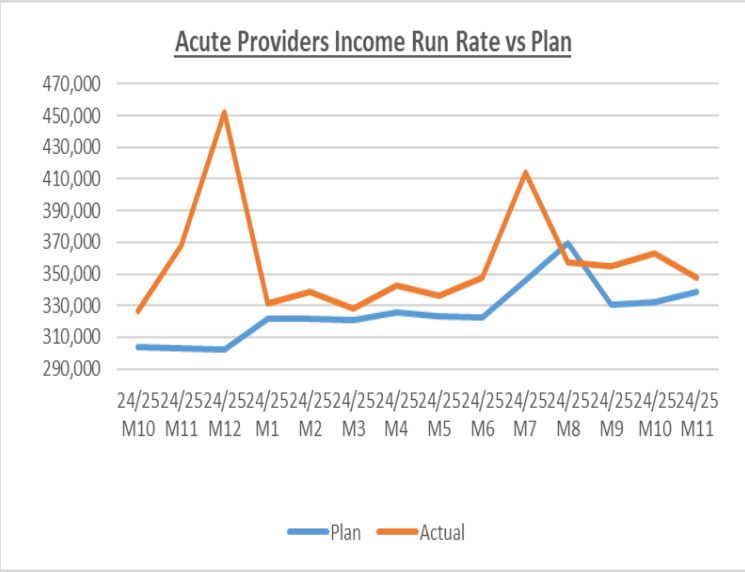
- This appendix shows the monthly run rates of income, pay and non-pay for the APC and trusts 23/24 to 24/25. Month 7-12 23/24 is compared to M1-11 24/25 (average).
- Non pay excludes non-operating items.
- The spike in M12 March 24 in pay and income relates primarily to the accrual for additional employer's pension costs.
- The increase in M7 24/25 on pay and income accounts for the additional 3.3% tariff uplift to income and payment of the 2024/25 pay award (including backpay). Previously Teams were accruing 2% per national planning assumptions.
- The table below shows the percentage changes comparing the average month YTD 24/25 with the average of M7-M11 23/24:

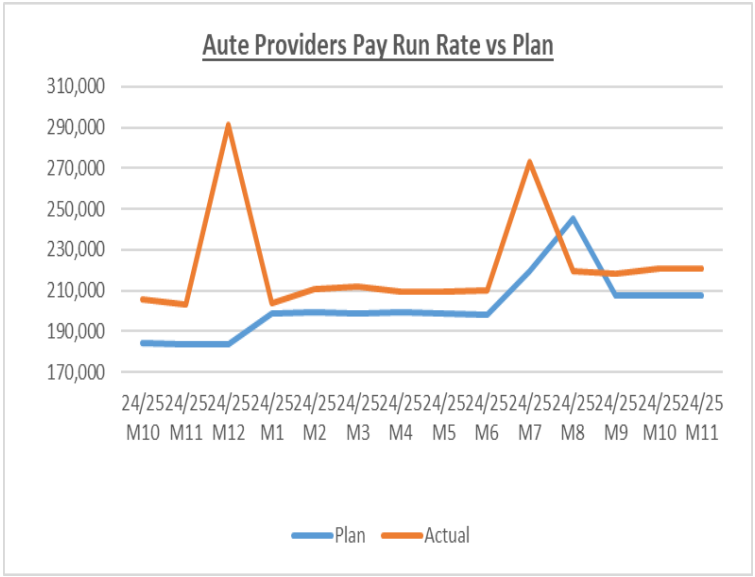
	% change M7-M11 23/24 to M1 - M11 24/25 (average)				
	APC	CWFT	ICHT	LNWH	THH
Income	3.5%	4.7%	4.4%	3.3%	(3.3%)
Total Expenditure	6.9%	4.8%	6.1%	10.4%	6.7%
Pay	8.6%	9.5%	8.9%	8.0%	7.2%
Non Pay	4.2%	(1.2%)	1.7%	14.9%	5.9%

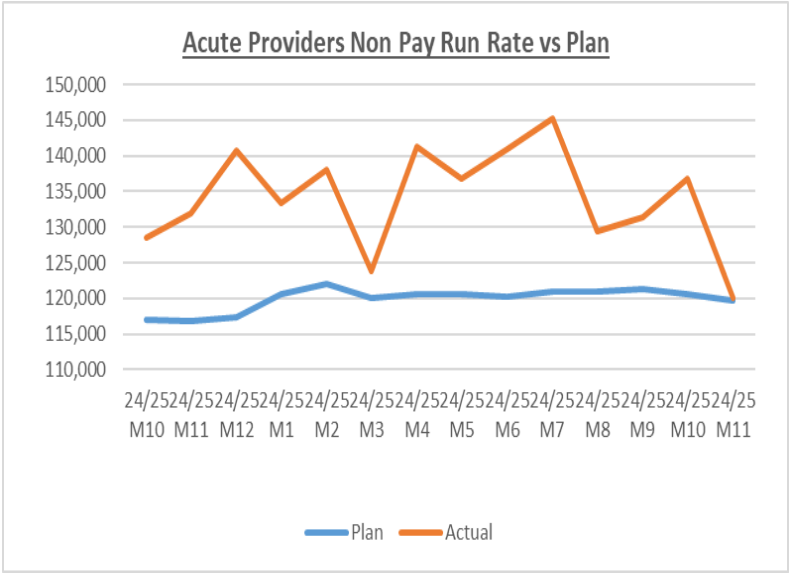
- Overall, for the APC income has increased by 3.5% and expenditure increased by 6.9%
- All trusts report increases in income except THH (3.3% lower).
- Pay has increased across all trusts as expected to account for the pay awards, %'s are variable across the trusts ranging from 7.2% at THH to 9.5% at CWFT.
- Non pay notes an increase of 4.2%, reporting material increases in LNWH (14.9% and THH 5.9%) and a reduction of 1.2% at CWFT.

Run rate - APC

			2024/25 M10	2024/25 M11	2024/25 M12	2024/25 M01	2024/25 M02	2024/25 M03	2024/25 M04	2024/25 M05	2024/25 M06	2024/25 M07	2024/25 M08	2024/25 M09	2024/25 M10	2024/25 M11
Acute	Income	Plan	303,602	302,955	302,293	321,475	321,666	320,539	325,500	323,565	322,848	345,715	369,084	330,615	332,516	339,042
		Actual	326,872	367,546	451,692	331,115	338,746	328,474	342,410	336,354	347,443	413,762	357,704	354,616	362,619	347,597
	Pay	Plan	184,002	183,632	183,778	198,923	199,417	198,901	199,285	198,655	198,357	219,285	245,138	207,915	207,751	207,399
		Actual	206,006	203,442	291,212	204,087	210,445	211,972	209,651	209,640	210,436	273,043	219,555	218,251	221,118	220,890
	Non-pay	Plan	116,924	116,913	117,366	120,626	121,971	120,082	120,678	120,626	120,244	121,038	120,953	121,369	120,565	119,680
		Actual	128,490	131,876	140,753	133,376	137,970	123,814	141,375	136,793	140,852	145,225	129,509	131,446	136,819	120,030

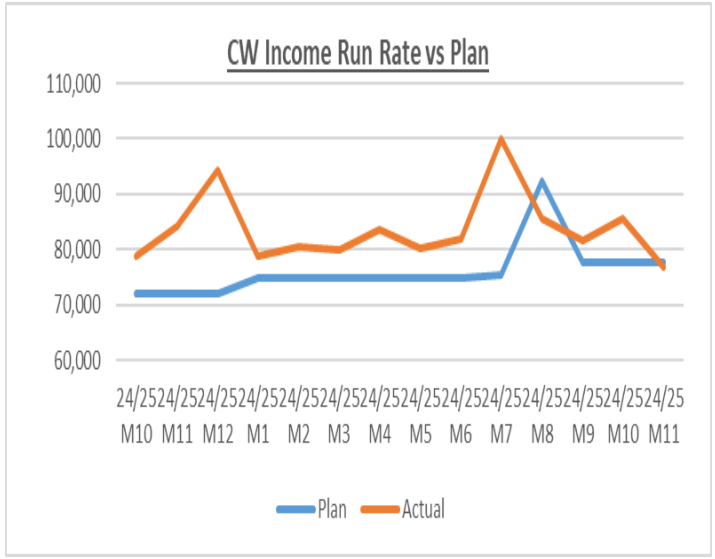


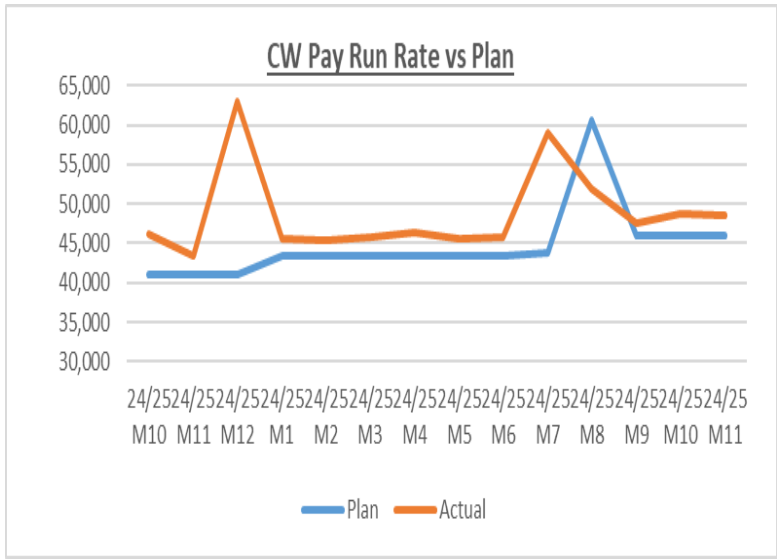


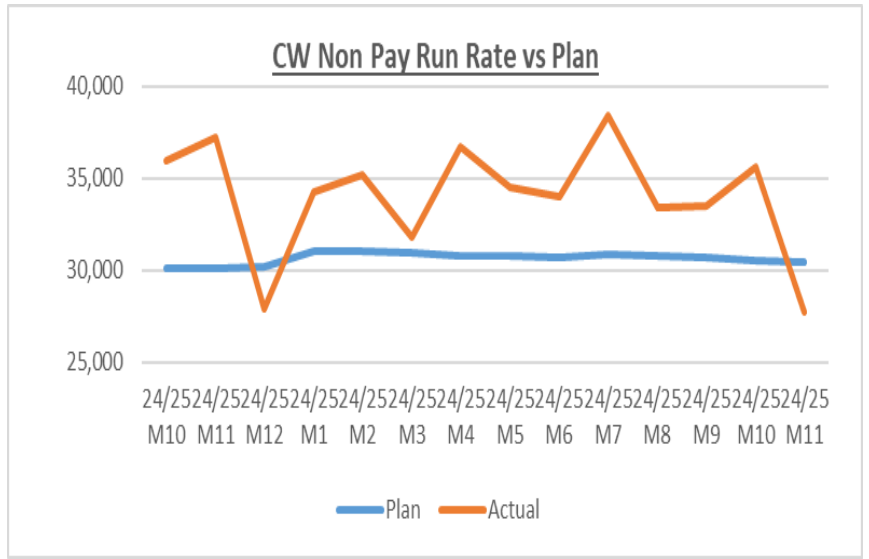


Run rate - CWFT

			2024/25 M10	2024/25 M11	2024/25 M12	2024/25 M01	2024/25 M02	2024/25 M03	2024/25 M04	2024/25 M05	2024/25 M06	2024/25 M07	2024/25 M08	2024/25 M09	2024/25 M10	2024/25 M11
CWFT	Income	Plan	71,978	71,978	71,974	74,808	74,808	74,808	74,808	74,808	74,808	75,522	92,220	77,533	77,533	77,533
		Actual	78,892	84,282	94,262	78,860	80,560	80,031	83,602	80,140	81,936	99,962	85,690	81,637	85,461	76,861
	Pay	Plan	41,001	41,001	40,948	43,318	43,318	43,318	43,318	43,318	43,318	43,887	60,585	45,898	45,898	45,898
		Actual	46,134	43,431	62,931	45,623	45,403	45,770	46,468	45,650	45,857	58,936	51,917	47,577	48,663	48,546
	Non-pay	Plan	30,100	30,102	30,156	30,985	31,036	30,968	30,787	30,750	30,695	30,830	30,778	30,714	30,517	30,450
		Actual	35,948	37,171	27,887	34,204	35,181	31,808	36,661	34,507	34,006	38,423	33,433	33,465	35,607	27,677

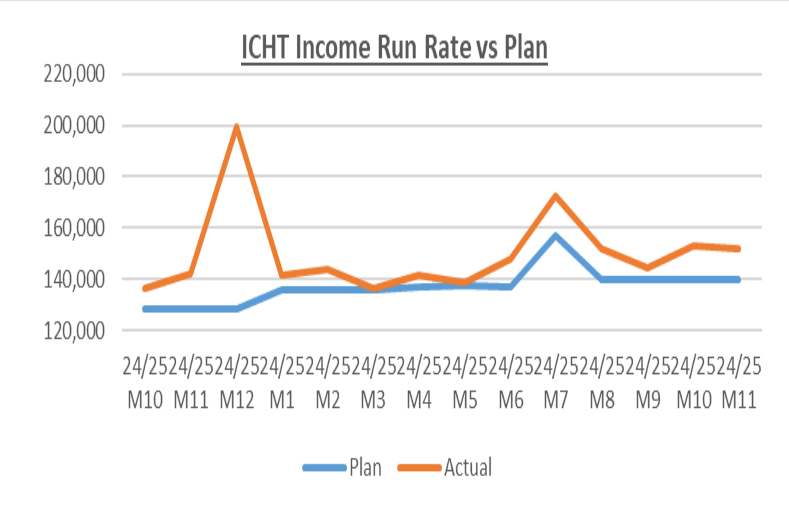


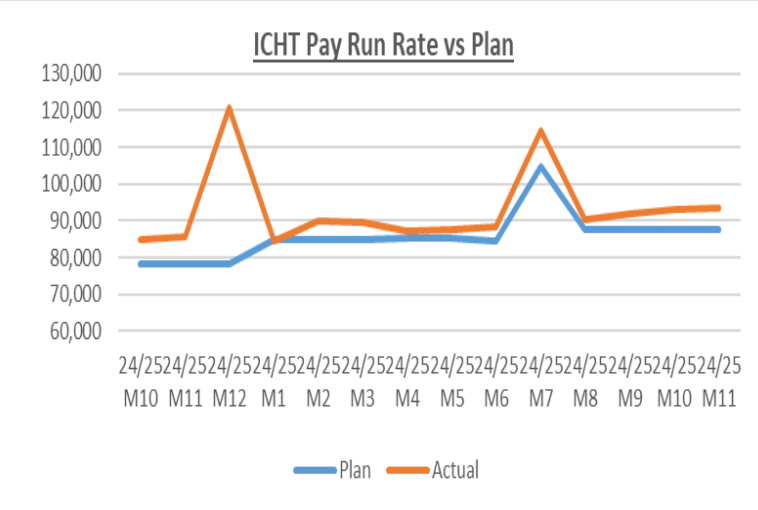


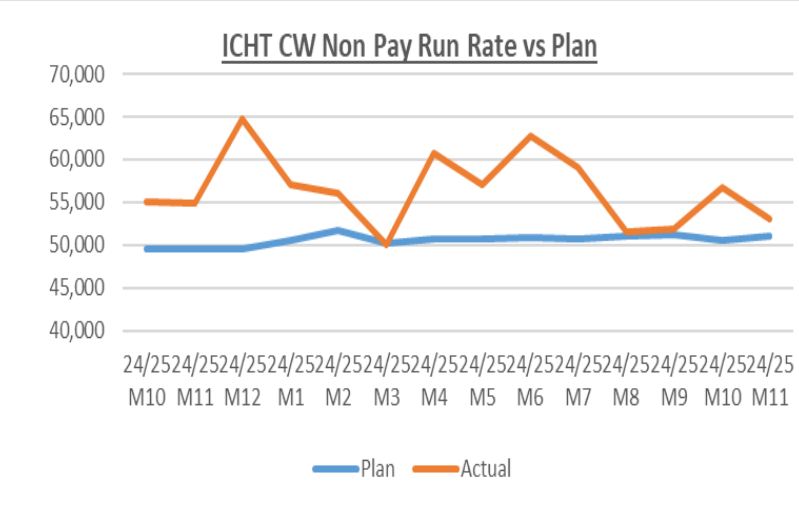


Run rate - ICHT

			2024/25 M10	2024/25 M11	2024/25 M12	2024/25 M01	2024/25 M02	2024/25 M03	2024/25 M04	2024/25 M05	2024/25 M06	2024/25 M07	2024/25 M08	2024/25 M09	2024/25 M10	2024/25 M11
ICHT	Income	Plan	128,530	128,526	128,506	135,760	135,760	135,760	136,804	137,429	136,905	156,995	139,774	139,774	139,774	139,774
		Actual	136,304	142,143	199,604	141,488	143,780	136,157	141,580	138,705	147,961	172,534	151,682	144,221	152,938	151,850
	Pay	Plan	78,173	78,168	78,158	84,996	84,996	84,995	85,100	85,163	84,640	104,736	87,512	87,512	87,514	87,515
		Actual	85,005	85,558	120,712	84,497	90,113	89,439	87,398	87,520	88,430	114,547	90,198	91,830	93,210	93,488
	Non-pay	Plan	49,599	49,600	49,582	50,604	51,657	50,214	50,760	50,745	50,891	50,688	51,112	51,179	50,510	51,065
		Actual	55,055	54,960	64,683	57,121	56,091	49,976	60,744	57,005	62,810	59,012	51,511	51,904	56,742	53,067



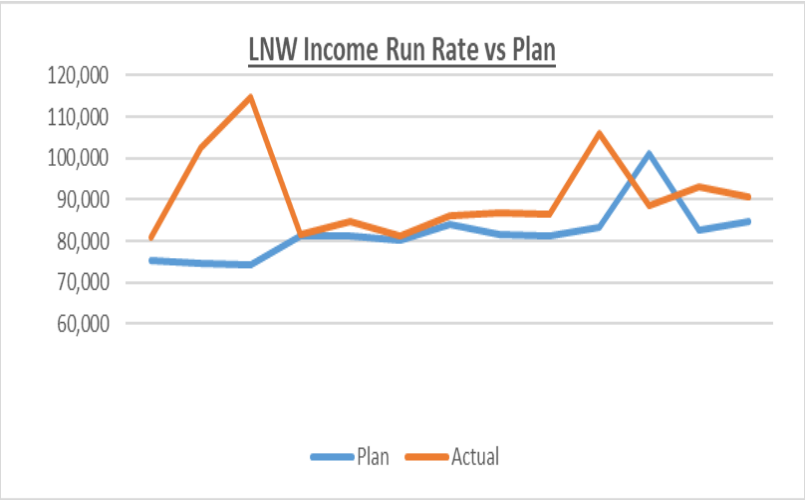


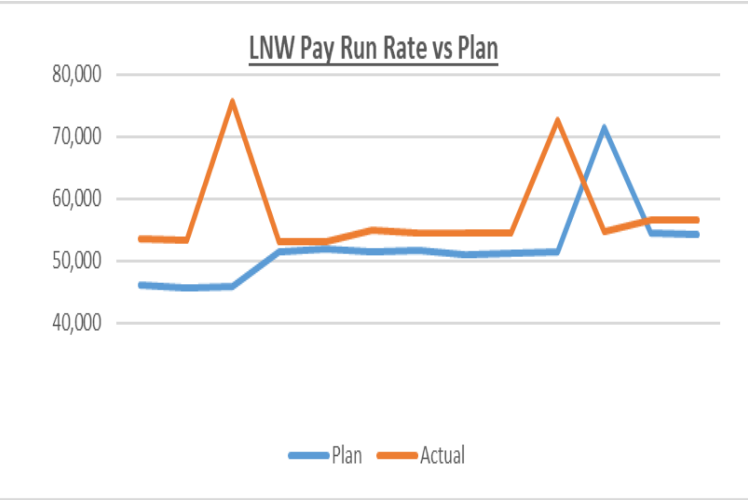


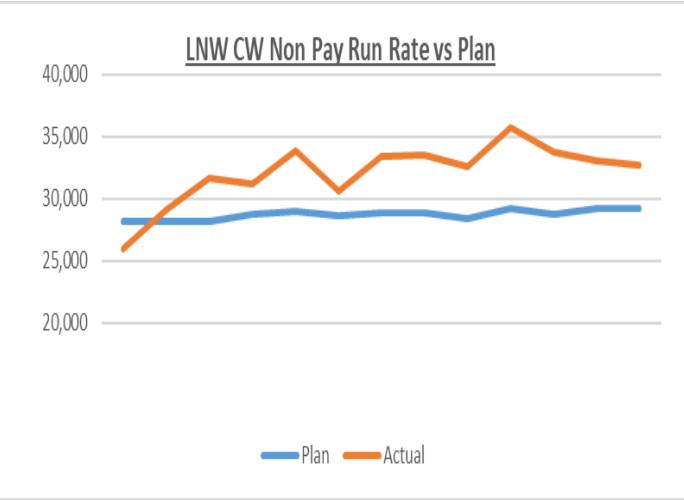
NHS North West London Acute Provider Collaborative

Run rate - LNWH

			2024/25 M10	2024/25 M11	2024/25 M12	2024/25 M01	2024/25 M02	2024/25 M03	2024/25 M04	2024/25 M05	2024/25 M06	2024/25 M07	2024/25 M08	2024/25 M09	2024/25 M10	2024/25 M11
LNW	Income	Plan	75,406	74,762	74,116	81,131	81,323	80,195	84,113	81,553	81,361	83,423	100,926	82,732	84,634	91,159
		Actual	80,717	102,490	114,750	81,741	84,681	81,061	86,270	86,948	86,306	105,953	88,534	92,925	90,800	86,651
	Pay	Plan	46,070	45,705	45,914	51,360	51,854	51,339	51,627	50,934	51,159	51,424	71,413	54,468	54,302	53,949
		Actual	53,644	53,339	75,502	53,080	53,112	54,937	54,399	54,560	54,419	72,550	54,642	56,635	56,576	55,360
	Non-pay	Plan	28,177	28,162	28,175	28,735	28,977	28,597	28,828	28,828	28,370	29,235	28,777	29,235	29,233	27,859
		Actual	26,019	29,168	31,722	31,164	33,883	30,679	33,428	33,559	32,591	35,774	33,802	33,089	32,749	30,623

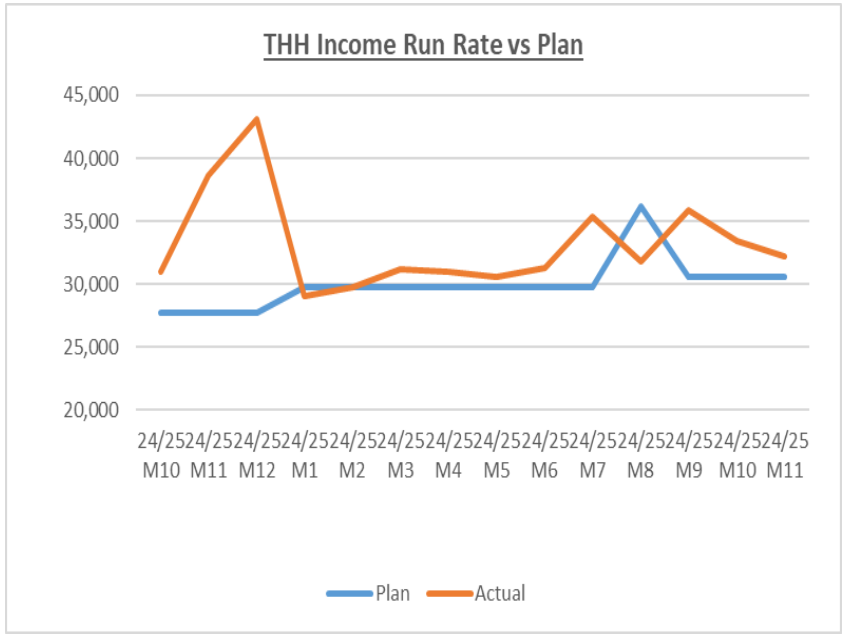


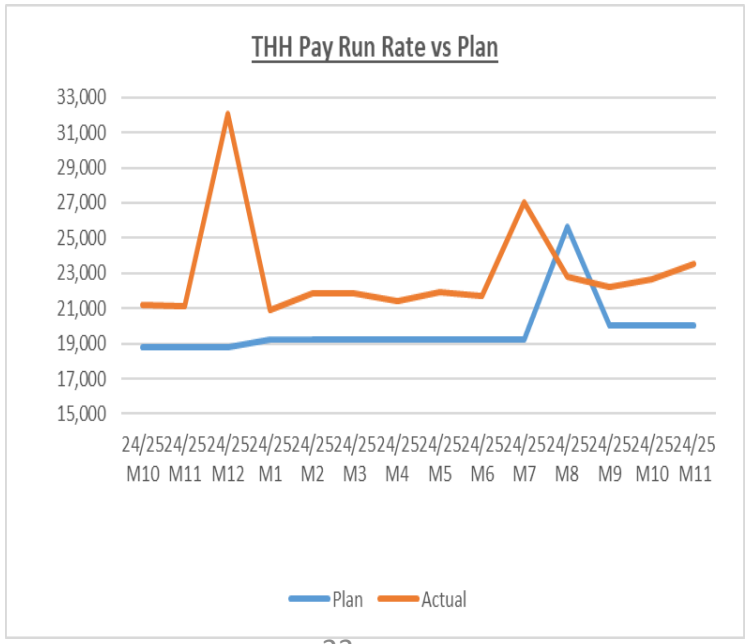


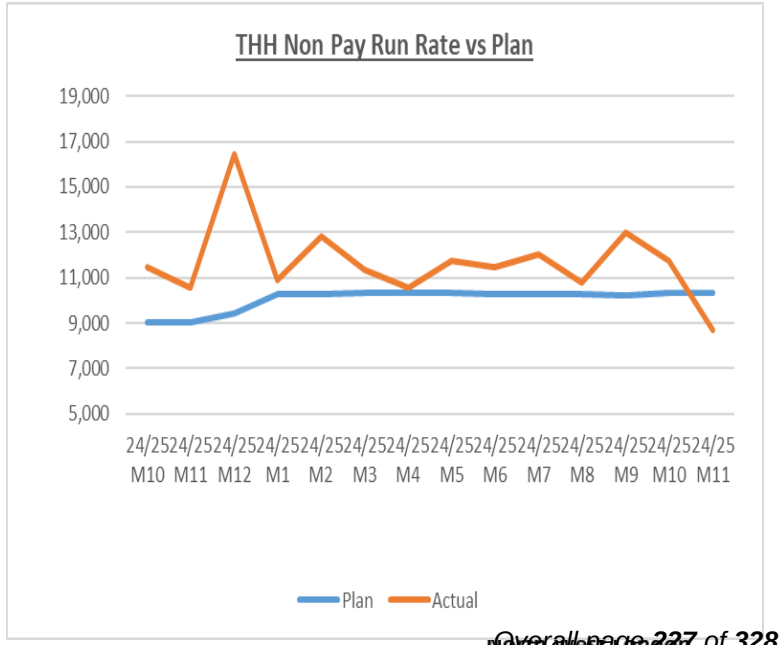


Run rate - THH

			2024/25 M10	2024/25 M11	2024/25 M12	2024/25 M01	2024/25 M02	2024/25 M03	2024/25 M04	2024/25 M05	2024/25 M06	2024/25 M07	2024/25 M08	2024/25 M09	2024/25 M10	2024/25 M11
THH	Income	Plan	27,689	27,689	27,698	29,776	29,775	29,776	29,775	29,775	29,774	29,775	36,164	30,576	30,575	30,576
		Actual	30,959	38,631	43,076	29,026	29,725	31,225	30,958	30,561	31,240	35,313	31,798	35,833	33,420	32,235
	Pay	Plan	18,758	18,758	18,758	19,249	19,249	19,249	19,240	19,240	19,240	19,238	25,628	20,037	20,037	20,037
		Actual	21,223	21,114	32,067	20,887	21,817	21,826	21,386	21,910	21,730	27,010	22,798	22,209	22,669	23,496
	Non-pay	Plan	9,048	9,049	9,453	10,302	10,301	10,303	10,303	10,303	10,288	10,285	10,286	10,241	10,305	10,306
		Actual	11,468	10,576	16,461	10,887	12,815	11,351	10,541	11,723	11,445	12,016	10,763	12,988	11,721	8,663







NHS
North West London
Acute Provider Collaborative

Four acute NHS trusts working together


Chelsea and Westminster Hospital NHS Foundation Trust


The Hillingdon Hospitals NHS Foundation Trust


Imperial College Healthcare NHS Trust


London North West University Healthcare NHS Trust

Appendix 3

Financial Performance Escalation

Financial Performance Escalation

- The financial performance escalation process implemented in 2023/24 is followed in 2024/25 due to the high risk in the financial plan.
- A set of escalation metrics are in place whereby a breach enacts escalation.
- This tests the variation from YTD plan, CIP delivery, ERF performance and annual plan.
- The M11 metrics range from a score of 1.3 (CWFT) to 4 (THH) – see table on the RHS.
- Upon breaching the metrics, the levels of escalation are shown in the table on the LHS.
- This is the 2023/24 process which has agreed to be followed in 2024/25.
- To note for 2024/25 there is no risk pool support funding.

Level	Escalation Process	ICB
1	Peer review by peer CFO to challenge recovery and support identification of mitigations	N/A
	Notification to CEOs	
2	As 1 above	Inform (i.e. advise of proposals)
	Turnaround plan developed and presented to CEOs	
	Implementation of turnaround controls e.g. vacancy review, discretionary spend review	
	Report to Trust F&P	
3	As 1 & 2 above	Engage (discuss and agree proposals)
	Trust in formal turnaround requiring APC led SOM style meeting to agree recovery plan and actions	
	Turnaround controls reviewed by multi-trust panel (double lock)	
	Report to CIC F&P	
	Release of support from APC to mitigate the financial position *	
4	As 1-3 above	Involve (likely to be part of wider escalation process)
	Turnaround controls reviewed by ICS panel (triple lock)	
	Report to CIC Board	

M11 Escalation Trigger Summary

Measure	Basis	Level 1	Level 2	Level 3	Level 4	CW	ICHT	LNW	THH	CW	ICHT	LNW	THH
Year to Date deterioration against plan *	T/over	0-0.5%	0.5-1%	0-1%	>1%	1	3	4	4	-0.1%	-0.7%	-3.2%	-6.9%
Year to Date Run Rate - deficit *	T/over	0-0.75%	0.75-1%	0-1%	>1%	2	3	4	4	-0.1%	-0.7%	-3.1%	-8.3%
CIP non-delivery against plan	CIP Value	0-10%	20-30%	30-40%	>30%	1	3	1	4	0%	-52%	-2%	-53%
Forecast Outturn '000	T/over	0	0-0.5%	0.5-0.75%	>0.75%	1	1	4	4	0	0	-2%	-7%
Ave score						**1.3**	**2.5**	**3.3**	**4.0**				

* impact of IA removed

4.3.5 COLLABORATIVE FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT (CAROLYN DOWNS)

REFERENCES

Only PDFs are attached

4.3.5. APC FPC Chair's Report to BiC APRIL 25 JT.pdf

North West London Acute Provider Collaborative
Collaborative Finance and Performance Committee Chair's Highlight Report to the Board in Common – for discussion
April 2025

Highlight Report

1.0 Purpose and Introduction

1.1 The purpose of this report is to provide the Board in Common (BiC) with assurance of the work undertaken by the Collaborative Finance and Performance Committee (FPC) at its last meeting held on 19 March 2025. The report is intended to provide any feedback to the BiC and request if further work within the Committee's remit is required.

1.2 The role of the Collaborative Committee, which has changed in light of the recent governance developments and establishment of Board Standing Committees, is:

- To identify, prioritise, oversee and assure strategic change programmes to support the delivery of the Acute Provider Collaborative (APC) strategy and to drive collaborative-wide and Integrated Care System (ICS) integrated improvements.
- To identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements

2.0 Key Highlights

2.1 Finance Report

The Committee was advised that at the end of January, the APC reported a year to date (YTD) deficit of £75m, £63.6m adverse to plan (£11.4m deficit) and £1.4m favourable against the YTD recovery plan. In-month, the APC reported a surplus of £0.2m, which is a favourable in-month variance of £3.7m against plan and £1.4m below the expected position for January as previously forecast.

The forecast for the APC (as reported to the BIC in January) remains a deficit of £50.1m with Chelsea and Westminster NHS FT (CW) and Imperial College Healthcare Trust (ICHT) projected to break even and deficits of £23m and £27.1m for London North West Healthcare (LNW) and The Hillingdon Hospitals NHS FT (THH) respectively.

The Committee was advised that cash is still a challenge for THH and LNW, however the capital funding secured by THH more recently has alleviated the immediate issue.

Investigation and Intervention (I&I) Reports – it was confirmed that the final reports had not yet been shared with Chief Finance Officers (CFOs) and CEOs, which is why the reports were not presented at the meeting. CFOs confirmed that they were meeting with the consultants who produced the reports after the Committee meeting. It was confirmed that the reports would be shared with the non-executive directors (NEDs) who advised they wanted to see this in advance of signing off business plans. CFOs advised that there were no surprises in the report, and the opportunities identified were those already being worked up for 2025/26.

Finance and productivity position by Trust: The report was presented, noting it did not contain the full level of detail that the Committee had requested. It was advised that there is movement nationally on approach and indicators, including a new indicator from April 2025 on 'implied productivity'. CFOs had given feedback on the methodology suggesting that value rather than cost weighting was a more effective measure. NHS England are considering the feedback and will advise in due course, however in the meantime they are supporting trusts to transition by providing data that allows the impact to be assessed as if introduced in month six of the current year. NWL has been an exemplar when compared to other systems, assessed as having the lowest productivity loss nationally since 2019-20 (-1.3% compared to national average of -13.5%). The new data suggests a 3.6% productivity reduction across the APC. In response to questions about why there has been a dip, whether costs have gone up disproportionate to activity and too much work undertaken at too high a cost (e.g. through outsourcing), it was agreed that further analysis was required.

The Committee heard how trusts are focused on addressing the growth since 2019/20 of non-clinical staff not directly involved in patient care, with plans to cut the growth by 50% and address the wider WTE reductions required. There is work across THH and CW to use staff resources more efficiently together. This is also involving Imperial given some of the recent leadership developments. Addressing follow up rates, stopping or consolidating some services and ensuring compliance with evidence based interventions (EBIs) were highlighted as just some of the ways productivity could be improved.

In response to a suggestion that a local model re productivity measurement is developed given some of the issues with the new methodology, Committee members advised that any model needs to be nationally comparable to be effective so urged caution regarding the suggestion.

A further report will come to the next Committee meeting setting out the positions and opportunities clearly.

2.2 2025/26 Plans – Latest Position

LW introduced the item, noting the challenging context and advised that some of the figures were changing through the final discussions across the APC and with the ICB. More generally LW advised that given the financial situation for the coming year and beyond, trusts would need to work together to look at service changes, including consolidation where it makes sense. Further difficult decisions will be needed, which will require the right decision making structure to support this. LW added that trusts are doing work that is not commissioned (EBIs) and this needs to stop. Further work on consolidation of corporate services continues to ensure the APC is as efficient as it can be.

In terms of achievement of operational performance standards it was confirmed that with pared back activity in terms of insourcing and outsourcing, while the four hour target for A&E and cancer performance could be met, diagnostic and referral to treatment (RTT) performance would be compromised and not met. LW added that trusts are doing all they can to try to meet the requirements, but with the cap in the elective recovery fund (ERF) this would be difficult.

LW advised that in terms of workforce there were also challenges with the new targets announced, including the additional 50% target in corporate/non-patent facing growth since 19/20, with conversations with staff beginning. LW added that investments in

staffing agreed last year had been frozen. Trusts would need to make their own decisions re safer staffing rather than sticking rigidly to absolutes as set out in guidance, using local knowledge and expertise to ensure safety given the limited financial envelope and required workforce reductions. The Committee challenged whether all trusts were using the same principles regarding staffing and making the commitment to the reductions in working time equivalents (WTEs) needed. All advised that they were, with some updates to figures in the draft plan required (e.g. LNW's data which had since been updated).

Discussions about the deficit support money from the ICB centred around ensuring that any funds that should sit recurrently with Trusts do so in future, rather than as one-off support. The focus over the next few days was to ensure a correct 'true-up' of such funds and that all trusts are being paid for the work commissioned and done, otherwise the same issue could reoccur next year.

Concern over the approach to developing and finalising the business plan was stated, with the late arrival of guidance, not having transparency over the full amount of funds available - recognising this was not all down to the ICB. It was agreed to write to the ICB regarding this.

Committee members and attendees discussed how challenging it would be to deliver the plan, with an absolute focus on productivity needed. A need to develop a medium term financial strategy (MTFS) was cited as critical, noting that all trusts did not meet efficiency plans agreed last year. All agreed to focus on the MTFS as a priority for 2025/26, with progress reported through this Committee.

2.3 Online Business Case for the NWL APC Data Warehouse and Reporting Strategy

RC joined the meeting to present the case. He advised that approval of the case will support the APC to be data-driven, adding that insights and intelligence will be available nearer to real-time enabling accurate predictions to support proactive intervention and management.

To do this requires investment of £12.28m over five years to consolidate into a modernised single APC technical data infrastructure (single data extraction process for each source system, single data warehouse, and single strategic reporting solution). RC advised that external funding will be sought to cover these costs, with the APC (constituent trusts) then expected to cover the ongoing cost in subsequent years after 2029/30 (£2m per year net revenue impact to budget split between the four trusts). RC advised that approval of the case was sought so that the APC had something ready for submission (noting some updates would be needed) should external funding become available.

A lengthy discussion followed about the rationale behind the case, and whether the full range of options had been considered. Committee members noted the competitive market for digital services/staff and whether external options/partnering, including the option of fully outsourcing, had been explored. Further comments on a need to see the potential savings for a shared warehouse/services were made, given there should be financial benefits from a joint approach re warehouses and licences. While challenges in producing detailed figures on this was noted, it was agreed that further work on the case should be done.

Challenges in recruiting data scientists and expert staff was noted given the wider competition for such roles, with a request for more imaginative solutions to be forthcoming.

In summary, the work on the case was welcomed as a broad strategic direction and it was recognised that it was drafted in such a way as to not close down options, however given the feedback from members, further work on the case was requested. This was to include detail on how solutions and tech would be implemented and embedded in organisations, where the responsibilities for making these work will sit and what the return on the investment will be. The case will be further discussed through the Digital and Data APC Committee and further details developed before any submission back to this Committee and then to local committees, noting authority to invest sits with each Trust.

2.4 Update re Financial Shared Services Programme

The Chair advised that the report should be noted as an update unless there were any questions for VM. The procurement for the establishment of NWL Trusts' Local Finance Shared Services Centre (LFSSC) had been abandoned, with a meeting scheduled for 27 and 31 March to agree a revised programme and timeline for the project. The paper was noted, with a further update to be provided at the next meeting.

2.5 Integrated Performance Report

The Committee considered January data (December for Cancer, Maternity and Operating Plan performance). Overall performance is where Trusts broadly expected it to be, with no major surprises since last quarter.

2.5.1 Urgent and Emergency Care (UEC): while it was noted that the APC benchmarks well in terms of London performance, it was acknowledged that performance over winter had been disappointing with a difficult winter and all off Type 1 trajectory. All trusts had implemented the winter plans discussed at the last meeting of the Committee, with February performance showing some improvement and March looking to be even better. Three of the four trusts were close to the 78% target. Performance on London Ambulance Service (LAS) handovers had deteriorated although was the best collectively in London. LNW was an outlier, with a February and March 'firebreak' agreed with LAS, taking patients to other hospitals within the APC. While this was welcomed as an example of collaborative working, concern was expressed regarding what could happen when the arrangement ends. COOs provided feedback that plans were in place to address this, as it does impact on flow for patients when they are not in their host hospital. LNW and the ICB are undertaking detailed demand and capacity work. It was agreed to have a deep dive into UEC at the next meeting to avoid this scenario in future.

2.5.2 Elective care: the Committee heard that overall there continues to be a sustained reduction in long-waiting patients, with overall good performance. The most challenged specialties remain ear, nose and throat (ENT), trauma and orthopaedics, general surgery, urology, and gynaecology. Mutual aid continues to be in place across the APC meaning that some breaches will be reported at the treating organisation.

2.5.3 Cancer: Cancer performance was overall cited as strong, with performance through the Royal Marsden Partners Cancer Alliance the best in the country. NWL overall exceeded the faster diagnostic standard (FDS) standard again in December, with a whole provider position of 81.5% against the 75% target. The 31-day standard was met for the sixth month in a row across the APC, with all Trusts individually meeting the standard.

2.5.4 Diagnostics: Overall delivery remains below target. Recovery plans are in place but the APC is unlikely to meet target this financial year due to financial constraints across the sector and data quality at LNW. LNW have some external support to correct the data flows driving the poor performance. Winter pressures combined with reduction in operational days saw capacity shortfalls and associated performance deterioration in December and January. Additional capacity has been created through waiting list initiatives, insourcing and the use of community diagnostic centres where possible. MRI capacity continues to be a risk across the sector. Other challenged modalities include neurophysiology, audiology and ultrasound which face capacity challenges due to staffing shortages and ageing equipment.

2.6 Equality, Diversity and Inclusion (EDI) Update

The Committee noted the update report and progress underway, however requested that reports on this come to the meeting when there is something significant to consider or address.

3.0 Key risks / topics to escalate to the NWL APC BiC

- The business planning process, including timing and transparency.
- Productivity data across the APC and understanding the correct position and actions required in response.
- Overall financial position and need for longer term solutions across the APC.
- Challenges in delivering the business plans for the coming year.
- UEC performance.

4.0 Concerns outstanding

The risks above set out the key concerns, with the actions below covering the key items the Committee requires further detail and assurance on.

5.0 Actions commissioned

- Write to the ICB regarding experience of the business planning process
- More detailed work on productivity position by Trust and across APC.
- Develop medium term financial strategy at pace
- Have a deep dive into UEC performance at the next Committee meeting

6.0 Decisions Made

6.1 None – the progress on business plans was noted, with the plans to be approved through local FPCs, standing committees and finally the Board in Common. The Outline Business Case for Outline Business Case for the NWL APC Data Warehouse and Reporting Strategy was welcomed as a strategic direction but not approved, with a request for further work to be undertaken.

7.0 Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Financial Report, including: CIPs, Financial recovery, and Productivity Position by Trust	To note	5.	Integrated Performance Report and operational performance updates on UEC, elective care, cancer	To note

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
2.	2025/26 Plans – Latest Position	To note	6.	Equality Diversity and Inclusion (EDI) Update	To note
3.	Outline Business Case for the NWL APC Data Warehouse and Reporting Strategy	To agree	7.	Escalation report from local Trust committees	To note
4.	Update on the Financial Shared Services Programme	To note	8.	Review of Forward Planner	To note

8.0 Attendance

Members:	Attendance
Carolyn Downs, Non- executive director (NED) of THHT F&PC - (Chair)	Y
Mike O'Donnell, NED, Chair of CWFT F&PC	Y
Bob Alexander, NED, Chair of Imperial F&PC	Y
Loy Lobo, NED, Chair of London North West (LNW) F&PC	Y
Lesley Watts, CEO, Chelsea and Westminster NHS FT (CWFT) and Collaborative Lead for Finance and Performance	Y
Attendees:	
Matthew Swindells, Chair of NWL Board in Common and Collaborative	Y
Tim Orchard, Chief Executive Officer – Imperial	Y
Tracey Cotterill, Interim Chief Financial Officer - Hillingdon	Y
Tina Benson, Chief Operating Officer - Hillingdon	N
Claire Hook, Chief Operating Officer - Imperial	Y
Jazz Thind, Chief Financial Officer - Imperial	Y
Virginia Massaro, Chief Finance Officer - CWFT	Y
Laura Bewick, Hospital Director – CW - CWFT	Y
Sheena Basnayake, Hospital Director WM - CWFT	Y
James Walters, Chief Operating Officer - LNW	Y
Don Richards, Chief Financial Officer - LNW	Y
Helen Berry, Associate Director of Finance, NWL APC	Y
Peter Jenkinson, Director of Corporate Governance	N
Marie Price, Deputy Director Corporate Governance - CWFT	Y
Alexia Pipe, Chief of Staff to the Chair	Y
Robbie Cline, Chief Information Officer – NWL APC	Y

5. DATA AND DIGITAL

5.1 COLLABORATIVE DIGITAL AND DATA COMMITTEE REPORT (MATTHEW SWINDELLS)

REFERENCES

Only PDFs are attached

5.1a. Collaborative Digital and Data Meeting Summary report March 2025 v3.pdf

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

March 2025

Highlight Report

1. Purpose and Introduction

The role of the Digital and Data Committee is:-

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

2. Key Highlights

2.1 Data Strategy – APC Data Warehouse and reporting Strategy

Committee members received the proposal for the outline business case for a single data warehouse. The business case recommended an investment of £12.28m over 5 years to consolidate into a modernised single APC technical data infrastructure. Committee members noted that external funding was being sought. Ongoing costs in subsequent years from 2029/30 would be split between 4 Trusts funded through the APC. Committee members supported the direction of travel of the business case noting the importance of supporting the data strategy and agreed that there was extra work needed on the business case to quantify benefits before seeking financial approval from individual Trusts.

2.1.1 Cyber Security Strategy – ICB Cyber Security Strategy

The Committee received the report which provided the Committee with a progress update on the development of the cyber security strategy for the ICB. Committee members noted that each Trust would remain responsible for its own Cyber Security posture and, that each Trust would need to fund investments from their own existing resources. Each Trust would be developing a financial impact model for costs associated with cyber incident, to ensure that financial implications are understood.

2.1.2 Digital Record

NWL Joint Programmes & Projects Benefits

Committee members received the report which described high level benefits that were expected from a range of products on which the four Trusts are collaborating. Committee members noted the importance of effective implementation, adoption, and benefits realisation of the EPR ecosystem projects, with a focus on addressing technical challenges and securing necessary resources. The Committee discussed the desire to see the impact from the list presented.

Patient Communication System
Committee members received the report which highlighted the current use of multiple systems such as Care Information Exchange (CIE) and DrDoctor for patient communication, the funding challenges we face, and the exploration of future strategies, including potential integration with the NHS app. The Committee noted there is currently no funding in place for when the contracts end in March 2026. The report also emphasised the need for a unified approach across the ICS to support a seamless patient experience.

2.1.3 Federated Data Platform (FDP) – Progress with roll out across the APC

Committee members received an update on the progress of the Federated Data Platform, including the FDP first approach, current status of projects, the roadmap for future developments, and the importance of addressing data latency issues. The Committee noted it was important to focus on adoption across the four Trusts.

2.1.4 Equality and Diversity

Equity Index Methodology
Committee members noted the equity index, a composite measure of clinical equity, and its application in identifying and addressing inequities in clinical outcomes at London North West. Committee members noted the potential to adopt a shared methodology across the APC.

Update on the 2025/26 workplan
Committee members received an update on the EDI work plan, highlighting progress in areas like patient communications and open roaming, noting the lack of progress in digital health literacy.

2.1.5 Innovation – Use of AI

Committee members received an update on the AI governance framework in North West London, including the new systems process for identifying and managing AI schemes and the development of a consistent AI policy across the four organisations.

2.1.6. APC Performance Report – steps to automation

Committee members noted the challenges and plans for automating the performance report, starting with the integration of ECDS data into the Federated Data Platform and reporting the urgent and emergency care Performance Report metrics that can be derived from that.

2.1.7. ICT Risk Register

Committee members received an update on the risk register, highlighting key digital and data risks, including cyber security, EPR Ecosystem benefits realisation, and effective reporting systems. Committee members agreed that the risk register would be updated to reflect the risk of achieving productivity benefits from new and existing systems.

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

- APC Data Warehouse – a further business case will be submitted once the costs have been sourced and benefits determined.
- The draft cyber security strategy has been added to the BiC reading room for

information.
- More work is required by the Trusts on AI governance to get the balance of risk management and innovation right
- The theme of adoption and productivity, particularly related to the Federated Data Platform (FDP) and other digital tools, will be emphasized.

4. Concerns outstanding

- No additional APC level concerns which require escalation to the Board.

5. Key actions commissioned

- An update on Oracle Health Partnership pilots will be presented at the next Committee.
- Data Warehouse and Reporting Strategy OBC will be updated.
- Look for a single product that can cover all use cases of patient communication systems across NW London and address the funding problem beyond March 2026.

6. Decisions made

7. Summary Agenda

No.	Agenda Item	Purpose
1.	Digital Strategy – APC Data Warehouse and reporting strategy	For discussion & approval
2.	Cyber Security Strategy • ICB Cyber Security Strategy	For Information and Discussion
3.	Digital Record • NWL Joint Programmes & Projects Benefits • Patient communication systems	For Information and Discussion
4.	Federated Data Platform (FDP) • Progress with roll out across the APC	For Information and Discussion
5.	Equality and Diversity • Equity Index methodology • Update on the 25/26 work plan	For Information and Discussion
6.	Innovation - Use of AI	For Information and Discussion
7.	ICT Risk Register	For Information and Discussion

8. Attendance

Members	March 2025 attendance
Matthew Swindells (NWL APC Chair in Common) – Chair of the NWL APC D&D Committee	Y
Tim Orchard (Chief Executive, ICHT)	Y
Simon Crawford (Director of Strategy – LNWH & Senior Information Risk Owner (SIRO) Representative)	N
Robbie Cline (Joint Chief Information Officer – LNWH/THHT/ICHT/C&WFT)	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 – ICHT/THHT)	Y
Janet Campbell (NED THHT)	Y
Loy Lobo (NED – LNWH/ICHT)	Y
In Attendance	
Alexia Pipe (Chief of Staff to the Chair in Common)	Y
Peter Jenkinson (Director of Corporate Governance)	Y
John Keating (Deputy CIO LNWH, THHT)	Y
Mathew Kybert (Deputy CIO, ICHT)	Y

6. ESTATES AND SUSTAINABILITY

6.1 COLLABORATIVE STRATEGIC ESTATES, INFRASTRUCTURE AND SUSTAINABILITY COMMITTEE REPORT (BOB ALEXANDER)

REFERENCES

Only PDFs are attached

6.1. Collaborative Strategic Estates and Sustainability Committee - March 2025 final.pdf

North West London Acute Provider Collaborative (NWL APC)
Strategic Estates and Sustainability Committee Chair's Highlight Report to the NWL APC Board in Common (BiC) – for discussion
March 2025

Highlight Report

1. Purpose and Introduction

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

- To oversee and receive assurance that the Trust level processes governing estates maintenance and development are functioning properly and identify areas of risk where collaborative-wide interventions would accelerate and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements in estates optimisation and usage, and sustainability.
- To receive assurance regarding capital planning and prioritisation across the Collaborative.
- To oversee the development of an estates strategy across the Collaborative, including site optimisation and redevelopment, and to inform the design of the human resource required to deliver the strategy.
- To oversee the strategic consideration of opportunities across the Collaborative in relation to soft facilities management contracts.
- Ensuring equity is considered in all strategic estates development.

2. Key highlights

2.1 The Strategic Estates and Sustainability Collaborative Committee met on 4 March 2025. The following papers were discussed.

2.2 **Summary update on any key changes on green plan and sustainability plans**

2.2.1 The paper provided an update on the Green Plans of the four Trusts within the North West London APC (Acute Provider Collaborative), with a specific focus on waste segregation. There had been an overall reduction in waste across the APC; 3% reduction in waste and 20% reduction of waste emissions since 2020/21.

2.2.2 To reflect new NHSE guidance, Trust green plans would be refreshed for the next three year cycle. It is hoped to bring the refreshed plans to the next committee on 18 June, ahead of sign off by the Board in Common on 15 July 2025; however, the Committee has noted the tight timescales.

2.2.3 The Committee discussed energy costs across the APC. Between 2019/20 and 2023/24, the combined APC gas consumption fell 4% whilst electricity increased by 5%. In terms of the associated combined APC cost, this increased 129% for gas and 61% for electricity. Each Trust saw a significant increase in energy costs; however, the scale depended on which framework for the individual Trust was on.

2.2.4 The Committee noted the good progress on green plans. Members suggested it would be useful to undertake variance analysis to demonstrate the economics of green activities to justify investment or identify areas where the narrative could be

strengthened to reflect opportunities to provide costs savings / invest to save areas.

2.3 The Hillingdon Hospitals NHS Foundation Trust Redevelopment programme

2.3.1 The Committee received a confidential verbal update on the redevelopment plans for The Hillingdon Hospitals NHS Foundation Trust.

2.4 High-level contingency planning for Imperial College Healthcare NHS Trust

2.4.1 Following the announcement on the NHP from the Secretary of State for Health and Social Care earlier this year, the St Mary's (SMH) and Charing Cross (CXH) and Hammersmith (HH) hospitals redevelopment programmes have been placed in the third wave, delaying the start of rebuilds from 2030 to 2035-2039. This therefore increased operational and service risk. Members were informed considerable investment would be required to maintain the sites in the intervening period.

2.4.2 The Committee received a paper which built on some work previously undertaken, considering the risks of catastrophic failure of the critical infrastructure of parts or the whole of either hospital site. The paper had been updated to reflect the significant increased risk and quantified the level of impact of such failure and the consequences for the health system across the capital.

2.4.3 Members noted that management of risks relating to estates and contingency planning would continue to be managed through local redevelopment committees, reporting into Trust Standing Committees. However wider application of contingency planning, narrative and tactics around APC engagement with regional and national partners on contingency planning should be reported and considered by the Board in Common. The Committee recommended it would be helpful to include major estate related incidents in the CEO report to the Board in Common to ensure the Board were sighted.

2.5 Benchmarking the APC Estate and Workplan

2.5.1 The APC workplan had been prioritised and reduced to 12 workstreams, which had the greatest potential to be cash releasing or cost pressure avoiding. A lead Estates and Facilities Director had been assigned to each workstream, with each Director responsible for 3-4 projects. Each workstream would be defined into a Project Initiation Document (PID) to be completed by the end of March 2025.

2.6 APC Draft Capital Plan and Prioritisation 2025/26

2.6.1 The paper provided an update on the NWL APC draft capital plans and the NWL ICS Capital Prioritisation Criteria and Capital Strategy. Draft plans had been discussed at the February Board in Common development session. Trusts were working through the allocation process, focussing on priority areas for critical infrastructure. The final capital plan submission required approval by Trust Boards as part of the 2025/26 planning submissions at the end of March.

2.6.2 The issue of the estates safety funding allocation was raised and the Committee highlighted estates risk was not equal across the APC.

2.6.3 A discussion took place around the split between digital and non-digital capital. It was suggested this should be discussed by CEOs in the first instance and a proposal brought to the Board in Common Cabinet.

2.7 Register of forward business cases and capital plan

2.7.1 Following discussions at the last Committee, the register had been revised to include themes of the business cases, productivity implications of not funding cases and to

remove business cases which had ceased or had been approved. The APC Estates and Sustainability Executive Group monitored the register of forward business cases and capital plan. Several additions were suggested for future iterations.

2.7.2 The Committee discussed the need to re-affirm and validate Trust-level business cases to ensure these were genuinely local, and not collaborative, level and to be clear what business cases each Trust have. This would demonstrate collaborative working and ensure Trusts were not competing for the same capital funds.

2.8 Summary report from the Estates and Sustainability Executive Group

2.8.1 The paper provided a summary of the Estates and Sustainability Executive Group discussions since December 2024.

3 Positive assurances received

3.1 The Committee noted the positive work on the green / sustainability plans and welcomed the future refreshed green plans aligned to the new NHSE guidance.

4 Key risks to escalate

4.1 The condition of the estate across the Collaborative and cost of backlog maintenance remains a significant risk. Contingency plans for estates needed to be refreshed and considered by individual trust Redevelopment Committees, with each Trust Standing Committee receiving assurance regarding the robustness of contingency planning.

5 Key actions commissioned

5.1 The Committee asked for a register of land be compiled, including land owned across the APC but not occupied by buildings and what the current use is.

6 Decisions made

6.1 N/A

7 Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Update on green plan and sustainability plans	To note	5.	APC Draft Capital Plan and Prioritisation 2025/26	To note
2.	THHFT strategy for redevelopment engagement	Verbal update	6.	Register of forward business cases and capital plan	To note
3.	High-level Contingency Planning for ICHT	To note	7.	Summary report from the Estates and Sustainability Executive Group	To note
4.	Benchmarking the APC Estate and Collaboration Workplan	To note	8.		

8. Attendance Matrix

Members:	September Meeting
Bob Alexander, Vice Chair (ICHT) (Chair)	Y
Aman Dalvi, NED (CWFT/ICHT)	Y
Vineeta Manchanda, NED (THHFT/CWFT)	Y
David Moss, NED (LNWH/ICHT)	Y
Matthew Swindells, Chair in Common	Y
Tim Orchard, Chief Executive (ICHT)	Y
Bob Klaber, Director of Strategy, Research and Innovation (ICHT)	Apologies

Virginia Massaro, CFO (CWFT)	Y
Gary Munn, Interim Director of Estates (LNWH)	Y
Janice Sigsworth, Chief Nurse (ICHT)	Y
Steve Wedgwood, Director of Estates (THHFT)	Apologies
Tina Benson, Chief Operating Officer (THHFT)	Y
Jason Seez, Deputy CEO (THHFT)	Y
In attendance:	
Huda As'ad, Associate NED (LNWH)	Apologies
Rachel Benton, Redevelopment Programme Director (THHFT)	Apologies
Philippa Healy, Business Manager (minutes)	Y
Peter Jenkinson, Director of Corporate Governance (ICHT and CWFT)	Y
Eric Munro, Director of Estates and Facilities (ICHT)	Y
Deirdra Orteu, Redevelopment Clinical Design Director (ICHT)	Y
Mark Titcomb, Managing Director of NWL EOC, CMH and Ealing Hospital, Executive Director for Estates and Facilities (LNWH)	Y
Alexia Pipe, Chief of Staff – Chair's office	Y
Matt Tulley, Redevelopment Director (ICHT)	Apologies
Iona Twaddell, Senior Advisor to the CEO	Y

7. CHIEF EXECUTIVE OFFICERS

7.1 ACUTE PROVIDER COLLABORATIVE EXECUTIVE MANAGEMENT BOARD (EMB) SUMMARY (TIM ORCHARD)

REFERENCES

Only PDFs are attached

7.1a. APC EMB Chair's Report - Apr 2025 v05.pdf

North West London Acute Provider Collaborative (NWL APC) Executive Management Board (EMB) Highlight Report to the NWL APC Board in Common (BiC) – for discussion

April 2025

Highlight Report

1. Purpose and Introduction

The role of the NWL APC Executive Management Board (EMB) is:

- To oversee the delivery of the Collaborative strategy and business plan, including the financial and operational plan.
- To be the executive decision-making body for the Collaborative, commissioning and approving Collaborative programmes and associated resources, ensuring that the various programmes are aligned in their objectives and delivering against agreed milestones.
- To draw to the NWL APC Board in Common's (BiC's) attention matters they need to agree or note.

2. Key highlights

The APC EMB met on 6 February 2025, 3 March 2025 and 9 April 2025. Key discussion items are summarised below.

2.1. Performance reporting

2.1.1. At each meeting, the APC EMB reviewed quality, workforce, operational and financial performance across the Trusts, receiving assurance on outliers and activity ongoing to address variation.

2.2. Finance reporting and recovery

2.2.1. The APC EMB discussed the financial performance and forecast in detail. Cash was discussed as a key area of focus. The APC EMB received an update on the I&I process which had commenced on 20 December 2024. The initial findings on system governance were reviewed as well as the initial observations relating to system drivers of cost, financial forecasting and grip and control.

2.3. Business planning

2.3.1. The APC EMB discussed the draft priorities for the APC business plan, with productivity, corporate consolidation and savings and APC clinical pathways identified as the three main priorities for 2025/26. Against these priorities,

each workstream has identified specific projects that will be focused on in 2025/26, with associated plans, benefits and milestones. The business plan will be taken through collaborative committees and shared for approval at the next Board in Common. Progress against the business plan will be overseen by APC EMB.

2.3.2. APC EMB also received updates on our capital prioritisation programme including the first draft of a register of business cases and an APC wide capital plan.

2.4. APC clinical pathways

2.4.1. The APC EMB received regular updates on the APC clinical pathways programme. This operationalises a key strand of the APC strategy by aligning 28 pathways across the APC to best practice, each led by one of the CEOs. APC EMB noted the good progress and positive clinical engagement with the pathways and the move to implementation phase.

2.4.2. APC EMB also received updates on the progress of the pathways and implementation templates for 27 of the 28 pathways, including metrics to measure progress and implementation plans. APC EMB received updates on the lessons learned from phase one of the pathways, including the need for a consistent BI approach across the APC.

2.4.3. At the April APC EMB meeting, APC EMB noted the positive progress so far, with the majority of pathways soon to be implemented, and positive relationships built across the APC for this work. APC EMB agreed that over the next few months, pathways teams will work to ensure the first phase of pathways are fully implemented. Subsequent pathways will then be chosen for the next phase of the project.

2.5. Governance

2.5.1. The APC EMB received an update on the collaborative Board Assurance Framework (BAF), noting this is not an aggregation of individual trust BAFs, but highlights risks to delivering the APC strategy. The BAF will be reviewed by relevant Collaborative Committees in May before presentation to the Board in Common in July.

2.6. Collaborative projects

2.6.1. The APC EMB receives monthly updates on progress in developing and implementing the Collaborative business plan and strategic priorities. These include the projects within the quality, workforce, finance and performance and digital transformation workstreams.

2.6.2. The APC EMB received updates on sector priorities, including Urgent and

Emergency Care (UEC), diagnostics and planned care and outpatients

2.6.3. The APC EMB noted the collaborative business case pipeline, which sets out upcoming business cases across the collaborative.

2.6.4. The APC EMB were also provided with assurance and decisions on key collaborative projects. This included:

- **Collaborative courier contract**: APC EMB approved a recommended procurement strategy to initiate a collaborative tender for general courier services. It was noted that the output of the procurement would be a rate card and therefore would allow a reduction in use which would further reduce cost.

- **Data strategy**: APC EMB noted the proposed approach for a data warehouse across the collaborative. EMB members were supportive of the approach but agreed that there needed to be clearer detail around the external funding available.

- **Cerner EPR training**: APC EMB approved a proposal to trial a new model of training as proof of concept for a widespread change in approach to the delivery of training for clinical systems. APC EMB will receive further updates after the proof of concept is completed.

- **Principles for joint learning responses**: APC EMB supported guiding principles that had been agreed for a collaborative learning response when more than one Trust within the APC is involved in a patient safety event. Once tested, there would be potential to roll this out with other organisations frequently involved in patient safety incidents such as CNWL and LAS.

- **Elective orthopaedic centre (EOC)**: The APC EMB received updates on and discussed the EOC optimisation plan, seeking assurance on the trajectory of increasing activity and productivity. APC EMB noted the increased performance and that the EOC continued above the optimisation trajectory.

- **Corporate transformation:** APC EMB discussed the corporate transformation programme noting programme updates on finance, digital and people services improvement programme.

- **Nursing and midwifery levels benchmarking** – the APC EMB received

an update on a self-assessment on best practice for nursing and midwifery. All Trusts had self-assessed as being compliant with standards and it was agreed that a senior nurse group would review current processes to identify opportunities to standardise.

- **Virtual wards** – the APC EMB received an update on the NWL virtual wards programme and the models in place across the APC.

3. Attendance of members

The APC EMB is attended by all 4 CEOs and a representative of each 'functional group' of executive roles.

The current membership as of April 2025 is:

- **CEOs** – Tim Orchard, ICHT (Chair), Lesley Watts, CWFT & THHFT, Pippa Nightingale, LNWH
- **Chief Financial Officer** representative – Jazz Thind, ICHT
- **Chief Operating Officer** representative – James Walters, LNWH
- **Medical Director** representative – Raymond Anakwe, ICHT
- **Chief Nurse** representative – Lisa Knight, LNWH
- **Chief People Officer** representative – Kevin Croft, CWFT, THHT, ICHT
- **Strategy lead** representative – Bob Klaber, ICHT
- **Chief Information Officer** representative – Robbie Cline, Collaborative
- **Collaborative Director of Corporate Governance** – Peter Jenkinson, Collaborative
- **Communications** representative – Emer Delaney, CWFT

7.2 REPORTS FROM THE CHIEF EXECUTIVES OFFICERS AND TRUST STANDING COMMITTEES

7.2A LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST (PIPPA NIGHTINGALE / DAVID MOSS)

REFERENCES

Only PDFs are attached

- 7.2a0. LNW Board in Common CEO Reort 290425 Final.pdf
- 7.2a1. 2025.04.09 - LNWH TSC Report to BiC FINAL.pdf

Chief Executive Officer's Report - London North West University Healthcare NHS Trust

Accountable director: Pippa Nightingale
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

1.1 On the 13 March I attended a meeting with the Chief Executives of all NHS trusts with the incoming transitional Chief Executive of NHS England, Sir Jim Mackey.

At this meeting we were informed that NHS trusts are required to reduce spend on corporate services' budgets so that they return to pre-pandemic levels. In addition, we were advised that both individual NHS organisations and Integrated Care Board (ICB) systems will be expected to produce and deliver breakeven financial plans for the coming year as part of this financial planning round.

Following several related media announcements made by the Government and NHS England, I wrote to all staff on the 17 March about the changes to the way the NHS will be run and what it will mean for LNWH.

A briefing session for managers and team leaders was arranged at pace and held on Monday 17 March. This was followed by an all-staff listening event on Tuesday 18 March, which was attended by more than 600 staff.

Throughout these communications we have emphasised that these changes will not affect the way our patients access or use the NHS, which will continue to provide services free at the point of use. This key message is being shared with stakeholders through our regular channels.

At the time of writing we are waiting for formal communication from NHSE and this is expected in early April.

However, given the financial challenges, my executive team and I have advised staff that we must now make several difficult decisions very rapidly, while still following a process to assess their impact and minimise the effect on both patients and staff. We are asking staff to help us do this in various ways over the coming weeks.

I am committed to supporting staff through this process, which is being required of all NHS organisations across the country. I greatly value and appreciate the resilience and

leadership being shown in the face of these challenges, and the unwavering commitment to providing ongoing high quality, timely and equitable care for our patients.

1.2 To achieve our business plan aims in 2025/26 we have now identified four priorities. These are:

- Reduce how often we use temporary escalation spaces so patients get high-quality, safe care in the right place.
- Increase access to treatment so more patients start treatment within 18 weeks
- Create a better working environment so more staff members recommend working at LNWH
- Live within our means by reducing waste and providing high-quality care efficiently and sustainably.

These priorities are linked to Our Way Forward objectives of providing high-quality care and being a high-quality employer.

1.3 The Trust moved to Level 4 of the Operational Pressures Escalation Levels (OPEL) framework for several days in January, February and again in March. This is the highest escalation level in the framework and was in response to a massive rise in demand for emergency care.

As in previous occasions where the Trust has moved to OPEL Level 4 we worked closely with key partners to put additional measures in place so that all patients could leave hospital as soon as it was safe to do so.

Staff worked hard to ensure that all patients who needed care received it as swiftly as possible in the most appropriate place. In some cases, this meant transferring patients to other hospitals which had more capacity. I am grateful to colleagues across the Acute Provider Collaborative (APC) for their support in this regard.

These escalations are challenging and stressful for staff, and I remain grateful for their professionalism, focus and dedication whilst working under great pressure.

1.4 In March we shared our staff survey results for 2024. Some 58% of staff (more than 5,200 people) responded to the survey, placing us amongst the most engaged trusts in the country.

We now score among the best acute trusts in the country at caring for staff health and safety, preventing burnout at work, and offering the highest quality appraisals and access to learning opportunities. More staff now recommend LNWH as a place to work and to receive care than at any time in the last four years.

We have also seen dramatic improvements in our freedom to speak up culture. For the first time in five years, we scored better than average for feeling confident that LNWH would address a concern when raised.

There remain areas where we still need to do more. These include violence and aggression from patients and the public, reducing experiences of bullying and harassment (though we have seen a small improvement here) and experiences of discrimination at work.

It takes time to make meaningful change on these issues. However, the positive trajectory shown in these survey results instils confidence that we will do more this year to have a positive impact on staff experience.

1.5 We are moving to increase the pay band of Health Care Support Workers (HCSWs) from Band 2 to Band 3. This is in awareness of the increased activity and responsibilities taken on by HCSWs in recent years, and echoes similar action taken by some other NHS organisations.

1.6 For two weeks in early January, our Perfect Weeks initiative focused on safely discharging patients sooner. This not only helps the individual patient but all other patients too.

We worked closely with colleagues in social care and neighbouring trusts to help reduce external delays, and managers and clinical teams made extra effort to support the flow of patients through our services and into our community. A command centre set up as part of our OPEL 4 Trigger and Actions provided additional support, advice and monitoring to address issues in a timely manner.

All inpatient wards were linked with a senior director who visited regularly to hear ideas staff were testing to improve discharges before 5pm. A discharge hotline was in place for when a senior colleague's advice could support discharge sooner, and a WhatsApp group was set up to share advice and ideas.

New ideas, workable solutions and reoccurring problems are being collated to support planning of on-going improvements throughout 2025.

2. Quality and safety

2.1 Our Summary Hospital-level Mortality Indicator (SHMI) data is among the best in the country. The latest SHMI data continues the low mortality trend, significantly below the national expected rate.

It places us in London's top 6 trusts and in 10th place overall compared to all of England.

The data suggests patients receive safe and high quality care at LNWH, with SHMI a

significant safety metric which measures the chance of survival after receiving hospital care.

3. Operational performance

3.1 Emergency department performance: 4 hour performance reported 73.9% for February 2025 against 78.0% operating plan standard. This is the 10th highest performance in London for the 17 acute trusts reporting against this standard

92.0% of patients were treated within 12 hours against the 98% standard

Ambulance cohorting continues, aligned to the London wide ambulance 45 minute handover process.

Bed occupancy remains high at Northwick Park and Ealing sites due to overall demand for beds from ambulance arrivals and walk-in attendances.

The Trust continues to receive high volumes of mental health presentations which the Trust is not registered to care for.

Covid position: February 2025 Covid-19 cases reported 1 inpatient with a LoS <7 days on the last day of the month. In comparison, the previous month end position also reported 3 inpatients with a LoS<7 days.

Key priorities include:

- Following our launch of the new internal OPEL actions in January as part of the Perfect Weeks programme, these measures continue to be embedded across all three sites, with ongoing reviews to ensure effectiveness in managing surges in demand.
- The final phase of our winter temporary bed plan remains in place across our Northwick Park and Ealing sites, with these beds scheduled to close by the end of February 2025, aligned with demand profiles.
- The UEC Action Plan continues to focus on improvements at the front door, emergency department, and inpatient flow, working closely with system partners.
- The London-wide 45-minute ambulance handover process remains in effect alongside the REACH pilot and SPA. Discussions are ongoing regarding the impact of the ambulance service winter plan on acute providers, with new standard operating procedures in development. In January, the Trust completed a reset of capacity within the Emergency Department Temporary Escalation Spaces.
- Collaborative planning across the sector continues to enhance digital tools that support bed flow coordination across health and social care partners.

3.2 Referral to treatment: As per the national focus the Trust continues to reduce the number of patients waiting over 78 weeks as well as 65 weeks. This has resulted in the 78ww cohort reporting 0 patients breaching at the end of February.

The 65-week cohort reported 63 for February against a trajectory of 69 and the Trust is on track with delivering its March trajectory of under 25 breaches.

The focus on reducing patients over 52 weeks continues.

The Trust RTT performance has also improved to 50.8% this month, continuing with an upwards trend.

The Trust is progressing a sustainable solution looking at training as well as digital solutions such as the Rova model.

3.3 Cancer pathways: The Trust continues to maintain focus on the number of patients waiting over 62 days for diagnosis and treatment in line with the operating plan and remains compliant with the trajectory.

The Trust did not meet the FDS standard this month due to capacity and patient choice challenges over the Christmas season. However, the Trust is on track to achieve the standard in February.

As the Trust has started to stabilise its backlog, there has been significant improvement in the 62 day performance with the Trust continuing to be above the London target of 70%.

3.4 Diagnostics 6 week wait: Final position for February 2025 reported 70.3% with 6,138 patients waiting over 6 weeks.

The DM01 remains challenged however the focused recovery planning in all areas with weekly monitoring meetings led by Head of Operations for COO's office has resulted in a 5% improvement in the DM01 from the previous month.

Insourcing for ECHOs has been approved and there is a trajectory in place to monitor its impact.

4. Finance and estates

4.1 Finance: As reported at the last Standing Committee meeting, the Trust – alongside other trusts in the system and the North West London Integrated Care Board (ICB) – had set out a challenging breakeven plan for the 2024/25 financial year.

We acknowledged that achieving this target will be particularly difficult due to pressures from emergency demand, which must be managed within a financial framework that caps

funding for emergency care at fixed amounts. Nonetheless, as a system we remain committed to delivering against this plan.

We have reported a deficit of £30.7m at M11 which is £32.0m off plan. This is broadly in line with our financial recovery plan.

The elective recovery fund has been capped, and both the Trust and the wider system are operating within this limit. Our agreed financial recovery target with the ICB is a deficit of £23m.

Current savings and recovery initiatives remain on track to support this position, accounting for increased emergency activity, unexpected pressures from system optimisation plans that have not delivered anticipated outcomes, underperformance in elective orthopaedic centre activity, pathology-related challenges, and unfunded inflation across several areas.

The capital programme is progressing as planned and remains within the allocated target, with ongoing oversight from the Capital Review Group to ensure financial discipline. While we aim to maintain expenditure within approved limits, the Trust is facing cash flow pressures due to the revenue deficit. These pressures have recently eased following the receipt of a significant portion of the elective recovery fund overperformance and the approval of Public Dividend Capital (PDC) support. An additional application for PDC support has been submitted for March.

Our financial forecast remains optimistic, reflecting confidence in cost containment over the winter period. We had expected a land sale before year-end to close the gap to forecast but have agreed a mitigation with the ICB ensuring that the land sale takes place in 2025/26. This change keeps our forecast at £23m deficit.

We remain in close collaboration with the NWL ICB to ensure that overall financial forecasts for the health system align with the resources available.

4.2 Estates and facilities: As we approach 2025/26, the commencement of a new financial year provides an opportunity to redirect focus on backlog maintenance and supporting better patient flow and experience.

The Trust has now significantly fewer major build or refurbishment programmes than during the past two years. This will allow the team to rebalance resources towards the more routine, but critically important, backlog, lifecycle and minor works adjustments. For example, lift repairs, roof maintenance, and improving the upkeep of clinical spaces that are most heavily used.

During the past few months, the team have been busy completing improvements to several clinical areas. These include: Ealing Hospital Emergency Department resus and theatre recovery facilities, refurbishment of Fielding and Edgar wards at Northwick Park

Hospital, and several smaller clinical changes within the dermatology and gynaecology outpatient areas at Ealing hospital. These works are now complete and provide a better patient and staff working environment.

The team is also ready to support operational teams in their challenge to reduce the Trust's cost base via a reduced and more efficient use of premises and spaces.

The major procurement of the Trust's soft facilities management contract is continuing at pace. This contract provides cleaning, portering, catering and other support facilities for patients and staff across all three main hospital sites and some off-site facilities.

The tender process will run through until the autumn of 2025 and is following standard procurement and Cabinet Office cost control process. It is currently at the invitation to tender phase. Numerous staff and patients participate in the process via focus groups and provision of specialist service knowledge. This will continue during the bid evaluation phase when the tenders will be reviewed and clarifications sought. The procurement process is due to conclude with a contract award in September 2025 ahead of a short mobilisation period.

Work continues to update the Trust's sustainability policies and deliver a refreshed Green Plan by July 2025. This is required by NHSE. The work links closely to future clinical planning for climate change and the wider NHS plan to achieve net-zero by 2040. Furthermore, some of this work is being undertaken in collaboration with Acute Provider Collaborative colleagues to reduce potential duplication, share best practise, and deliver the patient and staff benefits in a collaborative and efficient manner.

5. People

5.1 Our divisional director of operations (DDO) for surgery, Kevin Finlinson, recently left the Trust. I am grateful to Kevin for his work and dedication over the last few years as we have increased our surgical activity following the pandemic.

I am delighted to announce that former divisional director of operations for urgent and emergency care, Norrita Labastide, has taken up the DDO role for surgery. This is cover for six months, allowing us to continue our vital work on planned care without needing to bring in interim cover.

Our former director of site operations, John Ross, has in turn temporarily taken up the DDO role for urgent and emergency care, after a competitive interview process.

5.2 Beryl Carr, the NHS's oldest volunteer, celebrated her 103rd birthday in January. Beryl continues to visit Ealing Hospital regularly to volunteer at the League of Friends café.

6. Equity, diversity and inclusion

6.1 The Trust has secured funding to deliver training to more than 100 Speciality and Specialist doctors. These doctors are specialists in their field often with decades of

experience. However, they have not followed the traditional career path to consultancy, often due to personal or professional reasons.

Whilst many will be happy in their current roles, those looking at career progression can now do so. Tailored support will help doctors grow and share their expertise without compromising their personal or professional choices. This will also help enriching our workforce with more diverse skills and perspectives.

6.2 During the sacred month of Ramadan, lead Chaplain Imam Rizwan Rawat, held a series of presentations on Ramadan and the impact of fasting on health care workers, with practical tips and strategies for managing fasting during the month.

Staff were also invited to join special events across our three sites to mark Iftar - the fast-breaking meal eaten after sunset during Ramadan. The Iftar was open to all staff to foster a sense of community cohesion across our hospitals.

7. LNWH updates

7.1 BBC News visited Northwick Park Hospital in February to cover a successful surgical procedure to replace fused bones in the ear with an implant, reversing damage caused by otosclerosis, a common type of hearing loss.

The patient developed the condition while pregnant and was then unable to hear her baby son properly. The condition affects about three in 1,000 people, but it is not yet understood why the condition can be triggered in pregnancy. Following the surgery the patient was able to hear her son properly for the first time.

The BBC covered the story online and in both their lunchtime and evening programmes.

7.2 More than 200 colleagues joined our Covid day of reflection events on Tuesday 11 March. Across the Trust we took a moment of silence to honour those whom we lost in the pandemic.

We heard deeply moving memories and testimonies from several of our colleagues from across the organisation speaking about their personal memories of the pandemic, and what it meant to them.

LNWH Charity also reflected on the extraordinary support that our communities offered us through donations, whether of money, equipment, food or time.

8. Research and innovation

8.1 LNWH clinicians and pharmacists have published a medical paper describing a safe method for testing for penicillin allergy in inpatients who believe that they are allergic.

The study showed that around 90% of people who believed they had an allergy to

penicillin, did not have an allergy to it.

The medical paper is an early contribution to the growing body of evidence that penicillin allergy labels can safely be removed, and a simple oral challenge used in most low-risk inpatients.

8.2 The Commercial Research Delivery Centre (CRDC) has granted LNWH £7m in funding to enable delivery of more clinical trials across outer north west London, as well as to function as a two-way conduit accommodating commercial industry trials and funding local research. The grant will help double our capacity to accommodate trials with a goal of 40 trials a year by 2029. LWNH is one of only three London trusts designated as CRDCs, which brings a lot of new opportunities.

8.3 We are now using artificial intelligence (AI) to support analysis of chest X-rays in early diagnosis of lung cancer. Combining AI analysis with the expertise of a radiologist or reporting radiographer is helping improve diagnostic accuracy of chest X-rays and support clinical decisions. Patients will also benefit from quicker reporting times.

8.4 In ophthalmology, our research and innovation team are the first outside the US to recruit to the ReNeW study. This phase 3 clinical trial is evaluating elampretide, a new therapy to treat age-related macular degeneration. The condition is the world's most common cause of sight loss.

8.5 In cardiology, we have recruited the UK's first and second patients to CYCLE 2. This phase 2 clinical trial is looking at diastolic heart failure – an under-researched area that disproportionately affects people from multi-ethnic backgrounds.

8.6 In haematology, we are the first site in the UK to open recruitment for the phase 2 study CLL-211, which is evaluating a new treatment for refractory chronic lymphocytic leukaemia. The study is taking place at our clinical research facility at Northwick Park Hospital.

9. **Stakeholder engagement**

9.1 In February, Deirdre Costigan MP for Ealing Southall visited our fracture clinic, same day emergency care centre, and care of the elderly wards, to learn about the work and challenges of the department for medicine for older people and our older persons' rapid access clinic.

Speaking with Dr Kate Senger, consultant geriatrician and physician, and Dr Maxine Hogarth, consultant rheumatologist, Ms Costigan learnt how more collaborative care and the fracture liaison service is benefiting older patients with osteoporosis in Ealing.

9.2 Danny Beales MP for Uxbridge and South Ruislip, visited The Wakley Centre in Hayes to meet the LNWH Integrated Sexual and Reproductive Health team.

Clinical lead and consultant Dr Luciana Rubinstein, service manager Kamy Dosajh, and colleagues spoke about their work in sexual health, HIV, contraception provision, health promotion, and prevention and management of STIs.

9.3 Divisional Medical Director Dr Scott Rice and Clinical Director Obstetrics and Gynaecology Asra Saleem, attended the Harrow Health and Social Care Scrutiny subcommittee on the 4 March to present an update on services to support women during menopause. Deputy Chief Executive Simon Crawford was also in attendance.

10. Recognition and celebrating success.

10.1 Ralph Schafer has been named Student Nursing Associate Mentor of the Year for the third successive year by Brunel University. Ralph is a Practice Development Lead at Ealing Hospital, and was nominated by students for his enthusiasm, support and open-door approach to helping his young colleagues.

10.2 The ninth annual Sister Gwen Richardson Midwifery Awards took place at Northwick Park Hospital in January. LNHW's Mercy Sigauke was the overall winner. Mercy's commitment to being a well-rounded midwife includes a 16-month secondment as a bereavement specialist midwife, which she says provided a broader perspective on maternity and bereavement care. Therese Witham, our Head of Midwifery, was runner-up.

10.3 Ioan Morgan, clinical therapy lead for stroke and neurology, has won a prize for the highest scoring abstract submitted by an allied health professional, at the UK Stroke Forum – the UK's largest multidisciplinary conference for stroke care professionals Ioan's work has helped the Trust set up the Harrow stroke early supported discharge pilot and the Bridging the Blues collaborative project with Chelsea FC Foundation to deliver a healthy lifestyle after minor stroke programme.

Northwick Park Hospital's stroke unit also had 17 scientific abstracts accepted for display at the forum.

10.4 Margaret Vance, Nurse Consultant in Gastroenterology at St Mark's Hospital, has won this year's British Society of Gastroenterology award for Outstanding Contribution to Gastrointestinal and Hepatology Nursing. The award is given for exceptional performance in patient care, leadership, innovation, research, education and training or quality improvement projects.

10.5 Consultant Gastroenterologist Dr Kevin Monahan has come first place out of four winners at this year's British Society of Gastroenterology Service (BSG) Development Prize. Kevin's submission will be published on the BSG website, with the aim of highlighting

successful service innovations that will be a resource for learning and good practice.

10.6 Nurse Consultant Mia Small, and Clinical Nurse Specialist Jo Gent, have won the British Journal of Nursing silver award for Nutrition Nurse of the Year. They received the award for their work in developing a ‘nursing decision tree’ that is helping manage patients at home with parenteral nutrition needs. Mia Small was also recognised with an individual bronze award in the same category.

10.7 Cyber Security Manager Nasser Arif has won two national awards for his work in cyber security. The first award was for Diversity in Cyber Security, awarded by the NHS England Cyber Associates. Judges recognised Nasser’s work on promoting neuro diversity in cyber security and the value of employing people across the spectrum.

Network. Nasser also received the Pete Rose Outstanding Achievement Award for his contribution to cyber security.

London North West University Healthcare NHS Trust (LNWH) Trust Standing Committee Highlight Report to the North West London Acute Provider Collaborative Board in Common (BiC) – for discussion

April 2025

Highlight Report

1. Purpose and Introduction

1.1 The role of the LNWH Trust Standing Committee is:

1.1.1 To oversee the delivery of the Trust's strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

2. Key highlights from the Trust Standing Committee

2.1 **Committee Escalation Reports**

2.2.1 Escalation reports from the local LNWH Committees were presented by the Non-Executive Director Chairs, including the Quality and Safety Committee; the Finance and Performance Committee; the Appointments and Remuneration Committee; the People, Equity and Inclusion Committee; the Charitable Funds Committee; and the Audit and Risk Committee. These reports provided assurance on the respective Committee's delegated duties and responsibilities, performance against key metrics and the management of risk in their respective areas.

2.2.2 As part of the escalation reports, the Committee received and discussed the Financial Report and the Integrated Quality and Performance Report for M11, noting that the Trust was on track to achieve its forecast position for year-end.

The Committee also:

- Noted the Maternity Clinical Negligence Scheme for Trusts (CNST) Self-Assessment; and
- Scrutinised and approved a proposal for the reclassification of the Trust's Charitable Funds.

2.2 **Elective Orthopaedic Centre – One Year Report**

2.2.1 The Committee received and discussed a report on the North West London Elective Orthopaedic Centre (EOC) following its first year of operations, including performance against key metrics, challenges and next steps for future service development. Staff from the EOC attended the meeting to present a staff story to provide the Committee with an understanding of their experience of the past year.

2.3 **Board Assurance Framework**

2.3.1 The Committee received and approved the closing Board Assurance Framework for Q4 2024/25 and received positive assurance that strategic risk was being managed robustly in the organisation with the majority of strategic risks having been reduced in the year. The Board Assurance Framework is published and available on the London North West University Healthcare NHS Trust website fulfilling public transparency requirements.

2.4 **Operational Plan 2025/26**

2.4.1 The LNWH Operation Plan for 2025/26 and associated Board Assurance Statements were approved by the Committee at an extraordinary meeting held on Wednesday, 26 March 2025 for submission to the national office.

2.4.2 A 'Big Planning Meeting' has been scheduled for Wednesday, 16 April 2025 to discuss and agree the approach for the implementation of the plan and how its four priorities will be delivered.

3. Positive assurances received

3.1 Strategic and operational risk management processes are much improved and are working effectively.

3.2 The Trust was on track to achieve its forecast outturn for 2024/25.

3.3 There had been good performance in Accident & Emergency (A&E), cancer, and diagnostic services, with improvements in Referral to Treatment (RTT) 18-week performance.

3.4 The staff survey results showed the most improved staff survey results in London, particularly in respect of the metrics for recommending the Trust as a place to work and receive care.

3.5 The Trust is building a significant research portfolio, with efforts focused on targeting deprived and diverse populations for research studies.

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

4.1 Cash flow remains a critical issue for the Trust which will require effective management of creditors.

4.2 In respect of the Elective Orthopaedic Centre, there is a need for continued collaboration with partner trusts to ensure that patient lists are pooled and theatre schedules are optimised in order to maintain the required activity levels.

4.3 The Trust is facing challenges in meeting infection control targets and efforts are ongoing to manage and mitigate these risks.

5. Concerns outstanding

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

6. Key actions commissioned

6.1 A Board development session on risk appetite will be scheduled in Q1 2025/26.

7. Decisions made

7.1 The Committee:

- Approved a proposal for the reclassification of the Trust's Charitable Funds; and
- Approved its Annual Cycle of Business for 2025/26.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Elective Orthopaedic Centre – One Year Report	Assurance	9.	Board Assurance Framework	Assurance
2.	Board committee report – Quality & Safety • CNST Self-Assessment	Assurance	10.	Operational Plan Implementation	Information
3.	Board committee report – Finance & Performance • M11 Finance Report • M11 Integrated Quality and Performance Report	Assurance	11.	Trust Standing Committee Annual Cycle of Business	Decision
4.	Board committee report – People, Equity and Inclusion • Q3 Workforce Performance Report	Assurance	12.		
5.	Board committee report – Appointments and Remuneration	Assurance	13.		
6.	Board committee report – Charitable Funds	Assurance / Approval	14.		
7.	Board committee report – Audit & Risk Committee	Assurance	15.		
8.	Chief Executives Report	Discussion			

9. Attendance

Members	April 2025 attendance
Matthew Swindells, Chair, Board in Common	**Y**
David Moss, Vice Chair (Chair)	**Y**
Bob Alexander, Non-Executive Director	**Y**
Huda Asad, Associate Non-Executive Director	**N**
Loy Lobo, Non-Executive Director	**Y**
Martin Lupton, Non-Executive Director	**Y**
Ajay Mehta, Non-Executive Director	**Y**
Simon Morris, Non-Executive Director	**Y**
Sim Scavazza, Non-Executive Director	**Y**
Syed Mohinuddin, Non-Executive Director	**Y**
Baljit Ubhey, Non-Executive Director	**Y**
Pippa Nightingale, Chief Executive Officer	**Y**
Simon Crawford, Deputy Chief Executive	**Y**
Bimal Patel, Chief Financial Officer	**Y**
Jon Baker, Chief Medical Officer	**Y**
Lisa Knight, Chief Nursing Officer	**Y**
James Walters, Chief Operating Officer	**Y**

Tracey Connage, Chief People Officer	**Y**
Dawn Clift, Director of Corporate Affairs	**Y**
Tracey Beck, Director of Communications	**Y**
Mark Titcomb, Managing Director of EOC, CMH and Ealing	**Y**
James Biggin-Lamming, Director of Strategy and Transformation	**Y**
Attendees	
Sharon Balmer, Corporate Governance Manager	**Y**
David Jenkins, Joint Director of Charities	**Y**
Pavitra Naidoo, Lead Therapist, Elective Orthopaedic Centre	**Y**
Alexia Pipe, Chief of Staff to Chair in Common	**Y**
Sebastian Timmermans, Highly Specialist Physiotherapist, Elective Orthopaedic Centre	**Y**
Himali Vyas, Service Manager, Elective Orthopaedic Centre	**Y**

7.2B IMPERIAL COLLEGE HEALTHCARE NHS TRUST (TIM ORCHARD / BOB ALEXANDER)

REFERENCES

Only PDFs are attached

- 7.2b0. ICHT CEO Public Report - April 2025 v03.pdf
- 7.2b1. ICHT Trust Standing Committee Chair's report to BiC April 2025 final.pdf

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

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

1 Key messages

1.1 Operationally, we continue to have some of the fastest ambulance handover times in London with 95.0 per cent performance against the 30-minute handover standard. We were above the England average for four-hour performance with 74.8 per cent of patients admitted, transferred or discharged from the emergency department within four hours in February, but below our improvement target and the national standard. We are making progress on long waiters, but concentrating on reducing the longest wait backlog, at the end of February 258 patients were waiting over 65 weeks for treatment (48 due to patient choice).

1.2 Financially, at the end of February, we are currently anticipating to deliver a break-even plan at the end of the financial year, although this will require the use of some non-recurrent funding.

1.3 We have submitted our business plan for 2025/26, in which we commit as a trust to break even financially. This is an ambitious plan with high risks to delivery and is contingent on realising £80m of efficiencies and productivity gains. There are some outstanding issues to be resolved before we can sign a contract.

1.4 The team at our Wembley Community Diagnostic Centre is offering patients the option to have scans up until midnight by using new technology that enables radiographers to operate the MRI remotely. In its first month, the extended imaging pilot allowed us to scan an extra 306 patients between 8pm and midnight, and has had positive patient feedback and low 'did not attend' rates. The pilot has seen the waiting time of patients attending the extended hours service reducing by over two thirds.

1.5 We have limited routine maternity self-referrals at both St Mary's and Queen Charlotte's & Chelsea hospitals. We are now only able to accept self-referrals from those living in NHS North West London or NHS North Central London and we are not taking any routine, post 30-week self-referrals. This is so that we can ensure capacity for complex pregnancies and births in light of significant and unanticipated increases in demand, especially from outside our sector and our neighbouring sector. The changes do not affect complex pregnancy care referrals from GPs or other maternity units. We are exploring a range of options for a longer-term, more strategic response and need to have the temporary limits to self-referral in place to manage safely in the interim.

1.6 We received our highest ever staff survey response (65.2 per cent) and we are now above the average for acute trusts for eight of the nine themes, up from seven out of nine in 2023.

1.7 The Government announced the outcome of its review of the New Hospital Programme on 20 January 2025, including an updated timeline for existing schemes. St Mary's, Charing Cross and Hammersmith hospitals have been included in the third wave where construction has been delayed until 2035 at the earliest. However, we have made it clear we cannot wait that long for a new hospital and have been pursuing alternative routes for redevelopment. In early February, the New Hospital Programme confirmed that we will be able to continue to detailed design and planning for the redevelopment of St Mary's Hospital, aiming to conclude with planning approval in 2027/28, with an anticipated total of around £50 million to complete this phase.

1.8 To help us with next steps, we have been working closely with Westminster City Council as the host borough for St Mary's, and with Hammersmith and Fulham Council, the home borough for Charing Cross and Hammersmith hospitals. We are setting up a taskforce with Westminster City Council to identify additional funding options for St Mary's. And we will be helping to expand Imperial College London and Hammersmith and Fulham Council's Upstream London industrial strategy that focuses on the benefits of life science developments for economic growth and local job opportunities as well as for healthcare.

1.9 Stanton Williams has been selected as the architect to design the new Fleming Centre following a competitive RIBA process. The research and public engagement facility will be built on the St Mary's Hospital campus and is due to open in 2028 as part of the wider Fleming Initiative, established jointly by our Trust and Imperial College London to find solutions to antimicrobial resistance (AMR).

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 and incident reporting rates remain high, which is a positive reflection of our safety culture. Our harm levels remain below national averages with a small recent increase which we are monitoring. Themes link to the trust wide quality and safety improvement priorities with excellent progress being made in many areas e.g. sustained improvement in hand hygiene, implementation of Martha's rule, national recognition for our work to involve patients in patient safety and for our new anticoagulant clinic, comprehensive training and education packages for our staff to support them to provide improved care to patients at the end of their life, and to manage patients with complex mental health needs.

2.2 Ongoing operational pressures in the emergency departments (EDs) are resulting in an increase in long lengths of stay for patients with mental health needs and a negative impact on patient experience. Our teams are mitigating the risk as far as possible, with no significant increase in harm despite the delays.

2.3 Due to the increasing demand for our maternity services, we no longer accept self-referrals from outside north west and north central London unless there is a clinical indication. A maternity activity dashboard shows an overall increase in incidents, though not in harm, which is testament to the team's focus on patient safety. We have declared full compliance with the Maternity Incentive Scheme Year 6 ten safety actions.

2.4 We have agreed to temporarily pause our neuro-oncology surgical service, initially for two weeks, due to concerns raised internally and following an invited review by the Royal College of Surgeons (RCS) and Society of British neurosurgeons (SBNS). Criteria for recommencing the service have been agreed and external expert support in place. Patients are being treated at the National Hospital for Neurology and Neurosurgery during this

period. We have a detailed action plan in place across Neurosurgery covering all areas of known risk.

3 Operational performance

3.1 We continue to have some of the fastest ambulance handover times in London. Our February 2025 performance against the 30-minute handover standard was 95.0 per cent, and we achieved 99.1 per cent against the London-wide standard for handovers within 45 minutes. In February, 74.8 per cent of patients were admitted, transferred or discharged from the emergency department within four hours. This was below our improvement trajectory target (but above the England average of 73.4 per cent) and we are working to improve to meet the national standard.

3.2 The number of patients waiting for treatment on our referral to treatment waiting list has continued to reduce and stood at 88,834 at the end of February 2025, 16.3 per cent lower than its peak of 106,192 in August 2023. We are also making significant and sustained progress in reducing the overall long waiter backlog. At the end of February, 2,251 of our patients had been waiting over one year for treatment, 45 per cent lower than its peak in September 2023. At the end of February 2025 the number of 65 week waits for treatment was 258, of which 210 were due to capacity constraints and 48 to patient choice. We continue to face capacity challenges across our neurosurgical, neurological and ENT pathways, and we are working alongside NHS England to mitigate these.

3.3 Diagnostics performance continued to improve with 8.9 per cent of patients waiting over six weeks for their diagnostic tests or procedures at the end of February 2025, against the goal of 5 per cent by March 2025. The level of waits reduced across Imaging, Neurophysiology and Cardiology echocardiogram diagnostic services.

3.4 In terms of cancer performance, we continue to meet the faster diagnostic standard of at least 77 per cent of patients given a positive or negative cancer diagnosis within 28 days of referral, reaching 80.1 per cent in January 2025. We met the national standard for 96 per cent of patients to receive treatment within 31 days from decision to treat (96.5 per cent in January 2025). 71.9 per cent of cancer patients were under 62 days between referral and starting treatment, achieving the national NHS objective of 70 per cent for 2024/25, but below our more ambitious improvement trajectory target.

4 Financial performance

4.1 At the end of February, the Trust had a year-to-date actual deficit of £11.6m, against a planned £0.2m surplus. The key drivers of the year-to-date deficit include: under achievement of the planned system wide benefits as well as lower than planned delivery of efficiencies, offset by continued good performance on elective income. We continue to deliver against our financial recovery plan and should achieve a breakeven position by year end, our original plan.

4.2 Year to date the Trust has incurred £72.6m of total capital spend against a £80m budget, £7.4m behind plan. There has been delays to several capital projects due to the building safety act. Further spend is being brought forward to manage the capital position and we forecast meeting our annual capital plan.

4.3 At the end of February 2025, the Trust had a cash balance of £83.3m. The year-end forecast remains unchanged at £70.4m and reflects a significant reduction in cash by £53.5m from the opening cash balance.

5 Workforce update

5.1 Our vacancy rate is 7.5 per cent, reduced from 10.2 per cent in April 2024, and our turnover rate at 8.3 per cent reduced from 10.1 per cent in April 2024 are both exceeding their target and are special cause improvement variation following a sustained improvement.

5.2 As part of the Trust Improving Doctors Lives programme, we launched a programme specifically targeted to improve the experience of resident doctors joining or rotating through Imperial including with timely access to rota information. This programme has delivered several successes, including meeting the 100 per cent target for delivery of work schedules, strong positive feedback on the regular pay clinics available and a welcomed focus on schedules for our Less than Full Time residents.

5.3 **NHS Staff survey -** NHS Staff Survey results were published on Thursday 13 March. We had our best ever response rate of 65.2 per cent compared with the acute trust average of 49 per cent. We achieved statistically significant improvements in three themes – 'we are safe and healthy', 'we work flexibly' and 'morale' – while the previous year's statistically significantly improved scores for the remaining six themes held steady. We are now above the average for acute trusts for eight of the nine themes, up from seven out of nine in 2023. While we are slightly below average for 'we work flexibly', this theme saw the biggest improvement. Encouragingly, the proportion of staff who would recommend the Trust as a place to work has statistically significantly improved to 70.7 per cent, ten percentage points higher than the acute trust average. And, while the proportion of staff who say they would be happy with the standard of care we provide if a friend or relative needed treatment remained steady at 74.5 per cent, this is now 13 percentage points above the acute trust average.

5.4 **Violence and aggression -** I continue to chair the violence and aggression steering group. We are launching a range of new communication materials, posters and films, continuing to roll out body worn cameras, and providing bespoke training and support for staff including in conflict resolution. We have also reviewed and relaunched our Policy on withholding treatment for patients and our behavioural contracts for use with relatives and visitors.

5.5 **EDI update -** We continue to embed our Anti-Racist and Anti-Discrimination Commitments and have been rolling out workshops to promote these to teams and departments. Over 1,200 have accessed the individual commitments via our Intranet pages and work continues to these are embedded across all staff groups.

5.6 **Vaccination programme -** The seasonal vaccination programme for healthcare workers finished at the end of January at which point 30.5 per cent of our staff had their flu vaccination and 18.5 per cent their Covid vaccination. Although more of our staff had their Covid vaccination compared to the London and NWL average, our flu vaccination rate was lower.

<u>Senior leadership changes</u>

5.7 Claire Hook, chief operating officer and deputy chief executive, has been appointed chief operating officer at the Francis Crick Institute. She will leave the Trust in June 2025 to take up her new role. We will miss Claire greatly and wish her all the best.

5.8 After more than ten years as Imperial Health Charity's chief executive, Ian Lush is to retire this summer. Ian was pivotal in driving charitable support for our hospitals and the wider NHS during the pandemic and I would like to thank him for all his work.

6 Research and innovation

6.1 Towards the close of the current financial year, we have recruited 38,838 participants into NIHR Portfolio studies. This recruitment was generated from 356 individual studies (95 of these commercially sponsored) across 33 different specialties. We continue to deliver UK, European and global first patient recruits into commercial studies. In 2025 to date, we have achieved seven “first-in-Europe patients for commercial studies – the second highest in the country.

6.2 With support from the NIHR Imperial BRC and RRDN, we have now appointed Professor David Wingfield as Lead for Primary Care Research Facilities who is responsible for a network of 5 primary care research sites across NWL which will provide more community-based options for patients to get involved in clinical research studies.

6.3 Recent BRC-funded projects making the news include:

- A new AI model which can flag female patients who are at higher risk of heart disease based on an electrocardiogram (ECG). The algorithm, designed specifically for female patients, could enable doctors to identify high-risk women earlier, enabling better treatment and care.
- Encouraging results from the first phase of clinical trials for a new peanut allergy vaccine. In the latest paper, a phase 1 first-on-human clinical trial demonstrated the VLP peanut allergy vaccine’s safety and tolerability, with no reactivity observed during skin prick tests comparing the vaccine to control treatments.
- New genetic tests which could predict a potentially fatal heart muscle condition, known as hypertrophic cardiomyopathy (HCM).

6.4 From Tuesday 18 March, we implemented a new artificial intelligence solution to support clinical analysis of chest X-rays. The AI platform uses algorithms to provide extra information that can support diagnosis. The radiologist or reporting radiographer will report the X-rays in the normal way and may use the AI generated image alongside their review, before issuing their final radiology report.

7 Green plan update

7.1 We have made solid progress in delivering our Green Plan including:

- Recruiting 682 Green Community Network members and 80 Green Champions
- We have won a bid to the NHS National Energy Efficiency Fund for £12.9 million to replace our lighting and gas and electricity controls. Works will begin in April and continue until December
- Progressing a nitrous oxide waste mitigation project at Western Eye Hospital (WEH) and seen desflurane as a percentage of all volatile anaesthetic gases usage fall from 5.2 per cent in March 2024 to 0 per cent in December 2024.

8 Redevelopment update

8.1 The outcome of the New Hospitals Programme (NHP) review was announced on 20 January with the disappointing outcome is that all three of our schemes have had their construction start date pushed back to between 2035-2040. This is clearly untenable as the condition of our existing hospitals is so poor. It has been agreed that funding of around £50m will be allocated to allow the design and town planning process for St Mary’s to continue to gain a full planning consent. The Trust has also submitted a case to

continue the master planning work of Charing Cross and Hammersmith Hospitals. We have been working with Westminster City Council and Hammersmith and Fulham Council to explore alternative funding mechanisms that accelerate the delivery of our new hospitals.

9 Estates update

9.1 As requested at the APC Estates, Infrastructure and Sustainability Committee in Common, I will report all the estates-related incidents in the last quarter. For this report they include:

- On Saturday 8 March an equipment fire caused evacuation and a business continuity incident at North West London Pathology lab at Charing Cross. The fire was extinguished by NWLP staff, London fire brigade was called, ongoing samples diverted to other sites, 15 staff were evacuated and two staff members were seen at the ED for suspected smoke inhalation. Staff were confirmed to be fine and all returned back to the laboratory within the same shift.

10 Stakeholder engagement and visits

10.1 Below is a summary of significant meetings I have had with stakeholders.

- Cllr Sheth, JHOSC Chair, 8 January 2025, 5 February 2025, 5 March 2025
- Meetings on redevelopment, including with leaders of Westminster Council, Hammersmith and Fulham Council and local MPs.
- Andy Slaughter MP and Ben Coleman MP, 5 February 2025
- Cllr Butler-Thalassis and Cllr Albert (Westminster), 4 March 2025
- Cllr Perez and Cllr Sanderson (Hammersmith & Fulham), 7 March 2025
- Cllr Paul Swaddle (Westminster), 27 March 2025
- Hammersmith and Fulham save our NHS and other NWL Campaign groups, 31 March 2025

10.2 We welcomed Howard Dawber, Deputy Mayor of London (business and growth), to St Mary's on 19 February to hear about our plans for redevelopment.

10.3 We welcomed Her Royal Highness The Princess Royal to St Mary's on 20 February 2025 to hear about our partnership with the charities Redthread and Catch22, whose youth violence intervention and young women's services are embedded in the hospital.

11 Recognition and celebrating success

11.1 In January, our anaesthesia departments achieved Anaesthesia Clinical Services Accreditation from the Royal College of Anaesthetists (RCoA). This significant milestone reflects years of hard work, collaboration, and a shared commitment to delivering the highest standards of care.

11.2 Duncan Burton, Chief nursing officer for England, visited St Mary's on 7 February to present three nurses with Chief Nursing Officer Gold Awards. Congratulations to our award winners Carys Barton, heart failure nurse consultant; Mary Dawood, consultant in emergency nursing; and Sylvia Turner, lead advanced nurse practitioner for our rapid diagnostic service.

11.3 Congratulations to all our teams shortlisted for HSJ digital awards. These include nominations for the Trust's innovative use of AI, efforts to improve equality, diversity and inclusion in ICT and success in improving use of our electronic patient record system. It also includes James Bird, our chief nurse information officer, who is up for Digital Leader of the Year. The winners will be announced on 26 June 2025.

Imperial College Healthcare NHS Trust (ICHT)
Trust Standing Committee Chair's Highlight Report to the North West London Acute Provider Collaborative Board in Common (BiC) – for discussion
8 April 2025

Highlight Report

1. Purpose and Introduction

The role of the ICHT Trust Standing Committee is:-

- To oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

2. Key highlights

2.1 Patient and Public Involvement 2024/25

The Committee received a report and presentation from the Trust Strategic Lay Forum, highlighting their priorities and achievements in 2024, drawing primarily on its new 'deep dive' reviews of topics of key interest. Deep dives undertaken in 2024 focussed on how the Trust seeks and responds to patient feedback; the appointment and booking process and how to reduce waits; preventing ill health (including partnerships and integrated care initiatives); and, cancer care. The report also included a summary of the focus and achievements of wider patient and public involvement activities last year which included developing the lay partner programme; patient safety partners; training, support and development; our first patient voice remuneration policy; and, community engagement. The key priorities for 2025/26 included person/patient centeredness and health equity.

The Strategic Lay Forum highlighted their appreciation of the Trust's transparency and commitment to embed patient and public involvement in the culture and leadership. The Committee recognised that the Strategic Lay Forum were involved from the early stages of strategic change, transformation and redesign, however would welcome further amplification of this in specific reports and proposals being presented to the board.

2.2 Chief Executive's report

The Committee received and noted the updates within the Chief Executive's report. The key points were:

- The Trust had achieved financial break-even for 2024/25, subject to audit; however this had required the use of some non-recurrent funding.
- The business plan for 2025/26 had been submitted and was the subject of today's deep dive.
- An update on operational performance.
- Mortality rates remained consistently amongst the lowest in the NHS.
- Emergency Department operational pressures continued, resulting in an increase in long lengths of stay for patients with mental health needs and had a negative impact on patient experience. Teams were mitigating the risk as far as possible, with no significant increase in harm despite the delays.

- The Wembley Community Diagnostic Centre had commenced a pilot on extended hours for imaging which allowed patients to receive scans up until midnight. In its first month of the pilot, an extra 306 patients had received scans between 8pm and midnight. Patient feedback had been positive and the 'do not attend' rates were low.
- The Trust had achieved the highest response rate ever for the Trust staff survey (65.2%) and the results were very positive, with the Trust being above average for acute trusts for eight of the nine themes.
- The Trust were working closely with Westminster City Council to establish a joint taskforce to identify additional funding options for St Mary's Hospital redevelopment.
- New communication materials, posters and films were been launched around violence and aggression. The Trust continued to roll out body worn cameras and the policy on withholding treatment for patients and behavioural contracts for use with relatives and visitors had been reviewed and relaunched.
- Claire Hook, Deputy Chief Executive and Chief Operating Officer, will leave the Trust in June 2025 to take up her new role as Chief Operating Officer at the Francis Crick Institute. The Committee thanked Claire for her hard work and wished her well.
- Ian Lush, Chief Executive of Imperial Health Charity, would retire in the summer. The Committee thanked Ian for all of his hard work.

2.3 Delivering the 2025/26 Business Plan - Deep Dive

On 26 March 2025, the extraordinary Trust Standing Committee reviewed the Trust's 2025/26 business plan submission and noted the financial plan was break-even after receipt of £46m of cash backed support funding (ICB deficit funding and NHSE distance from target funding) and included the need to deliver £80.1m of recurrent cash releasing efficiencies. The efficiency plan has been allocated to all divisions and further split across all directorates. The overall efficiency plan is split across income (£8.0m), pay (£43.3m) and non-pay (£28.8m).

The workforce plan reflected a net 451 WTE reduction across substantive, bank and agency from 2024/25 forecast outturn and equated to a c£27m reduction in pay costs next year. This met the requirement of 15% reduction in bank usage and reduced agency usage by 33%, with a stretch target of 1% reduction to substantive establishment. This included reductions in response to the corporate and admin growth however the initial comparison year of 2019/20 had recently been revised to 2018/19 by NHS England.

The operational plan does not achieve all of the performance standards, specifically the referral to treatment (RTT), where national guidance was awaited, and 52 week waits; performance against these were 55.5% and 3.1% respectively. It was likely that the Trust's RTT plan would be escalated to the national team.

Teams continued to work to deliver the 2025/26 plan including immediate grip and control measures to mitigate any slippage in quarter one, incorporating recruitment pause and temporary staffing controls. Average expenditure on bank and agency was £8.5m per month, with over £7m of this on bank. Short term measures would need to deliver a 20% reduction to help support the April 2025 financial position. Daily bank and agency reviews were being held. The committee were informed there was some further work to do around retrospective medical bank and agency.

Whilst confidence remained high that the short-term plans would deliver a run rate reduction, further work was needed to support the delivery of the £80.1m efficiency target. The majority of this work would be focussed on cost and headcount reduction, productivity work, service reconfiguration and other actions to accelerate the delivery of the efficiencies. In line with the process set up at other Trusts within the Acute Provider Collaborative, the Trust were seeking to establish a Non-pay Oversight Group from May 2025. Terms of Reference would be discussed with the Executive.

The Committee were informed there were outstanding commissioning issues to be resolved with the ICB before the Trust could sign a contract. Currently the Trust provided several services that were not commissioned and therefore not paid or not fully paid for. There would need to be some challenging decisions around some services, including low priority work or areas which could be consolidated across the APC.

The Committee also received an update on business planning for Imperial Private Healthcare. Private care revenue growth had benefited from being a key strategic priority for the Trust. The Committee noted full year forecast revenue was increased on the prior year and an ambitious growth plan had been set for the year ahead, delivering increased contribution against the 2024/25 outturn. It was anticipated that a stretch contribution target would be delivered by year end. Income from the private practice would be used for a new theatre at Charing Cross for private patient utilisation. It was emphasised that income from the private practice goes immediately back to support the NHS side of the Trust. It was agreed it would be helpful to receive a mid-year update on Imperial Private Healthcare at either the Finance, Investment and Operations or Trust Standing committee.

2.4 Board Assurance Framework and Risk Appetite

The Committee received a report on the Board Assurance Framework (BAF) which contained the Trust's strategic risks and assurances to ensure such risks were managed. The Committee were reminded that the Trust Executive Management Board (EMB), via the EMB Risk Group, reviewed the BAF on a monthly basis to ensure risks to the objectives were correctly identified and to oversee the development of robust controls to manage the risks. Risks on the BAF aligned to local committees to ensure Board Committees received the appropriate assurances that the strategic risks were being managed appropriately.

The Committee noted the key risks at year-end that would be reported in the annual report, and noted the proposed amendments to reflect the strategic risks going into 2025/26.

Members discussed in particular the scores for industrial action, in-year financial and GDPR. The updated BAF would go through local committees to review and discuss risks aligned to the appropriate Board Committee. The updated BAF would be brought to the next Trust Standing Committee.

The current risk appetite statement had been reviewed to support the BAF and to ensure that the Trust aligned target risks scores to the risk appetite. Decisions around staffing (agency and bank) and referral to treatment were discussed.

At the next Trust Standing Committee, it was anticipated further clarification would be available on service performance, grip and control financial measures and from regional / national teams. This would allow a further discussion on risk appetite.

2.5 Quality Assurance Report

The Committee received and noted the assurance report which summarised quality performance and emerging risks and actions / mitigations.

The Committee were informed that following a whistleblowing incident and triangulation of other sources of information, the Trust had temporarily stopped undertaking brain tumour operations in its neuro-oncology service, for two weeks, to allow for the Royal College of Surgeons to undertake an external review. Following assurances received, activity had re-commenced and the service would be closely monitored. A review was being undertaken to ensure no harm had come to affected patients. The Committee received assurances around the steps taken to address the concerns. It was noted this was a specialised service and more national audits around this type of work would be welcomed. A more detailed report would be presented to the next Quality Committee.

2.6 Operational performance report

The Committee received and noted the operational performance report for month 11.

2.7 Finance update and financial recovery report

The Committee received and noted the forecast outturn position at month 11 including the current cash position and forecast. The Committee were informed the Trust would break-even for 2024/25.

2.8 People Assurance report

The Committee received and noted the People and Organisational Development (P&OD). On the back of the positive responses from 2024/25, and in light of the upcoming financial challenges for 2025/26, the Chair of the People Committee had requested a temperature check on staff morale during the year.

2.9 Managing estates risks and contingency planning – St Mary's and Charing Cross hospitals

The Committee received a report which built on previous St Mary's Hospital (SMH) site-wide contingency work in 2023, with the addition of a similar assessment at Charing Cross Hospital (CXH). The paper provided an impact assessment of estates failure by building and highlighted the consequences of catastrophic estates failure to clinical service delivery and limitations of the Trust's ability to provide mitigation. The paper also identified those clinical services that, in the event of catastrophic estates failure, would require external support at North West London Integrated Care System, regional or national level. Whilst the paper identified risk and impact, it did not capture the mitigations for catastrophic estates failure. An estate management strategy was being developed, led by the Estates team in consultation with clinical divisions, to address this. The Trust had, however identified critical infrastructure risks across the hospital sites and a plan to mitigate these risks via backlog maintenance and additional capital funding. The Committee agreed the need to engage colleagues at NHS England and London region to work through the mitigation strategy, in particular around the risks articulated and the potential impact on other providers in the region.

Whilst the highest risk of catastrophic failure lay at the St Mary's hospital site, the highest cost for backlog maintenance related to Charing Cross Hospital. This was because the site was built at the same time and there were issues around the removal of asbestos and aged mechanical, electrical and plumbing systems.

2.10 NWL Acute Provider Collaborative (APC) Executive Management Board (EMB)

The Committee received an update of the key discussions held at the APC EMB on 6 February and 3 March 2025. Discussions included performance, finance and recovery, business planning, APC clinical pathways and collaborative projects.

2.11 Board Committee Reports

The Committee received summary reports from the Quality; Finance, Investment and Operations; People; and Audit, Risk and Governance Committee meetings that took place in March 2025. The Committee received assurance that key risks overseen by each Board Committee were being managed appropriately.

3. Positive assurances received

The Committee recognised that the Strategic Lay Forum were involved from the early stages of strategic change, transformation and redesign, however would welcome further amplification of this via specific reports and proposals being presented to the Trust Standing Committee.

The Committee received confirmation that the Trust would achieve break-even for 2024/25, subject to audit.

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

There are no key risks which require escalation to the Board.

5. Concerns outstanding

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

6. Decisions made

No decisions were made that require reporting to the Board in Common.

7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Patient and Public Involvement 2024/25	To note	8.	Operational performance report	To note
2.	CEO report	To note	9.	Finance report	To note
3.	Business Planning 2025/26 - Deep Dive	To discuss	10.	Board committee report – Finance, Investment and Operations	To note
4.	Board Assurance Framework and Risk Appetite	To note	11.	People Assurance report	To note
5.	Board Committee report – Audit, Risk and Governance	To note	12.	Board committee report – People	To note
6.	Quality assurance report	To note	13.	Managing estates risks and contingency planning – St Mary's and Charing Cross hospitals	To note
7.	Board Committee report – Quality	To note	14.	Report from APC Executive management Board	To note

8. Attendance

Members	January attendance
Bob Alexander, Non-Executive Director (Vice Chair)	**Y**
Matthew Swindells, Chair, Board in Common	**Y (ex-officio)**
Aman Dalvi, Non-Executive Director	**Y**
Nick Gash, Non-Executive Director	**Y**
Loy Lobo, Non-Executive Director	**Y**
David Moss, Non-Executive Director Designate	**Y**
Sim Scavazza, Non-Executive Director	**N**
Helen Stephenson, Non-Executive Director	**Y**
Catherine Williamson, Non-Executive Director	**Y**
Tim Orchard, Chief Executive Officer	**Y**
Jazz Thind, Chief Financial Officer	**Y**
Julian Redhead, Chief Medical Officer	**Y**
Janice Sigsworth, Chief Nursing Officer	**Y**
Claire Hook, Chief Operating Officer	**Y**

7.2C THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST (LESLEY WATTS / CAROLYN DOWNS)

REFERENCES

Only PDFs are attached

- 7.2c. THHT CEO Board Report April 2025 v1.5.pdf
- 7.2c1. THHFT SC Chairs Report March 2025 Final CD.pdf

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

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

1.1 We have undertaken a review of our Executive Team structure with a number of changes/appointments to strengthen our executive leadership and enhance collaboration in the Acute Provider Collaborative. These appointments are effective from 1 April 2025 and represent a new chapter for the future of Hillingdon Hospital.

1.2 A team of surgeons from Hillingdon Hospital performed pioneering breast reconstruction surgery. In a UK first, in collaboration with a surgical team from the Royal Free Hospital, successfully carried out an innovative approach to the operation, which was a UK first. This pioneering procedure promises enhanced outcomes for patients, showcasing the power of multidisciplinary collaboration in pushing the boundaries of surgical innovation. Excitingly, this approach has the potential for even greater advancement through robotically assisted techniques, further revolutionising the field of breast reconstruction.

1.3 In collaboration with Brunel University London, we are developing an innovative digital solution for clinicians and patients, enabling physiotherapists and occupational therapists to remotely interact with patients to treat and monitor stroke rehabilitation. By designing a clinician dashboard, our physiotherapists and occupational therapists will remotely interact with patients, treat them, and monitor stroke rehabilitation, enhancing therapy efficiency and improve accessibility for our stroke survivors.

1.4 We launched our new staff recognition scheme known as 'Hillingdon Hearts', where staff can easily show appreciation for each other by sending 'hearts' and messages online. In the first week, over 500 hearts were received and shared right across the organisation. On the day of the launch over 100 staff took part and the tool is now an integral part of our staff recognition.

2. Quality and Safety

2.1 The rate of Inpatient Falls was 3.3 in February (per 1000 occupied bed days) below Trust target of 4.6 and below the national average of six.

2.2. 47 hospital acquired pressure ulcers and moisture associated skin damage were reported in February, a rate of 1.6 per 1000 bed days, above the Trusts threshold of 1.0.

2.3 There were 25 complaints received in February, the lowest in the last 12 months and for the first time since July 23, we are meeting the Trust target of < 25. Complaints response time remains strong with Complaints per the priorities are identified and devised in response to local, sector wide and

2.4 The Trust have set the following priorities for 2025/26:

- Reduce hospital acquired healthcare infections by strengthening the Infection Prevention & Control Practices across the Trust
- Reduce the length of stay for patients attending the emergency department and inpatients
- Improve staff and population health by reducing smoking
- Rollout of adult deteriorating patient pathway
- Improve quality safety and patient experience in maternity and neonatal services by delivering selected actions of the 'Three Year Delivery Plan'

3. Operational performance

3.1 Referal to treatment (RTT) 52 week waits (ww), 65ww remain special cause improvements for the Trust.

3.2 Elective activity continues to outperform planned targets. DMO1 performance improved with continued focus on MRI and NOUS capacity.

3.3. The Trust still needs more focus on monitoring and improving performance, maintaining Emergency Department 'All types' performance below target. It is not supporting the emergency desk it is that the whole organisation takes responsibility for delivering the ED target.

4. Financial performance

4.1. At M11, the Trust is reporting a year-to-date deficit of £29.4m, which is £24.3m adverse to our plan, £22.9 adverse to our internal budget (realigned for CIP delivery).

4.2. The Trust's financial performance for month 11 continues the improvement in run rate, driven by income and reduced agency costs. The Trust remains on track with its recovery plan but recognises there is still much to do in Month 12.

4.3 The Trust's 2025/26 operating plan was approved by the board on 27 March at a breakeven position, comprised of a deficit of £34.5m offset with deficit support funding. The plan includes a cost saving requirement of £15.7m

and a further reduction in cost to align to a reduction in elective (ERF) funding of £4.6m.

4.4 The Trust must make a step change in cost reductions. We are determined to treat as many patients as possible, to continue to look after our staff and of course do this within the determined financial constraints.

5. People

5.1 Vacancy rate and turnover rates: The organisation is performing well against key metrics for vacancy and turnover rates. We received positive feedback on a People Promise visit from the national team, highlighting the good work led by the organisation.

Turnover, and substantive vacancies, are still well below the Trust targets however sickness levels remain high at 5.1% and require special focus. Personal Development Review's (PDR) compliance has improved to 87.3%, below Trust target of >=95%. The percentage of agency spend continues but remains reduced.

5.2 Annual NHS Staff Survey results

We are pleased to share that we demonstrated some improvement across staff survey measures in the latest NHS Staff Survey. In particular, that we are 'always learning', continuously staying safe and healthy, working flexibly. The measures showed improvement in overall staff morale, highlighted that 71% of staff feel they receive the respect they deserve from colleagues at work, 69% of staff said they feel valued by their team, and 68% of staff said their immediate manager values their work.

5.4 The Trust scored significantly better than the previous year for the question relating to discrimination on grounds of ethnic background (-9.7%).

5.5 There was one people promise/theme where we scored significantly worse than 2023. Overall staff engagement was 6.71 (significantly worse than 2023 score of 6.83) (-0.13). This is largely due to a decline in the motivation sub score, from 7.28 in 2023 to 7.09 in 2024.

5.6 As part of our people plan and People Promise work moving forward these results reinforce our priorities of:

- Staff engagement / We are compassionate and inclusive
- We are always learning
- Discrimination, bullying, and harassment

5.7 I am delighted to announce the following changes/appointments to strengthen our executive leadership:

- **Alan McGlennan –** has been appointed as the managing director for the Trust. This is a new post which has been created to take on accountability for the management and leadership of the hospital sites. Alan will also maintain his role as the chief medical officer.
- **Jason Seez** (Previously deputy CEO at Hillingdon) - has been appointed as the chief infrastructure and redevelopment officer for both Chelsea and Hillingdon.
- **Virginia Massaro** (Previously chief finance officer at Chelsea) **–** has been appointed as the chief finance officer for both Chelsea and Hillingdon.
- **Kevin Croft** (Previously chief people officer at Imperial) – has been appointed as the chief people officer for Imperial, Chelsea and Hillingdon.
- **Peter Jenkinson** (Previously director of corporate affairs for Imperial and Chelsea) – has been appointed as the director of corporate affairs Imperial, Chelsea and Hillingdon.
- **Emer Delaney** (Previously director of communications at Chelsea) – has been appointed as the director of communications for both Chelsea and Hillingdon.
- **Sarah Burton –** Continues as the Chief Nursing Officer

I would like to thank Tracey Cotterill who departs as our Interim Chief Finance Officer and Tina Benson who departs as the Trust Chief Operating Officer (COO) and congratulate Tina on her appointment as the COO at Frimley Health NHS Foundation Trust.

6. Updates from the Council of Governors (CoG)

6.1 The CoG formally met in public on 13 March 2025. The CoG received a briefing on the Trusts Clinical Services Strategy in January 2025, and a briefing on the conclusion of the government's review of the the New Hospital Programme and next steps for the Hillingdon Hospital redevelopment in March 2025.

6.2 I am pleased to announce the appointment of Jeanne Davey as our Deputy Lead Governor from 1 April 2025.

7 Redevelopment

7.1 We were delighted when the redevelopment of Hillingdon Hospital was approved following a review of the New Hospitals Programme. The Secretary of State for Health and Social Care, Wes Streeting, announced that our Trust will be in wave 1 of the scheme, with construction of the new hospital expected between 2025 and 2030.

8. Hillingdon Hearts

8.1 We launched a new staff recognition scheme 'Hillingdon Hearts' in March, an easy way for colleagues to highlight appreciation of each other. The popular scheme saw hundreds of hearts being sent between colleagues on the first day, and thousands of views to the Hillingdon Hearts intranet page. Recipients of five 'hearts' in a month are invited to a celebration breakfast with the CEO, Lesley Watts.

9. Sustainability

9.1 Our Trust has been awarded £242,000 to install solar panels at Hillingdon Hospital. The award from the Department for Energy Security and Net Zero will enable us to install solar power and battery storage solutions, to help drive down energy bills at the hospital.

10. Research and innovation

10.1 We have been awarded funding through the New Hospital Programme to develop a digital health solution for stroke rehabilitation. In collaboration with Reneural (a neurotech company dedicated to transforming stroke recovery) and Brunel University London, we are developing an innovative digital solution for clinicians and patients, allowing physiotherapists and occupational therapists to remotely interact with patients to treat and monitor stroke rehabilitation.

10.2 Our Trust is part of the Saving Babies' Lives Care, aimed at reducing perinatal mortality. As part of this, we have participated in two trials – SNAP (Smoking, Nicotine and Pregnancy) 2 and SNAP3. We are in the top 10 centres nationally for recruitment to these trials and our recruitment of more than 100 participants to SNAP3 is the second highest in England, earning us a commendation from Nottingham University, one of the trial sponsors. We have also be announced as Site of the Year for the trial. Crucially, we have been able to provide additional support to these women to help stop smoking and thus help improve their pregnancy outcomes and general health outcomes, in line with the NHS long term plan.

11. Equity, diversity and inclusion

11.1 We held a Race Equality Event in February, where our colleague Ellen Omungo, a senior sister in outpatients at Hillingdon, shared her experiences of being a woman of colour working in the NHS. Race Equality Week was celebrated with a special online event featuring Ellen Omungo, out-patients senior sister, sharing her personal journey and experiences about the realities of working in healthcare as a person of colour.

11.2 We recognised Ramadan, for our staff and community in Hillingdon as an important period of reflection, compassion and togetherness. Many of our staff celebrated Eid-al-Fitr with their friends and family recently and a number of staff shared welcome treats with their colleagues on the day.

11.3 International Women's Day was marked with a series of events open to all colleagues, including a networking event at Hillingdon (run by our Women's Network) and a series of inspirational online talks held across the sector

11.4 The LGBTQ+ Network has been relaunched, with the successful recruitment of two new network chairs, and a webinar on 'Ageing in the LGBTQIA+ population'. The session explored this community's distinct needs and making changes within the NHS to accommodate and support them as they age.

11.5 Our Able4All Network celebrated Neurodiversity Week with an information stall, guest speakers, and a staff webinar.

11.6 The Women's Network held a 'Time to Talk' Day focussing on the topic of domestic violence and creating a safe space for discussion.

12. Recognition and celebrating success

12.1 We have started our new, monthly celebration breakfasts with our Trust Executive Team, to recognise the exceptional contributions and dedication of our staff. The winners of the monthly CARES Awards, recipients of Long Service Awards, and staff who have received five 'hearts' from our new Hillingdon Hearts scheme, are invited to the breakfast with Lesley, to honour their hard work and commitment.

12.2 Our Sustainability Team has been awarded for our ongoing achievements in the field of sustainability, net zero strategy and waste reduction. The award was presented at the Metsä 2025 Sustainability Awards at Canary Wharf on Wednesday 19 March.

12.3 Our tissue viability nurses were awarded a high commendation in the Patient Safety Collaboration of the Year category of the HSJ Partnership Awards. In collaboration with equipment supplier Medstrom, their tireless efforts to improve patient outcomes, relieve pain, adopt new technology and develop end-of-life pathways have been recognised for their huge contribution to compassionate patient care.

12.4 Mohan Selvaraj, one of our Nurse Education Team's practice educators, has been named Mentor of the Year at the Brunel University of London Apprenticeship Awards for his work supporting Apprentice Nurse Associates and acting as the liaison between us and the university

12.5 During National Apprenticeship Week in February, we honoured the latest cohort of colleagues completing either a clinical or non-clinical apprenticeship. The Trust has completed 85 apprenticeships to date, 58 clinical and 27 non-clinical

12.6 We recently bid farewell to nurse Vicky Johnson, who spent an amazing 49 years working at Hillingdon Hospital. Her dedication and commitment to nursing over that time is truly incredible. Most of that time was spent in specialist gynaecology, where her care, compassion, and expertise made a difference to so many patients.

The Hillingdon Hospitals NHS Foundation Trust

Trust Standing Committee report to the North West London Acute Provider Collaborative Board in Common (BiC) – for discussion 29 April 2025

Highlight Report

1. Purpose and Introduction

1.1 The role of The Hillingdon Hospitals NHS Foundation Trust Standing Committee is: -

1.1.1 To oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

2. Key highlights from the Extraordinary Trust Standing Committee Meeting on 24th March 2025

Financial Plans and Budget for 2025-2026:

- The meeting focused on reviewing and recommending approval of the financial plans and budget for the financial year 2025-2026 to the Board in Common (27 March 2025).
- Key discussions included the projected deficit, cost improvement programs (CIP), productivity and efficiency opportunities, and the impact of inflation and activity growth on the budget.
- The committee received and discussed the financial projections, including a £34.5 million deficit before system support funding.
- The CIP and productivity targets, emphasising the need for realistic and achievable plans.
- Activity and performance expectations, noting a 6% reduction in elective activity and a 4% increase in emergency care activity.

Quality and Safety Considerations:

- The committee discussed the impact of financial constraints on quality and safety and received assurance that quality impact assessments (QIA) and equality impact assessments (EQIA) are in place to monitor and mitigate risks. The committee agreed to enhance governance and oversight of these via the Quality and Safety Committee.

Business Planning Board Assurance Statements:

- The committee discussed the draft Board Assurance statements.

Approval and Caveats to the plan:

- The Committee agreed to recommend approval of the budget to the Board in Common, with specific caveats added to the assurance statements, including the need for further assurance on quality impact assessments and the funding of activity growth.
- Further work was required around productivity calculations and benchmarking analysis.

3. Key highlights from the Trust Standing Committee Meeting on 3rd April 2025

3.1 CEO Report

The Committee noted the CEO report, key highlights and messages. The CEO's full report is provided in the Board in Common papers.

3.2 CQC Improvement Plan

The Committee received and discussed the CQC improvement plan noting the following:

- **Background and Context**: The improvement plan follows unannounced visits by the CQC in July and August of the previous year, focusing on the core services inspections. The plan addresses the CQC concerns received and aims to improve the overall rating. The committee noted the CQC reports from the recent inspections remain draft and are awaiting publication.
- **Governance and Oversight**: The governance structure involves monitoring through Hillingdon Care Quality Programme which reports into the Executive Management Board and Quality and Safety Committee.
- **Ongoing Monitoring**: The plan includes a cycle of focus on CQC readiness, peer reviews, and ward accreditation with broader metrics. The aim is to ensure sustainability and continuous improvement beyond just meeting CQC requirements.
- **Integration and Coherence**: There is an effort to integrate various CQC actions and ensure coherence across different areas, avoiding a fragmented approach. This includes differentiating between immediate CQC actions and long-term quality monitoring.

2.3 Board Committee Report and IQPR update – Quality & Safety

Highlights provided included: -

- **Patient Story and Cancer Care**: The Committee received a story from a patient who shared their ongoing colorectal cancer experience, highlighting the quick diagnosis and treatment, the support from the stoma team, and the challenges faced with communication from Hammersmith Hospital. The importance of trust and communication between hospitals was emphasized.
- **Maternity and Emergency Care**: Improvements were noted in the data sets for maternity and emergency care, which are now better and allow for clearer tracking. The committee discussed ongoing issues in the Emergency

Department (ED) and maternity services, including specific concerns around sonography.

- **Infection Rates and Control**: infection rates and control remain a significant concern despite ongoing actions and audits. While actions are in place, the situation is not yet at the desired level. Continuous monitoring and audits are ongoing.
- **Mortality Rates**: The discussion highlighted that while overall mortality rates are stable, there are variations due to changes in disease group models and coding practices. Efforts are being made to improve coding alongside regular engagement with local mortality groups and health authorities to ensure that no signals are missed regarding mortality issues
- **Staffing and Quality Impact**: The meeting also touched on the impact of staffing on quality, with a focus on ensuring safe staffing levels and addressing any potential quality or safety risks.

2.4 Board Committee Report and IQPR update – People

Highlights provided included: -

- **Staff Survey Results**: The staff survey results have plateaued after previous improvements. The committee emphasized the importance of integrating these results into the people strategy to address the areas for improvement.
- **Staffing Numbers**: Staffing numbers are a significant challenge and focus area. The business plan discussions have included this issue, and maintaining good performance in other areas is also crucial.
- **Quality of People Management**: The committee discussed the need to focus on the quality of people management, as the staff survey serves as a barometer for this. Improving people management quality is a key focus area moving forward.
- **Gender Pay Gap**: There was a discussion about the gender pay gap, with a noted 6.6% decrease over eight years. However, it was acknowledged that more work is needed. Succession planning and addressing both gender and ethnicity gaps were highlighted as areas needing improvement.
- **Cross-Trust Learning**: The committee noted the introduction of a senior Tri-Trust leadership team to bring together work around learning, development, organisational development (OD), and equality, diversity, and inclusion (EDI). This initiative aims to leverage the best practices across the three trusts.
- **Staff Engagement**: Emma emphasized the importance of shifting the tone to reflect pride in the organization and to attract new talent. This involves changing the narrative to highlight the positive aspects and opportunities within the organization.
- **Hotspots and Quality Impact Assessment**: The committee discussed overall staffing numbers and hotspots that may have substantial cost implications, particularly in terms of backfill and agency usage and the need to focus on specific hotspots that may have significant cost implications and create quality or safety risks. The importance of maintaining safe care and monitoring metrics was discussed.

2.5 Board Committee Report and IQPR update – Finance & Performance

The committee meeting scheduled in March 2025 was stood down to

accommodate an extraordinary standing committee to review the Trusts 2025/26 business plan.

The Trust standing committee noted the report from the Finance and Performance Committee from its meeting held on 25th February 2025.

2.6 Finance Report (M11)

Highlights provided included: -

At M11, the Trust is reporting a year-to-date deficit of £29.4m, which is £24.3m adverse to our plan, £22.9 adverse to our internal budget (realigned for CIP delivery).

The Trust's financial performance for month 11 continues the improvement in run rate, driven by income and reduced agency costs. The Trust remains on track with its recovery plan but recognises there is still much to deliver in Month 12.

Elective recovery with NWL ICB continues to show overperformance, as does underperformance against plan for border contracts. In Month the Trust recognised £1.5m of income for Environmental Controls following resolution of contracting issues with NHS England.

In month 11 the Trust is reporting a £27.1m deficit to NHSE, as part of a breakeven ICB position. This forecast includes the loss of planned ICB support and does not include the effects of potential investment property adjustments. The total benefits required to deliver the forecast, as a change to the current run rate, is £2.9m, which is down from £7.99m reported in M7.

2.7 Board Committee Report – Audit & Risk

Highlights provided included: -

- **Capital Projects Internal Audit Report**: The design was substantial, and the effectiveness of the control around that was Moderate. The committee has requested that benefits realisation should be looked at as part of regular evaluation and reported to the Finance Committee.
- **Draft Internal Audit Plan 2025/26**: The plan is being reviewed in conjunction with what's happening across the APC, considering areas where internal audits can be pulled together, such as procurement.
- **Non-compliance with Standing Financial Instructions**: There were 17 waivers to financial instructions last year, mainly due to insourcing. Monitoring non-compliance is being handled by the Northwest London procurement service.
- **Debtors and Creditors**: Issues with cash flow have impacted the better payment practice.
- **External Audit Recommendations**: Progress against last year's recommendations may be affected by the turnover and broader financial issues faced by Hillingdon.

- **Awards**: The estates and facilities team won several awards for green initiatives.

4. Positive assurances received

- **Maternity and Emergency Care**: The data sets have improved, allowing for better tracking and clarity.
- **Infection Rates and Control**: Actions are in place to address issues, and various audits and actions are ongoing.
- **Mortality Rates**: There is no extended problem with mortality, and regular conversations with local mortality groups ensure no signals are missed.
- **Cancer Care**: The position has improved immensely over the last three years, particularly in detecting and informing patients about cancer within 28 days.
- **Staff Survey Results**: Although results have plateaued, the integration of these results into the people strategy is seen as important.
- **Staffing Numbers**: The focus on staffing numbers is a key challenge, but there is a commitment to maintaining good performance in other areas.
- **Cross-Trust Learning**: The introduction of a Tri-Trust senior leadership team to bring together work around learning, development, and EDI is seen as beneficial.

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

The Trusts challenging financial position, covered in the BIC Finance report.

6. Concerns outstanding

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

6. Key actions commissioned

None

7. Decisions made

24th March 2025 – Business Plan 2025/26

- The Committee agreed to recommend approval of the budget to the Board in Common, with specific caveats added to the assurance statements, including the need for further assurance on quality impact assessments and the funding of activity growth.
- Further work was required around productivity calculations and benchmarking analysis.

8. Summary Agenda 24 March 2025

No.	Agenda Item	Purpose
1.	Business Plan 2025/26	To note
2.	Final NWL I&I Report (to note)	Assurance

9. Attendance 24 March 2025

Members	07 January 2025 attendance
Carolyn Downs, Vice Chair (Standing Committee Chair)	**Y**
Matthew Swindells, Chair – North West London Acute Provider Collaborative	**Y**
Baljit Ubhey, Non-Executive Director	**Y**
Martin Lupton – Non-Executive Director	**Y**
Linda Burke, Non-Executive Director	**Y**
Nick Gash, Non-Executive Director	**Y**
Patricia Gallan, Non-Executive Director	**Y**
Simon Morris, Non-Executive Director	**Y**
Mike O'Donnell, Non-Executive Director	**Y**
Vineeta Manchanda, Non-Executive Director	**Y**
Lesley Watts, Chief Executive Officer	**Y**
Jason Seez, Chief Infrastructure and Redevelopment Officer	**N**
Alan McGlennan, Managing Director/Chief Medical Officer	**Y**
Tracey Cotterill, Interim Chief Finance Officer	**Y**
Sarah Burton, Chief Nursing Officer	**Y**
Tina Benson, Chief Operating Officer	**N**
In attendance	
Janet Campbell, Associate Non-Executive Director	**N**
Virginia Massaro, Chief Finance Officer (CW)	**Y**
Peter Jenkinson – Director of Corporate Affairs	**Y**
Emer Delaney, Director of Communications	**N**
Neetu Sharma – Deputy Director of Strategy	**Y**
Jo Hunter – Director of Productivity and Efficienct	**Y**
Alexia Pipe, Chief of Staff to the Chair in Common	**Y**
Brenda Campbell – Corporate Governance Officer	**Y**
Vikas Sharma, Trust Secretary	**Y**

10. Summary Agenda 3 April 2025

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Chief Executive's report	To note	8.	Board committee report – Audit & Risk	To discuss
2.	CQC Improvement Plan	Assurance	9.	AOB	
3.	Integrated Quality and Performance Report	To note			
4.	Board Committee report & IQPR – Quality & Safety	To discuss			
5.	Board Committee report & IQPR – People	To discuss			
6.	Board Committee report & IQPR – Finance & Performance	To discuss			

7.	Finance report – month 11	To discuss			

11. Attendance 3 April 2025

Members	07 January 2025 attendance
Carolyn Downs, Vice Chair (Standing Committee Chair)	**Y**
Matthew Swindells, Chair – North West London Acute Provider Collaborative	**Y**
Baljit Ubhey, Non-Executive Director	**Y**
Martin Lupton – Non-Executive Director	**N**
Linda Burke, Non-Executive Director	**Y**
Nick Gash, Non-Executive Director	**Y**
Patricia Gallan, Non-Executive Director	**Y**
Simon Morris, Non-Executive Director	**Y**
Mike O'Donnell, Non-Executive Director	**Y**
Vineeta Manchanda, Non-Executive Director	**Y**
Lesley Watts, Chief Executive Officer	**Y**
Jason Seez, Chief Infrastructure and Redevelopment Officer	**Y**
Managing Director/Chief Medical Officer	**Y**
Virginia Massaro, Chief Finance Officer	**Y**
Sarah Burton, Chief Nursing Officer	**Y**
Tina Benson, Chief Operating Officer	**N**
In attendance	
Janet Campbell, Associate Non-Executive Director	**Y**
Peter Jenkinson, Director of Corporate Affairs	**Y**
Keving Croft, Chief People Officer	**Y**
Emer Delaney, Director of Communications	**Y**
Alexia Pipe, Chief of Staff to the Chair in Common	**Y**
Vikas Sharma, Trust Secretary	**Y**

7.2D CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

(LESLEY WATTS / PATRICIA GALLAN)

REFERENCES

Only PDFs are attached

7.2d0. CEO Board Report April 2025 CW FINAL.pdf

7.2d1. CWFT Standing Committee Chair's Report - Mar 2025.pdf

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

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

1.1 The Trust has a significant financial challenge and cost reduction plan for 2025/26, including a cost improvement programme (CIP) target of £33.5m (£10m higher than 2024/25) and reduction in elective funding, resulting in a further cost reduction of £10m. Our CIP identification for 2025/26 is at 70%, with a c£10m unidentified gap. This is a £0.8m pressure per month and therefore, non-recurrent means are required to be implemented from 1st April to mitigate the unidentified CIP gap until it is closed.

Our own operational plan for 2025/26 includes around £33.5m of savings/cost improvements as well as an absolute requirement for every service and team to manage within their budget. It is absolutely essential that we maintain a grip on our resources from day one of the financial year as we know that the challenge increases as the year progresses. To achieve this, will require a further organisational shift and accountability to cost improvement, ensuring our focus remains on high quality patient care. The implementation plan is currently being finalised, and will be approved and monitored closed through the organisation's governance.

1.2 We have undertaken a review of our executive team structure with a number of changes/appointments to strengthen our executive leadership and enhance collaboration in the Acute Provider Collaborative. These appointments are effective from 1 April 2025 and represent a new chapter for Chelsea and Westminster Hospital NHS Foundation Trust.

1.3 Our pioneering AI-driven tele-dermatology service has been hailed a Global first. Using world-first AI technology, the DERM AI app is able to process rapid and highly accurate skin cancer checks, autonomously discharging patients with benign lesions. This innovation has allowed us to see thousands of patients more efficiently, easing pressure on our dermatology teams and reducing waiting times and anxiety for patients on the suspected skin cancer pathway. This was featured in The Times and international media.

1.4 Our emergency department (ED) teams at both sites delivered an excellent performance over a 24-hour period - achieving a combined performance for the Trust of 83.1%. This has contributed to a combined A&E performance for March of 79.3% against the 78% standard (Chelsea 80.8% and West Middlesex

77.9%), and a combined year-to-date performance of 77.9%. Our teams have done significant work to reduce the number of patients experiencing long waits for treatment. At the start of this financial year, we had around 1,800 patients who had waited over 52 weeks for treatment, in March it was reported at 403 and is continuing to reduce daily.

1.5 In partnership with the London Fire Brigade (LFB), we successfully led a major live fire evacuation drill in the paediatric ward at West Middlesex University Hospital. The mock exercise tested response times, staff coordination, and evacuation procedures in a challenging environment with poor visibility, loud alarms, and trip hazards. Volunteers and staff played a crucial role in ensuring a realistic and rigorous scenario. These simulations are a vital part of testing our preparation and resilience in emergency response planning.

1.6 BAFTA Award for MediCinema: our cinema which provides a positive experience to many of our patients was honoured with the Outstanding British Contribution to Cinema award. The charity provides therapeutic cinema experiences to adults and children in NHS hospitals. Now, after 25 years, the work of MediCinema –for which Chelsea is one of the original sites across the UK is being recognised with BAFTA's Outstanding British Contribution to Cinema.

1.7 Marking our 10-year merger of Chelsea and West Middlesex, we are leading on a site-to-site walk on 28 September, to mark a decade since Chelsea and West Middlesex merged into one Trust. Staff and the public will walk from Chelsea and Westminster Hospital to West Middlesex Hospital (the scenic route along the Thames). Please do join us.

2. Quality and Safety

2.1 The rate of Inpatient Falls was 3.3 in February (per 1000 occupied bed days) below Trust target of 4.6 and below the national average of six.

2.2. 47 hospital acquired pressure ulcers and moisture associated skin damage were reported in February, a rate of 1.6 per 1000 bed days, above the Trust's threshold of 1.0.

2.3 Complaints response time remains strong with 25 complaints received in February, the lowest in the last 12 months and for the first time since July 23, we are meeting the Trust target of < 25. Taking the lessons from complaints is a key element of our learning culture.

2.4 As we aim to deliver high-quality patient-centred care, it is essential to focus our resources on initiatives where data, national and local priorities indicate a need for improved patient safety, experience, addressing health inequalities, and clinical effectiveness. Extensive data collection and information gathering have highlighted the importance of the selected quality priorities.

These initiatives have been chosen based on an analysis of patient outcomes, incident reports, and compliance with national healthcare standards. Throughout the business planning process, we have worked with divisions to

ensure that their unique insights and needs were considered. This collaboration has been instrumental in defining our priorities for 2025/26 as follows:

- Deteriorating Patient (PEWS)
- Implementation of NatSSIPs2
- Violence and Aggression
- Reducing medication incidents with moderate harm or above
- Single Delivery Plan
- Dementia
- Deteriorating Patient (SEPSIS)

3.0 Operational performance

3.1. A&E 4-hr Waiting Times

In February 2025, the Trust A&E 4-hour reported target was 74.11%. The Trust met the NHS England Cancer 28- Day Faster Diagnostics Standards whist the 31-Day, 62-Day were non-compliant in January 2025.

The 74.11% A&E performance represented a slight reduction from January's performance and below the national target. The flow remains challenged across both sites with a sustained increase in long-stay MH patients and discharge to assess (DTAs) remaining in ED.

3.2 18 Weeks RTT

Elective Referral to Treatment (RTT) 18-Week Wait performance decreased in February 2025, reported at 60.72%. Elective admitted and outpatient activity levels are above operational plans.

For February 2025, the total RTT Patient Treatment List (PTL) increased to 64,944 (+503), 52ww reduced to 537 (-132), 65ww reduced to 19 (-2) and there is one patient waiting above 78ww. For the 65ww position of the 19 breaches, one is complex, four relate to patient choice and 14 are due to capacity.

The focus is backlog eradication for the 65ww, continually addressing chronological booking for the 52ww backlog cohort and long-waiting pathways as enhanced oversight and targeted interventions continue for at-risk specialities.

4. Financial performance

4.1. At M11, the Trust remains on track for a break-even position at year end.

4.2. The Trust's financial performance for month 11 continues the improvement in run rate, driven by income and reduced agency costs. The Trust remains on track with its recovery plan but recognises there is still much to do in Month 12.

4.3 The Trust's 2025/26 operating plan was approved by the board on 27 March

at a breakeven position. The plan includes a cost saving requirement of £33m with an additional £10m reduction required due to the Elective Recovery Fund cap.

4.4 The Trust has implemented a number of steps for a step change in cost reductions. We are determined to treat as many patients as possible, to continue to look after our staff and of course do this within the determined financial constraints.

4.5 Implementation of the Trust's business plan will be monitored closely throughout the organisation's governance and through the Finance and Performance Committee.

5. People

5.1 I am delighted to announce the following appointments to strengthen our executive leadership across both Chelsea and Westminster NHS FT and the Hillingdon Hospital's NHS FT, making the best use of our resources and leadership:

- Virginia Massaro (Previously chief finance officer at Chelsea) – has been appointed as the chief finance officer for both Chelsea and Hillingdon.
- Kevin Croft (Previously chief people officer at Imperial) – has been appointed as the chief people officer for Imperial, Chelsea and Hillingdon.
- Jason Seez (Previously deputy CEO at Hillingdon) - has been appointed as the chief infrastructure and redevelopment officer for both Chelsea and Hillingdon
- Peter Jenkinson (Previously director of corporate governance for Imperial and Chelsea) – has been appointed as the director of corporate governance for Imperial, Chelsea and Hillingdon.
- Emer Delaney (Previously director of communications at Chelsea) – has been appointed as the director of communications for both Chelsea and Hillingdon.
- Osian Powell (Previously Divisional Director of Operations for Planned Care) has been appointed Director of Transformation for Chelsea and Westminster.

5.2 Annual NHS Staff Survey results

The 2024 annual staff survey results reported us as performing significantly better than the national average in a number of areas, including staff engagement, morale, learning, flexible working and staff feeling safe and healthy. This year, we will be focusing more on respect, understanding others' roles, and harassment and bullying—experiencing harassment, bullying or abuse from colleagues.

Standout results

- Number one for learning culture in all London NHS providers
- 84% of staff agreed that Care of patients is my organisation's top priority.
- An increase in colleagues recommending Chelsea and Westminster as one of the top places to work in London, well above the sector average.
- Out of the nine NHS People Promise themes, we scored significantly above the national benchmark in eight.
- An increase in the Trust takes positive action on health and well-being for staff. This includes increases in staff feeling they have the opportunity and ability to access learning and development and improved scores on questions relating to support and relationships with immediate line managers.

5.3. We wished farewell to Chief People Officer, Lindsey Stafford-Scott, who left after almost four years at the Trust. During her time here, Lindsey has helped transform the organisation from transitioning payroll providers, implementing new core HR operating model and supporting the Trust create a positive workplace culture.

5.4 Generation Smoke Free —12 March

We supported National No Smoking Day on 12 March as an important reminder of the impact of second-hand smoke in a hospital setting. The government's Tobacco and Vapes Bill aims to protect children and the most vulnerable by targeting settings such as hospitals and playgrounds where there is prolonged exposure to second hand smoke. We have a duty of care to protect the health of those who use or work in our services and to promote healthy behaviour.

.

6. Updates from the Council of Governors (CoG)

6.1 The CoG formally met in public on 23 January 2025. The CoG received the annual report from the Chair of the People and Workforce Committee, a briefing on Quality and made plans for the away day. New members, elected in late 2024 were welcomed to the meeting.

7. Research and innovation

7.1 56 Dean Street and sexual health services welcomed DHSC, UKHSA, and NHS England representatives to discuss HIV prevention, treatment, PrEP use, and support services. The visit was a successful showcase of the innovative work that the service provides.

8. Equity, diversity and inclusion

8.1 We recognised Ramadan, for our staff and community in Chelsea and Westminster Hospital as an important period of reflection, compassion and togetherness. Many of our staff celebrated Eid-al-Fitr with their friends and family recently and a number of staff shared welcome treats with their

colleagues on the day. Thanks to the generosity of local charity, Aariyan and Bader Community Initiative and the support of local Councillor, Samia Chaudhary, 50 Iftar food gifts were donated to staff at West Middlesex Hospital who were observing Ramadan.

8.2 International Women's Day was marked with a series of events open to all colleagues, including an all staff webinar (run by our Women's Network) and a series of inspirational online talks held across the sector

9. Recognition and celebrating success

9.1 Congratulations to Cormack Mylchreest who won Newcomer of the Year at this year's MyPorter Awards. The awards shine a spotlight on remarkable individuals and teams within healthcare porter and domestic services.

Cormack who was born at Chelsea and Westminster Hospital, and has been diagnosed with cerebral palsy, works as an ISS Healthcare Porter for two days and volunteers for three days. He continues to be a beloved and recognised colleague and always manages to leave a smile on every face he meets.

9.2 We have been recognised at the HSJ Partnership Awards 2025 for our commitment to innovation, collaboration, and excellence in patient care. Our Sexual Health London (SHL) e-service, which has revolutionised access to sexual health testing while significantly reducing plastic waste won Environmental Sustainability Project of the Year.

We also received the award for Most Effective Contribution to Improving Cancer Outcomes for our pioneering AI-powered tele-dermatology service, improving early cancer detection and patient outcomes. Additionally, our AI integration in dermatology received high commendation for Effective Contribution to Integrated Health and Care.

9.3 On National Apprenticeship Week (10–16 February), we recognised the impact of our apprenticeships and the contributions of our staff. We hosted a number of workshops and events to celebrate the week. Thanks to colleagues who shared their inspirational stories on their apprenticeship journey.

9.4 Jasjit Syan, Clinical Research Fellow in Cardiology at the Trust, recently presented at the Royal Society of Medicine's annual health inequalities conference. He led a session on how wearable devices impact clinical outcomes and the challenges of digital health adoption, particularly for underrepresented communities. The session explored practical solutions, including co-designing digital health tools with underrepresented communities, improving accessibility and leveraging community-based initiatives to support uptake.

9.5 To mark Endometriosis Action Month, our women's health teams held patient engagement sessions at both sites. At Chelsea, nearly 40 patients attended a panel discussion and Q&A with our gynaecology, endometriosis, colorectal

and gastroenterology consultants and physiotherapists. A new art piece by patient and photographer Natalie Blake was also unveiled which will go up in the gynaecology outpatient department. At West Mid, Lauren Trepte, Research Midwife led a listening event for 15 patients, supported by Natalie Nunes, Consultant Gynaecologist, to explore a variety of themes including nutrition, barriers to care, research, treatment advances and more.

9.6 We have Women's Health Group, led by our colleagues Archana Dixit, Natasha Singh and Darshana Rathod, hosted the Punjabi Women's Health Group event—an open conversation about women's health with members of the Punjabi community. Local Punjabi women shared personal insights into the health needs of their community and discussed how their needs can be met, focusing on topics including dementia, mental health, and care of elderly women.

Chelsea and Westminster NHS Foundation Trust (CWFT) Standing Committee Chair's Highlight Report to the North West London Acute Provider Collaborative (NWL APC) Board in Common (BiC) – for discussion
March 2025

Highlight Report

1. Purpose and Introduction

1.1 Each Trust within the North West London (NWL) Acute Provider Committee (APC) has established a local Trust Standing Committee following a decision at the April 2024 Board in Common (BiC) meeting in line with the wider review of the APC and local Trusts' governance.

1.2 The Committee will meet on a quarterly basis in advance of the BiC. The role of the Trust Standing Committee is to oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

2. Key highlights

2.1. Overview from extraordinary business planning meeting held on 26th March 2025

The Trust is reporting a £60m adverse variance to plan against a £50m planned deficit. A revised break-even plan has been developed, supported by £16.1m ICB funding, increased CIP targets (+£5m), and a freeze on unapproved investments. Capital plans have been updated to £63m.

Productivity and cost-efficiency remain key focus areas, with workforce reductions (net 243 FTE), tighter vacancy controls, and significant reductions in agency and bank spend planned (30% and 15% respectively).
Performance continues to improve, particularly in RTT, cancer standards, and bed flow. The next phase of the frailty strategy is set to launch. Follow-up rates are under review, with potential for clinically appropriate service rationalisation.
Work is ongoing to optimise theatre scheduling, standardise rostering, and enhance workforce planning—shifting toward input-based staffing models with measurable outcomes.

Cross-Trust collaboration remains essential, with a shared ambition to deliver a 4% productivity improvement. A forensic review will be conducted to understand financial performance variances across NWL Trusts.

Board Assurance Statements will reflect key risks and mitigations to those risks, including elective/non-elective demand assumptions, capacity, and system pressures, and the introduction of in-year "true-up" funding mechanisms.

2.2 Chief Executive's Report
The Chief Executive Officer (CEO) presented the report, which is provided in full to the BiC. The CEO reported on the current pressures within hospital sites and work underway to maintain safe care.

The CEO updated committee members the Trust met its financial targets for the year 2024/25, with most objectives achieved. Implementation of the 2025/26 plan is underway, with risks to delivery acknowledged. At the recent EMB meeting, a solid financial plan was presented, including a realistic 50% reduction in growth. The CEO expressed pride in the progress made and highlighted productive discussions with consultants to align expectations.

2.3. Integrated Quality and Performance Report (IQPR) – November (M11)
The Committee was updated on operational performance, noting progress made, but recognising improvement required in achieving the 4-hour delivery target, with March at 79.9% and April at 78%.

Reductions in the longest waiting patients continued, with RTT performance stands at 60%, with significant reductions in long waits (78 weeks eliminated, and patients waiting reduced from 2,000 to 300).

Cancer performance remains strong, especially for the 62-day target, with ongoing urology work and compliance with 31-day metrics

Diagnostic performance DOM01 achieved 96% compliance. A clinical harm review is underway, and tumor site audits are being reviewed annually. Urology pathway improvements across three trusts are progressing well.

In response to questions regarding corridor care, although challenges with temporary escalation areas persist.

2.4. Quality Report and Safeguarding Annual Report
The Committee was advised on the outcome of the most recent Quality Committee, with several areas highlighted for attention.

The organisation has exceeded expectations in C. difficile assurance, with no evidence of strain overlap or cross-infection identified.

Three Never Events were reported, with one resolved and two under ongoing investigation; improvements are being implemented through the APC working group to standardise procedures.

The mortality rate remains the lowest recorded, and under the Patient Safety Incident Response Framework (PSIRF), 13 open learning events are in progress, with updates expected at the next meeting.

Progress continues in addressing staff safety, particularly around violence and aggression, through a dedicated working group. The Trust has exceeded targets in

sepsis management and feeding practices, with ongoing focus on the care of deteriorating patients. Dementia screening rates remain above 95%, with work underway to improve consistency and care standards, particularly for patients outside of acute settings.

In maternity services, significant improvements have been made following a serious adverse event, including better escalation procedures, enhanced record-keeping, and strengthened support for newly qualified staff. While maternity staffing levels have improved, there are ongoing concerns around skill mix and reliance on agency staff, with increased emphasis on training and preceptorship.

The Trust has made substantial changes to safety protocols, foetal monitoring, CNST compliance, and staff training as part of its continued commitment to learning and quality improvement.

There was one Never Event reported regarding a retained vaginal swab which is being investigated in line with patient safety methodology.

Efforts are ongoing to balance cultural expectations with financial pressures, ensuring safe staffing levels and care standards are maintained.

The organisation has handled a high-profile case with transparency, effectively addressing both legal and public concerns while maintaining ongoing engagement with the Coroner. An update was provided on a recent Coroner's case, including the receipt of a Regulation 28 notification, to which a formal response has been submitted. A meeting with the Coroner has also taken place, attended by the Chief Executive Officer and the Chief Medical Officer. It was confirmed that the process for providing advance notification to the Board regarding high-risk inquests has been reviewed, with the aim of offering greater assurance to the Executive. Going forward, the Board will be informed in advance of such inquests, with all relevant background information provided.

The Committee noted the following reports, which had been considered at the Quality Committee meeting:

- Annual Safer Staffing Report
- Q3 Learning from Deaths Report

2.5. Finance Report, including Committee Chair's Report

The Committee was advised that the organisation successfully achieved a breakeven position at year-end and delivered against the capital plan, with a significant proportion of spend occurring in Month 12. Plans for 2025/26 are already in place.

Overall, this is a positive financial outcome, and continued focus will be required. Key headlines are detailed within the full report.

Regarding receivables, 365-day debt has reduced, with overseas debt notably decreasing in Month 12. Payments from local authorities have largely been received. However, embassy-related debt remains an area requiring further action, as payments continue to be slow.

2.6. People and Workforce Report, including Committee Chair's Report
The Committee considered the latest report which demonstrated overall positive performance, with a low vacancy rate and nearing achievement of the turnover target. Sickness rates were reported as down since the last meeting, however winter viruses were beginning to have an impact and the rate remained slightly above the target rate.

The areas cited for improvement were in line with the previous focus on personal development review (PDR) compliance which continues to sit below target. A new PDR window has been initiate to ensure that objectives are met throughout and achievement of the Model Employer Goals (MEG) regarding increased diversity at senior leadership levels.

Cultural issues are being addressed through triangulated staff and patient data. The staff survey response rate was 52%, with improvements achieved in 9 areas. Work on the People Plan continues, with a six-month progress update to follow.
Key areas of focus:

- Bullying and harassment
- Violence and aggression
- Flexible working

The Committee acknowledged the positive response levels in the recent staff survey, following a thorough discussion. However, it was also noted that the Trust remains an outlier in certain areas of concern. The Committee requested a further update with additional details, addressing both internal and external factors. The full People Survey will be circulated to all Board members.

2.7. Audit and Risk Committee (ARC) Chair's Report
The ARC Chair provided a summary of the March meeting, including A productive meeting was held, with several key areas of assurance reviewed. A new audit partner from Deloitte, Kate Waite, was introduced. Deloitte reaffirmed the organisation's status as a Public Interest Entity.

The following assurance ratings were noted:

- Freedom to Speak Up (FTSU): Moderate assurance; noted under-resourcing and team changes
- Cost Improvement Programme (CIP): Mixed assurance—moderate and substantial across different areas.
- Pharmacy Stocktaking: Moderate assurance.
- Falls Management: Substantial assurance—commendation given to the teams involved.
- Board Assurance Framework (BAF) maturity continues to improve, with further actions taken where performance declined.
- Cyber Security: Work is ongoing to strengthen password management and phishing protections. The team is actively addressing identified risks.
- An update regarding the appointment of external auditors was provided.

2.8. Board Assurance Framework (BAF)
The current version of the Board Assurance Framework reflects feedback from the most recent cycle (Q4) and was presented at the Audit & Risk Committee. The year-end

position has been updated in the Annual Report to align with risk and business planning priorities. The structure and format remain consistent across APC submissions and will continue to evolve in line with 2025/26 planning.

Committee Effectiveness:
While response rates have been low, initial findings suggest consistency in key themes. Efforts are ongoing to improve the quality and standardisation of papers through aligned templates and expectations. Committee chairs are engaged in supporting this improvement.
The environment continues to support open and constructive conversations, enabling honest reflections and continuous development.

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

There are no key risks / topics from this report which require escalation to the BiC.

4. Concerns outstanding

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

5. Key actions commissioned

Audit Chairs to discuss arrangements for sign off of annual accounts and reports.
An update and further details regarding the staff survey implementation plans to be discussed in October meeting.

6. Decisions made

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

7. Summary Agenda

The agenda for the June meeting of the Standing Committee was as follows:

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Chief Executive's report	To discuss	7.	Board Committee Report – Audit & Risk	To discuss
2.	Integrated Quality and Performance Report	To discuss	8.	Trust strategy review	
3.	Quality Report Board Committee Reports: Safeguarding Annual Report	To discuss To note	9.	Annual reports: Seven day services annual report Guardian of Safe Working Annual Report Raising Concerns Annual Report incorporating	

				FTSU, raising concerns, whistleblowing and LCFS)	
4.	Finance Report Board Committee Report – Finance & Performance	To discuss	10.		
5.	People and Workforce Report Board Committee Report – People & Workforce	To discuss			

8. Attendance

Members:	March attendance
Patricia Gallan, Vice Chair and Senior Independent Director (SID) - Chair	Y
Matthew Swindells, Chair in Common, NWL APC Chair in Common	Y
Mike O'Donnell, Non-executive Director	Y
Vineeta Manchanda Non-executive Director	Y
Ajay Mehta Non-executive Director	Y
Dr Syed Mohinuddin Non-executive Director	Y
Carolyn Downs Non-executive Director	Y
Catherine Williamson Non-executive Director	Y
Members:	March attendance
Aman Dalvi, Non-executive Director	Y
Dame Helen Stephenson, Non-executive Director	Y
Lesley Watts CBE, Chief Executive Officer	Y
Roger Chinn, Chief Medical Officer	Y
Robert Bleasdale, Chief Nursing Officer	Y
Virginia Massaro, Chief Financial Officer	Y
Kevin Croft , Chief People Officer	Y
Sheena Basnayake, Managing Director (West Mid - WM)	Y
Laura Bewick, Managing Director (Chelsea - CW)	Y
Natasha Singh, Board Adviser, Equality Diversity & Inclusion (EDI)	Y
Emer Delaney, Director of Communications	N
Peter Jenkinson, Director of Corporate Governance	Y
Chris Chaney, Chief Executive Officer, CW+	Y
Attendees:	
Faye McLoughlin, Corporate Governance Officer	Y

Marie Price, Deputy Director of Corporate Governance	N
Alexia Pipe, Chief of Staff to NWL APC Chair in Common	Y

8. REPORTS FOR INFORMATION ONLY

8.1 USE OF THE TRUST SEAL (PETER JENKINSON)

REFERENCES

Only PDFs are attached

8.1 BIC Trust seal annual report 24-25.pdf

NWL Acute Provider Collaborative Board in Common (Public)
29/04/2025
Item number: 8.1
This report is: Public

Trust Seal Annual Report

Author: Jessica Hargreaves

Job title: Deputy Director of Corporate Governance, ICHT

Accountable director: Peter Jenkinson & Dawn Clift
Job title: Director of Corporate Governance (ICHT & CWFT) & Director of Corporate Affairs (LNWH)

Purpose of report

Purpose: Information or for noting only

The Trusts' standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis. The report includes the use of the Trust seal during FY 2024/25 for all four Trusts within the Acute Provider Collaborative.

The Board in Common is asked to note the report and the use of the Trust Seal.

Report history

Outline committees or meetings where this item has been considered before being presented to this meeting: N/A

Executive summary and key messages

The Trust's standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis. This report includes the use of the Trust seal during FY 2024/25 for all four Trusts within the Acute Provider Collaborative.

The Board in Common is asked to note the report and appendices and the use of the Trust Seal.

The appendices detail each Trust's use of their seal:

Appendix 1: Chelsea & Westminster NHS Foundation Trust
Appendix 2: The Hillingdon Hospitals NHS Foundation Trust

Appendix 3: Imperial College Healthcare NHS Trust
Appendix 4: London North West University Healthcare NHS Trust

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Reporting use of the Trust seal enables review of the contracts, property agreements and other documentation that has been entered into during the year, acting as a control to reduce risk of misuse

Reason for private submission

Tick all that apply

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

If other, explain why

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Appendix 1

Use of the Trust Seal - CWFT

This report covers the period 1 April 2024 to 31 March 2025.

Seal No.	Date	Description of document sealed	Signed by
230	12/04/2024	CWFT+ Bouygues UK Ltd. Contract relating to design, construction and completion of a new Ambulatory Diagnostic Centre at WMUH incorporating the conditions of the Jet Design and build contract 2016	Virginia Massaro and Roger Chinn
231	03/06/2024	Parent Company Guarantee between Bouygues Construction and Chelsea and Westminster Hospital NHS Foundation Trust	Roger Chinn and Robert Bleasdale
232	03/06/2024	Parent Company Guarantee between Bouygues Construction and Chelsea and Westminster Hospital NHS Foundation Trust	Roger Chinn and Robert Bleasdale
233	17/10/2024	Founding agreement Ambulatory Diagnostic Centre (ADC) CW Hospital between Chelsea and Westminster NHS Foundation Trust and the Mayor and Burgesses of the London Borough of Hounslow	Virginia Massaro and Lesley Watts
234	06/02/2025	Deed of Variation of JCT Design and Build Contract in Relation to Design, Construction and Completion of New Ambulatory Diagnostic Centre at WMUH (Dated 12 April 2024) between CWH NHS FT and Bouygues (UK) Ltd.	Virginia Massaro and Other signature - Bouygues (UK) Ltd.

The Hillingdon Hospitals
NHS Foundation Trust

Appendix 2

Use of Trust Seal - THHFT

The report covers the period 1 April 2024- 31 March 2025

Seal No.	Description of document sealed	Parties	Signed by		Date Signed & Sealed
0038	Lease Relating to Land at Mount Vernon	Between THHFT and Tenant : On Tower UK Ltd	Patricia Wright	CEO	17/04/2024
			Jon Bell	CFO	17/04/2024
0039	Tower Lifts UK & Western Buildings	Between THHFT Tower Lifts and Western Buildings	Patricia Wright	CEO	07/06/2024
			Jon Bell	CFO	07/06/2024
0040	Bailey Partnership (consultants) LLP & Western Building Systems	Between THHFT Bailey Partnership & Western Buildings	Patricia Wright	CEO	07/06/2024
			Jon Bell	CFO	07/06/2024
0041	Bailey Partnership (consultants) LLP & Western Building Systems	Between THHFT Bailey Partnership & Western Buildings	Patricia Wright	CEO	07/06/2024
			Jon Bell	CFO	07/06/2024
0042	Vodaphone Deed of Surrender	Between THHFT and Vodaphone	Patricia Wright	CEO	07/06/2024
			Jon Bell	CFO	07/06/2024
0043	Leases and Car parking licences of premises at Mount Vernon Hospital to East and North Herts NHS Trust	Between THHFT and East and North Herts	Patricia Wright	CEO	30/08/2024
			Jon Bell	CFO	30/08/2024
0044	JCT - ICD 2016 Intermediate Building Contract - Electrical Infrastrucutre Upgrade Mount Vernon	Between THHFT and WT Partnerships	Patricia Wright	CEO	19/12/2024
			Tracey Cotterill	ICFO	19/12/2024
0045	JCT - ICD 1016 Intermediate Building Contract - Hillingdon Hospital Endoscopy Refurbishment	Between THHFT and Storm Building Limited	Patricia Wright	CEO	19/12/2024
			Tracey Cotterill	ICFO	19/12/2024

Imperial College Healthcare NHS Trust

Appendix 3

Use of the Trust Seal - ICHT

This report covers the period 1 April 2024 – 31 March 2025

Seal number	Parties	Description of document sealed	Signed by	Date sealed
288	Imperial College Healthcare NHS Trust and R Naish, D.D. Ross and R. Campbell and R. Dhugold	Three year lease renewal for rooms in GP practice in Hanwell to provide breast screening 01/04/24 – 31/03/27	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	11/4/24
289	Imperial College Healthcare NHS Trust and Rambolt UK Ltd	For provision of ground and site surveying services relating to CXH, HH and QCCH	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	19/4/24
290	Imperial College Healthcare NHS Trust and UK Research and Innovation	Deed of surrender and lease of ground floor of Mansfield Building, Hammersmith Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	26/6/24
291	Imperial College Healthcare NHS Trust and LP HCS Ltd	Novation of licensee to provide outpatient dispensary services due to internal restructure by Lloyds	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	26/6/24
292	Imperial College Healthcare NHS Trust and Third Party Contractors	Collateral warranties relating to LMS development at Hammersmith Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	26/6/24
293	Imperial College Healthcare	Standard JCT contract for building and	Professor Tim Orchard, Chief	26/6/24

Seal number	Parties	Description of document sealed	Signed by	Date sealed
	NHS Trust and T&B Contractors Ltd	construction work relating to replacement of 3T MRI scanners	Executive Eric Munro, Director of Estates and Facilities	
294	Imperial College Healthcare NHS Trust and Vertex Pharmaceuticals	For supply of exacel – cell collection agreement for gene therapy	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	21/10/24
295	Imperial College Healthcare NHS Trust and Cornerstone Telecommunications Infrastructure Ltd	Upgrade works to telecoms equipment	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	22/10/24
296	Imperial College Healthcare NHS Trust and LP HCS and L.Rowland and Company (retail) Limited	License to assign all out patient dispensing pharmacy services leases at the three hospital sites	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	11/12/24

Appendix 4

Use of the Trust Seal – LNWH

This report covers the period 1 April 2024 to 31 March 2025

Seal No.	Date of sealing	Date of authority	Description of document sealed	Name of person attesting sealing
2024/04	16/10/24	16/10/24	Lease and licence for alternations – Retail unit, level 2, Main Entrance, Ealing Hospital, Uxbridge Road, Southhall UB1 3HW	Jonathan Reid, Chief Financial Officer Pippa Nightingale, Chief Executive
2024/05	24/10/24	24/10/24	Lease related to land on east side of Central Way Park Royal London between sovereign network homes, London North West University Healthcare NHS Trust and MNA Electricity Ltd	Pippa Nightingale , Chief Executive James Walters, Chief Operating Officer
2024/06	24/10/24	24/10/24	Deed of Indemnity related to Sobstaron lease on lad to east side of Central Way, Park Royal London and related access requirements between Sovereign Network Homes and London North West University.	Pippa Nightingale, Chief Executive James Walters, Chief Operating Officer
2024/07	31/10/24	31/10/24	Deed of agreement variation for provision of certain soft FM services between London North West University Healthcare NHS Trust Compass Contract Services (UK) LTD (T/A Medirest)	Jonathan Reid, Chief Financial Officer Simon Crawford, Deputy Chief Executive
2024/08	20/12/24	20/12/24	Deed of indemnity relating to deed of easement relating to the roadway and adjoining land at Central Middlesex Hospital. Sovereign Network Homes and London North West University Healthcare NHS Trust	Don Richards, Interim Chief Financial Officer J Walters, Chief Operating Officer
2024/09	20/12/24	20/12/24	Licence for alterations between London North West University Healthcare NHS Trust and The Royal Free London NHS Foundation Trust	Don Richards, Interim Chief Financial Officer

				J Walters, Chief Operating Officer
2024/10	20/12/24	20/12/24	Lease relating to Part of block W Level 3 North West University Healthcare NHS Trust and Royal Free London NHS Foundation Trust.	Don Richards, Interim Chief Financial Officer J Walters, Chief Operating Officer
2024/11	20/12/24	20/12/24	Deed of Easement for Roadway list at Central Middlesex Hospital between London North West University Healthcare NHS Trust and Sovereign Network Homes.	Don Richards, Interim Chief Financial Officer J Walters, Chief Operating Officer
2025/01	17/02/25	17/02/25	Deed of variation between London North West University Healthcare NHS Trust and by Central Limited and Central Middlesex Hospital Project Limited	Pippa Nightingale, Chief Executive Simon Crawford, Deputy Chief Executive

9. ANY OTHER BUSINESS

10 QUESTIONS FROM MEMBERS OF THE PUBLIC (MATTHEW SWINDELLS)

11. DATE OF THE NEXT MEETING: 15 JULY 2025