



**North West London
Acute Provider Collaborative**

**NORTH WEST LONDON ACUTE
PROVIDER COLLABORATIVE BOARD IN
COMMON PUBLIC 15TH OCTOBER 2024**



NORTH WEST LONDON ACUTE PROVIDER COLLABORATIVE BOARD IN COMMON PUBLIC 15TH OCTOBER 2024




15 October 2024



13:00 GMT+1 Europe/London



Hammersmith Hospital, W12 Conference Centre, Artillery Lane, 150 Du Cane Road,
London, W12 0HS




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1. WELCOME AND APOLOGIES FOR ABSENCE

 Chair in Common Matthew Swindells

REFERENCES

Only PDFs are attached



0. Agenda NWL APC BiC Public Board October 24 - FINAL.pdf

**North West London Acute Provider Collaborative
Board in Common - Public
Tuesday 15 October 2024, 13.00-16.00**

**W12 Conference Centre, Hammersmith Hospital, Artillery Lane,
150 Du Cane Road, London, W12 0HS**

Members of the public are welcome to join this meeting in person or by Microsoft Teams, via the following link: [APC Public Board in Common](#) (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 chelwest.corporategovernance@nhs.net but this is not a requirement, you can ask new questions on the day. Any questions that are submitted in writing but are not addressed in the meeting due to time will be answered in writing on the Acute Provider Collaborative (APC) website.

A G E N D A

Time	Item No.	Title of Agenda Item	Lead	Enc
13.00	1.0	Welcome and Apologies for Absence	Chair in Common Matthew Swindells	Verbal
	1.1	Declarations of Interest	Matthew Swindells	Verbal
	1.2	Minutes of the previous NWL Acute Provider Collaborative Board Meeting held on 16 July 2024	Matthew Swindells	1.2
	1.3	Matters Arising and Action Log	Matthew Swindells	1.3
	1.4	Patient Story <i>To note the patient story</i>	Lesley Watts	1.4
2. Strategy/planning				
13.15	2.1	Winter – Update on Urgent and Emergency Care Action Plans across the APC <i>To receive latest position on planning for winter</i>	Lesley Watts	2.1
	2.2	Business Plan Progress Report Months 1-6 <i>To receive latest position on progress</i>	Jazz Thind	2.2 2.2a
3. Report from the Chair in Common				
13:35	3.1	Report from the Chair in Common <i>To note the report</i>	Matthew Swindells	3.1
	3.2	Board in Common Cabinet Summary <i>To note any items discussed at the Board in Common Cabinet meetings</i>	Matthew Swindells	3.2

Time	Item No.	Title of Agenda Item	Lead	Enc
4. Integrated Quality and Performance Report				
13:45	4.1	Integrated Quality, Workforce, Performance and Finance Report <i>To receive the integrated performance report</i>	Lesley Watts Patricia Wright Pippa Nightingale	4.1 4.1a
5. Quality				
13:55	5.1	Collaborative Quality Committee Chair Report <i>To note the report</i>	Steve Gill	5.1
	5.2	Learning from Deaths Quarterly Report <i>To note the report</i>	Chief Medical Officer	5.2
	5.3	Complaints Annual Report – APC Summary <i>To note the report</i>	Lisa Knight	5.3
6. Workforce				
14:15	6.1	Collaborative People Committee Chair Report <i>To note the report</i>	David Moss	6.1
	6.2	Freedom to Speak Up Annual Report – APC Summary <i>To note the report</i>	Lindsey Stafford-Scott	6.2 6.2a
7. Data and Digital				
14:30	7.1	Collaborative Data and Digital Committee Report <i>To note the report</i>	Steve Gill	7.1
8. Estates and Sustainability				
14.40	8.1	Collaborative Strategic Estates and Sustainability Committee Report <i>To note the report</i>	Bob Alexander	8.1
9. Finance and Performance				
14:50	9.1	Collaborative Finance and Performance Committee Chair Report <i>To note the report</i>	Carolyn Downs	9.1
	9.2	Financial Performance Report <i>To receive the financial performance report</i>	Jazz Thind	9.2 9.2a
10. Chief Executive Officers				
15:10	10.1	Executive Management Board (EMB) Summary <i>To note any items discussed at the EMB meetings</i>	Tim Orchard	10.1
	10.2	Reports from the Chief Executive Officers and Trust Standing Committees <i>To note the reports</i> <ul style="list-style-type: none"> London North West University Healthcare NHS Trust 	Pippa Nightingale/ David Moss Patricia Wright/ Carolyn Downs	10.2a, b 10.2c, d

Time	Item No.	Title of Agenda Item	Lead	Enc
		<ul style="list-style-type: none"> The Hillingdon Hospitals NHS Foundation Trust Imperial College Healthcare NHS Trust Chelsea and Westminster Hospital NHS Foundation Trust 	Tim Orchard/ Bob Alexander Lesley Watts/Steve Gill	10.2e, f 10.2g, h
11. Reports for Information Only				
	11.1	Nil Advised		
12. Any Other Business				
	12.1	Nil Advised		
13. Questions from Members of the Public				
15:35	13.1	The Chair will initially take one question per person and come back to people who have more than one question when everyone has had a chance, if time allows.	Matthew Swindells	Verbal
Close of the Meeting				
Date and Time of the Next Meeting				
21 January 2024				
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)				

1.1 DECLARATIONS OF INTEREST


 Matthew Swindells

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

 Matthew Swindells

REFERENCES

Only PDFs are attached

 1.2 Draft BiC public minutes 16 July 2024 FINAL.pdf

North West London Acute Provider Collaborative Board in Common

Meeting in Public

Tuesday 16 July 2024, 09.00-12.00

Meeting Rooms 5 & 6, Hilton London Wembley, Wembley

Members Present

Mr Matthew Swindells
Mr Robert Alexander
Mr Stephen Gill
Ms Catherine Jervis
Mr David Moss
Ms Linda Burke
Mr Aman Dalvi
Ms Patricia Gallan
Mr Nick Gash
Mr Ajay Mehta
Mr Loy Lobo
Dr Martin Lupton
Ms Vineeta Manchanda
Dr Syed Mohinuddin
Mr Simon Morris
Ms Baljit Ubhey
Ms Pippa Nightingale
Professor Tim Orchard
Ms Lesley Watts
Ms Patricia Wright
Mr Simon Crawford
Ms Tina Benson
Ms Claire Hook
Mr James Walters
Mr Jon Bell
Ms Virginia Massaro
Mr Jonathan Reid
Ms Jazz Thind
Dr Jon Baker
Dr Roger Chinn
Dr Alan McGlennan
Professor Julian Redhead
Mr Robert Bleasdale
Ms Sarah Burton
Professor Janice Sigsworth

Chair in Common
Vice Chair (ICHT) & Non-Executive Director (LNWH)
Vice Chair (CWFT) & Non-Executive Director (THHFT)
Vice Chair (THHFT) & Non-Executive Director (CWFT)
Vice Chair (LNWH) & Non-Executive Director (ICHT)
Non-Executive Director (THHFT & ICHT)
Non-Executive Director (CWFT & ICHT)
Non-Executive Director (CWFT & THHFT)
Non-Executive Director (ICHT & THHFT)
Non-Executive Director (CWFT & LNWH)
Non-Executive Director (LNWH & ICHT)
Non-Executive Director (LNWH & THHFT)
Non-Executive Director (THHFT & CWFT)
Non-Executive Director (LNWH & CWFT)
Non-Executive Director (THHFT & LNWH)
Non-Executive Director (LNWH & THHFT)
Chief Executive Officer (LNWH)
Chief Executive Officer (ICHT)
Chief Executive Officer (CWFT)
Chief Executive Officer (THHFT)
Deputy Chief Executive (LNWH)
Chief Operating Officer (THHFT)
Chief Operating Officer (ICHT)
Chief Operating Officer (LNWH)
Chief Financial Officer (THHFT)
Chief Financial Officer (CWFT)
Chief Financial Officer (LNWH)
Chief Financial Officer (ICHT)
Chief Medical Officer (LNWH)
Chief Medical Officer (CWFT)
Chief Medical Officer (THHFT)
Chief Medical Officer (ICHT)
Chief Nursing Officer (CWFT)
Chief Nursing Officer (THHFT)
Chief Nursing Officer (ICHT)

In Attendance

Mr Kevin Croft
Mr Phil Spivey
Ms Tracey Connage
Ms Lindsey Stafford-Scott

Chief People Officer (ICHT)
Chief People Office (THHFT)
Chief People Officer (LNWH)
Chief People Officer (CWFT)

Ms Helen Hardy
Mr Peter Jenkinson
Ms Dawn Clift
Ms Emer Delaney
Ms Michelle Dixon
Dr Scott Rice

Mr Abdul Shlebak

Mr James Biggin-Lamming
Ms Sheena Basnayake
Ms Alexia Pipe
Ms Nikki Walcott

Deputy Chief Nurse (LNWH)
Director of Corporate Governance (ICHT & CWFT)
Director of Corporate Affairs (LNWH)
Director of Communications (CWFT)
Director of Engagement & Experience (ICHT)
Divisional Medical Director for Women's, Children's, Clinical Support, Specialist Services & Integrated Cancer Care (LNWH)
Consultant Haematologist, Clinical Director for Clinical Haematology (ICHT)
Director of Strategy and Transformation
Hospital Director, West Middlesex Hospital
Chief of Staff
Head of Corporate Governance/Assistant Trust Secretary (LNWH)
- minutes

Apologies for Absence

Ms Carolyn Downs
Professor Neena Modi
Ms Sim Scavazza
Ms Lisa Knight
Mr Jason Seez

Non-Executive Director (ICHT & CWFT)
Non-Executive Director (ICHT & CWFT)
Non-Executive Director (ICHT & LNWH)
Chief Nursing Officer (LNWH)
Deputy Chief Executive Officer/Director of Strategy (THHFT)

Minute Ref		Action
1.0	Welcome and Apologies for Absence	
1.0.1	Mathew Swindells (MS), the Chair, welcomed everyone to the public Board in Common meeting.	
1.0.2	Apologies were noted from Carolyn Downs, Neena Modi, Sim Scavazza, Jason Seez and Lisa Knight (Helen Hardy is attending as deputy Chief Nursing Officer).	
1.1	Declarations of Interest	
1.1.1	Loy Lobo (LL) advised that there has been changes to his declarations of interests. Two new interests were declared: Business Advisor for Radiant Science UG and Consulting Partner to Salesforce.com. Two interests have ceased: Sana Health Solutions Ltd and Healthme.AI.	
1.2	Minutes of the Meeting held on 16 April 2024	
1.2.1	The Board in Common approved the minutes of the Board in Common meeting held on 16 April 2024, with the following amendment: - Add Loy Lobo - Non Executive Director (LNWH & ICHT) to members present.	
1.3	Matters Arising and Action Log	
1.3.1	The Board noted the updates provided within the action log.	

<p>1.4 1.4.1</p>	<p>Patient Story</p> <p>The Board received a story from a patient diagnosed with sickle cell disease at birth. The patient spoke of her experience of care across three of our hospital sites: Central Middlesex, Hammersmith and Northwick Park.</p> <p>Scott Rice (SR) noted the importance of the inpatient pathway for patients experiencing a sickle crisis and highlighted the effective system at Hammersmith, where patients bypass the emergency department and receive immediate, appropriate treatment. He noted the ongoing efforts to create a seamless inpatient pathway with the London Ambulance Service (LAS), and the challenges at Northwick Park, particularly the need to ensure patients are placed in the right bed, especially when they require high doses of controlled drugs. It is proposed that all inpatient care is moved to Hammersmith for acute crises. He underscores the importance of the role of Central Middlesex in ambulatory care, particularly in preventing crises. He highlighted the importance of education and research into sickle cell disease to ensure medical and surgical teams can effectively care for sickle cell patients.</p> <p>Pippa Nightingale (PN) advised that the Acute Provider Collaborative (APC) appointed Abdul Shlebak (AS) as Clinical Director across both trusts to help break down organisational boundaries and deliver a care pathway that patients co-designed. She expressed optimism that these changes will lead to better outcomes across the whole system.</p> <p>AS reported on plans to improve the patient journey. He acknowledged the significant lack of red blood cell consultants in the country but believes that by collaboration, the APC will be best equipped to provide high quality care.</p> <p>The Board noted the patient story and thanked the teams for their hard work.</p>	
<p>2.1 2.1.1</p>	<p>Acute Provider Collaborative Strategy</p> <p>Tim Orchard (TO) introduced the strategy paper, which has been reviewed by the APC Committees.</p> <p>James Biggin-Lamming (JBL) outlined the strategy to align to align our practices with firstly the best that is happening in north west London, then with the best across the NHS and ultimately, for specific specialties that we judge like this, with the best in global health. He noted the role of research and continuous improvement to push these standards even higher, with engagement from patients, partners, and communities. He highlighted the role of the Board and senior leaders in improving outcomes and achieving equity. He stressed the importance of challenging staff, ensuring the availability of data, promoting learning and sharing and providing support for improvements.</p> <p>MS gave his support for the strategy, noting the radical approach to determine and continuously measure best practice in NWL and spreading this across the system.</p> <p>The Board in Common had a discussion on the APC Strategy, with a number of NEDs commending the strategy. The Board in Common (BiC) discussed potential targets, with improvement and equity as indicators of the strategy's</p>	

	<p>effectiveness. There was an acknowledgment of the potential issues surrounding resources noting that standardising practices could release resources rather than consume them. The BiC stressed the importance of a communication plan to avoid confusion amongst staff.</p> <p>The Board approved the NWL APC Strategy 2024-2027.</p>	
<p>2.2</p> <p>2.2.1</p>	<p>Clinical Pathways Programme</p> <p>TO presented the proposed framework for the clinical pathways programme. The proposal is for specialties that are common across the APC to work together to reduce variation in their approaches and improve patient care. In the first year of the strategy, each specialty will be asked to align one clinical pathway to best practice. This should reduce variation, improve outcomes and raise standards.</p> <p>Alan McGlennan (AM) commented that this change will be a realised benefit of the APC to clinicians. He stressed the need for proportionate representation and highlighted the importance of integrating the mechanism into a single data platform.</p> <p>Robert Bleasdale (RB) said this is a significant opportunity to creatively rethink workforce delivery to ensure its sustainability for the future. He added that rotating staff between Trusts would be beneficial for patients.</p> <p>David Moss (DM) acknowledged that while the focus is on clinical pathways, there could be patient frustration around non-clinical pathways and asked how this might be addressed. TO explained that several initiatives are underway concerning non-clinical pathways, but argued that the most immediate impact for patients would come from tackling the clinical pathways.</p> <p>Linda Burke (LB) asked how meaningful patient involvement will be achieved and how the team will ensure that addressing inequalities underpins all activities. She also asked about Human Resource (HR) support that will be provided to staff whose roles might change significantly. TO explained that the teams have standing groups of patients and members of the public that they consult. He said the approach will help address inequalities by driving up standards across the entire pathway. TO clarified that he does not anticipate this initial process resulting in significant site or service relocations requiring HR support.</p> <p>LL highlighted the complexity of some pathways and said these pathways would necessitate collaboration with other system partners. TO explained that specialties will begin with the pathways they are confident they can deliver, and he agreed that the next step will be to identify areas where they need to engage primary and community care, to ensure effective collaboration and service delivery.</p> <p>Robert Alexander (RA) expressed his support but felt that some of the language used was too vague. He suggested a more definitive approach to ensure consistency and rigour. He also highlighted the need for prioritisation, deciding which areas to focus on first.</p>	

	<p>Nick Gash (NG) emphasised the need to consider the financial implications of standardisation and suggested liaising with the Integrated Care Board (ICB), given their role in funding.</p> <p>The Board in Common noted the report.</p>	
<p>3.1 3.1.1</p>	<p>Report from the Chair in Common MS presented his report to the Board in Common, highlighting the recent general election. He expressed his congratulations to the re-elected local MPs and those elected for the first time.</p> <p>NG noted corrections to the paper regarding incoming and outgoing MPs. Action: NG/Alexia Pipe.</p> <p>MS noted this as Catherine Jarvis' (CJ) last Board in Common meeting as Vice Chair of THHFT, and extended thanks to her for her significant role in improving THHFT and her support in forming the APC. MS also noted this as the final Board in Common meeting for Jon Bell (JBe), and MS thanked him for his contribution and service.</p> <p>MS welcomed Vineeta Manchanda (VMa) to her first Board in Common meeting. He expressed his delight that Patricia Gallen (PG) has agreed to take on the role as the new Vice Chair for CWFT when SG steps down later in the year. He also announced that Carolyn Downs (CD) has been appointed as the Vice Chair for THHFT for when CJ steps down.</p> <p>MS congratulated Janice Sigsworth (JS), who received a Damehood for her services to nursing.</p> <p>The Board in Common noted the report.</p>	<p>NG/AP</p>
<p>3.2 3.2.1</p>	<p>Board in Common Cabinet summary MS presented the report from the meetings of the Board in Common Cabinet since the last Board in Common meeting, highlighting that the Cabinet had approved the following:</p> <ul style="list-style-type: none"> • Imperial College Healthcare NHS Trust (ICHT) – Charing Cross and Hammersmith hospitals procurement bids • Imperial College Healthcare NHS Trust (ICHT) – Registered nurse degree apprenticeship business case • CQC National Review of Paediatric Audiology / Hearing Services for each Trust • Imperial College Healthcare NHS Trust (ICHT) – St Mary's Hospital Redevelopment RIBA Stage 2 Contract Variation <p>The Board in Common noted the report.</p>	
<p>4.1 4.1.1</p>	<p>Integrated Quality, Workforce, Performance and Finance report The Board in Common received the integrated quality, workforce, performance, and finance report.</p> <p>Patricia Wright (PW) reported that the team is changing the format of the report and refining the indicators reported to the Board. PN reported that the</p>	

	<p>APC People Committee have agreed their new metrics in line with the changes to the national quality standards, and these will be built into future performance reports.</p> <p>AM provided an update on Quality, noting that all Trusts have formally moved to the Patient Safety Incident Response Framework (PSIRF). Venous thromboembolism (VTE), a previous concern, has now markedly improved, largely due to the embedding of Cerner in both reporting and workflows. Infection prevention and control is a known issue and is being addressed as a quality priority across different trusts within the APC. The national safety standards for invasive procedures (NatSSIPs2) has been confirmed as a new APC Quality Priority.</p> <p>RB provided an update on Maternity, noting that the maternity metrics have been refined to align to national definitions. The team will standardise the reporting per 1,000 births for better benchmarking and sharing of best practice across the four Trusts.</p> <p>NG noted the generally high level of incident reporting and asked for more information. PN explained that a good culture will see a high number of incidents reported and low levels of harm. She noted that some of the difference in reporting across the Trusts is due to what each Trust reports as an incident, and work is being done to standardise this. A tender is in process for a single incident reporting system for implementation across the four Trusts.</p> <p>Claire Hook (CH) provided an update on Performance, noting the M2 performance report. The position on urgent and emergency care has been held reasonably steady, maintaining the best ambulance handover times in London. However, work is being done with the LAS to support pressures at Northwick Park. The APC is delivering their performance with many winter beds still open and with very high numbers of patients in hospital. To prepare for winter, this issue must be addressed imminently and each of the Emergency Departments (EDs) have produced an action plan for delivering the 78% standard.</p> <p>Sheena Basnayake (SB) highlighted the extended pressures experienced in May and June, which have significantly impacted the flow through all hospital sites. She noted a slight decrease in patients waiting over 12 hours and longer from the time of arrival. However, this remains a challenge and is variable, indicating more work needs to be done. She noted that their biggest challenge is patients not meeting the criteria to reside. Despite a slight decrease, this remains a significant issue across all APC and acute sites. The focus is on ongoing work with local authorities to ensure delays are worked through quickly.</p> <p>Lesley Watts (LW) reported on Discharges, noting that she has agreed to lead the sector work on discharge with the ICB, as overall progress has not been as expected. This work includes collaboration with local authorities, the community and mental health units to improve the flow of patients outside of acute units.</p>	
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	<p>DM asked for more information about the actions being taken across the APC to reduce the cohorting challenge. CH explained an initiative is in place which allows the LAS to proactively move patients around the system. This initiative, known as Step 2, is in its early stages and aims to prevent any ED from experiencing a peak in demand it cannot manage. James Walters (JW) highlighted their focus on maintaining flow and reducing patient time in the ED at Northwick Park. He noted a small but significant improvement in flow through the hospital, with LNWH reducing its difference from target from 4.9% to 4.4%.</p> <p>Tina Benson (TB) provided an update on the area of Electives and Diagnostics, noting that the APC are working towards meeting the national ask to treat all patients waiting 65 weeks by the end of September. She noted that some upticks in long waits are due to industrial action in June. She highlighted the national position on access to diagnostics. She reported early signs of recovery in the APC, with a significant improvement at THHFT, and all Trusts, except ICHT, have trajectories to recover by the end of Q2. ICHT is dealing with significant problems with ageing equipment.</p> <p>JW provided an update on cancer performance, noting that performance for April continued to exceed National Cancer average performance levels. The faster diagnosis standard was achieved for the third month in a row, suggesting a sustained improvement. The 2-week wait performance was most unstable at LNWH, so there has been a focus on recovering capacity in the front end of the pathway. The 31-day decision to treat standard was 3% below the 96% standard. Both tumour specific plans and capacity plans are in place to reduce shortfalls in the availability of treatment. The 62-day performance metric continues to recover and is on an upward trajectory over the last six months.</p> <p>SG noted concern about the access to cancer specialists at LNWH, which has been impacted by the Cerner implementation and is currently running at half of what is normally expected. He asked about the timeline for recovery. JW acknowledged that April was a difficult month, particularly for the two-week wait measure. He explained that capacity challenges, especially around the skin and breast pathways, made it difficult to provide enough appointments to cope with the additional demand. However, he reported that performance improved in May.</p> <p>Tracey Connage (TC) provided an update on Workforce, highlighting the positive direction of travel in each of the key performance areas. The vacancy rate is under target and has reduced throughout the year. Voluntary turnover has reduced from the target of 12% to the current position of 10.6%. Sickness levels are currently at target and reflective of the seasonal range. There has been a reduction in agency usage to 2.5%, but this is above the 2% target. There is a focus on following national guidance to ensure that agency usage in non-essential posts is removed from organisations. Performance reviews are improving, and teams are working towards achieving the 95% target level. Each Trust is working closely with their EDI lead on focused inclusive recruitment.</p>	
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	<p>Aman Dalvi (AD) noted that the agency spend is higher at THHFT and asked for further information. PW explained that the agency spend is largely due to mental health nurses posts. She noted that actions to control agency spend are already in place and a piece of work is underway to change the mental health nurse delivery model.</p> <p>The Board in Common noted the report.</p>	
<p>5.1 5.1.1</p>	<p>Collaborative Quality Committee Chair's Report</p> <p>SG presented the Chair's report from the Collaborative Quality Committee, highlighting the key areas of focus. He raised concern about the decreasing number of employees in mental health trusts, which is causing significant pressure in the acute sector. He also noted the decision to undertake best practice work across Maternity, including a stillbirth review.</p> <p>AD asked about BME deaths, particularly around stillbirths, and how the review will address this issue. He also asked for more information about THHFT recording above the national stillbirth rate. RB explained that the stillbirth data is being reviewed by ethnicity and whether English is a first language. AM acknowledged that there are wider determinants of health, outside their control impacting the THHFT stillbirth rate. He noted that the review will identify the different healthcare needs within the population and said the Trust must do all they can to mitigate the situation including additional appointment time.</p> <p>AD highlighted that minority communities often do not present themselves early enough to GP services and primary care and asked what is being done to resolve this issue. LW advised that this forms part of the strategy for the ICB who must address the needs of patients and communities that are underserved; this will be added to future discussions.</p> <p>The Board in Common noted the report.</p>	
<p>5.2 5.2.1</p>	<p>Learning from Deaths Report</p> <p>Jon Baker (JBa) presented the report highlighting that each Trusts' quarterly report had been reviewed at local Quality Committees and summarising key themes across the four trusts.</p> <p>Board members were pleased to note that the mortality rates continued to be lower than, or as expected, when compared nationally, with regular review of these occurring both internally and through the Collaborative Quality Committee.</p> <p>PW highlighted the usefulness of site-based information in the report and suggested that other reports consider adopting this format.</p> <p>The Board in Common noted the report.</p>	
<p>6.1 6.1.1</p>	<p>Collaborative People Committee Chair's Report</p> <p>DM presented the Chair's report and highlighted three areas of escalation: violence and aggression towards staff, hard-to-fill vacancies, and overall workforce productivity. He highlighted the need to ensure productivity across the entire workforce especially in light of the over-establishment of posts.</p>	

	<p>CJ noted the violence and aggression and asked if it is possible to understand the impact of having mental health patients within the trust. PN explained that the data is broken down into violence from staff to staff and from patients to staff. She emphasised the importance of helping staff understand mental capacity when dealing with violent patients. Focus is being given to train staff to deescalate situations and deliver restraint safely.</p> <p>LL reported findings from a focus group which found uneven workload distribution along racial and ethnic lines amongst staff. He asked whether similar data is identifiable across the APC. PN explained that this data is not currently available but focus is given to set safe staffing metrics in every ward and department. RB added that Staff Networks and the Freedom to Speak Up mechanisms are used to gather soft intelligence. MS requested that LL shares the material from the focus group to facilitate learning.</p> <p>Action: LL.</p> <p>Baljit Ubhey (BU) asked whether the APC is also looking at sexual violence. PN confirmed that they consider sexual safety for both staff and patients. She reported that the APC has signed up to the sexual safety in healthcare charter and have updated their policies to explicitly include sexual aggression.</p> <p>The Board in Common noted the report.</p>	LL
<p>6.2 6.2.1</p>	<p>APC Improvement Plan – EDI Action Plan</p> <p>Ajay Mehta (AM) presented the APC EDI Improvement plan, which has been reviewed by the Collaborative Committees. The plan has been shared with the EDI leads from each Trusts and has received external input, and all feedback has been incorporated into the plan. He encouraged both executive and non-executive members of the Board to support the plan and commit to change.</p> <p>PN reported that the plan has been well received. She advised that they have decoupled the patient equity focus from this plan and this will be explored in Phase 2.</p> <p>PG asked whether baseline measures of improvement are included in the plan. PN explained that these measures will be built into the equity plan, and will be reflected in the dashboard which is being developed.</p> <p>BU commended the plan and suggested that this work should be showcased during political engagement. She added that teams should continue to challenge any unconscious bias that might be leading to different treatment outcomes.</p> <p>TO noted the action to standardise pay awards and said consideration should be given to how the APC can mitigate the effect of pay awards being incorporated into salaries, as is with the clinical excellence awards.</p> <p>The Board in Common approved the recommended actions to promote equity, diversity and inclusion for our people, and approved the establishment of a steering group to recommend actions for Phase 2 – Patients and communities.</p>	

<p>7.1 7.1.1</p>	<p>Collaborative Data and Digital Committee Chair's Report SG presented the report highlighting that the implementation of Cerner at LNWH and THFT has gone well and commended the teams for their excellent work. He highlighted the need to not only consider their own cyber security risks but also those associated with their suppliers.</p> <p>PG asked whether any immediate action is being taken to mitigate cybersecurity risks across the APC. PW explained that significant work has been done to support their cyber resilience as part of the Digital Strategy and emphasised the need to gain assurance from their suppliers. MS added that whilst it is important to ensure their suppliers are secure, it is impossible to be completely assured in every area. He stressed the need for a robust recovery plan in case of a cyberattack.</p> <p>The Board in Common noted the report.</p>	
<p>8.1 8.1.1</p>	<p>Collaborative Estates and Sustainability Committee Chair's Report RA presented the report, noting the ongoing work on joining up the Green Plans and benchmarking the APC estates. He noted each Trust's duty to enable accessibility but said approaches differ and this situation presents an opportunity to learn and bring consistency across the APC.</p> <p>The Board in Common noted the report.</p>	
<p>9.1 9.1.1</p>	<p>Collaborative Finance and Performance Committee Chair's report CJ presented the report, highlighting the EDI report which shows a rise in people not attending appointments (DNAs) linked to deprivation and ethnicity. This led to a broader conversation about developing a comprehensive set of metrics around access.</p> <p>CJ noted the APC's successful collaborative efforts last year, which resulted in a good financial position. Break-even plans were agreed going forward, which will require active management due to the current context of patient volumes and winter bed issues. The key risk to escalate to the Board is the position coming out of month 2. Issues around discharge and ongoing industrial action were noted as potential impacts.</p> <p>The Board in Common noted the report.</p>	
<p>9.2 9.2.1</p>	<p>Financial Performance Report JBe presented the month 2 (May 2024) finance report. The APC reported a deficit of £23.9m against a year-to-date deficit plan of £6.1m, a £17.8m adverse variance to plan. All four trusts report adverse variances to plan. Consistent themes include the under-delivery of CIP, with only 56% delivery against plan reported, and significant operational and inflation pressures. Elective recovery reports a favourable variance of £6.6m. The capital plan reports an underspend of £2.6m against the plan of £17.8m; the total capital plan for the year is £239m. The APC combined cash balance is £279m, a decrease of £59.5m since the end of the financial year and lower than the planned cash balance by £45.3m. Work is being done with the ICB to</p>	

	<p>mitigate the cash problem. A further peer review meeting will be held shortly, and all Trusts have recovery plans in place to address the challenges.</p> <p>VMa inquired about the extent to which centralised functions like Procurement are delivering anticipated savings. JBe reported on their close work with the procurement function and noted significant progress and improvement in the delivery of CIPs. He noted that there are some areas of challenges, particularly around the large targets set for Procurement.</p> <p>RA said as part of local mitigations, there is a need for robust analysis of the industrial action from both a cost and lost income perspective. He also mentioned the system optimisation work, which is part of their final plan, and noted concern about the financial risk due to little traction with the work.</p> <p>Martin Lupton (ML) noted the general decline in NHS productivity and asked whether teams understand how their productivity has been impacted. Virginia Massaro (VM) explained that work is being done to understand what is driving the drop in productivity. She noted that the APC are performing better than others and ranks well nationally. MS noted the work being done and the APC's productivity compared to the rest of the NHS but said more needs to be done to recover the position.</p> <p>The Board in Common noted the report.</p>	
9.3 9.3.1	<p>Acute Provider Collaborative and Trust Business Plans – Priorities, Operating and Financial</p> <p>The Board noted the confirmed submission of the financial, operating and workforce plans for 2024/25 in May 2024. Jonathan Reid (JR) advised that following the approval of the APC Strategy, there will be a full refresh of the Business Plan priorities, which will be reported on in due course.</p> <p>The Board in Common noted the report.</p>	
10.1 10.1.1	<p>Acute Provider Collaborative Governance Model and Scheme of Delegation</p> <p>Peter Jenkinson (PJ) presented the report, outlining the revised governance process and amendments to the Scheme of Delegated Authority for the four Trusts of the APC. This implements the decisions made at the last Board in Common meeting which include the establishment of Trust Standing Committees.</p> <p>The Boards of Chelsea and Westminster Hospital NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundations Trust approved:</p> <ol style="list-style-type: none"> 1. The revised Scheme of Delegated Authority for the APC 2. The draft Terms of Reference for the Trust Standing Committees 3. The establishment of the revised governance arrangements at Trust and Collaborative level. 	

11.1 11.1.1	<p>Executive Management Board Summary Report</p> <p>TO presented the summary report from the Acute Provider Collaborative Executive Management Board meetings held in April to July 2024. TO highlighted good progress on the coding of patient ethnicity data.</p> <p>The Board in Common noted the report.</p>	
11.2 11.2.1	<p>Reports from the Chief Executive Officers and Trust Standing Committees</p> <p><u>London North West University Healthcare NHS Trust</u> PN reported on the successful opening of the Elective Orthopaedic Centre and the new acute medicine unit in May. The acute medicine unit includes 32 beds which will help ease some of the ED pressures at Northwick Park.</p> <p><u>Chelsea and Westminster Hospital NHS Foundation Trust</u> LW reported that good progress is being made with the Ambulatory Diagnostic Centre and the Treatment Centre. She highlighted the collaborative digital inclusion project, funded by the Health Foundation, where their charity and Imperial College Health Partners won an MJ award.</p> <p><u>Imperial College Healthcare NHS Trust</u> TO reported on the upcoming publication of their first anti-discrimination and anti-racist statement in September. He noted that the Trust has been nominated for an award for the Healthcare Leaders Fellowship. TO commended the excellent data on research, with nearly 25,000 participants into NIHR portfolio studies and over 1,000 active studies.</p> <p><u>The Hillingdon Hospitals NHS Foundation Trust</u> PW reported on the significant focus on improvements in maternity performance and thanked AM and Sarah Burton (SB) for their leadership. She highlighted that the Trust are now in year four of their five-year enabling and decant programme for the clearance of the West of the Hillingdon site, ready for the construction of a new hospital.</p> <p>The Board in Common noted the reports.</p>	
12. 12.1	<p>Reports for Information Only</p> <p>Nil advised.</p>	
13. 13.1	<p>Any Other Business</p> <p>Nil advised.</p>	
14.0	Questions from members of the Public	
14.1	<p>The Board in Common noted that questions were received in advance of the meeting. MS summarised the questions and asked members of the Board to provide answers, noting that written responses would be provided on the NWL Acute Provider Collaborative website.</p> <p>From: Tiago Sousa, GE HealthCare</p> <p>Question: In the aftermath of parliament election, the labour manifesto to build an NHS fit for the future has gained public attention. While this brings up multiple questions to all of us – members of the public, Trusts, industry, and procurement services –would you be able to share the approach you intend to</p>	


	<p>take regarding the necessary workforce expansion and infrastructure development to support the Labour manifesto?</p> <p>Pippa Nightingale explained that the APC have a very ambitious NHSE workforce plan that we are implementing across the four Trusts that makes bold commitments around student training expansion numbers, new roles and workforce models and better usage of the apprentice levy. The four acute Trusts across the APC are working together to deliver these workforce objectives, and is demonstrated through the approval of the registered nurse degree apprenticeship business case, which is significant funding for the Imperial College Healthcare NHS Trust.</p> <p>Infrastructure development is a critical area of focus for all services, ensuring that our healthcare facilities, are modern, efficient and capable of meeting the demands of a growing and aging population. Together the four acute Trusts are driving forward pioneering digital plans, building on a track record of joint working demonstrated by delivering the only electronic patient record system working across all the hospitals in one region. Thus enhancing optimisations and taking away some of the mundane and laborious duties from staff. We also have ambitious plans for our estates development working in partnership with our local community, stakeholders, with both Hillingdon Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Trust working in partnership with the Government's New Hospital Programme. We are proud to be at the vanguard of this national flagship programme.</p>	
14.2	<p>The Chair drew the meeting to a close and thanked the Board and members of public for joining the meeting.</p>	

1.3 MATTERS ARISING AND ACTION LOG

 Matthew Swindells

REFERENCES

Only PDFs are attached

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

North West London Acute Provider Collaborative

Board in Common (public) Action Log

Matters Arising and Action Log

Status: For noting

Meeting Date: 15 October 2024

Lead Responsibility and Paper Author: Matthew Swindells

Purpose

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

Part 1: Actions from Previous Meetings Remaining Open

Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
5.2	APC Improvement Plan – EDI Action Plan	The Board discussed the need to set challenging and measurable targets and ensure we address unconscious bias. Carolyn Downs (CD) suggested that we include the issue of measurement of local populations to ensure effective measurement of data.	Pippa Nightingale	Action complete re stage one of EDI plan. Stage two - second phase EDI action plan focussed on patients and communities due for end of 24/25	April 2025

Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes	Expected Completion Date
11.2	Health & Safety Annual Report 2022-23	It was suggested that a health & Safety story would be beneficial at a future Board in Common Meeting.	Trust Governance Leads.	Added to forward plan.	

Part 2: Actions previously outstanding but now completed

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

Meeting Date	Agenda Item Number	Subject Matter	Action	Lead	Progress Updates, Notes & Status
April 2024	8.3	Acute Provider Collaborative Business Plans	The Board in Common agreed to delegate authority to their respective Finance & Performance committees to approve submission of break-even final plans by 2 May 2024.	Trust Finance & Performance Committees	Action complete.

1.4 PATIENT STORY

 Lesley Watts

REFERENCES

Only PDFs are attached

 1.4 Patient Story - AEC FINAL.pdf

NWL Acute Provider Collaborative Board in Common (Public)

15/10/2024

Item number: 1.4

This report is: Public

Patient Story – Ambulatory Emergency Care

Authors: Rob Bleasdale
Job title: Chief Nursing Officer, Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)

Accountable director: Lesley Watts
Job title: Chief Executive Officer, CWFT

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.

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Executive summary and key messages

The Ambulatory Emergency Care (AEC) Pathway offers same-day emergency care, reducing unnecessary hospital admissions by providing timely assessments and treatment in an outpatient setting. This model is especially vital during winter, alleviating pressure on the NHS as demand rises from seasonal illnesses. Patients like Avril, who recently received efficient antibiotic treatment through AEC, benefit from quicker care and the ability to return home, while freeing up hospital beds for those in greater need.

The following patient story shares a recent experience from the AEC at the Chelsea hospital site, demonstrating the role of this highly responsive and multidisciplinary unit. Avril was assessed, diagnosed and treated as an outpatient in one afternoon, returning each day for the next three days for her IV antibiotic treatment. She praised the AEC concept for its swift access to specialist clinicians and diagnostic tests, highlighting how it allowed her to receive excellent care while still being able to go home each day.

Strategic priorities

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

Impact assessment

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


2. STRATEGY/PLANNING

2.1 WINTER ? UPDATE ON URGENT AND EMERGENCY CARE ACTION PLANS ACROSS THE APC

 Lesley Watts

REFERENCES

Only PDFs are attached

 2.1 Winter - UEC Planning - Cover and Report FINAL1.pdf

NWL Acute Provider Collaborative Board in Common (Public)

15/10/2024

Item number: 2.1

This report is: Public

Update on the UEC action plans across the Acute Provider Collaborative

Authors:	Claire Hook; Sheena Basnayake; Phil Edmunds
Job title:	COO and Deputy Chief Executive Officer, Imperial College Healthcare NHS Trust (ICHT); Hospital Director, Chelsea and Westminster Hospital NHS Foundation Trust (CWFT), Business Manager to the Chief Operating Officer (COO) and Deputy Chief Executive Officer, ICHT
Accountable director:	Claire Hook
Job title:	Chief Operating Officer and Deputy Chief Executive, Imperial College Healthcare NHS Trust; and APC Lead for Urgent and Emergency Care

Purpose of report

Purpose: Information or for noting only

The Board is asked to note this report, which details the progress of the four acute Trust’s UEC action plans in meeting the targets and supporting actions outlined in NHSE’s letter ‘Urgent and emergency care recovery plan year 2: Building on learning from 2023/24’, as well as the guidance issued in subsequent publications. These plans pre-date the Care Quality Commission’s inspection of surgery and urgent and emergency care at The Hillingdon Hospital Foundation Trust (THHFT) at the end of July 2024, and work continues to ensure that any learning is incorporated into all four Trust plans as appropriate.

Report history

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

Acute Provider Collaborative Executive Management Board 07/08/2024 Noted	NWL Acute Provider Collaborative Finance and Performance Committee 18/09/2024 Noted	NWL Urgent and Emergency Care Board 18/09/2024 Noted
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Executive summary and key messages

This paper outlines the progress of the NWL Acute Provider Collaborative (APC) in meeting the two primary aims of the two-year Urgent and Emergency Care Recovery Plan. Each of the four Trusts have continued to progress their Urgent and Emergency Care action plans, which detail how performance will be improved and maintained until the end of March 2025 and beyond. These plans have been shared between the 4 Trusts to ensure best practice is applied across the APC, and have then been discussed with the APC UEC Lead and UEC National Clinical Director.

NHSE has released guidance throughout the year to help providers improve UEC performance by following best practice and benefitting from learning at other providers. The guidance has detailed a number of case studies where Trusts have significantly bettered their performance, and includes examples from the NWL APC. ICHT's 'SDEC access improvement project' improved access across both St Mary's and Charing Cross hospitals. The introduction of direct electronic booking allowed NHS 111 and the ambulance Trust emergency clinical assessment service to book patients directly into a slot at either SDEC unit without the clinician having to telephone the unit first. Referrals increased by over 250% from June 2023. At THHFT, 2023/24 winter funding was utilised to develop its Frailty Assessment Unit (FAU). Following a successful pilot, the unit is now operating under the new model as business as usual. Through avoided admissions and reduced length of stay for patients admitted through the FAU, there was a reduction of 127 bed days by inpatients with a Clinical Frailty Score of 5 or more compared to the previous winter.

Strategic priorities

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

Impact assessment

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

Main Report

1. Purpose

- 1.1. The purpose of this paper is to update the Board on the work in progress to improve Urgent & Emergency Care (UEC) performance across the APC in order to fulfil the requirements of the NHSE operating guidance for 2024/25. The paper provides assurance that APC commitments will be met through the delivery of the individual Trust's UEC action plans.
- 1.2. The Integrated Care System (ICS) has continued to experience sustained demand on its UEC services and pathways. As such, the four acute Trusts have reviewed their UEC plans to ensure that performance further improves and aligns with the targets set out in NHSE's letter – [‘Urgent and emergency care recovery plan \(UECRP\) year 2: Building on learning from 2023/24’](#). The UECRP is a two-year plan and the APC Trusts have revised and added to the UEC action plans that were approved towards the end of 2023/24.
- 1.3. The Board should note that these plans pre-date the Care Quality Commission's inspection of surgery and urgent and emergency care at the Hillingdon Hospital in July 2024. Since then, THHFT have responded to three of the five elements of the Section 29A warning notice issued by the CQC in August 2024, and responses to the remaining two elements are due in October and November 2024. Work is underway to ensure that any learning is incorporated into all four Trust plans as appropriate.
- 1.4. The Board should also note that this paper has been updated since it was presented at the meetings stated in the above ‘Report history’. The updates reflect further NHSE winter guidance received in September 2024 and the completion of planned review meetings between each of the four Trusts and the APC UEC Lead and UEC National Clinical Director.
- 1.5. The 2024/25 NHS priorities and operational planning guidance requires that providers:
 - 1) *improve A&E performance with 78% of patients being admitted, transferred or discharged within 4 hours by March 2025*
 - 2) *improve Category 2 ambulance response times relative to 2023/24, to an average of 30 minutes across 2024/25*
- 1.6. In addition to these two headline ambitions, NHSE has asked providers to focus on a range of supporting actions; those relating to acute providers form the basis of the Trust's UEC action plans, and the specific NHSE guidance has been shared the Trusts and system.

2. Context

- 2.1. Year-end and current performance:

The APC finished 2023/24 with each of the four Trusts achieving the NHSE 4-hour performance target of 76%, with March-end performance recorded at 78.8%. Performance has been sustained into the new financial year, with August recorded at 78.7%. Within this CWFT, ICHT and LNWH achieved the national target, whilst THHFT were below. A range of measures have been put in place at each of the APC sites to

improve performance further.

- 2.2. A significant amount of work has been done to improve resilience across UEC services. As with the previous year, an additional allocation of capital has been ring-fenced within the NHS operational capital budgets, to incentivise both highest performance and greatest improvement since 2023/24. The reward scheme focuses on improvements in 4-hour performance, Category 2 performance, and improved 12-hour delays in ED.
- 2.3. NWL ICS overall UEC plan:
NWL ICS' winter planning approach started in late 2023/24 to evaluate last year's winter schemes and identify early on how funding would be allocated in 2024/25. The focus was on those schemes that would make the biggest impact over winter, quantified by the impact identified over winter 2023/24. This includes schemes that will be delivered on a year round basis and extend over the winter period. Aligned with this sector-level approach are individual borough-level plans, which focus on prevention, admission avoidance and locality-level actions that involve Local Authorities, primary care and the Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance. Additionally, there is a system-wide communication and engagement campaign to support local residents with decisions about access to healthcare services using a range of channels – such as social media – to provide information, and help people get to the right place for care. Data from previous winter campaigns will be used to target and support areas and communities.
- 2.4. Additional discharge grant funding is available to build upon the successes of those schemes that were implemented last year – e.g. expanding bridging arrangements where these were not implemented. All boroughs will now have a pathway 3 scheme, which was not in place last year, with the operationalising of these starting from September 2024 and which will support discharges from the acute Trusts.
- 2.5. NHSE guidance:
[A letter from NHSE on the 25th January 2024](#) asked for Trusts to review their internal processes to support ED teams, and ensure that 'Five Priority ED Improvement Initiatives' were in place: streaming and redirection; rapid assessment and treatment (RAT); maximising the use of Urgent Treatment Centres (UTCs); improving ambulance handovers; and reducing time that patients spent in the department. Evidence showed that the best performing Trusts followed these approaches routinely, and therefore these themes continue to be at the forefront of the Trust's improvement action plans. These initiatives build on the ambitions laid out in the first letter from NHSE in January 2023 – 'Delivery plan for recovering urgent and emergency care services' – which commenced a two-year plan to improve UEC performance.
- 2.6. On 16th May 2024, NHSE released the second phase of this plan – '[Urgent and emergency care recovery plan year 2: Building on learning from 2023/24](#)'. The letter confirmed that the 4-hour performance target had increased to 78% by March 2025, and outlined a variety of supporting actions to improve and maintain UEC performance over the coming year.
- 2.7. The importance of achieving these improvements was further outlined in NHSE's letter from 26th June 2024. This asked that providers ensure the interventions set out in the UEC Recovery Plan year 2 letter were being implemented, so as to safeguard against patients experiencing unacceptable levels of care. This was then further supported in [NHSE's letter from the 16th September 2024, 'Winter and H2 priorities'](#), and also the

[letter from the 26th September 2024, 'Clinical and Operational Excellence'](#), which shared further improvement guides and the details of the newly-established learning and improvement networks (LINs).

- 2.8. Each of the four Trusts met with the APC UEC Lead and UEC National Clinical Director during the first week of September 2024 to discuss their action plans. The discussions had a particular focus on maintaining quality and safety, partly as a response to the letter from NHSE. The meetings highlighted that all four Trusts have undertaken a significant amount of work to ensure that UEC performance continues to improve in the face of rising demand. The action plans detail how performance will be maintained and improved over the course of the rest of 2024 and beyond.
- 2.9. On 16th September 2024, NHSE released two letters providing further guidance on how best to support the ongoing delivery of safe, dignified and high-quality care for patients this winter. The 'Winter and H2 priorities' letter acknowledged that demand is running above expected levels across the UEC pathway and that services would likely come under strain. It highlighted that a focus should be on maintaining patient safety and experience and supporting people to stay well, with providers to ensure eligible staff groups have easy access to relevant vaccinations from 3rd October 2024. The second letter on temporary escalation spaces (TES) outlined that the delivery of care in such settings is not acceptable outside of times of extremis, and detailed the principles which will support staff to deliver the safest, most effective and highest quality care when TES care is deemed necessary.
- 2.10. The Trust leads for each of the action plans have acknowledged the guidance within the September NHSE letters and are incorporating these within their action plans where these were not previously explicit.
- 2.11. One of the main focuses of the guidance issued by NHSE is the criteria to admit (CTA) decision support tool, which can support real-time decision making as well as provide a retrospective audit tool to identify bed utilisation, potential saving of bed days and any gaps in service provision. The Trusts have agreed to undertake an exercise to establish a baseline and review this as part of their ongoing UEC improvement work.

3. Trust's UEC action plans

- 3.1. Each of the Trusts have produced an action plan, outlining their performance and the actions, progress and risk ratings associated with each of the improvement themes.
- 3.2. The 9 improvement themes on which the plans are built are:
 - 1) *Streaming and redirection, and Rapid assessment and treatment (RAT) & senior decision making (SDM)*
 - 2) *Maximising the use of Urgent Treatment Centres (UTCs)*
 - 3) *Increase the utilisation of SDEC and ensure compliance with the minimum opening hours*
 - 4) *Provide an Acute Frailty Unit (AFU) on a 10/7 basis*
 - 5) *Reduce ambulance handover delays*

6) Reduce time in EDs (across admitted and non-admitted pathways)

7) Reduce the number of patients past their Discharge Ready Date (DRD)

8) Maintain acute G&A bed capacity at the level funded and agreed through operating plans

9) Paediatric ED performance (linked to ED peer review themes)

- 3.3. In June 2024, the Trusts presented their action plans to their peers and the APC UEC Lead to ensure shared learning and best practice had been applied across the APC. The meeting highlighted that the action plans were progressing positively and that each Trust had a clear list of actions to ensure delivery. These discussions were then progressed further in September 2024 with the APC UEC Lead and UEC National Clinical Director.

4. Improvement themes

4.1. 1) Streaming and redirection & RAT and Senior decision making (SDMs)

Average streaming to initial assessment times vary across the four Trusts, ranging from 8 minutes at LNWH to 22 minutes at CWFT. All Trusts have highlighted the importance of continued staff engagement and training in order to improve performance in streaming and redirection processes, with the latter an effective mechanism for admission avoidance and therefore safely managing the increased demand on UEC pathways – especially during out of hours. At THHFT, a RAT'ing process is being embedded.

4.2. 2) Maximising the use of UTCs

At CWFT, the current integrated service model within ED allows for maximal use of the UTC. Likewise, the integrated model at LNWH means a diverse and skilled multidisciplinary workforce can work across the three sites, and therefore the majority of patients within the UTCs are promptly assessed and discharged within 4 hours. ICHT are working towards UTC performance of 97% across all sites, which will be aided by plans to expand redirection and accessing of slots via NHS 111. ICHT's performance will be bolstered by the expansion of the St Mary's UTC, which is expected to be in place at the end of November 2024. THHFT are revisiting all pathways to ensure that ED avoidance is maximised whilst SDEC is open, and exploring ring-fencing additional staff to help increase operational flow.

4.3. 3) Increase utilisation of SDEC and ensure compliance with opening hours

All Trusts are compliant with the required minimum SDEC opening hours. All are currently reviewing their inclusion/exclusion criteria to support better flow.

4.4. 4) Provide an AFU on a 10/7 basis

The operational planning guidance requires that all Type 1 providers have an acute frailty service in place for at least 10 hours a day, 7 days a week, to increase patient flow and the proportion of patients over 65 with a Clinical Frailty Score. Currently, only THHFT meets this requirement (though without consultant cover overnight or at the weekends), with CWFT, ICHT and LNWH currently offering the service across 5 days only. ICHT continues to progress the plan to implement this on a 10/7 basis, with frailty Advanced Clinical Practitioners and therapists working on both front doors; 65 hours at Charing Cross hospital and 50 hours at St Mary's hospital. The plan to roll out a weekend pilot at St Mary's hospital is progressing via a weekly forum and is planned to go live during

winter. CWFT are currently recruiting to a 7-day service, and LNWH are re-evaluating current funding and service model arrangements.

4.5. 5) Reduce ambulance handover delays

Generally this has been an area in which the APC has demonstrated consistent performance, and continues to have the best handover performance across London. Collectively, the APC is participating in transformation work with the LAS and ICB to maximise the use of alternatives to ED and expand the use of direct referral routes. Each of the Trusts is also reviewing their internal processes to ensure that performance continues to improve. THHFT are using capital funding awarded by NHSE for improved 2023/24 performance to redevelop existing areas to improve issues identified during the recent CQC inspection, focusing on mental health, infection control and waiting room space. There are further, funded estates works due for completion at LNWH to maximise space. The REACH model has now been funded until March 2025, and work is ongoing with LAS and system partners to ensure better utilisation of the model.

4.6. 6) Reducing time in ED (across admitted and non-admitted pathways)

Across the APC, non-admitted pathways have been performing well whilst admitted pathways have been more variable. All Trusts fed back around the importance of SDEC units in significantly reducing the time patients spend in ED. CWFT are planning to relocate their ED SDEC and LNWH now have LAS direct to SDEC pathways implemented at both sites. CWFT have implemented cross-specialty meetings in order to improve specialty engagement, and a working group will review the current space, staffing model and admission criteria. This focus on specialty pathways is also present at ICHT, where work is also being carried out to increase utilisation of the Enhanced Observation Unit.

4.7. 7) Reducing the number of patients past their DRD (Discharge Ready Date):

All Trusts fed back that continued engagement with and support from community partners is key in reducing patient length of stay and progressing timely discharges. ICHT and CWFT in particular have experienced consistently high numbers of patients who do not meet the criteria to reside waiting for discharge on pathways 1-3, and have been outliers in this respect. Pathway 1 is a discharge that requires further support at home with input from health or social care; pathway 2 is for discharges to a community bed-based setting which has dedicated recovery support; and pathway 3 is a discharge to a care home for those patients requiring long-term bed-based care. In terms of the bed base occupied by patients who do not meet the criteria to reside and have not been discharged, this was 13.7% at CWFT and 12.5% at ICHT in August 2024 (*these trusts are cited as are outliers across the APC*). Another common theme was that the Trust's planned to review their board rounds in order to minimise the number of patients continuing to reside in hospital due to internal reasons, and to review escalation processes – both internally and across the NWL ICS– to ensure that timely escalations are maintained as business as usual. Underlying this, the Trusts also have a focus on their data. ICHT have updated the process of recording patients awaiting medical review on Cerner, and CWFT have identified further opportunities for mapping. LNWH are forecasting discharge dates on admission in order to track social care needs in advance, and this has been working well; and THHFT are working on improving the visibility of discharge data and closely monitoring and tracking delayed patients.

4.8. 8) Maintain acute G&A bed capacity at the level funded and agreed through operating plans

The [NHSE operational planning guidance](#) states that systems should maintain acute G&A

beds as a minimum at the level funded and agreed through operating plans in 2023/24. However, the NWL ICB has not agreed to fund G&A capacity at this level for 2024/25. All of the Trusts in the APC have maintained some level of winter capacity in order to support flow and maintain patient safety, but this is becoming an increasing financial pressure. In May 2024, a new 32-bed acute medical unit opened at Northwick Park Hospital, and 24 beds were opened substantively at the beginning of July 2024 at West Middlesex Hospital.

4.9. 9) Paediatric ED performance (linked to ED peer review themes)

At ICHT, weekly paediatric 4-hour performance meetings are being reinvigorated. At LNWH, an additional senior decision maker will be in place to implement a RAT model at Northwick Park Hospital to support increased demand, which has been very successful in the past three winters. Four recently opened paediatric HDU beds will support the timely admission of critical care level 1 and 2 patients. The service is also keen to support young people living with mental health challenges in innovative ways. In May 2024, a 'mind and body' clinic was launched whereby an outpatient clinic is jointly delivered by a paediatrician and psychologist, supporting young people with a physical illness coupled with mental health challenges. At THFT, additional medical staffing has been ring-fenced and opportunities are being explored to implement a paediatric emergency medicine consultant or an alternate management model. These Trust-based initiatives sit below the wide-ranging improvement work that is taking place under the umbrella of the NWL paediatric peer review, which is focusing on: data and coding; optimising capacity, space and flow; workforce; SDEC; CYP mental health; and the work to readdress the focus on 16-17 year olds.

5. Quality and Safety

- 5.1. Our aim, at all times, is to deliver high standards of care for patients in the right place at the right time. As this is typically more challenging during the pressurised winter period when our emergency departments are very busy, it is imperative that all four Trusts have arrangements in place to monitor and manage the risks of potential harm, actual harm, experience and the impact on patients and staff.
- 5.2. Each of the Trusts met with the APC UEC Lead and UEC National Clinical Director during the first week of September 2024 to discuss their plans. These meetings, in addition to seeking assurance about operational delivery, had a focus on maintaining quality and safety. Processes and procedures for assessing and mitigating the risk of potential harm and safety for staff and patients were reviewed. All four Trusts have working escalation models and established governance and reporting structures, which include regular reviews of complaints, incidents and metrics, such as waiting times for assessment and treatment and occupancy within the emergency departments. The use of the NHSE Operational Pressures Escalation Levels (OPEL) framework is embedded across the APC.
- 5.3. In terms of risk, the impact of the high number of patients delayed in hospital after they are ready to be discharged to an alternative care setting, and long waits for admission to a mental health bed, were highlighted consistently as the areas of greatest concern.

6. Mental Health

- 6.1. There are pressing quality, safety and patient experience risks at the interface of care between acute and mental health care providers in NWL, driven by an increase in the

number, and complexity, of patients presenting to emergency departments with mental health care needs.

- 6.2. On average, patients with acute mental health needs spend twice as long waiting in our emergency departments compared with those with physical health needs. In August 2024, data from the Emergency Care Data Set confirmed that circa 5% of 38,000 emergency department attendances in NWL were for patients with an acute mental health problem. Of these, one-third were referred to mental health services, and two-thirds were managed by the acute provider with discharge or onward referral to primary care or community services as needed. Of the one-third of patients referred to mental health services, a third spent 12 hours or longer in the emergency department.
- 6.3. Patients who are violent, whose behaviour is difficult to manage and those with a forensic or risk history, present a particular challenge in keeping them safe from self-harm, and minimising contact with other vulnerable patients and staff members.
- 6.4. This increasing pressure represents a risk to quality, safety, equity of care and patient experience. In addition to enhancing mitigating measures within our emergency departments, the APC is active in discussions with the ICS about actions to better manage risk across the whole system. These should take into account both the needs of the individual patients and the wider risk to other patients within the emergency department.

7. Discharge

- 7.1. The focus remains on key performance indicators, such as the utilisation of bridging services, and reduction in the average length of stay. The impact of these metrics on patient outcomes is being monitored, and the four Trusts are working on delivering the discharge specific metrics. The first NWL System Flow Optimisation Board on 8th October 2024 brings together the key stakeholders and senior decision-makers.
- 7.2. The crucial indicator for all schemes is a reduction in delay days and the subsequent impact on percentage of beds occupied by those with no Criteria to Reside (CTR). For patients on pathway 1, the target is a saving of 1.5 days compared to the NWL average delay days by the end of 2024/25, and for pathway 3, a saving of 10% by the end of 2024/25.
- 7.3. A recent deep dive by the NWL UEC team showed that all four Trusts experience noticeable delays with out of area discharges to the South-West London (SWL) region. The data also showed that this is a particular issue for CWFT and ICHT, across all pathways. Following this deep dive, the NWL UEC team are liaising with SWL to review their processes and work towards improving the efficiency of discharges.


8. Conclusion

- 8.1. All of the Trusts in the APC have provided action plans that align with the targets and supporting actions outlined in the NHSE guidance issued over the course of 2024. The improvement themes target a range of overarching areas, including: increasing the productivity of services across bedded and non-bedded capacity; improving flow, length of stay and clinical outcomes; and shifting activity from acute hospital settings by

supporting proactive care, admission avoidance and hospital discharge.

- 8.2. The leads for the Trust's UEC plans have shared and discussed their plans with each other to ensure that shared learning and best practice is applied across the APC. The plans have also been reviewed in a range of forums, including the individual Trust Finance and Performance Committees, the APC Executive Management Board, the APC Finance & Performance Committee, and the NWL UEC Board.
- 8.3. Additionally, all four Trusts met with the APC UEC Lead and UEC National Clinical Director in September 2024 to review their action plans and ensure that they were sufficient to maintain the level of progress required to March 2025 and beyond.
- 8.4. The plans are now also being reviewed following the Care Quality Commission's recent inspection of surgery and urgent and emergency care at the Hillingdon Hospital to ensure any learning is incorporated as necessary.
- 8.5. As stated in recent NHSE guidance, UEC services are likely to come under significant strain this winter. The NWL APC has undertaken a significant amount of work to ensure that the four acute Trusts are as prepared as possible for this increase in UEC demand, and the action plans have focused improvement efforts on those areas that will help to deliver the necessary resilience. The plans will allow the APC to meet the standards set out in the 2024/25 operating plan, and continue to make further improvements in the care provided for patients attending via UEC pathways.

2.2 BUSINESS PLAN PROGRESS REPORT MONTHS 1-6

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REFERENCES

Only PDFs are attached

 2.2 Business Plan Progress Report - Months 1-6 cover FINAL.pdf

 2.2a Business Plan Delivery M1-6 FINAL.pdf

NWL Acute Provider Collaborative Board in Common (Public)

15/10/2024

Item number: 2.2

This report is: Public

2024/25 NWL APC Business Plan Progress Report Q1 & Q2

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

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

Purpose of report

Purpose: Assurance

This paper sets out a high level summary of progress at Q1 and Q2 for the Collaborative Business Plans. It recognises solid progress, noting the context of a challenging financial position, but also acknowledges the need for greater pace and delivery on the Collaborative Business Plan priorities and indicates that this will be built into the planning process.

Report history

The Business Plan delivery report is built on reports considered at the Executive Management Board (EMB). Progress was reviewed by the EMB, with a subsequent refinement of ratings in the Finance and Performance Domain.

NWL APC EMB
09/10/2024
Reviewed

Executive summary and key messages

The NWL APC Business Plan for 2024/25 was set in draft at the start of the financial year, recognising that the APC Strategy was being finalised. A significant number of schemes were rolled over into the year, based on the solid work in progress during 2023/24.

At the planning stage, 24 priority schemes were carried forward into the 2024/25 financial year. At the July APC meeting, these were presented and are represented in this paper, with 5 rated

as green and 19 as amber at Q1. Each month, Executive Management Board reviews the priorities, including their rating, and undertakes deep dives and detailed reviews. At the end of Month 6, there are 30 key components of the Business Plan Priorities programme, with a refresh in the make-up and constitution of these priorities. This reflects the ongoing work within the CEO-led groups to refine and re-articulate their priorities following the publication of the Strategy. The 'core' business priorities have reduced, primarily through the grouping of workforce priorities into the People Services Improvement Programme. 6 priorities are rated green, 2 core priorities are rated as red and 8 core priorities are rated amber, with the balance of priorities still under development and as yet unrated. Further work is in hand to articulate the work programme of the estates and sustainability priorities.

13 priority productivity and efficiency schemes were developed as part of the planning process, with 4 of these schemes 'fast-tracked' by the Transformation Directors to move into delivery in year. A recent Executive Workshop across the APC undertook a full review of these schemes, recognising that some were progressing ahead of plan, and some needed reframing – and a full refresh of these productivity and efficiency schemes was agreed, recognising the financial context in which the APC is operating.

Looking ahead to Q3 and Q4, there is an opportunity to fully refresh the priorities on a more formalised basis as part of the planning process for 2025/26, recognising the significant impact that the financial challenge in 2024/25 has had on capacity and capability. As the Collaborative starts the planning process for next year, this rearticulation will be supported by detailed trajectories for improvement, building on the solid foundations put in place this year.

Strategic priorities

Tick all that apply

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

Impact assessment

Tick all that apply

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

- ☒ Finance
- ☒ Communications and engagement
- ☒ Council of governors

Reason for private submission

N/A



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 Business Plan 2024/25 Mid-Year Review and Briefing

Executive Summary

- For 2024/25, the Business Plan Priorities were rolled over from 2023/24, reflecting the work in 2023/24 on building an aligned set of priorities which sit within the APC governance arrangements. Each CEO has a lead area in delivery, supported by a set of appropriate governance meetings which bring together the relevant Executives. At the same time, the APC Strategy was being finalised – and was subsequently approved by the Board and published – and the Business Plan priorities would be refreshed in the context of the new strategy.
- At the planning stage, 24 priority schemes were carried forward into the 2024/25 financial year. At the July APC meeting, these were presented and are represented in this paper, with 5 rated as green and 19 as amber at Q1. Each month, Executive Management Board reviews the priorities, including their rating, and undertakes deep dives and detailed reviews. At the end of Month 6, there are 30 key components of the Business Plan Priorities programme, with a refresh in the make-up and constitution of these priorities. This reflects the ongoing work within the CEO-led groups to refine and re-articulate their priorities following the publication of the Strategy. The ‘core’ business priorities have reduced, primarily through the grouping of workforce priorities into the People Services Improvement Programme. 6 priorities are rated green, 2 core priorities are rated as red and 8 core priorities are rated amber, with the balance of priorities still under development and as yet unrated. Further work is in hand to articulate the work programme of the estates and sustainability priorities.
- 13 priority productivity and efficiency schemes were developed as part of the planning process, with 4 of these schemes ‘fast-tracked’ by the Transformation Directors to move into delivery in year. A recent Executive Workshop across the APC undertook a full review of these schemes, recognising that some were progressing ahead of plan, and some needed reframing – and a full refresh of these productivity and efficiency schemes was agreed, recognising the financial context in which the APC is operating.
- Looking ahead to Q3 and Q4, there is an opportunity to fully refresh the priorities on a more formalised basis as part of the planning process for 2025/26, recognising the significant impact that the financial challenge in 2024/25 has had on capacity and capability. As the Collaborative starts the planning process for next year, this rearticulation will be supported by detailed trajectories for improvement, building on the solid foundations put in place this year.

Planning for 2025/26 and Lessons Learnt

- 2024/25 can be seen as a transition year, with the schemes rolling forward. Whilst there are a range of positive improvements across the planning priorities, progress has not been at the pace expected given the level of opportunity identified. Whilst progress on the Clinical Service review schemes has accelerated, for example, and the Estates Directors are working more closely, there are other areas where progress is not happening at the pace required, such as the Elective Orthopaedic Centre.
- A recent Executive Workshop identified this challenge in a detailed review of progress against the 13 high priority productivity and efficiency challenges. The workshop concluded that the priority schemes needed an overhaul to reflect a number of key themes – greater realism and achievability, greater focus on specificity of outcome, more robust programme and project management arrangements, and a clearer sense of the improvements which would be driven by the APC rather than by actions undertaken by individual Trusts.
- This is echoed in Committee feedback on the developing priorities and the associated programme of work. The Finance and Performance Committee have identified a need for much greater granularity in trajectories and actions to deliver the specified KPIs for the improvement in performance being sought. The Workforce Committee has recognised the granular actions which have been developed, but is looking for a more strategic perspective on the benefits which accrue from APC actions, rather than a collation of Trust actions. The Strategic Estates and Sustainability Committee has identified key areas of focus, and has recognised work in hand to move towards a more strategic and aligned approach to estates management, but is also seeking to develop a register of Trust business cases and to understand the relationship between Trust plans and APC plans. This provides valuable feedback for the next stage of planning into 2025/26.
- The planning process for 2025/26 will start shortly and there are a number of key areas where the business planning process can be strengthened. At present, it is undertaken alongside the detailed operational and financial planning process, which means that the challenges of setting a robust operating plan can lessen the focus on the more strategic and collaborative process of identifying opportunities for improvement at the Collaborative level, and developing these into more robust plans. At the same time, the level of resource deployed to business plan priorities varies, and is not standardised across the piece. A more standardised and robust planning process for 2025/26 can address the issues identified in 2024/25, and can enable full delivery of the ambitions described in the Strategy.

Business Plan Priorities 2024/25 Initial Plan

- The Business Plan for the Collaborative was rolled over into 2024/25 with some minor refresh as the Collaborative Strategy is finalised. On a monthly basis, Executive Management Board receives an update on the progress against the priority programmes within the plan, as shown below at the end of Q1.

Quality Priorities - 2024/25	
Priority	Q1 Rating
Clinical harm review, access and inequality	A
Infection prevention and control	A
Peer review	A
User insights and focus	A
Care of the deteriorating patient	A
End of life care	A
Maternity and Neonatal – delivery plan	A
Mental health in an acute setting	A
Implement new national patient safety strategy	G
Incident and risk management system	A

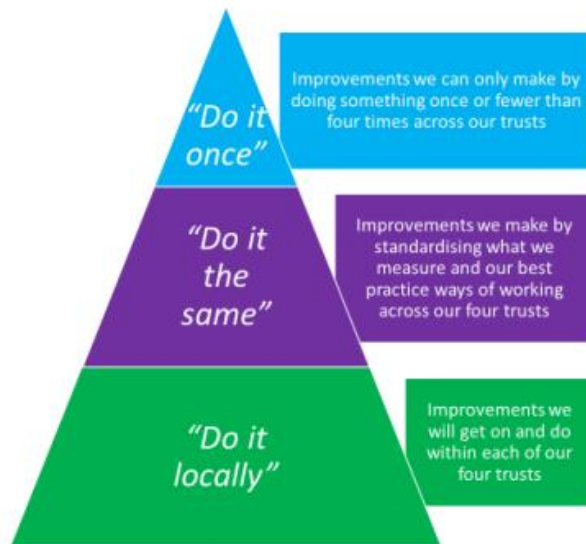
Workforce Priorities - 2024/25	
Priority	Q3
Reduce premium rate staffing expenditure	A
Recruitment hub for hard to fill vacancies	A
Careers hub and staff transfer scheme	A
Increase apprenticeship levy uptake	A
Reduce violence, aggression, bullying and discrimination	A
Digital Transformation Priorities - January 2024	
Priority	Q1
Finalise the APC Digital and Data Strategy	G
Implementation and Optimisation of Cerner system	G
Federated Data Platform	A

Finance & Performance Priorities - 2024/25	
Priority	Q1
Delivery of the activity targets in the 24/25 operational plan, including ERF	G
Support Services Consolidation	G
Implementation of Collaborative and ICB Programme 'System Optimisation'	A
Develop a clear financial model for a move to sustainability within a 3-5 year period, including rebalancing of earned/unearned income and reduction in ICB support	A
Outpatient Transformation	A
Implementation of ICB/Trust Business Case Review Outcomes	A

- Sitting alongside these programmes of work are priority Collaborative Productivity and Efficiency Schemes. An initial 13 schemes were identified earlier in the planning cycle – four have now been prioritised and are being supported by Directors of Transformation as well as Chief Financial Officers and Chief Operating Officers.

Progress from Q1 to Q2

- Q1 to Q2 has seen a significant refresh of the Business Plan priorities in the light of the published strategy. The individual programmes are starting to become more aligned with the 'do it once' (particularly in Digital and Estates) and 'do it the same' components of the Strategy. However, there remains work to do across all of the priorities to articulate these more fully in line with the Strategy and supported by appropriate key performance indicators for measurement of progress.



		Q1	Q2
Priorities in the Business Plan	R	0	2
Priorities in the Business Plan	A	19	10
Priorities in the Business Plan	G	5	6
Priorities in the Business Plan	n/a	0	1
Productivity and Efficiency Priorities	n/a	0	13
		24	32

- The self-assessed ratings for the majority of schemes remain amber, with some movement to green for the workforce, digital and elements of the financial and performance schemes (recognising that the scale of the in-year financial challenge has impacted on capacity to deliver). The productivity and efficiency priorities are subject to a refresh and review following an Executive challenge workshop.

Summary of Business Plan Priorities at Q2

- During Q1 and Q2, CEO leads have been refreshing their priorities in the context of the APC Strategy, and as appropriate the Committees of the APC have been reviewing progress on this refresh. This work continues and will play into the planning process for 2025/26. This means that the composition of the priorities has changed, with a narrowing of focus and a clear articulation of the work to be undertaken at Collaborative level. This is particularly prominent for the workforce priorities where a single and comprehensive People Services Improvement Plan has been drawn together and is reviewed by the relevant APC Committee.

Workforce Priorities	Q2	Finance and Performance Priorities	Q2	Quality Priorities	Q2
People Services Improvement Programme	G	Delivery of the activity targets in the 24/25 operational plan	G	Infection prevention and control	A
		Support Services Consolidation	G	Incident and risk management system	A
Digital Priorities	Q2	System Optimisation	R	Mental health in an acute setting	A
Finalise the APC Digital and Data Strategy	G	Develop a clear financial model for a move to sustainability within a 3-5 year period, including rebalancing of earned/unearned income and reduction in ICB support	A	Care of the deteriorating patient	A
Implementation and Optimisation of Cerner system - [<i>Now focuses on the continuous Enhancement and improvement of the single NWL APC EPR system</i>]	G	Outpatient Transformation	A	Maternity and Neonatal – delivery plan	A
NWL APC data and analytics strategy	G	Business Case Review Programme (supported by the ICB)	R	NatSSIPS 2 implementation	N/A – In discovery
Federated Data Platform (previously known as Improving patient flow and capacity using care co-ordination solution)	A				

- Five priorities are now rated as green, reflecting solid progress in workforce, in digital (at the level of the APC) and in some aspects of the financial priorities. However, the quality priorities remain in amber, despite extensive work in each of the key areas. As KPIs and deliverables are more clearly defined, a move to 'green' will be more readily achievable. Financial performance
- A recent Executive Workshop reviewed the 13 productivity and efficiency priorities and noted the need for a full refresh of these, recognising the financial position of the Collaborative and the need to prioritise schemes which would deliver at the Collaborative level. This work is currently being undertaken through the Finance and Performance Working Group.

Notes on Performance at Q2

Workforce Priorities	Q2
People Services Improvement Programme	G
Digital Priorities	Q2
Finalise the APC Digital and Data Strategy	G
Implementation and Optimisation of Cerner system - <i>[Now focuses on the continuous Enhancement and improvement of the single NWL APC EPR system]</i>	G
NWL APC data and analytics strategy	G
Federated Data Platform (previously known as Improving patient flow and capacity using care co-ordination solution)	A
Finance and Performance Priorities	Q2
Delivery of the activity targets in the 24/25 operational plan	G
Support Services Consolidation	G
System Optimisation	R
Develop a clear financial model for a move to sustainability within a 3-5 year period, including rebalancing of earned/unearned income and reduction in ICB support	A
Outpatient Transformation	A
Business Case Review Programme (supported by the ICB)	R
Quality Priorities	Q2
Infection prevention and control	A
Incident and risk management system	A
Mental health in an acute setting	A
Care of the deteriorating patient	A
Maternity and Neonatal – delivery plan	A
NatSSIPS 2 implementation	N/A – In discovery

- Q2 has seen solid performance in the deliverables set out in the People Services Improvement programme, and continued work on the consolidation and standardisation of Digital Services. This latter programme of work will be further enhanced by the appointment of a Chief Digital Officer across the Collaborative.
- The core financial position of the Trust remains challenging, and this has impacted on capacity. The Trusts are – in aggregate – delivering well above the activity plan requirements for the year, and have made good progress on the corporate consolidation work. However, work on the system optimisation and business case projects (joint projects with the ICB) has fallen behind plan. System optimisation has been given a strong system impetus in October with the formation of an oversight Board, led by Lesley Watts, CEO at C&W. Whilst the in-year trading position of the Collaborative has significantly deteriorated, detailed work has been undertaken with the ICB to understand the underlying position and develop a medium-term financial plan for the system and the APC.
- The quality priority projects continue to evolve and to deliver improvements across the APC, with ongoing work on ensuring standard and consistent approaches in infection control, incident and risk-management, care of patients with mental health needs in an acute setting,, deteriorating patients and maternity/neonatal care.

Developing APC Productivity & Efficiency

- To support the Business Plan priorities, the CFOs worked with Transformation Directors to identify APC Productivity and Efficiency schemes which would support an improvement in the underlying position.
- The Transformation Directors supported EMB to prioritise four major schemes for the year, ensuring resources were made available and looking at options for support. These are highlighted in green.
- The APC priority schemes were reviewed at a recent workshop and a further re-articulation is planned, aimed at more clearly specifying deliverables and financial outcomes. Solid progress in key areas was identified, alongside challenges (such as the Elective Orthopaedic Centre), indicating a new for enhanced and strengthened monitoring and support for APC-wide projects and programmes.

Ref	Workstream	Status Note
1	Adult Critical Care	Local pricing agreement proposed. Work required to optimise benefits and agree APC bed base with ICB
2	Outpatients Transformation	Detailed programme plan developed and agreed by FPW working group. KPIs being confirmed.
3	EPR – Cerner	Trusts have moved to a single instance and co-ordinating a centralised team. Extensive work on benefits realisation and activity recording in place at LNWH and THH.
4	Elective Orthopaedic Centre	Challenged start to implementation. Recovery plan presented to the EMB in October 2024.
5	Ophthalmology	Pilots across APC footprint bearing fruit, with positive results, and initial discussions in train around broader strategic piece and next steps.
6	Mental Health	Extensive work in train across the four Trusts supporting a standardised approach. THH reviewing approach to in-house capability to align with APC approach. Monthly cost model developed and used by Steering Group.
7,8,9	7.UEC – LOS/Discharges 8.UEC – ED service costs 9.UEC – SDEC models	Operation performance being maintained with significant system pressures. Capacity challenges around continued utilisation of winter beds. Detailed peer review process is driving standardised process. Cost base has not reduced, and APC is showing a significant increase in the value/volume of NEL/SDEC work which is not funded.
10	Corporate Consolidation	Agreement across all Executive Teams to accelerate progress on Consolidation and to standardise where evidence demonstrates benefits. Solid progress on financial consolidation and improvement in the Procurement delivery and responsiveness.
11	Clinical Review Groups (CRG) workstreams	Extensive programme of work in train, across the APC, with CEO allocation of lead areas and extensive clinical engagement. CFOs to work to understand the support the financial improvements which will emerge from this programme.
12	Independent sector contracts	NWLP engaged to support an aligned programme of work on IS contracts and the opportunities to support a reduction in cost/benefits from scale. New APC CFO Commercial and Procurement Group set up
13	Theatre Productivity	NWL consistently reporting upper quartile performance in theatres, but variation in key specialties remains and will continue to be reviewed through the CFO group.



Chelsea and Westminster
Hospital NHS Foundation Trust



The Hillingdon Hospitals NHS
Foundation Trust



Imperial College Healthcare
NHS Trust



London North West University
Healthcare NHS Trust

Appendix: Breakdown of Business Plan Priorities

Quality priorities

Priority	Lead	Key metrics (including current performance)	Status (RAG)	Summary of progress since the last meeting (If no change, please write 'no change')	What are the risks to delivery and barriers to quicker progress?	Actions/milestones in the next period
Infection prevention and control	Julian Redhead, Medical director, ICHT	<ul style="list-style-type: none"> Hospital acquired infections (C diff; MRSA bacteraemia, E.coli) COVID/Flu outbreaks Number of patients delabelled for penicillin allergy AMS metrics to be agreed <p>NHSE thresholds for 2024/25 have been published. Based on these we are above trajectory for key infections within most trusts</p>		<ul style="list-style-type: none"> Review underway of project management support required to further the work around procuring a joint IPC and AMS surveillance system. Work continues on reviewing the key issues contributing to the increase in cases of C. Difficile (delayed or inappropriate sampling and in isolating patients), and a review of MRSA screening to understand where there are opportunities for standardisation is also underway APC winter planning will commence in October. 	<ul style="list-style-type: none"> Capacity within IPC teams to support another work stream Variation in data collection, measurement and access to data Differing capacity across teams to support improvement priorities Possible cost implications with changes in practice and reporting 	<ul style="list-style-type: none"> IPC rates and national benchmarking have now been sourced and are being reviewed in each trust and will be included in this dashboard by the November APCQC.
Incident and risk management system	Shona Maxwell, Chief of staff, ICHT	Proposed KPIs for the new shared system will be developed further as a preferred solution is identified.		<ul style="list-style-type: none"> Updated PID presented to September APCQC. Demos with the 2 suppliers who submitted bids took place on 25-26 September. Preferred supplier expected to be confirmed in October. 	<ul style="list-style-type: none"> Procurement support: project slippage due to delayed / lack of procurement support to launch tender. Risk now addressed with dedicated procurement lead. Full business case: risk of delay post tender if full business case and funding model (cost split) cannot be agreed at APC level. Project support: risk of delay due to lack of dedicated subject expert project leadership required to steer implementation post tender. 	<ul style="list-style-type: none"> Governance group to be established during Q3 Full business case due to be submitted in October 2024 System live / in use across APC 01/04/2025

Quality priorities

Priority	Lead	Key metrics (including current performance)	Status (RAG)	Summary of progress since the last meeting (If no change, please write 'no change')	What are the risks to delivery and barriers to quicker progress?	Actions/milestones in the next period
Mental health in an acute setting	Lisa Knight, Chief Nursing Officer, LWN	KPI dashboard under development		<ul style="list-style-type: none"> Bid made on behalf of all 4 trusts for the national enhanced observation programme – unknown timescales for NHSE to decide on the 10 national trusts. RMN tracker being piloted across 3/4 trusts with a view to go live in the fourth. Working group in place focused on aligning assessment models – which will ultimately determine the staffing required for each patient. Mapping of mental health training against the new London wide framework underway. Agreement in principle to use ICHT mental health strategy and make minor changes at Trust level – governance approval processes not yet agreed. Working with ICB to try to draw down system money for the refurbishment of mental health rooms in emergency departments. 	<ul style="list-style-type: none"> Other operational and strategic priorities Potential financial costs of training and capital projects Project infrastructure 	<ul style="list-style-type: none"> Full review of programme project plan to be undertaken with transformation lead. Head of strategy at LNWH has agreed to facilitate the development of APC mental health strategy - date for event being confirmed.
Care of the deteriorating patient	Raymond Anakwe, Medical Director, ICHT	<ul style="list-style-type: none"> ICNARC national audit participation and performance No and outcomes of Medical Emergency Calls/Critical Care Outreach Calls NEWS/MEWS/PEWS audit outcomes Outcome from in-hospital cardiac arrest calls: mortality within 24-hours Sepsis: Administration of antibiotics within 1 hour of diagnosis Workforce and staffing GPICS standards Complaints and incident theme numbers <p>No key issues to escalate from metrics currently available. The group aim to automate data collection where possible.</p>		<ul style="list-style-type: none"> A project update was presented to September's APCQC. Revisions to the proposed acute physical deterioration and sepsis pathway are continuing. Comments have been received from colleagues across the APC and an implementation group is being stood up to take this forward. 	<ul style="list-style-type: none"> Resource requirements to lead, plan and implement priority projects. Project resourcing could influence quality outcomes, benefit realisation and implementation timelines. Risks will further be reviewed as part of the project planning process to define level of risk and mitigating actions. 	<ul style="list-style-type: none"> Additional metrics to be added to the clinical outcomes dashboard. Agreed updates to the Cerner sepsis alert are scheduled to be actioned during Q3.

Quality priorities

Priority	Lead	Key metrics (including current performance)	Status (RAG)	Summary of progress since the last meeting (If no change, please write 'no change')	What are the risks to delivery and barriers to quicker progress?	Actions/milestones in the next period
Maternity and Neonatal – delivery plan	Robert Bleasdale, Chief Nursing Officer, CWFT	<ul style="list-style-type: none"> Crude still birth rate Crude neonatal death rate Suspected intrapartum brain injuries Pre-term births Maternal deaths <p>No new risks to escalate. Work is in progress to improve the timeliness of this data.</p>		<ul style="list-style-type: none"> Quarterly report setting out APC themes and Actions including compliance with Saving Babies Lives and National CQC Maternity Patient Experience survey results action plan and maternity workforce measures due to be presented to September APCQC. Report setting out latest positions across the 4 trusts with MIS year 6, Saving Babies' lives care bundle v3, the single delivery plan reported to APCQC. Areas at risk have mitigations in place. Staffing rates reported to APCQC – all trusts plan to undertake a full assessment or re-fresh of Birth rate plus in 2024 	Resourcing requirements due to the national reporting requirement specific to maternity and neonatal services. There is an opportunity to mitigate some of the burden through standard reporting template and resources within LMNS	<ul style="list-style-type: none"> MIS year 6 – peer review of evidence scheduled for January 2025 Incorporate ethnicity data for key metrics in APC maternity dashboard
NatSSIPS 2 implementation	Alan McGlennan, Chief Medical Officer, THH	<ul style="list-style-type: none"> Training compliance metrics Audits of template and CERNER tools usage Long term reduction in adverse events and incidents associated with invasive procedures, including a specific reduction in procedural errors and deviations from established protocols. 	N/A – In discovery	<ul style="list-style-type: none"> The working group held its second meeting on 13 September 2024. Project initiation document submitted to September's APCQC. Gap analyses being collated (ICHT's received). Next steps will include using the local gap analyses to summarise an APC position and set priorities and timelines. 	<ul style="list-style-type: none"> Risk of not meeting increasing requirements for patient safety training Digital capacity to make changes to CERNER Number of LocSSIPs in place and resistance to moving to standardised templates which reduces local variation may hinder progress 	<ul style="list-style-type: none"> Audit of LocSSIPs in use in all trusts by November 2024 Training needs analysis to be completed by January 2025.

Workstream		PEOPLE SERVICES IMPROVEMENT PROGRAMME	Workstream vision (What we are trying to achieve)	Deliver a People Services Improvement Programme for 2024/26, which maximises opportunities to eliminate, simplify, standardise, automate, and consolidate	Current RAG Status		On Track
SRO	Kevin Croft	Reporting period			September 2024		
Project lead	Amy Callow						
Metrics			Baseline	Deliverables / targets			
<ul style="list-style-type: none">Organisational workforce metrics examples:<ul style="list-style-type: none">staffing cost and productivity metrics (e.g. premium rate pay, rostering, attendance, turnover, overpayments)Staff engagement and satisfaction metrics (e.g. staff survey scores)Equality, diversity and inclusion metrics (e.g. WRES, MEGs)People services quality and performance metrics examples:<ul style="list-style-type: none">Time to hireContract release on timeER case management durationPeople services cost metrics<ul style="list-style-type: none">Cost per organisation WTEPeople service cost per WTECost per unit of activity (e.g. recruitment episode)Customer service (net promoter) metrics			Sickness absence – 4.1% Agency expenditure - 3% Pay overspend - 1,927 WTE; 5.6% over plan Time to Hire – 35 days	<ul style="list-style-type: none">Improved employee and customer experienceImproved access to people services for all NHS colleaguesIncreased quality and resilience across service provisionReduction in time to recruit and agency expenditureRecurrent cost savings and productivity efficiencies across the sub-functionsReduced errors through automation and streamlined processesReduced time spent by managers and staff on transactional activities to increase capacity to careReduced people service delivery costs by enabling and championing the use of the employee self-service and virtual agents (supported by robotic automation and artificial intelligence)Reduced administrative time for all employeesReduced estate costs and carbon footprintSavings from joint procurement of systems			
Milestones/tasks achieved over the last month				Milestones/tasks due over the next month		Quarter 3 Milestones	
<ul style="list-style-type: none">KPIs identified for all workstreamsShared access to National Inclusion week eventsHandover of Royal Free reporting processes to ICHT COEAssessment of BOT performance and initial remedial planning instigatedDraft KPI calculations document shared to begin detailing the data and methodologies for the NWL ICS workforce submission.Standardize Time to Hire, Shared London Staff Movement Agreement & template for NWL APC recruitment policy workstreams established with leads identified.Nursing agency rate card saving £41k (Q1) and over £200k FY forecastLeaver to bank improved to >5 daysReviewed existing RPAs in operation relating to HR AdminDate set and agreed for a combined Menopause conference across the 4 Trusts on 17 October using speakers across the 4 TrustsMapping of all benefits and suppliers across the Trusts complete			<ul style="list-style-type: none">E-Rostering - Pre-tender market engagement taken place with a Request for Information (RFI) pack developed by NWL Procurement to support engagement with suppliers. West London NHS Trust have joined the tender exercise.Commenced review EDI metrics collated against APCMapped APC EDI action plan to project charter prioritiesCompleted mapping of all Core skills and core clinical skills topics, compliance calculations, definitions and methodology.LMS – ChelWest focused on 'go live' and associated activity (e.g. comms, briefing sessions) and resolving teething problems. LNW has commenced using system	<ul style="list-style-type: none">Identify process for detailing benefits realisation of each Robotics Process Automation.Finalise the lever to bank SOP and communicate across TrustsReview collated AHP agency rate card and determine next stepsScope out existing chatbot/enterprise system (linking with CLCH, WL and Devon)Conduct an audit of existing Qliksense licenses and identify gaps across all Trusts.Job evaluation process mapping event to take placeLevy gifting paper to be produced and shared with appropriate APC Trust committees to ensure smooth release of funding as neededOptions to be presented to CPO's around continuation of Medics rostering with RLDatix for a further 2 years – fine tuning of paper already producedConfirm savings for each Trust from agreeing the new 2 year contract with RL DatixJoint event for Black History Month		<ul style="list-style-type: none">Map resources to identify future areas of alignment and best practiceReview process variation and remove/alignApprenticeships - All Trusts in APC look to gift the maximum 25%Map current use of Chatbots across people services and standardise use of RPAAgree core set of KPI's to support all servicesPropose and agree the future dataset and definitionsCreate proposal for future preferred reporting platform	
Risks		Mitigating actions				RAG	
<ul style="list-style-type: none">NHS track record in scaling people servicesLocal capacity to support the programmeRisk of losing staff in the HR teams who fear what 'scaling' may mean for their roles and their futureAppropriately resourcing the programme to achieve impact		<ul style="list-style-type: none">Capture and apply learning from local examples and outside the NHS and agreement of resources for the programme linked to business case process.Local engagement and prioritisation and effective use of Vanguard funding.Engagement of HR teams in the process, generate a compelling case for change highlighting opportunity for greater development and the creation of genuine career pathways which are known to be attractors of talent and will allow the organisation to align the delivery model to the employment offer to HR professionals allowing some to move on but attracting a skill set that will be required in the future.The structured business-case approach to decision-making will help establish the benefits to justify investment in advance of the commitment of significant resources.				AMBER	
Escalation/Support/Decisions required							
<ul style="list-style-type: none">Nothing to escalate							

NHS

Northampton

Doncaster

Leeds

Sheffield

South Yorkshire

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Acute Provider Collaborative

Finance and Performance Priorities – 1 of 3

Priority	Lead	Key metrics	Status (RAG)	Summary of progress	Risks to Delivery	Upcoming milestones/ decisions
Delivery of the activity targets in the 24/25 operational plan	COOs	ERF activity delivery against plan. ERF funding recovered.		<ul style="list-style-type: none"> The Collaborative has agreed a challenging and ambitious set of ERF targets. They are being monitored at each trust,. Key enablers will be supporting efficiency, clinical priority, productivity and waiting list reduction; such as CRG's, ECB, UEC Board Pathways & Planned Care Programme Board and NWL Productivity Improvement Group. Progress on activity delivery against YTD ERF target is reported by the COOs each month to the FPW Meeting. Reconciliation of ERF activity performance to £ performance undertaken by COOs and CFO Group. ERF financial performance reported and monitored at APC Income Leads Group. Forecast ERF has been revised in month 5 and shows a significant improvement compared to the month 4 performance. Report to Aug FPW on NEL activity Vs plan. 	CFOs will need to continue to work closely with COOs and the ICB to monitoring performance. Underperformance remains a significant risk at LNWH, with focused work in hand with Divisional Teams on a weekly basis.	<ul style="list-style-type: none"> Confirmation of the 2023/24 outturn is anticipated in Sept, which may give rise to adjustments to the 2024/25 targets. ERF financial performance reported and monitored at APC Income Leads Group. Collation of all income recovery actions to be complied as part of M4 recovery plans. True up of activity V contract (at Q1) complete. M4 in progress. A&E conversion ratios and maternity activity to be reviewed in future FPW meeting
Support Services Consolidation	Virginia Massaro	KPIs to be confirmed through working group and in alignment with metrics proposed per APC Strategy.		<p>Progress is reported to the Corporate Programme Board and FPW Group monthly basis.</p> <p>Projects in progress are :</p> <ul style="list-style-type: none"> Financial Shared Services including financial and procurement system. To note – there was agreement in July on OBC option for roll out model of the Financial Shared Services Project People Services Improvement programme underway Occupational Health - CWFT & THH at CNWL hub. Ambition for rest of APC tbc Procurement - embedding new Target Operating Model (TOM) Digital - Prioritisation exercise completed with SRO, Currently developing systems convergence programme Payroll - ICHT & LNWH hubs, CWFT on ICHT hub. THH signaled intent Corporate governance - Prioritisation exercise completed with SRO. <p>The APC Contracts Teams are working together to prepare a proposal for further collaboration on work processes and standardisation.</p>	<p>Capacity for change across the Collaborative creates a risk to delivery.</p> <p>However, the programme management arrangements are robust and dedicated support is in place to help encourage delivery.</p>	<ul style="list-style-type: none"> Corporate benchmarking completed for 23/24 awaiting national output to review for APC. In the meantime, the 22/23 Corporate benchmarking output was presented to the FPW meeting (Aug 24) to review areas of largest opportunity. Report going to Sept 24 EMB to agree next steps with CEOs- see slide 8.

Finance and Performance Priorities – 2 of 3

Priority	Lead	Key metrics	Status (RAG)	Summary of progress	Risks to Delivery	Upcoming milestones/ decisions
System Optimisation	Jonathan Reid Sheena Basnayake Jazz Thind Laura Bewick	KPIs to be confirmed through working groups.		<p>NWL System flow optimisation Board has been set up (meeting on 8th October), to track progress of Task force groups for delayed discharges and mental health care models.</p> <p>Task force updates from FPW 20TH Sept as per below:.</p> <p>Task Force 1 - Delayed discharges and medically optimised patients Phase 1 - To ensure collecting, reporting and monitoring of accurate activity data regarding medically optimised patients in mental health and acute beds. This data will be used to quantify medically optimised mental health length of stay and financial impact for each organisation. Interventions to be identified once this is established. Targets are being agreed and set on delayed discharge related KPIs by pathway.</p> <p>Task Force 2 - Mental Health Models of Care. Initial discussions have identified following collaborative opportunities –</p> <ul style="list-style-type: none"> - Review commissioning of psych liaison services to attain improved value overall for the system - Explore effectiveness of existing interventions underway to improve patient outcomes and hospital flow. - System wide dashboard in development for finance, performance, activity and quality measures. 	<ul style="list-style-type: none"> • Capacity constraints for CFOs and COOs potentially challenges delivery. • Availability of BI support and production of relevant data insights to support the workstreams • Availability of PMO resources to support the workstreams 	<ul style="list-style-type: none"> • Agreement and production of data to support programmes to be agreed • Resources : BI and PMO to support to be agreed. • Articulation of the overall programme objectives and milestones to be agreed by TF groups.
Develop a clear financial model for a move to sustainability within a 3-5 year period, including rebalancing of earned/uneared income and reduction in ICB support	Jonathan Reid/ Virginia Massaro	Agreement of 5 yr plan, and allocation of earned/uneared income confirmed with ICB and Trusts		<ul style="list-style-type: none"> • Underlying position has been recalculated during the financial planning process and is being updated for Q1. • Uneared /earned income (23/24) has been assessed for differences in classification and APC has agreed and shared proposal with ICB who agreed APC classification. Next steps to agree recurrent/non recurrent income and update contract income modelling. • LTFM models have been shared across APC and CFO discussions are underway around progressing a LTFM model for the APC (agreeing level of alignment, formats, outputs and timescales). 	<ul style="list-style-type: none"> • Capacity within Collaborative and ICB to support this workstream including working through the detailed calculations 	<ul style="list-style-type: none"> • To agree LTFM models and outputs by Dec 24 • To agree resources to support development of LTFM model.

Finance and Performance Priorities – 3 of 3

Priority	Lead	Key metrics	Status (RAG)	Summary of progress	Risks to Delivery	Upcoming milestones/ decisions
Outpatient Transformation	Jonathan Reid & Tina Benson	Articulation of a clear programme for the Transformation in delivery of Outpatients.		<ul style="list-style-type: none"> Outpatients APC monthly workstream meetings scheduled. So far 3 meetings taken place, focusing on data flows, digital projects (CCS, e-checkout) show and tell, PIFU and DIFU show and tell. Opportunities to process map variation in data and workflows and identify roadmap for alignment across APC. Possible corporate transformation opportunity to simplify and standardise appointment clinic times. Outpatient procedure coding project could yield one off financial quick wins but not going to address the productivity challenge Next steps – build a APC P&E dashboard, agree PIFU SOP, standardise communications with patients to reduce DNA's, project timelines for FDP support for creation and management of universal waiting list for APC, working groups for A&G and e-checkout standardisation. FPW update for 18th October focused on follow up to new attendance ratio variations across the APC. 	Capacity and resourcing	<ul style="list-style-type: none"> Build an APC P&E dashboard, review PIFU SOPs for variation, standardise communications with patients to reduce DNA's Identify PMO and BI resource to support
Business Case Review Programme (supported by the ICB)	Jonathan Reid	Planned cost reductions per mitigations in financial plan.		<ul style="list-style-type: none"> The ICB commissioned a work programme from Hunter Healthcare to review business cases in all APC trusts and confirm the intended benefits have been realised. The aim is the output will be used to deliver anticipated financial improvements. Hunter Healthcare produced the outcome reports in July. There is an APC wide report, this is being reviewed and linked to current work programmes on going in the APC both within the Business plan priorities and within the agreed Productivity and Efficiency schemes. All trust have reviewed their organisation specific reports and reported to local exec/F&P committees, and trusts have work programmes in place to progress relevant proposals. 	Outcome of programme & the appetite to disinvest. Capacity & Resourcing	<ul style="list-style-type: none"> Link proposals from HH APC wide report to initiatives on going in the APC (Business Plan and P&E schemes)

Digital Transformation Priorities

Priority	Lead	Key metrics (including current performance)	Status (RAG)	Summary of progress since the last meeting (If no change, please write 'no change')	What are the risks to delivery and barriers to quicker progress?	Actions/milestones in the next period
Finalise the APC Digital and Data Strategy	Robbie Cline & Kevin Jarrold	<ul style="list-style-type: none"> Engage end users and get their involvement and input into the strategy. Secure approval for the APC Digital and Data Strategy 	G	<ul style="list-style-type: none"> The APC Digital and Data Strategy has been through trust governance and taken to the APC Digital and Data Steering Group. It has been noted at the NWL APC Collaborative Digital and Data Committee Progress - The strategy has been developed alongside the wider ICS Digital and Data Strategy and was approved at the last meeting of the APC Digital and Data Steering Group. Work is now getting underway on the 23/24 implementation plan - [No change] 	Other pressures including competing digital priorities and strategy	<ul style="list-style-type: none"> Develop and sign off the 2024/5 Digital and Data Implementation Plan
Implementation and Optimisation of Cerner system - [Now focuses on the continuous Enhancement and improvement of the single NWL APC EPR system]	Robbie Cline & Kevin Jarrold	<ul style="list-style-type: none"> Deploy and implement Cerner EPR across LNWH & THHT- Complete A single Cerner domain across NWL Acute Collaborative – Complete NWL Cerner Optimisation - Continuous improvement and enhancement of the Cerner Solution - On-going 	G	<ul style="list-style-type: none"> The Innovation Release (NWL Oracle Cerner Code Upgrade) was completed on 5 Jun 2024 as scheduled and project closure and lessons learnt have been completed. The Oracle Cerner Stabilisation Programme has concluded and focus is now turning towards embedding good system utilisation practice, which will enable and drive the benefit realisations of a joint and single EPR system across the APC. <p>NWL Patient Engagement Portal (Direct Booking):</p> <ul style="list-style-type: none"> A Mirth Server migration, has been completed for ICHT and CWFT. [all NWL now standardised] Technical readiness of the capability is now complete. Operational plan for enabling patients to actively book their own appointments has been developed. Technical subgroups have been established and the programme is working with OPD operational leads across the APC to identify suitable clinics for deployment , which is dependent on demand and capacity and clinic slot availabilities. <p>Internal Referrals:</p> <ul style="list-style-type: none"> Working group deliverables achieved - DCW, RFCs to ensure consistency in existing build and agreed scenarios for types of referrals. Wider stakeholder workshop held 6th September to commence redesign work. <p>NWL Ophthalmology System Consolidation:</p> <ul style="list-style-type: none"> ICHT Medisight upgrade is currently underway NWL migration to cloud instance outline business case is being developed. <p>NWL Endoscopy system consolidation:</p> <ul style="list-style-type: none"> The integration development work has started for the Demographic, Scheduling/Orders and Pathology interfaces The go-live will be later than planned due to a delay on accessing data from the legacy Scorpio system at ICHT. There is an outstanding issue (ChelWest only) with lack of 	Resource availability to ensure successful delivery of the NWL Cerner Optimisation and other competing priorities	<p>NWL Patient Engagement Portal (Direct Booking):</p> <ul style="list-style-type: none"> Finalise and seek endorsement across of the plan for enabling patients to actively book their own appointments across the APC Commence full scale pilot in agreed specialities. <p>Internal Referrals:</p> <ul style="list-style-type: none"> Fortnightly working group to continue design work and configuration. Agreed and finalise proposed Internal referrals build across the APC. Develop a proposed implementation plan <p>NWL Ophthalmology System Consolidation:</p> <ul style="list-style-type: none"> Develop and finalise gap analysis and options appraisal to identify the best cloud migration approach and value for money for the APC. Develop a proposed road to consolidate and streamline the solution for the APC. <p>NWL Endoscopy system consolidation:</p> <ul style="list-style-type: none"> Project plan to be re-baselined for new go-live date. Secure capital allocation to offset cost related to the delay of the programme. Agree a contingency plan to mitigate further delays associated to the data migration workstream. <p>NW ChemoCare system consolidation:</p> <ul style="list-style-type: none"> Commence decommissioning of the current system (ARIA). Complete project closure by Jan 2025. Complete CWFT aseptics worksheet & labels go live. Finalise the CMM (Pharmacy) interface scope and agree timeline. <p>NWL Sexual Health System:</p> <ul style="list-style-type: none"> Tender award to the preferred supplier is projected as 08th October 2024. Implementation planning with the supplier will begin from 22nd October 2024.

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Digital Transformation Priorities

Priority	Lead	Key metrics (including current performance)	Status (RAG)	Summary of progress since the last meeting (If no change, please write ‘no change’)	What are the risks to delivery and barriers to quicker progress?	Actions/milestones in the next period
NWL APC data and analytics strategy	Ruth Holland	<ul style="list-style-type: none">Indicative costs for 2024/25 financial planning by December 2024Data and analytics strategy by Mach 2025	G	<ul style="list-style-type: none">Data strategy steering group meeting regularlyHigh level principles relating to future state technical infrastructure shared with NWL APC EMBPre-procurement supplier engagement in progress	Urgent issues requiring tactical solutions divert resources from strategic work	<ul style="list-style-type: none">Supplier engagementSenior stakeholder engagementPresent indicative costs to Collaborative Digital and Data Committee 10th DecPresent indicative costs to NWL APC EMB 12th Dec
Federated Data Platform (previously known as Improving patient flow and capacity using care co-ordination solution	Bruno Botelho	<ul style="list-style-type: none">Continue to deploy and adopt agreed modules and associated workflows: Inpatient 360, Outpatient, RTT, OPTICA, EOC, Virtual Wards.For CW and LNWUH, there are additional modules being deployed and as result of the FDP Incubator development (Cancer 360, Command Centre (Timely Care Hub), RTT Validation, Patient Cohorting, Clinic Management, AI Dsums). Full roadmap / catalogue available through NWL FDP governance structureContinue to develop Incubator work on both APC as well as ICB: i.e. System Control Centre, Sector / Trust Discharge Reporting, PLICS/ costing, Diagnostics London Ambulance Service, Population Health Management, Mental Health support tools, Community	A	<ul style="list-style-type: none">Data Programme Manager now in place and undertaking review of existing infrastructure to identify priority areas for remediation to reduce latency and align best practices across all 4 trustsCompleted technical and IG work required to enable NWL organisations to formally transition to the FDP, with THH now live on the strategic platform which provides improved live service support model, integration with national cybersecurity monitoring, and registration of data flows with privacy enhancing technology (PET). Smartcard authentication also available once trusts are transitioned onto the FDP.Continuing to work in collaboration with NHSE to exploit AI opportunities within the FDP and align to existing modules (including incubator) to support the Productivity, Efficiency and Innovation agenda. Testing AI-assisted tool for drafting discharge summaries in order to refine the use of the LLM, user interface and clinical processesOptica (Discharge) – successfully completed pilot of shared tools with two Local Authorities. Now working on sector plan to fully roll out to all NWL trusts and Local authorities ahead of winter <p>Focus on Q3 + Q4 of 2024/25 to deploy and embed tools but dependent on risks being fully mitigated.</p>	<ul style="list-style-type: none">Latency All trusts have highlighted adverse operational impacts from the time being taken to make data available to FDP. Latency is affecting the adoption & use of the tools across NWL and is being tracked as a key risk<ul style="list-style-type: none">Data Extraction from the main Cerner EPR Capability is delayed, which is impacting latency.Number of DQ related issues originating from Cerner Oracle The EPR system (including variations in how the system is used across APC) impacts both the data warehouse and how the information is seen on the platform.Writeback Lack of writeback functionality currently preventing trusts from achieving full benefits of FDP (although net benefit still positive). Technical solutions being explored but limited progress to date, not helped by lack of positive engagement from Cerner to support this workFunding – available programme funding only covers period to end of Q3. Delays due to latency have impacted planned	<ul style="list-style-type: none">Complete governance and technical work to provide Smartcard authentication for all NWL acute trusts – addressed key barrier to clinical adoption of FDPContinue to support LIVE and Incubator products and develop a sustainable model to support trusts in 2024/25Support work being led by new FDP Data Programme Manager and align resources in BI/IT to reduce latency by looking into diverting existing developments into FDP, attempting to avoid duplication.Working with THH/LNWUH CIO to resolve data extraction. Anticipate a plan in Oct 2024Continue to work with suppliers to unblock writeback. There are options that require IG signoffSecure sustainable funding to enable NWL organisations, including the ICB, to fully benefit from current modules and rapidly scale adoption as new products become available / develop new products

3. REPORT FROM THE CHAIR IN COMMON

3.1 REPORT FROM THE CHAIR IN COMMON

 Matthew Swindells

REFERENCES

Only PDFs are attached

 3.1 Chair's Report NWL APC BiC 15 October 24 FINAL.pdf

NWL Acute Provider Collaborative Board in Common (Public)

15/10/2024

Item number: 3.1

This report is: Public

NWL Acute Collaborative Chair's 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](#)

Chair's Report

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

1. Independent Investigation of the NHS in England

- 1.1 The new Government have been in office for almost three months; one of their first actions was to ask Lord Ara Darzi, a consultant surgeon at Imperial College Hospital NHS Trust (ICHT), to undertake an independent review into the performance of the NHS in England. The report is a diagnosis of the challenges the NHS is facing, looking specifically at what the issues are but not the solutions to solve them. The report is evidence based, using verifiable data throughout, and it has been widely welcomed as the definitive description of the landscape which will feed into a 10-year plan (discussed below). Whilst the department of health and social and NHS are now embarking developing the plan, there is much in Lord Darzi's report that we can be starting address now and doesn't require us to wait for another publication.

[Lord Darzi's report can be found here.](#)

- 1.2 The Prime Minister has announced there will be a new NHS 10-year plan, expected to be published in spring 2025. The plan will focus broadly on three key areas, firstly a move from hospital to home for patients who don't need to be in hospital; secondly a shift from "analogue to digital" with greater use of technology and automation to support staff and patients; and thirdly, more focus on the prevention to reduce the need for future treatment.

2. The Care Quality Commission (CQC) Inspections

- 2.1 THHFT have had three CQC inspections over the last three months, one at the Hillingdon site, one at Mount Vernon and a Well Led inspection. The Nursing, Medical and Admin teams have done a tremendous job in getting the Trust prepared and I would like to add a special thanks to Vikas Sharma, Trust Secretary and Leigh Franklin Assistant Trust Secretary, who supported and led a lot of the preparation needed to facilitate CQC inspections.
- 2.2 On 7 August 2024 the Trust received a section 29A warning notice from the Hillingdon inspection, where some immediate concerns were highlighted. A programmatic approach has been taken in response to these concerns to improve, and embed systems and processes that ensure high quality care, progress is being fed back regularly to the Board and to the CQC. On 27 September 2024 the Trust received some high-level feedback from the Mount Vernon inspection. This was largely positive with some suggested areas for improvement, which THHFT are actively seeking to address. The Well Led inspection was due to take place between 24-26 September, though the process extended through to last week.

3. The Acute Provider Collaborative

- 3.1 A proposal from the four CEOs to identify the most significant strategic risks facing the Collaborative and to outline the options available in terms of governance structures that could assist in addressing these risks has been discussed at CWFT and THHFT Standing Committees.
- 3.2 The risks being faced by the APC are significant financial pressures, in particular by THHFT. Three options were considered at the Board in Common Cabinet in addressing the risks. The Cabinet agreed that option 3 of the paper was preferred, having a shared leadership model with a single Accountable Officer across CWFT and THHFT. The paper was updated to go to the CWFT and THHFT Trust Standing Committees for their approval on the recommended approach ahead of the final decision.

4. Appointments and Recruitment

- 4.1 I am delighted to welcome Dame Helen Stephenson on to the BiC, Helen started with the APC on 1 October, she is the Chair of the Quality Committee at ICHT and sits on the People and Finance and Performance Committees at Chelsea and Westminster Hospital NHS Foundation Trust (CWFT). Helen is an experienced NED and CEO with a strong track record in the public and voluntary sector. She has recently retired as the Chief Executive of The Charity Commission for England and Wales.
- 4.2 As I reported at the last BiC, Steve Gill, Vice Chair at CWFT will be stepping down at the end of this month, at the end of his term. I would like to take this opportunity to thank Steve for the tremendous work and dedication he has shown to CWFT over the last seven years. He has especially supported me in his Vice Chair role at the Trust and the wider APC, working closely with the Council of Governors and as Chair of the Quality Committee. Since September 2022 Steve has also been a NED on THHFT Board and I know has shown the same amount of commitment there as he has at CWFT. Enjoy your retirement Steve, we wish you all the best for the future.
- 4.3 In July, we held interviews for two vacant NED posts, one of which has now been filled by Helen Stephenson, we did not recruit into the other role:
- Board member for Chelsea and Westminster Hospital NHS Foundation Trust, where they will chair the Finance and Performance Committee, and board member for The Hillingdon Hospitals NHS Foundation Trust, where they will be a member of the Quality and Safety Committee and the Audit Committee.

There are interviews for this post next week and an update will be shared thereafter.

- 4.4 Jonathan Reid, Chief Finance Officer (CFO) at LNWH will be leaving the Trust at the end of this month. Jonathan worked at LNWH for four years, he not only leads the finance departments but also estates and health and safety teams and has played an integral part in keeping the Trust running. I am particularly grateful for the leadership role he has played across the APC as the four Trusts have worked ever closer over the last two years. I want to thank Jonathan on behalf of the Board. Don Richards has joined LNWH as interim CFO.
- 4.5 As I flagged in my July BiC report, Jon Bell, CFO left THHFT last month and Tracey Cotterill has joined the Trust as interim CFO.
- 4.6 Across the four Trusts a new role of chief information officer (CIO) for the North West London Acute Provider Collaborative has been created, congratulations to Robbie Cline, who has been appointed. Kevin Jarrold has retired from his role as the joint chief information officer (CIO) for ICHT and CWFT. He has done a wonderful job across the NWL data and digital agenda, I wanted to add my thanks for the work he has done across the sector.

4. Redevelopment and Capital Projects.

- 4.1 On the 29 July 2024, the Chancellor announced a review of the New Hospital Programme (NHP) to ensure that it has a 'thorough, realistic and costed timetable for delivery'. NHP expect the review to be completed shortly, with the outcome part of the Government's wider spending review process, feeding into the Chancellor's Autumn Budget on 30 October 2024. The review will exclude RAAC schemes and those with FBC approval, leaving 25 schemes in scope including Hillingdon, St Mary's, Charing Cross and Hammersmith. The outcome of the review is expected to be a new programme with clarity on where each

scheme is in the programme and the profile of spend. Both redevelopment teams continue 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.

5. Annual Members/General Meetings and THHFT Staff Awards

- 5.1 In July CWFT and ICHT had their AMM and AGM respectively, then in September the final two meetings for THHFT and LNWH took place. These meetings allow for staff and members of the public to hear first hand a review of 2023/24 from each of the Trusts, highlighting the achievements across the organisations and a chance look ahead to our challenges, opportunities and plans for this current year. A huge thank you to all our staff and volunteers. They have demonstrated huge commitment and expertise, often working as one team in our Trusts and achieving a huge amount in the face of some very significant challenges. I also want to thank our patients, members of the public and voluntary sector organisations and leaders. We are very proud of our strong relationships with our local communities.
- 5.2 THHFT had their staff awards on Thursday 5 September; it was a chance to celebrate the great work of individuals and teams across the Trust. I had the honour of presenting the Board's 'I am the Change' Award - for people or a team exemplifying 'I am the Change', innovation or who have introduced new initiatives to the workplace, which is voted for by the NEDs. Congratulations to Dr Usman Ahmed, Consultant, Acute Medicine Unit (AMU) who won the award, he has shown exceptional dedication to his patients, team and the department. Displaying an all-round commitment to a fantastic and supportive team ethos on AMU and general medicine as a whole.

6. Acute Provider Collaborative Visits

- 6.1 On Friday 26 July, I joined Danny Beale, newly elected MP for Uxbridge for a visit of the Hillingdon site, the visit was to learn more about the new hospital programme and a chance to visit staff at the site.
- 6.2 At the end of July, I attended the opening of the Acute Medical Centre (AMC) at Northwick Park hospital.
- 6.3 On 30 July I had a delightful session with the THHFT Estates and Facilities team to hear all about the work they are doing to across the THHFT hospital sites and also the decant programme to get THHFT ready for a new hospital. I was pleased to be able to celebrate with them winning the Health, Estates and Facilities Management Association (HEFMA) Team of the Year Award 2024.
- 6.4 On 3 September I visited CWFT Dean Street clinic, visiting Dean Street Express, meeting lead, Dr Tara Suchak, Clinic Manager Jon Clark and Senior Nurse Miriam O'Connor.
- 6.5 On the 10 September I was at Ealing hospital, I visited Ward 6N and 5N, two Care of the Elderly wards. I was shown around by Junierose Gazzingan, Matron Care of the Elderly Ward 5N and 6N, Julie Labial, 6N Ward Manager, Geeta Sharma, 5N Ward Manager and Sybil Fagbohungebe, Corporate Senior Nurse. The team showed me the work on the Timely Care Hub, which has recently been rolled out on all wards across LNWH. I also had a walk around with Christian Bonita, Superintendent Lead MRI, at the recently opened Community Diagnostic Centre (CDC), which is a state of the art diagnostic facility. It provides a full range of tests including CT, MRI and ultrasound scans.
- 6.6 On 1 October, I with a group of the ICHT NEDs who did a visit of the Acute Medicine Unit (AMU) and Emergency Department (ED) at Charing Cross hospital, to get a better

understanding of flow for our patients when they first arrive at the Trust. We were taken around by Brenda Deocampo, Lead Nurse Acute Medicine, Amy Hill Matron ED and Emma Tippins Lead Nurse Urgent & Emergency Medicine.

- 6.7 On 2 October, I again visited care of the elderly wards, this time at West Middlesex with NEDs from CWFT. We saw the Trust's Discharge Ready Unit, Crane Ward, which is a nurse led ward and supports getting older patients discharged as quickly and smoothly as possible. Jenny George, Head of Service Improvement and Efficiency and Dharmen Govinden, Deputy Director of Nursing within the Emergency and Integrated Care division showed us around, accompanied by Sanjay Krishnamoorthy, Medical Director for West Middlesex Hospital.
- 6.8 Site visits/walkabouts are an important element in enabling Board members to learn about the services provided within their trusts. More importantly, they provide more direct insight about the experience of patients and staff, supporting triangulation of information and data presented in committee and board meetings. I want to thank all the staff who have taken time out of their busy days to show me the great work they and their team are doing for patients in NWL.

3.2 BOARD IN COMMON CABINET SUMMARY

 Matthew Swindells

REFERENCES

Only PDFs are attached

 3.2 BiC Cabinet Committee Summary 12 September 2024 FINAL.pdf

NWL Acute Provider Collaborative Board in Common (Public)

15/10/2024

Item number: 3.2

This report is: Public

Board in Common Cabinet – Committee Summary

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

Accountable director: Matthew Swindells

Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

This paper provides an update on items discussed at the Board in Common Cabinet held on 12 September 2024. The Board in Common Cabinet due to be held on 20 August 2024 was stood down due to annual leave.

Report history

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

**Board in Common
Cabinet**

12/09/2024

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

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

1. Imperial College Healthcare NHS Trust (ICHT) – Fleming Centre Strategic Outline Case

1.1 Members of the ICHT Board approved the Fleming Centre Strategic Outline Case.

2. Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) – Treatment Centre Redevelopment Full Business Case

2.1 Members of the CWFT Board agreed the business case.

3. Imperial College Healthcare NHS Trust (ICHT) - Data Centre Business Case

3.1 Members of the ICHT Board approved the Data Centre Business Case.

4. Imperial College Healthcare NHS Trust (ICHT) – Public Sector Decarbonisation Contract award

4.1 Members of the ICHT Board approved the contract award.

5. Imperial College Healthcare NHS Trust (ICHT) SMH Development Manager Procurement Appointment

5.1 Members of the ICHT Board approved the appointment.

Executive summary and key messages

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

The key items to note from the Board in Common Cabinet meeting held on 12 September 2024 were:

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

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

CWFT

- A consultant orthopaedic surgeon, Dr Yaser Jabbar, had been a locum at CWFT, prior to working at Great Ormond Street Hospital where he is being investigated. CWFT were reviewing all cases and carrying out a risk assessment. This matter had been discussed in detail at CWFT's Quality Committee.

THHFT

- There was an unannounced CQC inspection at The Hillingdon site at the end of July and an unannounced CQC inspection at Mount Vernon site in August. The Trust also had a CQC Well-Led inspection on 24, 25 and 26 September.
- Following the Hillingdon site inspection, the Trust received some high level feedback, where some immediate concerns were highlighted. The Trust have taken a programmatic approach to respond to these concerns to improve, and embed systems and processes that ensure high quality care and are feeding back on progress regularly to the Board and to the CQC.

7. Acute Provider Collaborative Executive Management Board

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

8. Paper on addressing strategic risks across North West London acute providers

8.1 The Cabinet discussed a paper from the four CEOs to identify the most significant strategic risks facing the Collaborative and to outline the options available in terms of governance structures that could assist in addressing these risks.

8.2 The risks being faced by the APC are significant financial pressures, in particular by THHFT. Three options were considered in addressing the risks. The Cabinet agreed that option 3 of the paper was preferred, having a shared leadership model with a single Accountable Officer across CWFT and THHFT. The paper would be updated to go to the CWFT and THHFT Trust Standing Committees for their approval on recommended approach.

9 Elective Orthopaedic Centre

9.1 The Cabinet noted there was very positive news from the point of view of patient safety and patient experience; the quality of care there is excellent. However, there was a need to reach the capacity that had been set out in order to reach the financial plan which is currently at risk, also work needed to be done on efficiency. A trajectory for recovery is being developed and would be monitored in future months by the APC EMB and it would be discussed at a future Cabinet.

10 Financial position and recovery

10.1 There was a detailed discussion of what actions were needed to ensure the financial position for 2024/25 was brought back in line. The Cabinet noted that the M5 situation presented was a difficult position. All four Trusts had recovery plans in place. Consistency in reporting was important: the CFOs were working together to ensure position is recovered. A meeting with the ICB to discuss the position had been arranged.

Strategic priorities

Tick all that apply

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

[Click to describe impact](#)

Impact assessment

Tick all that apply

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

[Click to describe impact](#)

Reason for private submission

Tick all that apply

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

[If other, explain why](#)

4.1 INTEGRATED QUALITY, WORKFORCE, PERFORMANCE AND FINANCE REPORT

 Patricia Wright, Pippa Nightingale, Lesley Watts

REFERENCES

Only PDFs are attached

 4.1 BIC Integrated Performance Report cover sheet summary FINAL.pdf

 4.1a BIC Performance Report _Oct 24_Final FINAL.pdf

NWL Acute Provider Collaborative Board in Common

15/10/2024

Item number: 4.1

This report is: Public

Integrated Performance Report

Author:	Various
Job title:	N/A
Accountable director:	Patricia Wright
Job title:	CEO

Purpose of report

Purpose: Assurance

The performance report has been reviewed and updated to reflect comments from Board members as part of an ongoing piece of work being co-ordinated alongside the development of the APC Data Strategy. The report has been streamlined, with existing indicators revised and/or updated. The finance section has been removed as this is covered comprehensively in the stand-alone Finance report. Changes have been made to the structure of the report with a key themes for escalation/noting section and revisions to the Performance summary sheet.

The report will be further reviewed over the next few months to include EDI indicators and to move toward a more automated report that will allow analysis at different levels and in close to real time.

Report history

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

Executive management Board	Changes proposed to various sections.	10 Oct 2024
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Executive summary and key messages

Patient safety and experience performance at APC level is similar to previous months. In August, standards (where they exist) were met for the majority of metrics. Mortality rates and harm levels remain low, and the incident reporting rate trend is increasing which is positive. Our patient experience 'FFT' results are consistently above national and London averages although there is work to do to increase completion rates to ensure the validity of the responses.

Against a background of rising infection rates nationally, trajectories are being exceeded for the majority of infections included in this dashboard and in most Trusts. There was a particular increase in cases of c. Difficile across the APC in August, driven largely by an in-month rise at ICHT, and a recent period of special cause concerning variation for E. Coli. NHSE have now published trust-level thresholds for mandatory reportable infections for 2024/25, which represent a 5% reduction on the numbers reported at the end of last financial year (FY 23/24). All trusts have local improvement plans in place focused on improving routine IPC practice (e.g. hand hygiene and invasive line care).

Maternity indicators have been reviewed and brought into line with national reporting standards. Following agreement at the APC quality meeting 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. Work is underway to improve the timeliness of the data for these metrics and the next iteration of the report will include a breakdown of relevant KPIs by ethnicity.

There are still challenges to address on **patient access**, particularly with regards to UEC targets and ageing diagnostic equipment which is impacting on the ability to achieve the DM01 target. UEC pathways are stable, despite the ongoing pressure, which is high for the time of the year and activity has not shown any reduction although performance at THHFT remains challenged. Long-waiting patients have remained statistically stable, with NWL performing well nationally. The APC is predicting a number of 65ww at the end of September (833), whilst still working through all mitigations to the risks. Cancer performance has been sustained, meeting the 28-Day Faster Diagnosis Standard and 31-Day standard with sustained improvements to 62-Day standard. Diagnostics performance has stabilised below target, but all Trusts have recovery plans in place.

There are no **workforce** metrics currently performing as special cause concern variation with three meeting the Acute Provider Collaborate agreed targets; (vacancy, turnover & core skills).

Agency spend, as a proportion of overall pay bill, is the productivity measure with a collective target set at 2%. Current performance for August 2024 was 2.2% and is a common cause variation with spend at THHFT significantly above target although this is now reducing.

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.

This month's report provides a quarterly update on workforce equity. Specific actions being taken and developed to support MEG goals across the ACP at trust level include:

- 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

Key Actions:

All areas of variance in the data are being managed with action plans in place to support improvement.

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

Integrated Performance Report

August 2024 data
(Cancer, Maternity & Op Plan Performance = July 2024)
received by EMB and BIC October 2024

Areas to Note or Escalate by Theme

Theme	Notable successes	Significant concern
Patient Safety and Experience	Despite the pressures in A&E, at APC level, the percentage of patients accessing our emergency departments who report a good experience has been consistently above standard since January 2023 and is well above the London and national average.	Given the rising infection rates nationally, all Trusts are likely to exceed their NHSE set IPC thresholds for 2024/25. Rates per 100,000 bed days and national data will be included in next month's report to allow for improved benchmarking.
Mortality	None to report	None to report
Maternity	None to report	The rate of neonatal intrapartum brain injuries is an emerging area of concern with rates exceeding the national standard 6 times in the last 12 months.
Patient Access	Note to report	Although the APC generally performs better than London and national averages, system pressures are starting to impact on performance across a number of indicators. The APC is predicting a number of 65ww at the end of September (833)
Operating Plan and Capacity	The APC is out-performing targets on day case and first outpatient activity.	Trusts are not meeting inpatient elective targets and there is further work to do to increase Patient Initiated Follow Up rates which would release Outpatient capacity and reduce follow up rates.
Workforce	Voluntary turnover: over the past year, there has been a steady reduction from 12.8% to the current position of 9.4%	All trusts need to increase action to achieve WRES targets by 2025 and there is collective action to ensure recruitment and retention processes are fair and equitable.

Performance Summary

Link to Slide	Section KPI	Expected	Actual	Improvement Trend	Assurance
Patient Safety and Experience					
Link	Reporting rate of patient safety incidents	≥54.9	51.7	▲	✓
Link	Serious Incidents (Sis/PSIIs)	n/a	0.14	▲	-
Pressure ulcers (data collection to be finalised)					
Inpatient falls (data collection to be finalised)					
Link	Healthcare Associated c. Difficile Infections	n/a	35	▼	!
Link	Healthcare Associated E. coli BSIs	n/a	33	▼	!
Link	Healthcare Associated MRSA BSI	0	1		!
Link	Formal complaints received	n/a	7.83		-
Link	Good experience reported by inpatients	≥94%	95.6%		✓
Link	Good experience reported for emergency depts.	≥74%	89.3%	▲	✓
Link	VTE Risk Assessments Completed	≥95%	96.4%	▲	✓
Mortality					
Link	SHMI (as expected or better)	<100	4/4		✓
Link	HSMR (as expected or better)	<100	4/4		✓
Maternity					
Link	Crude still birth rate	<3.3	1.3		
Link	Rate of suspected neonatal intrapartum brain injuries	<1.8	3.1		
Link	Pre-Term births	<8%	6.4%		
Link	Neonatal Crude Deaths	<0.94	1.8		
Link	Maternal Deaths	0	0		
Link	Good experience reported for maternity services	≥90%	83.4%	▼	
▲ ▼	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 Access					
Link	Ambulance handover waits	≥65%	51.5%		!
Link	Waits in urgent and emergency care > 4 hours	≥78%	78.7%	▲	✓
Link	Waits in urgent and emergency care > 12 hours	</=2%	3.7%		!
Link	Referral to treatment waits > 52 weeks	</=2%	3.4%	▼	!
Link	Access to diagnostics > 6 Weeks	</=5%	20.7%		!
Link	Access to Cancer Care (Faster Diagnosis) < 28 days	≥75%	75.8%		✓
Link	Cancer First Treatment from Diagnosis < 31 days	≥96%	97.7%	▼	✓
Link	Referral to Cancer Treatment Pathways < 62 days	≥85%	76.0%	▲	!
Operating Plan and Capacity					
Link	Elective Inpatients (variance from target)	n/a	-8.2%		
Link	Day Cases (variance from target)	n/a	10.3%		
Link	Outpatient New Appointments (variance from target)	n/a	7.1%		
Link	Theatre Utilisations (Hrs)	≥85%	83.4%		
Link	Outpatient Transformation - PIFU	≥5%	3.4%	-	!
Link	Critical Care – Unoccupied Beds	≤85%	86.0%		
Link	Patients not meeting Criteria to Reside	n/a	n/a		
Workforce					
Link	Vacancy Rate	≤10%	9.0%		✓
Link	Voluntary Turnover Rate	≤12%	9.4%	▲	✓
Link	Sickness Absence Rate	≤4%	4.1%	▲	-
Link	Agency spend	≤2%	2.2%		-
Link	Non-medical appraisals	≥95%	90.7%		!
Link	Core skills compliance	≥90%	92.2%		✓
Overall page 80 of 274					

Patient Safety and Experience

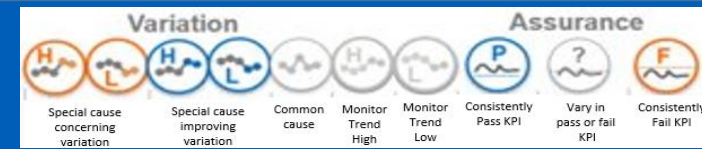
The quality metrics and reporting methodology were agreed following review of the trust board scorecards, national guidance and CQC insight reports. This data pack contains charts showing the trend over time at acute provider collaborative (APC) level for each metric, with in-month and rolling 12-month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

Changes have recently been made to this report following review and feedback from executive and non-executive directors, including:

- combination of incidents reported as resulting in severe/major harm or extreme harm/death into one percentage and inclusion as a supporting metric on the incident reporting slide
- inclusion of data related to timeliness of our responses to complaints on the formal complaints slide
- removal of maternity patient experience 'FFT' results to sit alongside other maternity metrics on the maternity dashboard
- a focus on themes and learning, rather than individual incidents.

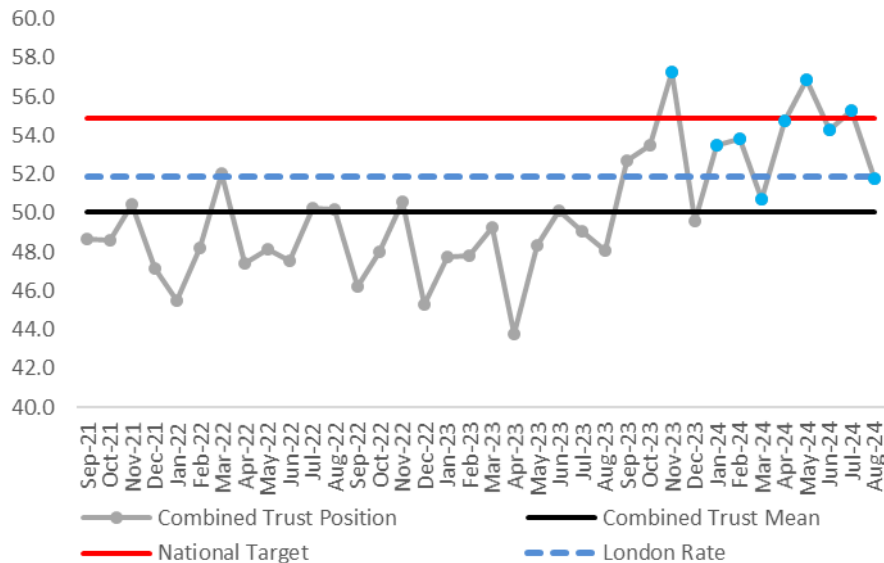
Additional metrics related to falls and pressure ulcers (by ethnicity), IPC rates and national benchmarking have now been sourced and are being reviewed in each trust and will be included in this dashboard by the November APCQC.

Patient Safety Incidents



TREND

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



≥54.9

STANDARD

51.75

PERFORMANCE



TREND

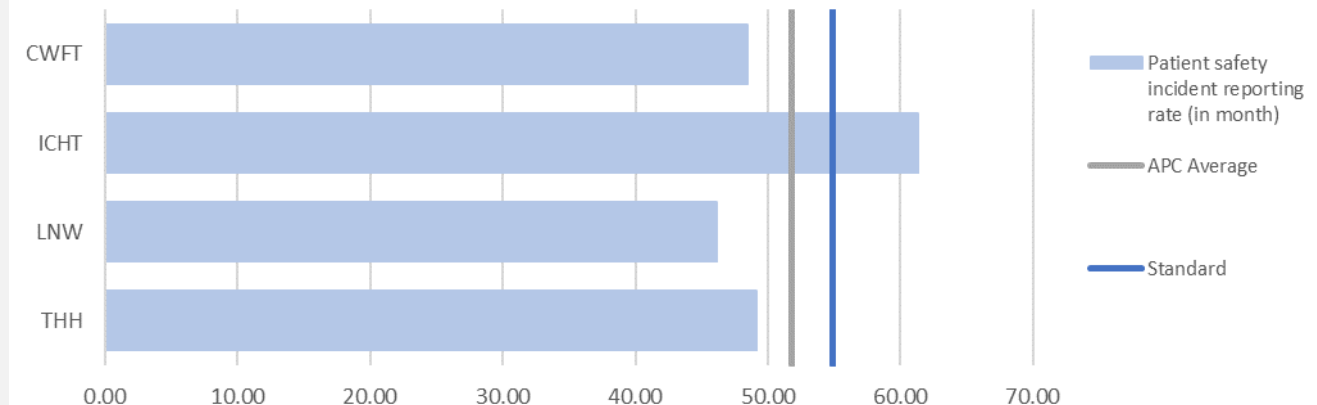


ASSURANCE

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	23,957	48.50	-6.40	1,162	1	0.09%	46.41	0.17%
ICHT	29,971	61.36		1,839	4	0.22%	65.58	0.14%
LNW	31,837	46.17	-8.73	1,470	4	0.27%	50.54	0.27%
THH	12,467	49.17	-5.73	613	1	0.16%	47.25	0.30%
APC	98,232	51.75	-3.15	5,084	10	0.20%	53.66	0.16%

STRATIFICATION



NARRATIVE

Performance: Incident reporting is an indicator of the safety culture, higher rates indicating willingness of people to speak up when an incident occurs. The rate is variable and reduced below the standard (national average) in month and on the 12 month rolling data. ICHT continues to meet the standard. The percentage of incidents causing severe or extreme harm is below national average (0.40%) at APC level (in-month and rolling 12 month) and within all Trusts. All cases are investigated and reviewed for themes and learning (see next slide).

Recovery Plan: All Trusts have now implemented Learn From Patient Safety Events (LFPSE); the transition is providing opportunity for training and communications to encourage reporting.

Improvements: Implementation of the new incident management system, once the procurement process has been completed (expected April 2025), will support standardisation of processes and ensure the system is as user-friendly as possible. Staff regularly feedback that current systems are barriers to reporting. Local plans to encourage reporting are in place in each Trust.

Forecast Risks: Not applicable.

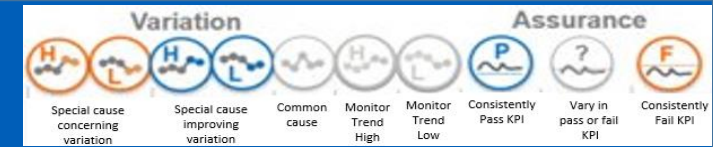
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

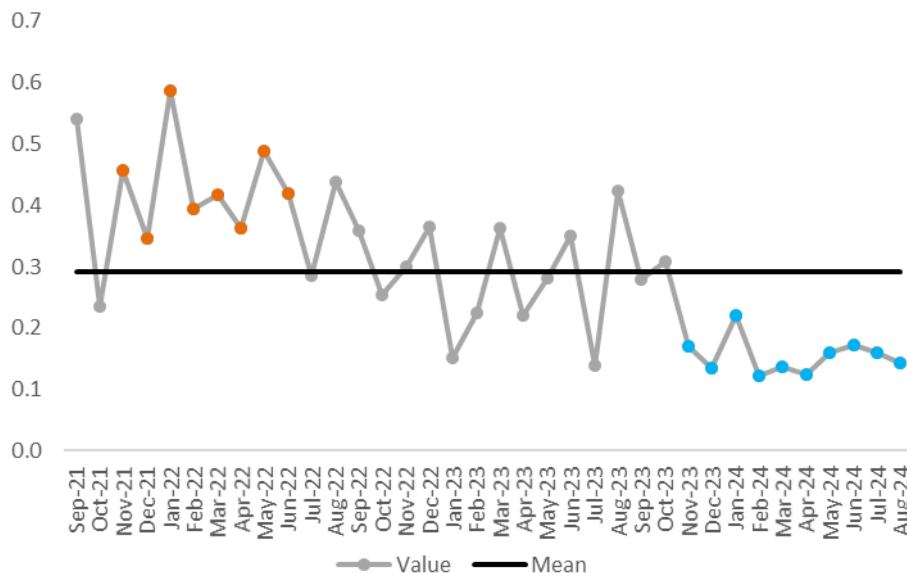
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

Patient Incidents reported on STEIS (SIs/PSIIs)



TREND

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



n/a

STANDARD

0.14

PERFORMANCE



TREND

ASSURANCE

NARRATIVE

Performance: The data includes serious incidents (SIs) declared under the old framework, and Patient Safety Incident Investigations (PSIIs) declared under the new PSIRF. The trend shows a reduction in the number declared as expected with PSIRF encouraging proportionate responses focused on opportunities for learning. One never event was declared in August, by ICHT related to administration of high strength midazolam. The patient did not come to harm, PSII underway & immediate actions confirmed.

Recovery Plan: N/A

Improvements: Themes from incidents and learning responses are regularly reviewed and used to identify local quality and safety priorities and inform our Patient Safety Incident Response Plans (PSIRPs). Recent themes include:

- CWFT: themes align with current improvement priorities, evaluation underway of learning responses initiated which may identify additional areas.
- ICHT: diagnosis delays and invasive procedure complications – other themes link in most cases to on-going safety improvement priorities, with additional actions underway in response to specific issues.
- LNW: operational pressures including admission delays, availability of suitable beds & patients being cared for in the most appropriate specialty areas. Improvement plans in place.
- THH: pressure ulcers and maternity incidents (postpartum haemorrhage and 3rd/4th degree tears) - improvement work underway.

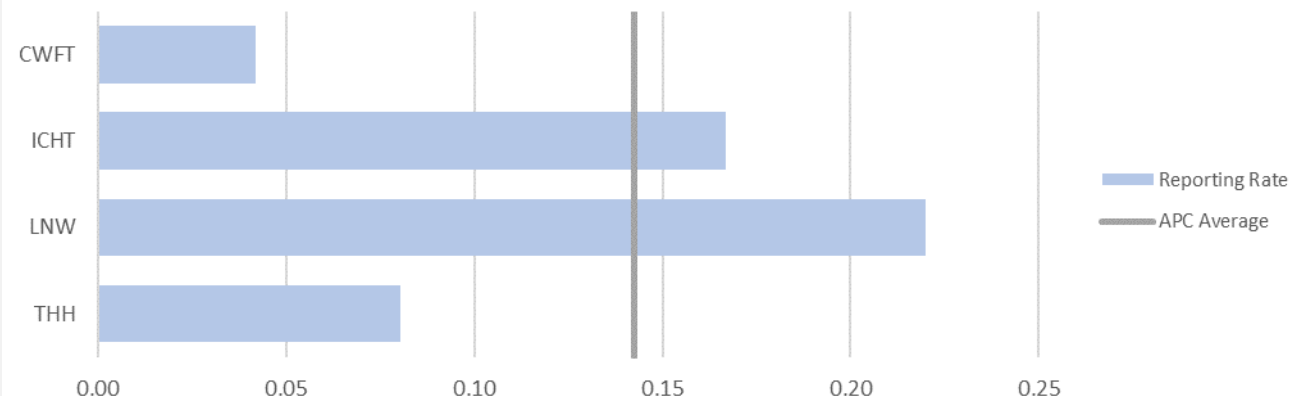
APC work streams continue for priority areas including care of the deteriorating patient and implementation of the new national safety standards for invasive procedures.

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

CURRENT PERFORMANCE

	Total bed days (in month)	In Month SIs & PSIIs	Reporting Rate	12 Month Rolling SIs & PSIIs	12 Month Rolling Reporting Rate
CWFT	23,957	1	0.04	39	0.13
ICHT	29,971	5	0.17	85	0.24
LNW	31,837	7	0.22	48	0.13
THH	12,467	1	0.08	35	0.23
APC	98,232	14	0.14	207	0.18

STRATIFICATION



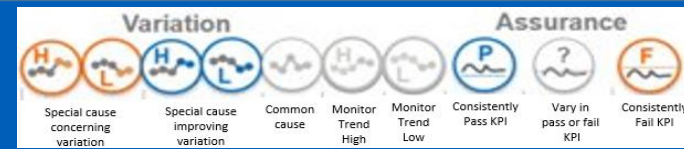
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

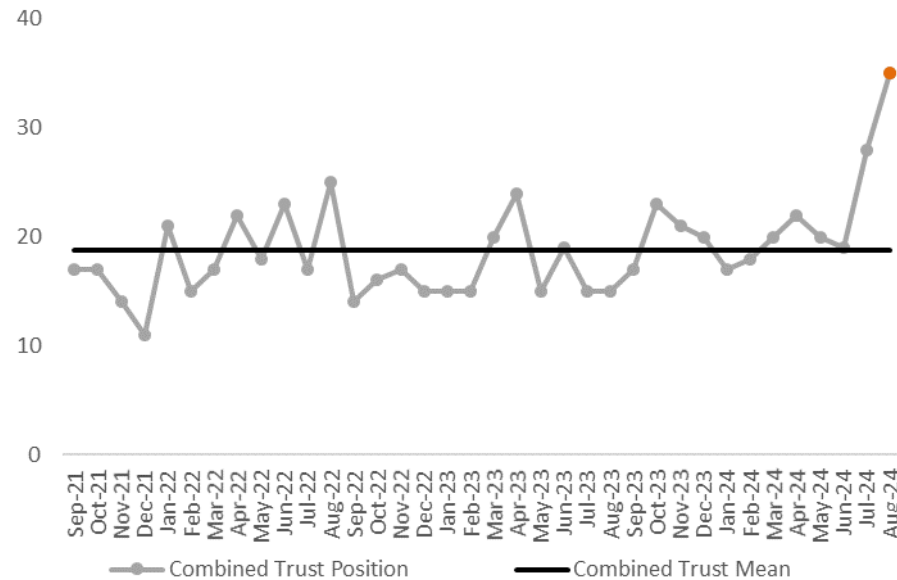
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

(Patient) Healthcare Associated C.Difficile Infections



TREND

Healthcare Associated c. Difficile Infections



Trust Specific

STANDARD

35

PERFORMANCE



TREND

ASSURANCE

NARRATIVE

Performance: NHSE have now published trust-level thresholds for mandatory reportable infections for 2024/25. The improvement targets are based on a 5% reduction on the numbers reported at the end of last financial year (FY). In month there were 35 cases reported across the APC. There has been an increase in the number of cases of C Difficile across London and NWL. Three of 4 trusts in the APC have noted a particular increase between June-August 2024 with the greatest in-month spike in cases seen at ICHT. 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. Benchmarking NWL ICS against other ICS across London, NWL in July reported the highest number of cases, however not the highest rate at 16.4 per 100,000 population below the London average of 16.7.

Recovery Plan: Every case is reviewed to determine if there have been any lapses in care or opportunities for improvement and this includes peer and ICB review. ICHT have reviewed the 16 cases reported in August and there are no outbreaks or evidence of cross-transmission. In depth analysis of C. difficile epidemiology has commenced with support from colleagues in NWL to allow for a better understanding of the factors driving the increase at ICHT, as well as the national profile. A review of the policy has commenced to make it clearer for staff the actions to take when a case is suspected or identified, and the process for C. difficile data collection and documentation in Cerner is being redesigned.

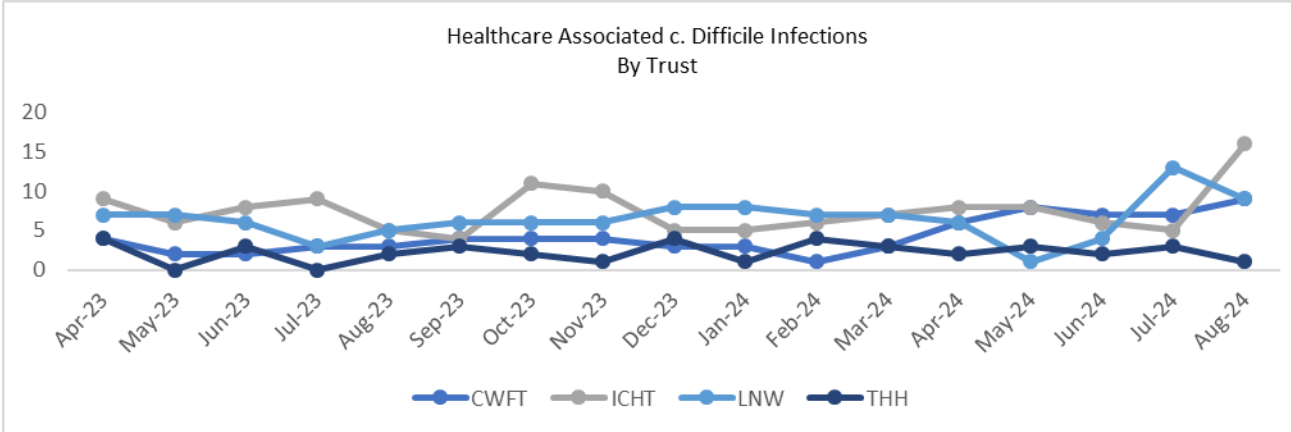
Improvements: There is ongoing work across all four trusts, as a collaborative and with system /ICB partners. Work is focussing on timeliness and appropriateness of sampling, isolating unwell and/or symptomatic patients as well as strengthening guidance and policies.

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.

CURRENT PERFORMANCE

	Count of c.Diff cases in month	Count of c.Diff cases in year (FY 24/25)	Trust Threshold (FY 24/25)	Difference from Threshold
CWFT	9	37	33	-4.0
ICHT	16	43	81	
LNW	9	33	75	
THH	1	11	26	
APC	35	124	215	

STRATIFICATION



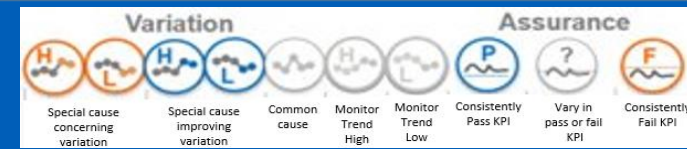
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

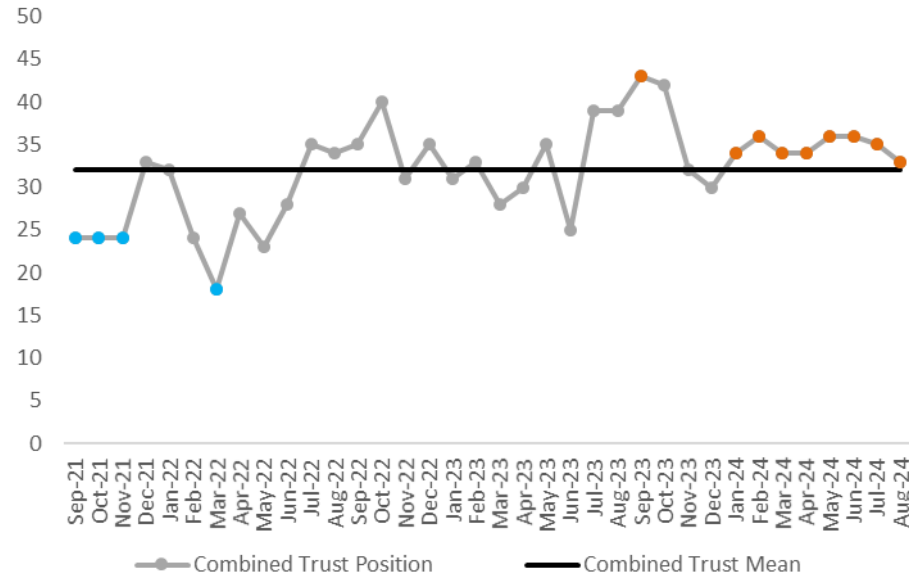
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

Patient Healthcare Associated E. coli Infections



TREND

Healthcare Associated E. Coli Infections



Trust Specific

STANDARD

33

PERFORMANCE



TREND

ASSURANCE

NARRATIVE

Performance: At APC level, the chart shows an increase above the mean over the last 8 months. There were 33 cases reported in total in August, slightly less than last month. NHSE set thresholds are in place for 2024/25. LNW and THH are above trajectory for this point in the FY.

Recovery Plan: The ICB is focused on reduction of E.coli BSIs in line with the NHS Long Term Plan. A regular ICS-led meeting is in place to drive improvement as a significant proportion of the Gram negative blood stream infections are attributed to community acquisition and it is important for there to be greater understanding around the risk factors for those attributed to acute organisations. Reduction therefore requires a whole health economy approach. Each organisation has now put in place a meeting to review their Gram negative blood stream infections presents their Gram negative improvement plan at the ICS meeting, 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 infections.

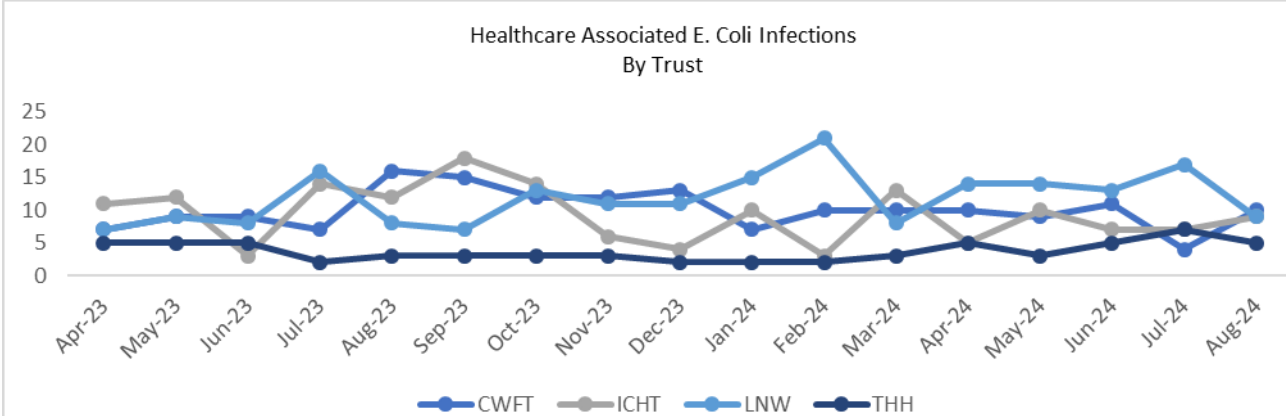
Improvements: Impact of actions taken through local and ICS reduction plan are monitored in each trust.

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

	Count of E.Coli BSIs in month	Count of E.Coli BSIs in year (FY 24/25)	Trust Threshold (FY 24/25)	Difference from Threshold
CWFT	10	44	120	
ICHT	9	38	116	
LNW	9	67	132	
THH	5	25	39	
APC	33	174	407	

STRATIFICATION



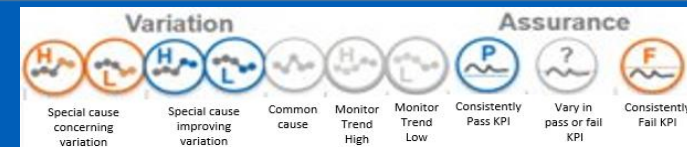
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

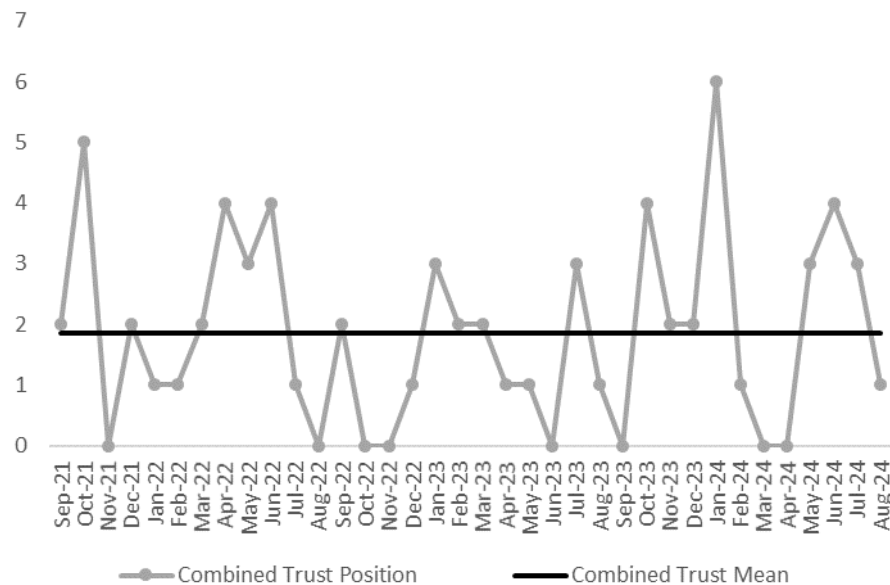
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

Patient Healthcare Associated MRSA Infections



TREND

Healthcare Associated MRSA Infections



0

STANDARD

1

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: There was one MRSA BSI reported in August across the APC, at CWFT, bringing the total number of cases this financial year to 11 against a threshold of 0. The largest number of cases (n=6) 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. 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 given the number there who are also focusing on effective MRSA eradication post surveillance. The APC group is also reviewing MRSA screening to understand where there are opportunities for standardisation.

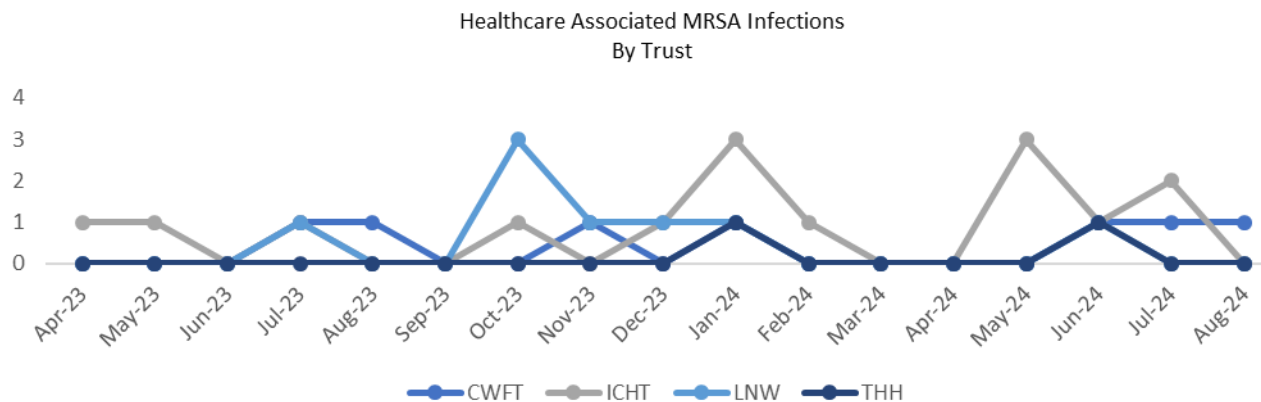
Improvements: A review of these cases will feed into the APC priority workstream to support identification of collective action or learning. Each trust has improvement work in place in response to these infections, the outcomes of which will report into the APC work stream and any shared learning planned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

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Count of MRSA BSIs in month	Count of MRSA BSIs in year (FY 24/25)	Trust Threshold (FY 24/25)	Difference from Threshold
CWFT	1	3	0	-3.0
ICHT	0	6	0	-6.0
LNW	0	1	0	-1.0
THH	0	1	0	-1.0
APC	1	11	0	-11.0

STRATIFICATION



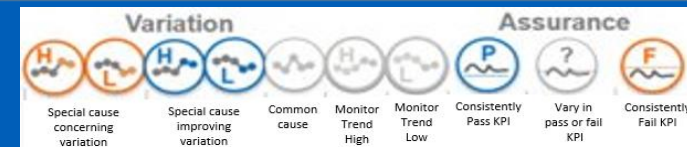
GOVERNANCE

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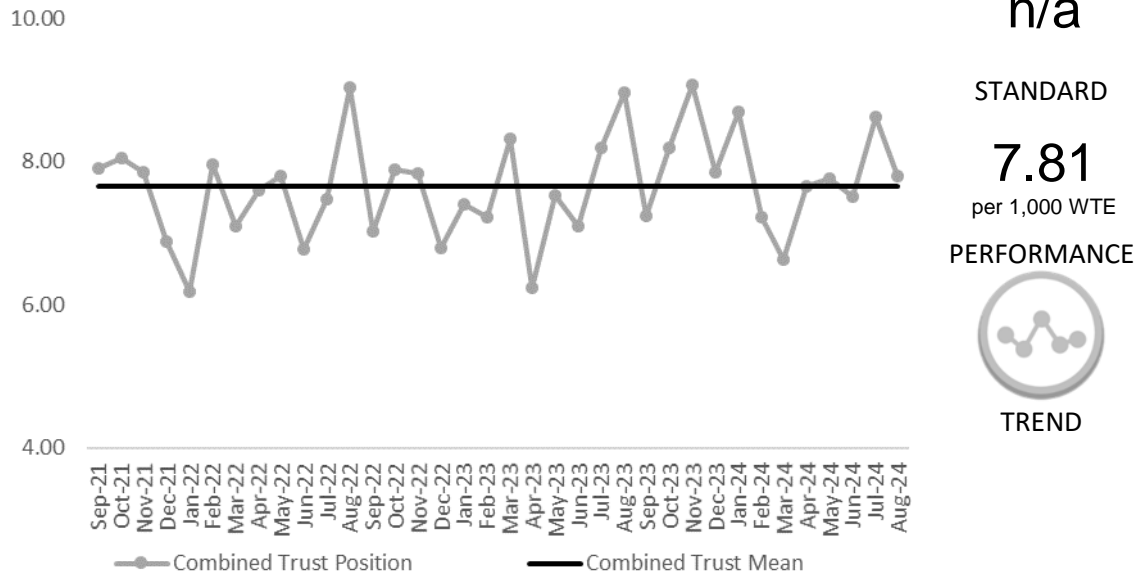
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

Patient Formal Complaints



TREND

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



NARRATIVE

Performance: The trend graph shows a decrease in month following an increase in July, however this is in line with standard variation. Rates vary at trust level, with THH having the highest rate in month and across the last 12 months. Each trust monitors complaint performance and activity. Data on completion of complaints responses has been added to this dashboard to allow closer monitoring of performance. This demonstrates that ICHT takes the longest average time to complete responses and has the highest number of complaints open for more than 90 working days (N.B. CWFT and LNW reports to first response while ICHT reports to final response, taking into account any re-opened complaints).

Recovery Plan: Not applicable

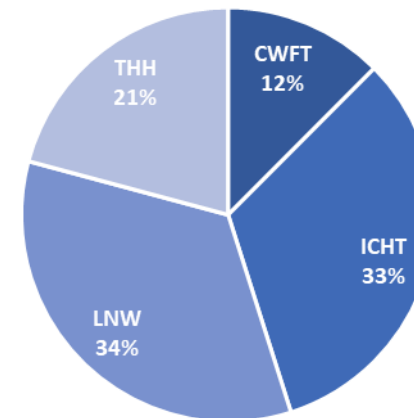
Improvements: Quarterly reporting on APC level complaints data and themes to APCQC commenced in September. This demonstrated differences between how individual trusts are reporting performance, outcomes and themes from complaints making comparison difficult. This is under review and will be standardised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

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Total WTE Staff	Rate per 1,000 WTE	Count of Patient Complaints	12 Month Rolling Rate per 1,000 WTE	Average days to complete responses	Number of open complaints >90 days
CWFT	6,951	4.75	33	5.29	33	1
ICHT	13,724	6.27	86	6.88	52	7
LNW	9,518	9.46	90	9.93	44	5
THH	3,620	15.19	55	10.99	30	0
APC	33,813	7.81	264	7.86	40	13

STRATIFICATION



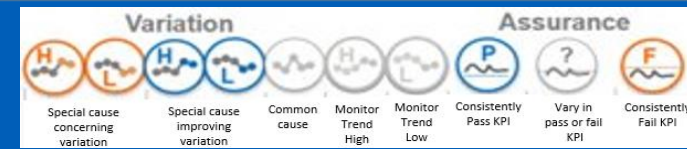
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

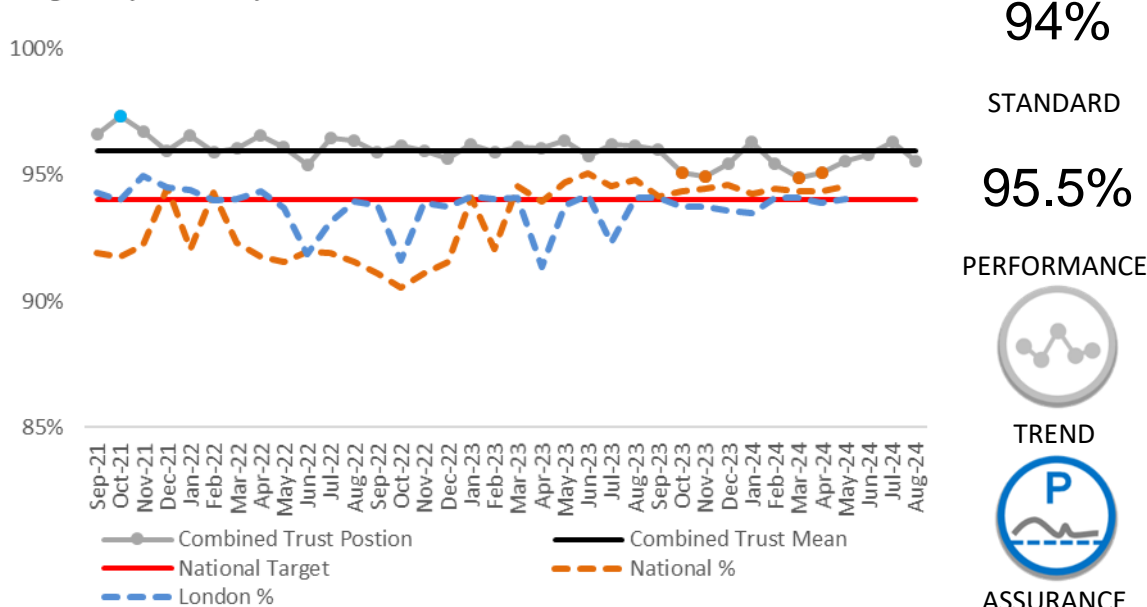
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

Patient Inpatient Friends & Family Test



TREND

% good experience - Inpatients



NARRATIVE

Performance: At APC level, the percentage of inpatients reporting a good experience is consistently above target and above national and London average (N.B. national data from May 2024 onwards is not currently available). Similar to the last few months, all trusts met the target in August, except for THH which was slightly below.

Recovery Plan: Not applicable

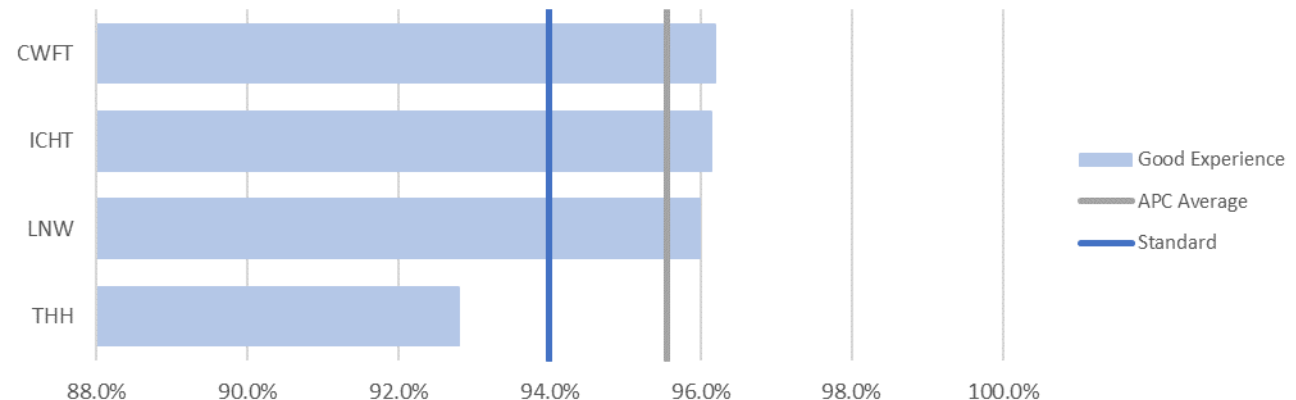
Improvements: A joint procurement plan for a patient survey platform is now in place, which will support better identification of areas for collaborative improvement once implemented.

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

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	788	96.2%		758	95.9%
ICHT	2,717	96.1%		2,612	96.4%
LNW	2,918	96.0%		2,801	95.6%
THH	1,235	92.8%	-1.2%	1,146	93.5%
APC	7,658	95.5%		7,317	95.5%

STRATIFICATION



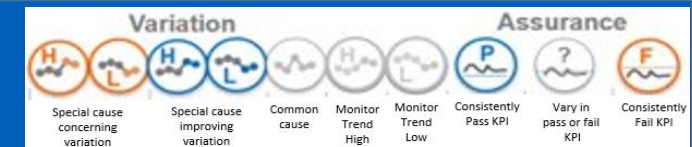
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Patient Emergency Dept Friends & Family Test



TREND

% good experience - ED

100%

90%

80%

70%

60%

Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24

— Combined Trust Position

— National Target

— London %

— Combined Trust Mean

— National %

74%

STANDARD

89.3%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: At APC level, the percentage of patients accessing our emergency departments who report a good experience has been consistently above standard since January 2023, with a period of special cause improving variation since July 2023. All trusts met the standard in August.

Recovery Plan: Not applicable.

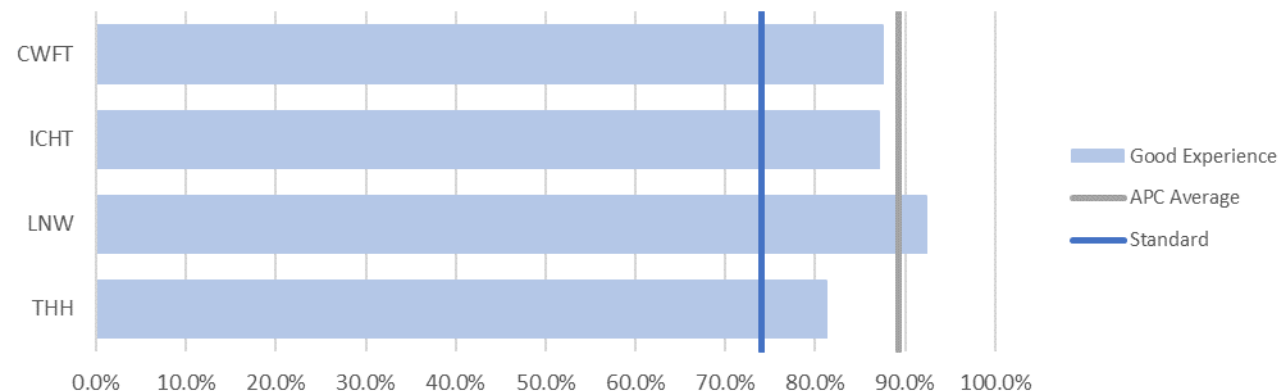
Improvements: N/A

Forecast Risks: Increasing winter pressures resulting in longer waits in ED may have a detrimental impact on patient experience. All Trusts will have robust winter plans in place.

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Recommended Care	12 Month Rolling Good Experience
CWFT	1,672	87.5%	1,463	81.9%
ICHT	1,069	87.1%	931	82.3%
LNW	4,108	92.3%	3,791	90.6%
THH	834	81.2%	677	73.6%
APC	7,683	89.3%	6,862	85.0%

STRATIFICATION



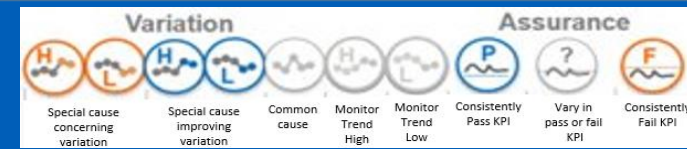
GOVERNANCE

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Committee: Acute provider collaborative executive management board

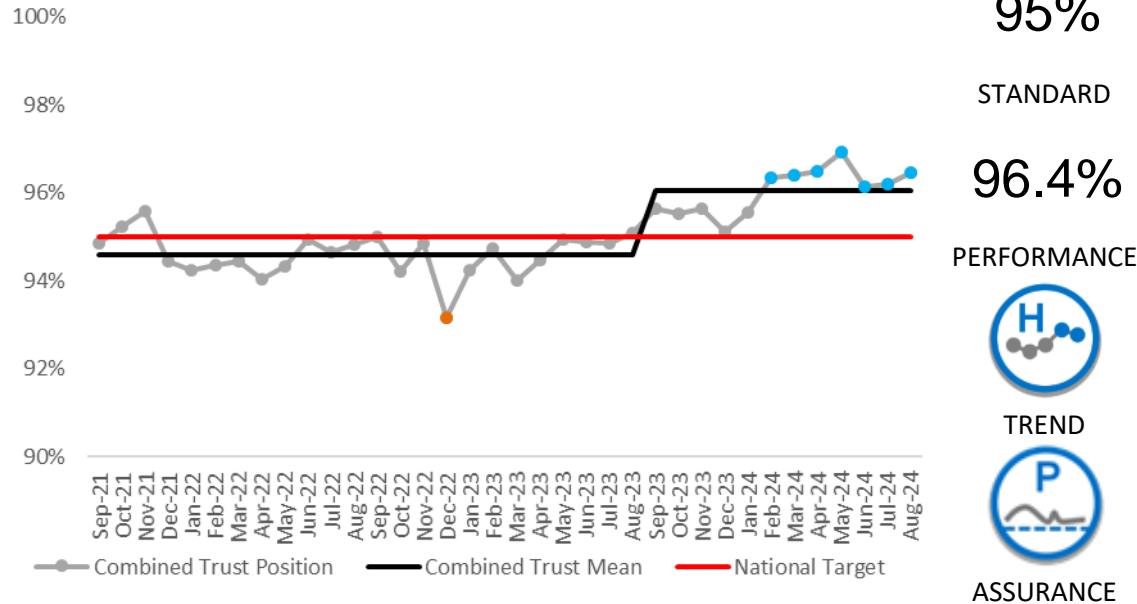
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

Patient VTE Risk Assessments Completed



TREND

% VTE risks completed



NARRATIVE

Performance: Benchmarking data is not currently available for this metric; however national data collection has now re-started following a pause from 2020 in response to the pandemic so this will be included once published by NHSE. LNW and THH are now reporting directly from Cerner which has resulted in an improvement at APC level. We are above the standard in month and across the last 12 months in all Trusts except THH which was just below in August but are expected to make continued improvements and to meet the standard going forward.

Recovery Plan: Not applicable

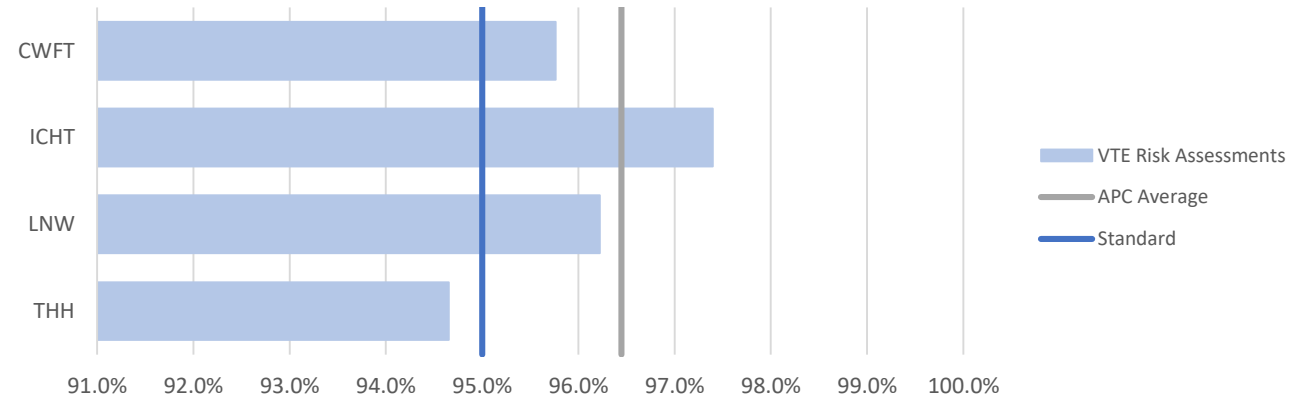
Improvements: THH has mandatory training for clinical staff in place and education is on-going to ensure the message on importance of risk assessment is disseminated.

Forecast Risks: Not applicable

CURRENT PERFORMANCE

	Total Inpatient Admissions	VTE Risk Assessments	Difference from Target	Count of Inpatients With Completed Risk Assessments	12 Month Rolling VTE Risk Assessments
CWFT	7,082	95.8%		6,782	95.1%
ICHT	16,214	97.4%		15,792	97.2%
LNW	13,693	96.2%		13,176	96.8%
THH	4,191	94.7%	-0.3%	3,967	91.5%
APC	41,180	96.4%		39,717	96.1%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

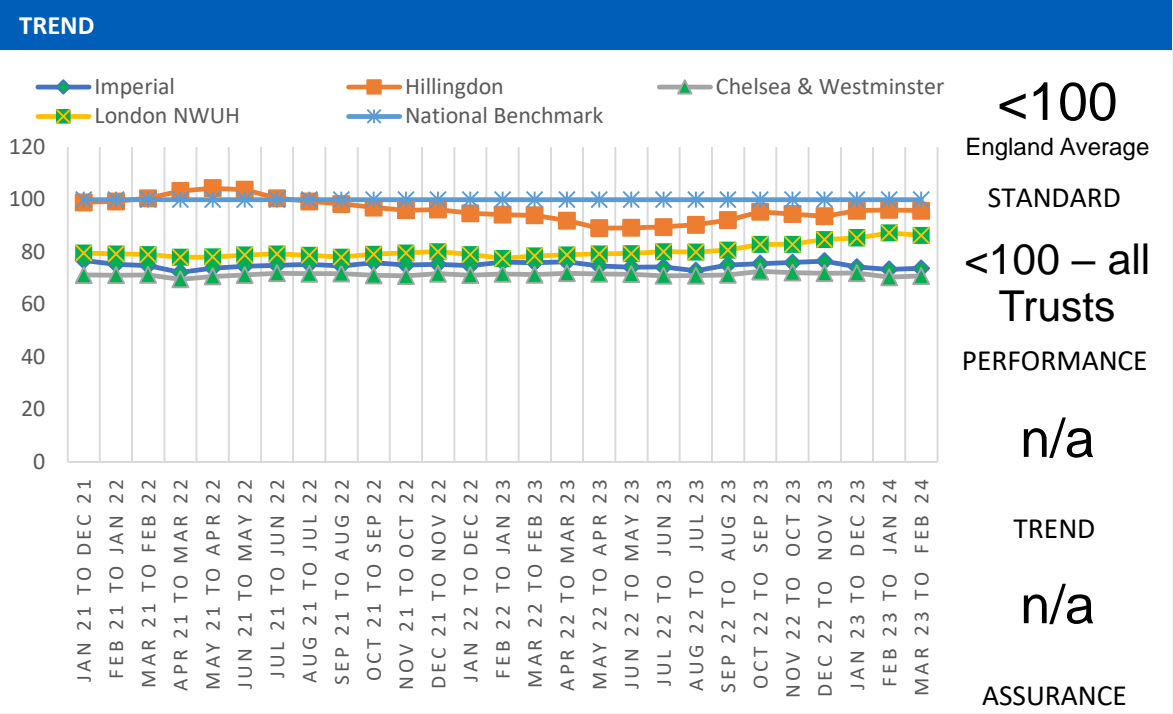
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

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



NARRATIVE

Performance: For three of the four trusts (CWFT, LNW and ICHT), the rolling-12 month SHMI remains lower than expected with the most recent data available (March 2024 – February 2024). THH’s rate is consistently ‘as expected’. There has been a recent increase at LNW and THH, although they remain below the national benchmark of 100, which will be reviewed and any findings summarised in the next quarterly learning from deaths report to this committee.

Recovery Plan: Not applicable.

Improvements: All Trusts are investigating variations between observed and expected deaths by diagnostic group. Reviews for quarter one are summarised in the learning from deaths report presented separately to Board in common with no issues to escalate.

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Provider Spells	SHMI	SHMI- relative risk ranking
CWFT	96840	70.85	Lower than expected
ICHT	107750	73.77	Lower than expected
LNW	105470	86.35	Lower than expected
THH	41520	95.76	as expected

STRATIFICATION

SHMI

Expected number of deaths

National baseline = 1

Hillingdon

ChelWest

Imperial

London NWUH

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GOVERNANCE

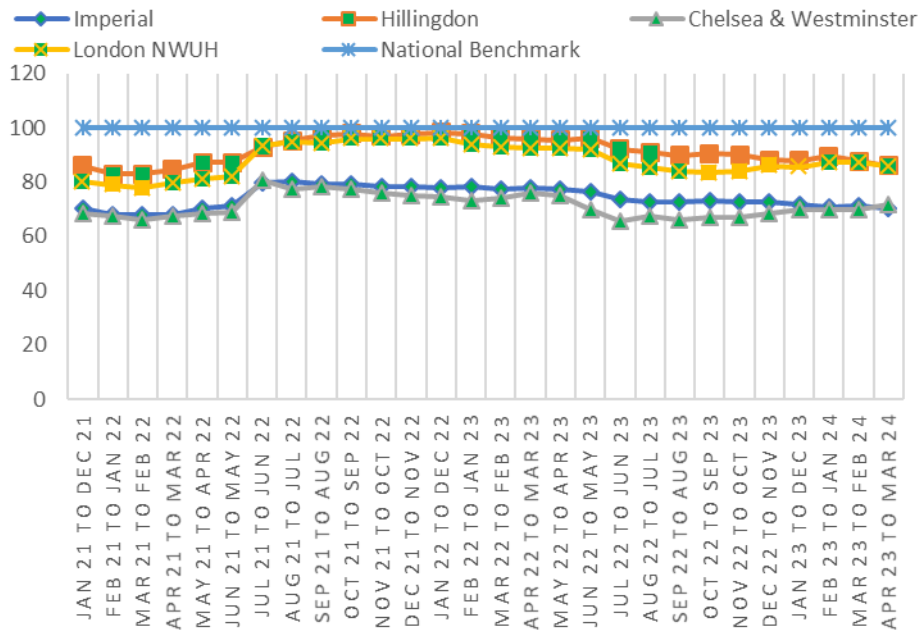
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

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

Patient Hospital Standardised Mortality Ratio

TREND



<100

England Average

STANDARD

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

NARRATIVE

Performance: The most recent data (for March 2023 – February 2024) shows that each trust has a rolling 12-month ratio which is lower than expected and below the national benchmark.

Recovery Plan: Not applicable.

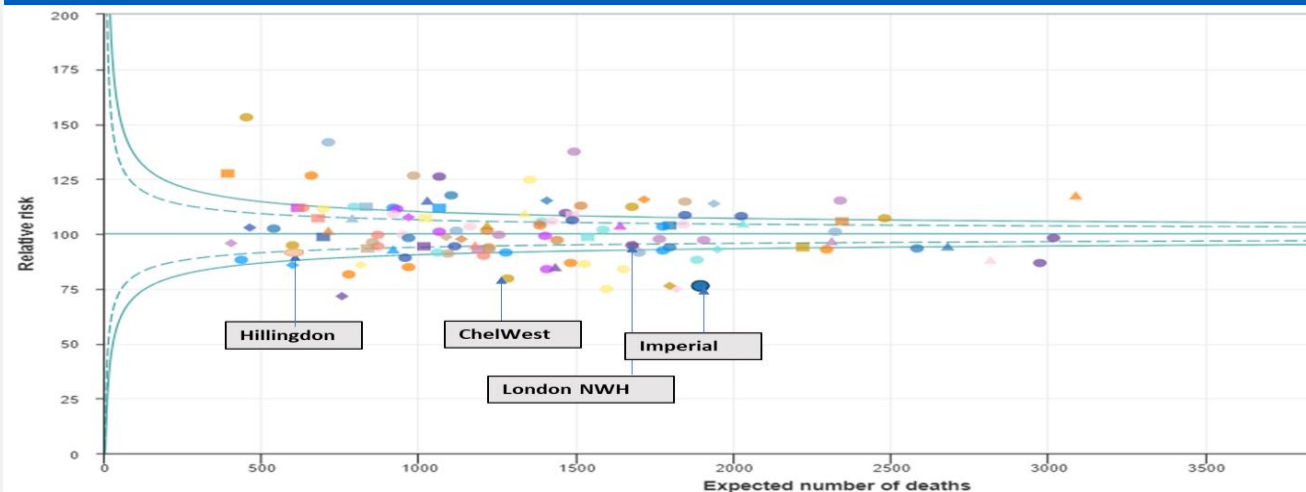
Improvements: All Trusts are investigating variations between observed and expected deaths by diagnostic group. Reviews for quarter one are summarised in the learning from deaths report presented separately to Board in common with no issues to escalate.

Forecast Risks: Not applicable.

CURRENT PERFORMANCE

	Provider Superspells	HSMR	HSMR- relative risk ranking
CWFT	50788	71.9	Lower than expected
ICHT	71095	70.1	Lower than expected
LNW	59334	86.1	Lower than expected
THH	18442	86.0	Lower than 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

Maternity

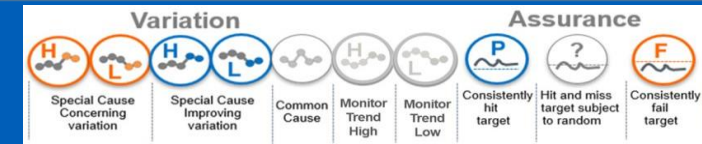
July 2024

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.

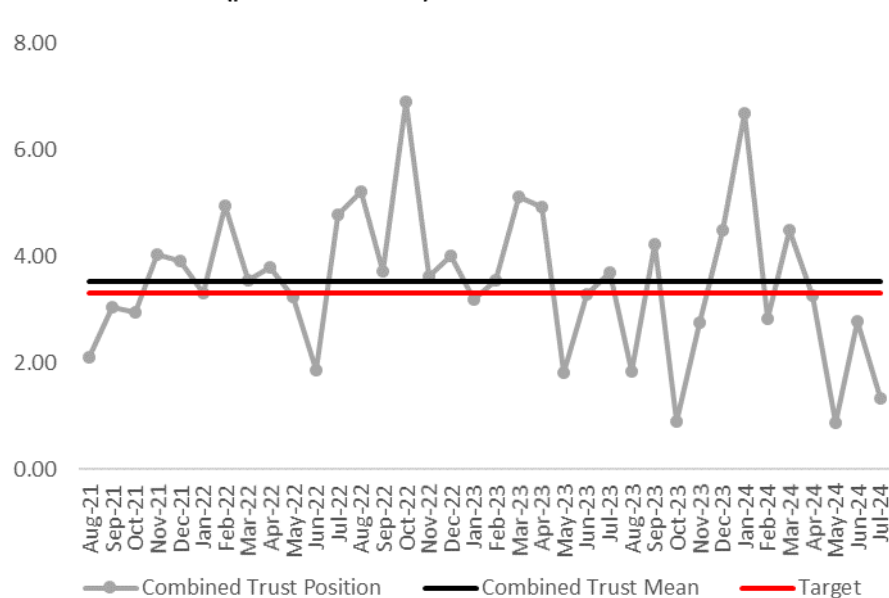
Work is underway to improve the timeliness of the data for these metrics and the next iteration of the report will include a breakdown of relevant KPIs by ethnicity

Maternity Crude Still Birth Rate



TREND

Crude still birth rate (per 1000 birth rate)



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 below the standard in July.

Recovery Plan: All cases are investigated via the Perinatal Mortality Review Tool (PMRT) to identify learning and actions. A review of all stillbirths across the APC is underway to identify any additional themes and learning and review health inequalities. This will be completed by October 2024 with identification of three areas of focus across the APC for the next 12 months (two likely areas are reduced fetal movements and translation services).

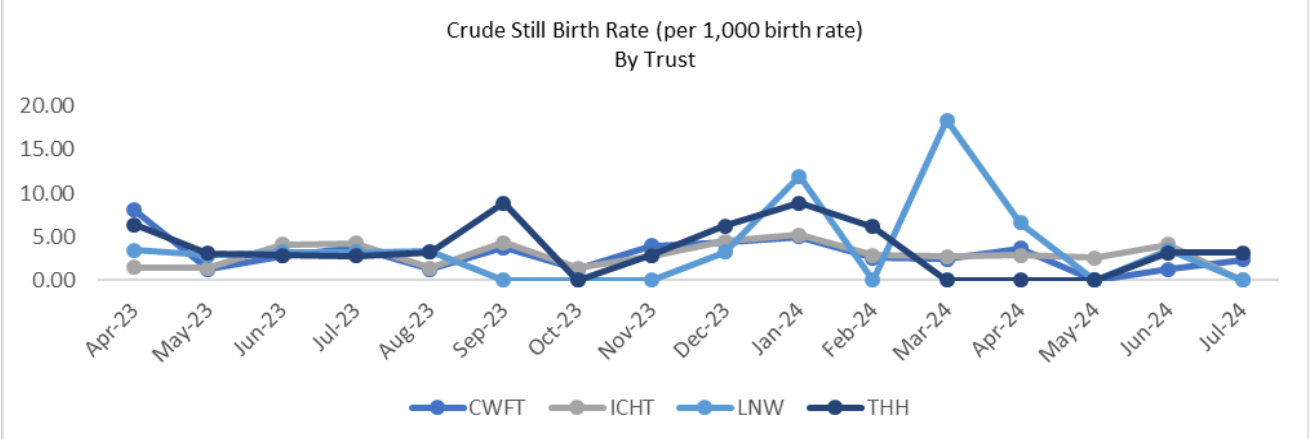
Improvements: National stillbirth tool kit being reviewed and implemented, and all trusts are working towards full achievement of Saving Babies' Lives Care Bundle version 3 (ICB assessed position in September was 84% for CWFT, LNW and THH, and 83% for ICHT – however, ICHT and CWFT understand their compliance to be higher and are currently reviewing the evidence with the project team).

Forecast Risks: N/A

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	849	5	2	3	2.4	1.8	
ICHT	752	1	0	1	0.0	2.4	
LNW	332	1	0	1	0.0	2.4	
THH	319	1	1	0	3.1	1.5	
APC	2252	8	3	5	1.3	2.0	

STRATIFICATION

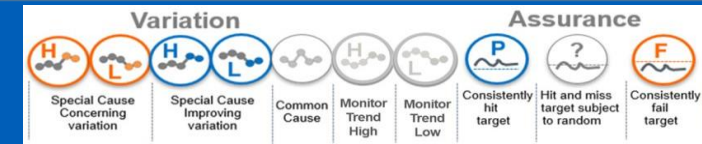


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

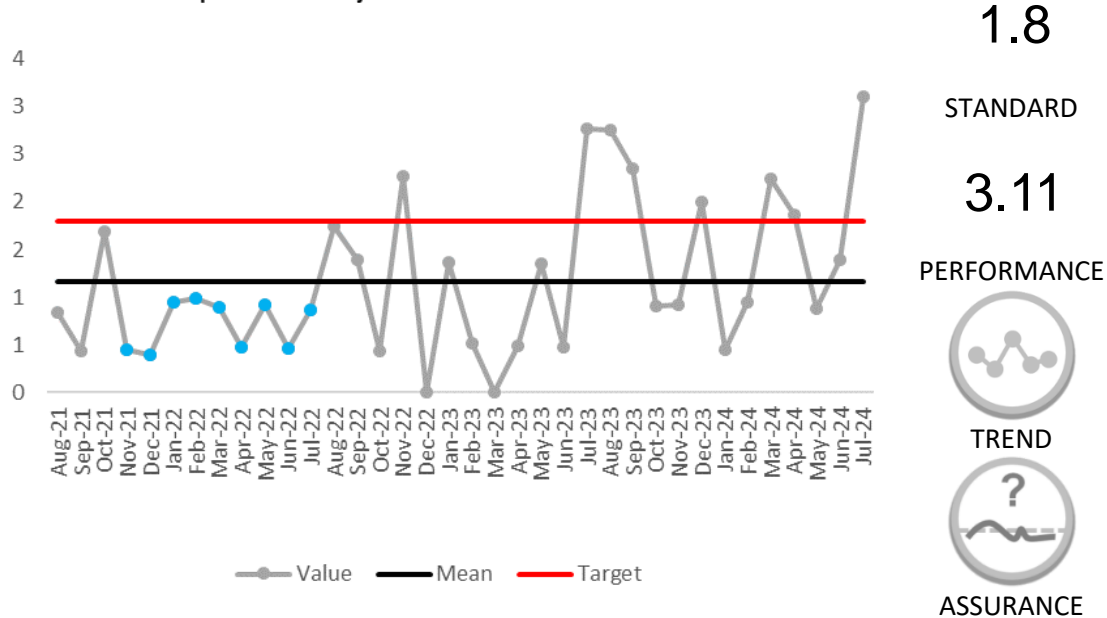
Committee: Acute provider collaborative executive management board

Maternity Suspected Neonatal IBI



TREND

Rate of neonatal intrapartum brain injuries as escalated to HSIB



NARRATIVE

Performance: Data is now being reported as a rate per 1000 births. At APC level we are above the 1.8 standard in month. There were 7 cases of suspected intrapartum brain injury meeting the definition in July, four at CWFT (3 at CW and 1 at WM), two at ICHT and one at THH.

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

Recovery Plan: A significant improvement project on escalation commenced at CWFT in June as this is a theme from completed MNSI investigations, alongside a change in practice to move to physiological fetal monitoring interpretation in 2024/25. The service will evaluate the impact of the campaign in September.

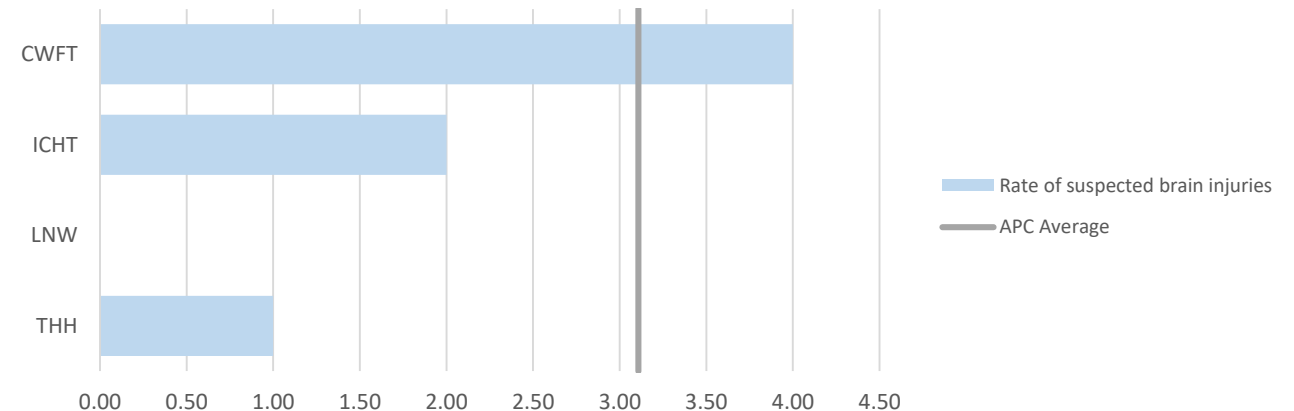
Improvements: All services have undertaken a high-level initial review of their HIE cases for 23/24 which is being reviewed by the ICB to identify any cross-cutting themes. The outputs will be shared next month. CWFT and THH have undertaken a more detailed review following an increase in suspected intrapartum brain injuries in 23/24, which will feed into the ICB review. At CWFT recurrent themes of escalation and situational awareness, acuity/activity levels, fetal monitoring and communication were identified and an action plan has been developed that address the themes. Progress will be monitored via the maternity quality and safety report.

Forecast Risks: N/A

CURRENT PERFORMANCE

	Total Births	Suspected Brain Injuries in Month	Rate of suspected brain injuries	Suspected Brain Injuries FYTD	Rate of Suspected Brain Injuries
CWFT	849	4	4.71	8	2.40
ICTH	752	2	2.66	3	1.01
LNW	332	0	0.00	3	2.44
THH	319	1	3.13	2	1.54
APC	2252	7	3.11	16	1.81

STRATIFICATION

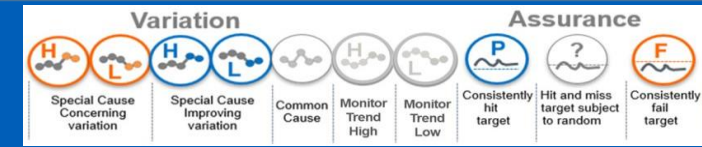


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

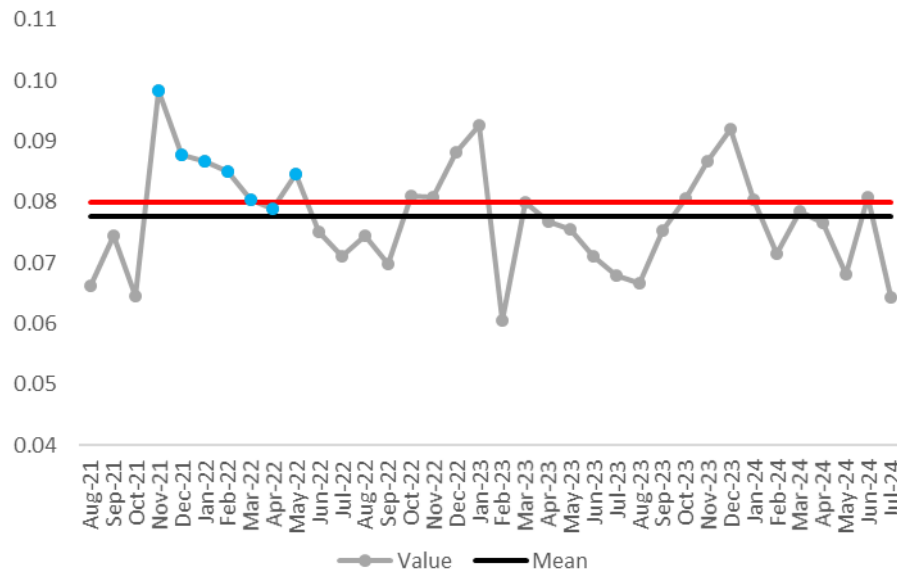
Committee: Acute provider collaborative executive management board

Maternity Preterm Births



TREND

Pre-term Birth Rate



8%

STANDARD

6.4%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: In month, the APC had a pre-term birth rate of 6.4% which is below the standard.

Recovery Plan: In 2023/24 CWFT saw a sustained increase in pre-term births this is mostly driven by iatrogenic preterm birth (this is mainly due to pre-eclampsia, growth restriction/abnormal USS, abnormally invasive placenta). The pre-term birth rate has now returned to below the standard and will continue to be monitored by the team.

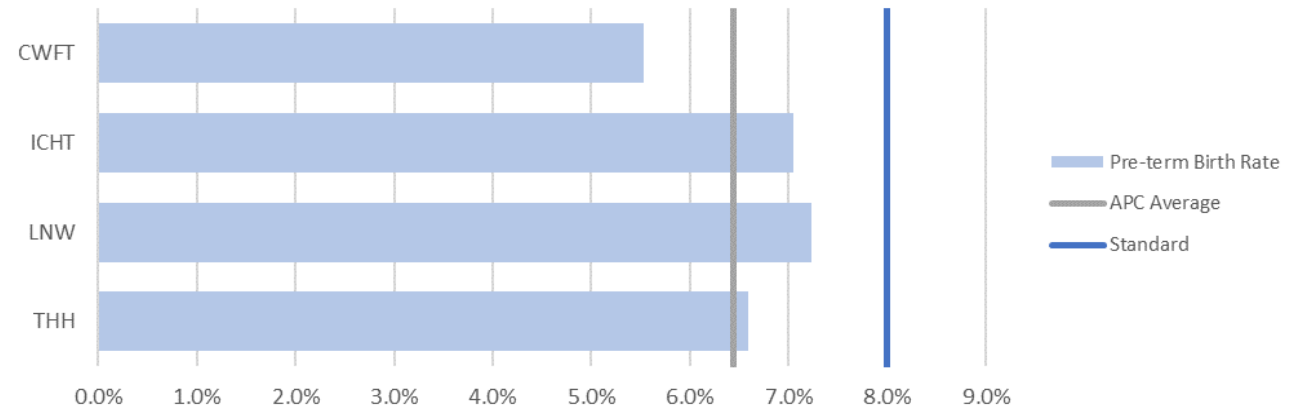
Improvements: LNW has appointed a Preterm birth midwifery lead and set up a preterm birth working group focusing on their local data/audit/guidelines and some wider QI initiatives to review rates. The APC is undertaking a review of all preterm births and IUT across both sites at CWFT as part of the business case development to support service redesign of the level 2 NICU as well as the preterm birth antenatal service at WM site. WM has a newly appointed pre-term birth lead MW to work as part of the MDT.

Forecast Risks: No risks identified.

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	47	4	43	849	5.5%		194	5.8%
ICHT	53	13	40	752	7.0%		256	8.6%
LNW	24	4	20	332	7.2%		102	8.3%
THH	21	2	19	319	6.6%		87	6.7%
APC	145	23	122	2252	6.4%		639	7.2%

STRATIFICATION

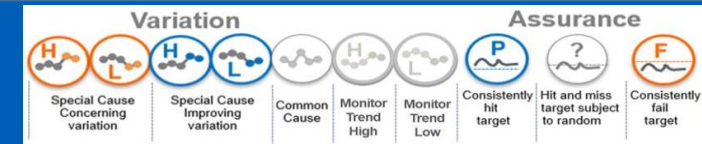


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

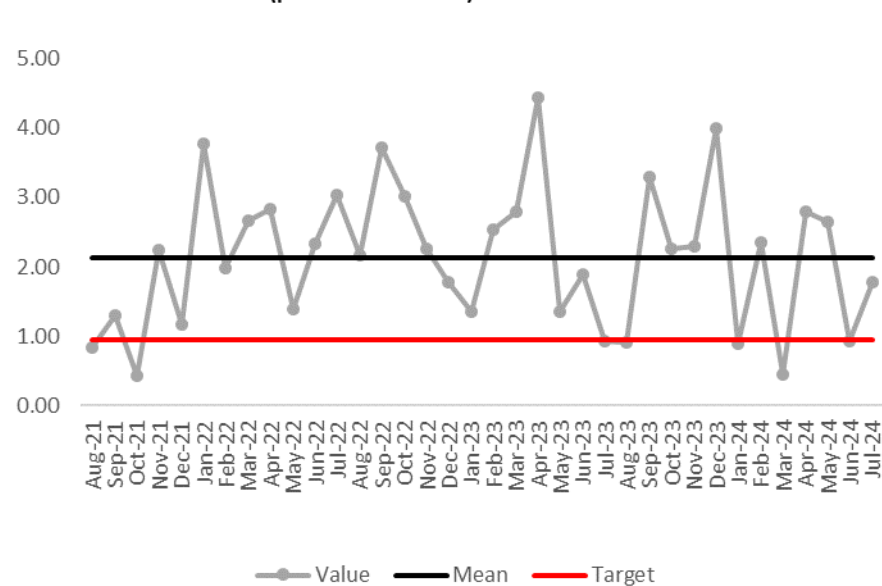
Committee: Acute provider collaborative executive management board

Maternity Neonatal Crude Deaths



TREND

Crude neonatal death rate (per 1000 birth rate)



0.94

STANDARD

1.8

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: This metric now includes all neonatal deaths between 22+0 and 40+ weeks in alignment with the national metrics. The crude neonatal death rate at APC level was above the standard in July and so far this financial year. There were four cases across the APC in July, all at CWFT (two at CW and two at WM). 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 MNSI or PMRT processes and updates are provided in the quarterly Q&S report.

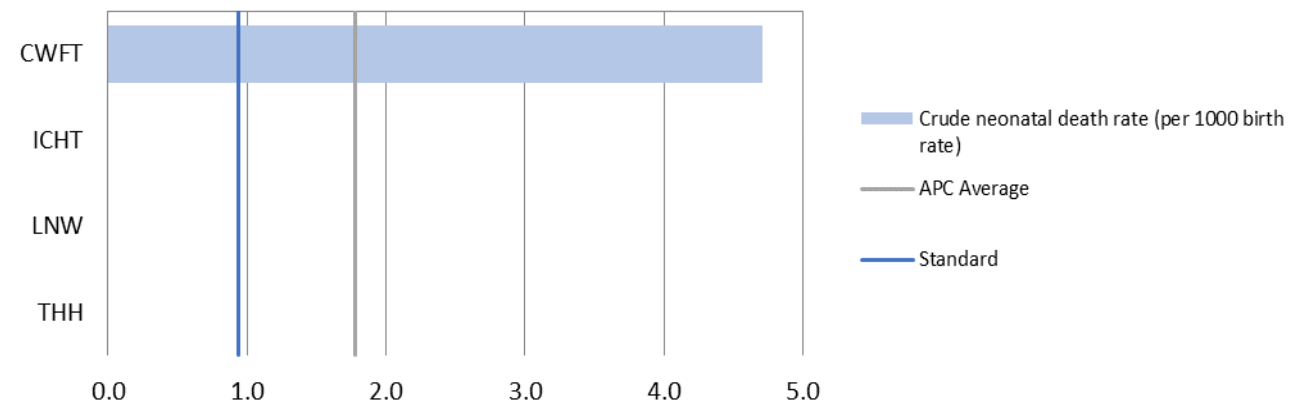
Improvements: The Neonatal CRG and the Trust teams will continue to monitor any new cases.

Forecast Risks: None identified.

CURRENT PERFORMANCE

	Number of Neonatal Deaths	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	4	2	2	849	4.7	3.8	12	3.61
ICHT	0	0	0	752	0.0		5	1.68
LNW	0	0	0	332	0.0		1	0.81
THH	0	0	0	319	0.0		0	0.00
APC	4	2	2	2252	1.8	0.8	18	2.04

STRATIFICATION

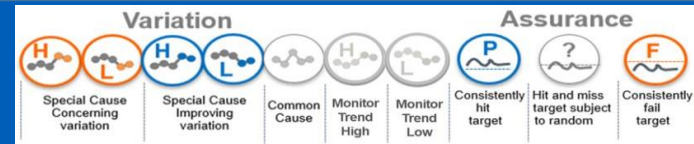


GOVERNANCE

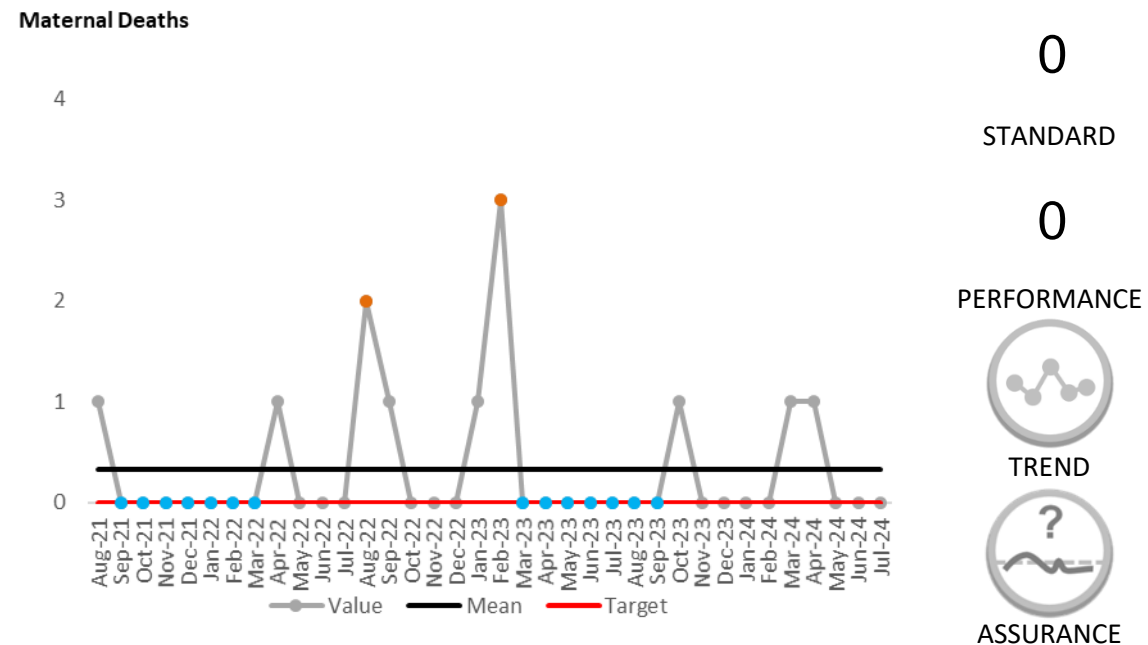
Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

Maternity Maternal Deaths



TREND



NARRATIVE

Performance: There were no maternal deaths reported in July 2024.

Recovery Plan: N/A

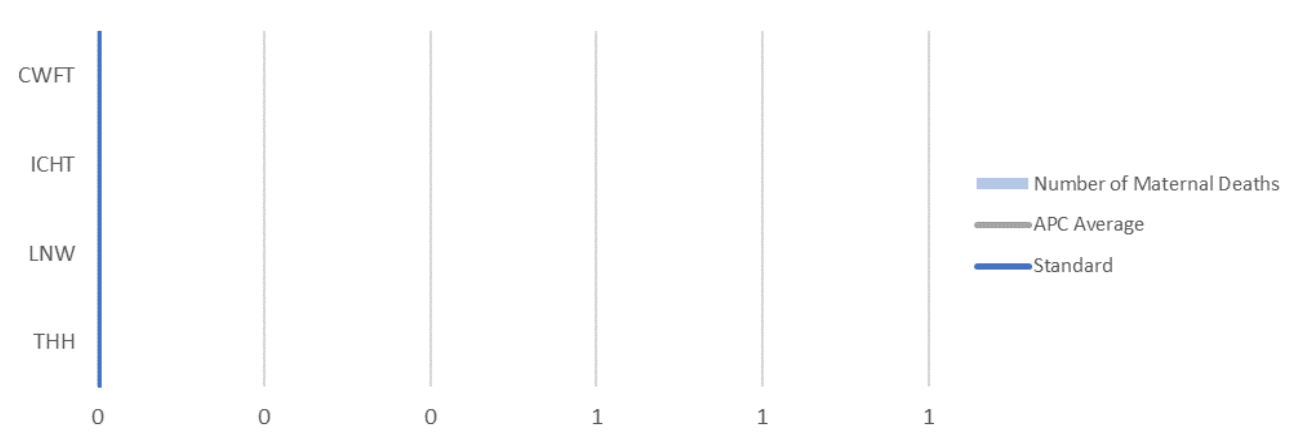
Improvements: There have been 16 maternal deaths in 5 years across the APC. This has been identified as an area of focus for the newly created ICB maternity and neonatal quality and patient safety group. A preliminary review of the data is underway and the findings will be shared in next month's report.

Forecast Risks: No current risks.

CURRENT PERFORMANCE

	Number of Maternal Deaths	Total Births	Difference from Threshold	Number of maternal Deaths FYTD
CWFT	0	849	0	1
ICHT	0	752	0	0
LNW	0	332	0	0
THH	0	319	0	0
APC	0	2252		1

STRATIFICATION

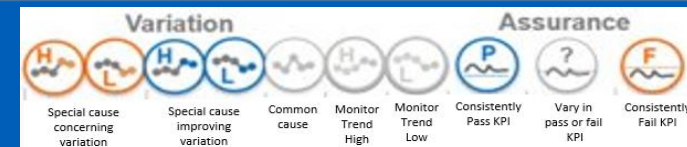


GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

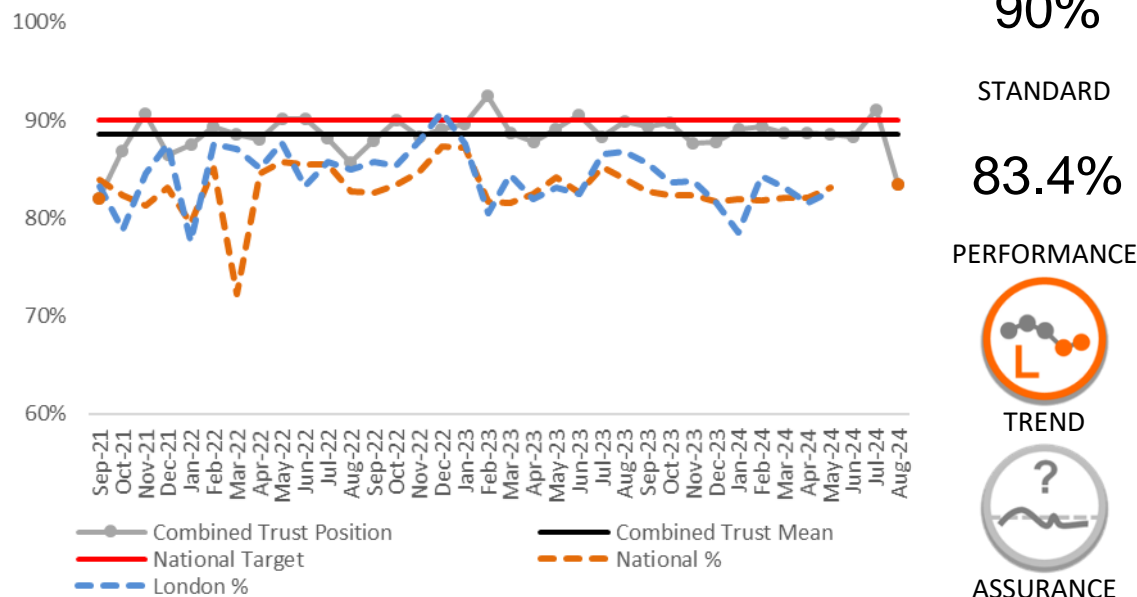
Committee: Acute provider collaborative executive management board

Patient Maternity Friends & Family Test



TREND

% good experience - maternity



NARRATIVE

Performance: At APC level, the percentage of maternity patients who report a good experience varies and although we are consistently above national and London averages, we are below the 90% standard across the last 12 months of data. In August there was a significant decrease, with only LNW exceeding the standard, although the number of responses they received is low. LNW have a dedicated patient experience coordinator who is clinically based and multilingual to support the collation of feedback and responsive actions in real time.

Recovery Plan: The work to improve maternity care and patient experience within each organisation is ongoing. At ICHT, user feedback is showing the pressure that current high activity levels is having on experience, a plan for improvement is being developed.

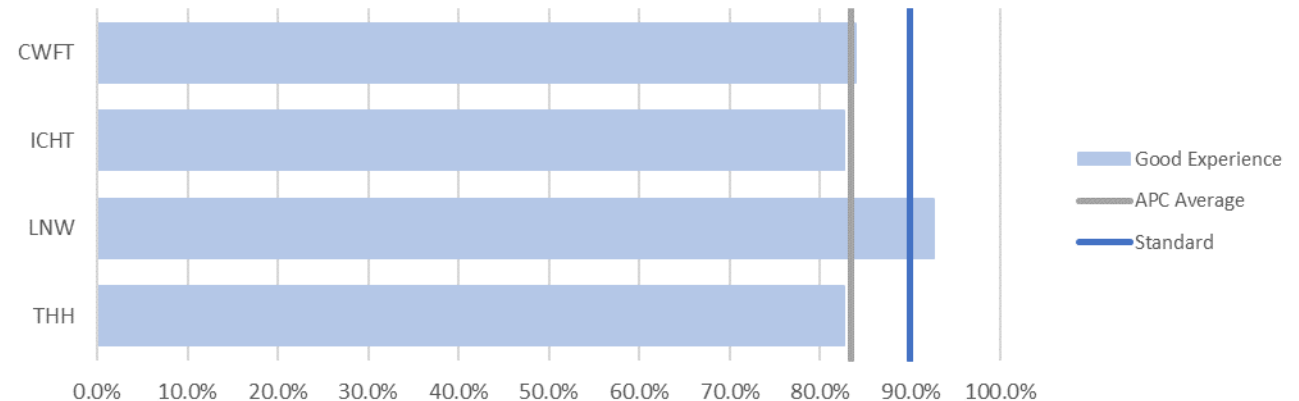
Improvements: All services have a detailed Maternity and Neonatal Voices Partnership (MNVP) workplan in place to co-produce improvements in their services based on the results of the CQC maternity survey.

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

CURRENT PERFORMANCE

	Responses Received	Good Experience	Difference from Target	Recommended Care	12 Month Rolling Good Experience
CWFT	186	83.9%	-6.1%	156	89.2%
ICHT	230	82.6%	-7.4%	190	88.0%
LNW	27	92.6%		25	90.6%
THH	179	82.7%	-7.3%	148	87.8%
APC	622	83.4%	-6.6%	519	88.6%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale, CEO, LNW

Committee: Acute provider collaborative executive management board

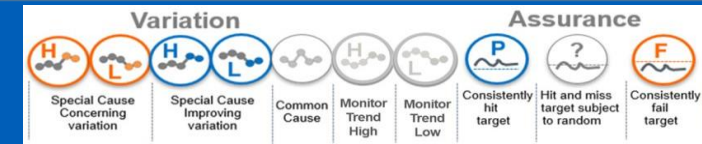
Data Assurance: Data is supplied by each trust individually and quality assured through their internal processes.

Patient Access

August 2024, except Cancer service metrics July 2024

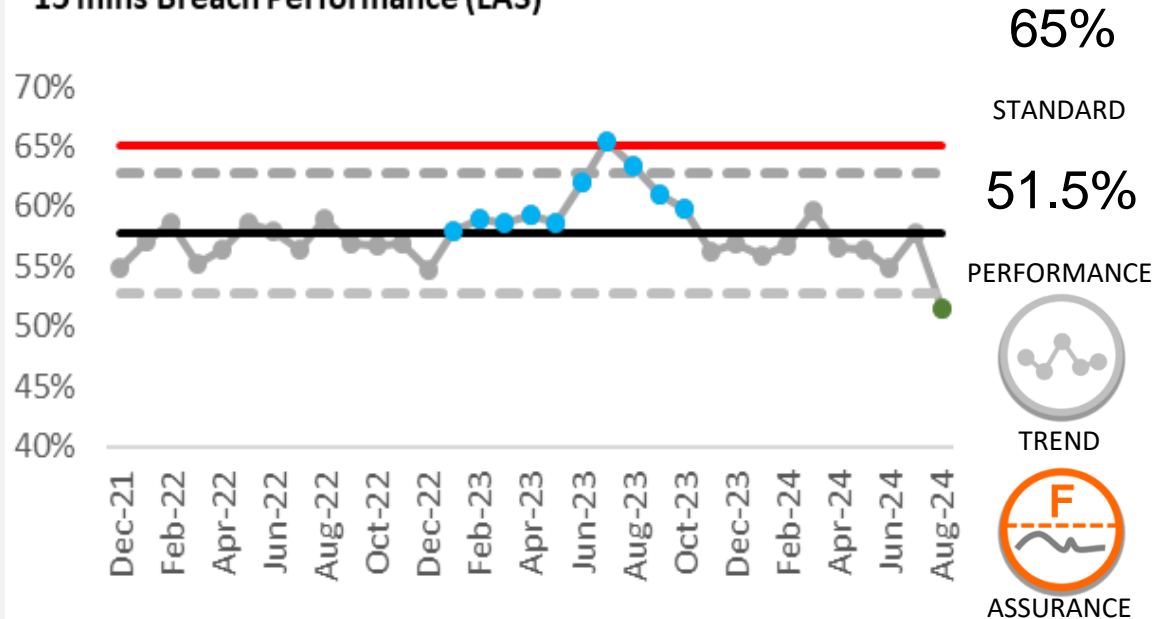
Equity of access for the population of NWL is central to the principals of the Acute Provider Collaborative (APC) and the Integrated Care Board (ICB). From next month, this section will include a report on DNA rates by ethnicity and deprivation as initial analysis suggests that there are differences in DNA rates determined by ethnicity and deprivation. Further work will be undertaken to determine action to reduce inequity of access.

Operations Ambulance Handover Waits



TREND

15 mins Breach Performance (LAS)



NARRATIVE

Performance: NWL continues to have the best handover performance across London, with the lowest average overrun per breach. Performance has remained stable over recent months. In August 2024, 86.5% of ambulances were handed over within 30 minutes against a target of 90%.

Recovery plan: We are participating in transformation work with LAS and the ICB to maximise the use of alternatives to ED and expand the use of direct referral routes and direct booking. We have reviewed how we use the LAS escalation process at times of peak pressure and we are monitoring this closely.

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

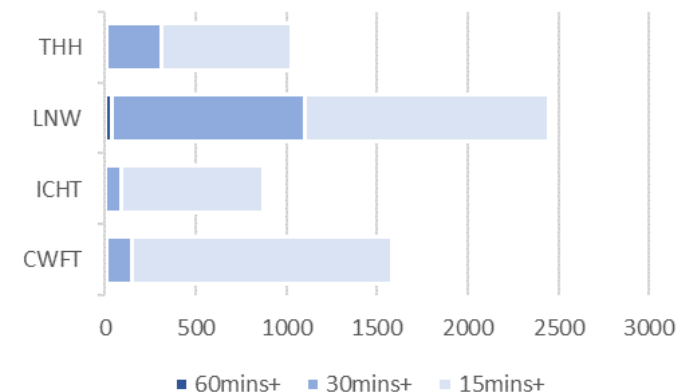
Forecast risks: Continued increases in the number of conveyances.

CURRENT PERFORMANCE

LAS Handover Waits within the fifteen minute standard Aug-24

	Total Handover	15mins Performance	Difference from target	15 min + delays	Of w hich		
					30min + delays	60 min + delays	Impacts on LAS time lost (hours)
CWFT	3207	50.6%	-14.4%	1583	149	1	188
ICHT	2871	69.6%		872	91	0	99
LNW	3989	38.7%	-26.3%	2444	1101	36	1231
THH	2149	52.2%	-12.8%	1027	311	7	242
APC	12216	51.5%	-13.5%	5926	1652	44	1760

STRATIFICATION



Trust share of APC waits longer than standard

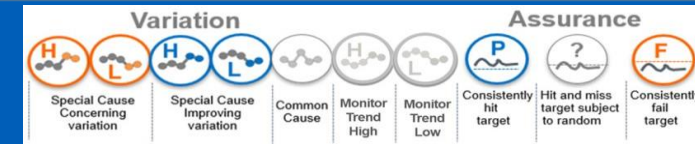
GOVERNANCE

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

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

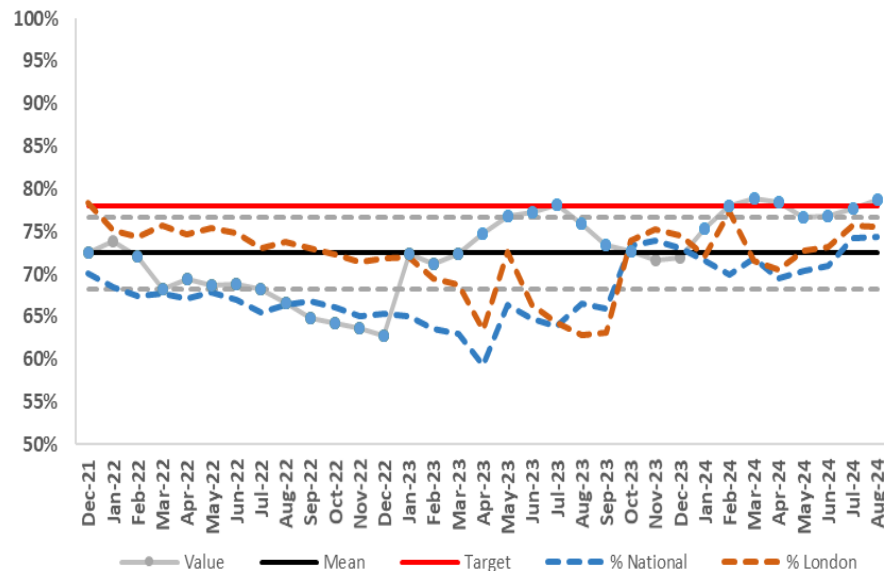
Data Assurance: These figures are provided by LAS

Operations Urgent & Emergency Department Waits



TREND

A&E 4 hour performance



78%

STANDARD

78.7%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: In August 2024, 78.7% of patients attending A&E were admitted, transferred or discharged within four hours, meeting the current national 78% target.

Recovery plan: Work continues across the North West London UEC programme to reduce demand and waits across the pathway to achieve the national objective of a minimum of 78% of patients seen within four hours by March 2025. Each Trust has a comprehensive action plan to improve and, importantly to sustain four-hour performance and maintain safe levels of care.

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

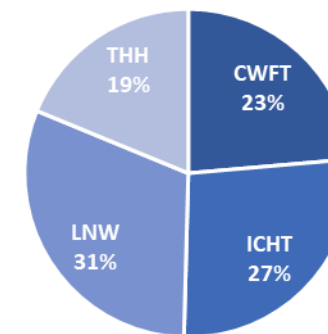
Forecast risks: Increases in demand, continued delays with discharge for medically optimised patients.

CURRENT PERFORMANCE

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

	Total attendances (All Types)	4 hour Performance	Difference from target	4 hour + delays (All Types)	Impacted by Referrals to SDEC
CWFT	23456	82.1%		4192	1342
ICHT	22220	78.6%		4758	4873
LNW	25852	78.9%		5463	1083
THH	11838	71.8%	-6.2%	3336	1826
APC	83366	78.7%	0.7%	17749	9124

STRATIFICATION



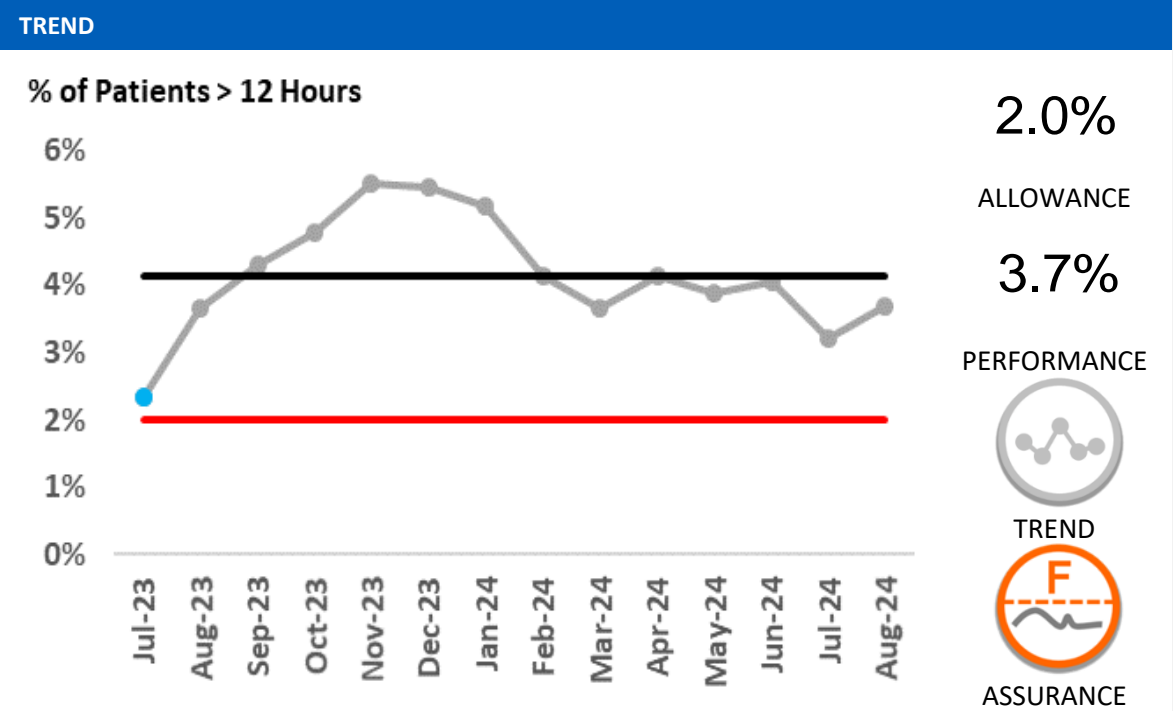
Trust share of APC waits longer than standard

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



NARRATIVE

Performance: Increased demand, patient flow through the hospital and those waiting for beds outside the hospital are all factors impacting long waits in ED. In August 2024 there has been an overall slight increase in the proportion of patients waiting 12-hours or more from their time of arrival.

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

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

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

CURRENT PERFORMANCE

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

	Total attendances (All Types)	12 hour Performance	Difference from target	12 hour + delays
CWFT	23456	1.2%		289
ICHT	22220	3.4%	-1.4%	765
LNW	25852	5.7%	-3.7%	1467
THH	11838	4.7%	-2.7%	559
APC	83366	3.7%	-1.7%	3080

STRATIFICATION

Category	Percentage
LNW	48%
ICHT	25%
THH	18%
CWFT	9%

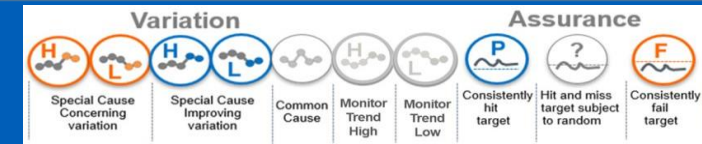
Trust share of APC waits longer than standard

GOVERNANCE

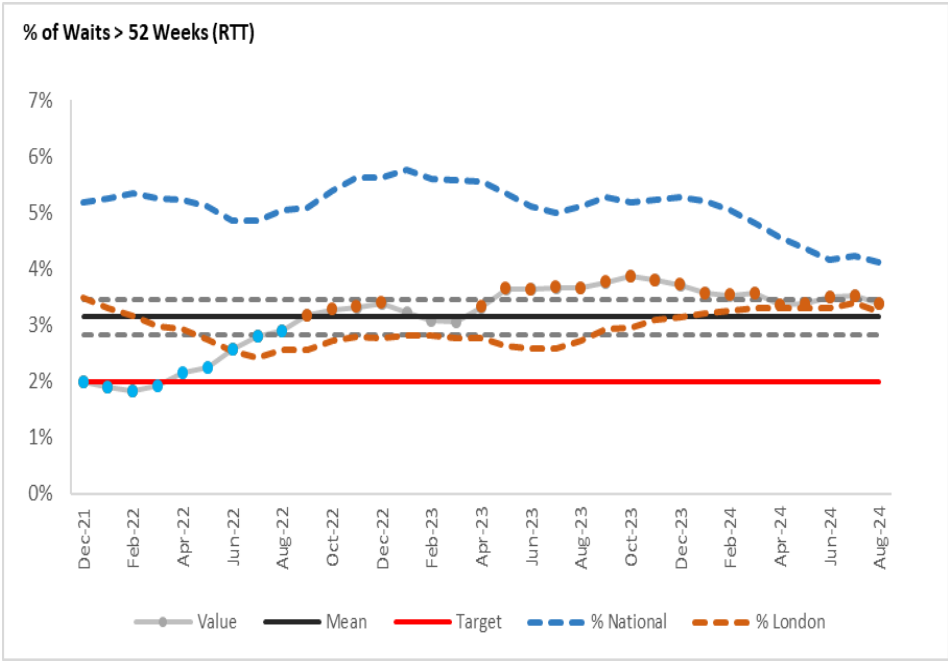
Senior Responsible Owner: Sheena Basnayake, Deputy Chief Operating Officer,
Committee: APC EMB (Chair: Tim Orchard); NWL UEC Board (Chair: Rob Hurd)
Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE (except 12hr+ waits from arrival)

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Operations Referral to Treatment Waits



TREND



2.0%

ALLOWANCE

3.4%

PERFORMANCE

TREND

ASSURANCE

NARRATIVE

Performance: Long waits are being monitored at the patient level, with a downward trend in 52-week waits to August. All Trusts are committed to the operating plan targets, the end of September 2024 current forecast is 833 for patients over 65 ww.

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

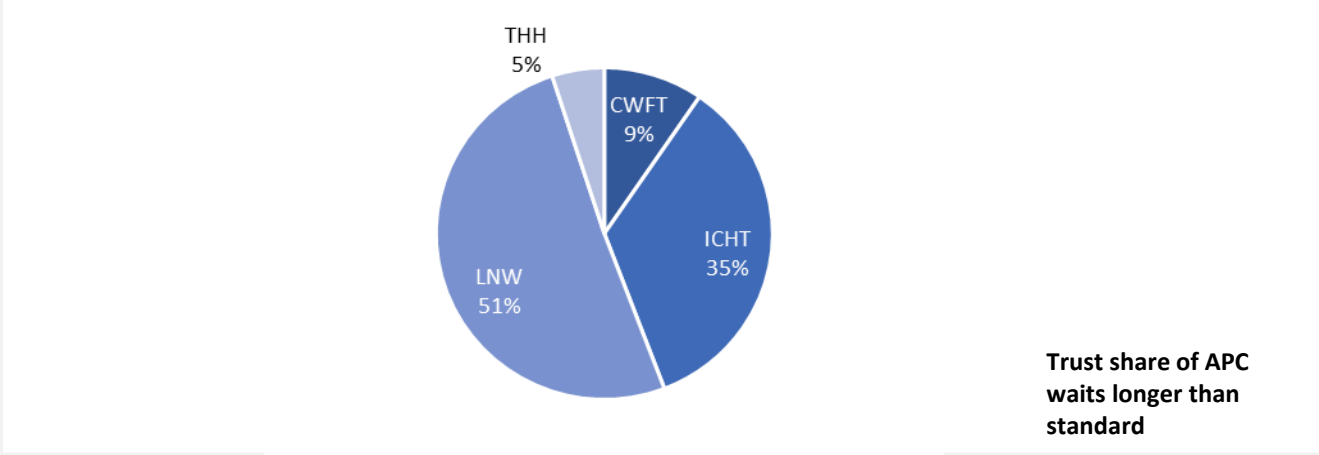
Improvement: There has been a sustained reduction in long-waiting patients.

Forecast Risks: Risks to RTT reduction include overall capacity shortfalls, anaesthetic staffing shortages (ICHT) and consultant toil.

CURRENT PERFORMANCE

Unacceptable Waits for Treatment: 18-Week Standard Aug-24								
	Total Waiting List	Waits > 52 weeks	Difference from target	52 + weeks	Of which		Impacted by	Impacts on
					65 + Weeks	78 + weeks	104 + weeks	OTDCs not booked < 28 days
CWFT	62132	1.5%		963	113	5	0	3
ICHT	95672	3.6%	-1.6%	3479	650	44	1	21
LNW	108489	4.7%	-2.7%	5104	820	54	0	0
THH	30062	1.7%		506	9	0	0	0
APC	296355	3.4%	-1.4%	10052	1592	103	1	24

STRATIFICATION



GOVERNANCE

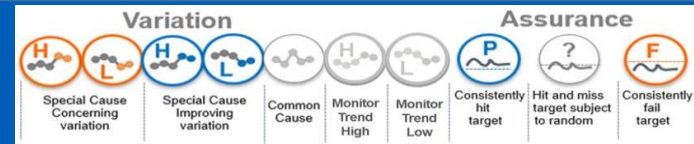
Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

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

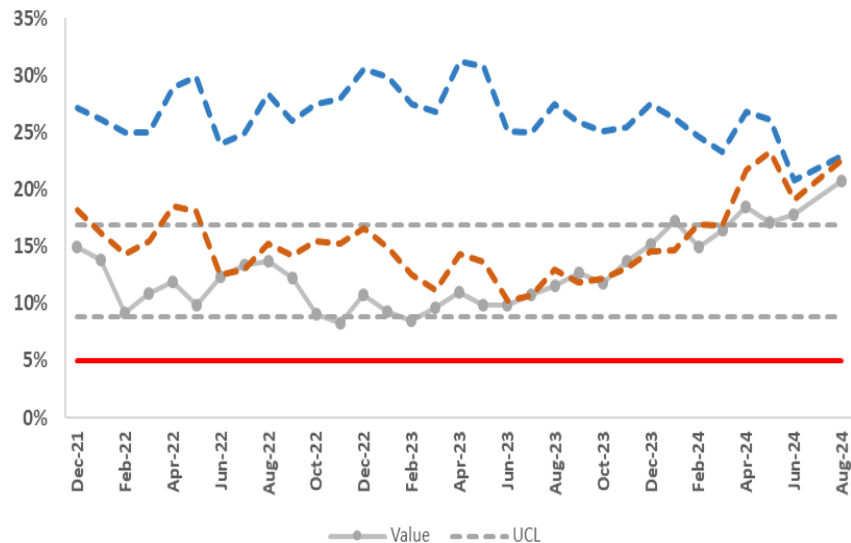
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Operations Access to Diagnostics



TREND

% of Breaches > 6 Weeks (Diagnostics)



5.0%

ALLOWANCE

20.7%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Overall delivery remains below target. Recovery plans are in place but the APC is unlikely to meet target until later in the financial year.

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

Improvements: Minor improvements in delivery over the APC.

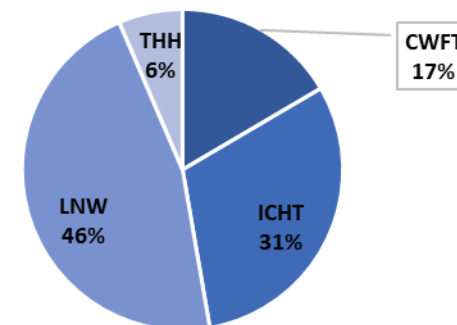
Forecast Risks: MRI, Neurophysiology and Ultrasound face capacity challenges due to staffing shortages and ageing equipment.

CURRENT PERFORMANCE

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

	Total Waiting List	Waits > 6 weeks	Difference from target	6 + weeks	Of which
					13 + weeks
CWFT	11376	17.6%	-12.6%	1997	756
ICHT	19452	19.1%	-14.1%	3710	1129
LNW	20542	27.2%	-22.2%	5584	1581
THH	6846	11.4%	-6.4%	780	17
APC	58216	20.7%	-15.7%	12071	3483

STRATIFICATION



Trust share of APC waits longer than standard

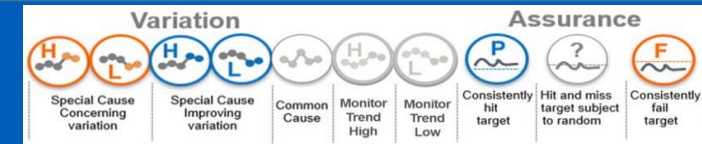
GOVERNANCE

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

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

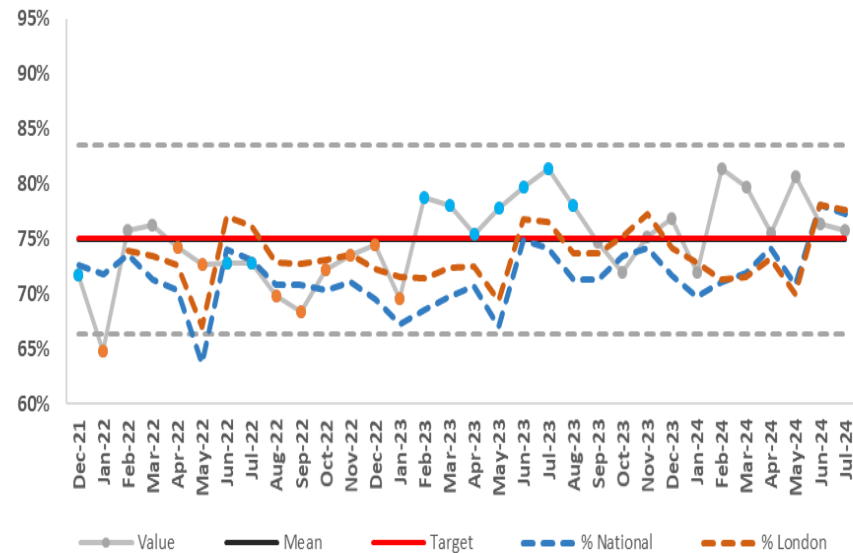
Data Assurance: These figures are validated ahead of a monthly performance return and the performance data is published by NHSE

Operations Access to Cancer Care (Faster Diagnosis)



TREND

% Contacted within FDS Cancer standard



75%

STANDARD

75.8%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: FDS was met as a whole system and all providers except LNW – with a whole provider position being posted of 75.8% against 75% target.

Recovery Plan: Continue to work with all trusts to resiliently deliver cancer pathways. GI pathway review at LNW and additional recruitment within Dermatology to support capacity,

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

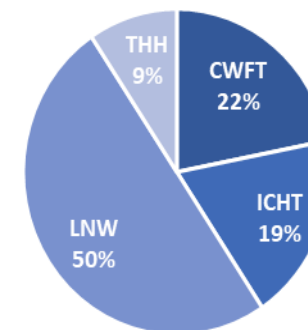
Forecast Risks: Continued planning of capacity for pinch points in pathways to protect cancer delivery as much as possible. Plan for seasonality and on-going impact of any additional industrial action. Dermatology significantly challenged at LNW – plans in place to improve position to end Q2.

CURRENT PERFORMANCE

Access to Cancer Care (Faster Diagnosis) Jul-24

	Total Contacts	Faster Diagnosis performance	Difference from target	28 + days	Of which 62 + days
CWFT	2886	79.9%		580	107
ICHT	3242	84.7%		496	0
LNW	3533	62.6%	-12.4%	1323	154
THH	1280	80.5%		249	48
APC	10941	75.8%		2648	309

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

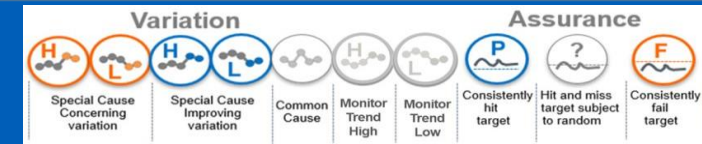
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

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

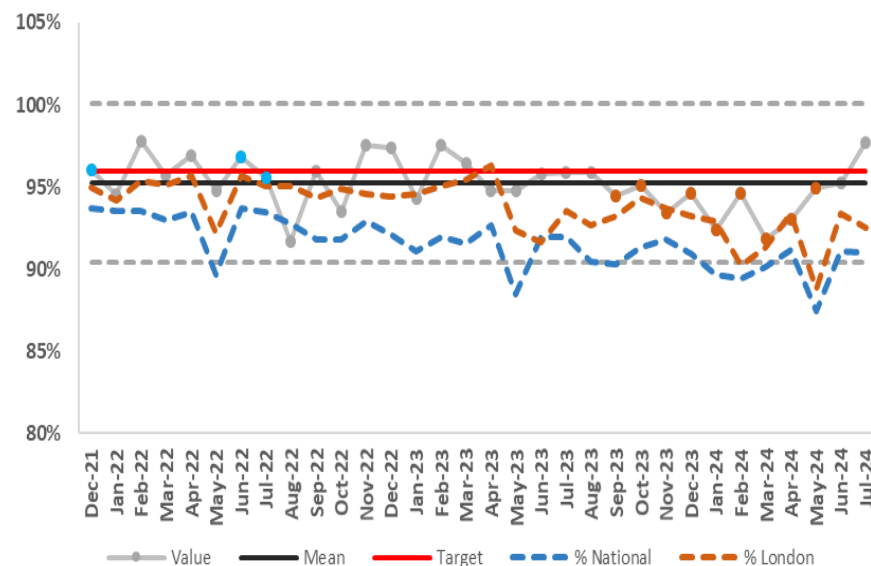
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Operations Cancer 31-Day Decision to treatment Combined Standard



TREND

% Treated within 31 Day Cancer standard



96%

STANDARD

97.7%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: 31-day standard met for the first time in 2024/25 in July due to big improvement in ICHT Urology treatments. However, there remains on-going challenges particularly at ICHT across the board for available capacity for treatments that is continually being monitored.

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

Improvements: Maintaining oversight and planning ahead of time for treatment pathways. Focus on data capture of subsequent treatments as there should be more captured than is currently.

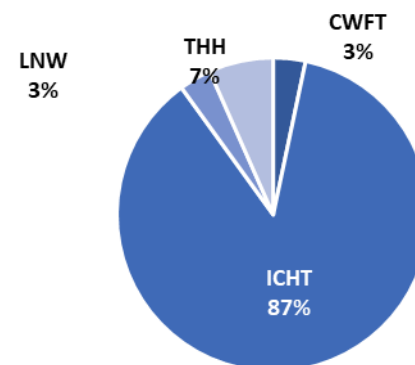
Forecast Risks: As referral rates continue to stay high, there is a growing risk of a significant gap between demand and capacity due to workforce challenges.

CURRENT PERFORMANCE

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

	Total Treated	31 day performance	Difference from target	31 + days	Of which 62 + days
CWFT	192	99.5%		1	0
ICHT	806	96.8%		26	0
LNW	200	99.5%		1	0
THH	104	98.1%		2	0
APC	1302	97.7%		30	0

STRATIFICATION



Trust share of APC waits longer than standard

GOVERNANCE

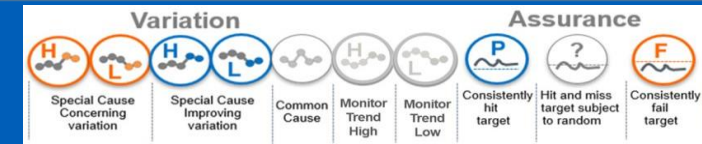
Senior Responsible Owner: James Walters, Chief Operating Officer, LNW

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

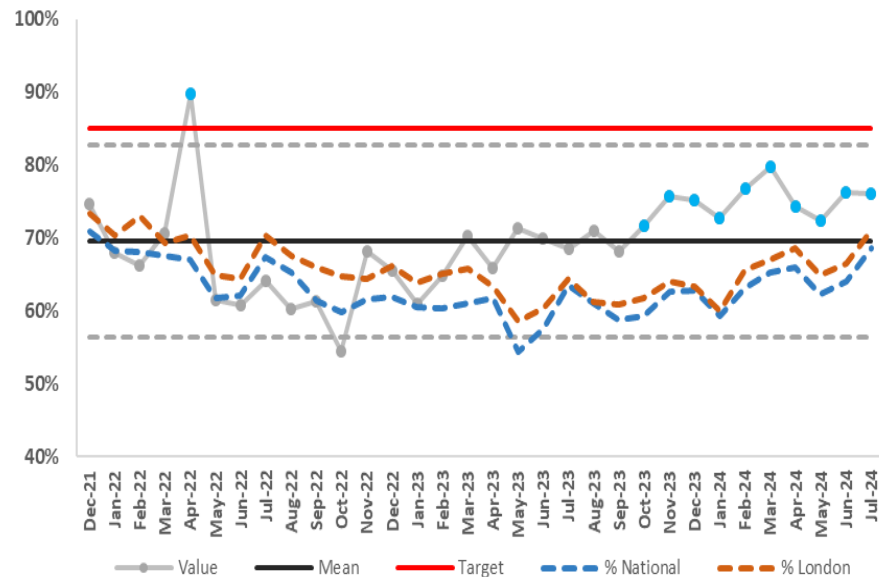
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Operations Referral to Cancer Treatment Pathways



TREND

% Treated within 62 Day Cancer standard



85%

STANDARD

76.0%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

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

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

Improvements: Strengthening the coordination and communication between multidisciplinary teams involved in cancer treatment to help avoid unnecessary delays and ensure timely initiation of treatment. Demand reduction pathways such as Breast, Pain and Gynaecology will aim to speed up the diagnostic pathway to treatment,

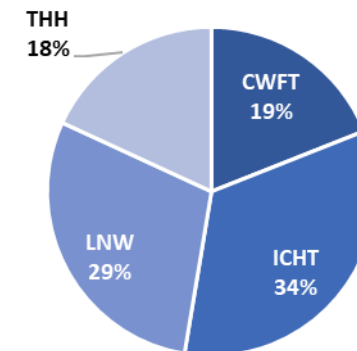
Forecast Risks: Workforce pressures and the potential from GP Industrial action may create bulges in referrals and affect capacity. Capacity affected during August which will likely see impact in September performance.

CURRENT PERFORMANCE

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

	Total Treated	62 day performance	Difference from target	62 + days	Of which	Impacts on
					104 + days	Backlog 104 + days
CWFT	185	82.4%	-2.6%	32.5	16	0
ICHT	225.5	74.5%	-10.5%	57.5	0	61
LNW	201	75.1%	-9.9%	50	14.5	20
THH	100.5	69.2%	-15.8%	31	10	10
APC	712	76.0%	-9.0%	171	40.5	91

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

Overall page 109 of 274

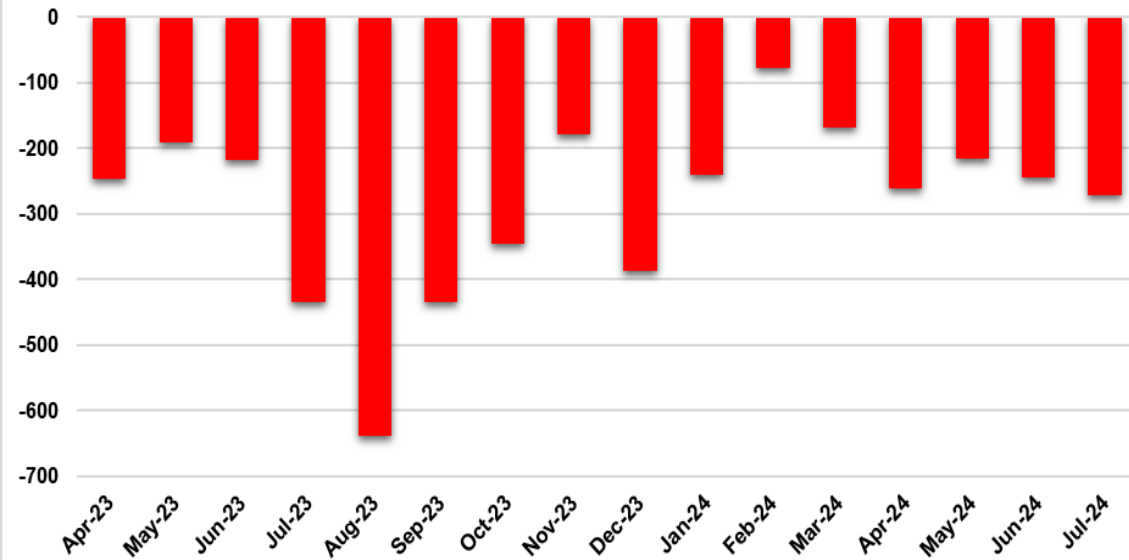
Operating Plan and Capacity

July 2024

Operating Plan Performance: Elective Inpatient

TREND

Elective Inpatients variance from Plan



NARRATIVE

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

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

Improvements: CWFT/ THH are over-delivering on ERF overall.

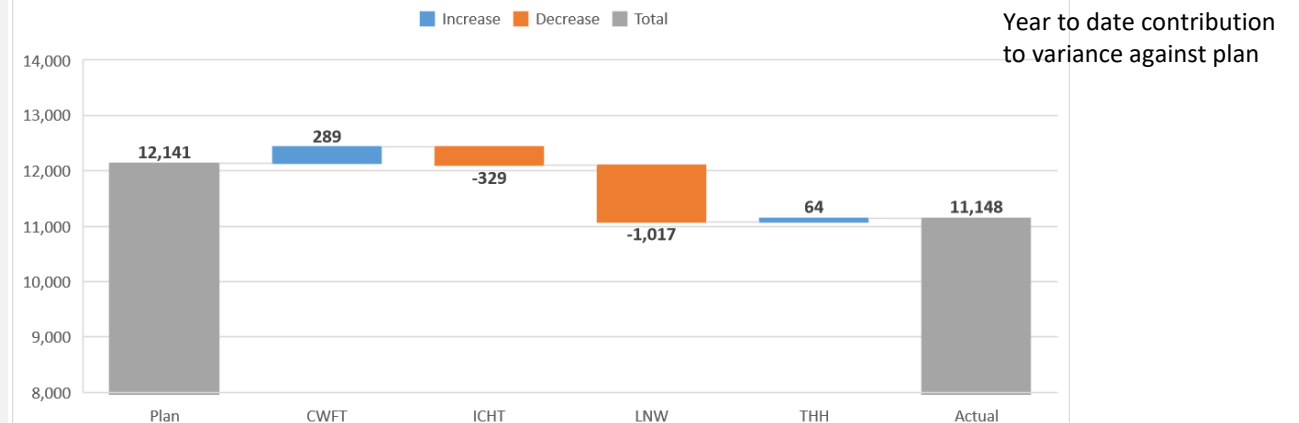
Forecast Risks: None

CURRENT PERFORMANCE

Year to Date: Jul-24

	Plan	Actual	Var	% Var
CWFT	2,030	2,319	289	14.2%
ICTH	5,408	5,079	-329	-6.1%
LNW	3,929	2,912	-1,017	-25.9%
THH	774	838	64	8.3%
APC	12,141	11,148	-993	-8.2%

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Tina Benson, COO, THH

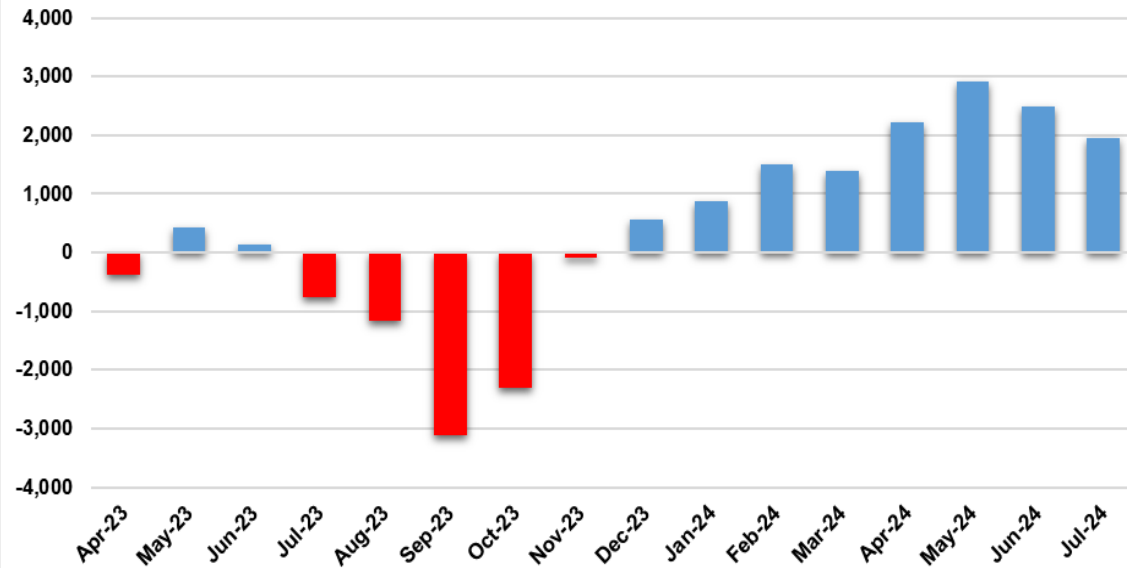
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Roger Chin);

Data Assurance: tbc

Operating Plan Performance: Day Case

TREND

Elective Daycase variance from Plan



NARRATIVE

Performance: Day case activity is showing variation across Trusts.

Recovery Plan: Insourcing is supporting delivery

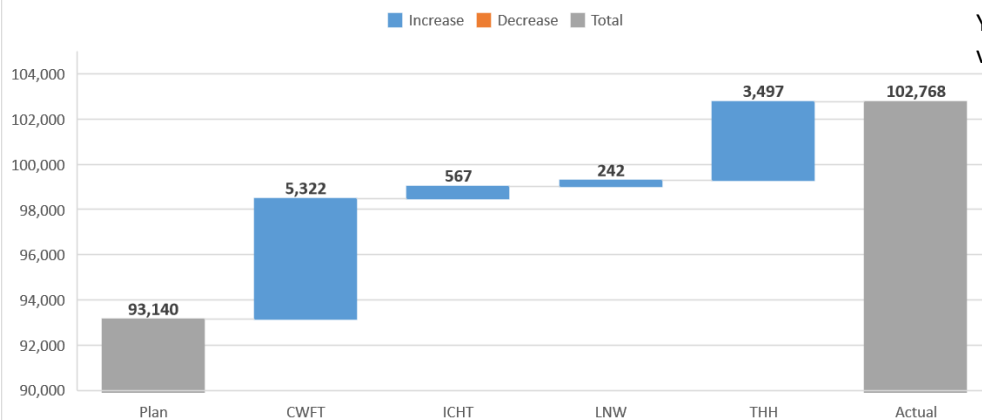
Improvements: LNW are still in a recovery process with weekly oversight meetings which has improved performance this quarter.

Forecast Risks: None forecast

CURRENT PERFORMANCE

	Year to Date: Jul-24			
	Plan	Actual	Var	% Var
CWFT	18,970	24,292	5,322	28.1%
ICHT	37,961	38,528	567	1.5%
LNW	27,751	27,993	242	0.9%
THH	8,458	11,955	3,497	41.3%
APC	93,140	102,768	9,628	10.3%

STRATIFICATION



Year to date contribution to variance against plan

GOVERNANCE

Senior Responsible Owner: Tina Benson, COO, THH

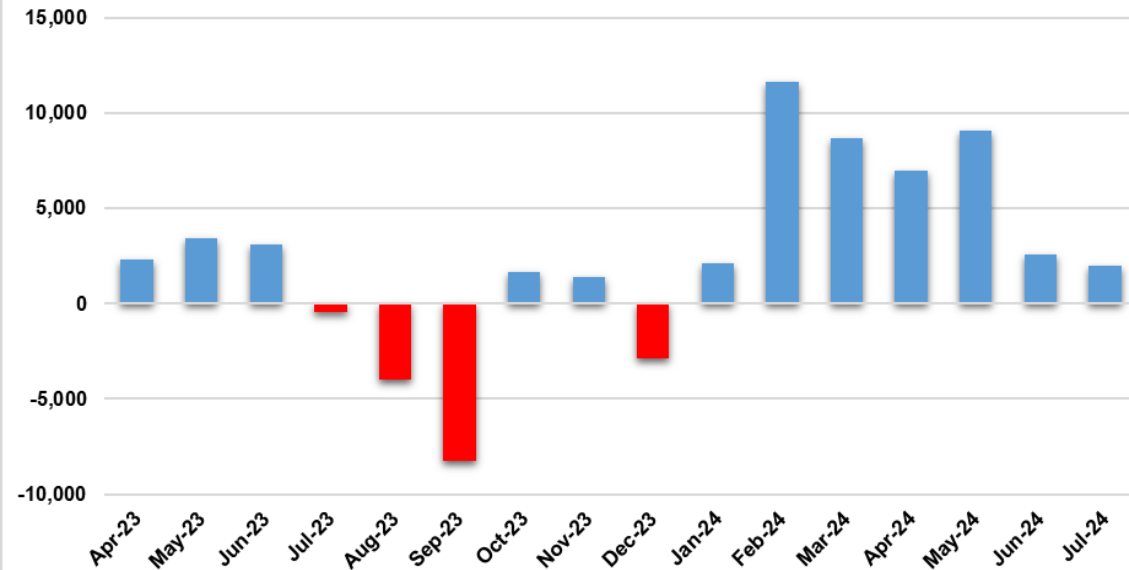
Committee: NWL Acute Care Board (Chair: Tim Orchard); NWL Elective Care Board (Chair: Roger Chin);

Data Assurance: tbc

Operating Plan Performance: Outpatient New

TREND

Outpatient New variance from Plan



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.

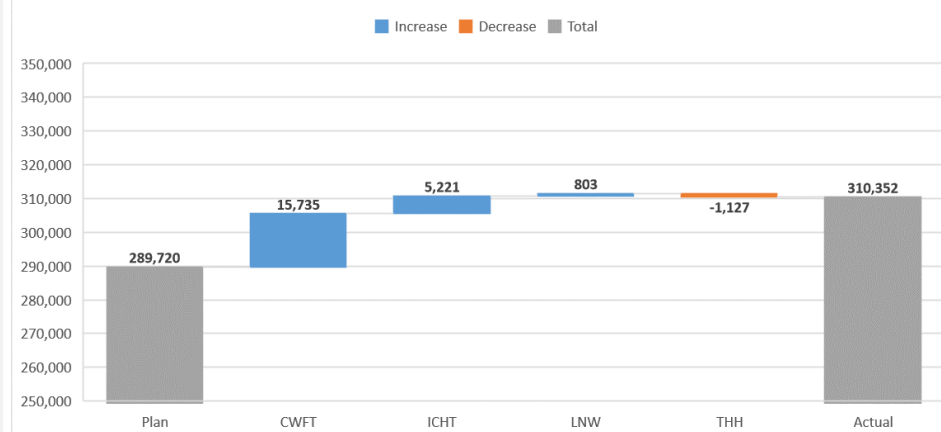
Forecast Risks: None forecast

CURRENT PERFORMANCE

Year to Date: Jul-24

	Plan	Actual	Var	% Var	Follow ups	FU Rate
CWFT	66,438	82,173	15,735	23.7%	325,087	4.0
ICHT	89,296	94,517	5,221	5.8%	615,610	6.5
LNW	98,707	99,510	803	0.8%	339,811	3.4
THH	35,279	34,152	-1,127	-3.2%	148,529	4.3
APC	289,720	310,352	20,632	7.1%	1,429,037	4.6

STRATIFICATION



Year to date contribution to variance against plan

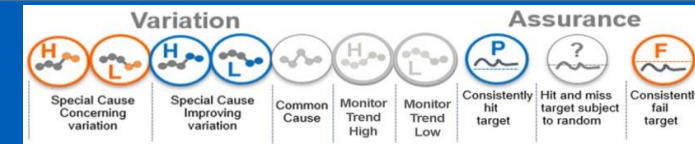
GOVERNANCE

Senior Responsible Owner: Tina Benson, COO, THH

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

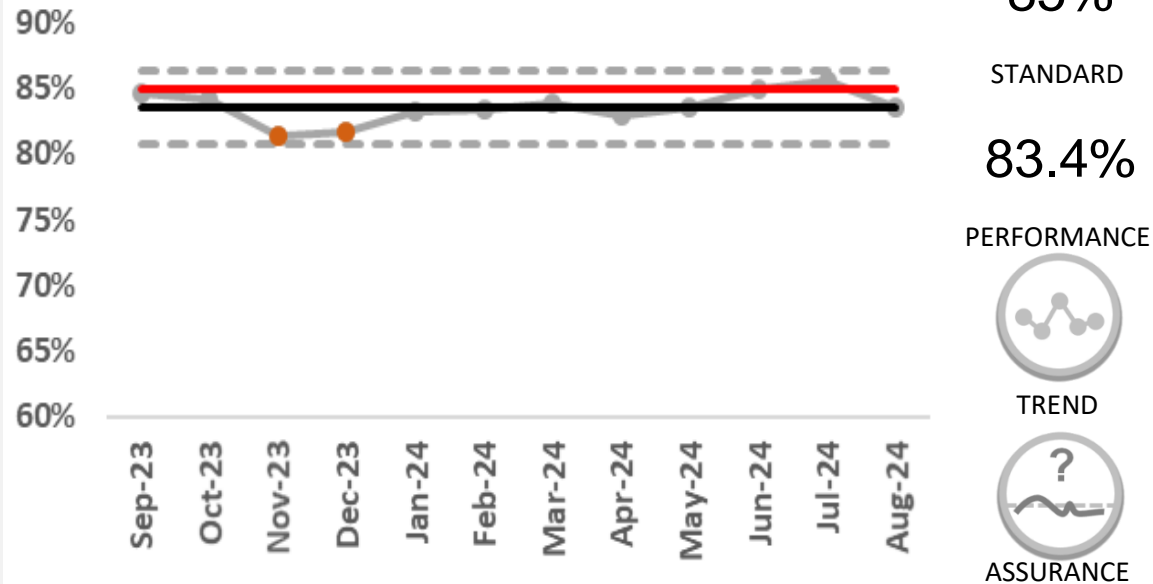
Data Assurance: tbc

Operations Theatre Utilisation (Uncapped)



TREND

Theatre Utilisation



NARRATIVE

Performance: Theatre utilisation dropped below target in August against a prior 3-month improvement trajectory. This will be monitored to ensure this does not become a trend.

Recovery plan: ICHT and CWFT performance dipped in August with THH and LNW remaining above standard.

Improvement: Trust-wide improvement programme for ICHT across the full surgical pathway as well as in theatres themselves.

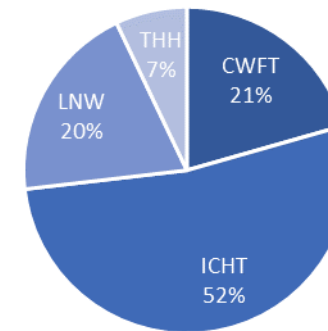
Future risk: Shortages in critical staffing groups.

CURRENT PERFORMANCE

Theatre Utilisation Aug-24

	Planned operating time (hours)	Theatre utilisation	Difference from target	Unused time (hours)
CWFT	2548	83.6%	-1.4%	418
ICHT	5079	79.9%	-5.1%	1020
LNW	3220	88.1%		383
THH	940	85.3%		138
APC	11786	83.4%	-1.6%	1959

STRATIFICATION



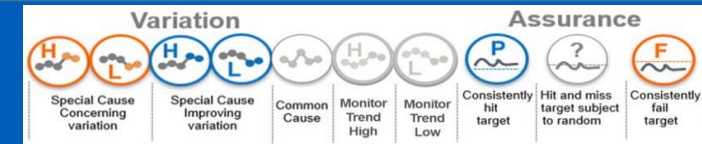
GOVERNANCE

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

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

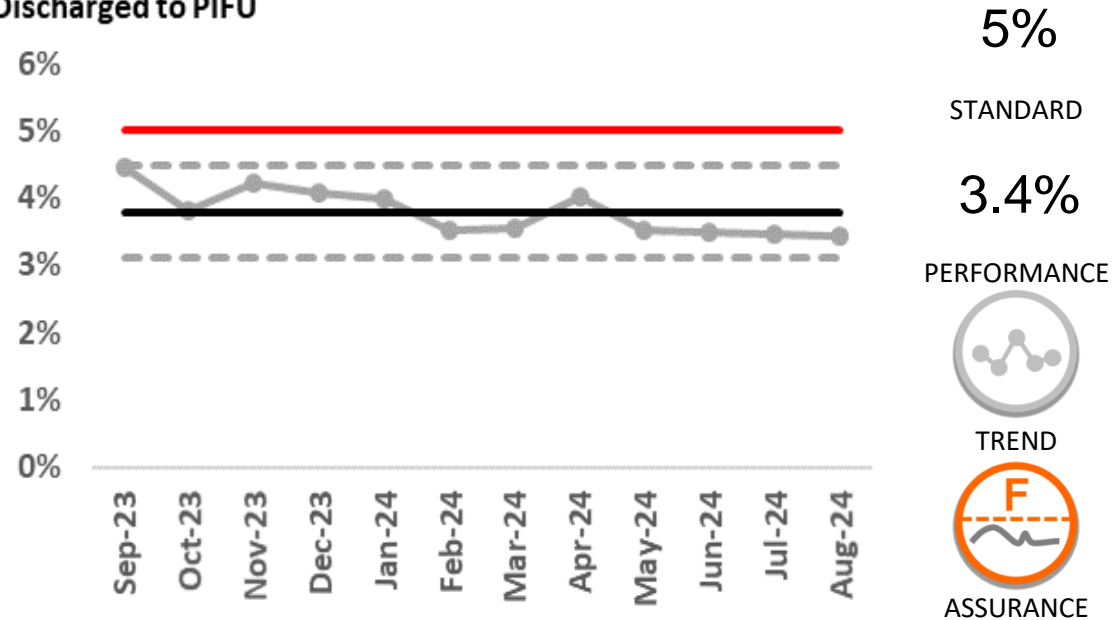
Data Assurance: tbc

Operations Outpatient Transformation



TREND

Discharged to PIFU



NARRATIVE

Performance: Pathways discharged to PIFU are under target. A programme of work looking at those services with the greatest opportunity to utilise PIFU using GIRFT as a guide is underway. A Cerner flow meeting to improve the usability of PIFU and standardisation has been held and which will now support clinical decisions. Next steps is a clinical audit of key specialities.

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

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

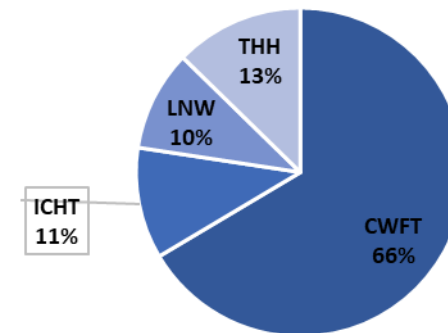
Future risks: Stability, usability and interoperability of digital infrastructure

CURRENT PERFORMANCE

Outpatient Transformation Aug-24

	Total OP contacts	Discharged to PIFU	Difference from target	Moved / Discharged to PIFU	Impacts on		
					OPFA DNAs	OPFU DNAs	Virtual contacts
CWFT	65984	7.5%		4956	10.2%	8.4%	7467
ICHT	47891	1.7%	-3.3%	816	11.9%	9.2%	18357
LNW	70734	1.0%	-4.0%	738	10.1%	9.6%	10973
THH	32623	2.9%	-2.1%	947	7.6%	9.3%	2478
APC	217232	3.4%	-1.6%	7457	10.4%	9.1%	39275

STRATIFICATION



Trust share of APC discharges lower than standard

GOVERNANCE

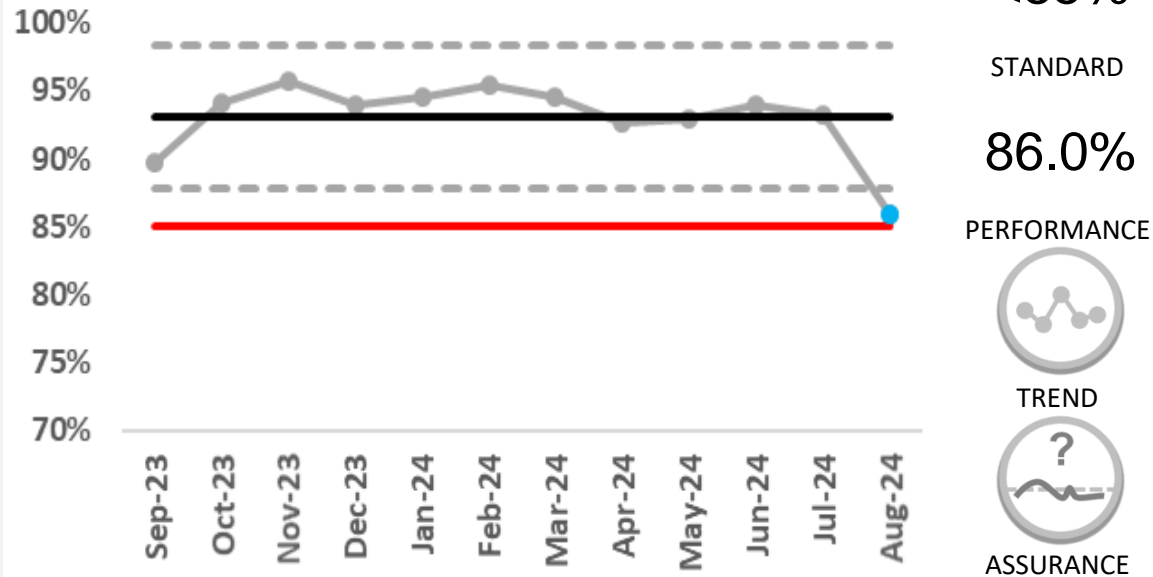
Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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

Data Assurance: tbc

TREND

Critical Care Bed Occupancy



NARRATIVE

Performance: Critical Care bed occupancy overall is broadly in line with the target, with the reduction in August 2024 due to seasonal variation.

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.

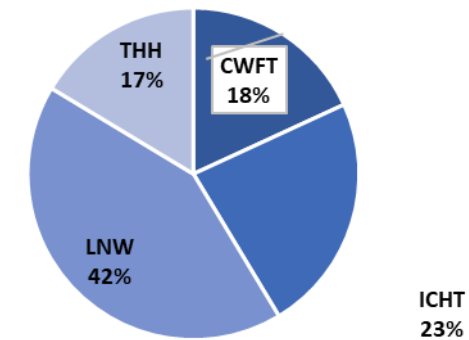
Note: There is a review in progress to ensure alignment of occupancy reporting

CURRENT PERFORMANCE

Critical Care Aug-24

	Available critical care beds	Bed occupancy	Difference from target	Unoccupied critical care beds
CWFT	19	75.7%		4.6
ICHT	94	93.7%	8.7%	5.9
LNW	56	80.8%		10.7
THH	12	65.3%		4.2
APC	181	86.0%	1.0%	25.4

STRATIFICATION



GOVERNANCE

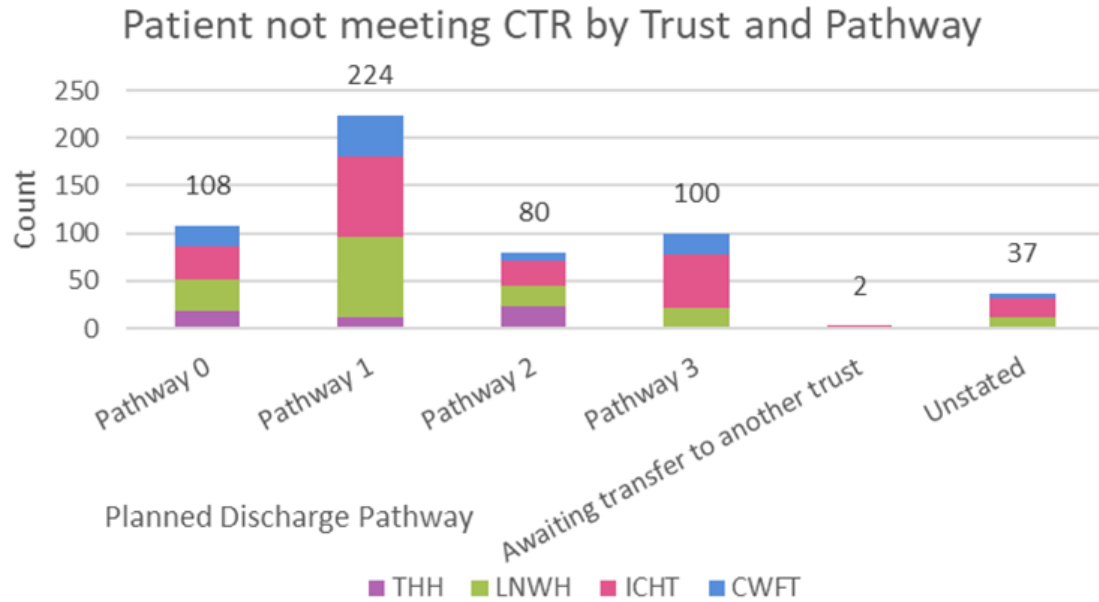
Senior Responsible Owner: Tina Benson, Chief Operating Officer, THH

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



NARRATIVE

Performance: There has been a marginal decrease in the number of patients not meeting CTR in the sector from 612, since last reported, to 551. This decrease is noted in the P0 pathway, while the P1 pathway remains broadly stable at the end of August 2024 with week-on-week variation expected during the month. All patients are input into the Optica system, not just pathway 1-3. Improvements are noted across all Trusts in the sector.

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

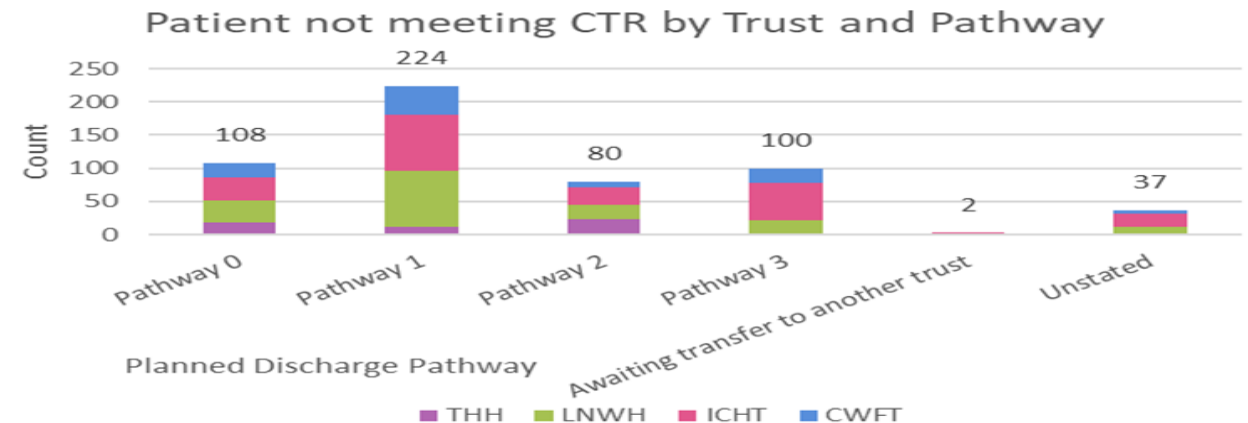
Improvement: Ongoing work with each local authority to improve P1 discharges.

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

CURRENT PERFORMANCE

Local Authority	CWFT	ICHT	LNW	THH	Total	List Size	Rate r per 10,000
Brent	0	31	54	0	85	470,344	1.81
Ealing	4	32	54	6	96	433,987	2.21
H&F	13	56	0	0	69	296,710	2.33
Harrow	0	1	34	1	36	260,337	1.38
Hillingdon	0	6	6	40	52	324,843	1.6
Hounslow	41	10	3	3	57	338,787	1.68
Kensington & Chelsea	13	24	2	1	40	268,576	1.49
Westminster	3	30	2	0	35	253,186	1.38
Out of area	28	33	14	6	81		
Total	102	223	169	57	551		

STRATIFICATION



GOVERNANCE

Senior Responsible Owner: Sheena Basnayake, Deputy Chief Operating Officer

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

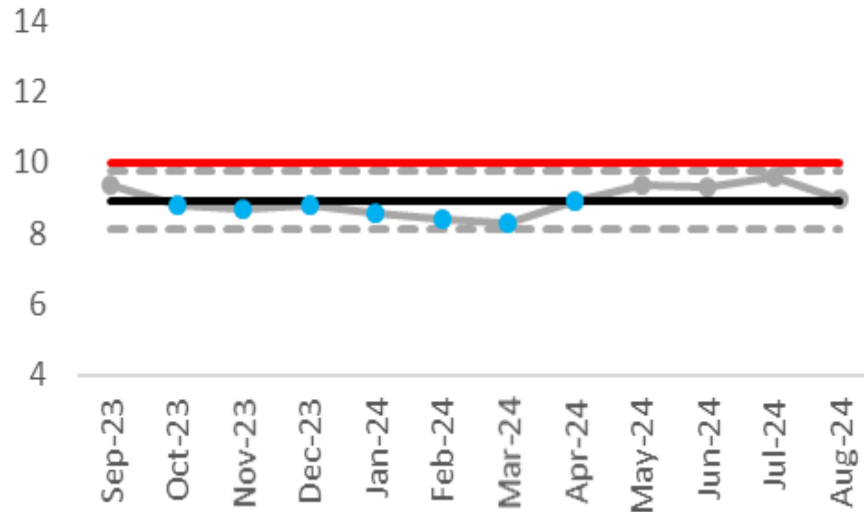
Data Assurance: These figures come for the FDP via the ICB

Workforce

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.

TREND

Acute Collaborative - Vacancy Rate %



=/ \leq 10%

STANDARD

9.0%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Vacancy rates at collaborative level are consistently hitting target and are common cause variation. Since August 2023, the collaborative vacancy level has maintained below the agreed target of 10.0% and in August 2024 was 9.0%. This performance is the result of targeted recruitment campaigns, both at home and abroad, with a continuing focus to drive further improvement.

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

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

We continue to see increasing numbers of internationally appointed nurses, and this continues to have a positive impact on general nursing vacancies and we have a strong pipeline 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.

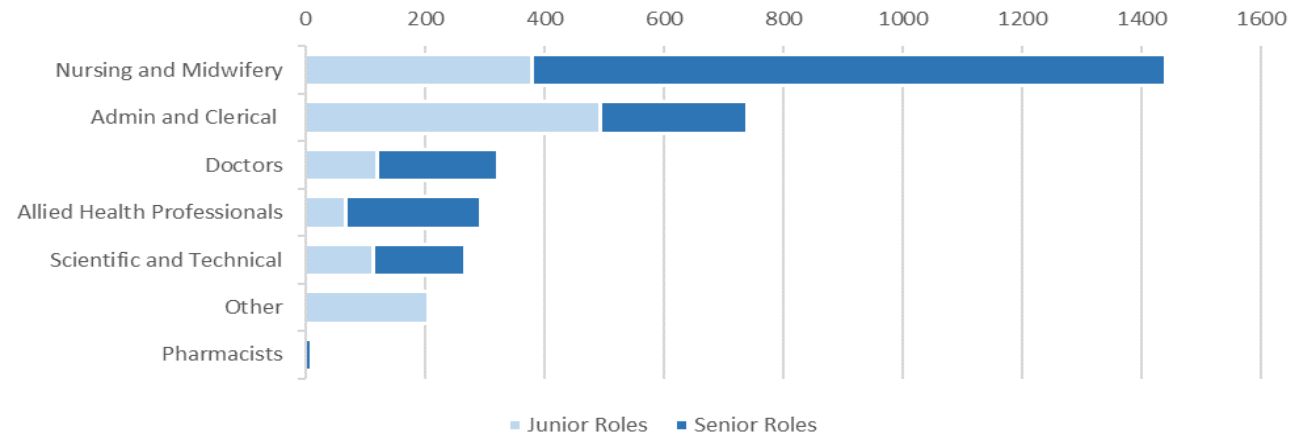
Forecast Risks: High levels of vacancies puts additional pressure on bank staffing demand at a time of increased activity (elective recovery) and industrial action.

CURRENT PERFORMANCE

Vacancies

	Target %	Month 05 Vacancy Rate %	Variance to Target %	Vacancy WTE
CWFT	10%	6.0%	4.0%	443
ICHT	10%	10.4%	-0.4%	1,641
LNW	10%	9.5%	0.5%	921
THH	10%	7.2%	2.8%	268
APC	10%	9.0%	1.0%	3,273

STRATIFICATION



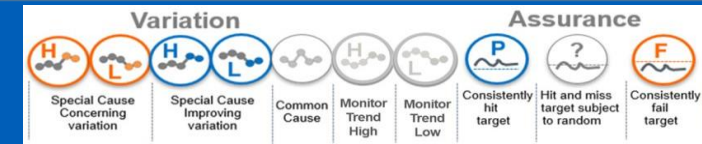
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

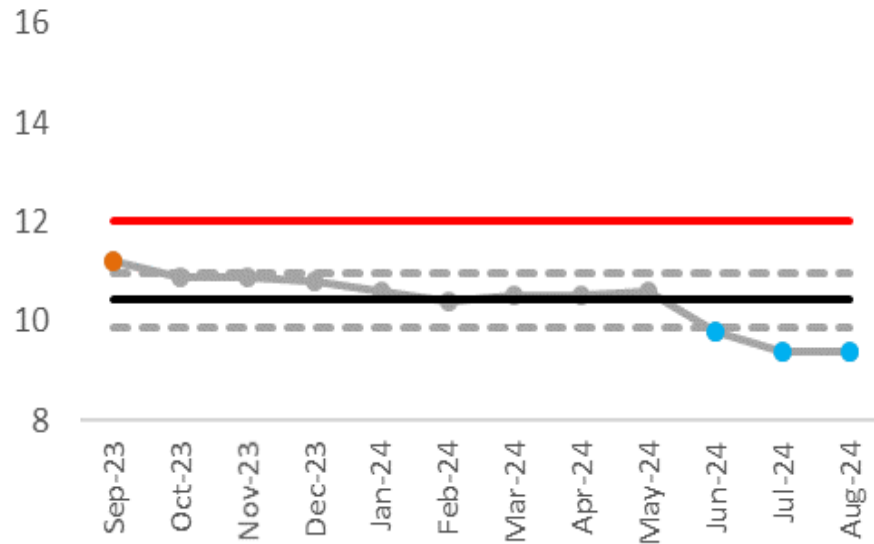
Data Assurance: tbc

Workforce Voluntary Turnover



TREND

Acute Collaborative - Turnover Rate %



=/<12%

STANDARD

9.4%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Voluntary turnover continues as a special cause improving variation as, over the past year, there has been a steady reduction from 12.8% to the current position of 9.4% 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.

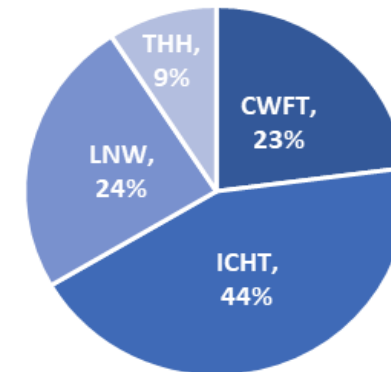
CURRENT PERFORMANCE

Voluntary Turnover

	Target %	Month 05 Turnover Rate %	Variance to Target %	Voluntary Leavers WTE (rolling 12 months)
CWFT	12%	11.4%	0.6%	591
ICHT	12%	9.5%	2.5%	1,120
LNW	12%	8.1%	3.9%	624
THH	12%	9.0%	3.0%	237
APC	12%	9.4%	2.6%	2,571

STRATIFICATION

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



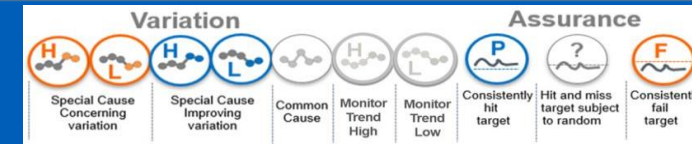
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

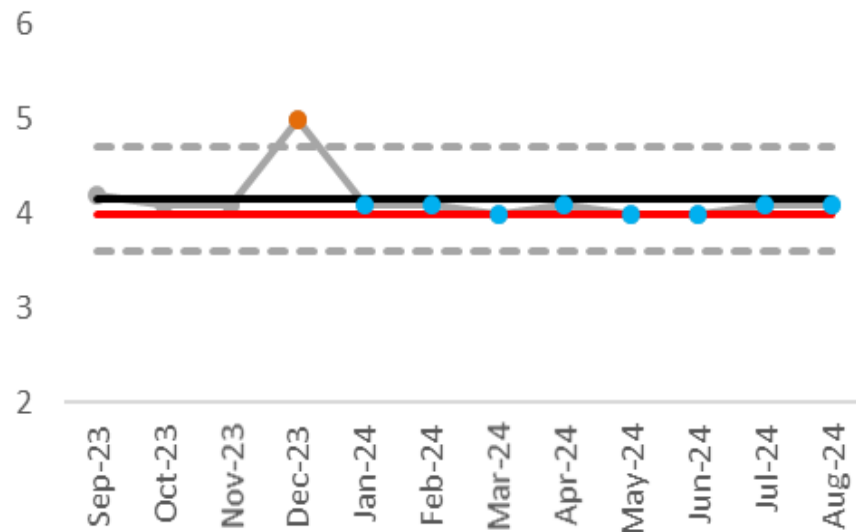
Data Assurance: tbc

Workforce Sickness Absence



TREND

Acute Collaborative - Rolling Sickness Rate %



=/ < 4%

STANDARD

4.1%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Within seasonal normal range and for August 2024 we are collectively at 4.1%; almost meeting the agreed 4.0% target and a common cause variation.

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

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

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

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

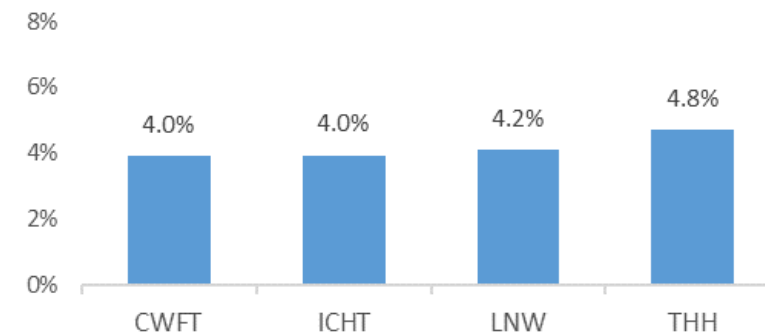
CURRENT PERFORMANCE

Rolling Sickness Absence

	Target %	Month 05 12 Month Rolling Sickness Absence Rate %	Variance to Target %	Month 05 In-Month Sickness Absence Rate %
CWFT	4%	4.0%	0.0%	4.1%
ICHT	4%	4.0%	0.0%	3.8%
LNW	4%	4.2%	-0.2%	4.1%
THH	4%	4.8%	-0.8%	4.5%
APC	4%	4.1%	-0.1%	3.9%

STRATIFICATION

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



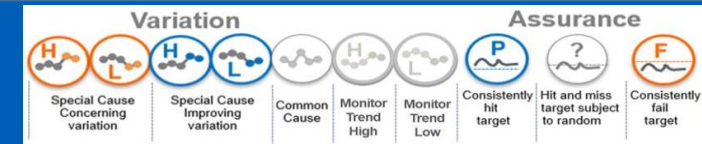
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

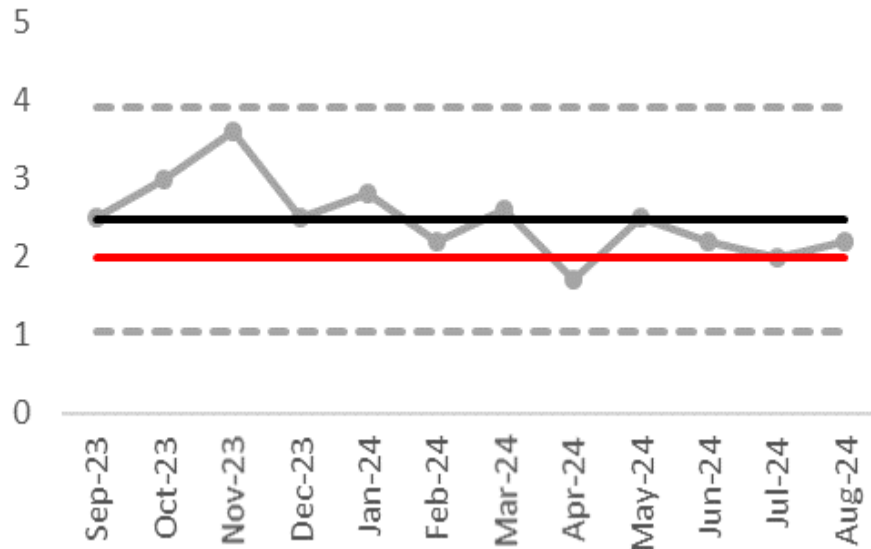
Data Assurance: tbc

Workforce Productivity - Agency Spend



TREND

Acute Collaborative - Agency Spend % of Paybill



=/ < 2%

STANDARD

2.2%

PERFORMANCE



TREND



ASSURANCE

NARRATIVE

Performance: Agency spend, as a proportion of overall pay bill, is our productivity measure with a collective target set at 2%. Current performance for August 2024 was 2.2% and is a common cause variation.

Reliance on agency workers is key for the delivery of some services, particularly where there is a national skills shortage such as for sonography, 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.

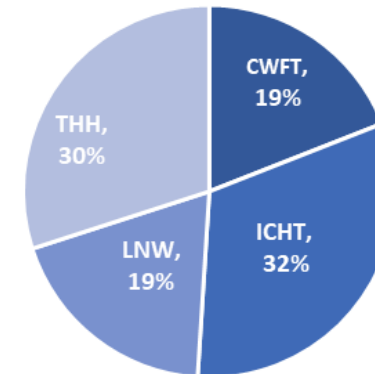
CURRENT PERFORMANCE

Productivity - Agency Spend

	Target %	Month 05 Agency Spend Rate %	Variance to Target %	Agency Spend £ (in Month)
CWFT	2%	1.9%	0.1%	881,255
ICHT	2%	1.7%	0.3%	1,478,059
LNW	2%	1.6%	0.4%	879,763
THH	2%	6.3%	-4.3%	1,385,913
APC	2%	2.2%	-0.2%	4,624,990

STRATIFICATION

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



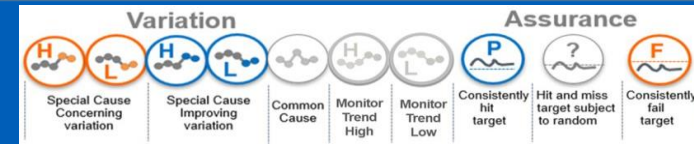
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

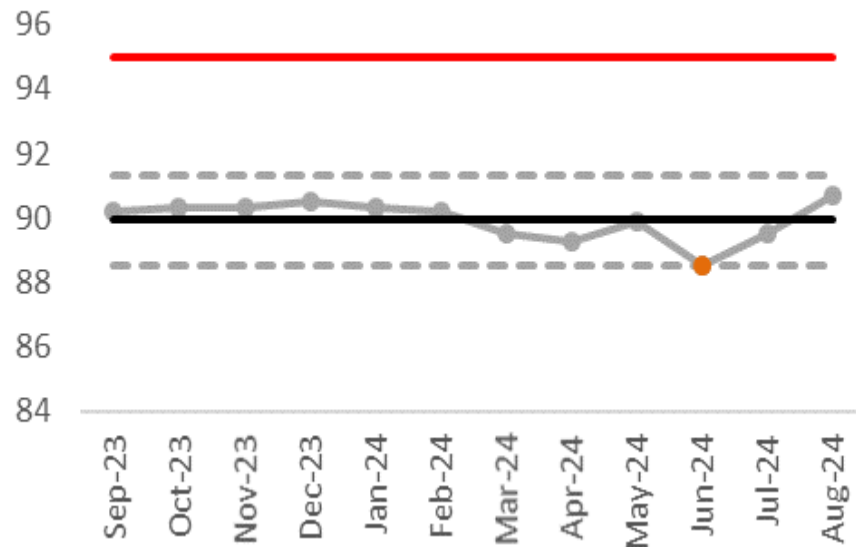
Data Assurance: tbc

Workforce Non-Medical PDR



TREND

Acute Collaborative - PDR Completion Rate %



=/ \leq 95%

STANDARD

90.7%

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 05 has a medical PDR rate of 91%, which is split as follows CWFT 88%; ICHT 91%; LNW 91% & THH 97%.

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.

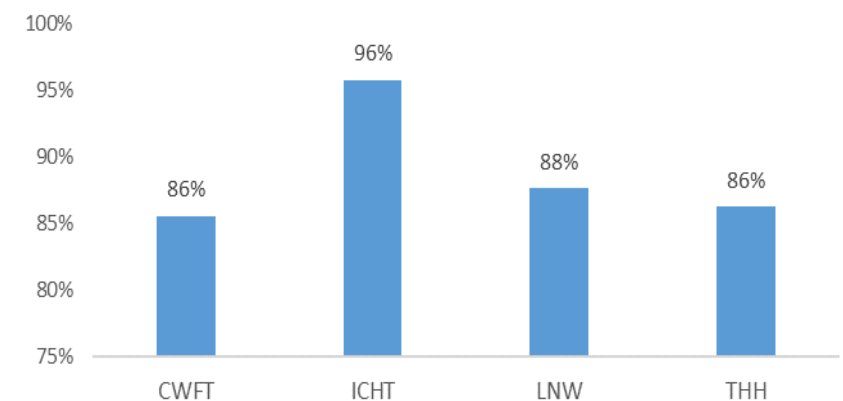
CURRENT PERFORMANCE

Non Medical PDR

	Target %	Month 05 PDR / Appraisal Rate %	Variance to Target %
CWFT	95%	85.6%	-9.4%
ICHT	95%	95.8%	0.8%
LNW	95%	87.6%	-7.4%
THH	95%	86.3%	-8.7%
APC	95%	90.7%	-4.3%

STRATIFICATION

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



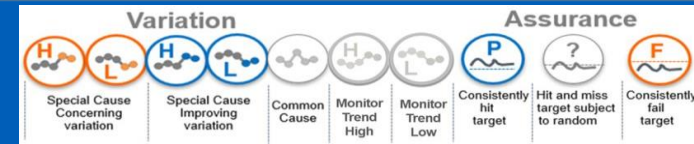
GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

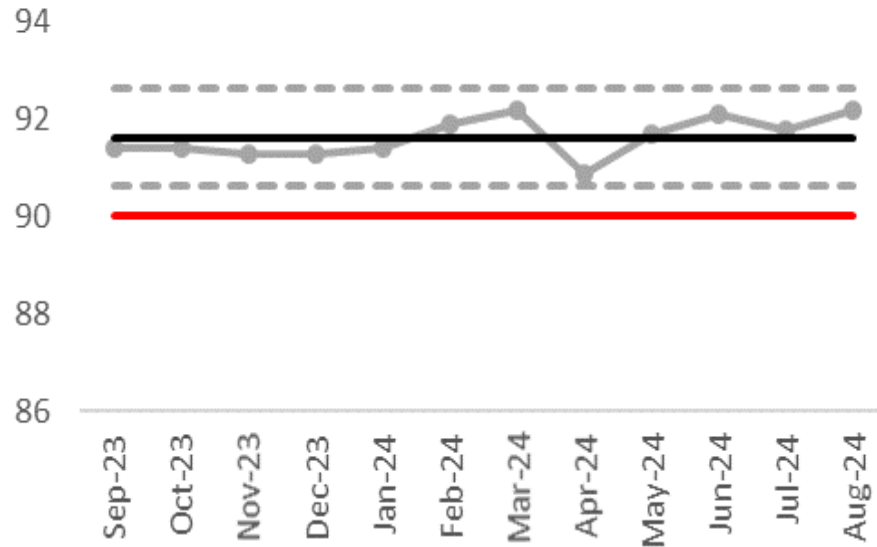
Data Assurance: tbc

Workforce Core Skills Compliance



TREND

Acute Collaborative - Core Skills Rate %



=/ \leq 95%

STANDARD

92.2%

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 September and August. 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

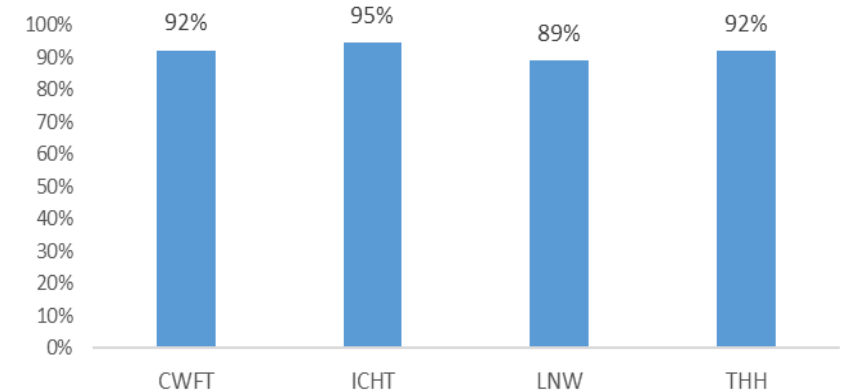
CURRENT PERFORMANCE

Core Skills Compliance

	Target %	Month 05 Core Skills Compliance Rate %	Variance to Target %
CWFT	95%	92.3%	2.3%
ICHT	95%	95.8%	4.7%
LNW	95%	89.1%	-0.9%
THH	95%	92.1%	2.1%
APC	95%	92.2%	2.2%

STRATIFICATION

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



GOVERNANCE

Senior Responsible Owner: Pippa Nightingale

Committee: APC People Committee

Data Assurance: tbc

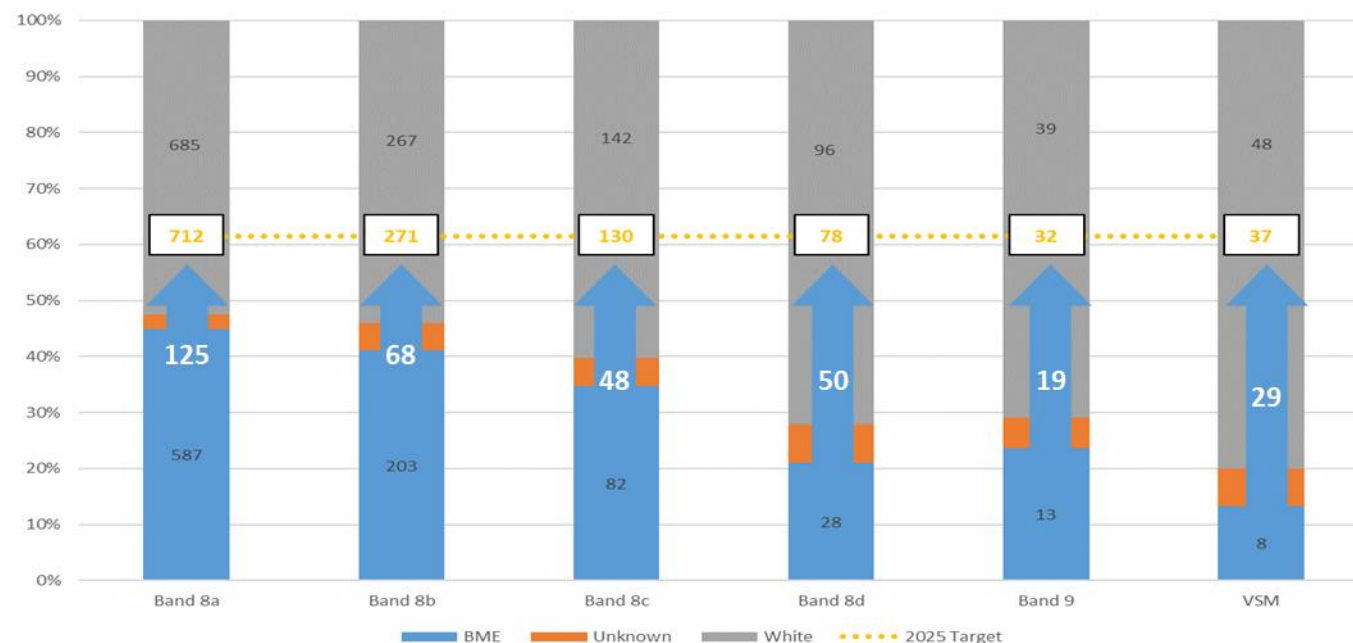
Workforce Equity

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 August 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.

Workforce Model Employer Goals - Overview

- Additional recruitment of staff from Black, Asian and minority ethnic groups is required for all bands in order for equity to be reached by August 2025.
- While the increase in numbers required to achieve equity varies across the APC 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 for August 2025 requires focus on external recruitment and internal progression routes including secondment opportunities to gain exposure and leadership trials.

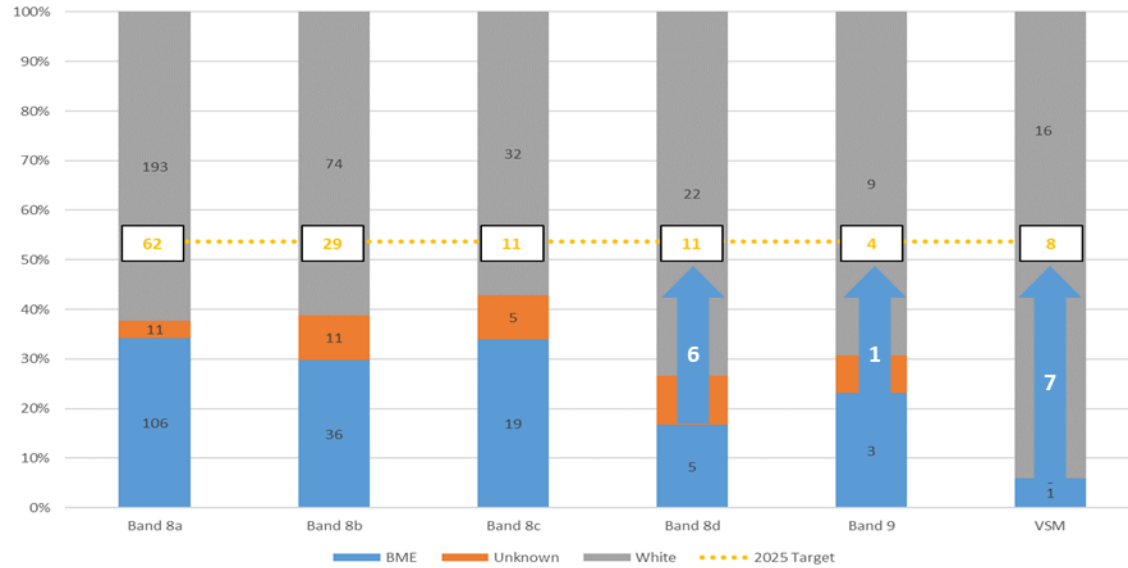


Actions being taken and developed to support MEG goals across the ACP at trust level are as follows (but not limited to);

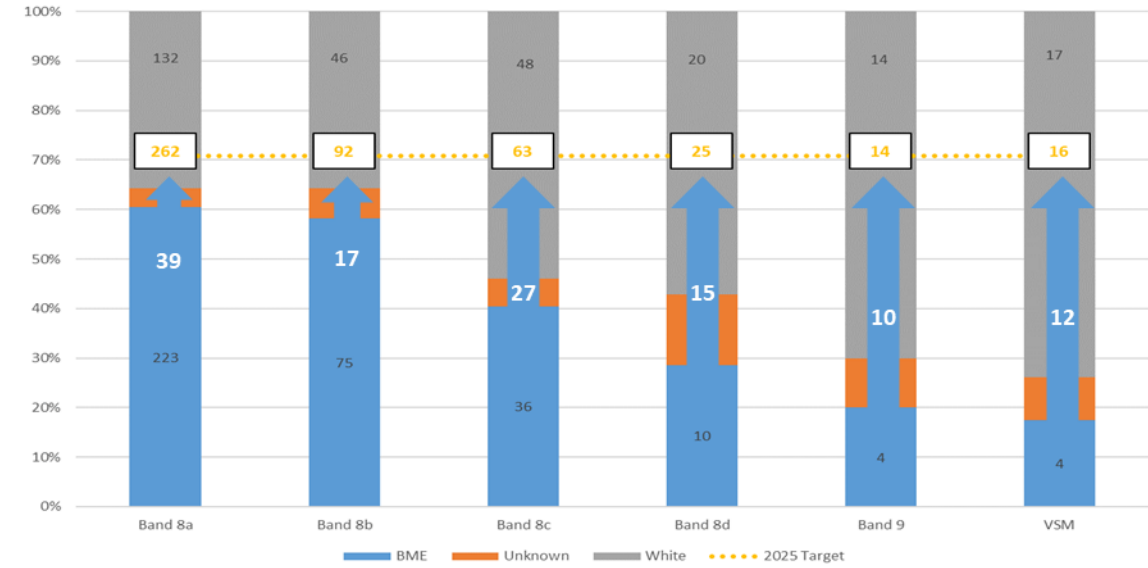
- Inclusive talent management strategies
- Succession planning to enable identifying, support and promotion of talent
- Inclusive recruitment means panels are gender-diverse and ethnically inclusive
- Diverse recruitment panels for all roles above band 7
- Regular monitoring and reporting on MEG targets

Workforce Model Employer Goals - Provider

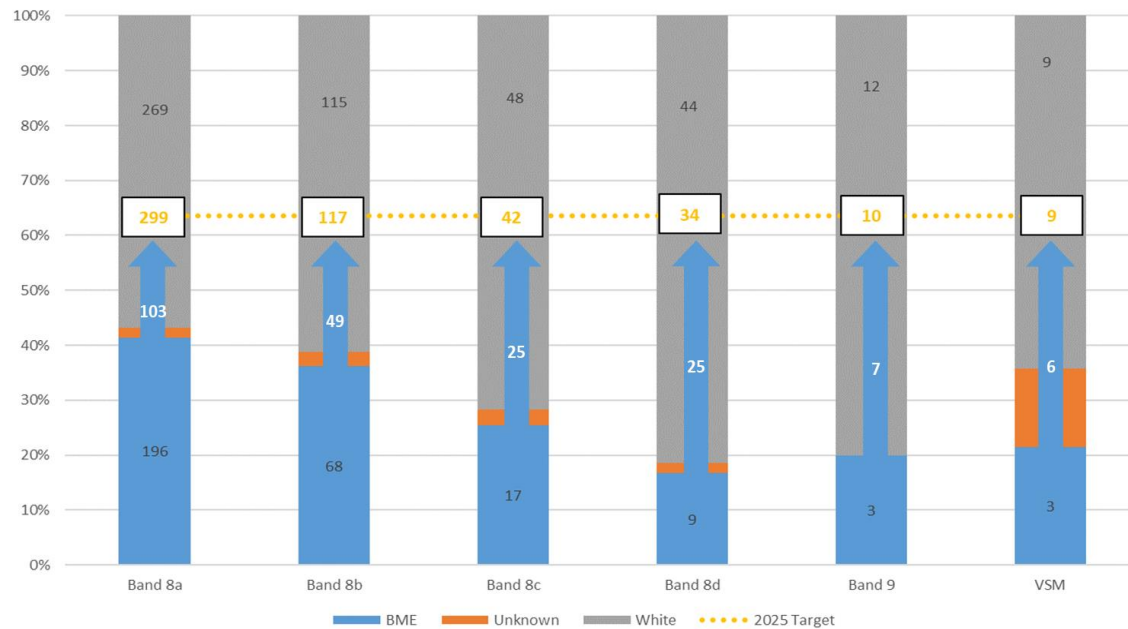
CWFT



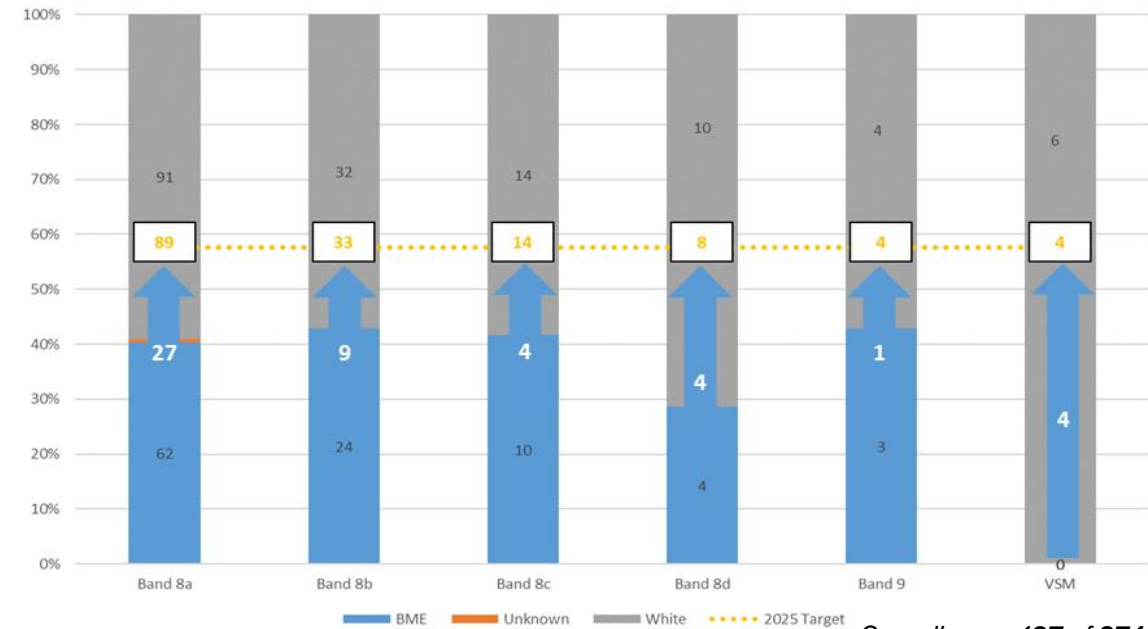
LNW



ICHT



THH



5.1 COLLABORATIVE QUALITY COMMITTEE CHAIR REPORT

 Steve Gill

REFERENCES

Only PDFs are attached

 5.1 Collaborative Quality Committee Chair's Report -September 2024 - FINAL.pdf

**North West London Acute Provider Collaborative (NWL APC)
Quality Committee Chair's Highlight Report to the NWL APC Board
in Common (BiC) – for discussion
September 2024**

Highlight Report

1. Purpose and Introduction

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

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

2. Key highlights

2.1. Deep Dive – User Insights/Patient Experience including Complaints Annual and quarterly Report and Themes and alignment of APC Complaints metrics

- 2.1.1. The Committee commenced a deep dive into the complaints 2023/24 Annual Report and the 2024/25 Q1 Report noting the key themes and trends in the types of complaints received across all four Trusts within the Acute Provider Collaborative. Committee members discussed the plans proposed for the year ahead noting that each Trust will be gathering and reviewing data using a set of common metrics to include in an integrated quarterly report to the Committee.

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 areas adverse to target included Infection Prevention & Control with all Trust exceeding their annual thresholds for 2023/24 for all three mandatory reportable healthcare associated infections. 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, and the new national sepsis guidance. Committee members noted that Martha's Rule had been launched across three out of the four Trusts with the Chelsea & Westminster Hospital NHS FT Trust launch on 30 September.

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 with a focus on:

- Aligning the clinical assessment model for deciding on the level of enhanced observation that mental health patients require.
- Standardising the requirements for safe environments for patients with mental health needs
- Delivering an Acute Provider Collaborative Mental Health Strategy based on the work already completed by Imperial College Healthcare NHS Trust.

Committee members noted the progress of the work stream noting that good progress was being made in regards to patient safety however further work was required to manage the increasing demand of patients presenting with mental health support needs within the emergency departments in all the Trusts across the North West London Acute Provider Collaborative.

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

Committee members received a progress update against the new priority work stream to implement the recently revised national safety standards for invasive procedures. The Committee noted that the initial priority was for each Trust to undertake a gap analysis against the standard to allow a detailed programme to commence. In the meantime, it was agreed to focus on harmonising invasive procedure policies.

2.2.4 The Procurement and Improvement of the Incident and risk management system

The Committee received an update on the progress of the implementation of a new Incident and Risk Management System. The Committee noted that the current phase of the programme would implement a single system for all four Trusts however other Integrated Care Board organisations would not be included within the first phase of the programme.

2.3 Maternity Quarterly Report Acute Collaborative Themes and Actions including compliance with Saving Babies Lives and National CQC Maternity Patient Experience survey results action plan and maternity workforce measures

The Committee received the report which provided the Committee with an update on the changes and reporting timescales for the Maternity Incentive Scheme Year 6, and the position of each Trust against the 10 safety actions. Committee members noted that all four Trusts had made significant progress against the safety actions with plans in place to mitigate the risk of non-delivery. The Committee received assurance on the delivery of Saving Babies Lives v3 care bundle following its launch in July 2023.

2.4 Maternity update – The Hillingdon Hospitals NHS Foundation Trust

Committee members received an update from the Hillingdon Hospitals NHS Foundation Trust noting the progress of the Maternity and Neonatal

Improvement Programme. Committee members noted that the programme was progressing however remained rated as Amber due to key actions being uncompleted. Key risks and issues were highlighted to the Committee which included capacity and readiness of teams to lead the programme, agreement on recruitment of key posts to address triage/flow and data quality issues, driven by poor Cerner workflow compliance. Actions were in place to manage these which were being monitored in detail by the local Trust Quality Committee.

2.5 Combined Risk Escalation Report from Local Trust Quality Committees

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.

Chelsea & Westminster Hospital NHS FT Trust won the HSJ award for Patient Safety Team of the Year.

The Hillingdon Hospitals NHS FT Trust received a section 29A warning notice across surgery and urgent care. In response to the notice the Trust had commenced a programme of improvement. The Trust had submitted their first response to the CQC on 5th September 2024 with appropriate evidence for improvement, further responses are due to the CQC on 5th October and 5th November. Feedback from the CQC was awaited.

The Imperial College Healthcare NHS Trust Quality Committee had commenced a deep dive into Health Equity which will be shared with the APC Quality Committee in December.

London North West University Healthcare NHS Trust would be exiting the National Maternity and Neonatal Safety Improvement Programme.

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

2.6 Collaborative Quality Committee Terms of Reference

2.6.1 The Committee approved the Committee terms of reference.

2.7 Learning from Deaths Quarterly report on Acute Collaborative Themes – Quarter one 2023/24

2.7.1 The Committee reviewed the combined NWL APC Q1 report incorporating all four Trusts which outlined the key themes and outcomes from the learning from deaths process.

2.7.2 The Committee noted that the report provided assurance regarding each Trust's processes to ensure scrutiny of, and learning from, deaths was in line with national guidance, with 3 of the 4 Trusts consistently achieving 'lower than expected' and 1 Trust achieving 'as expected' Summary Hospital-level Mortality Indicator (SHMI) scores. Actions in place where the need to improve these further had been identified.

2.8 Progress update on APC Clinical Pathway work streams

2.8.1 Committee members received the report noting that good progress was being made on setting up the work stream consisting of 28 specialty leadership

groups, chief executive oversight groups and forums for sharing learning across Trusts. Committee members noted that positive feedback had been received so far, with enthusiasm for the work and good engagement.

2.9 APC EDI patient equity work stream update

- 2.9.1. Committee members received the report noting the work stream's terms of reference had been agreed and work was commencing this month. Committee members noted that the work stream would be a focused task and finish group for a period of 6 months.

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

Mental Health across the emergency departments within the Acute Provider Collaborative.

5. Concerns outstanding

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

6. Key actions commissioned

None noted.

7. Decisions made

The Committee approved the Committee terms of reference.


8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Deep dive User insights/Patient Experience including Complaints Annual Report and Themes and alignment of APC complaints	For discussion and noting	8.	Collaborative Quality Committee Terms of Reference	To approve
2.	Acute Collaborative Quality Performance Report	To discuss	9.	Learning from deaths quarterly reports – Quarter one 2023/24	To discuss
3.	Work Stream PIDs and Project Updates:	To discuss	11.	Progress update on APC Clinical Pathway Work streams	For noting
4.	Maternity Quarterly Report Acute Collaborative Themes and Actions including compliance with Saving Babies Lives	To discuss	12.	APC EDI Patient equity work stream update	For noting
5.	National Patient Safety Strategy and Quality System Standardisation	To discuss	13.	Any Other Business	To discuss
6.	Maternity update – Hillingdon Hospitals NHS Foundation Trust	To discuss	14.	Committee forward planner	To note
7.	Combined Risk Escalation report from local Trust Quality Committees	To discuss and noting			

9. Attendance


Members	September attendance
Steve Gill, Vice chair (CWFT), NED (THHT) (Chair)	Y
Syed Mohinuddin, Non-executive director (LNWH/CWFT)	Y
Linda Burke, Non-executive director (THHT/ICHT)	Y
Carolyn Downs, Non-executive director (ICHT/CWFT)	Y
Pippa Nightingale, Chief executive (LNWH)	Y
In attendance	
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)	N
Sarah Burton, Chief nurse (THHT)	Y
Robert Bleasdale, Chief nurse (CWFT)	Y
Janice Sigsworth, Chief nurse (ICHT)	Y
Lisa Knight, Chief nurse (LNWH)	Y

5.2 LEARNING FROM DEATHS QUARTERLY REPORT

 Julian Redhead

REFERENCES

Only PDFs are attached

 5.2 BiC quarter one learning from deaths FINAL.pdf



NWL Acute Provider Collaborative Board in Common (Public)

15/10/2024

Item number: 5.2

This report is: Public

Acute Provider Collaborative Learning from Deaths Quarter One 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 committee, with this overarching summary paper drawing out key themes and learning from the four acute provider collaborative (APC) trusts. This report has been presented to the September APC Quality Committee.

Report history

Trust Quality Committees

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

Acute Provider Collaborative mortality surveillance meeting

09/09/2024
Trust reports were reviewed and the contents of this paper discussed and agreed.

Acute Provider Collaborative Quality Committee

17/09/2024
The committee noted the findings within the report and the on-going work of the mortality surveillance meeting to standardise key processes and metrics. The report was approved for onward submission to Board-in-common.

Executive summary and key messages

- 1.1. In line with national guidance each Trust provides a quarterly report to their quality committee on mortality surveillance and other learning from deaths processes. This report provides a summary of the quarter one 2024/25 reports.
- 1.2. Individual Trust reports have been provided to the Quality Committee and provide assurance that deaths are being scrutinised in line with requirements and learning shared and acted upon through Trust governance processes.
- 1.3. Our mortality rates continue to be lower than, or as expected, when compared nationally, with regular review of these occurring both internally and through the APC quality committee. All Trusts have a “lower than expected” hospital standardised mortality ratio (HSMR) for the period March 2023 to February 2024. The Hillingdon Hospitals NHS Foundation Trust (THH) has an “as expected” standardised hospital mortality indicator (SHMI), although this is below the national benchmark of 100, with all others remaining “lower than expected”. The SHMI data is not currently provided at site level for all sites but will be included in the next quarterly report.
- 1.4. There continue to be low numbers of cases where clinical concerns are identified through Level 2 reviews across the APC. Instances of sub-optimal care where different care might have made a difference decreased to five cases in this quarter compared to ten in quarter four. No common themes were identified across these cases.
- 1.5. Work to improve care at the end of life, a consistent theme across most quarters, continues with local actions in place. There were no new common improvement themes identified this quarter although each Trust has identified new areas of local improvement work.
- 1.6. All Trusts are investigating variations between observed and expected deaths by diagnostic group on an on-going basis. Reviews undertaken in quarter one were presented to the APC mortality surveillance group in September. London North West University Healthcare NHS Trust (LNW) and Imperial College Healthcare NHS Trust (ICHT) have both completed reviews of diagnostic groups related to cardiac services and found no clinical concerns.
- 1.7. Work continues to analyse ethnicity data for deceased patients. ICHT have found relatively low mortality risk for all ethnic groups in the period analysed. THH and LNW reviews did not trigger any concerns. Chelsea and Westminster NHS Foundation Trust (CWFT) have introduced changes to how ethnicity data is captured which will allow better reporting and analysis in future quarters.

Strategic priorities

Tick all that apply

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

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

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

Impact assessment

Tick all that apply

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

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

Main report

2. Learning and Improvements

- 2.1. Each Trust has processes in place to ensure learning from deaths happens after all in-hospital deaths and that this is shared and actions implemented where required.
- 2.2. There are no issues for escalation to this committee.
- 2.3. The key theme for improvement from 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.
- 2.4. At individual trust level the reviews show evidence of improvements in some key areas, as well as some themes for improvement including:
 - **CWFT:** reviews continue to highlight areas for improvement around communication between clinical teams, particularly at handover, and activity and staffing levels. Whilst end of life care is no longer a Trust quality priority, the Trust continues to recognise the importance of delivering high quality end of life care and has laid out key areas of focus around earlier identification of dying patient, Advance Care Planning, timely discharge planning to patient's preferred place of care or preferred place of death.
 - **ICHT:** reviews in this quarter have identified examples of excellent team working and good 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 consistent theme across other quality insights, including incidents, and is a safety

improvement priority for the Trust. Learning and improvements identified through recent level 2 reviews are informing the improvement plan.

- **LNW:** reviews have identified a number of key themes and areas for improvement including timely response to changes in Electrocardiogram (ECG), earlier involvement of mental health professionals in patient care, more frequent use of second opinions for Do not attempt cardiopulmonary resuscitation (DNACPR) decisions when family concerns have been raised, and the need to increase awareness of the criteria for emergency transfers and different transfer modes available. Divisional Quality Boards and Governance Groups and the Trust-wide Learning from Patient Deaths Group will identify improvement work required.
- **THH:** reviews identified recognition of nutritional deficit, including electrolyte and fluid management, and recording observations and clear document plans as areas for improvement. Findings have been sent to divisional leads for further review at Specialty M&Ms and to agree 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 HSMR and SHMI data shows that each Trust continues to have a rolling-12 month HSMR below the national benchmark of 100. All Trusts are 'lower than expected' for latest HSMR scores and THH remains 'as expected' for SHMI with all other Trusts 'lower than expected' for this indicator.

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

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

- **ICHT:** a review was completed for Acute Myocardial Infarction (AMI), which was a diagnostic group with more observed deaths than expected (although still within expected range). The review found no new clinical concerns about the treatment of patients who died from acute myocardial infarction. The cardiac directorate are being supported through a quality review meeting process in response to an increase in incidents with moderate and above harm. The mortality rate is being considered through that process also.
- **LNW:** The Learning from Patient Deaths Group considered thirteen diagnostic groups with higher observed deaths than expected. These groups are detailed in the individual Trust report. There was assurance that relative risk within these diagnostic groups remained below or within the expected range. A detailed review of Invalid primary diagnosis group identified issues around capturing primary diagnosis from clinical notes and database updates are planned for quarter three to support improvement in this area.

A clinical review of the Cardiac arrest and ventricular fibrillation group concluded that higher observed deaths were primarily linked to out of hospital cardiac arrests with appropriate treatment and escalation to ITU as required. No deficiencies in care were identified during this review.

3.2.4 THH continue to review the following groups: Other Perinatal Conditions, Hypertension complicating pregnancy, childbirth and the puerperium, Poisoning by other medications and drugs, and Gastroduodenal ulcer (except haemorrhage). Outcomes will be summarised in the quarter two report.

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

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

Provider Rolling 12 month HSMR	Mar 23 to Feb 24
ICHT (St Mary's)	66.9
ICHT (Charing Cross)	71.2
ICHT (Hammersmith)	79.3
CWFT (ChelWest)	62.5
CWFT (West Middx)	77.8
THH (Hillingdon)	88.0
LNW (Northwick)	87.6
LNW (Ealing)	86.1
LNW (St Mark's)	82.4
National Benchmark	100.0

3.2.7 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 occurring in these sites are monitored through the same trust mortality surveillance and learning from death governance processes that are used for other sites within these trusts.

3.3. Medical examiner (ME) reviews

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

3.3.2 Trusts continue to work collaboratively via a North West London (NWL) task and finish group to expand medical examiner scrutiny to all non-coronial deaths occurring in NWL boroughs ahead of this becoming statutory on 9 September 2024 (delayed from April 2024). The number of referrals from non-acute providers continues to increase as the system prepares for this date.

3.3.3 All four Trusts continue to provide weekend ME scrutiny, prioritising urgent cases i.e. faith deaths requiring urgent body release. Learning from each Trust continues to feed into collaborative work that aims to establish a shared weekend medical examiner service in Q4 2024/25.

3.3.4 ICHT have changed their internal processes so that submission of a summary of death submissions from clinical teams is now a non-mandatory step. This is in response to recent complaints and incidents around delays in issuing Medical certificates of cause of death (MCCDs) and aligns with processes in other NWL ME offices. An evaluation of these changes following implementation found that MEs were able to complete scrutiny within one day after the death for all urgent referrals and within two days for all deaths. This is a significant improvement compared to the performance in weeks preceding this change. These key performance indicators will continue to be monitored and reported monthly by the service.

3.3.5 THH continue to experience issues with timely and accurate identification of new acute deaths since the implementation of Cerner in November 2023. Collaborative work amongst all NWL ME offices has been carried out in this quarter to review system requirements and agree Cerner change requests designed to resolve these issues.

3.4. Level 2 reviews

3.4.1 Deaths where there are concerns, or which meet certain agreed criteria, are referred on by the medical examiner for a case note 'Level 2' review. The percentage of deaths referred for a Level 2 review during quarter one were 15% at LNW, 14% at THH, 12% at ICHT and 45% at CWFT.

3.4.2 A shared set of 'triggers' for these reviews was implemented at the end of quarter one to allow consistent reporting on themes. CWFT have also retained local triggers to be used where potential learning was identified at initial screening by consultants (31% of cases) or for other local reasons such as requests from divisional mortality review groups (3% of cases), this explains the higher percentage referral data.

3.4.3 'Unexpected deaths' was the most frequently used trigger at ICHT (35% of referrals) but this has decreased since previous quarters following adoption of the National Audit of Care at the End of Life (NACEL) definitions. This trigger accounted for 52% of deaths in quarter four and 65% of deaths in quarter three.

3.4.4 Concerns raised by family or carers continues to be the most used trigger in THH in this quarter, accounting for 39% of cases in the period. Referrals made by the Medical Examiner is the most frequently used trigger at CWFT (53% of cases referred) and LNW (31% of cases referred).

3.4.5 All Trusts have implemented the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) grading system to identify whether a death was avoidable in order to produce standard outputs from Level 2 reviews. This grading system is also used for adult death reviews across our Trusts. Five cases where sub-optimal care might have contributed to the patient's outcome have been identified from completed reviews in this quarter which is a decrease from ten in previous quarter.

3.4.6 Outcomes show low numbers of cases where definite issues are confirmed through Level 2 review which is reassuring. For quarter one:

- **CWFT:** 98 completed with no case of sub-optimal care that might have made a difference to the patient's outcome.
- **ICHT:** 54 completed with two cases of sub-optimal care that might have made a difference to the patient's outcome. The two cases have been referred for an after action

review (AAR) through the incident management process and will be discussed at the Trust death review panel once the investigation has been completed.

- **LNW:** 63 completed with three cases of sub-optimal care that might have made a difference to the patient's outcome.
- **THH:** Five reviews have been completed with no cases of sub-optimal care that might have made a difference to the patient's outcome

3.5. Other mortality reviews

- 3.5.1 A number of other national processes are in place for review of deaths for specific cohorts of patients. These include the Perinatal mortality review tool (PMRT), Learning disability mortality review (LeDeR) and Child death overview panels (CDOP), which are described in the glossary below. Work has continued to align reporting of cases and outcomes from these process in each Trust and data is now being presented in scorecards.
- 3.5.2 Hillingdon Safeguarding Partnership have established a task and finish group with the Child Death Review team and local police services in response to another teenage death by suicide occurring in this quarter. Details around Youth Mental Aid First Aid training and promoting the use of psychosocial screening questionnaires for young people have been included in local Child Death Review newsletters.
- 3.5.3 LNW and THH have both identified an area for improvement following PMRT reviews in this quarter which is to provide women with information in different languages to better support non-English speakers. THH maternity services have implemented CardMedic in this quarter, an application that translates key information into different languages. LNW have also identified improvements required around monitoring and responding to reduced fetal movement.
- 3.5.4 LNW have reviewed their internal LeDeR reporting processes, integrating them into the Trust mortality review processes, and have established a monthly meeting to reviewing potential LeDeR cases before submission to improve reporting accuracy. Training took place in June to enhance staff understanding and knowledge of assessment and support of patient care needs.
- 3.5.5 Through review of LeDeR cases, ICHT identified common themes around excellent communication with families and support offered from the safeguarding team. CDOP reviews at the Trust found no immediate concerns relating to the care of children receive at the Trust. The previously reported backlog of PMRT cases, caused by pausing of the process in pandemic surges, have now all been completed with no new issues identified.

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. Telstra Health UK have supported THH and ICHT to review mortality rates by ethnicity for previous years. ICHT reviewed ethnicity data from January 2017 to December 2023 and found all groups had fewer observed than expected deaths and had a significantly low HSMR score when compared nationally. THH reviewed data from April 2021 to

March 2024 which showed consistent mortality rates across all groups and no areas that triggered concern.

- 4.3. LNW, THH and ICHT have also analysed ethnicity data for Level 2 review referrals and outcomes but sample size of data is too small to draw meaningful conclusions.
- 4.4. ICHT has a higher proportion of patients where ethnicity is unknown (20% compared to 11% at LNW) and work is underway to import data from the NWL Whole Systems Integrated Care (WSIC) system into mortality system to reduce this error rate and improve data quality.
- 4.5. CWFT have implemented changes in this quarter to how they capture ethnicity data for deceased patients and import data from other sources into mortality records. This work is expected to be completed in September 2024 at which point analysis of ethnicity data can commence.
- 4.6. Local areas of focus include:
 - ICHT continue to monitor compliance against Specialty Mortality & Morbidity (M&M) guidance that was agreed and implemented in January 2024. There is evidence of good practice in some specialties but overall compliance remains low. Compliance data has added to the quality and safety scorecards and divisions have been asked to bring improvement plans to the performance and accountability review meetings in September.
 - THH have identified a number of issues related to recording deaths in Cerner it was implemented, which are being reviewed. Work continues to align Specialty M&M meetings across the Trust and to improve the timeliness of Level 2 review completion.
 - LNW have identified issues related to palliative care capture and coding processes and work is underway to identify improvements.

5. Conclusion

- 5.1. The individual Trust reports provide assurance regarding each Trust's processes to ensure scrutiny of, and learning from, deaths in line with national guidance, with actions in place where the need to improve these further has been identified.
- 5.2. There continue to be low numbers of cases where clinical concerns are identified through Level 2 reviews. This aligns with mortality rates which are consistently good and small numbers of incidents reported overall where the harm to patients is confirmed as severe or extreme/death.
- 5.3. Local reviews into HSMR and SHMI diagnostic groups will be overseen through the APC mortality surveillance group and will continue to be summarised in this report going forward.

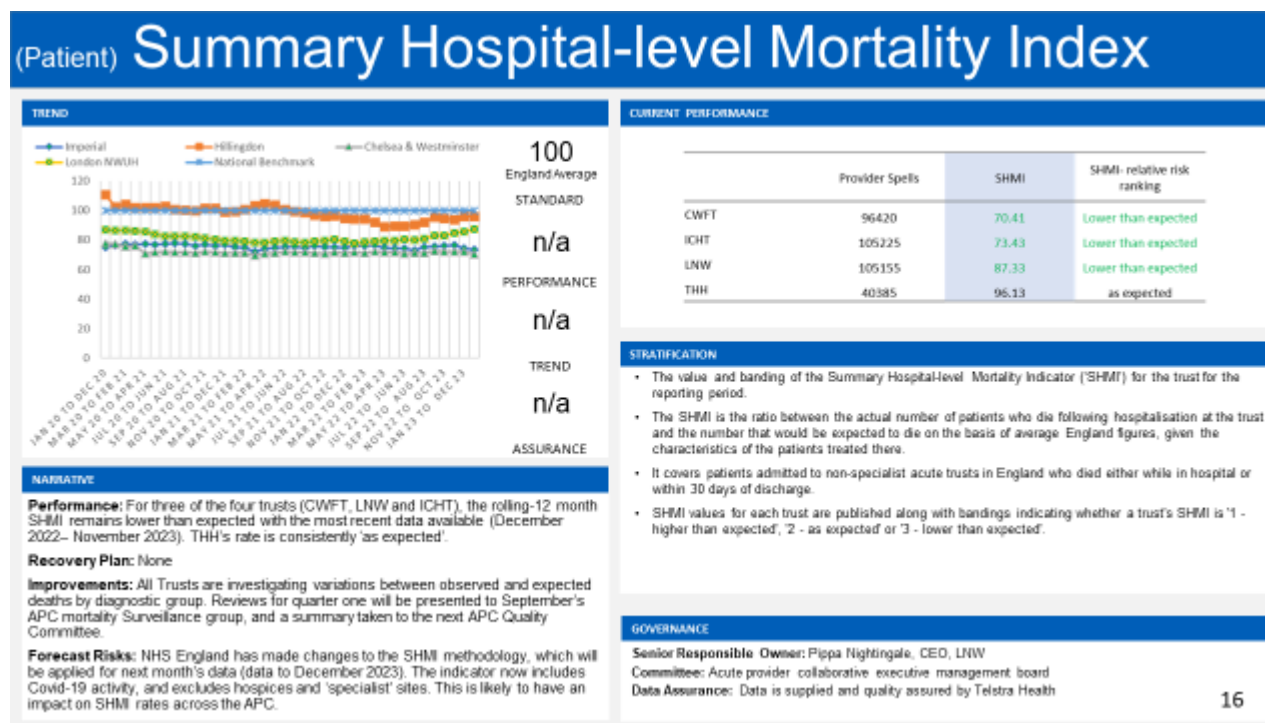
6. Glossary

- 6.1. **Chelsea and Westminster NHS Foundation Trust (CWFT)**
- 6.2. **Imperial College Healthcare NHS Trust (ICHT)**
- 6.3. **London North West University Healthcare NHS Trust (LNW)**
- 6.4. **The Hillingdon Hospitals NHS Foundation Trust (THH)**
- 6.5. **The Hospital Standardised Mortality Ratio (HSMR)** shows the overall rate of deaths within a NHS trust. The HSMR looks at the proportion of people who died after being admitted to hospital with any of a number of diagnoses that account for 80% of all deaths in hospital. The HSMR calculation compares the number of deaths for an NHS trust with the number of deaths that would be expected for the trust based on the type of cases treated.
- 6.6. **Summary Hospital-level Mortality Indicator (SHMI)** also shows calculation comparing the number of deaths for an NHS Trust with the number of deaths that would be expected for the trust based on the type of cases treated. SHMI also includes deaths that occurred in hospital or within 30 days of discharge.
- 6.7. **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.
- 6.8. **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.
- 6.9. Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) grading system is used by all trusts as a standard grading system for Level 2 reviews, including for adult death reviews. The grades are
 - Grade 0 - No Suboptimal care
 - Grade 1 - Suboptimal care, but different management would have made no difference to the outcome
 - Grade 2 - Suboptimal care - different care MIGHT have made a difference (possibly avoidable death)
 - Grade 3 - Suboptimal care would reasonably be expected to have made a difference to the outcome (probably avoidable death)
- 6.10. **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.
- 6.11. **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

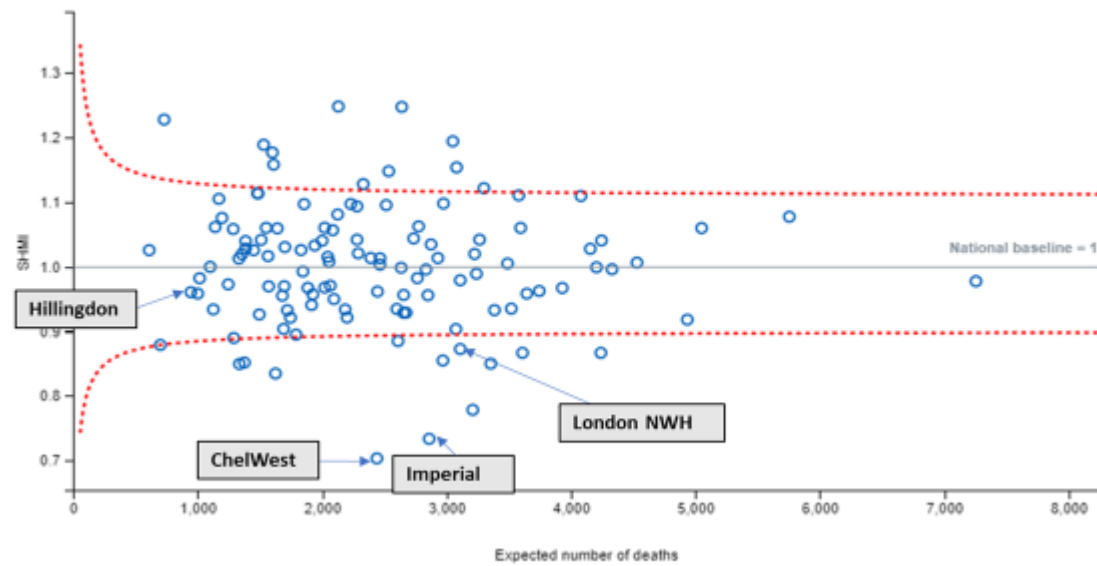
deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

- 6.12. **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.
- 6.13. **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

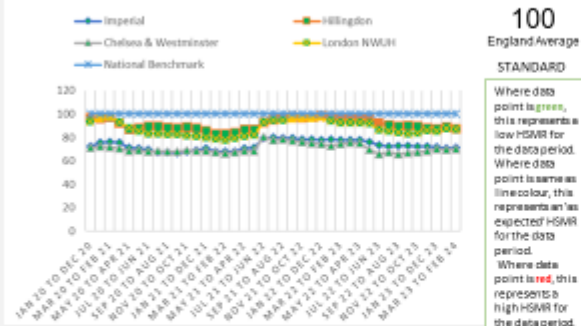


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(Patient) Hospital Standardised Mortality Ratio

TREND



NARRATIVE

Performance: The most recent data (for the year January – December 2023) shows that each trust has a rolling 12-month ratio which is lower than expected and below the national benchmark. N.B. Due to data quality issues within NHSE this data is the same as reported in the April dashboard – this should be resolved before next month.

Recovery Plan: N/A

Improvements: All Trusts are investigating variations between observed and expected deaths by diagnostic group. Reviews for quarter one will be presented to September's APC mortality Surveillance group, and a summary taken to the next APC Quality Committee.

Forecast Risks: N/A

CURRENT PERFORMANCE

	Provider Superspills	HSMR	HSMR - relative risk ranking
CWFT	49999	70.0	Lower than expected
ICHT	70773	71.2	Lower than expected
LNW	59216	87.3	Lower than expected
THH	17772	87.7	Lower than expected

STRATIFICATION

- HSMR is a summary mortality indicator. It is based on a subset of 55 diagnosis groups that give rise to approximately 85% of in hospital deaths.
- It is adjusted for case mix, taking into account factors such as age, gender, comorbidities, palliative care coding, deprivation, month of admission, method of admission, admission source, number of previous emergency admissions, discharge year.
- Each patient has a 'risk' of death based on these factors. Risks are aggregated to give an expected number of deaths.
- The HSMR is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures and taking into account the adjustments outlined above.

GOVERNANCE

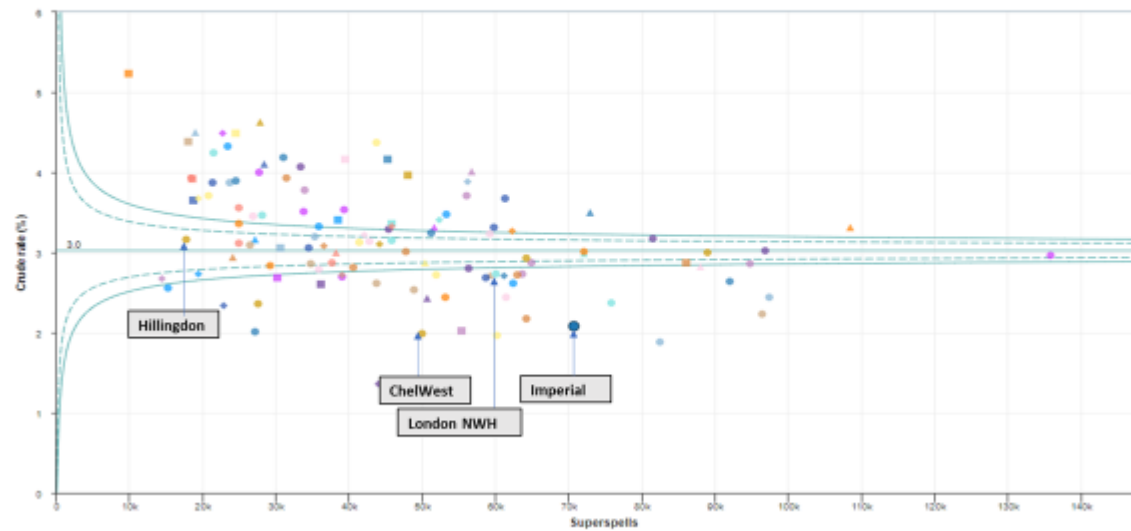
Senior Responsible Owner: Pippa Nightingale, CEO, LNW
Committee: Acute provider collaborative executive management board
Data Assurance: Data is supplied and quality assured by Telstra Health

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(Patient) Hospital Standardised Mortality Ratio

Diagnoses - HSMR | Mortality (in-hospital) | Mar-23 to Feb-24 | ALL (acute, non-specialist)

Peers Measure Benchmarks Group by Show



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5.3 COMPLAINTS ANNUAL REPORT ? APC SUMMARY

 Lisa Knight

REFERENCES

Only PDFs are attached

 5.3 Oct BiC APC annual complaints report 23-24 FINAL.pdf

NWL Acute Provider Collaborative Board in Common (Public)

15/10/2024

Item number: 5.3

This report is: Public

APC complaints annual report 2023/24

Author: Daniel Marshall
Job title: Head of Complaints, Imperial College Healthcare

Accountable director: Lisa Knight
Job title: Chief Nursing Officer, London North West University Healthcare

Purpose of report

Purpose: Information or for noting only

The Board in common is requested to:

Note this report and provide any comments and feedback.

Be assured that each Trust Quality Committee and Standing Committee has scrutinised and approved the complaints annual report for their respective Trust and that each report has been published on the respective Trust website.

Report history

APC quality meeting 19/08/2024 Noted/feedback	APC quality committee 17/09/2024 Noted and approved for onward submission.
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Executive summary and key messages

This paper summarises the key findings of the statutory annual complaints reports for the period 1 April 2023 to 31 March 2024 for the four Trusts comprising the North West London Acute Provider Collaborative.

Each individual Trust has submitted its own annual complaints report to its Quality Committee and Standing Committee. Each Trust has also published its annual report on its own website.

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

North West London Acute Provider Collaborative Complaints Annual Report 2023/24

1. Introduction

Each of the four Trusts within the APC can provide assurance that:

- they have a complaints policy that is in date and reflects national legislation and regulatory requirements
- they have a dedicated and established complaints department to support implementation of the complaints management and learning process
- they have a named executive director responsible for the complaints function and process
- learning from complaints is considered at local divisional levels and is also reported at executive and sub board level
- learning from complaints forms an integral part of the role of their quality committee.

2. Background

As a collaborative, we are committed to improving the consistency and quality of our complaints management processes across our Trusts. Our goal is to ensure that complainants receive a high quality service and that we all use our complaints to develop insights and learning about user needs and potential improvements. To help achieve this, the complaints leads for each Trust meet regularly as a complaints working group, and also meet as part of a wider Collaborative standing group on patient experience.

Each Trust has used its own suite of metrics and standards to monitor performance as well as its own approach to extracting insights and learning. For 2024/23, we are developing and trialling a set of common metrics and reporting approach for quarterly review. This annual report, using data for 2023/24, compares like with like as far as possible within this context.

3. Formal complaints received

The table below shows the number of formal complaints received by each Trust in 2023/24.

Trust	Number of complaints	% change on 2022/23	Rate per 1,000 WTE
Chelsea and Westminster	458	<5	65.89
Imperial College Healthcare	1060	>5	77.58
LNWH	1146	>21	120.40
Hillingdon	415	>35	114.64

4. Acknowledging complaints

The complaints regulations require NHS organisations to acknowledge all formal complaints within three working days of receiving them. The table below shows as a percentage the number of complaints that were acknowledged within this time frame by each Trust.

Trust	% acknowledged within three days
Chelsea and Westminster	96 (two days)
Imperial College Healthcare	96
LNWH	99
Hillingdon	100

Chelsea and Westminster reports against a two-day standard.

5. Responding to complaints

The number of complaints closed differs to the number of complaints received as some complaints closed in 2023/24 would have been received towards the end of the previous year while some complaints received towards the end of 2023/24 would have a response due date in the following year. Each Trust has been working to different standards for response time – there is no national standard for response time.

Trust	Number closed	Average (working days)
Chelsea and Westminster	470	28
Imperial College Healthcare	966	50
LNWH	1122	43
Hillingdon	375	N/A

Chelsea and Westminster and LNWH report to first response.

Imperial College Healthcare reports to final response (taking into account any re-opened complaints).

We are moving to a common approach to reporting response times (to also include final response time for reopened complaints) in our new quarterly reports for 2024/25.

Hillingdon is now providing data for average response time for the new quarterly reports for 2024/25.

6. Reopened complaints

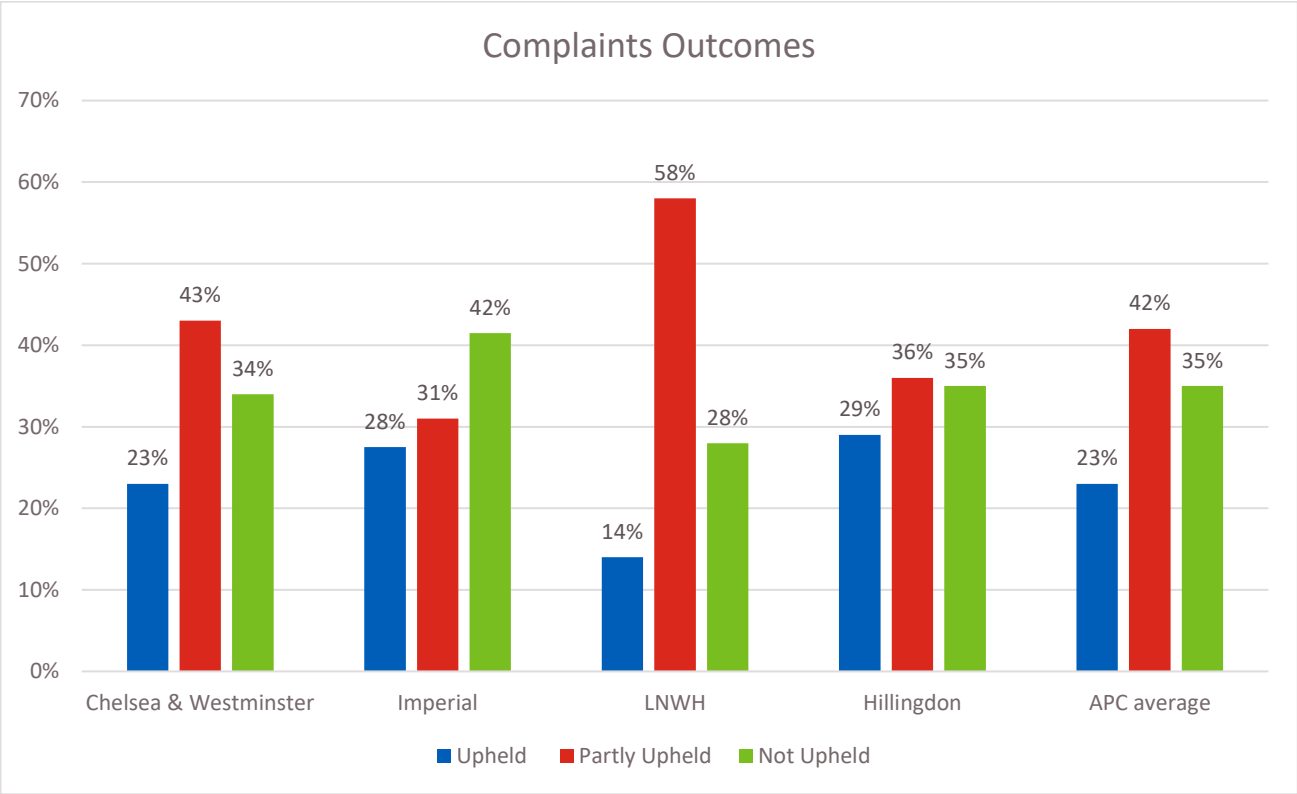
The complaints regulations allow for complainants to contact the Trust again should they feel the response they have received has not fully addressed their concerns. These complaints are then reopened and a further investigation carried out, with resolution either by letter or a meeting. The chart below details the number of complaints reopened by each Trust during 2023/24.

Trust	Number of formal complaints closed	Number of reopened complaints	% of complaints reopened
Chelsea and Westminster	470	28	6
Imperial College Healthcare	966	42	4
LNWH	1122	86	8
Hillingdon	375	N/A	N/A

Hillingdon will provide data on reopened complaints for the new quarterly reports for 2024/25

7. Outcome of complaints

Each complaint closed is recorded as to whether it was fully upheld (all the concerns identified required action), partially upheld or not upheld. The graph below shows the complaint closed by outcome for each of the Trusts.



We are developing more detailed, common criteria for assigning complaint outcomes to one of the three categories – fully upheld, partially upheld, not upheld.

8. Complaint themes

Each formal complaint is categorised according to a standard set of subjects. These are called KO41 codes and are nationally set so that complaints data submitted to NHSE can be compared across all NHS organisations. The graph below shows the top five themes for 2023/24.

Trust	Clinical treatment	Values and behaviours	Appoint-ments	Communi-cations	Patient care
Chelsea and Westminster	29%	12%	4%	23%	18%
Imperial College Healthcare	20%	17%	13%	12%	8%
LNWH	29%	10%	14%	21%	7.5%
Hillingdon	46%	35%	0	19%	0

Hillingdon records multiple subjects within a single complaint and does not report complaints related to appointments or patient care. As a result, the percentages in the table above reflect the proportion of all logged 'subjects' rather than individual cases. We will be moving to a common approach for our new quarterly reports for 2024/25.

Chelsea and Westminster reports a significantly lower proportion of complaints related to appointments. We believe this is largely due to the bookings team proactively engaging with complainants early on to de-escalate issues and we will be exploring this further to establish best practice and learning.

9. The Parliamentary and Health Service Ombudsman

If a complainant is dissatisfied with the attempts to resolve their complaint, they can ask the Parliamentary and Health Service Ombudsman (PHSO) to carry out an independent investigation.

Complainants refer their complaint to the PHSO directly and if the PHSO decides to investigate they will request copies of the complaint investigation and correspondence.

The table below shows the number of complainants who contacted the PHSO during 2023/24 and the PHSO's actions and decisions.

The PHSO can take up to a year from deciding to investigate a complaint to producing their final report. Enquiries received in one year will therefore often have the final report produced during the following year.

Trust	Number of enquiries	Progressed to investigation	Upheld	Partially upheld	Not upheld
Chelsea and Westminster	21	6	0	0	0
Imperial College Healthcare	12	3	1	1	1*
LNWH	9	9	0	0	1
Hillingdon	1	1	0	0	0
Total	43	19	1	1	2

*Resolved via mediation

10. Learning from complaints

One of the key components of a complaints investigation is identifying actions and learning. This forms the final principle in the Parliamentary and Health Service Ombudsman's complaints handling guide. Each Trust incorporates complaints into their quality monitoring and improvement processes. Below are some examples of improvement actions identified from complaints during 2023/24:

Chelsea and Westminster

- Lack of trigger to start advanced care planning, resulted in siloed care. As a result, improvements in MDT discussions have been taken forward with multiple providers.

- Antenatal clinic matron has sent communication to midwives asking them to be vigilant when filing papers into patient records.

Imperial College Healthcare

- After a patient complained about significant discomfort during an ear impression, the audiology service made improvements to departmental training and peer review. The team also explored the benefits of different impression materials, impression guns and tip sizes and updated their standard operating procedures and risk assessments.
- Identifying an increase in complaints about different aspects of cancer care led to the establishment of a review of cancer care pathways. The review, chaired by the chief executive and involving a steering group made up of external partners as well as staff, is well progressed and is drawing on a detailed analysis of complaints as well as of PALS concerns, FFT comments and bespoke qualitative research.

LNWH

- Physio policy for payment and rebooking of appointment extended to over the phone rather than just paying in clinic.

11 Complainant demographics

Imperial College Healthcare has included a breakdown of complainants by ethnicity and socio-deprivation score in its annual report. It shows almost identical disparities to the breakdown in the previous year's annual report. The other trusts are undertaking further validation and analysis of their data and we will begin to include demographic breakdowns in the new quarterly APC complaints reports.

12. Plans for the year ahead

We have agreed that each Trust will gather and review data using a set of common metrics to include in an integrated quarterly report to the APC Quality Committee, starting with Q1 2024/25. These data will be included in local quality reporting considered via each Trust's local quality governance processes.

6.1 COLLABORATIVE PEOPLE COMMITTEE CHAIR REPORT

 David Moss

REFERENCES

Only PDFs are attached



6.1 Collaborative People Committee Chair's Report September 24 FINAL.pdf

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

Highlight Report

1. Purpose and Introduction

1.1 The role of the People Collaborative 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 identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements.
- To draw to the Board in Common's attention matters they need to agree or note.

2. Key Highlights

- The Committee heard the experience of a staff member who described the difficulties working in a demanding A&E environment, particularly noting the rise in violence and aggression towards staff over the past year, including those with mental health issues and those brought in by the police. A few measures to help the challenging environment was noted such as management support from the matron, body worn cameras, security presence and the increase in mental health nurses. However, areas for improvement included capacity issues, support with enforcing zero tolerance behaviour, better management of patient behaviour and immediate consequences. Initiatives like the extra birthday day off was received and boosted morale. The Committee recognised the importance of training and support available for dealing with violence and aggression. Additionally, improving systems and processes should be the top priority to reduce patient wait times and alleviate staff stress. Immediate support should be provided through tools and policies to manage violence and aggression, empowering staff to handle challenging situations more effectively.
- There was assurance on risks related to the achievement of the 'people' strategic goals of the collaborative and that they are managed appropriately. There were a few comments from the Committee which has resulted in a refresh to be made of the risks presented.
- The Committee received an update on the delivery of the NWL APC People Priorities 24/25.

The People Service Improvement Programme focused on realising the benefits of collaboration and integrated working. This programme supports the priorities within the APC's vision for corporate services and will assist the delivery of existing

Cost Improvement Programmes (CIP) for each of the four people teams. The programme aims to standardise, automate, and potentially consolidate HR functions across the collaborative to improve efficiency and reduce costs.

The paper highlighted the progress and engagement emphasising the focus on data, customer service, and professional development as key enablers. A discussion focused on enhancing the HR function across the collaborative while aiming to reduce costs by 20%. One of the points raised included adopting a consolidated structure albeit there are currently no proven models in the APC or ICS.

Careers Hub and Transfer Scheme Progress: There is a roll out of careers platform and engaging with line managers.

Violence and Aggression; and Bullying and Harassment: There is a need for improved collaboration and development across various workstreams.

EDI Improvement Plan: The Committee discussed the integration of the EDI Improvement Plan into the collaborative broader EDI programme, aiming to align actions with the Trust EDI plans and address gaps. The Plan includes high-impact actions like cultural intelligence training for board members and creating shadow executive boards to include diverse staff voices in decision-making.

- 2.1 The Anchor Institute Deep Dive highlighted the difficulties of displaced international care workers and the project in place to support them. Additionally, there is work with the social care teams to support the most vulnerable workers. The lack of capacity to support overseas nurses and the setting up of OSCE training for nurses and midwives was noted.
- 2.2 There was a discussion on workforce productivity highlighting the efforts to address workforce planning, vacancy controls and maximising income. The current financial constraints in the organisation were recognised and the emphasis is a reduction by the end of the year.
- 2.3 The EOC lessons Learnt paper emphasised the need for clarity in workforce planning, early decision on staff transfers, learning from experience, innovative recruitment approaches and applying successful strategies from special projects like the EOC to regular recruitment and operational processes to help address ongoing challenges more effectively.
- 2.4 The APC Annual Freedom to Speak Up report key highlights there were more concerns about staff experience as opposed to direct patient safety concerns. During 2023/24 our Freedom to Speak Up guardians have handled 221 cases raised with them by colleagues across the 4 Trusts that form the North West London Acute Provider Collaborative. The Committee highlighted the culture of raising concerns for international works and a review was proposed around this area of concern.

- 2.5 The Committee received and noted the Combined Risk Escalation Report from Local People Committees.

3. Positive Assurances Received

- 3.1 The Committee received positive assurance in the following areas:
1. There has been significant progress in the People Services Improvement Programme with active engagement from direct reports leading various aspects of the programme. The focus is on enhancing data reporting, customer service, and professional development to drive efficiency.
 2. The APC Workforce Performance Report provided a clear view and high-level summary of the key people performance metrics across the APC providing context against the pressures and drivers, risks, and mitigations.
 3. Workforce Productivity Report provided assurance on the work to review establishment growth, staffing in key areas and agreeing the right number of staff for the Trusts.

4. Key Risks to Escalate

A rise in violence and aggression towards staff over the past year is notable and more needs to be done to mitigate this risk.

5. Concerns Outstanding

- 5.1 The challenges in consolidating HR functions were discussed and the need to enhance the HR function across the collaborative while aiming to reduce costs by 20%.
- 5.2 To reduce pay costs in frontline clinical services without compromising safety.
- 5.3 There is need to reduce the financial constraints in the organisation by the end of the financial year.
- 5.4 There are concerns that the current headcount exceeds what the number should be.
- 5.5 There were concerns that the performance report is not focusing on the targets, the actions taken to address the gaps and the realistic milestones set to meet those targets.

6. Key Actions Commissioned

- Assure progress on the EDI Improvement Plan and establish clear timelines for projects.
- Review the safe staffing metrics and consider adjustment to ensure financial sustainability.
- Conduct a comprehensive review to understand and improve the speak up culture among internal staff.
- Provide a fuller picture of actions being taken to address the gaps in meeting targets across the collaborative.

- Clarify the role and expectations of the Non-Executive Director wellbeing champion across the collaborative.

7. Decisions Made

The Committee:

- approved the Freedom To Speak Up Annual Report
- Approved the Our People Strategic Risks subject to comments

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	NWL APC – Our People Strategic Risks	Approval	7.	EOC Lessons Learnt	Information
2.	NWL APC People Priorities 24/25	Information /Noting	8.	NWL APC Freedom to Speak Up Annual Report 23/24	Approval
3.	EDI Improvement Plan	Information /Noting	9.	Combined Risk Escalation Report from Local People Committee	Noting
4.	Anchor Institute Deep Dive – NWL Integrated Skills & Talent Hub Update	Information/ Noting			
5.	APC Workforce Performance Report	Assurance			
6.	Workforce Productivity Report	Assurance			

9. Attendance

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

6.2 FREEDOM TO SPEAK UP ANNUAL REPORT ? APC SUMMARY

 Lindsey Stafford-Scott

REFERENCES

Only PDFs are attached



6.2 FTSU 23-24 covernote BiC Oct 24 FINAL.pdf



6.2a Collab FTSU Annual Report 23-24 FINAL.pdf

NWL Acute Provider Collaborative Board in Common (Public)

15/10/2024

Item number: 6.2

This report is: Public

Collaborative Freedom to Speak Up Annual Report 2023/24

Author: Dawn Clift
Job title: Executive Lead – Freedom to Speak Up (FTSU) LNWUH

Accountable director: Lindsey Stafford-Scott
Job title: Chief People Officer, Chelsea and Westminster Hospital NHS Foundation Trust

Purpose of report

Purpose: Assurance

To receive assurance that each of the Local Trust People Committees have received and approved their local Freedom to Speak Up Annual Report for 23/24

To receive assurance that the Collaborative People Committee has received and approved the Collaborative level Freedom to Speak Up Annual Report for 23/24

To receive the Collaborative Freedom to Speak Up Annual Report for 23/24 at the Board in Common in public

Report history

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

Local People Committees
Q1 and Q2 2023/24
Approved

Collaborative People Committee
01/09/2024
Received and noted

Executive summary and key messages

During 2023/24 our Freedom to Speak Up guardians have handled 221 cases raised with them by colleagues across the 4 Trusts that form the North West London Acute Provider Collaborative.

We experienced an increase in concerns relating to worker safety and wellbeing, bullying and harassment and inappropriate behaviours and attitude – together they represented 83.5% of all concerns raised. As such we can see that the way that we listen, respond and care for our people is by far the main cause for concern being raised through the Freedom to Speak Up service. We therefore know we have work to do to improve this position for our colleagues across the Collaborative and have several workstreams dedicated to this within our people promise priorities. During 2023/24 all 4 Trusts in the Collaborative refreshed their Freedom to Speak Up Policies to reflect the policy requirements and template prescribed by the National Guardians Office. In addition, each Trust took the opportunity to complete the Freedom to Speak Up Reflection and Planning Tool published by the National Guardians Office. As a result of this we have some improvements to our Freedom to Speak Up services that we are taking forward across the Collaborative and some more localised improvements that are pertinent to individual Trusts.

Those being taken forward across the Collaborative include:-

- Promotion of Freedom to Speak Up at Induction
- Refresh of Freedom to Speak Up Intranet Pages
- Procurement of standardised Freedom to Speak Up reporting and analytical software
- Greater visibility of FTSU within the staff wellbeing offer and wellbeing rounds
- Greater triangulation of FTSU intelligence with other raising concerns routes to identify core themes and improvement opportunities
- Refresh of the Freedom to Speak Up Champion role working in partnership with our committed team of champions to place more structure around the role and to commence data and intelligence gathering about this aspect of the Freedom to Speak Up service
- Greater exploration of how we can support our international recruits to feel comfortable to access Freedom to Speak Up
- Deployment of the National Guardians Office Freedom to Speak Up Training (including the listen up module for managers and leaders)

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

Addressing matters of concern experienced by our staff helps to improve their wellbeing and in turn their performance at work. This also then aids the patient safety agenda and offers opportunity to learn of opportunities for continuous improvement in quality (be that patient or staff related).

Impact assessment

Tick all that apply

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

The improvements we are seeking through our learning via FTSU will enable us to develop an inclusive culture that listens and supports its staff to thrive and develop, thus improving quality of care, staff experience, operational performance and improved efficiency as a result of a reduction in staff sickness.

Reason for private submission

Tick all that apply

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

If other, explain why

Freedom to Speak Up Annual Report 2023-24

Foreword

During 2023/24 our Freedom to Speak Up guardians have handled 221 cases raised with them by colleagues across the 4 Trusts that form the North West London Acute Provider Collaborative.

Colleagues access our guardians for numerous reasons. During 2023/24 we experienced an increase in concerns relating to worker safety and wellbeing, bullying and harassment and inappropriate behaviours and attitude – together they represented 83.5% of all concerns raised. As such we can see that the way that we listen, respond and care for our people is by far the main cause for concern being raised through the Freedom to Speak Up service. This matters because we know that working environments effect quality and safety; they impact on staffing, on retention, and ways of working. In healthcare, we are in the relationships business: every interaction - whether patient, family member, or colleague - makes a difference to lives and outcomes. Culture is a patient safety issue. We therefore know we have work to do to improve this position for our colleagues across the Collaborative and have several workstreams dedicated to this within our people promise priorities.

This report summarises the data shared by guardians about the speaking up cases they received between 1 April 2023 and 31 March 2024.

Headlines 2023/24

Total cases

Our Freedom to Speak Up guardians reported receiving 221 speaking up cases cross the collaborative during the period 1 April 2023 to 31 March 2024. The breakdown by Trust can be seen below:-

Trust Name	Total Number of Cases Raised with FTSU Guardians	Rate per 1,000 WTE
Chelsea and Westminster Hospital NHS Foundation Trust	31	4.4
Imperial College Healthcare NHS Trust	55	4.0
London North West University Healthcare NHS Trust	91	9.5
The Hillingdon Hospitals NHS Foundation Trust	44	12.1
Total	221	

All Trusts with the exception of Chelsea and Westminster Hospital NHS Foundation Trust saw an increase in the number of concerns reported in comparison with the previous year. The increased use of the Freedom to Speak Up service was also replicated at national level.

Who is speaking up to our Freedom to Speak Up guardians?

Professional/Worker Groups

Registered nurses and midwives accounted for the biggest proportion of cases raised with our Freedom to Speak Up guardians during the year. There was variance between Trusts in relation to the volume of concerns raised through other staff groups such as administrative staff, medical and dental staff, Allied Health Professionals and technical staff.

Diversity of those raising concerns

The diversity of those raising concerns was not consistently reported by the 4 Trusts, however this has been implemented as a mandated requirement for reporting in 2024/25. Chelsea and Westminster Hospital NHS Foundation Trust did report on this indicator and it was noted that 8 of their 31 concerns were raised by female staff from a Global Majority background.

How are workers speaking up to Freedom to Speak Up guardians?

People can choose to speak up openly, confidentially, or anonymously to their Freedom to Speak Up Guardian.

When workers speak up openly, their identity is known to all involved. Speaking up confidentially means the worker reveals their identity to the Guardian on the condition that it will not be disclosed further without their consent unless legally required. In contrast, no one knows their identity when someone speaks up anonymously.

Workers speaking up anonymously may be an indicator that speaking up arrangements or culture need improvement. For instance, workers may choose to speak up anonymously because they are concerned about detriment for speaking up.

Anonymous reporting

The number of cases raised anonymously was:-

- Chelsea and Westminster Hospital NHS Foundation Trust - 0
- Imperial College Healthcare NHS Trust – 2 (3.63%)
- London North West University Healthcare NHS Trust – 8 (8.8%)
- The Hillingdon Hospitals NHS Foundation Trust – 1 (2.27%)

What are our people speaking up about?

Wellbeing and Worker Safety

The National Guardian's Office introduced a new reporting category of worker safety or wellbeing in 2022/23. Concerns relating to wellbeing and worker safety totalled 206 (ie 93% of concerns raised included an element of wellbeing and worker safety) during the year. Where guardians told us about the themes of cases within this category, incivility amongst the workforce was the most common factor alongside concerns relating to perceived non-compliance with HR policies and procedures by colleagues and managers. In its simplest form, civility and respect is about how we treat each other at work. In highly pressurised NHS systems, behaviours of incivility and disrespect can become common place, and this rude and unkind behaviour can have a detrimental impact on staff wellbeing and patient care. Cultural issues such as attitudes of discrimination towards protected characteristics (ethnicity in particular) were also raised with guardians.

Inappropriate attitudes or behaviours

The National Guardian's Office introduced a new reporting category of inappropriate attitudes and behaviours in April 2022. Within our Collaborative, 69 concerns (31% of concerns raised) included an element of inappropriate attitudes and behaviour. Examples reported to Freedom to Speak Up guardians, included incivility, favouritism, swearing and belittling of workers.

Bullying or harassment

The number of concerns reported to our Freedom to Speak Up guardians under this category was 55 (i.e. 25% of concerns raised included an element of bullying and harassment). Examples reported to Freedom to Speak Up guardians included intimidating behaviours, humiliation, discrimination, and inadequate support at work from colleagues, managers, and senior leaders. There is large cross-over with the types of cases raised within the inappropriate attitudes and behaviours category because the National Guardian's Office guidance recommends a broad interpretation of bullying and harassment, with a focus on the perceptions of the person bringing the case.

Patient safety and quality

38 concerns (ie 17% of concerns raised) involved a direct element of patient safety and quality. Examples of cases that people raised with our Freedom to Speak Up guardians about patient safety or quality included:

- Staffing pressures; workloads
- Unsafe working practices

Detriment

Disadvantageous and/or demeaning treatment for speaking up (often referred to as 'detriment') may include fear of being ostracised, given unfavourable shifts, being overlooked for promotion, or moved from a team as a result of raising a concern. This can play a significant factor in whether people choose to access the Freedom to Speak Up service or indeed other channels for raising concerns. Of the 221 individuals who did formally contact the Guardians, a fear of detriment for speaking up was indicated in 13 cases (5.8%). This is marginally above the national average of 4.0% and suggests that we have more work to do to help improve our management and leadership culture, learning culture and the psychological safety of our workforce.

What is the impact?

On the organisation:

- Greater risk of human error²
- Poorer patient care
- Lower morale
- Increased absenteeism
- Reduced productivity and teamwork⁴

On the individual:

- Anxiety and depression
- Disengagement and isolation
- Take their feelings home with them³
- Reduced confidence⁴

Developing our Freedom to Speak Service

During 2023/24 all 4 Trusts in the Collaborative refreshed their Freedom to Speak Up Policies to reflect the policy requirements and template prescribed by the National Guardians Office. In addition, each Trust took the opportunity to complete the Freedom to Speak Up Reflection and Planning Tool published by the National Guardians Office. As a result of this we have some improvements to our Freedom to Speak Up services that we are taking forward across the Collaborative and some more localised improvements that are pertinent to individual Trusts.

Those being taken forward across the Collaborative include:-

- Promotion of Freedom to Speak Up at Induction
- Refresh of Freedom to Speak Up Intranet Pages
- Procurement of standardised Freedom to Speak Up reporting and analytical software - data is essential for informed decision making, allowing leaders to analyse trends, identify opportunities and mitigate risks. The effective use of data also promotes a culture of transparency, providing visibility into overall performance and culture of our organisations. We will launch a new freedom to speak up reporting and analytical module across the Collaborative during 2024/25 to enable 24/7 reporting, case work tracking, trend analysis and associated learning points.
- Greater visibility of FTSU within the staff wellbeing offer and wellbeing rounds

- Greater triangulation of FTSU intelligence with other raising concerns routes to identify core themes and improvement opportunities
- Refresh of the Freedom to Speak Up Champion role working in partnership with our committed team of champions to place more structure around the role and to commence data and intelligence gathering about this aspect of the Freedom to Speak Up service
- Greater exploration of how we can support our international recruits to feel comfortable to access Freedom to Speak Up
- Deployment of the National Guardians Office Freedom to Speak Up Training (including the listen up module for managers and leaders)

Conclusion & Recommendations

This report is more than an overview of speaking up data. It is a strong call to all of our leaders to listen and take action; to ensure that every colleague feels safe to speak up and confident that their concerns will be addressed. Our internal systems and the safety and quality of the care they deliver depends on our ability to listen and respond effectively to all voices: colleagues (the focus of this report) as well as patients, families and carers.

As a team of Guardians we would recommend that:-

- The Collaborative People Committee seeks assurance that we have the right workstreams in place to address the themes being raised through raising concerns intelligence and have a suite of metrics to measure the effectiveness of such workstreams.
- Note that each individual Trust in the Collaborative has presented their own FTSU Annual Report through their local People Committee
- Recommend approval of this Collaborative FTSU Annual Report to the North West London Acute Provider Collaborative Board in Common

7.1 COLLABORATIVE DATA AND DIGITAL COMMITTEE REPORT

 Steve Gill

REFERENCES

Only PDFs are attached

 7.1 Collaborative Digital and Data Meeting Summary FINAL.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
September 2024**

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 Digital and Data Priorities for 2024/2025

2.1.1 Data strategy, including management information system – short- and long-term solution

- The NWL APC Executive Management Board (EMB) has agreed the proposed data strategy and timeframe, this would now proceed for final approval at the March 2025 NWL APC EMB and the April NWL APC BiC.
- The Committee noted that the NHS needed to use the analytics to improve performance, and asked if there was funding in place to enable this work to done. The Committee agreed that a business case should be prepared.

2.1.2 Cerner optimisation

- It was confirmed that there were thirty to thirty-five downstream systems that dealt with patients from their initial referral to their return home after being discharged, and that the programme would be enhanced to improve on what was already in place;
- there were over sixty projects which were funded and resourced; and
- twelve stakeholder groups who met monthly to provide oversight and guidance.

2.1.3 Federated Data Platform (FDP)

- Migrating information to the FDP was on track and would be completed by the end of September 2024, the resources that had been used on this would then be applied elsewhere on the FDP roll out; and
- virtual wards had been paused to enable connection to a new system supplier.

2.1.4 NWL System Interface group update

- There are four main areas of consideration - Onward Referrals; Complete Care; Call and Recall; and Points of Contact – that would be integrated into the Digital Strategy and Roadmap, which was due to be presented at the APC EMB meeting in

December 2024, with an update presented at the December NWL APC D&D Committee.

2.1.5 Equality, Diversity, and Inclusion (EDI) Update

- The Committee noted that more EDI information was urgently needed for this Committee to ensure that metrics were agreed and implemented prior to the start of fiscal year 2025/26. The Committee agreed that the EDI work needed to be accelerated with a clear timeline on what would be delivered when. The Committee agreed that a presentation on this topic was to be circulated in advance of the December meeting.

The Committee also discussed co-ordination across different committees regarding EDI and agreed the Committee would include digital accessibility as part of the EDI plan.

2.1.6 ICT Risk Register

- A Risk Management Framework is being developed and the ICT risks will be reassessed against this framework;
- a meeting had taken place with NWL Procurement regarding supply chain Risk Management and developing a Risk Management system for procurement, in which the auditors RSM UK were participating;
- Single Finance System – a business case in development for the APC, workshops would be run to review and mitigate risks;
- the Committee agreed that key risks (including Cyber Security, both internally and regarding key suppliers) should be listed with appropriate target risk scores, and the mitigation for these risks were to be agreed in the appropriate committee with an update to the December D&D Committee meeting;
- a timeline was required to complete this work to enable funding for any critical mitigations to be agreed and linked to the Board Assurance Framework (BAF); and
- risks were to be identified across the four NWL APC Trusts and managed locally, and any risks that affected the Collaborative Strategy were to be highlighted.

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

- Cyber security risk both internally and re key suppliers.
- Accelerated progress required re EDI.
- Data Strategy on track for approval at the March 2025 APC EMB and April APC BiC.

4. Concerns outstanding

No additional APC level concerns which require escalation to the Board.

5. Key actions commissioned

- a. Data Strategy / Analytics funding Business Case.
- b. Accelerated EDI plan.
- c. Cyber security risk assessment.

6. Decisions made

The Committee approved the Terms of Reference (ToR).

7. Summary Agenda

No.	Agenda Item	Purpose
1.	Digital and Data Priorities for 2024/2025 – overall summary	For Discussion
2.	Equality, Diversity, and Inclusion (EDI) Update	For Discussion
3.	Leadership and structure update	For Information
4.	Terms of Reference	For Approval
5.	ICT Risk Register	For Discussion
6.	Forward Plan	For noting
7.	Key Areas for the Board in Common	Verbal Update

8. Attendance

Members	September attendance
Steve Gill (NED Chair – VC CWFT/NED THHT)	Y
Patricia Wright (Lead CEO - THHT)	Y
Simon Crawford (Director of Strategy – LNWH & Senior Information Risk Owner (SIRO) Representative)	Y
Kevin Jarrold (Joint Chief Information Officer – ICHT/CWFT)	Y
Robbie Cline (Joint Chief Information Officer – LNWH/THHT)	Y
Sanjay Gautama (Consultant anaesthetist & Chief Clinical Information Officer (CCIO) Representative)	Y
Bruno Botelho (NWL APC Programme Director & Operations Representative)	Y
Nick Gash (NED – ICHT/THHT)	Y
Loy Lobo (NED – LNWH/ICHT)	Y
In Attendance	
Matthew Swindells (NWL APC Chair in Common)	Y
Alexia Pipe (Chief of Staff to the Chair in Common)	Y
Peter Jenkinson (Director of Corporate Governance)	Y
John Keen (Deputy CIO LNWH & THHT)	Y
Graham Chalkley (Corporate Governance Officer CWFT (minutes))	Y
Mathew Towers (Business Intelligence (BI) Representative)	N

8.1 COLLABORATIVE STRATEGIC ESTATES AND SUSTAINABILITY

COMMITTEE REPORT

 Bob Alexander

REFERENCES

Only PDFs are attached



8.1 Collab Strategic Estates and Sustainability Ctte Report 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
September 2024

Highlight Report

1. Purpose and Introduction

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

- To identify areas of risk where collaborative-wide interventions would accelerate and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements in estates optimisation and usage, and sustainability.
- To receive assurance regarding capital planning and prioritisation across the Collaborative.
- To oversee the development of an estates strategy across the Collaborative, including site optimisation and redevelopment, and to inform the design of the human resource required to deliver the strategy.
- To oversee the strategic consideration of opportunities across the Collaborative in relation to soft facilities management contracts.
- Ensuring equity is considered in all strategic estates development.

2. Key highlights

2.1 The Strategic Estates and Sustainability Collaborative Committee was held on 18 September. The following papers were discussed.

2.2 Capital Prioritisation

- 2.2.1 Work was ongoing to develop an APC specific capital prioritisation approach, in the context of national and local discussions on forward capital allocations. Colleagues were working with the NWL ICB to agree plans for this year including around capital prioritisation.
- 2.2.2 Capital plans for 2024/25 for the ICB were in line with the planning process.
- 2.2.3 NHSE had asked all ICBs to produce a 10-year infrastructure plan by 31 July 2024.
- 2.2.4 Work was being undertaken to develop a 10-year consistent and prioritised forward capital plan. Acute CFOs would consider the development of an APC Capital Prioritisation Framework.
- 2.2.5 Work was also taking place around a forward plan of business cases.
- 2.2.6 The Committee noted the report.

2.3 Update on Sustainability / Green Plans

- 2.3.1 The paper provided an update on the Green Plans of the four Trusts within the North West London APC, with a specific focus on updating the committee on progress around standardisation of data collection and analysis relating to the NHS carbon footprint.
- 2.3.2 The paper also described work that is underway across the Trusts to:
- develop a shared approach for our NHS carbon footprint data and measurement
 - share and spread initiatives that have shown demonstrable benefit to carbon and

financial savings

- share learning of approach and to build multi-agency partnerships.

- 2.6.3 The Committee discussed building energy for the four Trusts. Analysis, based largely on Estates Returns Information Collection (ERIC) data, showed across the four Trusts the combined NHS carbon footprint for buildings has fallen by 10.3% between the 2019/20 baseline and 2023/24. It was agreed to bring further analysis of building energy use to the next meeting.

2.4 Equality, Diversity and Inclusion (EDI) Benchmarking – Accessibility

- 2.4.1 The paper outlined the next steps in a collaborative approach to improving accessibility of patients, public and staff across the North West London Acute Provider Collaborative, following benchmarking of approaches presented to the last meeting (held via e-governance).
- 2.4.2 Benchmarking identified further opportunities to improve the approach across the collaborative for the Committee's consideration including digital accessibility, estates benchmarking metrics such as PLACE and PAM assessments and the opportunity to use the organisation AccessAble to support on improving accessibility of our sites.

2.5 Collaborative business case pipeline

- 2.5.1 No major business cases were anticipated to come to this Committee in 2024/25.
- 2.5.2 CFOs and Directors of Estates were working to develop a pipeline of upcoming business cases.

2.6 Update on redevelopment plans

- 2.6.1 The papers outlined confidential briefings on the redevelopment plans for The Hillingdon Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Trust respectively.

2.7 Summary report from the Estates and Sustainability Executive Group

- 2.7.1 The paper provided a summary of the Estates and Sustainability Executive Group discussions which took place between 31 July and 10 September 2024.

3. Positive assurances received

- 3.1 The Committee noted the positive work on the green / sustainability plans.
- 3.2 The Committee thanked Jonathan Reid for his contribution to the committee and wished him well in his new role.

4. Key risks to escalate

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

5. Key actions commissioned

- 5.1 The Committee will ask individual Trust Standing Committees have an agenda item around local equality, diversity and inclusion activity to allow feedback on accessibility. This in turn needed to report up to the Board in Common in a consistent way.

6. Decisions made

- 6.1 N/A


7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Capital Prioritisation	To note	4.	Collaborative business cases pipeline	To note
2.	Update on green plan and sustainability plans, including decarbonisation	To note	5.	Update on redevelopment programmes - THHFT - ICHT	To receive
3.	EDI Benchmarking – accessibility	To note	6.	Summary report from the Estates and Sustainability Executive Group	To note

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
Jonathan Reid, CFO (LNWH)	Y
Janice Sigsworth, Chief Nurse (ICHT)	Y
Steve Wedgwood, Director of Estates (THHFT)	Apologies
Eric Munro, Director of Estates and Facilities (ICHT)	Apologies
Jason Seez, Deputy CEO (THHFT)	Y
In attendance:	
Huda As'ad, Associate NED (LNWH)	Y
Philippa Healy, Business Manager (minutes)	Y
Peter Jenkinson, Director of Corporate Governance (ICHT and CWFT)	Y
Hyder Mohammad, Head of Sustainability (THHFT) – representing Steve Wedgwood	Y
Andrew Murray, Head of Facilities (ICHT) – representing Eric Munro	Y
Alexia Pipe, Chief of Staff – Chair's office	Y
Matt Tulley, Redevelopment Director (ICHT)	Y
Iona Twaddell, Senior Advisor to the CEO	Y

9.1 EXECUTIVE MANAGEMENT BOARD (EMB) SUMMARY

 Tim Orchard

REFERENCES

Only PDFs are attached



9.1 Collaborative Finance and Performance Committee Chair's Report Oct 24 FINAL.pdf

North West London Acute Provider Collaborative

Collaborative Finance and Performance Committee Chair's Highlight

Report to the Board in Common – for discussion

September 2024

Highlight Report

1.0 Purpose and Introduction

- 1.1 The purpose of this report is to provide the Board in Common (BiC) with assurance of the work undertaken by the Collaborative Finance and Performance Committee (FPC) at its last meeting held on 18 September 2024. The report is intended to provide any feedback to the BiC and request if further work within the Committee's remit is required.
- 1.2 The role of the Collaborative Committee, which has changed in light of the recent governance developments and establishment of Board Standing Committees, is:
- To identify, prioritise, oversee and assure strategic change programmes to support the delivery of the Acute Provider Collaborative (APC) strategy and to drive collaborative-wide and Integrated Care System (ICS) integrated improvements.
 - To identify areas of risk where collaborative-wide interventions would speed and improve the response.
 - To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
 - To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements

2.0 Key Highlights

2.1 Income allocation across the APC

The Committee considered a report setting out the work to date on the split between 'earned' and 'unearned' income across the collaborative in 2023/24. Previously there was an £80m difference in position between the APC and Integrated Care Board (ICB), which has since been reviewed and updated to reflect a mutually acceptable position, which will now be the starting point for 2024/25. The Committee was also advised of the next steps for 2024/25 in reviewing the recurrent/non-recurrent income split to update the underlying position and review the allocation split by provider as part of the APC medium term financial plan.

This report generated a discussion with agreement that the following work be completed: to understand how much really is 'unearned', the impact of the tariff changes and to understand how efficient each of the four individual organisations are. The significant increase in emergency workload was highlighted, noting this will have an impact on costs for each organisation. Further details will come, segmented by Trust, to the next Committee meeting.

2.2 Operational performance

The Committee considered month 5 (M5) data. Overall performance is stable or improving across the majority of the 'scorecard' at APC level, with some variation at individual trust level. Plans are in place to improve trajectories where needed. Work is underway to explore the drivers of variability and spread best practice.

2.2.1 Urgent and Emergency Care (UEC) including winter plans: Pressures in the UEC pathway were highlighted, noting the impact in terms of mental health provider and local authority capacity to take patients not needing acute care, including those with mental health needs. Assurance will be sought from the local mental health provider collaborative on how these issues will be addressed, noting the plan has not yet been seen.

All Trusts have plans in place ahead of winter, to be further refined once the national requirements from NHS England (NHSE) are shared in the annual 'winter letter'. Actions against the nine high improvement pathways were set out in the plans shared at the meeting. In terms of current performance all advised of the current challenges, with trusts having some, if not all, winter beds still open.

It was confirmed that all units are expected to have a plan setting out where they will expand to if demand increases, noting the challenge given the amount of winter beds remaining open all year-round. Plans will be enacted should the system come under severe duress, which will include risk adjusting criteria to reside and who to discharge and admit. While the system will ensure there are robust plans in place, there was some concern expressed regarding anticipated pressures and funding constraints given the year-long pressures experienced and consistently high levels of demand.

The challenge to all was to ensure that all APC trusts are as efficient as possible, noting there is a differential in performance and flow through each site. Further discussions on managing winter will continue with the ICB and system partners.

2.2.2 Elective care: the Committee heard that the number of long-waiting patients continued to reduce with NWL performing well nationally. The APC is predicting a number of 65 week waiters (ww) at the end of September (699), whilst still working through all mitigations to the risks to clearing the backlog. Theatre utilisation is high and attention is now focused on improving patient initiated follow up (PIFU) via workflow optimisation in Cerner and a clinical audit of all specialities.

2.2.3 Cancer: Cancer performance was overall strong, particularly relative to national trust performance. Overall performance has been sustained, meeting the 28-day faster diagnosis standard (FDS), with in-month improvement in the 31-day and 62-day standard.

2.2.4 Diagnostics: The position continues to be challenging, particularly at CWFT, with recovery plans in place for all trusts. However the Committee was advised of the reported improvement seen in month 5.

2.3 Financial report, including cost improvement programme (CIP) delivery

The Committee noted the report which contained month 4 data and was provided with a verbal update on the M5 position noting it is significantly behind plan. The key drivers are industrial action (for which funding is anticipated), lower than planned delivery of efficiencies (£18m behind plan – 68% delivery vs plan), pay pressures, winter beds/operational pressures (specially the impact of supporting patients with mental health needs and those with 'no criteria to reside' in the acute setting) and excess inflation (currently estimated at £3.3m). Year to date elective recovery performance (ERF) is positive at £18.8m over-delivered against the financial plan, ensuring those waiting the longest are being treated.

Peer to peer APC chief financial officer (CFO) meetings continue to be held to check and challenge financial performance, assure grip and control actions and prepare and review recovery plan forecasts. Forecasts have been prepared since month 3 and refreshed each month thereafter.

2.4 Financial Recovery Plan

The Committee was updated on the overall APC and trust summary financial forecasts prepared at Month 4, with Q1 forecasts refreshed on the back of the month 4 financial performance.

The Committee was advised that each trust had produced a recovery trajectory showing the planned improvement in the monthly run rate and the drivers of the recovery. These were discussed in summary, however it was noted that each local Finance and Performance Committee is focussing on the detail at Trust level.

There are a number of factors to consider: the conclusion of discussions with the ICB on availability of additional funding to support UEC pressures (including urgent treatment centres); the need to extend 2023/24 winter plans into 2024/25, efficiency delivery, adverse impact of the elective orthopaedic centre (EOC) and elective recovery fund (ERF). Enhanced grip and control measures are in place within each Trust. The Committee agreed that analysis on the matters that are with the Trusts' gift must be set out, those impacting NWL specifically and others such as industrial action, inflation and increase in non-pay costs. A detailed review of the current forecast is required as a priority to ensure the APC has a clarity on the real position for each trust.

2.5 Equality, diversity and inclusion (EDI) update

This Committee discussed the report which set out the APC's ongoing efforts to address health inequalities. An update on the various elements of the EDI plan relating to operational performance was discussed, however the Committee agreed that there should be targeted focus on a specific element to ensure significant progress rather than thinly spreading capacity across a range of areas. The Committee agreed to focus on improved patient communications, ensuring that these are tailored to patients based on their language and other needs (ensuring all information is also always provided in English). It was agreed that this would cover texts, letters and the whole range of communications, which in part should support improved attendance, reduction in 'did not attends' (DNAs) and improve health outcomes overall. The impact of deprivation was also flagged as a key factor to be aware of. It was agreed to develop a set of metrics so that the Committee could be advised on and oversee progress and impact of the improvement to patient communications (as well as local committees monitoring impact for their populations).

2.6 APC Business Plan – Finance and Performance objectives

The Committee heard a brief update on the above, noting the progress, risks and actions against the objectives in the NWL APC Business Plan. The update focussed on the six objectives of the business plan, with a report also provided on the thirteen productivity and efficiency priorities, sitting alongside the six main objectives. The Committee fed back that they would like to see further acceleration in delivery, which was accepted, and were advised that progress is monitored each month at the executive level Finance and Performance Workstream meeting.

2.7 Elective Orthopaedic Centre (EOC)

A paper on the EOC was discussed given the centre is not yet operating at capacity, with some distance from being a fully optimised facility. There have been a number of

operational issues including the higher than anticipated initial rate of refusals of those patients referred (by clinical staff) and a challenge in securing anaesthetists. The EOC Board is overseeing the programme and plans to increase activity. The Committee was advised that if the current trajectory continues, with lower than anticipated income, there would be an adverse position for the APC trusts, and particularly London North West. The Committee heard that progress is being made, with productivity improving over recent months. A more detailed paper setting out operational performance and the detailed trajectory to move the centre to operating at full capacity will come to the next meeting.

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

- Risk to the year-end position given current pressures.
- Operational pressures impacting further during the winter months.

4. 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. Key actions commissioned

- Further work regarding the financial and productivity position by Trust.
- Metrics and further detail regarding the EDI indicator on patient communications which the Committee will oversee.
- Report on next steps with the EOC, with trajectories to full capacity.
- Further detail on progress against the APC business plan.

6.0 Decisions Made

6.1 None specifically in terms of strategy or business cases, but to note the actions agreed by the Committee as above. The Committee noted that the meeting was the last chaired by Catherine Jervis before she was to leave and thanked her for her chairing and leadership to the Committee during her tenure.

7.0 Summary Agenda


No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Matters arising – with note on Income Allocation across APC	To note	5.	Equality Diversity and Inclusion (EDI) Update	To note
2.	Integrated Performance Report and operational performance updates on UEC, elective care, cancer	To note	6.	NWL APC Business Plan – Finance and Performance Objectives	To note
3.	Finance Report including Cost Improvement Programme (CIP) Delivery	To note	7.	Escalation report from local Trust committees	To note
4.	Financial Recovery Report	To note	8.	Review of Forward Planner	To note

8.0 Attendance

Members:	Attendance
Catherine Jervis, Non- executive director (NED) of THHT F&PC - (Chair)	Y
Patricia Gallan, NED, Chair of CWT F&PC	Y
Bob Alexander, NED, Chair of Imperial F&PC	Y
Loy Lobo, NED, Chair of LNW F&PC	Y
Lesley Watts, CEO, Chelsea and Westminster NHS FT and Collaborative Lead for Finance and Performance	Y
Attendees:	
Matthew Swindells, Chair of NWL Board in Common and Collaborative	Y
Carolyn Downs, NED*	Y
Tina Benson, Chief Operating Officer – Hillingdon	Y
Tracey Cotterill, Interim Chief Financial Officer - Hillingdon	Y
Claire Hook, Chief Operating Officer - Imperial	N
Karen Powell, Deputy Chief Operating Officer – Imperial	Y
Jazz Thind, Chief Financial Officer - Imperial	Y
Virginia Massaro, Chief Finance Officer - CWT	Y
Laura Bewick, Hospital Director - CWT	Y
James Walters, Chief Operating Officer - LNW	Y
Jonathan Reid, Chief Financial Officer - LNW	Y
Helen Berry, Associate Director of Finance, NWL APC	N
Peter Jenkinson, Director of Corporate Governance	Y
Marie Price, Deputy Director Corporate Governance - CWT	Y
Alexia Pipe, Chief of Staff to the Chair	Y

*to be Chair of THHT F&PC and Chair of Collaborative F&PC from 1 October 2024

9.2 FINANCIAL PERFORMANCE REPORT

 Jazz Thind

REFERENCES

Only PDFs are attached



9.2 APC M5 Finance FPC Cover FINAL.pdf



9.2a NWL APC M5 financial performance FINAL.pdf

NWL Acute Provider Collaborative - Board in Common

15/10/2024

9.2

This report is: Public

2024/25 NWL APC Month 5 Finance Report

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
01/10/2024
Noted and approved

NWL APC EMB
09/10/2024

Executive summary and key messages

Key Messages :

- At Month 5, the APC reported a deficit of £63.3m against a year-to-date deficit plan of £7.5m, a £55.8m adverse variance to plan. All four trusts report adverse variances to plan.

The main drivers of the adverse variance are:

- No Resident Doctors' industrial action in month 5; however, YTD (3 days in June, 1 day in July) impact causes a pressure of c£6m (£4.5m pay and £1.5m income).
- Undelivered CIPs : CIP delivery YTD is £37.1m against a plan of £55m YTD, thus reporting an £17.8m adverse variance to date. The rate of delivery has dipped in the month at £5.5m delivered compared to the YTD average of £7.9m (to month 4). YTD : 23% (£12.5m) is via non recurrent means.

- YTD adverse variance on planning items : the System Optimisation Proposal and the Business Case Review project.
- Operational pressures: all trusts continued to have “winter” beds open causing a pressure. ICHT position includes the allocation of winter funding. All trusts report continuing pressure on supporting mental health patients.
- Excess inflation : c£3.3m pressure of inflation over funded levels contributes to the overall adverse.
- YTD ERF performance is £18.8m over delivered against the financial plan. Favourable movement of £6.9m in the month. This is in part compensated by marginal costs of delivering the performance.

Financial Performance Escalation and Recovery:

- The financial performance escalation process implemented in 2023/24 is in place in 2024/25 due to the high risk in the financial plan. A set of escalation metrics are in place whereby a breach enacts escalation. This tests the variation from YTD plan, CIP delivery, ERF performance and annual plan. At Month 5, three trusts breached all or some of the escalation metrics. *Appendix 3* details the escalation metrics.
- Peer to Peer CFO meeting have been held in 2024/25 from Month 2 reporting, to check and challenge financial performance, assure grip and control actions and prepare and review recovery plan forecasts. Forecasts have been prepared since Month 3 and refreshed each month thereafter.
- Trust forecasts are prepared using an agreed standard methodology and have been taken through APC & local trust F&P Committees. The month 5 forecast is included in a separate paper to the Board

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



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 August (Month 5)

Helen Berry, Associate Director of Finance
For NWL APC CFO Group

Executive Summary

- This paper presents the NWL APC Month 5 (August) financial position including income and expenditure, capital and cash.
- At Month 5, the APC reported a deficit of £63.3m against a year-to-date deficit plan of £7.5m, a £55.8m adverse variance to plan. All four trusts report adverse variances to plan.
- The main drivers of the adverse variance are:
 - Resident Doctors industrial action (3 days in June, 1 day in July) resulting in a pressure of £5.9m (£4.4m pay costs and £1.5m income). Removing the IA impact, the YTD I&E deficit is £57.4m. It has now been confirmed that national funding will be passed through to offset the cost impact.
 - Efficiencies: year to date (YTD) efficiency delivery is £37.1m against a plan of £54.9m, £17.8m adverse to plan. The in-month delivery reduced in month 5 to £5.5m compared to an average of £7.96m in the first four months. 68% of the YTD plan is reported as delivered with 23% (£12.5m) via non recurrent means.
 - YTD adverse variance on planning items includes the System Optimisation Proposal and the Business Case Review project.
 - The System Optimisation Proposals are in progress. Task Force groups for both workstreams (1. Focus on discharges & medically optimised patients and 2. Mental Health Models of Care) are in place with executive representation from Acute and Mental Health partner organisations. Meetings have taken place since August with progress reported to the Finance & Performance Workstream Meeting. The APC is not as yet seeing a financial benefit from these programmes.
 - Trusts have worked through the outcomes of their organisation specific reports for the ICB commissioned Business Case Review programme, and plans are being taken forward in all trusts to assess the opportunities identified, with progress reported to the Finance & Performance Workstream Meeting.
 - Operational pressures: all trusts continue to have “winter/core” beds open in 2024/25 causing a pressure. ICHT has utilised the 2024/25 winter funding to offset this cost. All trusts report continuing pressure on supporting mental health patients.
 - Excess inflation : c£3.3m of inflation over funded levels has been identified as contributing to the overall adverse variance. Further work remains in train to fully capture this across all Trusts.

Executive Summary - continued

- ERF performance reports a favourable variance of £18.8m, a further improvement of £6.9m in August, driven by CWFT & LNWH. Plan submissions have assumed additional ERF income above contractually funded values.
- YTD capital spend is £52.7m against a £60.7m plan, £8m underspend to date. Capital plans were updated during Q1 and refreshed again in July, decreasing from £239.4m to £220.8m to reflect the reallocation of ICB capital reserves originally held at CWFT.
- The combined cash balance at the 31st August 2024 is £261.5m, a decrease of £76.9m (23%) since the end of the financial year and lower than the planned cash balance at the end of the month by £59.3m. Cash resilience in 2024/25 remains a key area of concern for at least two Acute trusts.

Financial Performance Escalation and Recovery:

- The financial performance escalation process implemented in 2023/24 is in place in 2024/25 due to the high risk in the financial plan. A set of escalation metrics are in place whereby a breach enacts escalation. This tests the variation from YTD plan, CIP delivery, ERF performance and annual plan. At Month 5, three trusts breached all or some of the escalation metrics. *Appendix 3* details the escalation metrics.
- Peer to Peer CFO meeting have been held in 2024/25 from Month 2 reporting, to check and challenge financial performance, assure grip and control actions and prepare and review recovery plan forecasts. Forecasts have been prepared since Month 3 and refreshed each month thereafter.
- Trust forecasts are prepared using an agreed standard methodology and have been taken through APC & local trust F&P Committees. The month 5 forecast is included in a separate paper to the Board.

M5 I&E Performance table

NWL Acute Collaborative (Month 5 Financial Performance)

2024/25	In Month Plan	In Month Actuals	In Month variance	Year to date Plan	Year to date Actual	Year to date Var	YTD variance	Annual Plan	Annual Forecast	Forecast Variance
	£000	£000	£000	£000	£000	£000	%	£000	£000	£000
Income	323,565	336,354	12,789	1,612,745	1,677,099	64,354	4.0%	3,887,444	3,972,252	84,808
Pay	(198,655)	(209,640)	(10,985)	(995,181)	(1,045,795)	(50,614)	-5.1%	(2,391,599)	(2,439,568)	(47,969)
Non-Pay	(120,626)	(136,793)	(16,167)	(603,983)	(673,328)	(69,345)	-11.5%	(1,449,419)	(1,483,176)	(33,757)
Non Operating Items	(4,258)	(4,777)	(519)	(21,051)	(21,269)	(218)	-1.0%	(46,426)	(49,508)	(3,082)
Total	26	(14,856)	(14,882)	(7,470)	(63,293)	(55,823)		0	0	0

NWL Acute Collaborative (Month 5 Financial Performance by Trust)

2024/25	In Month Plan	In Month Actuals	In Month variance	Year to date Plan	Year to date Actual	Year to date Var	Year to date (deficit) / surplus as a % of YTD income	Annual Plan	Annual Forecast	Forecast Variance
	£000	£000	£000	£000	£000	£000	%	£000	£000	£000
CWFT	(6)	(1,021)	(1,015)	(644)	(2,784)	(2,140)	-1%	0	0	0
ICHT	595	(6,971)	(7,566)	(2,347)	(21,871)	(19,524)	-3%	0	0	0
LNWH	(94)	(3,075)	(2,981)	(2,187)	(21,557)	(19,370)	-5%	0	0	0
THH	(469)	(3,790)	(3,321)	(2,292)	(17,081)	(14,789)	-11%	0	0	0
Total	26	(14,856)	(14,882)	(7,470)	(63,293)	(55,823)	-4%	0	0	0

Key messages:

- YTD plan of £7.5m deficit, actual YTD of £63.2m deficit, a £55.8m adverse variance to plan at M5.
- In month deficit is £14.8m, £7.8m worse than that forecast deficit at month 4.
- No Industrial Action in M5. YTD Industrial action impact is £6m (month 3 and 4).
- Deterioration in run compared to month 4.
- Drivers of adverse variances are IA (£6m), identified excess inflation £3.3m, efficiency under delivery (£17.8m), shortfall against the mitigations agreed in the financial plan e.g. the system optimisation plan, the outcome of the business case review, and other operational pressures.
- Efficiency delivery is £37.1m against a £54.9m YTD plan (68% delivered). Rate of delivery has reduced to £5.5m compared to YTD average of £7.9m.
- YTD ERF performance is £18.8m over delivered against the financial plan. Favourable movement of £6.9m in the month .

M5 Industrial Action

2024/25 M3	June				July				Total YTD			
	Cost	Elective (ERF) Income	Other variable Income	Total	Cost	Elective (ERF) Income	Other variable Income	Total	Cost	Elective (ERF) Income	Other variable Income	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	818	0	0	818	228	100		328	1,046	100	0	1,146
ICHT	1,066	348		1,414	533	174		707	1,599	522	0	2,121
LNWH	1,050	477		1,527	225	223		448	1,275	700	0	1,975
THH	371	102	0	473	60	87	24	172	431	190	24	645
Total	3,306	927	0	4,233	1,046	584	24	1,654	4,351	1,512	24	5,887

Impact on run rate	M5 reported	M4 reported	IA impact	M4 net of IA	M3 reported	IA impact	M3 net of IA	M2 reported	M1 reported
	£000	£000	£000	£000	£000	£000	£000	£000	£000
CWFT	(1,021)	(535)	328	(207)	1,120	818	1,938	(680)	(1,668)
ICHT	(6,971)	(7,367)	707	(6,660)	(3,448)	1,414	(2,034)	(3,319)	(766)
LNWH	(3,075)	(3,471)	448	(3,023)	(6,479)	1,527	(4,952)	(4,230)	(4,302)
THH	(3,790)	(1,693)	172	(1,522)	(2,637)	473	(2,164)	(5,594)	(3,367)
Total	(14,856)	(13,067)	1,654	(11,412)	(11,445)	4,233	(7,212)	(13,823)	(10,103)

- No Industrial action in month 5.
- Resident Doctors' Industrial action took place from 7am June 28th to 7am July 2nd. In June this totalled 4 days comprising 2 working days and 2 weekend days and in July 1 working day.
- The overall impact is £5.9m - £4.4m additional pay related cost and £1.5m estimated loss of income.
- Table on the RHS shows run rate with IA impact removed across the APC. Note an improvement at month 3 (to £7.2m deficit) and a deterioration at month 4 (to £11.4m deficit) and month 5 (to £14.9m deficit).

M5 ERF Performance

NHS ERF Income under/overperformance YTD - M5

	NWL ICB ERF	Spec Comm ERF	Non NWL ICB ERF	YTD Total ERF	Forecast ERF
Trust	£000	£000	£000	£000	£000
CWFT	10,164	267	1,014	11,445	27,424
ICHT	720	2,885	(304)	3,301	13,069
LNWH	(1,516)	(100)	3,783	2,167	5,193
THH	2,627	(91)	(652)	1,884	4,374
Total APC	11,994	2,961	3,841	18,796	50,059

- ERF income in the financial plan is £702.7m across the APC, comprising baseline income in contracts of £633.3m and additional assumed income of £69.3m to account for planned overperformance over baseline values, in line with the operating plan submission.
- The table above shows the ERF variance (YTD plan vs YTD actual). At month 5 ERF income reports a favourable variance against the year-to-date plan of £18.8m. An improvement since Month 4 (£6.9m favourable in month favourable variance).
- Significant YTD overperformance at CWFT.
- Improvement in the month driven by material increases in month in CWFT & LNWH.

Month 5 Efficiency Performance

	YTD plan			YTD actuals			YTD Var	In Month Plan	In Month Actuals	In Month Variance	Annual Plan			Annual Forecast			Fcast Variance
Efficiency Month 5	R £000	NR £000	Total £000	R £000	NR £000	Total £000	£000	Total £000	Total £000	Total £000	R £000	NR £000	Total £000	R £000	NR £000	Total £000	Total £000
CWFT	6,821	1,587	8,408	5,840	2,657	8,497	89	1,867	1,748	(119)	17,926	5,594	23,520	17,289	6,231	23,520	0
ICHT	26,301	0	26,301	10,255	7,379	17,634	(8,667)	5,275	502	(4,773)	63,400	0	63,400	44,380	19,020	63,400	0
LNWH	10,935	2,701	13,636	7,377	863	8,240	(5,396)	2,902	2,363	(539)	28,494	6,352	34,846	31,600	3,246	34,846	(0)
THH	6,568	0	6,568	1,142	1,604	2,746	(3,822)	1,645	875	(770)	18,900	0	18,900	8,932	9,968	18,900	0
Total	50,625	4,288	54,913	24,614	12,503	37,117	(17,796)	11,689	5,488	(6,201)	128,720	11,946	140,666	102,201	38,465	140,666	(0)
% delivery of plan				45%	23%	68%								73%	27%	100%	

- The APC efficiency plan is £140.7m for the full year, an increase of £21.2m or 18% compared to the 2023/24 requirement.
- YTD delivery is £37.1m (68% of YTD plan), split 45% recurrent and 23% non-recurrent schemes.
- M5 in-month delivery has decreased to £5.4m compared to £8.6m in month 4.
- Efficiency plans are profiled fairly evenly across the year according to plan profile agreed by the APC CFOs.

APC Month 5 Capital

APC capital plan for 2024/25 is £220.8m, comprising schemes funded from trust cash and national funding. The capital plan reduced in July (from £239.3m) to account for the reallocation of ICB capital funds previously held in reserves at CWFT. The changes are:

ICHT - CORE CRL	3,918	Apportionment from add'l fair shares allocation - Data Comms
CWFT	2,950	Apportionment from add'l fair shares allocation - Various bids
CWFT	-27,959	Adjustment to Reserves held in CWFT
CWFT	2600	Anticipated allocation from NHSE
TOTAL	(18,491)	

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. The breakdown of the capital plan is per the table below::

APC Capital Plan 2024/25 (refreshed July)	CWFT £'000	ICHT £'000	LNWH £'000	THH £'000	Total £'000
CRL (excluding IFRS 16)	42,427	74,703	21,873	14,636	153,639
Impact of IFRS 16	95	11,573	1,500	1,197	14,365
Total CRL (including IFRS)	42,522	86,276	23,373	15,833	168,004
<u>PDC : National Schemes</u>					-
Diagnostic Digital Capability Programme	-	810	500	-	1,310
Elective Recovery/Targeted Investment Fund	20,206	-	-	-	20,206
Front Line Digitisation	-	-	780	-	780
New Hospital Programme (NHP)	-	1,281	-	26,100	27,381
PFI capital charges (e.g. residual interest)	2,126	-	1,032	1	3,159
					-
Total National Schemes	22,332	2,091	2,312	26,101	52,836
Total Capital Plan (Net CDEL)	64,854	88,367	25,685	41,934	220,840

At Month 5, the APC's capital spend is £52.7m against a £60.7m plan, an £8m underspend year to date and £4m underspend in the month of August.

The current forecast is an underspend of £5.8m, relating to THH's New Hospital Programme.

The YTD overspend at ICHT relates to bringing forward backlog maintenance in the capital programme. This is expected to smooth out over the balance of the year.

Capital (CDEL)	M5 2024/25			Annual 2024/25		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	19,118	15,092	4,026	64,854	64,854	0
ICHT	22,548	27,541	(4,993)	88,367	88,367	(0)
LNWHT	8,466	8,289	177	25,685	25,685	0
THH	10,581	1,831	8,750	41,934	36,111	5,823
Total	60,713	52,753	7,960	220,840	215,017	5,823

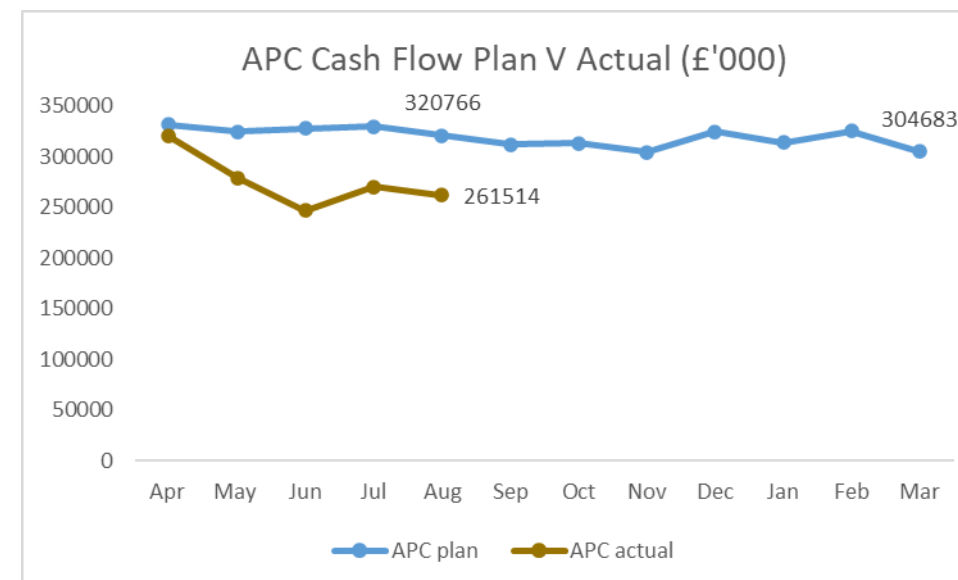
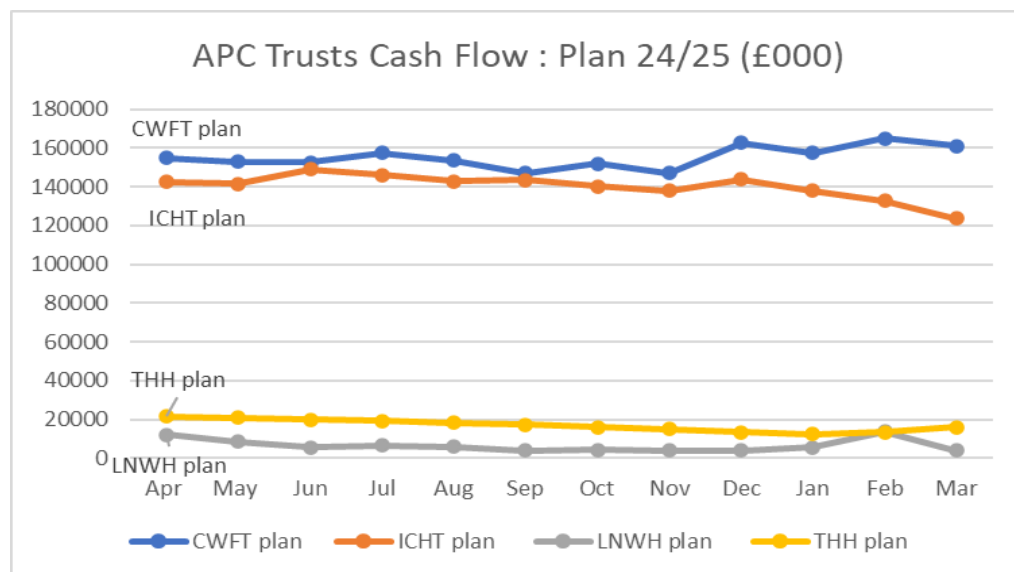
APC Month 5 Cash

The APC combined cash balance stood at £261.5m at the end of August, a decrease of £76.9m (23%) from the end of the previous financial year; and £59.3m lower than the August cash plan.

All trusts are reporting lower balances than planned except LNWH. The lower cash balances are driven primarily by movement in working capital and I&E deficits which are partially compensated for by the underspend on.

Cash flow plan per trust for 2024/25 and actual cash vs plan for the APC are shown in the graphs:

NWL APC Cash Balance					
Trust	31-Mar-24	31-Aug-24	Movement to YTD	31 Aug Cash Plan	Variance from plan
	£m	£m	£m	£m	£m
CWFT	161.6	132.7	(28.9)	153.5	(20.7)
ICHT	136.7	110.6	(26.1)	142.9	(32.3)
LNWH	19.8	9.8	(10.0)	6.1	3.7
THH	20.3	8.4	(11.9)	18.4	(10.0)
Total	338.4	261.5	(76.9)	320.8	(59.3)





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 M5

I&E Performance : CWFT

CWFT

2024/25 M5	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	YTD variance %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	74,808	80,140	5,332	374,040	403,193	29,153	8%	902,003	966,209	64,206
Pay	(43,318)	(45,650)	(2,332)	(216,590)	(228,914)	(12,324)	-6%	(523,203)	(547,255)	(24,052)
Non-Pay	(30,750)	(34,507)	(3,757)	(154,526)	(172,361)	(17,835)	-12%	(369,028)	(406,954)	(37,926)
Non Operating Items	(746)	(1,004)	(258)	(3,568)	(4,702)	(1,134)	-32%	(9,772)	(12,000)	(2,228)
Total	(6)	(1,021)	(1,015)	(644)	(2,784)	(2,140)		0	0	0

Key Messages :

- The Trust is reporting a YTD deficit of £2.78m, which is a £2.14m adverse variance to plan.
- CIP delivery is breakeven; CIP delivery has seen a further improvement in the identified position in comparison to M4 and are forecasting to deliver the Trust's £23.5m plan.
- Key drivers of the YTD position are Industrial action cost and income impact (£1.15m), cost pressure relating to WM UTC (£0.35m), escalation beds remaining open in Q1 net of any funding (£ 0.57m), RMN/ Specialising increase (£0.4m), non-pay inflation above the funded levels, which is 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 141% compared to the target of 117% (19/20 baseline), which is an income over performance of £11.4m and will be largely offset against additional costs.
- Forecast remains unchanged at breakeven. This assumes external funding for industrial action costs.

I&E Performance : ICHT

ICHT

2024/25 M5	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	137,429	138,705	1,276	681,513	701,710	20,197	3%	1,639,832	1,639,832	0
Pay	(85,163)	(87,520)	(2,357)	(425,250)	(438,967)	(13,717)	-3%	(1,017,717)	(1,017,717)	0
Non-Pay	(50,745)	(57,005)	(6,260)	(253,980)	(280,937)	(26,957)	-11%	(611,000)	(611,000)	0
Non Operating Items	(926)	(1,151)	(225)	(4,630)	(3,677)	953	21%	(11,115)	(11,115)	0
Total	595	(6,971)	(7,566)	(2,347)	(21,871)	(19,524)		0	0	0

Key Messages :

The main drivers of the £19.5m adverse YTD variance are:

- Industrial Action £2.1m (£1.7m (cost element) of which is expected to be funded).
- Under delivery of efficiencies against plan of £8.7m.
- Overall income is higher than plan. This includes £0.5m IA estimated loss of income; £3.3m ERF overperformance; over delivery on the variable element of the contract (drugs & devices) £7.6m; Pathology Services £3.1m; Overseas visitor charges £3.7m, R&D £6.9m.
- Pay overspend relates in the main to IA pay backfill; specialling and mental health observations; premium costs to deliver additional activity and system optimisation scheme delays and under delivery of pay related efficiencies.
- Non-pay overspend is partially offset by the positive income variance (drugs and devices, R&D, Education and training and CDCs) with the residual related to the under delivery of the efficiency plan, impact of true up adjustments relating to the managed equipment service and the impact of unfunded inflation.

I&E Performance : LNWH

LNWH

2024/25 M5	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	YTD variance %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	81,553	86,948	5,395	408,315	420,701	12,386	3%	988,300	1,008,407	20,107
Pay	(50,934)	(54,560)	(3,626)	(257,114)	(270,088)	(12,974)	-5%	(619,784)	(643,206)	(23,422)
Non-Pay	(28,828)	(33,559)	(4,731)	(143,965)	(162,713)	(18,748)	-13%	(345,904)	(342,589)	3,315
Non Operating Items	(1,885)	(1,904)	(19)	(9,423)	(9,457)	(34)	0%	(22,612)	(22,612)	0
Total	(94)	(3,075)	(2,981)	(2,187)	(21,557)	(19,370)		0	0	0

Key Messages

- The Trust is reporting a YTD deficit of £21.6m, £19.4m adverse to plan.
- Industrial action is estimated at £2m YTD - £0.7m income and £1.3m cost
- CIP delivery is £5.4m 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.
- Total ERF income YTD equates to an overperformance of £2.1m (including underperformance on the EoC which also results in reduced costs).
- Forecast remains unchanged at breakeven

I&E Performance : THH

THH

2024/25 M5	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	YTD variance %	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	29,775	30,561	786	148,877	151,495	2,618	2%	357,309	357,804	495
Pay	(19,240)	(21,910)	(2,670)	(96,227)	(107,826)	(11,599)	-12%	(230,895)	(231,390)	(495)
Non-Pay	(10,303)	(11,723)	(1,420)	(51,512)	(57,317)	(5,805)	-11%	(123,487)	(123,508)	(21)
Non Operating Items	(701)	(718)	(17)	(3,430)	(3,433)	(3)	0%	(2,927)	(2,906)	21
Total	(469)	(3,790)	(3,321)	(2,292)	(17,081)	(14,789)		0	0	0

Key Messages:

The primary drivers for the £14.8m adverse YTD variance are :

- Income is favourable YTD. Underlying cost pressures for NHSE income Environmental Controls (£0.8m) and reduced activity on border contracts (£0.7m) are offset by £2.9m additional drugs and devices income to date, £2.5m of ERF from NWL above plan and a further £0.2m from other income sources .
- Industrial action in the year to date has led to costs of £0.5m being incurred by the Trust to provide medical cover, and an income loss of £0.2m due to lost elective activity.
- Under achievement of savings £1.7m year to date against the internal plan (£3.8m compared to the submitted plan).
- Pay £11.6m adv primarily across Unplanned £4.5m adv; Planned Care £2.3m adv; Mount Vernon and Clinical Support Services £0.8m adv; Other £3.8m
- Non Pay £5.8m adv primarily due to NWL Pathology service £1.5m adv; Clinical Supplies and Services £2.0m adv; Drugs £1.5m adv
- Overperformance against plan for block activity is driving higher costs, particularly on the UEC pathway.
- Non-recurrent income expected in our plan (ICB Support) but not yet confirmed is accrued within our position, on the assumption that these will be resolved in future periods.
- There has been a worsening in the Trusts bottom line position in Month 5, mainly driven by movement on energy (ytd price adjustment in M4), increase on pay spend due to non elective activity and decrease income, in part due to year-to-date critical care coding/price adjustments in month



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Imperial College Healthcare
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Appendix 2

NWL APC Run Rates

Run Rates

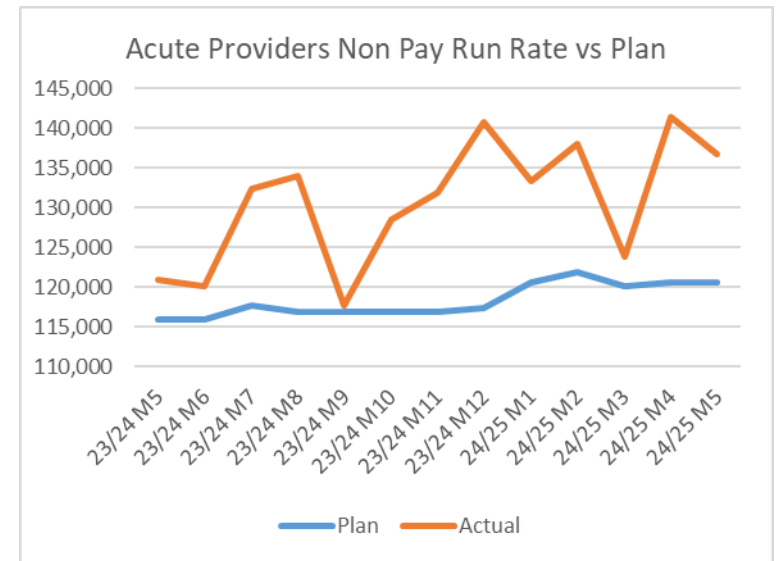
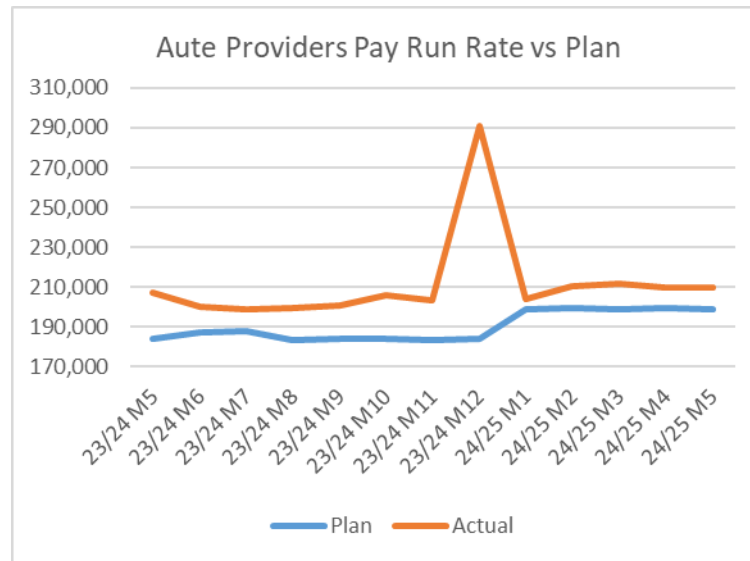
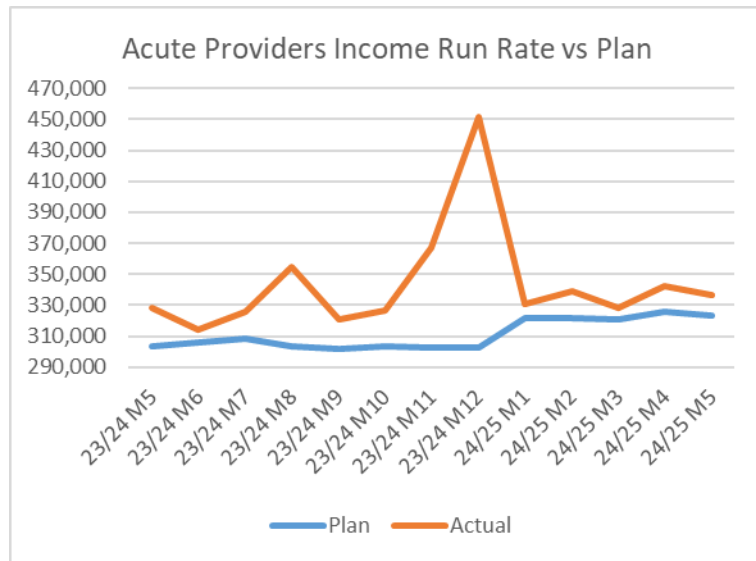
- This appendix shows the monthly run rates of income, pay and non-pay for the APC and trusts 23/24 to 24/25.
- Non pay excludes non-operating items.
- The spike in M12 March 24 in pay and income relates primarily to the accrual for additional employer's pension costs. To note in 2024/25 the pay uplift is accounted for in line with national planning assumptions, including the agreed consultants' pay award.
- 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 - M3 24/25 (average)				
	APC	CWFT	ICHT	LNWH	THH
Income	-1.1%	1.5%	-0.7%	-1.6%	-8.2%
Total Expenditure	4.0%	2.2%	3.3%	7.1%	4.1%
Pay	3.7%	4.0%	4.0%	3.5%	2.6%
Non Pay	4.5%	-0.1%	2.1%	13.8%	6.9%

- Overall, for the APC income has decreased by 1.1% and expenditure increased by 4%.
- All trusts except CWFT report decreases in income, with a material decrease in THH.
- Pay has increased across all trusts as expected to account for the consultants pay award and estimate of the AfC pay award, but %'s are variable across the trusts and THH reporting a small increase in comparison to others.
- Non pay reports significant increases in LNWH & THH but has decreased in CWFT.

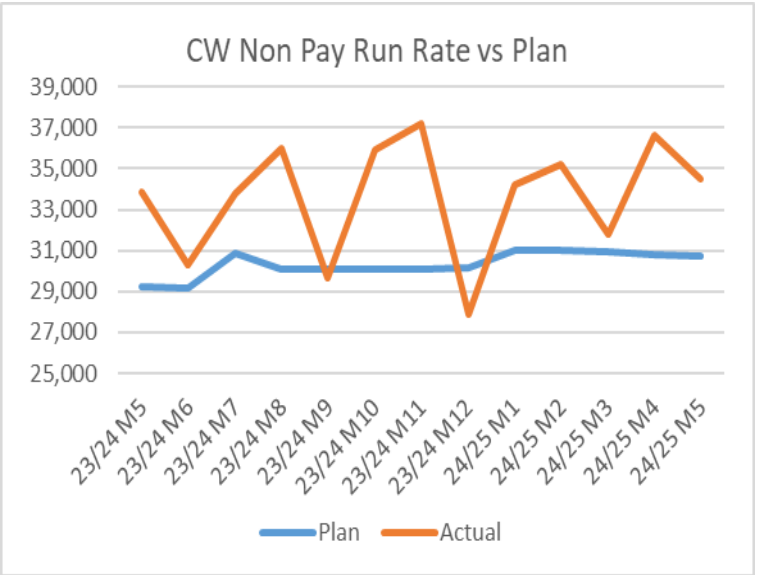
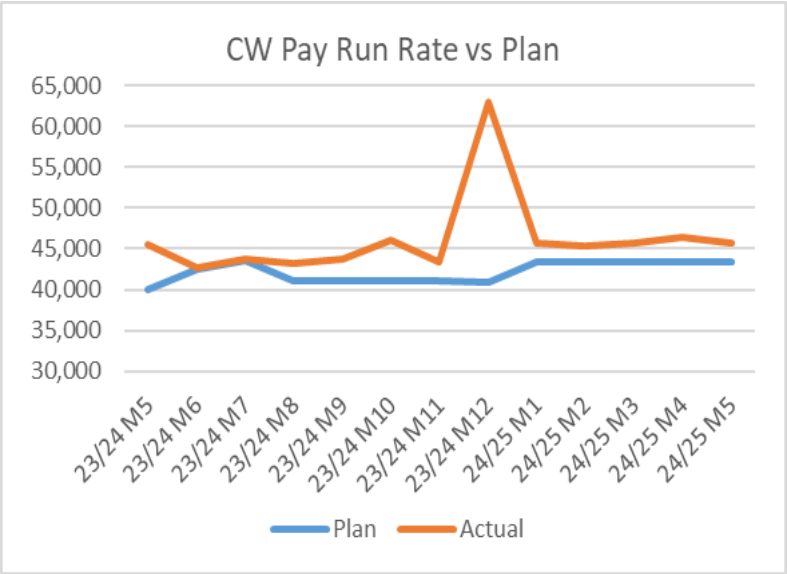
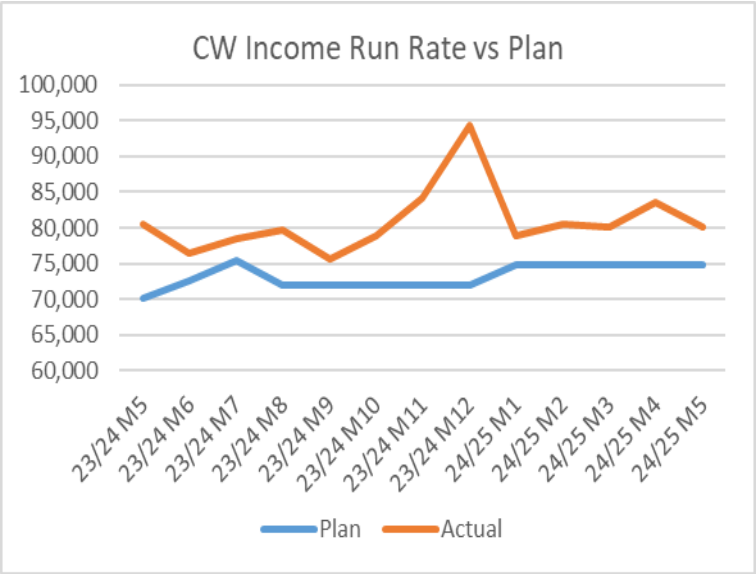
Run rate - APC

		23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2	24/25 M3	24/25 M4	24/25 M5
Income	Plan	303,520	306,236	308,438	303,436	301,481	303,602	302,955	302,293	321,475	321,666	320,539	325,500	323,565
	Actual	327,853	314,565	325,571	355,041	321,160	326,872	367,546	451,692	331,115	338,746	328,474	342,410	336,354
Pay	Plan	184,188	187,129	187,596	183,686	184,110	184,002	183,632	183,778	198,923	199,417	198,901	199,285	198,655
	Actual	207,265	200,358	198,686	199,395	200,686	206,006	203,442	291,212	204,087	210,445	211,972	209,651	209,640
Non-pay	Plan	115,999	115,922	117,704	116,905	116,902	116,924	116,913	117,366	120,626	121,971	120,082	120,678	120,626
	Actual	120,994	120,155	132,394	133,934	117,693	128,490	131,876	140,753	133,376	137,970	123,814	141,375	136,793
		23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2	24/25 M3	24/25 M4	24/25 M5



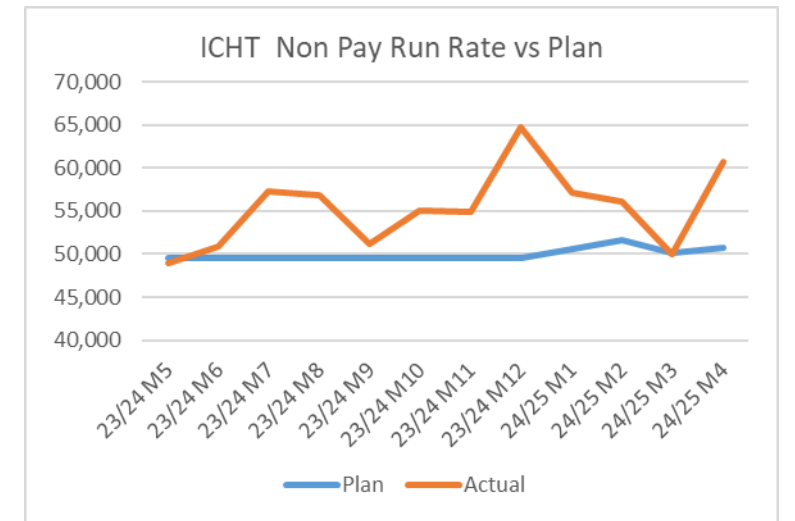
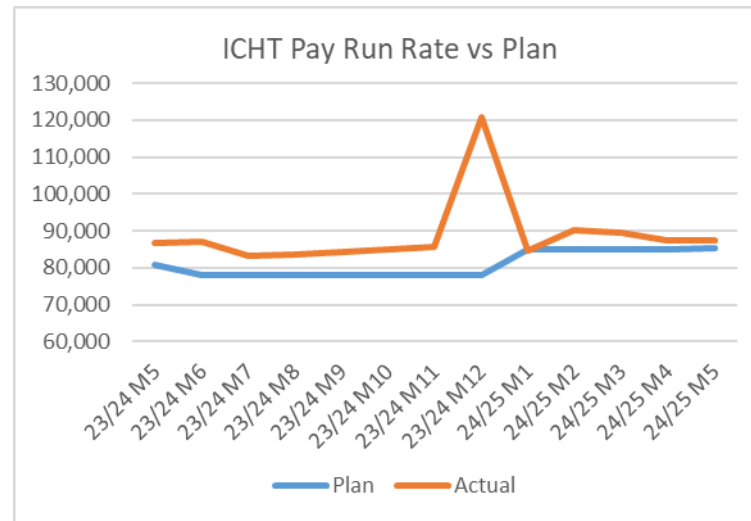
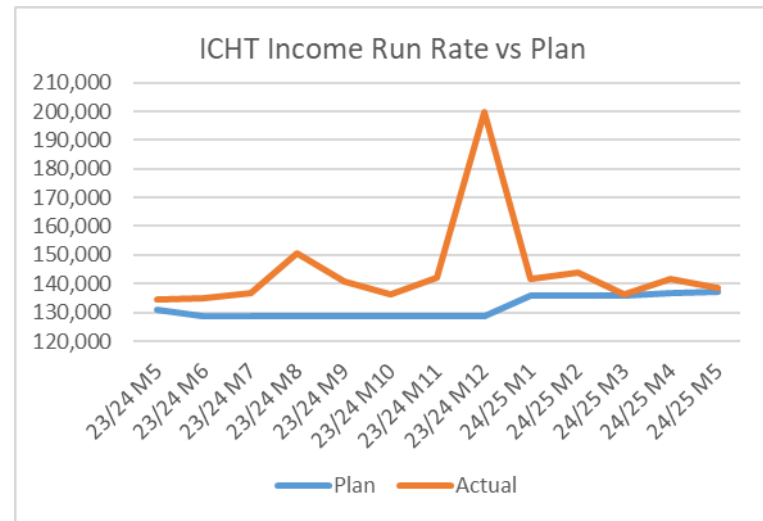
Run rate - CWFT

		23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2	24/25 M3	24/25 M4	24/25 M5
Income	Plan	70,217	72,604	75,414	71,978	71,978	71,978	71,978	71,974	74,808	74,808	74,808	74,808	74,808
	Actual	80,474	76,438	78,497	79,753	75,742	78,892	84,282	94,262	78,860	80,560	80,031	83,602	80,140
Pay	Plan	40,084	42,471	43,629	41,001	41,001	41,001	41,001	40,948	43,318	43,318	43,318	43,318	43,318
	Actual	45,487	42,712	43,759	43,167	43,700	46,134	43,431	62,931	45,623	45,403	45,770	46,468	45,650
Non-pay	Plan	29,203	29,187	30,893	30,083	30,079	30,100	30,102	30,156	30,985	31,036	30,968	30,787	30,750
	Actual	33,828	30,278	33,791	36,003	29,685	35,948	37,171	27,887	34,204	35,181	31,808	36,661	34,507



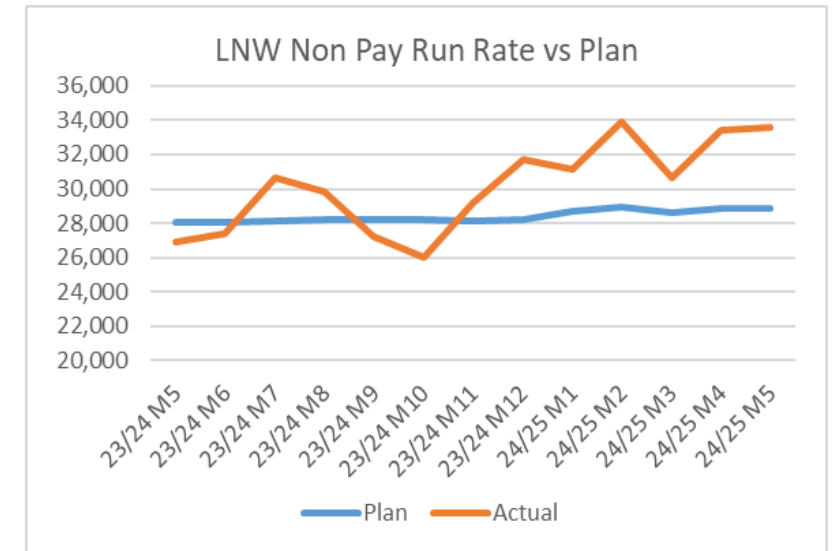
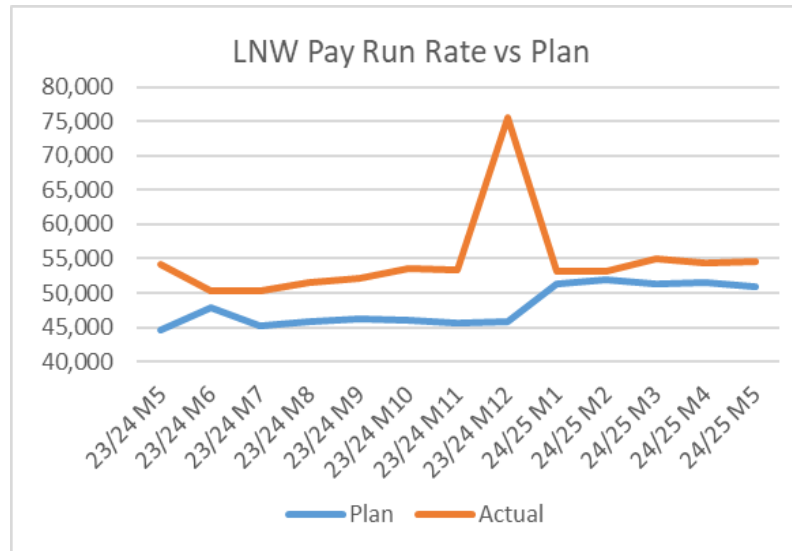
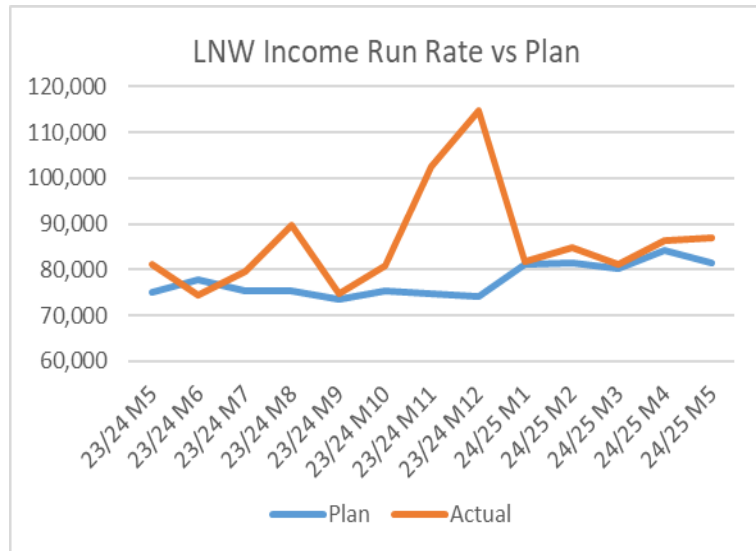
Run rate - ICHT

		23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2	24/25 M3	24/25 M4	24/25 M5
Income	Plan	131,067	128,526	128,530	128,530	128,508	128,530	128,526	128,506	135,760	135,760	135,760	136,804	137,429
	Actual	134,704	135,016	136,803	150,589	140,630	136,304	142,143	199,604	141,488	143,780	136,157	141,580	138,705
Pay	Plan	80,709	78,168	78,172	78,173	78,149	78,173	78,168	78,158	84,996	84,996	84,995	85,100	85,163
	Actual	86,677	87,010	83,311	83,728	84,330	85,005	85,558	120,712	84,497	90,113	89,439	87,398	87,520
Non-pay	Plan	49,600	49,600	49,600	49,599	49,601	49,599	49,600	49,582	50,604	51,657	50,214	50,760	50,745
	Actual	48,910	50,919	57,223	56,855	51,116	55,055	54,960	64,683	57,121	56,091	49,976	60,744	57,005



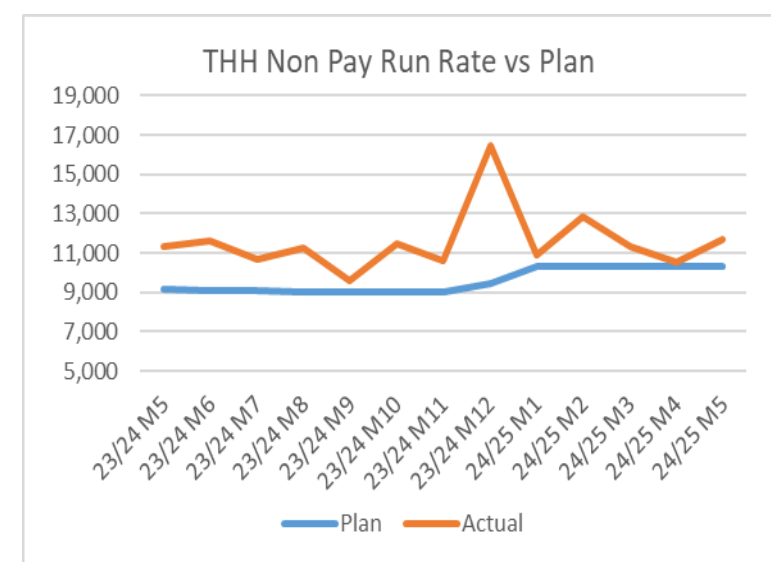
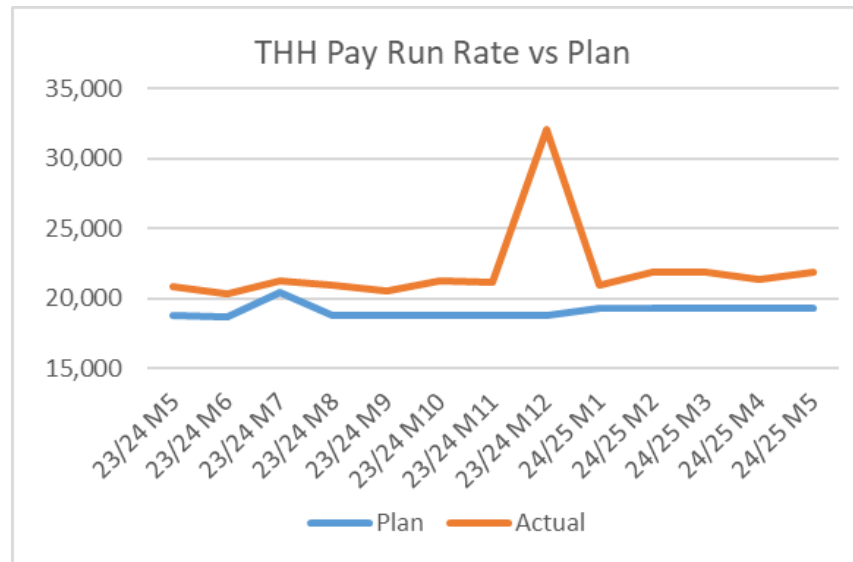
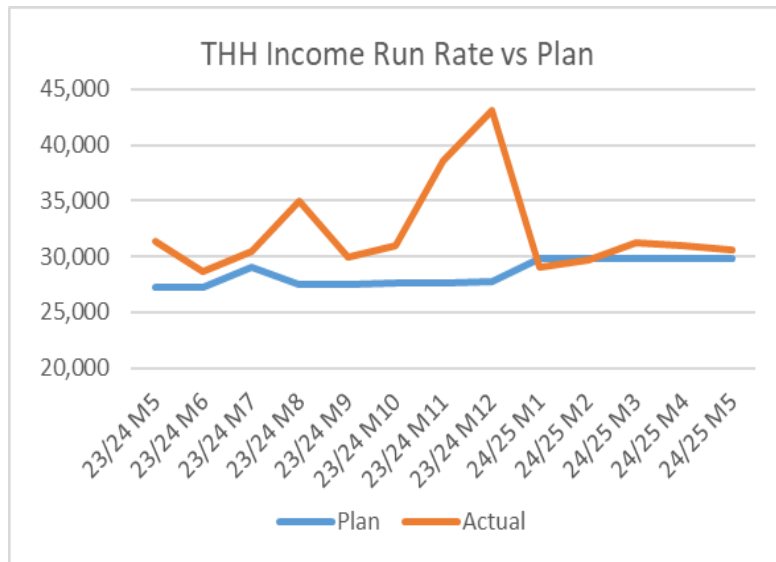
Run rate - LNWH

		23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2	24/25 M3	24/25 M4	24/25 M5
Income	Plan	74,980	77,845	75,407	75,407	73,471	75,406	74,762	74,116	81,131	81,323	80,195	84,113	81,553
	Actual	81,261	74,473	79,784	89,703	74,786	80,717	102,490	114,750	81,741	84,681	81,061	86,270	86,948
Pay	Plan	44,624	47,854	45,330	45,755	46,202	46,070	45,705	45,914	51,360	51,854	51,339	51,627	50,934
	Actual	54,268	50,366	50,335	51,548	52,167	53,644	53,339	75,502	53,080	53,112	54,937	54,399	54,560
Non-pay	Plan	28,028	28,028	28,104	28,175	28,174	28,177	28,162	28,175	28,735	28,977	28,597	28,828	28,828
	Actual	26,917	27,367	30,673	29,830	27,260	26,019	29,168	31,722	31,164	33,883	30,679	33,428	33,559



Run rate - THH

		23/24 M5	23/24 M6	23/24 M7	23/24 M8	23/24 M9	23/24 M10	23/24 M11	23/24 M12	24/25 M1	24/25 M2	24/25 M3	24/25 M4	24/25 M5
Income	Plan	27,256	27,261	29,087	27,521	27,524	27,689	27,689	27,698	29,776	29,775	29,776	29,775	29,775
	Actual	31,414	28,637	30,487	34,996	30,002	30,959	38,631	43,076	29,026	29,725	31,225	30,958	30,561
Pay	Plan	18,771	18,636	20,465	18,757	18,758	18,758	18,758	18,758	19,249	19,249	19,249	19,240	19,240
	Actual	20,833	20,269	21,281	20,952	20,489	21,223	21,114	32,067	20,887	21,817	21,826	21,386	21,910
Non-pay	Plan	9,168	9,107	9,107	9,048	9,048	9,048	9,049	9,453	10,302	10,301	10,303	10,303	10,303
	Actual	11,339	11,592	10,707	11,246	9,632	11,468	10,576	16,461	10,887	12,815	11,351	10,541	11,723





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Foundation Trust



Imperial College Healthcare
NHS Trust



London North West University
Healthcare NHS Trust

Appendix 3

Financial Performance Escalation

Financial Performance Escalation - 1

- 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, .
- Once a trust moves into escalation, formal peer review and reporting is initiated including testing grip and control measures, reviewing forecasts and run rates and developing financial recovery plans.
- Escalation metric scores to month 4 are shown in the table below. All trusts score 4 (the highest) for at least three metrics. On average, CWFT has the lowest score and the other three trusts the highest.
- The escalation process commenced during June (for month 2 reporting). A CFO Peer Review session was held on 14.06, a series of actions were noted. A further meeting was held 22.07 to peer review Q1 performance and trust financial recovery plans.
- Refreshed recovery plans (considering month 5 performance) have been prepared.

M5 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	4	4	4	-0.2%	-2.5%	-4.1%	-9.3%
Year to Date Run Rate - deficit *	T/over	0-0.75%	0.75-1%	0-1%	>1%	1	4	4	4	-0.4%	-2.8%	-4.7%	-10.8%
CIP non-delivery against plan	CIP Value	0-10%	20-30%	30-40%	>30%	1	4	4	4	1%	-49%	-65%	-139%
ERF activity delivery	ERF %	0-2.5%	2.5-5%	5-10%	>10%	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Forecast Outturn '000	T/over	0	0-0.5%	0.5-0.75%	>0.75%	1	1	1	1	0	0	0	0
Ave score						1.0	3.3	3.3	3.3				
* impact of IA removed													


Financial Performance Escalation - 2

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

- Upon breaching the metrics, the levels of escalation are shown in the table.
- This is the 2023/24 process which has agreed to be followed in 2024/25.
- * to note for 2024/25 there is no risk pool support funding.

10. CHIEF EXECUTIVE OFFICERS

10.1 EXECUTIVE MANAGEMENT BOARD (EMB) SUMMARY

 Tim Orchard

REFERENCES

Only PDFs are attached

 10.1 APC EMB Chair's Report - Oct 2024 v01.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

October 2024

Highlight Report

1. Purpose and Introduction

The role of the NWL APC Executive Management Board (EMB) is:

- To oversee the delivery of the Collaborative strategy and business plan, including the financial and operational plan.
- To be the executive decision-making body for the Collaborative, commissioning and approving Collaborative programmes and associated resources, ensuring that the various programmes are aligned in their objectives and delivering against agreed milestones.
- To draw to the NWL APC Board in Common's (BiC's) attention matters they need to agree or note.

2. Key highlights

The APC EMB met on 7 August 2024 and 11 September 2024. It is also due to meet on 9 October, which falls after the submission deadline for papers for the Board in Common. Key discussion items are summarised below.

2.1. Performance reporting

- 2.1.1. At each meeting, the APC EMB reviewed quality, workforce, operational and finance performance across the Trusts, receiving assurance on outliers and activity ongoing to address variation.
- 2.1.2. The APC EMB also discussed changes to the format of the performance reporting to make it easier to use. The latest version of the performance report is presented at this meeting.

2.2. APC strategy and clinical pathways project

- 2.2.1. The APC EMB received updates on the engagement approach following publication of the APC strategy in July. Reporting to the APC EMB will support tracking the progress of the strategy and identify any issues that need escalation.
- 2.2.2. The APC EMB discussed the progress on the clinical pathways project, which aims to operationalise a key strand of the APC strategy. APC EMB received assurance that specialty leadership groups are in place, CEOs have met with those responsible for leading their specialties and there is progress towards choosing a priority pathway to align to best practice across the APC. There are weekly touchpoints in place for trust transformation teams to share learning and progress.

- 2.2.3. Initial priority pathways are due to come to APC EMB for approval in November, though some may be ready to be approved at October APC EMB.

2.3. APC governance

- 2.3.1. The APC EMB agreed to a proposed approach to risk management across the Collaborative and a format for a board assurance framework at Collaborative level.

2.4. Updates and assurance on collaborative projects

- 2.4.1. The APC EMB receives monthly updates on progress in developing and implementing the Collaborative business plan and strategic priorities. These include the projects within the quality, workforce, finance and performance and digital transformation workstreams.
- 2.4.2. The APC EMB received an update on sector priorities, including Urgent and Emergency Care (UEC), diagnostics and planned care, as well as an update on the programme to optimise urgent and emergency care for babies, children and young people in NW London. The APC EMB noted ongoing preparations for winter. The APC EMB also noted an update on the NWL System Interface group to progress work so far, which will be monitored through the Planned Care Board.
- 2.4.3. The APC EMB also received updates and assurance on the Maternity & Neonatal Improvement Programme (MNIP) at Hillingdon.
- 2.4.4. The APC EMB were also provided with assurance and decisions on key collaborative projects. This included:
- **Elective orthopaedic centre (EOC):** The APC EMB discussed the EOC and noted the risk in delivering the operational plan. The APC EMB requested further assurance and work to ensure that the EOC is fully utilised, including discussing the optimisation plan at the September meeting and requesting a trajectory for improving utilisation.
 - **EDI phase 2:** APC EMB discussed the APC EDI Improvement Plan Steering Group Phase 2, which focuses on actions the APC will pursue to support equitable patient care and address health inequalities amongst our communities. EMB members acknowledged that the scope was ambitious and were cognisant that there may well be some data availability issues that could pose a risk to the achievement of the delivery of the objectives. The terms of reference will be updated following the feedback from APC EMB.
 - **Ethnicity coding of data:** APC EMB received an update on progress to improve ethnicity data coding at LNWH and THHFT. LNWH and THHFT now have a process to extract ethnicity data from WSIC for their patients. There is further work to develop a bot to update Cerner using extracted data from WSIC. Further update will be presented to APC EMB in October.

- **Data strategy:** The APC EMB noted an update on developing the APC data strategy, which focuses on four main areas: technical data infrastructure; leadership, people and skills required; data sharing, governance and security; and data standards and data quality. The Data Strategy will be developed in stages during 2024/25 and will be overseen by the Data Strategy Steering Group, which meets monthly. The aim is for the Data Strategy to be approved by the Board In Common by March 2025

3. Attendance of members

The APC EMB is attended by all 4 CEOs and a representative of each 'functional group' of executive roles. The executive representatives will rotate every six months.

The current membership as of September 2024 is:

- **CEOs** – Tim Orchard, ICHT (Chair), Lesley Watts, CWFT, Pippa Nightingale, LNWH, Patricia Wright, THHFT
- **Chief Financial Officer** representative – Jazz Thind, ICHT
- **Chief Operating Officer** representative – Tina Benson, THHFT
- **Medical Director** representative – Raymond Anakwe, ICHT
- **Chief Nurse** representative – Lisa Knight, LNWH
- **Chief People Officer** representative – Lindsey Stafford-Scott, CWFT
- **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

10.2 REPORTS FROM THE CHIEF EXECUTIVE OFFICERS AND TRUST

STANDING COMMITTEES

 Pippa Nightingale/ David Moss Patricia Wright/ Carolyn Downs Tim Orchard/ Bob Alexander Lesley Watts/St

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

REFERENCES

Only PDFs are attached

-  10.2a LNWH CEO report FINAL.pdf
-  10.2b LNWH TSC Escalation Report FINAL.pdf
-  10.2c BIC THHFT CEO Public Report - October 2024_FINAL.pdf
-  10.2d THHFT SC Chairs Report October 2024 FINAL.pdf
-  10.2e ICHT CEO Public Report - October 2024 FINAL.pdf
-  10.2f ICHT Trust Standing Committee Chair's report to BiC October 2024 FINAL.pdf
-  10.2g CWFT CEO Report October 2024 - FINAL.pdf
-  10.2h CW Trust Standing Committee Chair's Report - OCT 2024 FINAL.pdf

Chief Executive Officer's Report – London North West University Healthcare NHS Trust (LNWH)

Accountable director: Pippa Nightingale
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

- 1.1 Staff employed by Medirest took part in industrial action over four dates in July. This affected catering, cleaning, and portering services at Northwick Park Hospital. Robust plans were put in place to minimise disruptions to patient care and we did not cancel any appointments.

LNWH worked with Medirest to put forward an offer to the GMB union and its members. The GMB called off further industrial action planned for August, after members voted to accept improvements to sick pay, annual leave and pay.

- 1.2 A new £20m 32-bed Acute Medical Unit, built on top of the existing A&E department at Northwick Park Hospital, has held its officially opening event. The unit provides the hospital with much valued bed space, is helping to reduce the amount of time patients wait in A&E, improve patient safety, reduce ambulance waits and better manage seasonal demand. With one of the biggest and busiest A&Es in the country this is a welcome and much needed addition to our capacity.

- 1.3 The new £30m Ealing Community Diagnostic Centre has now opened at the Ealing Hospital site. GPs can make direct referrals to the centre, offering a faster and more convenient service as well as helping reduce unnecessary hospital visits.

The centre primarily serves communities in Hanwell, Southall and Greenford, as well as supporting Brent and Harrow boroughs, whilst providing the North West London Integrated Care Service with additional capacity.

- 1.4 St. Mark's Hospital has formally marked its move to a new home at our Central Middlesex site. The National Bowel Hospital (informally St Mark's) still has hubs at Ealing and Northwick Park, but the main hospital services are now permanently located at the Central Middlesex site in Park Royal.

The official opening event was held as the tenure of the hospital's co-medical directors,

Omar Faiz and Carolynne Vaizey ended. Carolynne and Omar will be staying with St. Mark's, and I'm grateful to them both for their commitment and time in post. I'd also like to welcome their replacement, Prof Siwan Thomas-Gibson. Prof Thomas-Gibson is a gastroenterologist and specialist endoscopist with a particular interest in Bowel Cancer Screening. She has been a consultant at St. Mark's since 2006.

2. Quality and safety

- 2.1 LNWH is the first trust in the country to develop a 'compound equity index' which ensures the quality of care offered is consistent regardless of factors such as gender, ethnicity, disability or social and economic circumstances. The equity index aggregates variation in care quality across thirty indicators, such as safety, effectiveness, patient experience, timeliness and access.
- 2.2 LNWH has been recognised as having one of the most accessible websites in London. This means more people with accessibility needs can easily use our website. The site was ranked by Silktide Index, which ranks public sector organisations based on their level of compliance with a globally recognised standard for web accessibility.

3. Operational performance

- 3.1 **Emergency department performance:** A&E performance reported 79.0% for July 2024 against the 4-hour standard, which is above the national ask of 78% and the Trust's highest performance in the last 12 months. This is the fifth highest performance in London for the 18 acute trusts reporting against this standard. 95.3% of patients were treated within 12 hours against the 98% standard

Ambulance cohorting continues to support patient safety but has a negative impact on 4-hour performance.

Bed occupancy remains high at the 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.

Key actions underway include:

- The annual bed plan is in place to flex capacity against the seasonal demands.
- Internal flow improvements continue to be discussed across divisions and through the Inpatient Standards Group.
- The ambulance 45-minute London wide handover process continues.
- The LNWH flow model is now part of the Trust's operating procedures to assist daily patient flow, alongside daily patient allocation to the same day emergency care setting. Continued focus is underway to increase daily discharges and use of the discharge lounges across sites.
- Daily escalation calls are in place with the London-wide community equipment provider.

- Joint planning continues across the sector regarding the Optica digital platform to support bed flow.

3.2 **Cancer waiting times:** The final position for June 2024 (reporting a month in arrears) was:

- 2-week wait for suspected cancer: reported 69.0% against the 93% standard
- 28-day faster diagnosis: reported 63.5% against the 75% standard
- 62-day wait for treatment following GP referral: reported 58.7% against the 85% national standard

The number of patients over 62 days reports positively below the operating plan trajectory.

The Trust saw a deterioration in its 2WW performance in June and the focus on improving wait times in dermatology remains.

The Trust did not meet the Faster Diagnosis Standard for a second month, again due to the challenges in dermatology capacity. However, the service has been successful in recruiting to some of the essential posts to allow an increase in activity.

3.3 **18 weeks referral to treatment:** The Trust continues its focus on reducing the number of patients waiting over 78 weeks as well as 65 weeks by end of September. This focus has resulted in a reduction of patients in the 78ww cohort to 42 at the end of July, with many of these due to patient choice agreement on the dates. There were also significant reductions in the 65-week cohort. The emphasis on reducing patients over 52 weeks continues.

The Trust total Patient Tracking List (PTL) has increased significantly since the implementation of Cerner go live and from validation campaigns the Trust has carried out; it is apparent that approximately 45% of the PTL is over inflated by data quality issues. These data quality issues are caused by incorrect data entry at the front end of the pathways, incorrect outcomes or missing outcome as well as duplicate pathways being created by users, in error. The Trust has invested in resource to focus on removing the data quality errors.

Finance and estates

4.1 **Finance:** Together with colleagues across north west London, within the Acute Provider Collaborative (APC) and the wider system, we set a balanced and challenging financial plan for this year.

We delivered a balanced financial position for 2023/24 with support from the Integrated Care Board (ICB) and the APC, to manage and mitigate the impact of the Cerner (electronic patient record) implementation on our activity recording. Our financial statements for the year were signed off by our external auditors over the summer.

Our plan for 2024/25 requires us to continue driving up standards of recording and reporting of our activity, as well as significantly improving our productivity and delivering a significant cost improvement programme of £34.8m. Our plan also requires us to work with system partners on a series of optimisation projects, aimed at bringing down activity and cost in key pressure areas. We also need to secure and deliver the benefits of the North West London Elective Orthopaedic Centre in terms of improved productivity and efficiency.

At the end of Month 5, and in common with Trusts across the APC, we have seen some challenges to the implementation and delivery of our financial plan. We started the year with a run-rate (difference between our income and our expenditure) of around £4.5m deficit each month. We have seen this slowly reduce through our recovery actions to around £3m each month. This represents positive progress but we need the deficit to reduce further and to find ways to recover the overspend we have incurred in the first few months of the year, which is £19.4m at the end of Month 5 against our plan.

We understand the reasons for our overspends, which include the impact of industrial action (£1.9m), additional inflationary costs (£1.5m) and additional costs for diagnostics and clinical supplies (£2.8m). There were also a series of specific pressures against service areas, including maternity and urgent care, and we have developed a Financial Recovery Plan to help us bring our monthly run-rate back into balance before the end of the financial year. This is a challenging and ambitious aspiration, but we have a track record of delivery through focused work and we will continue to maintain and strengthen our arrangements for 'Grip and Control' across the Trust.

Our capital programme is smaller this year than in previous years, as some of our strategic investment programmes come to an end. However, we do have some significant investments this year including the refurbishment of endoscopy at Northwick Park Hospital and the completion of the Community Diagnostic Centre at Ealing, but most of our programme is committed to strengthening our core infrastructure and replacing and refreshing key medical equipment.

We are carefully monitoring our capital budgets through the Capital Review Group, which meets monthly, to ensure that we get the best value for our limited resources. As a result of the year to date financial deficit, we are also keeping a close and watchful eye on our cash flow, ensuring that we maintain a flow of payments to suppliers, particularly local and smaller suppliers. We are working closely with our system partners – NWL ICB in particular – to manage the collective cash resources and carefully forecast cash requirements daily.

- 4.2 **Estates and Facilities:** Over the summer, we have seen several facilities completed, and official opening events have taken place or are planned, including the Elective Orthopaedic Centre, Ealing Community Diagnostic Centre and the Willesden Eyecare Centre.

However, the core focus of the estates and facilities teams has been working to maintain and refresh the infrastructure of the Trust sites. The team are working closely with

operational colleagues to strengthen urgent care facilities at Ealing, following the completion of the Acute Medical Unit at Northwick Park, and the in-year programme of ward refurbishment has been agreed and will commence shortly. The team have also been working with operational colleagues and service providers to strengthen patient transport service experience and delivery, building on an action plan developed with the help of internal audit partners.

5 People

- 5.1 Jonathan Reid, our Chief Financial Officer, is leaving LNWH in November. Since joining us in April 2020, Jonathan has brought efficient and compassionate leadership to his directorate, spanning finance, estates and facilities. This includes guiding our green plan and sustainability work, and the LNWH charity.

Prior to leaving Jonathan will provide a handover to Don Richards, who joins us on the 1 October as interim Chief Financial Officer.

- 5.2 Christiana Dinah, an ophthalmologist at Central Middlesex Hospital and Director of Research Innovation, is one of three diabetic retinopathy experts involved in developing and publishing the first ever NICE guidance for diabetic retinopathy.

6. Equity, diversity and inclusion

- 6.1 LNWH has been shortlisted for a Health Service Journal Award for championing race equality. A previous EDI score on the National Staff Survey, which was static for four years, saw LNWH ranked in the top quartile in 2022-23. The Health Service Journal will announce the winners in November.
- 6.2 LNWH took part in this year's PRIDE parade on Saturday 29 June. It was heart-warming to see so many staff joining in the celebrations, showcasing our LNWH family, guided by our shared HEART values. A special thank you to Medirest for their sponsorship this year.
- 6.3 Our latest Project SEARCH graduates have successfully completed their internship programme after joining us last September. The supported internship programme helps young people with learning disabilities and/or those on the autistic spectrum gain valuable work experience in preparation for fulltime employment. Several of the graduates will be staying with LNWH in various roles.
- 6.4 Throughout July we celebrated South Asian Heritage month with several staff, from pharmacies to maternity, sharing their career journeys with colleagues.
- 6.5 Starting this week our EDI festival returns with events to mark National Inclusion Week followed by Black History Month and Disability History Month in November.

7. LNWH updates

- 7.1 A new four-bed Paediatric High Dependency Unit has opened at Northwick Park Hospital. The unit provides specialised care closer to home for local families.

Northwick Park is one of only a handful of hospitals in London offering this service.

It is designed for young people who require long-term non-invasive ventilation, have tracheostomies (an opening in the windpipe to help air and oxygen reach the lungs), live locally and do not require intensive care support.

- 7.2 Our first ever Improvement Festival ran from the 8-19 July. The two-week festival showcased how improvement techniques can have a dramatic impact to patient and staff experience. The festival was a combination of in-person and online events. These included keynote talks from industry experts, deep-dives into improvement initiatives across LNWH, in-person workshops and showcasing improvement tools and techniques.
- 7.3 Some 2,815 members of attended our staff Health and Wellbeing Festival in June. Our Wellbeing and Engagement Team visited all three hospital sites, showcasing the support and advice available to all, from wellbeing, health, career development, learning and our internal support networks.
- 7.4 The functionality of our Timely Care Hub was upgraded in August. Timely Care Hub pulls information from Cerner EPR and displays it in real time on large screens in all our wards, so staff can see what a ward, department or area looks like at a glance.

A three month trial of the new version showed completion of patients' harm-free care metrics increased from an average of 54% to 88%. Ward managers and matrons report now takes half the time to complete documentation audits as they can see this information immediately on one screen.

8. Research and innovation

- 8.1 The pharmacy team at Northwick Park Hospital has set up a 'satellite' pharmacy in the maternity unit to help mothers and their newborns get home quicker. The initiative has helped cut discharge times from half-a-day to half-an-hour, helping reduce transfer time between the delivery suite to postnatal ward as well as freeing up bed space.
- 8.2 A portable scanner is now being used to check the condition of patients' livers. The fibroscan helps detect early signs of disease offering same day results, whereas traditional ultrasound elastography takes eight weeks from referral to results. The hepatology service has now hired two fibroscans and trained its own staff, saving time and money as the equipment does not require a radiologist to operate it.
- 8.3 Luxmi Dhoonmoon, a nurse at Northwick Park Hospital, is believed to be the first in the world to highlight the importance of using skin tone cards to spot potential pressure ulcers.

A lack of awareness and potential sensitivities around querying skin tone discolouration meant the use had gone unnoticed. But now news of the cards has reached as far afield as Australia where doctors say it could provide huge benefits in treating Aboriginal patients. The skin tone card can also be adapted to help identify early-stage cellulitis, a painful bacterial skin infection.

9. Stakeholder engagement

- 9.1 Chris Hopson, Chief Strategy Officer NHSE, visited Northwick Park Hospital on the 27 September for an interactive visit with our senior leaders, one-to-ones with frontline staff and a tour of several services.
- 9.2 Cllr Ketan Sheth, Chair of the North West London Joint Health Overview and Scrutiny attended the official opening of our new Acute Medical Unit at Northwick Park Hospital.
- 9.3 Dawn Butler MP attended the official opening St. Mark's at Central Middlesex in August.
- 9.4 In June we welcomed a delegation from the Royal College of Surgeons of England to LNWH. This included visits to the Elective Orthopaedic Centre and St. Mark's Hospital at the Central Middlesex site, and the new North West London Breast and Urology centre at Northwick Park Hospital. President Tim Mitchell, who is also an ENT surgeon, also met with maxillofacial and ENT teams and trainees.
- 9.4 In August we wrote to all GP practices in Brent, Ealing and Harrow to advise them on referrals to the new Ealing Community Diagnostic Centre (CDC). Key staff also provided information at our monthly GP update meeting. Further information and advice were provided in September, and details of the CDC were placed in the ICB's weekly GP bulletin.

10. Recognition and celebrating success

- 10.1 Retired theatre matron Rose Amankwaah has won a Long Service Recognition Award at the annual Black Healthcare Awards. Rose, who clocked up an impressive 49 years at Central Middlesex Hospital, received her award at a gala event in London's West End.

Rose has also been shortlisted for a Lifetime Achievement Award in the NHS Parliamentary Awards, having been nominated by Bob Blackman CBE MP.

- 10.2 Also at the Black Healthcare Awards, Sala Abdalla (Gen Surg) was shortlisted for the 'Clinical Excellence Award for Consultants' and Ben Jackson (Cardiac Cath lab Superintendent Radiographer) was shortlisted for the 'Allied Health Professional Award'.
- 10.3 Kevin Reyes has won a Cavell Star award. These are national awards given to staff who show exceptional levels of care.

- 10.4 Our Head of Safeguarding, Ludmila Ibesaine has received the national NHS Safeguarding Star award in recognition of her outstanding commitment to protecting others.
- 10.5 Nurses Maria Sarroza, and Intisar Ibrahim who have been shortlisted in the Practice Educator of the Year and Preceptor of the Year categories of the Nursing Times Workforce Awards. We wish them the best of luck.
- 10.6 TV celebrity Amanda Holden has publicly praised the work of staff at Northwick Park after her daughter was treated at the hospital. Amanda, who hosted our annual staff excellence awards last year, gave tickets for the Britain's Got Talent TV show to the nurses and team who looked after her daughter.

North West London Acute Provider Collaborative
London North West University Healthcare NHS Trust Standing
Committee report to the Board in Common – for noting
October 2024

Highlight Report

1. Purpose and Introduction

1.1 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

- The Committee received and discussed a range of statutory Annual Reports which had been scrutinised and approved at local Committee's as follows:-
 - Complaints Annual Report 2023/24
 - Health and Safety Annual Report 2023/24
 - Safeguarding Annual Report 2023/24
 - Infection Prevention and Control Annual Report 2023/24

All of the above reports are now published and available on the London North West University Healthcare NHS Trust website fulfilling public transparency requirements.

- The Committee received and discussed the Board Assurance Framework with local Committees providing assurance on the management of strategic risks to which they are aligned. This included an overview of assurance as to the system of control of the Board Assurance Framework via the Audit and Risk Committee. There had been no increase in risk scores during the quarter and two strategic risk scores had reduced following the effective implementation of additional controls. The Board Assurance Framework is published and available on the London North West University Healthcare NHS Trust website fulfilling public transparency requirements.
- Escalation reports were presented by each of the local Committee Non-executive Director Chairs providing assurance on the delivery of delegated duties and responsibilities during Quarter 2 of the year. This included assurance from:-
 - Audit and Risk Committee
 - Finance and Performance Committee
 - Quality and Safety Committee
 - People Equity and Inclusion Committee
 - Board Appointments and Remuneration Committee
- The Committee received and considered the integrated quality and performance report and the finance report.

3. Positive Assurances Received

The Committee received positive assurance in the following areas:

- Strategic risks are being appropriately governed through the Local Committee Structure
- Maternity services – a green rating has been achieved for maternity metrics held within the maternity data set
- National Maternity Safety Programme – positive improvements were evident in relation to the provision of maternity services and a meeting with NHS England is scheduled in late November 2024 to determine whether the Trust is in a position whereby it can exit the programme
- The Trust has achieved the London Living Wage status
- The Trust's Head of Safeguarding has attained a national award in recognition of her leading work on Domestic Abuse

4. Key Risks to Escalate

- A continued system wide focus is required to respond to a risk that the volume of acutely unwell patients with complex mental health needs attending the emergency department is impacting on patient outcomes and patient flow, alongside staff and patient experience.
- There is a financial challenge to recover the in-year financial position. Detailed work is taking place to ensure that all opportunities for recovery are fully exploited and as part of these measures the Finance and Performance Committee will temporarily increase its meeting frequency to monthly.

5. Concerns Outstanding

None further to issues raised above.

6. Key Actions Commissioned

- Board development session to take place to refresh the Trust's Risk Appetite and Risk Tolerance statements and associated levels.

7. Decisions Made

The Committee resolved to receive a report on the future of the Griffin Institute at its meeting in December 2024.

8. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Complaints Annual Report 23/24	Noting	7.	Chief Executive's Report	Noting
2.	Safeguarding Annual Report 23/24	Noting	8.	Board Assurance Framework	Assurance

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
3.	Infection Prevention and Control Annual Report 23/24	Noting	9.	Integrated Quality and Performance Report	Noting
4.	Health and Safety Annual Report 23/24	Noting	10.	Financial Report	Noting
5.	Griffin Institute	Noting			
6.	Committee Escalation Reports	Assurance			

9. Attendance

Members:	September attendance
Matthew Swindells, LNWH Chair and Chair in Common on NWL APC	Y
David Moss, Non-Executive Director Vice Chair	Y
Loy Lobo, Non-Executive Director	Y
Simon Morris, Non-Executive Director	Y
Ajay Mehta, Non-Executive Director	Y
Dr Syed Mohinuddin, Non-Executive Director	Y
Bob Alexander, Non-Executive Director	Y
Martin Lupton, Non-Executive Director	Y
Baljit Ubhey, Non-Executive Director	Y
Sim Scavazza, Non-Executive Director	N
Huda Assad, Associate Non-Executive Director	Y
Pippa Nightingale, Chief Executive	Y
Simon Crawford, Deputy Chief Executive	Y
Lisa Knight, Chief Nursing Officer	Y
Jonathan Reid, Chief Financial Officer	Y
James Walters, Chief Operating Officer	Y
Tracey Connage, Chief People Officer	Y
Dawn Clift, Director of Corporate Affairs	Y
James Biggin-Lamming, Director of Transformation	Y
John Baker, Chief Medical Officer	N
Tracey Beck, Director of Communications	N
Attendees:	
Jon Lewin, Deputy Medical Director	Y
Alexia Pipe, Chief of Staff to Chair in Common	Y

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

Accountable director: Patricia Wright
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

- 1.1 As mentioned in my previous report, the Trust has been undergoing a series of inspections by the CQC. The CQC carried out inspection for the Urgent and Emergency Care and the Surgical Care core services at Hillingdon and Mount Vernon in July and August 2024.
- 1.2 On 7 August 2024 the Trust received some high level feedback from the Hillingdon inspection, where some immediate concerns were highlighted. We have taken a programmatic approach to respond to these concerns to improve, and embed systems and processes that ensure high quality care and are feeding back regularly on our progress to the Board and to the CQC.
- 1.3 Between the 24 -26 September 2024 the Trust underwent a 'Well-Led' inspection, with subsequent interviews with leadership teams and individuals. This process will continue until 15 October 2024.
- 1.4 On 27 September 2024 the Trust received some high-level feedback from the Mount Vernon inspection. This was largely positive with some suggested areas for improvement that we are actively seeking to address.
- 1.5 I would like to thank all staff involved in what has been an intensive process. We expect a draft report to be received mid-late November 2024 and a final report published before the end of the calendar year.
- 1.6 We have commenced our staff seasonal flu and covid vaccination, and all staff are encouraged to take up the vaccination service as we enter the winter period.
- 1.7 The Trust financial position remains challenging and additional grip and control measures have been initiated to recover expenditure run rates which are in excess of plan as per section 4 of this report.

2. Quality and Safety

- 2.1 On the 15 October 2024 the Trust will launch the Martha's Rule 'Call for Concern' initiative. Martha's rule is a patient safety service available round the clock that gives patients the right to an urgent review. Martha's rule will guarantee an urgent clinical

review (from a member of the critical care outreach team or a senior clinician not part of the treating clinical team) when a patient is deteriorating but the patient or family feel no one is listening.

2.2 In response to the immediate concerns raised by the CQC following their inspection of the Emergency pathway and Surgical Assessment Unit in August 2024, the Trust has put in place more robust processes to address their concerns and has provided the CQC with evidence to support this.

2.3 As per my previous report the Maternity and Neonatal Improvement Programme (MNIP) and Maternity and Neonatal Assurance Group (MNAG) is continuing to drive actions to improve care in our Maternity and Neonatal services, and this is overseen by the Quality and Safety Committee.

2.4 Overall quality metrics continue to demonstrate safe and effective care and this is evidenced in the Integrated Quality and Performance Report (IQPR) attached separately. However, the Trust is not complacent about the need to continue to evidence improvements in care.

3. Operational performance

3.1 The Trust outperformed elective activity targets in August achieving 121% total activity (of 23/24 baseline) against a planned target of 110.4%.

3.2 We are performing best in NWL Acute Provider Collaborative (APC) for the percentage of patients having their diagnostic tests/procedures within 6 weeks of referral. In August 88.6% of all patients at the Trust were seen in 6 weeks for their diagnostic procedure.

3.3 We are the best performing Trust in the NWL APC for Reducing the Long Waiting Patient List. At the end of August the Trust had - 0 x 78 week waiters (ww) making us the best in sector for reducing patient waits for elective care. The Trust had 9 x 65ww at August 2024 end and the Trust has set the ambitious internal target to achieve 0 x 52ww by 31 December 2024.

3.4 The Trust achieved 82.1% theatre utilisation, continually outperforming peers and remaining consistently in the top quartile nationally and above 80% in model hospital data (national comparator database).

3.5 Faster Diagnosis Standard for Cancer Outperforming Target:
The Trust achieved 80.5% against the Faster Diagnosis Standard (FDS) for Cancer performance for July 2024 and has now achieved FDS performance 6 months in a row.

3.6 A&E 'all types' performance was 71.8% in August, meaning our patients are waiting too long to receive treatment in the department. There is trust-wide focus on monitoring and supporting the Emergency Department performance, alongside managing increasing demand for the service.

4. Financial performance

4.1 At Month 5 (August 2024) the Trust is reporting a significant year-to-date adverse variance to plan of £14.79m. This is measured against the initial plan submitted by the Trust as part of the annual planning process. A revised plan has since been created with more detailed profiling of items such as savings, which is used for budget level analysis. The Trust is £12.7m adverse to this budget.

4.2 Key drivers behind the Trusts position are; increased emergency activity preventing closure of winter escalation beds, medical staffing to support additional activity, an increase in pathology & radiology (diagnostic) testing and under-recovery of elective income. In addition, the Trust is receiving less income than planned in some areas due to ongoing negotiations with NHSE and reduced non-NWL activity.

4.3 Due to the Trusts year to date deficit, additional grip and control measures have been initiated to recover expenditure run rates which are in excess of plan. Despite initial signs in Month 4 these were having a positive impact, this has not continued into month 5 leading to further actions being required.

5. People

5.1 The Trust has introduced a Pregnancy and Baby Loss People Policy, to provide support during a very difficult time for colleagues, and to help managers support those affected. We have also updated our Managing Flexible Working Policy, to help ensure we meet both the needs of the Trust and our staff supported by a training package for managers to facilitate implementation.

5.2 Staff Support forums held in late summer have provided a wealth of information and feedback about issues affecting staff welfare and their ability to provide safe, high quality care. We are working through the findings and putting into place actions to address them in line with our People plan.

5.3 National Inclusion Week (23-29 September 2024) was marked with a busy programme of events, including the publication of a webinar held by me, and Phil Spivey, Chief People Officer.

5.4 Starting towards the end of October 2024, Dr Sriram Thillainayagam will cover the Divisional Clinical Director role for Unplanned Care whilst Dr Louise McCusker is away from the Trust on maternity leave.

5.5 In September 2024 we said goodbye to our Chief Finance Officer - Jon Bell and welcomed Tracey Cotterill as our Interim Chief Finance Officer. Tracey has held a number of senior financial management roles in the public and private sector.

5.6 At the end of September 2024, we said goodbye to our Vice Chair – Catherine Jervis and welcomed Carolyn Downs as our new Vice Chair. Carolyn is a recently retired chief executive of the London Borough of Brent and was previously chief executive of the

Local Government Association. Prior to that, she was deputy permanent secretary in the Ministry of Justice, chief executive of the Legal Services Commission and chief executive of Shropshire County Council. She has worked in local government in numerous councils for almost 40 years.

5.7 I would like to thank both Jon and Catherine for their dedicated services to the Trust and wish them both well for the future.

6. Hillingdon Hospital Redevelopment

6.1 The Trust is awaiting the outcome of the government review of the National Hospitals Programme which should be announced in November 2024. In the meantime the Trust is progressing work on the Decant and Enable programme to clear the site for the new hospital and continues to deliver against the communications and engagement plan. This has included engagement with local people on the new hospital plans by running stalls at the Colne Union PCN Roadshow (31 July 2024) and the Hillingdon Family Play Day (7 August 2024) and refreshing the stakeholder and meetings activity within the overarching communications plan. The next period will include the release of an updated set of digital videos of staff and people across the borough making the case for a new hospital, a press release marking the start of works to refurbish The Furze, and engagement events in local schools.

7. Updates from the Council of Governors (CoG)

7.1 On 16 September 2024, we briefed our governors on the new CQC inspections framework, recent inspections at the Hillingdon and Mount Vernon site, as well as the Well-Led inspection process and how we are preparing for this. We also shared some concerns raised by the CQC in respect of the Hillingdon site inspection and our programmatic response to address these issues.

7.2 On 17 September 2024, we held our Annual Members meeting where we shared key information about the Trusts performance, achievements and challenges in 2023/24 and looked ahead into 2024/25.

8. Research and innovation

8.1 The Urology team have started working with the Rezum package, an innovative way to treat prostatic hyperplasia. It is hoped this less invasive form of treatment will greatly improve surgical outcomes for hundreds of men every year.

8.3 Since July 2024 we have been using the DrDoctor online platform to send appointment letters to our patients. The plan is to have all four Trusts in the NW London (NWL) Acute Provider Collaborative using the system, which will help us provide a more consistent patient experience across NWL.

8.4 I am delighted to announce that our Trust became the first trust in NWL to transition over to the NHS Federated Data Platform (FDP). This is a significant milestone as the FDP will help us to rapidly connect and access data, free up vital clinical time and ultimately deliver more efficient, faster and safe care for our patients. The FDP will continue to improve patient care by bringing together the information needed to plan and deliver care and reduce the administrative burden on staff. Pilot sites like ours have seen list sizes reduce and waiting times fall, meaning patients are treated faster.

8.5 The Estates and Facilities department, in partnership with the Brunel Business school, have secured funding to support the development of a bespoke leadership training programme (Knowledge Transfer Partnership (KTP)). This will support a 26 month programme aimed at introducing and embedding an Innovation Leadership Culture throughout Estates & Facilities with a particular focus on digital innovation.

9. Stakeholder engagement

9.1 We were delighted to welcome Danny Beales the new MP for Uxbridge and South Ruislip, whose constituency includes Hillingdon Hospital, in July. He met the senior leadership team and colleagues from the Redevelopment Team.

9.3 We have partnered with the Hubs Mobility Service to boost our accessible travel offering to patients with additional needs. Patients who might need to visit one of our hospitals regularly and could benefit from alternatives to driving or being driven - but who might need extra help using public transport – can now access the service.

10. Recognition and celebrating success

10.1 Ranjit Kooner (CNIO) was one of only three people nationally shortlisted for the Chief Nursing Innovation Officer of the Year Award at the Digital Health Networks Awards in July, in recognition of her work to implement the Cerner patient record platform at our Trust.

10.2. Daniels Ward passed an important milestone in July 2024 – the tenth anniversary of its founding. Colleagues gathered in the garden of this vitally important rehabilitation ward at Hillingdon Hospital, alongside some of the patients who have been treated there and their families.

10.3 October is Black History Month, which aims to highlight the untold stories and histories of Black people in the UK. We have a month of events planned around the Trust to mark the occasion.

10.3 Our annual Staff Awards took place at Brunel University London in early September. The evening gave us the opportunity to recognise and honour staff who live our CARES Values and who have been shining examples of delivering outstanding care or performance in their role.

The Hillingdon Hospitals NHS Foundation Trust

Trust Standing Committee report to the North West London Acute Provider Collaborative Board in Common (BiC) – for discussion 15 October 2024

Highlight Report

1. Purpose and Introduction

1.1 The role of The Hillingdon Hospitals NHS Foundation Trust Standing Committee is:-

- 1.1.1 To oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust Board that Trust risks and issues relating to this are being managed.

2. Key highlights from the Trust Standing Committee

2.1 Annual Reports

The Committee noted the following annual reports highlighting that they had been discussed in detail at the relevant sub-committees of the Board.

- The Annual Patient Experience & Engagement Report providing a review of the Trusts activity during 2023/24 in relation to patient experience and engagement and demonstrated how feedback has provided opportunities for learning and service development and highlighted specific developments for delivery in 2024/25. The Committee discussed the differential in complaints upheld and the need to understand whether the increase relates to greater transparency or an underlying issue an update will be provided at the next meeting following review by the Quality and Safety Committee (QSC).
- The Annual Safeguarding Report outlining the activity of the safeguarding service over 2023/24. The report shows ongoing growth in both childrens and adults safeguarding, highlighting the challenges related to the move to Cerner EPR. The report provides assurance around the Trusts MCA and DoLs compliance, mental health activity and learning disabilities care. The Committee discussed the increase in Mental health patients and the ongoing discussions and the escalation to the ICB.
- The Health & Safety Annual Report provides the Committee with a summary of the Trusts health and safety activities in 2023/24 and provided a summary of the areas of focus for the next financial year. The Committee noted the rise in datix incidents related to aggression to staff, the Committee were advised that training is in place with staff and that the wider APC are working together on solutions. The use of bodycams for staff was discussed and further work will be undertaken to implement their use in specific high incident areas around the Trust.

- The Freedom to Speak Up Annual Report demonstrates work undertaken by the FTSU Guardian during the reporting period 2023/24, and the work in striving to shift the dial on making raising concerns and speaking up business as usual and removing barriers to speaking up. The Committee discussed the doubling of freedom to speak up concerns and discussed a possible correlation between these and complaints. The committee recognised that greater visibility, accessibility and awareness has contributed to rise in reported issues.

2.2 CEO Report

The Committee noted the CEO report, key highlights and messages. The CEOs full report will be provided in the Board in Common papers.

2.3 Board Committee Report and IQPR update – Quality & Safety

Highlights provided included:-

- Progress on the CQC high level feedback and other CQC inspection areas.
- There has been an issue in the reporting of Sepsis which is now rectified and the Chief Medical Officer (CMO) provided assurance that the right treatment is being administered to patients. A further report will be provided at the next QSC meeting.
- The committee raised the issue of the overdue SIs highlighted in the IQPR. The CMO reported that these have now been cleared and work underway to reduce the After Action Reviews (AARs).

2.4 Board Committee Report and IQPR update – People

Highlights provided included:-

- The People Strategy progress report including EDI was presented to the People Committee, the team have continued to progress a range of actions in all four pillars and have outlined where areas are behind plan, the expectation is to recover position by the end of quarter 4. A bi-annual review of both the people plan and the EDI action plan will be undertaken at the end of September 2024.
- A review of the GMC National Trainee survey results was discussed noting significant improvement in the national training survey results. There has been a reduction in self-reports, and the removal of the GMC enhanced monitoring from AMU.
- PDRs have continued to be an area of focus, it was however reported that current rates are 92.75% and therefore much improved.

2.5 Board Committee Report and IQPR update – Finance & Performance

Highlights provided included:-

- At M5, the Trust is reporting a position of £14.8m adverse to our plan, £12.7 adverse to our internal budget (realigned for CIP delivery)

- The negative areas of the Trusts financial performance as at month 5 are reductions in income due to a dispute on contractual income levels with NHS England, reduced chargeable activities (outside of North West London), alongside increased run rate in costs for medical wards including escalation beds, a run-rate in RMNs higher than plan, increased costs in Pathology and CIP underachievement.
- The current financial pressure was highlighted and the Committee agreed to have further discussion prior to the next Board in Common.

2.6 Maternity Improvement Plan Update

The Maternity Neonatal Assurance Group (MNAG) provided an update it was noted that progress around some of the CQC actions has not been as fast as expected. The Chief Nurse and Chief Medical Officer are reviewing this to ensure consistent traction, and this will be reported at the next QSC.

2.7 Annual Plan

The Committee reviewed the 6-month update, April to September 2024, against the metrics agreed as part of the 2024/25 annual plan, providing oversight and assurance on delivery progress. Each metric is aligned with one of the Trust's six strategic objectives and is linked with key areas of focus and delivery for the Trust during the course of the year.

2.8 Board Committee Report – Audit & Risk

Highlights provided included:-

- The committee has instituted a cycle of deep dive reviews of all the board committees on a cycle with particular focus around key areas of risk linked to the board assurance framework (BAF) and corporate risk register.
- The committee received significant assurance around cyber security and agreed to reduce the BAF cyber security risk(7b) and will undertake a deep dive into business continuity at a future meeting.
- The committee discussed the write-off of some aged overseas debt noting that aged debtor management was integral to cash requests to NHSE. The committee supported in principle to recommend to standing committee the write-off and would agree the final amount with the CFO after further analysis had been undertaken. Efforts will continue to recover the debt.
- The committee noted that a number of cases were concluded with NFA and discussed underlying HR and cultural aspects of some of the issues highlighted and will seek assurance that these are triangulated with the People Committee.

2.9 Board Assurance Framework Q4 2023/24

The Committee received the Board Assurance Framework (BAF) and note the update on the Trusts Board Assurance Framework Risks and Corporate Risks (scoring 12 and above) for Quarter 1 2024/25.

Highlighting:-

- New Risk 2a - EDI Plan is not delivered
- Note the reduction to risk 7b in relation cyber security (from 15 to 10) as discussed and agreed at the September Audit and Risk Committee.

2.10 Update on partnership development of Chelsea and Westminster NHS FT and The Hillingdon Hospitals Trust NHS FT

The Committee considered the proposal for closer alignment between the Trusts and approved the recommendation of the NWL APC BiC Cabinet.

3. Positive assurances received

- 3.1 Good performance across a number of areas within the IQPR as per section 2.3, with actions in place to ensure sustainable improvements in A&E Performance.

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

- 4.1 The Trusts worsening financial position, covered in the BIC Finance report.

5. Concerns outstanding

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

6. Key actions commissioned

- 6.1 Undertake a review of complaints to understand the increase in numbers and the differential number upheld assigned to the Quality & Safety Committee.
- 6.2 Develop a heat map to visualize the matrix of complaints data, Freedom to speak up data, PALs and any other relevant reporting data assigned to the People Committee.
- 6.3 The Committee will create and conduct a cost analysis for the implementation of body cameras across relevant staff areas.
- 6.4 Report back on how changes in maternity services are being embedded, focusing on culture change and leadership development.
- 6.5 A special meeting will be scheduled to discuss the financial performance prior to the next Board in Common.

7. Decisions made

The Committee recommended the approval of the proposal for closer alignment between the Trusts to the NWL APC BiC.

8. Summary Agenda 09 October 2024

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Patient Experience Annual Report	To note	8.	Board Committee report & IQPR – People	To discuss
2.	Safeguarding Annual Report	To note	8.	Board Committee report & IQPR – Finance & Performance	To discuss
3.	Health and Safety Annual Report	To note	9.	Maternity Improvement Update	To discuss
4.	Freedom to Speak Up Annual Report	To note	10.	Regulatory Update	To discuss
5.	Chief Executive's report	To discuss	11.	Annual Plan 2024/25 progress	To discuss
6.	Integrated Quality and Performance Report	To discuss	12.	Board committee report – Audit	For assurance
7.	Board Committee report & IQPR – Quality & Safety	To discuss	13.	Board Assurance Framework	For assurance
			14.	Update on partnership development of CWFT and THHFT	For discussion

9. Attendance

Members	3 rd July 2024 attendance
Carolyn Downs, Vice Chair (Standing Committee Chair)	Y
Matthew Swindells, Chair – North West London Acute Provider Collaborative	Y
Baljit Ubhey, Non-Executive Director	N
Linda Burke, Non-Executive Director	Y
Martin Lupton, Non-Executive Director	Y
Nick Gash, Non-Executive Director	Y
Patricia Gallan, Non-Executive Director	Y
Simon Morris, Non-Executive Director	Y
Steve Gill, Non-Executive Director	Y
Vineeta Manchanda, Non-Executive Director	Y
Patricia Wright, Chief Executive Officer	Y
Jason Seez, Deputy Chief Executive Officer, SRO New Hillingdon Hospital Programme	Y
Alan McGlennan, Chief Medical Officer	Y
Tracey Cotterill, Chief Finance Officer	Y
Sarah Burton, Chief Nursing Officer	Y
Tina Benson, Chief Operating Officer	Y
In attendance	
Janet Campbell, Associate Non-Executive Director	Y
Philip Spivey, Chief People Officer	Y
Steve Wedgwood, Director of Operational Estates and Facilities	Y
Gavin Newby, Deputy Chief Finance Officer	N
Lesley Watts, CEO Chelsea and Westminster Hospital NHS Foundation Trust	N
Vikas Sharma, Trust Secretary	Y

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

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

1 Key messages

- 1.1 I'd like to welcome Dame Helen Stephenson as our new Imperial College Healthcare NHS Trust Non-Executive Director (NED). Helen is an experienced NED and CEO with a strong track record in the public and voluntary sector. She has recently retired as the Chief Executive of The Charity Commission for England and Wales. Thank you to Carolyn Downs, who is moving to become a Vice Chair at The Hillingdon Hospitals NHS FT, for all her work and insight as a NED for Imperial College Healthcare.
- 1.2 Operationally, we continue to have some of the fastest ambulance handover times in London, performing at 96.8 per cent against the 30 minute handover standard in August 2024. We met the national target for 78 per cent of patients waiting less than four hours in the emergency department (achieving 78.6 per cent in August). We are working to reduce our long waiters, with 4 patients waiting over 78 weeks, 650 waiting 65 weeks and 3,479 waiting over 52 weeks at the end of August. We are working to recover our diagnostic performance (19.1 per cent of patients waited over six weeks for a diagnostic test at the end of August against a target of 5 per cent), which is largely due to issues with ageing equipment.
- 1.3 Financially, at the end of August, we reported a year-to-date deficit of £21.9m which is £19.5m adverse to plan. We have plans in place to recover our position and so continue to forecast that we will deliver our break even plan for the end of the financial year.
- 1.4 We launched a design competition with the Royal Institute of British Architects to appoint an architect to design the new Fleming Centre building proposed for St Mary's Hospital, which attracted 46 bids. A short-list of five architects are now competing to be selected. The competition will complete in December. The Fleming Business case has been approved by the Trust and is now with NHS England. The Fleming Centre will see scientists work alongside clinicians, patients, members of the public and policy makers to scope, test and scale solutions to the problems created by anti-microbial resistance. Due to open in 2028, it will be the first new building to open at St Mary's as part of the planned redevelopment of the whole hospital site over the next decade.
- 1.5 We welcome the Government's review of the National Hospital Programme (NHP) to get clarity on the funding and approval process. We hope to be able to progress work as soon as possible on the next stage of planning and design for a new St Mary's. We are able to continue to develop first-stage business cases for our Charing Cross and Hammersmith schemes. The urgency for redevelopment is growing, with continuing estates issues affecting our operational capabilities despite significant spending on backlog maintenance. Most recently, this has included the temporary closure of a section of the Mint Wing at St Mary's in order to carry out essential structural maintenance work.

- 1.6 In July, we were awarded the prestigious Pathway to Excellence designation for nursing at the Charing Cross Hospital site, following a 12-month assessment by the American Nurses Credentialing Centre. Pathway to Excellence is an international programme to recognise hospitals which demonstrate a commitment to creating a positive practice environment where nurses excel. Our work has included the introduction of shared-decision councils, which have helped staff make improvements in their work areas, and a renewed focus on staff wellbeing. We are the first acute hospital in London and within the Shelford Group to gain this international recognition. We will now build on this achievement by extending the approach to all our other hospitals.
- 1.7 Our review of our cancer pathways, to make sure our care is as patient-centred and joined-up as possible, is progressing well. With increasing and more complex needs, services are feeling stretched and patients and families don't always feel fully supported. We have mapped pathways for several tumour groups with 100 staff and have gathered insights from patients and their families about cancer care. The diagnostic phase and associated recommendations are due to report in October to the Trust executive.
- 1.8 In August, we launched a new care pathway to help inpatients to stop smoking. It involves recording all inpatients' smoking status on their electronic record and referring those who smoke to a newly recruited team of health improvement advisors for nicotine replacement therapy and support. The advisors work with ward teams as well as patients to provide tailored support and advice.
- 1.9 We are refreshing our approach to improvement across the trust with 'Improvement for All'. In August, I formally launched this new approach for nine clinical 'pathfinder' areas. Each team is being coached by an improvement lead to deliver a single improvement plan and prioritise key improvement initiatives. Teams have begun to adapt their local operational and clinical routines accordingly, for example repurposing retrospective performance review meetings into improvement huddles generating and testing ideas to improve. Staff have positive feedback and feel they have the permission and time to test change ideas.
- 1.10 We held our annual Gratitude week in September, with an extensive programme of activities and treats to say thank you to staff and to promote our support offers and opportunities to get involved. We timed Gratitude to coincide with National Inclusion Week, and the launch of our anti-racism and anti-discrimination commitments, developed through extensive engagement with staff and local community groups.

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 and our focus on encouraging colleagues to speak up, and harm levels are well below national averages. We have seen a small recent increase in reporting of complications following invasive procedures and delayed/missed diagnosis. An analysis of these incidents confirmed that most will feed in to existing safety improvement workstreams, but we have specific work to do to improve how test results are endorsed by clinicians and how specialty morbidity and mortality meetings are functioning.
- 2.2 Preventing hospital acquired infections continues to be a priority with challenges in meeting nationally set targets. Data comparison across the Shelford group trusts shows good performance except for MRSA bacteraemia, where we have seen an increase in numbers

this financial year. We are making good progress with our hand hygiene improvement programme, monthly audit data is showing an increase in compliance in general, the focus is now on supporting medical staff improvement. We have now agreed additional plans to improve MRSA screening and invasive line care to support associated bacteraemia reduction plans. The IPC quality review process with divisions remains in place to ensure progress continues.

- 2.3 We are making good progress embedding the changes required to meet the standards of the patient safety incident reporting framework (PSIRF) since full launch in April 2024. As we learn the processes, there are some delays in report completion. Divisions are working to identify time for clinical investigators, and we continue to provide support and training for teams to gain confidence and experience in the new methodology. The work we are leading on patient centred safety with our patient safety partners is being presented at a national patient safety conference in September.
- 2.4 Along with all trusts in the NWL acute provider collaborative (APC), we have been successful in securing funding from NHS England as part of 143 pilot sites to develop and agree a standardised approach to all three elements of Martha's Rule, ahead of scale up to the remaining sites in England in the following year. We have had components one and two in place since January 2024, with 24/7 adult and paediatric critical care outreach services and the 'Call for concern' service to empower patients and families in recognising and reporting deterioration. We are working with Imperial College London and the patient safety research collaboration (PSRC) to develop a robust approach to the third component – implementing a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily.
- 2.5 Our maternity and neonatal services continue to be very busy, with activity above plan. Additional funding has been approved to recruit new obstetric consultant posts and weekend clinics continue at Queen Charlotte's & Chelsea Hospital to help meet demand. We continue to focus on delivering key national and local schemes to improve patient safety, quality and experience. User feedback is showing the pressure that activity is having on experience, and we are planning improvements. We are currently meeting the requirements for eight out of ten of the safety actions for CNST (Clinical Negligence Scheme for Trusts) MIS (maternity incentive scheme) year 6, with plans in place to achieve the remaining two and no anticipated risks to delivery at present.
- 2.6 NHS Blood and Transplant, who are responsible for the national management of blood supplies, called a National Amber Alert for O positive and O negative red blood cells on 25 July 2024. In response, our Clinical Reference Group agreed a number of additional actions to manage the use of O blood stocks while we wait for levels to increase, to avoid any impact on urgent and emergency surgery. So far our teams are managing the shortage effectively and there have been no significant issues.

3 Operational performance

- 3.1 We continue to have some of the fastest ambulance handover times in London. Our August 2024 performance against the 30 minute handover standard was 96.8 per cent and we achieved 99.4 per cent against the London wide standard for handovers within 45 minutes. In August 2024, 78.6 per cent of patients were admitted, transferred or discharged from the emergency department within four hours, exceeding our improvement trajectory and meeting the national target of 78 per cent. We are working to

implement various improvements to ensure we consistently meet the national four-hour performance target of 78 per cent and to improve on it where possible.

- 3.2 Our overall referral to treatment waiting list was 95,672 at the end of August 2024, a decrease on the previous month and ten per cent lower than its peak in August 2023. 44 patients had been waiting over 78 weeks, 650 waiting 65 weeks and 3,479 waiting over 52 weeks. This position has been affected by industrial action and we are exploring many solutions to reduce long waits such as additional theatre capacity, mutual aid support from the sector, and weekend lists.
- 3.3 19.1 per cent of patients were waiting over six weeks for their diagnostic test at the end of August 2024 (against a 5 percent target). There are some specialties with excellent performance such as endoscopy who are consistently achieving less than 1 per cent of patients waiting over six weeks. We are focusing on challenged areas including MRI, neurophysiology and echocardiography, where issues include ageing equipment. Recovery plans to increase activity in the challenged areas were agreed by the executive management board in August 2024. We anticipate this will lead to a positive improvement in our diagnostic performance in the coming months and we are developing a longer term plan to manage demand.
- 3.4 In terms of cancer performance, we are meeting the faster diagnostic standard of at least 77 per cent of patients given a positive or negative cancer diagnosis within 28 days of referral (at 84.7 per cent in July 2024). We met the national standard for 96 per cent of patients to receive treatment within 31 days from decision to treat (our performance was 96.8 per cent in July 2024), with notable improvements seen in prostate treatment delays over recent months. 74.5 per cent of cancer patients had under 62 days between referral and starting treatment, meeting the national NHS objective of 70 per cent for 2024/25 but falling below our more ambitious improvement trajectory target.

4 Financial performance

- 4.1 At the end of August 2024, the Trust was £19.5m adverse to plan with a year-to-date deficit of £21.9m. Although, there was continued good performance on income with elective activity year to date equating to 114.1 per cent of pre-pandemic activity, August performance dipped to 107.8 per cent representing a £1.9m shortfall against plan. The drivers of the deficit include under achievement of the planned system wide benefits, as well as lower than planned delivery of efficiencies (year to date equally phased target £26.3m versus the £17.6m transacted). Given the current deficit position, the Trust has developed a financial recovery plan that should lead to the achievement of a breakeven position, our original plan.
- 4.2 Year to date the Trust has incurred £27.5m of total capital spend. This is £5m ahead of plan and continues to represent an acceleration of the backlog maintenance planned for the financial year. This is a timing issue only and does not at present alter the full year forecast.
- 4.3 At the 31 August 2024 the Trust had a cash balance of £110.6m. This reflects a reduction of £26.1m from the start of the year, with the key drivers being timings in operating cash flows and the current deficit position.

5 Workforce update

- 5.1 August saw the launch of a new Trust recognition approach, with summer events including our Long service awards and our Make a Difference winners' lunch. September events include Gratitude week.
- 5.2 Work continues to use the results from the 2023 Staff Survey to drive improvements across the Trust. We launched the 2024 Staff Survey on 16 September and are running an 11 week campaign to hear from as many staff as possible. We got off to our best ever first-week response rate.
- 5.3 The largest rotation of doctors in training takes place in August each year. This year we coordinated the start or transfer of 661 doctors, a combination of 524 doctors in training and 137 locally employed doctors. As part of our programme to improve the working lives of doctors, a pay task and finish group was established with the main focus on improving on-boarding, monitoring of rota gaps and recruitment to locally employed doctor roles as well as ensuring pay arrangements are clear and appropriate support to new starters is in place. The feedback has been positive and learning will be used to inform future rotations. Also, to note, we are moving to use the new term adopted by the BMA and the government, 'resident doctors' instead of doctors in training or junior doctors.

EDI update

- 5.4 The Engaging for Equity and Inclusion programme has completed its second phase with over 1,250 staff, patients and community partners taking part in discussions about what it would mean for us to be truly fair and inclusive. The outputs from this are the Forward Together EDI Workforce Plan 2024-2027 and our Anti-Racist and Anti-Discrimination Commitments, in the form of organisational and individual commitments which were launched in National Inclusion and Gratitude week in the week commencing 23rd September.
- 5.5 Our Equality, Diversity and Inclusion reports are now interactive and have been shared across committees ahead of publication in October. We have seen improvements in our WRES and WDES results across 16 of 19 areas.

Senior leadership change

- 5.6 Kevin Jarrold has retired from his role as the joint chief information officer (CIO) for Imperial College Healthcare NHS Trust, and Chelsea and Westminster Hospital NHS Foundation Trust. He has done a fantastic job driving many improvements for us since he became CIO for Imperial College Healthcare in 2011 and will be much missed. Congratulations to Robbie Cline, who has been appointed into the new role of chief information officer (CIO) for the North West London Acute Provider Collaborative.
- 5.7 Matt Ayres has joined the Trust as hospital director for Charing Cross Hospital from 1 August. Matt has a wealth of experience from the healthcare and charity sectors and joined us from St George's.
- 5.8 In September, Stewart Cooper joined us as divisional director of operations for medicine and integrated care. Stewart has significant operational experience at local, regional and national level and joined us from Portsmouth University Hospitals NHS Trust.
- 5.9 Dr Andreas Raffel has been appointed as the new Chair of Imperial Health Charity. Previously a non-executive director for the Trust, and with a long track record in

leadership in health and education as well as a distinguished executive career in global finance, he has taken over from David Crundwell who has stepped down after eight years in the role.

- 5.10 Professor Mark Thursz has been appointed director of Imperial College Academic Health Science Centre (AHSC). Professor Thursz is a consultant in hepatology at the Trust, professor of hepatology at Imperial College London and director of NIHR Imperial Biomedical Research Centre.

Vaccination programme

- 5.11 The seasonal vaccination programme for healthcare workers starts on 3 October. Last year, rates were lower than we wanted, so our plan for this campaign involves a variety of different ways to access vaccination. This includes remobilising the peer and occupational health vaccinator models that were deployed pre-pandemic alongside pop-up events and roaming services. Site nurse practitioners will also provide vaccinations for staff working out of hours.

6 Green plan

- 6.1 We have completed our analysis of our NHS Carbon Footprint for 2023/24. This is the aspect of our carbon footprint that the Trust can directly control. Between 2019/20 and 2023/24 our NHS Carbon Footprint has come down by 17.3 per cent. Progress has been made across all the major NHS Carbon Footprint emissions sources, this includes estates decarbonisation where building energy emissions are down 14 per cent, anaesthetic gases where emissions are down 60 per cent, and waste where emissions are down 10 per cent.

7 Research and innovation

- 7.1 We are developing our strategic approach to AI, working with lay partners and staff to co-produce our approach to AI ensuring we are delivering the most benefit for patients and staff. Our focus includes delivering a governance approach for implementing new AI innovations in the trust and developing a few use cases for AI that will address some of our key problems. Two of the areas we are looking at as a priority is ambient AI for clinical documentation to support clinicians in writing structured notes from consultations, and exploring how we can utilise Microsoft's Copilot AI technology to support us with the everyday work around documents, virtual meetings and presentations.
- 7.2 Over 5,400 patients have signed up to the Imperial Healthcare Knowledge Bank (IHKB), a major BRC-funded initiative which is consenting Trust patients to be contacted for suitable research studies in future, to use their clinical data in a secure way, and to provide additional blood samples for analysis and storage for future research. This exceeds our target of 5,000 patients in the first year.
- 7.3 We have recruited 32,470 participants into NIHR Portfolio studies so far this year (this includes an online study which has recruited thousands of participants), from 234 individual studies (47 of these commercially sponsored) across 27 different specialties. Commercial trials recruitment continues to be healthy - NIHR data has demonstrated that the Trust delivered the highest number of "first European" and "first Global" recruits to commercial studies in the country in the previous period.
- 7.4 Pharmacy is a critical support service and has experienced recruitment challenges. We are reviewing our R&D pharmacy operational and financial model to ensure we can deliver more research, and also adapt to the new technologies coming along such as RNA vaccines and cell and gene therapies. We are also planning to replace some of our imaging equipment. These operational capacity challenges have impacted the time it takes us to

set up and open clinical research studies. Whilst the average time to issue internal approval for a study has increased from 36 to 68 days, this is still extremely competitive in the sector which is attractive for commercial sponsors. In addition, the Trust is delivering patient recruitment “to-time-and-target” in around 75 per cent of its studies. We aim to achieve 80 per cent by the end of the year.

7.5 Recent research highlights include:

- A [study](#) supported by the NIHR Imperial BRC, in partnership with other charity and industry funders, has found that a drug prescribed for diabetes and weight loss can reduce brain shrinkage in Alzheimer’s patients by almost 50 per cent.
- In the area of prevention, a study by NIHR Imperial BRC cancer researchers, published in [The Lancet Gastroenterology and Hepatology](#), reveals that a single flexible sigmoidoscopy screening (flexi-sig) can reduce the chance of developing bowel cancer by 24 per cent and the chance of dying from bowel cancer by 25 per cent, for up to 21 years after screening.

8 Estates and redevelopment update

8.1 Our third flagship staff lounge has opened on the ground floor of the QEQM building. It joins lounges already open at Charing Cross and Hammersmith hospitals and marks the conclusion of the £2.5 million staff spaces improvement programme supported by Imperial Health Charity. Alongside the lounge, we have refurbished the public café and made improvements to the kitchen to facilitate a wider range of food options for staff, patients and visitors.

8.2 We have opened a new outpatients department at Hammersmith Hospital, made possible by a £2.9 million investment from the Trust’s annual capital allocation. The new and fully refurbished department is located on the ground floor of Hammersmith Hospital (Zone C), in what used to be the vaccination centre and stored medical records before that.

8.3 The education centre at St Mary’s reopened in September following a full refurbishment and expansion to include Imperial College London’s medical school library. Renamed the Lord and Lady Paul Education Centre, in acknowledgement of the generous donation to support the works, it can be found on the second floor of the Mint Wing. Open to all Trust staff and Imperial College London Faculty of Medicine students, it has study desks, quiet spaces and newly refurbished meeting spaces that can be booked.

Redevelopment

8.4 The Government has confirmed its support for all the hospitals in the New Hospital Programme and has announced a review to “assess the appropriate schedule for delivery for schemes in the context of overall constraints to hospital building and wider health infrastructure priorities, while also looking at where improvements can be made.” The Government has said it will confirm the outcome of the review as part of its wider spending review process, expected to be included as part of the autumn statement.

8.5 We understand our business case for funding to begin RIBA 2 design and planning for our St Mary’s redevelopment has been approved by the DHSC and NHS England Joint Investment Sub Committee. It now requires ministerial sign-off. The design team is primed and ready to commence work as soon as approval is received. We have also submitted a funding request in line with our New Hospital Programme spending envelopes to continue the development of first-stage business cases and early design for our Charing Cross and Hammersmith hospital schemes.

- 8.6 We continue to make progress with Westminster City Council in agreeing our planning strategy for St Mary's. We are also in the final stages of appointing a development manager to support the master planning of the St Mary's site.

9 Stakeholder engagement and visits

- 9.1 Below is a summary of significant meetings I have had with stakeholders.
- Andy Slaughter (MP) and Ben Coleman (MP), 24 July 2024
 - Hammersmith and Fulham Save our NHS and other north west London campaign groups, 5 August 2024
 - Rachel Blake (MP) and Joe Powell (MP), 8 August 2024
 - Georgia Gould (MP), 13 September 2024
 - Meeting with all our local MPs (Andy Slaughter MP, Ben Coleman MP, Rachel Blake MP, Joe Powell MP, Georgia Gould MP, Rupa Huq MP), 18 September 2024
- 9.2 On 11 July 2024, Minister for Veterans and People Alistair Carns OBE MC MP visited the Op RESTORE service hosted at St Mary's hospital to learn more about the care provided for veterans.
- 9.3 Feryal Clark MP, Minister for AI and digital government, visited Hammersmith Hospital on 20 August 2024, to find out more about artificial intelligence tools being researched and developed by clinicians and academics. I hosted the visit alongside Imperial College London's president, Professor Hugh Brady.
- 9.4 We are holding a Paddington Life Sciences Symposium on 9 October, which marks the first year of the Paddington Life Sciences partnership. Lord Patrick Vallance, Minister of State for Science, Research and Innovation, will be giving a keynote speech and there will be discussion and debate with NHS, academia, industry leaders and the voluntary sector.

10 APC clinical pathways project

- 10.1 The specialties I am responsible for as part of the APC clinical pathways work are: cancer, endoscopy, gastroenterology, imaging, neurology and stroke, cardiology and hepatology. Specialty general managers and clinical leaders have been meeting with their APC counterparts to discuss potential priority pathways. I have meetings with all the specialties at the start of October to agree priority pathways before they go to APC EMB for approval in November. Transformation colleagues from the four Trusts have been meeting on a weekly basis in order to share learning and ensure a consistent approach across the APC.

11 Recognition and celebrating success

- 11.1 In mid-August, the third series of Emergency was broadcast on Channel 4. Emergency is filmed across the London trauma system. The third series, which was filmed in July 2022, follows our staff and patients on the major trauma pathway, documenting their stories from pre-hospital care right through to rehabilitation.
- 11.2 Imperial College Healthcare teams and initiatives have been shortlisted as finalists in six categories in the annual HSJ awards. This includes our inclusive recruitment programme (which has also been shortlisted in two national HR awards schemes) and our remote monitoring service for patients waiting for cardiac procedures. North West London Pathology is shortlisted in three categories and we are part of a wider North West London Integrated Care System initiative up for the modernising diagnostics award.

- 11.3 I'm pleased that our end of life care and user insight and experience teams have been shortlisted for two Patient Experience Network National Awards 2024 for a project to understand and improve the experience of patients – and their families - who die in hospital.
- 11.4 Congratulations to our internationally educated nurses team who were shortlisted for three separate awards in the Nursing Times Workforce Awards - best staff wellbeing initiative (IEN buddy programme), preceptorship programme of the year and best international recruitment experience. Winners will be announced Thursday 28 November.
- 11.5 Congratulations to Indy Chahal, lactation consultant, who was presented with a Chief Midwifery Officer award for her dedication and commitment to supporting breastfeeding at the Lindo Wing.

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
1 October 2024

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 Chief Executive's report

The Committee received and noted the updates within the Chief Executive's report.

2.2 Quality assurance report

The Committee received and noted the Quality Assurance report which summarised the key quality exceptions, emerging risks and actions/mitigations. It was noted that there were no issues for escalation that required action or support from the Committee and Committee members noted assurance of the work of the internal governance processes; it was noted that the Quality Committee have oversight of the key quality risks and undertake regular deep dives into areas of concern with the Committee recently having deep dive discussions into improving health equity and infection, prevention and control, both of which are risks on the Board Assurance Framework. The Committee noted that good progress continued to be made with the actions to improve resident doctor experience in response to the NHSE visit in January 2024. The medical director met with the resident doctors on 13th September and Committee members were pleased to note that the feedback was more positive with recognition of the work underway to improve. The main outstanding issue related to operating experience. Regular updates on progress are provided to NHSE with the most recent being submitted on 20th September.

Other key areas of assurance provided to the Quality Committee related to the implementation of PSIRF, incident reporting, serious incidents (including never events), infection control, mortality, user insights and maternity.

The Committee also noted the quality scorecard and risk register.

2.3 Infection prevention and control (IPC) & antimicrobial Stewardship (AMS) Annual report

The Committee received and noted the Infection Prevention and Control and Antimicrobial Stewardship annual report 2023/24. This report had been reviewed and approved by the Quality Committee in September 2024 and would be published on the Trust website.

2.4 Learning from deaths Q1 2024/25

The Committee received and noted the Learning from Deaths Quarter 1 (2023/24) report which had been reviewed at the Quality Committee in September 2024 and would be presented to the Board in Common on 15 October 2024.

2.5 Operational performance report

The Committee received and noted the operational performance report for month 5, noting that both emergency departments continued to perform well for ambulance handover times. 2.2. Of the patients attending our A&E departments in August, 78.6% were admitted, transferred, or discharged within four hours of their arrival (+0.66 percentage points on the previous month). This exceeded our improvement trajectory target of 77.1% for the month and the current NHS objective of 78% performance by March 2025. Committee members noted the continuing work to implement our comprehensive improvement plan focussed on improving, but most importantly sustaining, four-hour performance.

The number of patients waiting for treatment on our elective waiting list has been gradually reducing however it was noted that the trajectory to reduce the number of patients waiting longer than 65 weeks was missed in August 2024. The Trust was pursuing multiple strategies to address challenges facing some specialties, including insourcing/outourcing, additional theatre capacity and weekend lists.

The Committee also noted the continuing work to improve diagnostic and cancer waiting times.

2.6 Finance update and financial recovery report

The Committee received and noted the forecast outturn position at month 5 and the proposed recovery plan to ensure the Trust can continue to signal a break-even position, excluding the adverse impact of industrial action costs.

2.7 People Assurance report

The Committee received and noted the People and Organisational Development (P&OD) Assurance report noting updates against the people priorities, workforce performance, and noting the risks on the P&OD risk register.

The Committee noted the key metrics on the people performance scorecard, the people productivity and efficiency scorecard, vacancies and turnover rates for month 5.

2.8 Equality, Diversity and Inclusion Annual Report 2023/24

The Committee received and noted the Equality, Diversity and Inclusion annual report 2023/24. This report had been reviewed and approved by the People Committee in September 2024 and would be published on the Trust website.

2.9 Health and Safety Annual Report 2023/24

The Committee received and noted the Health and Safety Annual Report 2023/24. The report had been reviewed by the Audit, Risk and Governance Committee in June 2024.

2.10 Responsible Officers Annual Report 2023/24

The Committee received and noted the Responsible Officers Annual Report 2023/24. The report had been reviewed and approved by the People Committee in July 2024 and would be submitted to NHS England by 10 October 2024.

2.11 Anti-racism and anti-discrimination pledges

The Committee received and noted the anti-racism and anti-discrimination pledges which set out the commitments the Trust has made, through discussions between staff and local community groups, to become a truly anti-racist and anti-discriminatory organisation. These pledges had been reviewed and approved at the People Committee in September 2024 and were launched across the Trust on Friday 27 September 2024 as part of the EDI strategic work plan during Gratitude and National Inclusion Week.

2.12 Board Assurance Framework

The Committee received and noted the Board Assurance Framework noting that the recently held Board Committees had reviewed and approved the risks aligned to them. The Committee noted the deep dive discussions that had taken place at the recent Committee meetings and the strategic risks that these were linked to. It was noted that the risk relating to industrial action would likely be reduced at the November People Committee due to the recently accepted offers to resident doctors.

2.13 Research and Life Sciences

The Committee had a deep dive discussion on the National Institute for Health and Care Research (NIHR) infrastructure at the Trust, noting the Imperial Biomedical Research Centre (BRC) structure and case studies. The Committee noted the progress with the Nurses, Midwives, Allied Health Professionals, Healthcare Scientists, Pharmacy Staff and Psychologists (NMAHPP) research, noting the successes in achieving the 2024 milestones as part of the five year research implementation plan including the research training programme for NMAHPPs, but noted some of the barriers to some of this work.

The Committee noted the work to improve health and wellbeing in the North West London sector through digital and data, with research ready curated data available in the same ICHT hosted secure data environment architecture to maximise potential benefits for our NWL patients and communities.

Committee members were pleased to note patient and public involvement and engagement of the NIHR BRC, with 77 recruited and trained community partners and links into the trusts Strategic Lay Forum.

The Committee also received an update on Paddington Life Sciences and the aim, in parallel with the redevelopment of St Mary's Hospital site, to bring together industry, academia, the NHS and local communities in a new life sciences cluster in Paddington, driving improved health and reducing inequalities.

The Committee were pleased to note progress with the Fleming initiative and Fleming Centre plans.

It was agreed that a further discussion relating to research and life sciences at a collaborative level would be helpful and this would be a topic for a future collaborative board development session.

2.14 Board Committee Reports

The Committee received summary reports from the Quality, Finance, Investment and Operations, People, Audit, Risk and Governance and the Redevelopment Committees that took place in August and September 2024. The Committee received assurance that key risks overseen by each Board Committee were being managed appropriately.

3. Positive assurances received

The Committee received assurance that the Trust was compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

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

There were no decisions made by the Committee.

7. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	CEO report	To note	7.	People Assurance report	To note
2.	Quality Assurance report	To discuss	8.	Board committee report – People	To note
3.	Board committee report – Quality & Safety	To note	9.	Board committee report – Audit, Risk and Governance	To note
4.	Operational performance report	To discuss	10.	Board assurance framework	To discuss
5.	Finance report	To discuss	11.	Board committee report – Redevelopment	To note
6.	Board committee report – Finance, Investment and Operations	To note	12.	Strategy - research and life sciences (including Fleming)	To discuss

8. Attendance

Members	July attendance
Bob Alexander, Non-Executive Director (Vice Chair)	Y
Matthew Swindells, Chair, Board in Common	Y
Sim Scavazza, Non-Executive Director	Y
Loy Lobo, Non-Executive Director	N
Nick Gash, Non-Executive Director	Y
Helen Stephenson, Non-Executive Director	Y
Aman Dalvi, Non-Executive Director	N
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
Kevin Croft, Chief People Officer	Y
Peter Jenkinson, Director of Corporate Governance	N



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

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

1.0 Key messages

- 1.1 Preparation for the winter months with a focus on the wellness of our staff and ensuring our pathways are winter ready remains a key priority for our organisation. Planning is underway across all divisions to prepare for high demand this winter. Staff COVID-19 and flu vaccination will roll out from the start of October, with a focused vaccination Wellfest week from 7 October. We have stepped up a wider 'ready for winter' programme aligned to NHS England winter priorities and see this as trust-wide aim.

In August, we led a proactive response to the threat of civil unrest with a planned protest close to our West Middlesex hospital site. The proactive response by our organisation with a number of forums, transport and out of hours support and catering demonstrated the best of our people and communities, coming together to say no to acts of racism. It showed the strength of feeling within our community here at Chelsea and Westminster Hospital and in times of adversity we stand together in solidarity.

This has presented an opportunity to reflect on a broader conversation about our staff and patients feeling safe and welcomed in our organisation. We have launched a new staff-led forum which seeks to examine staff user experience for everyone employed by the Trust - we have also used this period to proactively champion our role as an inclusive workplace aligned to National Inclusion Week.

- 1.2 National Awards and CQC Maternity report – we were incredibly proud to see our Critical Care Outreach Team be awarded winner of the overall Patient Safety Team category at the HSJ Patient Safety Awards and to be featured as best practice in the recent National CQC Maternity report.
- 1.3 Our focus to be a sustainable provider continues with the redevelopment of the Lakeside at our West Mid site. The Green Up project will improve the quality of green spaces at West Mid by promoting accessibility to nature and the outdoor environment. Enhancements to a currently under-used Lakeside area will include new planting, creating accessible pathways and a space for workshops. This will lead to opportunities for patients, staff and visitors to acquire new skills through a participation programme, enhancing wellbeing in the process.

2.0 Quality and safety

- 2.1 We are committed to ensuring there is a continuous improvement in the experiences of our patients, their family and carers and of the quality of care that we provide. To support this we gather information on patient experience from various sources and work with patients, carers and external stakeholders to ensure that the services we provide are responsive to the needs of our population. Our annual 2024/2025 Patient Experience Annual Report 2023-24 provides a vital overview on patient voice involvement and also the progress being undertaken in our organisation over the last year. Significant work has been undertaken across 2023/24 to ensure the process of engaging with patients and it is envisaged that the benefits of this hard work will be seen in 2024/25. The report is included within the Quality section of the agenda at this meeting.
- 2.2 Infections, such as C-difficile are running above thresholds locally, which is consistent with the sector, regional and national picture. It is however a focus for all staff, and additional communications have been cascaded to ensure best practice in terms of infection prevention and control, with a focused 'gloves-off' campaign underway.
- 2.3 Our Trust has been chosen as one of the pilot sites to roll out the national patient safety initiative under Martha's Rule, which we will be launching at the end of this month. As members may be aware, Martha Mills died in 2021 after developing sepsis in a London hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha could have survived had she been moved to intensive care earlier.

3.0 Operational performance

- 3.1 In August 2024, the A&E 4-hour reported performance stood at 82.13%, one of the strongest performers nationally. The Trust met the NHS England Cancer targets for 31-Day and the 28-Day Faster Diagnostics Standards in July 2024.
- 3.2 Operational teams remain focused on expediting long- waiting pathways and enhanced oversight and targeted interventions continue for at-risk specialities: Trauma and Orthopaedics, Colorectal Surgery, Plastic Surgery and General Surgery. Elective Referral to Treatment (RTT) 18-week wait performance remained challenged in August 2024, standing at 62.74%. Elective admitted and outpatient activity levels in August are above operational plans. For August 2024, the total RTT Patient Treatment List (PTL) increased to 62,132 (+882), 52ww decreased to 963 (-112), 65ww decreased to 113 (-67) and 78ww decreased to 5 (-12) and are on track to deliver in line with the trajectories set.

4.0 Finance and estates

4.1 Finance:

The financial position remains challenging for the Trust. At month five, the Trust is reporting a £2.8m deficit, which is £2.1m adverse variance to plan. This is largely driven by cost improvement plan (CIP) slippage of £1.3m, increased registered mental health nurse (RMN) spend, increased medical pay, the funding gap for the West Middlesex Urgent Treatment Centre and general non-pay increases/inflationary pressures.

Elective recovery fund (ERF) performance is over-performing (141% delivery against the 2019/20 baseline vs 117% planned) which will be offset against additional costs.

Additional controls have been implemented, which include non-pay controls, escalated sign off processes for additional waiting list initiatives, a reduction in agency staff and all divisions are working up recovery plans to get back to budget. The forecast for a break-even position at year end remains, with a focus on ensuring this is achieved.

The year to date capital spend is £17.1m against a plan of £21.4m and a full year forecast of £72.6m. The variance is due to timing differences between the plan and actual programmes. The largest programmes in 2024/25 are the Ambulatory Diagnostics Centre, the Treatment Centre and Neptune Ward refurbishments along with IT and Medical Equipment replacement programmes.

4.2 Site Developments

Our newly refurbished Therapy Outpatients Department at the Chelsea Hospital re-opened after six months of building works to create the new facility. The department features a new and improved hand therapy area, rehabilitation gym, consulting spaces for pelvic health and musculoskeletal physiotherapy and a burns therapy area – with all care delivered by our outpatient physiotherapists and occupational therapists.

Ambulatory Diagnostic Centre – in July we held a ground-breaking ceremony at West Middlesex University Hospital, marking the start of building works for our new £80m Ambulatory Diagnostic Centre (ADC), which will improve diagnostic and treatment times within our local community. This £80m investment is the largest capital project that the Trust has ever run. The ADC is expected to drive significant growth in activity over the first decade from its opening with a 43% increase in elective diagnostic capacity. This expansion will translate to approximately 67,000 additional imaging scans, ensuring timely and efficient diagnostic services for patients.

5.0 People

- 5.1 Dr Iain Beveridge, Hospital Medical Director at our West Mid site has stood down from his role as Medical Director. Iain initially joined the Trust as Registrar then returned as a consultant in Gastroenterology and was particularly supportive during the merger between our two hospitals. Iain will remain with the Trust, continuing to provide outstanding care as a part-time Gastroenterology Consultant. Thank you Iain for the leadership you have shown over the past 30 years.

6.0 Equity, diversity and inclusion (EDI)

- 6.1 National Inclusion Week –to mark the week we held several events with a focus on in-person activities to ensure more face to face engagement and listening events with our staff. Our EDI team held a cross-section of interactive webinars for all staff to attend, including some hosted by Inclusive Employers. We also shared personal stories from numerous staff on what inclusion means to them in the workplace- we shared a number of compelling stories of staff in their words.

- 6.2 Shameema Ali, Senior Communications and Engagement Manager, has joined a national independent taskforce to address the lack of diversity in NHS communications across England. The taskforce has been established by the NHS Confederation, NHS Providers and the Centre for Health Communications Research, as published in PR Week this week. Well done to Shameema for your involvement in addressing and improving diversity in NHS communications and for representing our organisation.
- 6.3 Dr Natasha Singh, Consultant Obstetrician at Chelsea and Westminster Hospital and Emer Delaney, Director of Communications at the Trust, met with women from the Muslim Women's Association in a Hounslow mosque, to give health advice regarding type 2 diabetes. They also heard from the local community who shared their view on effective health communications and how we can better support their needs.

7.0 Research and innovation

- 7.1 Jonathan Valabhji, Clinical Chair in Medicine and Consultant Diabetologist at the Trust, has led research published in the Nature Medicine journal. The paper explores the burden of diabetes-associated multiple long-term conditions on years of life spent with illness and on life expectancy, both at an individual and community level. The paper highlights the need to prioritise effective prevention and management approaches to multiple long term conditions.

The Lancet Diabetes and Endocrinology journal, finds that intensive lifestyle interventions that include a period of total diet replacement can lead to remission of type 2 diabetes. The study found that almost a third of participants receiving the intervention in real-world settings within the NHS put their type 2 diabetes in remission, results of which have received widespread coverage nationally.

8.0 Recognition and celebrating success.

- 8.1 CQC National Report on Maternity- our maternity services were recognised in the latest national CQC report on maternity services for best practice, showcasing a number of initiatives led by the service, such as the Telephone triage staffed by midwives. The service was also recognised for the 12 maternity cultural safety champions. The purpose of the cultural safety champions was to address inequalities and improve equity for staff and people using services with protected characteristics. The champions delivered cultural safety training as part of yearly mandatory training. Finally the adoption of a board safety champion was highlighted, mentioning the open forums run both virtually and in the maternity unit regularly to gather feedback from staff and listen to their concerns or queries.
- 8.2 Our maternity team at West Middlesex University Hospital featured in a photography editorial in The Times on International Day of the Midwife. The award winning photographer James Kent shared the moments of his daughter's birth at West Middlesex Hospital in 2020. The article titled 'It takes a village' highlights the multi-disciplinary team of healthcare professionals, including midwives, Operating Department Practitioners (ODPs), anaesthetists, obstetric surgeons and nurses who work together to bring life into the world, and shares some of their own personal stories. These photos were recently

displayed in an exhibition at West Middlesex hospital which was opened by the Chief Midwife for London.

- 8.3 National Patient Safety Award- Our Critical Care Outreach teams won the Patient Safety Team of the Year award at this year's HSJ Patient Safety Awards. The Critical Care Outreach Team, Advanced Clinical Practice won for its impact in improving the recognition and escalation of deteriorating patients (REDP) in the adult in-patient wards. The REDP project supports early recognition and escalation when a patient's condition is deteriorating, helping to increase the chances of survival and recovery. This award is testament to the incredible work that the entire team is doing to support vulnerable patients, taking the initiative to make early, lifesaving interventions.
- 8.4 Ganesh Sathyamoorthy, Assistant Director for the National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) has been nominated for a National BAME Health and Care Award for unsung heroes from ethnic minority backgrounds. This category recognises individuals who have made a huge impact in securing a community development beneficial to the local ethnic minority population through working directly with other agencies.

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
October 2024

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. Chief Executive's report

The Chief Executive presented the report, which is provided in full to the BiC. The CEO also updated on the on the Trust's Leadership Summit, held in late September, which included approximately 150 leaders from medical, nursing, operations, and corporate leadership teams.

In addition, the CEO commended the work of surgical and wider staff teams who oversaw 59 robotic surgery cases over one weekend in late September.

Members were also updated on the work in addressing the non-Referral to Treatment (RTT) waiting list, which is progressing well.

2.2. Integrated Quality & Performance report (IQPR) – August (M5)

The Committee was updated on the overall positive operational performance: Reductions in the longest waiting patients, noting achievement of the milestone of zero 78-week waiters (ww) at the end of September, and the trust is on track to reduce the 65-ww to zero by the end of December.

Improved performance in relation to the A&E four hour wait standard was welcomed (82.1% in August; 80.8% August year to date (YTD)), however the continued challenges from September onward were noted, with demand remaining high.

Cancer 31-day and 28-day Faster Diagnosis Standard (FDS) were achieved in July and July YTD, 62-day achieved 82.4% in July vs. the 85% target.

Summary Hospital-level Mortality Indicator (SHMI) at 70 (vs. Standard of 100) for August YTD, indicates that the Trust is one of the safest Acute Trusts nationally.

Diagnostic performance continues an upward trajectory in line with the additional capacity put in place to recover the position.

2.3. Quality Report, including Committee Chair's Report and Annual Reports

The Committee heard about the positive progress in delivery against the quality priorities in quarter one (Q1) 2024/25.

Infection rates were noted as above threshold currently, with actions and campaign activity in place to address this.

The Committee was advised of and welcomed the rollout of Martha's Rule as part of a national pilot, which through improved engagement with families and carers should result in better care and outcomes for patients.

The Committee received the Q1 Maternity Quality and Staffing Report and noted the following:

- Both sites maintained their CQC ratings following the February 2024 inspection (Chelsea – Good; West Mid – Outstanding). All 3 CQC 'Must Do' actions are complete; of the 14 'Should Do' actions 10 are complete and 4 are on track.

- The Maternity Single Delivery Plan was launched in March 2023, status: 26 actions compliant; 16 partially compliant with action plans in place; 1 non-compliant with plan in progress.

- Saving Babies Lives Version 3 (SBLv3) had seen significant improvement in compliance now at 91% with an action plan in place to be fully compliant by March 2025.

- The Trust was on track to be fully compliant for Maternity Incentive Scheme (MIS) Year 6 by the end of March 2025. Of the 10 actions 4 are compliant, 6 are partially compliant with plans in place to achieve compliance by the deadline.

- The Committee was pleased to hear that both hospital sites were re-accredited under the Baby Friendly Initiative (BFI) which supports breastfeeding and parent infant relationships.

- The CQC National Report on Maternity recognised the Trust's maternity services for several areas of best practice for example: the Telephone triage staffed by midwives; the 12 maternity cultural safety champions to address inequalities and improve equity for staff and people using services with protected characteristics; the adoption of an Exec and NED board safety champion was highlighted, mentioning the open forums run both virtually and in the maternity unit regularly to gather feedback from staff and listen to their concerns or queries.

The Committee noted the following reports, which had been considered in detail at the September Quality committee meeting:

- Patient Experience 2023/24 Annual Report
- Health and Safety 2023/24 Annual Report

2.4. Finance Report, including Committee Chair's Report

The Committee was advised that the Trust is reporting a year to date (YTD) deficit of £2.8m, which represents a £2.1m adverse variance to plan.

While Cost Improvement Programme (CIP) delivery was reported as £1.3m behind plan YTD, there has been further improvement in the identified position since M4 and the forecast is to deliver the Trust's £23.5m CIP plan for 2024/25.

The key drivers impacting the YTD deficit position were the costs of industrial action, the West Middlesex Urgent Treatment Centre (UTC), escalation beds remaining open in Q1, registered mental nursing (RMN) increase and non-pay inflation above the funded levels.

The benefits of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) and prior year over-performance were helping to mitigate the adverse position, along with elective recovery fund (ERF) performance at 141% YTD significantly above plan of 117%.

In summary, the 2024/25 full year forecast remains unchanged at breakeven, assuming external funding for industrial action costs (£1.1m). It was however noted as a challenging position, with focus on recovery and reducing the run-rate a priority.

2.5. People and Workforce Report, including Committee Chair's Report and Annual Reports

The Committee considered the latest report which showed that there has been a sustained reduction in turnover rate (at 11.4% is the lowest since September 2021).

The vacancy rate was reported at 6.1% (within 10% target and lowest within APC) and core training at 92% (above 90% target), with the new Learning Management System recently launched to further drive improvement.

The areas cited for improvement were personal development review (PDR) compliance which continues to sit below target and achievement of the Model Employer Goals (MEG) regarding increased diversity at senior leadership levels.

The People and Workforce Committee (PWC) Chair added that they had sought further assurance on improvement in these areas, with fewer details on new initiatives and focus instead on the actions that would move both in the right direction.

The Committee approved the following reports, which had been considered in detail at the September PWC meeting:

- Workforce Race Equality Scheme 2023/24 Annual Report
- Workforce Disability Equality Scheme 2023/24 Annual Report

2.6. Audit and Risk Committee (ARC) Chair's Report

The ARC Chair provided a summary of the August meeting, noting there were no issues to escalate to the Committee.

The ARC Chair and the Trust Vice Chair gave a verbal update on the ARC meeting held earlier on 2 October. The Committee noted the update.

2.7. Board Assurance Framework (BAF)

The BAF for Q2 was reviewed, noting that each Committee has considered their respective elements of the BAF, with the Audit and Risk Committee reviewing the full BAF.

There was no movement in scores between Q1 and Q2.

The Committee was updated on the planned updated format, with a one-page summary of all BAF risks and charts tracking risk movement over the year. The new template will be used for Q3. It was also noted that there will be a wider review of all risks in light of the now agreed trust clinical strategy, and consideration of risk tolerance and appetite levels.

2.8. CWFT and The Hillingdon Hospitals NHS FT (THHFT) Partnership

The Committee considered the proposal for closer alignment between the Trusts and approved the recommendation of the NWL APC BiC Cabinet.

The recommendation will also be considered for approval at the THHFT Standing Committee and at the October NWL APC BiC.

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

There are no key risks from this report which require escalation to the BiC, however the challenging financial situation was noted and the risks as the Trust heads into the winter months given current and anticipated operational pressures.

4. Concerns outstanding

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

5. Key actions commissioned

None specifically, however a request to review and refresh the BAF, and to do this in line with fellow APC Trusts was noted, including a review of risk appetite and tolerance levels.

6. Decisions made

To approve the recommendation regarding the CWFT and THHFT Partnership.

7. Summary Agenda

The agenda for the October meeting of the Standing Committee was as follows:

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Chief Executive's report	To discuss	5.	People and Workforce Report	
				Board Committee Reports: Workforce Race Equality Scheme Report Workforce Disability Scheme Report	To approve To approve
2.	Integrated Quality and Performance Report	To discuss	6.	Board Committee Report – Audit & Risk	To discuss
3.	Quality Report	To discuss	7.	Board Assurance Framework	To discuss
	Board Committee Reports: Patient Experience Annual Report Health and Safety Annual Report	To note To note			
4.	Finance Report	To discuss	8.	CWFT and THHFT Partnership	To approve
	Board Committee Report – Finance & Performance				

8. Attendance

Members:	October attendance
Steve Gill, Vice Chair and Senior Independent Director (SID) - Chair	Y
Matthew Swindells, Chair in Common, NWL APC Chair in Common	Y
Patricia Gallan 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
Aman Dalvi, Non-executive Director	Y
Dame Helen Stephenson, Non-executive Director	N
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
Lindsey Stafford-Scott, Chief People Officer	Y
Sheena Basnayake, Hospital Director (West Mid - WM)	Y
Laura Bewick, Hospital Director (Chelsea - CW)	Y
Natasha Singh, Board Adviser, Equality Diversity & Inclusion (EDI)	Y
Emer Delaney, Director of Communications	Y
Peter Jenkinson, Director of Corporate Governance	N
Chris Chaney, Chief Executive Officer, CW+	Y
Attendees:	
Faye McLoughlin, Corporate Governance Officer	Y
Marie Price, Deputy Director of Corporate Governance	Y
Alexia Pipe, Chief of Staff to NWL APC Chair in Common	Y

11. REPORTS FOR INFORMATION ONLY

Nil Advised

12. ANY OTHER BUSINESS

Nil Advised

13. QUESTIONS FROM MEMBERS OF THE PUBLIC



Matthew Swindells

The Chair will initially take one question per person and come back to people who have more than one question when everyone has had a chance, if time allows.

14. CLOSE OF THE MEETING

Date and Time of the Next Meeting: 21 January 2025 - W12 Hammersmith Hospital